

Narrateur

REFLECTIONS ON CARING



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

ISSUE ONE SPRING 2012

Narrateur

REFLECTIONS ON CARING

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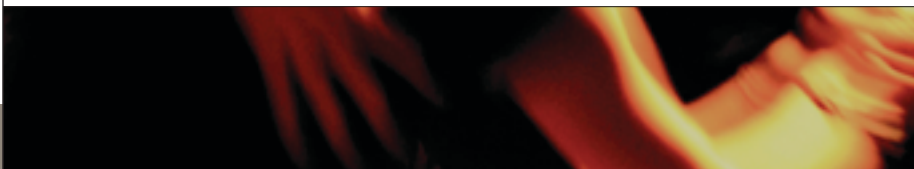
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On Acceptance

There is something extraordinary about beginning a new medical school with the birth of a literary journal. The stories that are shared in this first issue will reflect the merging of a new teaching model with the most basic values of doctoring that are critical in shaping a learned, self-reflective, intuitive physician. Writing and reflecting on our experiences with patients and colleagues will teach us how to listen and how to respond in ways that are meaningful and effective for those we are entrusted to heal.

Many in our first class of 40 students have shared their experiences in the form of prose, poetry, photographs and artwork. They are humbled by their lessons and excited about the opportunity to share new ways in teaching – and learning. They are tomorrow’s physicians, who are already reflecting on what it is like to start working with patients at the first bell. To hear their patients’ stories and write their own. To learn by doing. To understand by writing. To know that by accepting entry into the first class of a new kind of medical school they are pioneers in their own right.

This journal is dedicated to our students and their teachers, and to the hope that we have found a better way to create doctors who understand the narrative and what it means to the healing of their patients and to the stories they leave behind in the practice of medicine.

LAWRENCE G. SMITH, MD
Dean of the Hofstra North Shore-LIJ School of Medicine

From the Editor-in-Chief

Some of the best moments in life arrive by surprise, and the creation of this literary journal is one of them. I spent a few decades at a newspaper (*Newsday*) covering medicine and science. I believed listening was part of my job; It allowed me to help people understand their stories. Listening is a great strength, not just in writing but in life.

I deeply appreciate this opportunity to listen to the stories of the first generation of medical students and the faculty of the Hofstra North Shore-LIJ School of Medicine. I hope that people reading the narratives and looking at the incredible photos and artwork in this literary journal will be inspired to think about their experiences with illness and healing...and begin their own journey of creative self-expression.

JAMIE TALAN

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	<i>Milton Masur, MD, is an internist and painter in Roslyn Heights.</i>	

"Go Away"

was her silent warning:
her eyes warded off my exam
as a lighthouse repels the wayward ship—

beams of blue iris light
traversed the ocean of the exam room
to warn of disguised rocks
beneath a falsely docile sea

still I set out, a novice captain
at the helm of my stethoscope
well-equipped to handle those waters
but ill-prepared.

The rough and uncertain water
yielded to my skill
as I navigated ears, lungs, belly,
guided my exam through rapids and currents

but still the ward portrayed
the mighty sea's mistrust;
though I examined her with confidence
her stare pierced through my short white coat

and the beacon of truth
that exposed my naked inexperience
was not a timeless monolith
but a little blue-eyed girl, aged 3 years.

*Daniel Ohngemach
is in the inaugural
class of the Hofstra
North Shore-LIJ
School of Medicine.*



Lights of Shadow

Ankur Parikh

*Ankur Parikh, MD, is a radiologist at the North Shore-LIJ
Health System.*

Calm, Cool and Cholecystectomy

On the first of December I sprang out of bed excited about the opportunity to observe the surgery of a patient I had the pleasure of getting to know very well during my clinical experience. I arrived at the hospital with a smile that was too wide for the seriousness of the situation, but the excitement was too much to subdue. I was happy to see my patient in the preoperative room and I greeted her and assured her that I would be there for her every step of the way.

Waiting to go into surgery, I paced. The clock could not tick any slower. I felt the anticipation building as if it were my first time going into the operating room. I don't know why things were different this time. Perhaps it was the fact that I had been able to build a physician-patient relationship with her before the surgery. I couldn't seem to shake the butterflies in my stomach, which were vividly comparable to those that plagued me on the mornings of important track and field competitions. Despite my anxiety and excitement, I appeared as calm and confident as Michael Jordan in the dying seconds of a close NBA finals game.

I found my preceptor in the hallway outside of the operating room. We were talking as the anesthesiologist and nurse came toward us with my patient. My preceptor turned to the patient and said, "Look who I found!" Her eyes sprang open and she screamed, "Ace!" I have never seen a patient as ecstatic as she was, especially considering she was only minutes from surgery. Her reaction was a bit strange to me considering we had already spoken earlier. I remember thinking that her exaggerated response might be solely attributable to the drugs that the anesthesiologist had administered, as opposed to genuine excitement over seeing me. Nevertheless, I cherished it as a special moment that I will always remember. Her reaction in itself was enough to send me home with a smile on my face; as far as I was concerned, the day was already a success.

Shortly after our patient was prepped for surgery, my preceptor and I scrubbed in. My arms outstretched to nurses holding sterile jackets, I slipped into the blue fabric and it felt as if I were stepping into the suit I wore for my interview for medical school. It is not about the suit or the gown but about the events that will unfold once those garments are on. You are never certain what to expect. I

knew that once I was suited up, the uncertainty had to be overpowered by confidence. Having the gown and gloves held open for me was the icing on the cake. They helped me transition to my usual mentality, that of a performer who thrives under pressure. I felt that this patient was as much my responsibility as my preceptor's. I was ready to rock and roll!

You see, this patient's story is especially poignant for me because I had been the one to diagnose her cholecystitis; to be there at her preoperative consultation; and now to be standing in the operating room for her case. Having the opportunity to follow the patient from the beginning to the end of her care was, and still is, amazing to me. I was caught up in the thought when, to the right of me, I heard my preceptor's voice.

"Here," he said, handing me the scalpel. "Make the incisions." I reached for the scalpel and proceeded to follow his every instruction. I made the incisions, inserted the trocars, and used the laparoscopic graspers to mobilize the gall bladder and provide traction as he moved in to dissect out the cystic duct and cystic artery. He called it the "critical view of safety" to make sure that we were cutting and clamping the right duct and vessel. At this point, he did what I never thought would happen in my wildest dreams.

"Switch sides with me," he said. He wanted me in the driver's seat. I slipped carefully to the other side of the table and he moved to where I had been standing. He guided me as I clamped and cut both the cystic duct and cystic artery. Separating the gall bladder from the liver then became my new objective. I began to appreciate the intricate hand movements and pedal electrocautery involved in the process. Meanwhile, my preceptor held traction on the gall bladder for me. Just as I slowly started to feel more comfortable, my focus was broken momentarily by a surprised "Wow!" that cut through the silence like a knife through soft butter.

"These kids and their Nintendos," the nurse joked. She was shocked that I was doing so well and jokingly attributed my success to the video games I played as a child. The laughter subdued the little timidity I had left. After freeing the gall bladder from the liver, I took a few moments to cauterize bleeding on the liver bed and I pulled the gall bladder out of her umbilical incision. I must have looked intense and focused, but under my surgical mask I was

smiling so widely that my cheeks were burning.

I could not believe how happy I was that I was able to do what I did. My preceptor did an amazing job of teaching me and walking me through the procedure.

“You have some really good skills,” my surgery preceptor said, “There are some residents, chief residents and even some attendings who don’t have the touch that you have. You have potential to be something special.”

I will never forget his words and his generosity for as long as I live. And I will always find it easy to conjure up my patient’s beaming smile when she saw me on her way into surgery.

Asaph Levy is in the inaugural class of the Hofstra North Shore-LIJ School of Medicine.

Diagnosis: Left Breast Cancer
Procedure: Bilateral Mastectomies
Latissimus Flap Implant Reconstruction

Ron Israeli, MD, is a plastic surgeon specializing in post-mastectomy breast reconstruction and creates life cast sculptures of his patients. He is a co-founder of BreastReconstruction.org, a resource for women with breast cancer, and an attending physician at North Shore University Hospital and LIJ.



Restored

RON ISRAELI

“It wasn’t until I was physically healed that I allowed my emotional self to emerge. That’s when it all hit me... part of me was gone, yet I was fortunate to be made to feel whole again, in body and spirit, with the help of my amazing support system. Some say I am better than before!” *Patrice, age 52*

First Night on Call

In my third year of medical school I was assigned my first rotation on the ward. It was internal medicine. More precisely, it was Ward A2 of the old Bellevue Hospital. It was a 25-bed open ward and the only patients were women.

On my first night on call I met my resident team and the attending physicians. I found my bearings easily and was quickly oriented to all the patients on the service. Then I was told that the first night on call would be mine and that I should be prepared to stay in the hospital overnight. I should be ready, one of the attending physicians said, to present any new admissions in the morning. I was eager. I was ready for the night.

I worked closely with one of the interns and we handled several emergency admissions. One of these ER admissions was assigned to me as my primary patient. Hours later, after we finished the work on the floor, the intern looked up at me from one of his charts: "Go back to the call room and get some sleep. You never know when we will be called again."

Adrenaline was coursing through my body. Sleep? I wondered. How on earth could a medical student sleep when there was so much to do in the hospital? I went back to the call room and sat on the bed. Sleep was not even close. I stood up and walked out of the call room with a thought to go check on the women of Ward A2. I found myself instead carefully maneuvering my way to the Medical ICU, which was not an easy shot. The ICU was several buildings away. Our team had one patient in the ICU. I headed to the ward to find her.

It was the middle of the night. I entered the back door of the ICU and scanned the beds and the names on the charts. I stood at the bedside of one very old woman, our team's patient. She appeared to be sleeping easily. I stared at her body, hoping that my presence would not wake her. She seemed extraordinarily still.

The light from overhead cast a dim light on her body. I looked at her chest and could not see any respiratory movements. I glanced at the cardiac monitor and it appeared to show no EKG evidence of a heartbeat. I walked to the side of the bed and put my hand on her throat. I searched for her carotid pulse. I pushed down on her sagging pale skin. I held a firm touch and still could not muster a pulse.

While she remained extraordinarily still, I become extraordinarily anxious. I knew that I had not felt a carotid pulse on an earlier admission, and that person had been talking to me at the time. I certainly knew that my not feeling a carotid pulse did not mean a patient was dead. Maybe I was just in the wrong vicinity of the carotid. Maybe the pulse was too quiet to feel.

I stood by her side with my eyes fixated on her chest. I saw no signs of life in this patient. I wondered what I should do next. There was a cardiac arrest call button next to her bed. That red button looked so ominous. I knew that if I reached over her body and pushed that call button doctors from all over the hospital would descend on this bedside. If the patient was rattled by the commotion and sat up startled and confused, I would be permanently humiliated for having inappropriately called a cardiac arrest. Whatever my choices, neither option was good.

I inhaled a few more anxious times and reached for the button. Alarms went off. I stood looking over my patient, waiting for some sign of life. Meanwhile, nurses were on top of her. They seemed a bit startled to see a medical student on the unit, especially one who had sounded the alarm igniting a response team for a cardiac arrest. Then, residents from many floors and many wings arrived and there was quite a ringside crowd. The senior resident did the same pulse searching and came up empty. But his skill led him to a singular conclusion: The woman was dead.

They attempted resuscitation but it was unsuccessful. When the senior resident finished his documentation on the case, the residents drifted off to other work. Some went back to their call rooms to sleep some more. I stood there, once again alone at the bedside in this quiet ICU. I looked down at my crisp, clean white coat and felt a bit like a fraud.

How, I asked myself, could I call myself a doctor – even a student doctor – if I couldn't make the most basic of all diagnoses: Is my patient alive or is she dead?

Something BIG happened to me that night on the wards. For me, that is where it began; where I started my journey to become a doctor.

Lawrence G. Smith, MD, is the dean of the Hofstra North Shore-LIJ School of Medicine.

Why Am I Here?

With aching feet and nimble fingers
dampened by stress and labor
heightened senses actively monitor.
We came as we were called to do.
Why am I here?

Intuitively questioning the status quo
as we frequently question ourselves.
Do others see what we see
or are we in this alone?

Can we free ourselves enough to heal
between the noise, the lights, the smells?
Do I know you enough to see you?
Do you even know I am here?

Others have finished their work, yet
I've held but two hands today.
Can I finish what's left or forget something too?
I am frustrated, still wondering,
why am I here?

Can I nurture you, care for you,
or make just make this one moment better?
Who are you really and
is this what you wanted?

I know you are scared, I know you're in pain.
I've done everything I can.
What's needed is time, just to hold your hand
as I've done over again.

I must leave you now to document our day
or all might be for naught.
I'll be wondering, though,
will you be okay through the night?

Your face relaxes as I make my last tuck.
Is that a smile I see?
Oh, yes, as you reach for my hand,
It is clear to me now that this is simply
why I am here.

*Lynn E. Johnson, RN, is a certified
nurse midwife and nurse practitioner
at the North Shore-LIJ Health System.*

On Receiving Bad News

There is just this second and inside you wait forever
But time has stopped in this instance
The halt of your blood cools your skin
Your mouth collapses atop rattling teeth
Just a moment
You name it like a spider on the wall
Still the fear buckles your knees
The memory of what you thought your life would look like, a wet sponge
waiting to be wrung out.

*Melissa A. Affa is an
administrative assistant
at the North Shore-LIJ
Health System.*



Missionaries Crossing

Part of the Frederick Smith family archive.

Hands with Long Surgeon's Fingers

"Hands with long surgeon's fingers" was how my mother described mine, pretty early on. Maybe that was the root of my boyhood desire to become a doctor. Or maybe it was the novel about the missionary doctor who descended solo in his Piper Cub into African forest clearings, predictably outdid the local shaman in healing, and converted the local villagers to Christianity before takeoff.

This airborne medical hero seemed more self-sufficient and adventurous than my own missionary parents, who reached their preaching destinations in more plodding fashion: by horseback, if heading for an indigenous Guambiano hamlet on a mountain slope in Cauca; by pickup truck to any hot valley town in Huila or Tolima that had a passable road; by motorboat to Pacific fishing villages north of Buenaventura; or as mere passengers in a cargo-plane, sharing space with pigs, sheep, and chickens and their keepers, to Florencia, the capital of Amazonian Caquetá. The 10-year-old novel-reader – whose trumpet hung next to Mom's accordion on the trailing donkey, ready to accompany the hymn-singing in a one-room-school/worship hall that night – had no idea that the courage of his parents at least equaled that of his central-African paragon, nor that they and their five children daily shared huge physical risk, living and traveling in the provincial hotspots of 1950s la Violencia. (Three hundred thousand Colombians died in the partisan civil war; a few of my parents' local associates were directly targeted as subversive converts to the evangelical faith the *extranjeros protestantes* offered as the perfect antidote to the superstitions, alcoholism, wife-beating, illiteracy, exploitation, and dysfunctional poverty they saw in those remote spaces.) So, my nightly prayers included a request to become, one day, a missionary-doctor-pilot in Africa.

I went on my most memorable missionary trip when I was 15: a 10-day horse-trail circuit with my father to visit a number of widely scattered small churches he had helped nourish among Páez *indígenos* in Tierradentro, in the upper reaches of the Andean *cordillera central*, beyond road's end. In one school/worship hall, after putting my trumpet down, I couldn't take my eyes off a young woman who was

breast-feeding her infant. In another village, we visited the hut of a man who was dying. The African missionary-doctor might have carried a healing satchel, but we did not; Dad's prayer could not expunge the smell of death in the heavy air. Eros and Thanatos double-punched my child's faith, and I silently carried a lonely dread and guilty emptiness for the rest of the trip. The faith got refashioned – though it was not strong enough to withstand the onslaught of philosophy and anthropology (even) at evangelical Wheaton College. The prayers to emulate the missionary-doctor-pilot stopped.

I got my B.A. in history (taking one obligatory science course – in general biology, all taxonomy in 1962 – I believe there was a single paragraph on nucleic acids), accepted a free foundation ride through one year of divinity school, attended marches against the Vietnam War, and took a job with IBM in lower Manhattan, where I was trained as a software sidekick for salespeople marketing the company's new OS-360 computers, the first large commercial application of multitasking machines. I met my wife there; was shocked when my application for conscientious objector status was accepted by my draft board; and began some preparatory volunteer computer job training and placement in my Lower East Side neighborhood, until my 1970 lottery number proved too high for compulsory assignment to "civilian service." After being robbed a couple of times, I moved from East Second Street and Avenue C to the west sixties and held a series of computer jobs in the financial district.

I was restless. I had grown up with the idea that everyone had a divinely intended life vocation, and computer software obviously wasn't mine. I read *Mother Earth News* and *The Whole Earth Catalog*, bought two hillside acres from a farmer-friend in Bovina Center in Delaware County, built a one-room cabin, and (not being a pot-smoking hippie like my younger Woodstock-initiate/carpenter sister and her commune-mates) fantasized about a cooperative farming life. During the Watergate hearings, I told my wife about my interest in lawyering.

One evening in the summer of '74, having been in bed sick all day, I happened to watch a TV show about the need for medical care on a South Dakota Sioux reservation. I was inexplicably moved, and the thought formed in my mind: "Why not become a doctor?" Mercifully, my wife didn't laugh at me. I spoke to the premed adviser at Hunter College across town and enrolled in night science courses there for the next two years.

Before long I was traveling to med school interviews, aware of my 1-in-3 chance of acceptance (maybe less as an "older applicant"). The most probing interview was at Downstate. The professor was an almost-retired, white-mustachioed family practitioner who seemed skeptical about how much I could contribute when I graduated from medical school at 35. I provided the usual generalities about using science to help people; blah-blah-blah. He wasn't buying it. "What was the actual prompt to your decision to change your career at 29?" I foresaw only embarrassment if I told the truth, but Mom and Dad had pretty deeply inculcated the damnable consequences of lying. So I told him about the childhood dream and about the TV show about Sioux healthcare. He sat back, relaxed into his native avuncular persona, beamed, and exclaimed: "That's it!" I knew I was in; and that's where I went. A child's prayer partly answered.

(Thank you, God, for ignoring the pilot thing. The fingers enjoyed holding retractors so the eyes could widen at the marvel of billowing lungs; but the brain lacked the temperament to cut. The 4-O conscientious objector trained and worked with veterans at the NYVAMC for eight years. And no, I've never been to Africa.)

Frederick Smith, MD, directs the bioethics consultation service at the North Shore-LIJ Health System. Before doing these consults, he spent 30 years in primary care, geriatrics and palliative medicine.

What the Intern Saw

I

He saw a face swollen beyond ugliness
Of one who just a year ago
Was Adonis
Practicing routines of rapture:

A boy who could appear
To dodge the touch of time,
Immortal or immune—
A patient in a gown,
Almost gone.

II

In the beautiful school of medicine
He read about human suffering,
An unendurable drama
Until the screen of anaesthesia
And penicillin's manna.

But now, in myriad sheets
Of storefront glass refracting evening's
Razor blue, in a land of the freely
Estranged from the dead, he meets
That face and fear seizes his body.

III

His feet have carried him to bed.
He thinks he must be getting old
To so revise
His nature and his plan.

He shuts his eyes
And in his sleep he sees a gleaming bar,
The shore of pain.
It isn't far.
People live there.

*From Temples and Fields by Phillis
Levin (University of Georgia Press,
1988); also published in Poets for
LIFE: 76 Poets Respond to AIDS
(NY: Crown, 1992)*

*Phillis Levin, professor of English and poet-in-residence at Hofstra
University, is the author of four books of poetry, most recently May Day
(Penguin, 2008), and editor of The Penguin Book of the Sonnet (2001).*

Duet

Jacobi Medical Center, 5 West

Sounds from the eight-bedded room, unmistakably operatic:
“Caro Mio Ben” (my dear beloved, by Giordani?!)—

Heavenly, almost otherworldly strains draw me into the usually silent ward.
 Ruth, our “sarcoma patient,” recently diagnosed at an advanced stage,
 No apparent family and
 Frighteningly quiet until now.

Ashamed of shying away, afraid of my own vulnerability—
“Credimi almen” (believe me at last), her brilliant soprano stuns me.

Returning her cries for help I answer her in kind,
 With a kindness from deep within me,
 A place forgotten yet not still, not silenced.

“Il tuo fedel” (your faithful one), my heart, my mezzo allows.
“Cessa, crudel” (cease, cruel one), her crescendo implores
 The disease that controls her once-towering frame
 (Met photographs trace an illustrious career).

“Tanto rigor” (so much punishment), indeed.
 Narcotics provide only temporary relief from her necrotic postoperative
 state.

“Sebbe crudele, mi fai lan guir” (tho’ not deserving Thy cruel scorn),
 Without question, only admiration
 For your talent, bravery, and strength after decades of suffering.

“Sempre fedele ti voglio a mar” (ever unswerving Thee only I love)
 From so deep a place it shudders my soul.
 I know you will cross over surely and safely, and I will care for you,
 With you, each day I will answer your call.

Jill M. Rabin, MD, is professor of obstetrics and gynecology, chief of ambulatory care and head of urogynecology at LIJ. She is in training to become a cantor.

NARRATEUR



Watkins Glen

MARIA RUGGIERI

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

ISSUE ONE SPRING 2012

Arigatou

In my third year of medical school, my resident asked me to pronounce one of his patients who had just expired. In a nearby stairwell, I pulled out my “pronouncement checklist” and rehearsed the lines like a seasoned actor trying to be a seasoned doctor. When I entered the room and moved to the bedside of the lifeless patient, the sheet taken up only to his shoulders, I watched an elderly woman sitting in a chair at the other side of the bed. Her sky blue head scarf was tied neatly under her chin and her tiny, pale blue eyes peered at the body through heavily wrinkled eyelids. She sat still like a cat, staring, while I went through my checklist, out loud. I shined a penlight in the patient’s eye and saw what looked like the eye of a fish. When I got to the bottom of the list, I proclaimed the patient dead. I had not met him in life. I hesitantly mumbled the date and time of death.

“I’m sorry,” I said, looking at the old woman in the chair. She held her gaze and said nothing.

It is now five years later and I am a senior medicine resident. I have clocked thousands of days in the hospital and still I can’t shake thoughts of this man. I wonder what he saw through that eye in that very moment before his visual cortex ceased to fire. Was it the image of his children laughing, or his wife in a cotton summer dress like the one in the photo, or perhaps the view from his front porch he had grown to love over the past 60 years? Had he known the end was close? Had he fulfilled everything on his living checklist? Did he, in the seconds before he took his last breath, blink his eyes one last time, see his wife? Did she say anything? Move closer? Touch him? Or was she as I found her, transfixed in the memory of her husband?

While rotating through the Intensive Care Unit as a third-year resident, I received a frantic phone call from a nurse. “Please come quickly and evaluate a patient,” she said. Upon entering the room I saw a young girl reaching over the side of the bed, cradling the patient’s head in her youthful arms. Her cheek gently pressed against the smooth, round contour of the patient’s head and her palm held the peaceful face. The patient’s chest, cluttered with

wires and small white squares, now lay motionless. As the girl’s black eyes met up with mine, I held my breath, hoping that she would not notice how I desperately yearned to flee from her fearful gaze.

“Don’t just stand there, say something,” the girl said.

Whatever words I uttered would be carved into the young girl’s mind forever. It would be the moment she learned that she would never hear her mother call her name again.

“I’m very sorry, she passed away,” was all I could muster.

It took another moment for my eyes to focus on other people in the room. There was a man with a tanned face clenching his two fists, crying. When he heard my words, he started banging his closed hands against the wall that held up his weakened body. The soft rain of his tears turned into thunderous wails. Then, I watched as men and women singing in Spanish – love songs, I imagined – surrounded the patient’s bed. The hands moved in great jolts of love and loss from the body to the girl. I didn’t belong. I pushed my way through the human bodies in grief; swaying shadows. I couldn’t look back.

My grandfather was a family physician in a rural area of Kyushu, Japan. When the phone rang from one of the remote homes in his neighborhood, he grabbed his ivory stethoscope and his massive leather doctor’s bag in his left hand, jumped onto his small motorcycle, and headed off in the direction of the sick. They all knew Hasuo Kuwaki, and when he was around no one seemed that afraid of dying. “You are here to send me over to the afterlife,” they would say. “I am not afraid.” He smiled and cradled their hands in his. He would tell a joke just the right size to pull out a small smile. When the patient passed, he would gently pull down the eyelids, resting a moment or two at the patient’s side as if he were taking stock of all the times he made them well.

Later, families would visit my grandfather’s office and tell him how grateful the patients had been and how at peace they were in their final moments. Then it was my grandfather’s turn.

It happened at the end of a long, productive life. It was a warm

summer afternoon. My grandfather's three grown sons and two daughters sat in the dining room, quietly embracing the last chance they had to sit with him, alone. My grandmother would be the last one to sit by his bedside. She stood up and walked through the door and sat on the same chair that she had taken up residence in for the past year. She was devoted. He had lost the ability to take care of himself, so she would spend their time together cleaning, bathing, tickling, scolding, and joking with him. They had 60 years together. They were the hands of a finely tuned clock, and she understood that his time was near.

Grandfather was weak. He was now speaking in a soft whisper, and grandmother pushed her ear close to his cheeks, brushing against his face. "*Otousan*, what is it? I can't hear you. What did you say? You have to talk louder!" The words were shrouded in his breath, and she could not make out what he was saying. Then, even those words were gone. Her husband had taken his last breath. Then, it was as if the shade were pulled up to reveal a light, which came in the way of an answer. She realized that he had been saying the same word a thousand times over for days.

"*Arigatou*," he said. "*Arigatou*."

In Japanese, it means gratitude, love, and kindness. The word was like an old familiar garment for my grandfather. He said it to patients and their families in good times and bad. Hearing these words, my grandmother knew that he was prepared to move on. He was not afraid.

Cynthia Lien, MD, is a PGY-3 internal medicine resident at the North Shore-LIJ Health System and is interested in pursuing a career in pulmonary and critical care medicine.

While Mama Slept

KIMBERLI LILE

She lay on her belly,
her back aching from tumor,
bare legs in the air, not carrying weight
any more.

"I am not afraid to die," she said, then
looked at the woman from Ecuador
napping in the chair.

The Rev. Kimberli Lile is lead chaplain for oncology/hematology and bone marrow transplant at North Shore University Hospital.

You Made You

EMILY KAGAN TRENCHARD

It's a lie we mothers tell ourselves
to feel more miracle than landlord,
that our bellies are full of god hands
tilling the thick of our wise blood.
But here is the truth of it all:
when you grew
and then changed your mind
about having a tail,
counted five fingers for each hand,
sprouted them full of bone,
hatched a clutch of a thousand eggs
to take with you into the world,
I was nothing more than the weather.

Emily Kagan Trenchard is a project manager in corporate digital services at the North Shore-LIJ Health System. Her poetry had been widely published and she has been a guest lecturer and performer at reading series across the country.

The Plan

It might have been philosophy,
the major I preferred.
I loved epistemology –
connecting thought and word.

Determinists could not compete
with relativity,
I read through Husserl, Hegel, Kant's
phenomenology.

But science kept provoking me,
and calling for attention.
Bio, physics, chemistry,
competed for retention.

Philosophical, and medical,
they aren't antithetical.
Now Hofstra North Shore-LIJ
is more than theoretical.

To be in med school now at last,
fulfills a dream, the die is cast.
I wear my stethoscope with pride—
with ears and eyes now open wide.

Daina Blitz is in the inaugural class of the Hofstra North Shore-LIJ School of Medicine.

Sickle

The second week in a row
you come in sick,

your body a black
crescent of muscle

with a face on one end,
sobbing, and a pair of knees

at the other. Between them
lies your liver

like a sore swollen foot
stuffed in a small shoe.

Limbs on fire, you're
pummeled by shrapnel.

a kid from Wyandanch
whose pointed cells

are popping and shooting.
Shooting you dead.

And so you ask for fries
with plenty of salt

and a diet coke.
And you punch the pillow.

John Coulehan, MD, is a physician and medical educator whose latest collection of poems is Bursting with Danger and Music.

Being There

I was sitting with my brother in his hospital room. We were just passing the time between blood tests and visits from the nurses and doctors. He wanted a little something to eat, so I told him that I'd pick it up in the cafeteria.

Riding down in the elevator, I was alone with my thoughts in the crowded space. I was thinking back to when I was a kid and how I used to think my much older brothers — 10 and 16 years my senior — were like other father figures. We all idolized our Dad, and I idolized my brothers, too. And now here he was, my oldest brother, also a doctor, my godfather actually, a patient in my hospital. As I made my way to the cafeteria I thought, "How does this happen?"

I picked up the snack and headed back into the elevator. Other folks got in, including a resident who was talking on one of the hospital-issued phones. He was discussing details of a patient's plan with no regard for the fact that everyone in the elevator could hear everything he was saying — things that they shouldn't have heard and things they didn't want to hear.

The other folks happened to get off of the elevator, leaving just the resident — who had by that time finished his call — and me. I was seething. He showed no outward sign that he had conducted himself unprofessionally. His conversation was not about my brother, but I felt compelled to say something. There are guidelines we follow about communication in public areas. But really, it's just common sense.

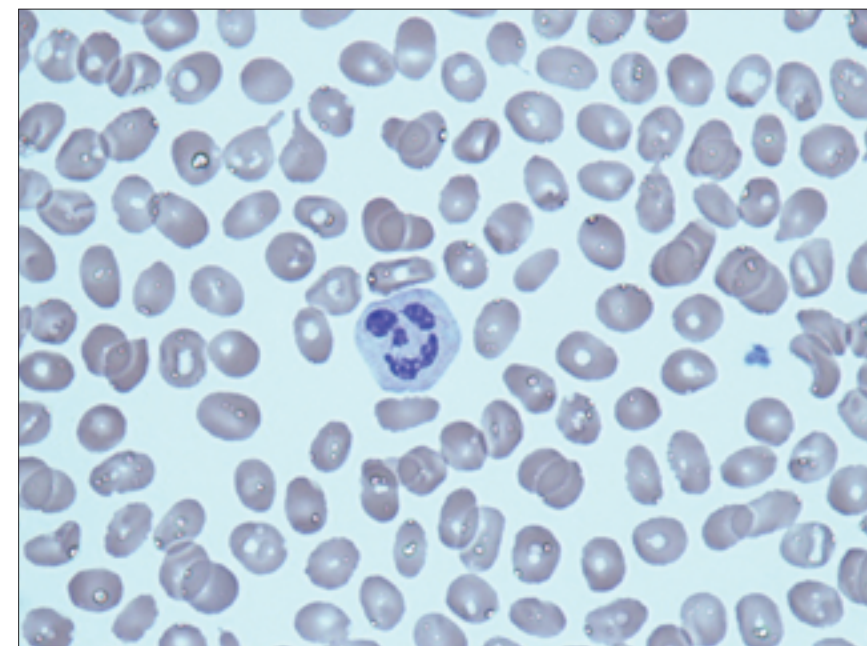
Then, I just snapped. I told him that he was doing a disservice to his patient and that he had created an uncomfortable situation for the other passengers in the elevator. As I was continuing my diatribe, the door opened and he escaped, looking back at me as if I were some unreasonable jerk.

Getting to my brother's room, I dumped the food on his bedside table, crashed in the recliner next to his bed, and let out a sigh.

"What's up?" he said. I told him the story — venting and offering an expletive or two. I told him I wanted to find out who the resident's supervisor was and speak to him.

My brother cut me off. "Listen, relax, let it go," he said. After a few bites of his snack, he continued, "Stop being a doctor for a minute. Just sit there and keep me company."

Andrew Menzin, MD, is vice chairman for academic affairs and associate chief of gynecologic oncology in the department of obstetrics and gynecology at North Shore University Hospital. He is a society master at the Hofstra North Shore-LIJ School of Medicine.



Hematologically Happy

JONATHAN FISH

Jonathan Fish, MD, is assistant professor of pediatrics in the division of pediatric hematology/oncology and stem cell transplantation at Cohen Children's Medical Center.

On the Bookshelf

Hello, I can't believe I am next to YOU!!
 You better believe it...welcome to my space.
 I meant to say, you are the wealth of knowledge after all.
 Well, thank you. But so are YOU.
 Let me ask you a question? Are you heavier than me?
 Perhaps so...I feel as if two of you can fit in me...
 Hahaha!
 Well, well, you want to have a little competition here, don't you?
 Is that what you want?
 Why not? What's the best one you've got?
 Antidisestablishmentarianism, And you?
 That's all? check this out:
 pseudopseudohypoparathyroidism. I win, mine is 30 and yours is only 28.
 Oh, I see.
 I can even do better, hepaticocholangiocholecystenterostomies
 OK, ok, you win. All I can say is that your smiles can beat them all
 Blush...
 And also, without me, you wouldn't exist.
 My reader is more sophisticated.
 Yes, but he couldn't read you if he hadn't been through me.
 Perhaps.
 Why are we arguing? I like you in green.
 I like you in black. You look very English.
 Thank you thank you, May I take you for a cup of tea?
 Why not? It will be my honor to have tea with a great one like you.
 I am honoured that you are next to me on this shelf..
 Let me introduce myself, I am Medical Stedman, and you can call me MedSted.
 I am Oxford English, my friends call me OED...

Kenar D. Jhaveri, MD, is in the department of internal medicine and the division of kidney diseases and hypertension. He is site director for the nephrology fellowship program at North Shore University Hospital.

Hands of Caring

Nurses are hands of caring
 Hands that help you, hold you, and guide you
 Hands that nurture you and make you whole
 Nurses are hands that support you
 Comfort and keep you
 Hands that make you strong once again

Nurses are hands that protect you
 From thoughts that discourage, thoughts of despair
 They are hands that surround you with goodness
 And kindness and settle your fears

Nurses are hands that understand you
 Love you and believe the best for you
 Hands that surround you with hope

Nurses are hands that bring inspiration
 Gentle reminders of your value and worth;
 Like a tiny seed planted in the earth
 that will grow a mighty oak, and spark your faith

Nurses are hands that bring kindness
 Creative words to heal you and soothe your soul
 They are hands that carry you
 up to the angels who whisper:
 "All is well, rise up, and be made whole."

Irene Fulmer, RN, is coordinator of CAM services at Syosset and Plainview Hospitals. She is a certified holistic amma therapist, hypnotherapist, interactive group therapist, and reiki practitioner.

How Benjie and His Mom Got Me into Med School

This story requires a romantic lens with a hazy view of scenes from 55 years ago.

I was in my freshman year of high school. The Knicks of the fifties with McGuire, Braun and Sweetwater were my heroes, in spite of their losing to the Boston Celtics so often. My love of basketball led me to the gym for tryouts and it was by sheer luck that I made the JV team.

My dream of basketball stardom lasted four months before my name was cut from the roster. I was crushed. Benjie, one of my new friends, was nonplussed by my loss. He saw the possibilities in everything. "I'll teach you how to swim," he said.

I had some Boy Scout merit badges for swimming gathering dust in my drawer but I would never have considered myself a swimmer. But Benjie and I walked over to the school pool. I held my own, stroking back and forth a thousand times over until I was good enough to make the team.

Benjie was soon my best friend, and I became a fixture in his kitchen, watching his mother take warm cookies from the oven, humming the score of *My Fair Lady* as the vinyl record played in their living room.

Benjie was a great student, and he taught me something I didn't know by instinct: how to study. His Mom, a life coach long before there were life coaches, also offered her fair share of support: The harder you work, the better you will feel, she would say.

I wasn't a great student, but I wasn't bad, and I figured that my grades and my prowess as a swimmer could land me in any college I chose. Then a large dose of reality hit me like a guidance counselor grabbing me by the ear and thumping me hard. "Maybe you should consider a vocational school," said a plump, middle-aged woman who looked at my grades and then up at me — or really through me.

She knew my father owned a restaurant in Williamsburg, Brooklyn, and she assumed that vocational training could pave the way to a career at the restaurant. So much for the swim team, the Olympics — a boy can dream — and my first pick of a university.

I walked out of the guidance office in a fog and found my way

to Benjie's kitchen table, more for his mom's wisdom than her oatmeal cookies. As I sat there hangdog and discouraged, mother and son encouraged me — complete with my low 80 average and modest board scores — to apply to colleges. "The guidance counselor is wrong," Benjie's mom said. "You are bright and can be anything you want in this world."

I got into many schools, and most of them came with good swimming teams.

While Benjie went off to Dartmouth and swam for a year, I swam for a year at Ohio University. I was never Olympic material, and that dream died quietly, but I found a new dream that interested me even more. Medicine.

My fraternity friends convinced me to reapply to my first pick, New York University, which I did. My parents needed me closer to home to help with the restaurant. My hard studying was reflected in my grades, and the day arrived when I opened a letter saying that I had been accepted into NYU's pre-med program.

Benjie and I were on our way to becoming doctors. I sometimes wonder whether Benjie and his mom understood the role models they were for me. Neither of my parents went to college, and for them it was enough that I was a good kid and stayed out of trouble.

I have remained a good kid for as long as I remember. I have stayed out of trouble, and along the way I became an ophthalmologist. I wonder whether my field of choice had anything to do with seeing things in new ways, something I picked up from the boy in Brighton Beach and his mother.

Samuel Packer, MD, is chair emeritus in the department of ophthalmology at the North Shore-LIJ Health System, and chief of the division of medical ethics and co-director of the bioethics center at Hofstra.



New York City

HILLEL DLUGACZ

Hillel Dlugacz is a social media specialist at the North Shore-LIJ Health System.

NARRATEUR

Bellevue

I slowly drew back the curtain of the Emergency Room cubicle to find a middle-aged man. He was handcuffed to his bed. He had just been transported to Bellevue Hospital from Rikers Island and he was my first assignment as an Emergency Department volunteer.

My job that day was to perform electrocardiograms. I quietly rolled the ECG cart past the curtain until it was next to the patient's bed.

"Are you really going to bother me right now?" the man shouted. My eyes darted toward the handcuffs, a reflex. I shook my head and my eyes found a spot on the linoleum floor. For a moment, I felt as if someone had grabbed hold of my wrists.

"Sorry," I said. It came out in a whisper. I didn't want to appear afraid. After all, I was the one moving freely. Then, with more confidence, I said: "It's standard procedure and it will only take a minute."

I explained that he needed to remove his shirt. He looked dead-on at me and I realized, moments after he did, that he could just as easily remove his shirt as he could scale Mt. Everest. I would have to be the one to do it if I wanted to see what was going on inside his heart.

I got closer to the bed, and to my patient. I lifted up the black sweatshirt and made a note to myself that his skin was warm to the touch. He was breathing heavily.

"Will this hurt?" he asked, not a hint nicer than he had been when I entered the room. I placed the electrodes on his chest and legs. "Not at all, the worst part is taking these stickers off," I said, all pleasant and smiley.

He was caught off guard and reflexively smiled back. Once the machine spit out the electrical waves from his heart, I turned it off and removed the electrodes. He didn't flinch.

"Thank you," I said, touching both sides of the cart and moving it out the door.

I spent the rest of the day taking care of other inmates, and while most of them seemed at first blush scary – maybe it was the handcuffs – I soon began to see individual differences. Some were

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pleasant and talkative. Others were difficult, refusing treatment, acting out, or making inappropriate comments to me or to other female volunteers and nurses. In the space of an hour or two, I was standing strong against even the most disagreeable of them. I no longer saw the prisoner, only the patient.

Learning to be comfortable around the patients and to treat them with equal compassion was difficult, but it was one of the most valuable lessons I learned as a volunteer in the prison program. It wasn't the only lesson learned — there was also the matter of trust in the doctor-patient relationship.

During one shift in the Urgent Care Unit, I was told to stay with an anxious patient in Room 2B. I knocked on the door and entered and found her pacing the room. She was moving but kept her gaze turned in my direction. "When will the doctor be here?" she repeated at least once every ten seconds. She seemed frantic. I suggested she sit down.

I tried to calm her mind. "What brings you to the hospital?" I asked.

She explained that she was feeling feverish and had been having panic attacks all week. When I asked if she had any idea what could be causing her anxiety, she said she was trying to figure out how to break some very bad news to her family. I asked her whether she would like to talk about the news she had to share.

She grew quieter, settling into her thoughts. "If you have the time to listen, I'd appreciate it," she said.

I assured her I had plenty of time and pulled a chair up beside her. For the next half hour I listened to her story. She had just been diagnosed with AIDS and was terrified of her prognosis. Moreover, she worried about what would happen to her young son if she became too sick to care for him.

I sat quiet as she spoke. I sat even quieter as she cried. When she finished, I held out my hand and she took hold of it and gripped it tightly. Then, it was time for me to speak. "You should place your trust in your doctor," I said. I also encouraged her to find the strength to tell her family what she was going through because she would need their love and support.

When the doctor arrived, I took my cue to move on to my next patient of the day. I still think about this exchange, and I hope that one day I am that doctor she chooses to put her trust in. I want to

be the doctor who sits in a chair and takes a hand and just listens. I want to be the one to give guidance for her fears and medicine for her symptoms.

I want her to know that I do have the time to listen.

Christina Scelfo is in the inaugural class of the Hofstra North Shore-LIJ School of Medicine.



Into the Wind

BARBARA HIRSCH

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

Empathy

As I entered the examining room, the first patient of the day eyed me suspiciously, his wariness subsiding only when the doctor introduced me.

It was my first day shadowing Dr. Susan Pincus while working for the summer at ACCESS Community Health Center in New York City, a clinic that specializes in treating vulnerable populations, specifically those who are developmentally disabled, uninsured or below 200% of the federal poverty level. Although it's a family practice, most of the patients are adults who are out of place in traditional primary care settings.

As I assisted her, Dr. Pincus saw one patient after another. A man with Asperger's syndrome, whose arm I held as the doctor aspirated two cysts from it. A man who suddenly began vomiting during a routine physical. A severely autistic child who became very uncooperative when blood had to be drawn. An incontinent patient who only spoke Mandarin, which neither Dr. Pincus nor I knew.

The pace never let up all day. When it was over, Dr. Pincus turned to me and said, "Are you having fun? Because this is it, this is really what it is like."

As a matter of fact, I loved it!

Until then I had mostly participated in laboratory work. Although I found lab work interesting, my experience at the clinic solidified my desire to focus on the patient care aspect of the medical field. I was energized by the feeling of being in the trenches and striving to make the ACCESS patients better. They were not always cooperative, but the patience and grace with which Dr. Pincus worked were inspiring.

I learned that dealing with patients like those who visit ACCESS is an art. They are often not pleased to be in the office and they may be scared. In order to care adequately for them you must be able to assess any situation by thinking on your feet.

Much of what I learned at ACCESS I have also found useful as an EARS counselor at Cornell University. EARS (Empathy, Assistance, and Referral Services) is a student-run hotline that also sees walk-ins.

Every time the phone rings in the EARS rooms or I see an individual standing uncomfortably in the doorway, my heart begins to

beat rapidly. I always feel anxious at the prospect of a session because I have learned it's important to quickly gain the trust of those seeking help and to be prepared for any issue they might bring up.

EARS has taught me to be comfortable engaging with individuals at what may be their darkest and most painful times. There is rarely an easy answer or a perfect solution, but it's my job not only to listen and comfort but also to provide a sense that working together we can solve any problem.

In one memorable session, I spoke with a young man for over an hour about his feelings of isolation and his struggle to accept his homosexuality. It was clear to me that while the session had been beneficial, he needed more assistance than EARS or I could provide. When I suggested that he see a campus psychologist he outright refused to go.

He confided that it had taken so much courage and effort for him to come to EARS that he didn't think he could explain his case all over again to another person. I thought for a moment. I did not want to break confidentiality, but I did not feel comfortable allowing him to leave without knowing that he would seek additional help. I had to think creatively. I offered to call the psychologist on his behalf and, with him listening, explain his situation as he had told it to me, lightening the burden of his starting over. He agreed, and I made the call.

My experiences at ACCESS and EARS have made me appreciate the realities and difficulties of practice. While medical knowledge is the basis of a doctor's craft, the relationship between doctor and patient is equally critical to practicing medicine well. If patients feel comfortable with their doctors they will more readily confide in them, providing reliable information. As important, they will be more likely to closely adhere to the advice of a doctor they trust.

Maxine Ames is in the inaugural class of the Hofstra North Shore-LIJ School of Medicine.

Visiting

When I stood beside her
 and watched her swollen eyes
 become grape skins and her legs
 fill with creamed fluid and her finger twitch
 up
 and
 down
 ever so slightly
 and her throat break open phlegm
 and her intestines detach themselves
 from her
 and the machines above her compress
 and beep
 steady unsteady
 steady
 I knew what it was to live in
 a Starry Night and to have whirlwinds
 abound and stars smash against
 gales and
 I knew what it was to live in
 a black forest where steeples
 are sparse and distant and
 horizons disappear
 between hill tops and our houses
 are so small and are lost
 between shrubs and the crescent
 moon screams fire into our
 lives and
 everything burns
 to
 star
 dust.

*Joseph Chilman teaches
 English at Molloy College
 in Rockville Centre and is a
 graduate student at Hofstra.*

Rocking in Limbo

My hands tremble if I hold a book open for too long.
 I bend paperbacks so that I can easily pick them up
 when they decide

to jump.

My binders are filled with the
 handwriting of others because the only thing I can write
 with any speed or clarity is

my name.

I've given up on spaghetti.
 It refuses to twirl around my shaking fork.

The only thing I can't work around is the back spasm
 that has changed into a knot.
 It is a slight but persistent reminder

I've been sitting too long.

I lean forward, back.
 The embarrassed bridge of my hips is out on display.
 My legs jump at the rustling of paper—

They search for a way out of the position they've been put in.

*Margie Suarez is working towards a graduate degree in creative writing
 at Hofstra University.*

Ernest at the Doctor's

Yale professor Harold Bloom has described the short stories of Hemingway as "easy to parody...but impossible to forget." It is in a spirit of appreciation for the master of this form that I offer the following.

It was late morning and the sun had already dried the puddles in the parking lot which was full of the older American cars that retired people drove around town because they didn't trust the Germans or the Japanese and made efforts to appear patriotic on the rare occasions when they bought a car. The old man entered the waiting room which was the color of dust and the nurse looked up without interest. He wondered when she started wearing rings in her nose.

It reminded him of the savannah and the thin dark man with cloudy eyes who was going to find him a rhino to kill, his first. It is not wrong to kill the rhino if a man's aim is true and his heart is heavy with the weight of killing and he makes a clean shot in the clear morning air.

"You have to go to central registration, and then come back here. It is down the stairs. You have to hurry because for once the doctor is not behind schedule and if you don't come right back you will keep him waiting."

The old man shuffled down the flight of thick green-carpeted steps to the mahogany desk that was marked with the sign that said please take one of these forms and we will be right back. He read the clean white form and sat down and picked up his fountain pen, which was pitted from the sand and which his hand had held when he wrote by the light of a gas lamp in clean notebooks on the slopes of Kilimanjaro. It was hard to write when the writing was honest and about death or the things we undertake to distract us from the presence of death.

On the white form the man listed his medications which sounded like the names of Hindu gods and saints. Losartan. Citalopram. Simvastatin. He imagined them conversing with one another within the precincts of his body, explicating the several paths to enlightenment, and the relative merits of good works, or self-deprivation, or the path of meditation. A young woman in a sari

sat down and touched the back of his hand. It felt cool against his parched skin.

"I am the nurse practitioner, please. It is time to come to the examining room."

He was partly covered now with a coarse white paper garment and was sitting on a narrow table of beige leather or some material meant to convey the general impression of leather.

"Let me help you fill out the history form. Do you have headaches, eye pain, difficulty seeing, ringing in your ears, or dizziness, please? Is there shortness of breath, or pains in the chest? Must you get up at night to urinate, please?"

He had been in this situation before, in Spain, when robbers had come upon his camp in the wind on a moonless night and the large eyes of their horses mirrored the glow of the dying fire. He did not know fear then because life was transient and not so important as living true and when the man's blade reflected the dim light of the fire and the robber smelled of fear and surprise he felt only disgust that the intruder could so easily be put off from his course of action.

A moment earlier the woman with skin the color of tea had left the room, having relieved him of his clothing. His skin prickled. The room was full of cold things, made of steel mostly, and rubber. A laminated poster showed the position of the heart and bowels.

The physician entered, smiled and quickly closed the door. "Sorry, full schedule. How can I help?"

They exchanged pleasantries. The physician's hands were large but well proportioned and his nails were trimmed neatly. He moved continuously as he spoke, picking up one instrument and then another. His stethoscope was pressed against the man's heart and he was looking past him at the window, staring at nothing in particular. The old man was sensing the pressure in his groin that was there all the time now, a steady background like the surf on a cool morning in Normandie. A man could choose to ignore it for a while until the urge returned.

"What should we drink?" the girl asked. She had taken off her hat and put it on the table.

"It's pretty hot," the man said.

"Let's drink beer."

"*Dos cervezas*," the man said into the curtain.

"Big ones?" a woman asked from the doorway.

"Yes. Two big ones."

"Yes, a big one," the doctor was saying. He shot the used rubber glove at a pail in the corner. The room smelled of rubbing alcohol. "A big prostate. My guess is that your aim is not straight or true."

The man emerged into the warmth of midday. These days, spring reminded him not of rebirth so much as of the impermanence of one's individual life in the face of nature's continuing existence. He looked down at the prescription which said take one daily until finished.

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



Bhutan: A View from Above

ALAN SLOYER

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

Love

When I met her, a wheelchair had already taken over for her legs. She had been hospitalized so many times that she'd say hello to dozens of nurses — by name — before she even reached her new room. Her body was so weakened by multiple sclerosis that she was pretty much resigned to the unrelenting pain.

She showed up at every appointment with her trusted body-guard, a handsome guy with long brown curly hair who made his money in designer clothes. They were magical in their devotion. He'd scoop her up in his arms the same way you would imagine he did for their children when they were small and sleepy.

He was in love, and he never for a minute took her for granted. He was, in ways big and small, obsessed with making her feel better than she should rightfully feel given that her disease was on a runaway course.

One day she called me at two in the afternoon. She was panicked and said that the pain was so bad that she couldn't move her limbs and she had burning between her legs. She was sure that she had a urinary tract infection. I told her she should go to the emergency room immediately.

Hours later, the piercing ring of the phone shook me from sleep. It was my patient. She was still home, still in agony. I am not sure if I showed that I was upset but I certainly let her know that I was concerned.

"You should have been at the hospital already," I said. I could not imagine why she didn't heed my instructions, and now I wondered what on earth I could do to help. Why was she calling me at midnight? "Let me explain," she said. "I am sorry. My daughter had a concert and I wanted my husband to go. If he knew that I was sick, he would not have gone and the whole family would have suffered. I am ready to go to the hospital now..."

Her love was just as strong, just as deep, for him and for her family.

A year later, her mind gave in to her now broken body and she decided that there would be no more treatments. She no longer could walk or talk.

By the time her husband called to ask me to make a final home visit, she was in a coma. He was her nurse. Keeping her comfortable, combing her hair with his fingers. He kissed her forehead and held her hand as he had done for 7,000 days.

She died that day, at peace and in love. For her, it made all the difference that never once had she fought the disease alone.

Karen Blitz-Shabbir, DO, is director of the MS care center at the North Shore-LIJ Health System.



Healing Art

RAISA YEGER-ARBITMAN

Raisa Yeger-Arbitman, MD is a pediatrician in Forest Hills, NY.

Jazz Trio: Virus, Man and Memory

Theme

He was hearing the half tones.

He was hearing the half tones. Joe sat across from me in the office. Sun lit his face. He told me how his classical music training had mutated into jazz.

You hear classical musical training in some jazz musicians, I said. But then there's Thelonius Monk sliding over the keys striking two piano keys at once.

No, that is not a mistake, Joe said. It was intentional. He was hearing the half tones. He was going for the sound in between the keys. He was hearing music beyond the capability of the instrument.

Solo for Virus

HIV swings.

HIV swings from person to person.

Out of Africa. Swinging on shared sex and blood around the world.

The virus sings on the cries of the human heart.

The virus explodes. Ten billion viruses are produced each and every day in the untreated body. Mutations pop out every thousand base pairs. The virus is only ten thousand base pairs long. Each and every mutation is produced each and every day. The genetic variations between the wild-type notes. The virus is dissonant. Ten billion viruses produced every day. It screams with variation: genetic genius; replication syncopation.

The early treatments never had a chance. New variants swarmed over medicine after brief benefit. The potent combos debuted a year after Joe died and HIV mellowed from death sentence to chronic condition.

Take it away, Joe.

Solo for Man

I studied classical music for years. I was obsessed. I loved the classics. But the music pointed somewhere else. Jazz improvisation is the culmination of classical music. There is music be-

tween the notes. It was at a major recital — I broke away from the notes on the page. My teachers did not understand how my jazz was a tribute to them. They were furious. They could not hear the music.

The jazz scene was wild. Jazz swung late into the night. Everyone did dope. I shot dope in these veins. The music faded. Everything — except the drugs — was going away.

Finding out that I was HIV positive saved my life. I would have been dead like everyone else years ago. I cleaned up. I got healthy.

I play ten billion notes every day.

Reprise and Coda

Joe heard the half tones. Joe sat across from me in the office. Sun lit his face. The shadow was dark in the hollow of his cheek.

He told me how he plays music every day. He showed me the small veins on the back of his hands where he used to inject heroin. He was grateful to be alive. He was grateful to the virus. Thelonius Monk slides over the piano — he strikes two piano keys at once. It is not a mistake. Joe said it was intentional. He knew the sound in between the notes. He heard the music beyond the capability of the instrument.

So many lives were lost to the virus. The music is not silenced. Chords reverberate through time. The memory plays chords of half tones on my heart.

Bruce Hirsch, MD, is an infectious disease specialist at LIJ and North Shore University Hospital who has worked with HIV+ patients since the beginning of the epidemic.

The Legacy

I was in second grade when I wrote about my desire to become a doctor. I wanted to become a pediatrician like Dr. Djerf.

Dr. Djerf was our family doctor, and his kindness toward and affection for us – we were a gang of six kids – made me feel as if we were his only patients. He often opened his practice for my mother on Sundays so that she didn't have to miss work.

In those days, Dr. Djerf would also make house calls. Most times, he would arrive at our home to check on a cough or snuffle. When I was eight, I had pneumonia, and I remember staring up at him from under the cool washcloth my mother placed on my forehead to lower my fever. He offered up jokes and encouraging words that were often the only medicine he left us with. And that was enough.

I still remember the smell of alcohol in the exam room and the ancient, amazing bronze microscope in his library that he let me handle after any visit.

I never stopped wanting to be a doctor, and I always knew that it had something to do with Dr. Djerf. The first-year stress of my pre-med studies led me back to my pediatrician's office to consult him, not as my doctor but as my mentor. Later, I would run into him on occasion at the local hospital, where I was working my way through pre-med as a laboratory technician and he saw patients. He'd smile and say: "Stick with it, Jimmy. You'll make it."

One night I was called to the Coronary Care Unit to draw blood on a patient who had just had a massive heart attack. I stood over the weakened, frail man — it was Dr. Djerf. His eyes were as kind as they were when I was a kid with a cold. "You did a good job drawing blood, Jimmy," he said. "Stick with it and you'll make it." The vials of blood in my hand, I said by good-bye and headed for the door. "Jimmy," he said, softly, "thank you." He smiled and his hand reached up from the mattress and waved.

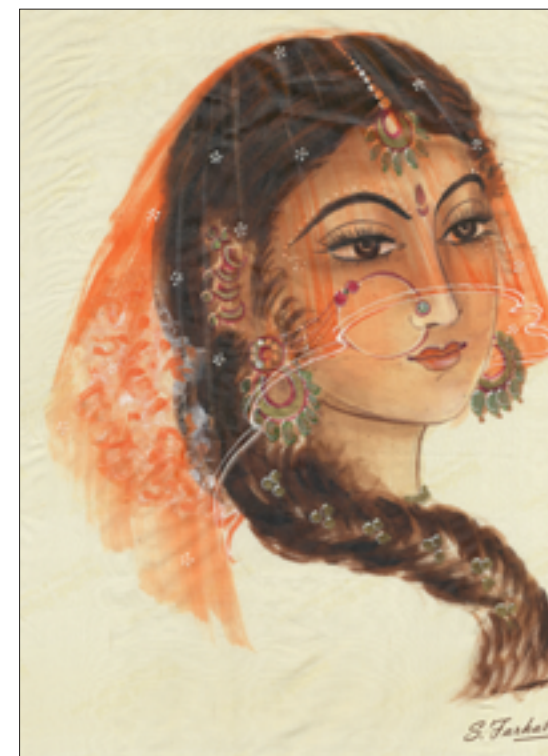
Dr. Charles Djerf died that day. He was 62. I was the last person to see him alive.

Years later, after I became a doctor (although not a pediatrician), I learned that Dr. Djerf and I shared the same birthday. My memories of his empathy and genuineness have always remained

with me, and I believe that he knew that his presence in the world shifted the ground I walked on.

In big, indelible ways, I am thankful for the man who so generously opened his door on Sundays and who let us know that as long as we were in his care we were the most important people in his world.

James D'Olimpio, MD, is director of the supportive care and cancer pain service at North Shore University Hospital.



Sanative Sublimity

SAKINA FARHAT

Sakina Farhat, MD, is a third-year internal medicine resident at Forest Hills Hospital.

Reading Faces

The patient sat with his daughter, his head down, his chin touching his chest. If you looked carefully enough you could see him taking in more air than he was putting out. Twelve inches from his nose was an untouched lunch tray. There seemed to be a direct line between his nostrils and a cut of beef on his plate.

We entered the room. There were three of us making weekly bedside complex care rounds, something a dozen of us do every week. We are interested in those patients who are in the hospital for over 45 days. We want to understand what their lives are like here and the reasons they remain under such guarded observation.

"Is everything okay?" I asked the old man, and his head lifted ever so slightly in my direction. The lines on his face were deep. He was sad.

"I am hungry," he said. If he had looked up I would have seen that he was missing his bottom denture. "They lost my teeth," he growled. He went back to staring at the steak, his nostrils grabbing at the air as if it would fill his stomach.

His daughter sat next to him. He had been in the hospital 57 days. In a matter of weeks his heart would give out. He knew the end was near and all he wanted, all he needed in this Intensive Care Unit, was right under his nose.

He wanted that steak.

"They lost my dentures two weeks ago. I can't eat. I just want to die...."

His daughter spoke up, admonishing him, coaxing him. "You can't give up," she ordered, as she hurled her reading glasses on the nightstand.

He was 89 years old. He was in the ICU, which meant his vital signs were taken every 15 minutes, which meant that 100 times every day the blood pressure cuff inflated to robotically strangle his left arm.

He was poked and sometimes prodded. He was frequently visited by nurses and support staff. But no one stopped to look at the sign on his face or on the trays of food that went untouched. No one stopped long enough in the ICU bustle to see that he was missing his bottom teeth.

We called for a dentist, who arrived the next day. New dentures arrived a few days later.

As a palliative medicine physician, I have learned to listen to stories, to read faces.

I recently stood at the door of a 79-year-old patient with metastatic lung cancer. His elderly wife had caught my sleeve before I entered and asked me not to tell him the truth. Not to mention that he was going to die, soon. I understood her suffering. I nodded.

When I listened to his lungs, he caught my sleeve and told me that he had metastatic cancer and was going to die, soon. He looked over to a picture on the side of his bed. "Can you hand me that?" he asked. I reached for the faded photo. It was of a teenage boy smiling and touching the Western Wall in Israel. It was his rite of passage in the year of his bar mitzvah.

He told me that he had things to do before he died. He wanted to take his grandson to Israel for his bar mitzvah. The boy was just turning 13. His granddaughter and his wife heard his plea and promised that they would honor his wish. He died in the Palliative Care Unit, as 75 percent of our patients do.

That's why we allow pets at the bedsides of their owners. That's why I keep a bottle of Johnny Walker Blue in my office — in case a patient wants a scotch to balance out the endless vital signs.

One patient said that he owned a restaurant and loved red wine at his meals. We took him at his word. We ordered red wine T.I.D., even with his morning eggs.

The guy loved his wine. The grandson made it to Israel. The man who finally got his bottoms also got his steak.

Dana Lustbader, MD, is chief of the palliative care unit at North Shore University Hospital.

Return to Sender

I volunteer in the mailroom at a local hospital.

Before you cast a questioning glance or ask if I am serious, the answer is yes, yes, I volunteered to work in the mailroom. I work with some very interesting people and I get to know the hospital and the hospital staff better than most volunteers. And, on occasion, I get to go into battle.

There is a huge, crotchety postage meter whose sole function is to automatically weigh outgoing mail and apply the proper postage. It is somewhat successful in this regard, but there is a price to be paid for its performance.

Occasionally the machine develops a demented mail-lust and demands the sacrifice of an unspoiled, neatly addressed piece of mail, which it attempts to devour until — warily — I risk my hand to extricate the masticated mess from its innermost rollers. Quickly, stealthily, I whisk the injured item from the meter's sealant-drooling jowls and place it in the middle of one of the outgoing bins so that the monolith can no longer see its injured prey.

There's a lot to be said about my volunteer role. I enjoy braving the meter. I take pride in knowing the layout of the hospital well. And I find it fascinating to learn who people really are from the way they treat "lowly" mailroom workers.

What I don't like about my job involves a big black marker and a little red stamp.

In this world of astronomical medical bills and insurer cutbacks, patients often come and go quickly. What happened to them?

I'd like to think that they all made complete recoveries and were issued clean bills of health by skilled, caring, compassionate physicians and waved a heartfelt goodbye by the attentive and knowledgeable staff. Or that they were carefully whisked away by a loving family and returned to the comforts of home. But most of the time the folks in the mailroom never know.

A patient may leave the hospital, but the mailroom is another matter. It's the repository of mail for patients who have come and gone — cards, boxes, even bills arrive for patients whose names no longer appear on the hospital's rolls.

So many things swirl through your head when a familiar name

appears on an envelope and there is no sign of the person's presence in the hospital. Is it call for celebration, sadness, or something in between? It makes us wonder, every day.

With a heavy heart and a steady hand, I must black out the hospital's address on these cards along with the printed barcode at the bottom of each envelope and apply a brash, impersonal stamp: RETURN TO SENDER.

My greatest fear is that a week after someone's friend has left this life, the card will show up in the sender's mailbox, unopened, unread, unappreciated.

Perhaps some cards should not have return addresses.

Branson Sparks is in the inaugural class of the Hofstra North Shore-LIJ School of Medicine.



The Couple

SIMON VELU

Simon Velu works part-time as a mental health worker at The Zucker Hillside Hospital.

The Last Song

The last
I attempted to compose
was before the call.

For then the harmony
of hope and youth
resounded in my soul
and hummed with bright insistence.

But that night
the cacophony of wheezes
metered by staccato breaths,
the choir of pleas
beseeching for a remedy to ease
but perhaps also to silence,
and the symphony of uncertainty within

stilled the mellifluous notes

And poetry was the song
I could no longer sing.

*Miriam C. Greenberg,
MD, is a voluntary
attending physician
at LIJ.*

The First Patient

I have counted the steps
from the desk to her door.
Simply put, a hundred forty four.
Exactly, precisely.
And at the threshold I can hear her breathe
loud...and slow.
Twenty-four blows per minute of mechanical nature.
I find her surrounded by colors and noises,
framed in a multitude of senses
and indistinct from them.
A carnival of lights
with warm breezes of summer,
with faint whistles of autumn
born from her rhythmic antrum.
And her crown made of hair,
horizontal by now,
a peaceful nest of snow.
With marbled skin carved by the years
and the frown of the sun
and the unforgettable smell of her faded rose.
She lies in a rectangle inside of a rectangle
floating in a symphony of hoses
and plastic tubes determined by numbers,
calculated to dictate the future courses
of probable hopes...or uncertain prognoses.
And as I try to connect her aura with her lonely star,
I am forced to sit down and remain apart.
Just forget about my sciences,
my ancient darkness,
as there is nothing more for me to offer
from my tree of knowledge.

Jorge D. Nieves, MD, did his general pediatrics residency at Schneider Children's Hospital in 1996. He is in private practice at Forest Hills Pediatrics.

On Acceptance

I emerged from the Hofstra interview experience to ceremoniously – and, okay, a little egocentrically — inform my dad that I was the ideal student for the program. The match between my wants, needs and desires in a medical school and Hofstra’s pattern-breaking approach was perfect. But there was a cloud on the horizon — the inaugural class of only 40 students would be selected from among thousands of qualified applicants.

While Hofstra felt right, I had to keep going. I kept a positive attitude and continued my journey through the medical school search/application process.

I will remember my acceptances into medical school for my entire life. Three of them were particularly poignant and hold extra significance for me.

My First Acceptance: Plain and simple, it meant that my career ambition for as long as I can remember would be realized. I called everyone I could think of to tell them “I am going to be a doctor!”

Being Accepted to a Program I Loved (let’s call it School A): At this point, although there were two or three other applications out there, I was done. I would be happy attending School A. It has a great program and met another key criterion by being close to my family. Also, one of the doctors that I interviewed with had the same name as an iconic doctor from a classic medical TV show. As a lover of everything TV, movies, comics and books, I saw this as a sign from the Pop Culture Gods that I was meant to be at this school.

When the news came that I had been accepted I was even sitting in a movie theater! I checked my phone before the previews and there were six missed calls and five text messages saying there was a thick packet at home for me from School A and my family was standing around it waiting for my go-ahead to open it.

I found out in a movie theater — my sanctuary — that I got into School A. Yet another sign from the Pop Culture Gods.

HOFSTRA: With my choice made to attend School A, I began to move from the application stage to the “OMG now I have to do all this stuff to make it happen” stage. You know, those little things, like finances, finding a place to live, filling out dozens of

forms, getting a physical, etc. After a full day of preorientation, having scheduled appointments to look at apartments, I settled in at home and proceeded to check my e-mail. And there, staring me right in the face, was my acceptance to Hofstra.

What was I going to do now? I was already committed, there could be no turning back, could there? However, the unlikely had happened. I was now one of the chosen 40.

I spent the weekend pretending that Hofstra did not exist as an option. Then, Monday morning, I received a phone call from a school representative, who spent about 45 minutes on the phone answering questions I had and refreshing my memory on the specifics of the program. The more I listened to Jodi, the more I realized I could not just dismiss Hofstra because I was happy with the other school.

Hofstra was my first love of the interview season, and you never forget your first love. I had to start the decision process all over again.

I spoke to some family friends who were physicians and people they knew in the medical school community. My mom even asked the periodontist she went to that day. Everyone said the same thing – North Shore-LIJ Health System was a great place and the medical school was going to be amazing. Everyone said that they had heard great things about the Hofstra program, that the clinical opportunities were unique and would be incredibly beneficial, and they predicted that in the future schools would be changing their programs to be more like Hofstra’s.

I thought about it for many painstaking, soul-searching hours. This decision was a little bigger than picking which movie to see. I was, in part, defining my future. Either way I was going to attend medical school at a good institution. It was a win-win scenario.

My one concern about Hofstra being a new medical school was no longer an issue after every doctor assured me that it was not something to worry about. In the end, I cut out every factor that did not relate to education and focused just on the curriculum. From that perspective Hofstra was the easy choice. At the end of the day — because I could not take a week of agonizing over the same

issues — I chose Hofstra North Shore-LIJ School of Medicine.

Over five months in and I know I made the right choice. In that time I have been embraced by the Hofstra North Shore-LIJ School of Medicine community of physicians, teachers, and administrators. I know that my clinical exposure as a “first year” is unprecedented when comparing notes with friends in other programs. I have taken patient histories, done physicals, performed pelvic exams and Pap smears, sutured an actual person (yes a person, not an orange rind), and learned more than I can fit in my brain. I know that Hofstra North Shore-LIJ School of Medicine and the faculty have created a new and, in my opinion, better way to learn.

Samantha Ruff is in the inaugural class of the Hofstra North Shore-LIJ School of Medicine.



Cardiac Surgery

ALAN HARTMAN

Alan Hartman, MD, is chairman of cardiovascular and thoracic surgery at the North Shore-LIJ Health System.

NARRATEUR

Midnight Flowers

I drive my dad’s crappy truck down the winding road where a kid died a year ago tomorrow. The leaves are changing colors again, green to red and orange and yellow. People are always saying how much they love the fall and the leaves. All I see are trees. Different color, different day. My phone rings.

“Sup?”

“You almost there?” It’s my mom.

“Yeah, I’m on Bellevue now. I may be a little late to homeroom, but they won’t mind. Senior year and all that.”

“What... what are you doing on Bellevue, Luke? We talked about this; you’ve been doing so well. Your doctor said that road can trigger—”

“Whoa, whoa, Mom, chill. It’s a shortcut, no big deal. Just driving.” I hit the red button on my phone and throw it in the cupholder. I’m sick of everyone thinking I’m crazy.

I slow around the next curve. In the distance, against a tree, are a bouquet of purplish plastic Wal-Mart flowers and a grainy school photo. It seems odd in the midst of the autumnal scene. The bark of the tree is dark—darker than that of the others around it. Like charred or something. And the leaves? Whoa. I get it. No wonder people are going nuts for these leaves. There are golden yellows and reds and oranges and even reddish oranges. And they’re everywhere. But that’s not even the best part. The leaves on the trees are nothing compared to the ones on the ground. The wind whips them around, back and forth, around and around in the air, and it’s...beautiful. I spend my whole goddamn drive to school just staring at leaves. My friend would have loved seeing the leaves like this.

I’m late to homeroom, as I knew I would be. I rush to my desk, breathing a little heavier than I’d like. (Note to self: start running after school.) The principal is on the loudspeaker, boring as ever.

“Students, today we here at Washington Township High School honor the memory of one of our own who died a year ago tomorrow in a late-night car accident. Rory Johnson is described by all those who knew him as a standout classmate, teammate, and, above all else, friend.”

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I tune out the words and home in on the voice. It has that sort of late-night-radio vibe to it ... you know it's on but you really don't feel like listening to it, so you put in a CD instead. Not that I really listen to the radio. I mean, it's 2011 — that's why I have an iPod. But it's just one of those voices that is so easily dismissed because it's so absolutely positively boring. I mean, honestly, how did this guy get the job? He's got to talk to hundreds of people a day and no one can stand to listen to him.

The bell rings. His speech has been over for about a minute now. I look at the clock and see the girl next to me staring at my wrists. I guess she's never seen scars before. Bitch. I grab my notebook. Eight more periods to go.

Gym class during physical fitness week is the equivalent of hell. I'm on my seventh lap around the track when I feel my bones shake and my muscles resisting each step. My friend would get a kick out of this.

I'm running surprisingly well, though. So well that I catch up with Brandon.

"This is bullshit, right? I'm exhausted," I say, gasping for air.

"Eh, we run all the time for baseball, so I'm okay."

Screw you.

"So what's up? I know everyone's been talking about—"

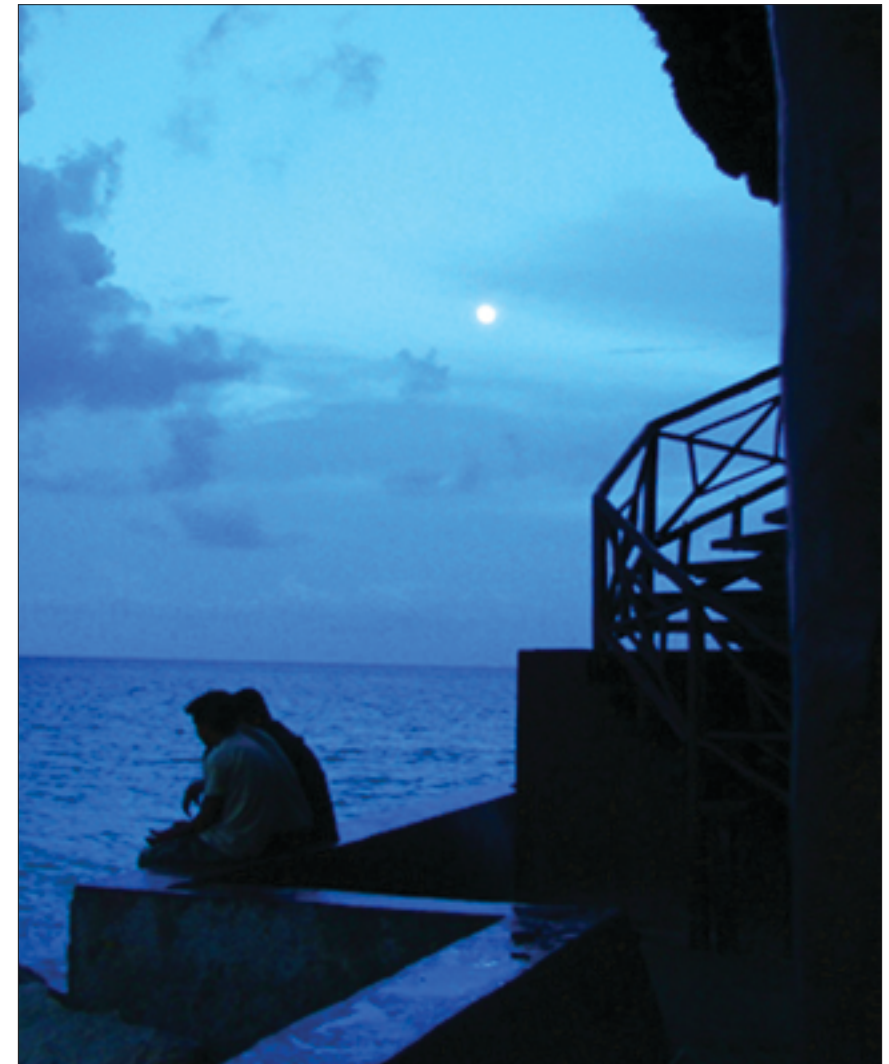
"You're right, this isn't so bad. I'm gonna run a bit faster now," I say as I book it, putting about half a lap between the two of us. I start to get a bit of rhythm into my run. Right foot, left foot, right foot, left, right, left, right. And then I see group of kids gathered on the football field, pretending to stretch but really just avoiding running. They're whispering and staring. I know what they're talking about. They're a pack of vultures, picking at whatever needs picking apart. Pulling and tearing until there's nothing left but the scraps that even they don't want. My friend hated that sort of people, too.

I hear my gym teacher calling us in. Finally. The day's almost over and the vultures can leave and I can go home and be by myself ... safe. They called it depression; I told them it was just life.

It's midnight and freezing. I have to hurry so no one notices I've gone. I shiver as I walk along the side of the road until I get to the tree. On it, there's the grainy high school picture of Rory with

his cheesy, toothy smile. I used to smile like that, too. I bend down, pick up the flowers, and put down a fresh bouquet. Autumn colors. He would have liked the leaves.

Luke Verrillo is a sophomore majoring in English-publishing studies at Hofstra University.



Solace

LISA FLICK

Lisa Flick, RN, is a nurse manager at the North Shore-LIJ Health System.

A Patient's Passing

I had almost finished the entire third year of medical school without losing a patient. It was one of those weird things, the idea of getting through clinical training without losing a patient. Death scared me and there was too much of it in the news.

I had chosen medicine as a profession because I liked working with people, helping people, curing people. I did not like my patients dying. I wanted to avoid it as much as I could. I felt that if I could keep my patients alive it would say something about me as a healer. Then Mr. Joe M. came into my life.

Joe, an African-American, was 76. His job with the New York City subway system had kept him underground for decades. A long history of type 2 diabetes mellitus and hypertension kept him busy with doctors over the years, and just prior to retirement he had suffered a myocardial infarction.

I met Joe on the vascular surgery service. He brought himself to the emergency room after spending half a day with severe leg pain. I was in my general surgery rotation and arrived to find him smiling despite the pain and appearing surprisingly healthy for his age. He looked so good that I thought his age might have been incorrectly entered into the chart.

Joe lived by himself. He loved smoking cigarettes and despite the endless recommendations to quit – or at least let up – he continued to burn through a pack a day. He'd been at it for 50 years. "No sense giving it up now," he said. His wife hated the smoking, but she'd been gone for a decade. He loved lighting up without a chorus demanding that he stop trying to kill himself. They had 40 great years together, he told me.

Joe had femoral popliteal bypass surgery. The complex operation was a success and the leg pain was gone. He was looking forward to getting back to his life. He wanted his rocking chair, his poker night with the guys and, of course, his smokes.

His postoperative course was without incident, and he was scheduled to leave the hospital. But on the eve of discharge Joe developed an acute occlusion of his bypass graft. He was rushed back into surgery for another bypass. Then he suffered a perioperative myocardial infarction followed by a stroke. Joe was in bad

shape. The surprisingly short four-day ordeal following his initial surgery felt like four months. And then it was over. There would be no rocking chair, no more poker nights.

I did not preside over the death call, but in my mind I sat with Joe for days, then years, and now it's been a decade. He was my first death, but what I most remember is the life that he shared with me. Not the medical life that filled his charts, but the life of the guy who fought in World War II and Korea. The Great Depression was as real to him as the milk his mother poured from the glass bottles slowly to make every drop count. He told me about his marriage and the daughter he and his wife produced. He had mentioned her with some sadness. "Yes, she's alive, and no, she doesn't visit." I couldn't get more out of him. Within three beats of his heart, he had moved on to better memories.

For years, I hated that Joe died alone. I don't know if it was his larger-than-life personality reduced to permanent silence, or his having no one to grieve over him. Or maybe it was simply that I felt powerless to do anything. But Joe remained more alive for me than the hundreds of people I have treated who got better and were able to go home. Joe taught me that smiling in the face of sickness is good medicine. He taught me about the profound influence that listening can have on a person in the hospital. It was in knowing Joe – my first patient to die – that I learned that patients who arrive in my operating room are shaped by their life history and not just their medical history. Thank you, Joe.

Sanjeev J. Suratwala, MD, is an orthopedic spinal surgeon in Great Neck and an assistant professor of orthopedic surgery at the Hofstra North Shore-LIJ School of Medicine.

Effusion

At first, I wondered what he was even doing in the emergency room. He couldn't be that short of breath; he was speaking in complete, grammatically perfect sentences. What did he expect? He knew, everyone knew, he had errant cells, cells with a wild streak that had eloped from their home in the right mainstem bronchus and wandered, like prodigal sons, into the otherwise sealed space between the two pleural layers surrounding his lung.

This was no torrent, no flood; it merely was a slow leak, a subtle, steady drip, drip, glide, that beat out the rhythm of mortality but could have been managed easily with a tiny indwelling catheter and weekly outpatient visits for drainage. Hadn't I read in *The New England Journal of Medicine* that family members or partners were now being trained to do this at home? Why did he need to show up in the emergency room at 2 o'clock on a sunshine-filled Saturday afternoon in May, expecting something he had no right to expect from someone so ill-equipped to provide it?

Oh, I knew how to do it. I knew how to slip behind the patient and identify the target, first distinguishing with my percussing fingers the dull thud of pleural fluid from the crisp resonance of air, then slipping a centimeter or two below that and inserting the needle above the corresponding rib at that level. But, ugh, I did not want to do it. Instead of scurrying to obtain a sterile thoracotomy tray from the 11th floor, I dug my heels into the floor and spewed out a bolus of angry indignation. It was always fashionable for NYU medical residents to argue with the emergency medicine staff. This was a case in point – another example of inappropriate utilization of inpatient care for someone who, with sticks of tobacco and a disposable lighter, had accelerated the speed his life otherwise would have taken toward its end.

My daily chest taps would add an hour to my already too-long workday, and less than that to his life. At best, my efforts would be temporizing measures, opening acts, until the real star of the show sealed the problematic space with a sticky glue made of talc or tetracycline. He would feel more comfortable, the thoracic surgery fellow would feel like a hero, and I would feel manipulated and angry. I already did. I argued with the ER docs, but I didn't

prevail. Richard's chest was tapped before he was served limpid baked chicken, steamed green beans, and gray mashed potatoes, the "early bird" hospital fare that day.

Bridget, the ER nurse, stood in front of Richard and clasped both of his sun-tanned hands as he sat on the edge of the bed, arms resting on a draped tray table, while I painted his back in iodine and punctured it. James Joyce bridged the gap between the three decades of Richard's experience as a writer and professor of English and Bridget's childhood in Ireland before she attended nursing school in Brooklyn. Richard's deep voice did not falter as the needle entered; his hospital ID bracelet simply fluttered for a moment as I breached the boundary between intercostal muscle and tense pleura.

Richard was born March 23, 1923, one year and two days before my father. I wondered if they both had learned to smoke in the Air Force, or the Army. I wondered if Richard's wife or daughter had been the first to hear the tiny wheeze, the sentinel rattle in his chest when he dozed on the couch while grading final essays for his "Modern Literature of the British Isles" students at Columbia. I was grateful that I was behind him so that he could not look into my eyes and register the subliminal rage or the subsequent shock in them as the first of what would be 110 cc's of opaque, blood-tinged, straw-colored fluid languidly oozed into the syringe.

I tapped Richard's chest 11 times before the sanctuary for his metastatic cells was destroyed. For five and one-half hours I stood behind him, not meeting his eyes, just as I had that first day in the emergency room. After that first day, Bridget was not in the room during our encounters; it was just Richard, James Joyce, and I. We did not get to discuss "Evangeline," "Two Gallants," "Counterparts," or "Ivy Day in the Committee Room" before Richard was discharged, but while he submitted his chest wall to me, we lost ourselves in every splendid, unresolved nuance of Joyce's characters in the 11 other Dubliners.

During the other 10 hours we spent together over Richard's 18-day hospitalization, we sat face-to-face venturing together into territories I never had explored with my own father. Perhaps because

he was an expert on Joyce or because he was a proficient observer of human nature, Richard seemed to hear the faint dissonances just beneath the apparent harmony of my life. Just as I was unafraid to break into the chamber that held his altered cells, he was confident in entering mine. With a gentleness that put my thoracotomy skills to shame, he uncovered guilt at having broken an engagement knowing that it would mean my father would not live to give his only daughter away; shame at having spent no more time at my father's bedside during the last two months of his life than I was spending now with Richard in what would be the last four months of his; and self-loathing for having allowed Richard's arrival in the ER – with the same terminal illness as my father and on the first anniversary of his death – to squeeze the first real tears of loss from my eyes and bring the first bitter taste of unprofessionalism to my tongue. Richard offered no judgment, forced no resolution: He was an expert on Joyce and not Dickens for a reason.

When he came to the emergency room that afternoon in May, Richard had no illusions about cure. He had just graded the last paper in the final course he expected to teach. He was ready for a measure of comfort, which I trust he ultimately received from someone initially so ill-prepared to offer it. He was wrong about closing the book on his last lesson – maybe it was given not at Columbia, but, instead, at NYU.

Veronica M. Catanese, MD, MBA, is senior associate dean for academic affairs and a professor of medicine at the Hofstra North Shore-LIJ School of Medicine.

Ars Poetica

STEPHEN DUNN

For a while I climbed the ladder,
not realizing I'd placed it
against the wrong house. The window
I tried to look into was a mirror.
I fell backward into the world.

Stephen Dunn is the author of 15 books of poetry, and two of prose. His most recent book is Here and Now (Norton). Different Hours was awarded the 2001 Pulitzer Prize in poetry. He lives in Frostburg, Maryland.

From Falling Backwards into the World: 20 Short Poems by Stephen Dunn (New York, NY: Jane Street Press, 2012).

First published in Bringing Gifts, Bringing News: Fifty Poems Five Lines Each. (Minneapolis, MN: DownStairs Press, 2011).

Lime Juice in a Paper Cut

ALEXA ALVEY

Jealousy is a sweet-and-salty lime
bathed in tequila, that makes my teeth itch.
It is the boil that forms under the switch
of the whip that catches hard and reminds
me how the flame burns. It cozies up
alongside agony, a festering wound
that's irritated by the looming
salt shaker that decides it's not enough
to just amp up the flavor, but bends you
over backwards while a million canker sores
bite at your tongue. Now you're paralyzed
by hate's noose that coils around your neck to
stop you from breathing in all those spores
that will only grow into acid-coated lies.

Alexa Alvey is a student at Hofstra University.

Being Patient

An ICU patient. In the dim, far left corner of an open, four-bed room. Male. Eighties.

Lucid, kind eyes. Pink, robust skin.

Paralyzed.

He cannot phonate, but he can spell, mouthing vowels, spitting consonants, telling me his story one painstaking letter at a time. I listen for each breathy “tih,” “buh,” “sss,” repeating each one, stringing them together like pearls.

The patient watches the cogs turn behind my eyes as words form, and small phrases. He shakes his head when I misunderstand, and when I get him, he nods.

The patient, I think. It’s not just a noun; it’s an adjective. He is so incredibly patient with me, so willing to work to be heard. It is heartbreaking, but I am patient with him, too. It is spiritual support on his own terms, the way it is supposed to be, the way I imagined it when I decided to train as a chaplain. If he can do this, so can the intern. I will stand here for as long as he needs me to stand here.

The man emerges like the image in an old Polaroid. I know what he once did for a living. I know all about his wife and children, how much they love him, how much they want him to go on.

He is tired. He has lived his life. He doesn’t want to be a burden. If something happens, he doesn’t want to be kept alive.

All at once, three phantom consonants appear in the room, yanking the privacy curtain, running it around us, closing the space. They are: D.N.R.

I lean in close. “Are you telling me that if you have a crisis, you want the paperwork to be in place to let you go?”

He is mouthing whole words now, eyelids flickering where the nods should be.

“Please. Tell. My. Wife.”

The patient’s patience with me has paid off. He is totally relieved, but now I’ve got a problem. I have done such a good job listening, he wants me to be his voice. I’m a student here. How am I going to do that?

Name it, my training speaks to me.

I lean in again. “I’m a student here,” I say. “I so want to advo-

cate for you, but I don’t think approaching your wife directly is the best way to do that. Would you be willing to trust me to reach out to other people who can help?”

Approval comes in the way he exhales, with eyes that remain closed through a slow sigh. It is like a sound effect of my own relief.

“Our social worker’s wonderful,” I say. “Let me go talk to her for you.”

Elizabeth Berger has recently completed 1600 hours of clinical pastoral education at North Shore University Hospital.



Reflection

BRANSON SPARKS

Branson Sparks is in the inaugural class at the Hofstra North Shore-LIJ School of Medicine.

Mum

By day, I teach new teachers how to teach. By night, I sit at the side of my mother, who is living – and dying – with Alzheimer’s disease.

Back in the day, my mother would shop for that night’s dinner and bring home empty cardboard boxes for her many projects: blankets to be sent to babies; clothes to be carted off to Goodwill. Then, things began to change, slowly. She would still go out every morning, but she often forgot to buy dinner, and she would remember the cardboard boxes but she did not know for what purpose she needed them.

I hired Ilca to help my mother continue her daily activities and help my father find some peace in his day. Mum would start asking, “What do you want for dinner?” in the morning ... and never stop. So, I sent Mum and Ilca out. Out to buy frozen dinners. Frozen dinners were safer. Out to buy apples – one at a time. Out to buy a new teapot – needed or not. Out again to mail a letter. It worked.

One morning I said to my father, “You look awful. What’s wrong?”

“I never thought life could be like this,” he quietly answered.

I sat down. He told me about my mother’s new distress about light bulbs wasting electricity. She would shut off the lamp as he was reading. He would put it back on and she would shut it off again. That cycle would repeat until he stopped and they just sat there together, in the dark. On more than one occasion, my father would finally turn the light on again and my once-gentle mother would take the book out of his hand, aim it at his chest, and throw it at him. We tried to laugh about it but it wasn’t funny. My father cried. I watched him cry.

He said, “This is my problem, not yours.”

He was right that my mother’s Alzheimer’s was his problem. But, it was also mine. This was quite simply a problem of the whole family and larger still, the community, and the world.

As my mother’s illness progressed, she struggled with her internal distress and we continued to look for novel ways to make her more comfortable.

I remember once, years before her diagnosis, when she asked me to explain the difference between an earthquake and a volcano. Then, there was the day when she read a question on the page of an open children’s science textbook. There were illustrations of three-legged tables with items on the surfaces with the question: Which table is most likely to tip?

“How would anyone know that?” she said.

Five feet two inches tall and 95 pounds for all of her adult life, my mother never got a cold or a headache or ever once complained of pain. She had osteoporosis and had broken ribs and wrists on several occasions. But everything healed and she was back running about in no time. At 85 years, she was diagnosed with Alzheimer’s, and one day after that, she rolled off of her bed and broke her hip. That fall – that diagnosis – changed everything.

At first it seemed like the beginning of the end. Then it seemed like the beginning of something new. Mum joined a new village. This one was a rehab nursing facility. Rehab morphed into long-term care, and a group of very special people joined her on a new journey in this new village.

With her broken hip and Alzheimer’s, Mum’s new community consisted of people in all stages of life on the brink. There were wheelchairs and geri-chairs and merry walkers and oxygen tanks and biohazard containers. Everywhere one turned there were lessons about living and dying.

As we reached a new arc in the great circle of life, Mum became my child, and I took care of her and her new friends.

I kissed Carlos on his clean and shiny bald head every day when I arrived at the nursing facility and when I left. He smiled every time he saw me. I was the only person who ever visited with him in the five years that he called the place “home.”

Jennie moaned and wailed every day, starting at about 4:00 PM. I tried talking to her, holding her hand, bringing her candy, but she never stopped screaming. Her daughter would visit on her way home from work, during Jennie’s escalated moaning and wailing period, and she would say, “Ma, stop. Stop, Ma,” a dozen or so times. Every day, she left in tears.

Katie, with two thin legs in braces from childhood polio, would call out to Jennie at least once every hour: “Oh, shut up. Why are you crying? You think anybody likes this crap?”

Alice, in her geri-chair, too weak to sit upright, petted her little white toy cat all day. “Miss, miss, miss,” she called out every time I walked by. I would approach and she would show me her cat. We always had a chat, and I talked to her cat. One day I walked over and said: “I came to say hello to your cat.” She replied: “Hello to my cat? It’s a toy. Say hello to me. I’m alive.”

In the background, one could hear at almost all times at least one nurse calling: “Henry! Henry, sit down. Sit down, Henry. Henry.”

I became the voice for my mother, my new child. We tried to address her discomfort when we didn’t know her words. We found ways to value her experience in this new changing reality. My mother’s old big ideas, concerns, needs, and perspectives were embedded in her newly altered self.

In her pre-Alzheimer life, Mum was always a giver. She always had a listening ear for family and friends. She carried little trinkets in her purse to give away to any child with whom she might interact. She never went any place without bringing something with her to give away. One day during her “new” life, her Alzheimer’s life, she put pieces of cheese on my plate. I said, “You’re sharing your cheese with me. Thank you.” She smiled.

Mum and I often walked the halls of the nursing home together. “Is the house okay? Is it still standing? Is 59 Willow Court okay?”

Willow Court is where she lived as a child. Mum’s childhood home was, indeed, torn down in the late 1960s to make way for a warehouse. It was a sad day for her. She was one of 10 children raised in that tiny four-room second-floor flat of the house. Mum renovated it after her marriage, lived there with her mother and my dad, and raised three daughters.

“Yes,” I lied. “The house is safe and we are, too.”

My mother fell eight more times in the nursing home. For her protection, the staff hooked her into a restraint when she was seated in a chair. My mother didn’t know she had broken her hip, didn’t know the bones needed time to mend, and didn’t know she couldn’t walk. She did know that she hated to just sit. She wanted

to get up. Her old days were like that. Her Alzheimer’s days were also like that. She hated the restraints. She ripped buttons off of her blouses. When that didn’t work, she ripped the whole blouse. All the while, she asked for scissors. She knew what tool she needed. With Depakote and Ativan to quiet her urge for freedom, my mother stopped ripping off her clothes and stopped asking for scissors.

Mum was considered the youngster on the unit. She had dark hair, velvety skin, and a slim physique. When she was freed from the lap belt, she moved about in her merry walker, the geriatric version of the device for toddlers learning to walk. In her cheerful-looking contraption, she followed the cleaning staff up and down the corridors, roamed behind the nurses’ station to “do some work at my desk,” and asked any passerby to open the locked doors for her. On many days, she would go into the facility’s laundry closet and get out stacks of clean hand towels, unfold them, and motion for a pile of laundry to fold. It was safe and calming. Shortly, the aides and nurses followed suit and gave Mum her morning laundry chores – at any time of day or night.

In her former life, my mother was never idle.

In her Alzheimer’s fog, her word choice was often poetic. Looking at her own empty merry walker in her own room one evening as I was putting her to bed, she remarked, “No one must use this room during the day because that’s always there.” “What is that?” I asked. She readily returned with, “It’s a hand walker for lame people.”

On another evening before bedtime, listening to a high-pitched moan from the next room, she asked, “Do you hear a bell?” “What kind of bell?” I asked. “It’s like a human bell,” she answered.

Jacqueline Grennon Brooks, EdD, is professor of science education in the department of teaching, literacy and leadership and director of the Institute for the Development of Education in the Advanced Sciences at Hofstra University.

Zoned

He rode contrails that crossed the sky.
One day here, one day there,
little cities thrust their skyscrapers
before him.

Between zones, he slept
beneath the surface of his waking,
body never sure
of where it really was.
Eyes and ears told him one tale,
but sounds and visions lingered
of places past.

His poor pineal
tried to regulate his body's clock,
but ticked
when it should have tocked –
a syncopation
better suited to a Brubeck gig
than the steady beat
of his biorhythm.
It sang him the Melatonin Blues.

Richard Bronson, MD, is a professor of obstetrics and gynecology and pathology and director of reproductive endocrinology at Stony Brook University Medical Center.



The Surgeon

ADAM COOPER

Adam Cooper is chief medical photographer at the North Shore-LIJ Health System.

Nights

A month into my second year of residency, I looked around the Medical Intensive Care Unit at the hospital where I was training and realized I was the most senior doctor there. It was the first time I would be spending all night tending patients admitted to the ICU.

With me was another second-year resident. Just two days earlier, we were interns. Suddenly, I was the senior doctor awaiting the next consult.

A woman in her early fifties was transferred to me from another floor. She arrived heavily sedated and intubated. I read her chart carefully. She was fighting an infection that was progressing, and she was in acute renal failure and dangerously headed straight for septic shock. Her skin was hot. Every organ seemed to be shutting down.

Was I ready to be the one treating this patient? All I could think was thank goodness the nurses were there; they had far more experience than I did when it came to caring for critically ill patients.

The first order of ICU business that evening was to put in a central line. I ordered IV antibiotics for her infection and fluid resuscitation. Given the seriousness of her condition I retrieved phone numbers of her contacts. I could not reach anyone. Meanwhile, the blood tests revealed that her potassium levels were off the charts. For hours we delivered medicines to stabilize the potassium, but by three in the morning the machines keeping her alive announced loudly that our patient was in cardiac arrest.

I followed the charge nurse into the room, and we delivered CPR and placed paddles on her chest and shocked her back to life. When we left the room I sighed in relief. No deaths under my watch, please.

Forty-five minutes later, the machines beep, beep, beeped and the alarm shook us into action again. We repeated the drill and once again she made it. I was never more than five feet from her all night.

Then, the third code. This time, nothing we did kicked her heart into action. My patient had died. We covered the woman with her sheet. I went back to the nursing station and reached into my pocket and pulled out a string of numbers I had been dialing all

night. Still, no one answered. I left messages for someone to get back to me.

“Dr. Ginzburg, pick up line 2,” a nurse said. I was hoping it was a family member, although I didn’t quite know what I was going to say.

It was the morgue. The man on the phone said something about my patient needing to be transferred to the Office of the Chief Medical Examiner. He wanted me to fill out her death certificate immediately and have her moved to the morgue in the hospital basement. Behind me, the ICU was bustling with the change of shift. Through the windows I could see the familiar light blue sky that meant my time on call was almost finished. The first sign of daylight also meant that morning rounds were approaching. Minutes before the attendings, fellows, and medical students arrived on the ICU, my patient was moved.

Rounds with seriously ill patients take time. We stand at the bedside of each patient and pore through the chart, talking about the pathophysiology, data, management, and the endless complications that require their stay in intensive care.

When we arrived at Bed 11, the life-saving attempts that kept us busy all night littered the floor — wrappers from the central lines, the bags of IV medicines and fluids, and the dangling wires attached to the machines that didn’t stop commanding attention.

The doctors pushing the chart cart briefly slowed as we passed. Someone must have noticed the now empty space where the bed had been and the remnants of the supplies used to try and keep my patient alive. They barely skipped a beat and walked by.

“She died this morning,” I said. It was as if no one was listening. “She died this morning, my patient...”

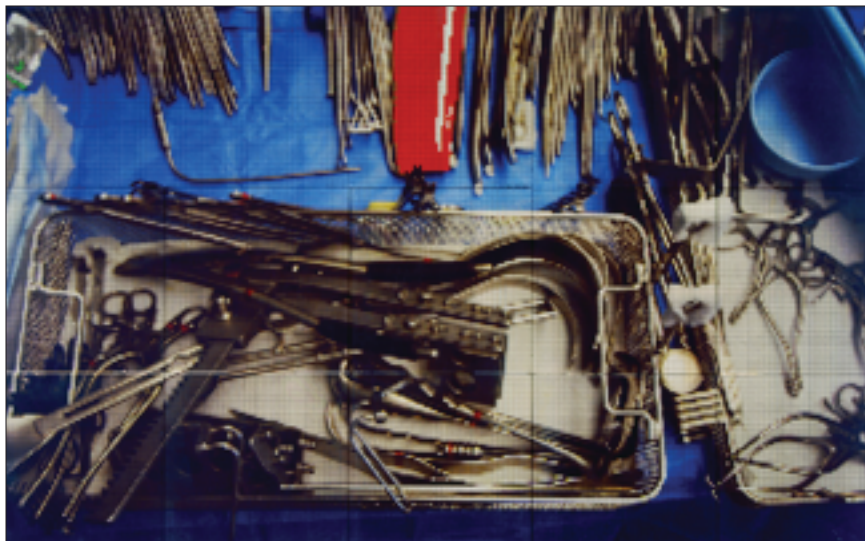
I wanted to talk about her symptoms and the complications, just as we had done for those patients in other rooms who were still attached to machines that were breathing for them and pumping medicines into their bodies.

“Right now we need to round on the patients who are here. Maybe you can discuss this patient afterwards with the fellow,” the senior attending said.

I was stunned, but I had no idea what the normal routine was on the medical ICU. The hard work of the night was over, and now I stepped in line with the other doctors who had probably just showered and had their morning coffee. They didn't seem to care about the failures of the night. They had the living to consider. The point of rounds in the ICU is to discuss the nuances of caring for the most difficult of patient care situations. How could we possibly have just skipped the critical lesson of the day?

Somewhere inside I knew – or at least I remember it this way – that this was wrong. So much happens overnight when no one is around, when it's solely on you to keep the patients safe. We need to capture and to share the learning that takes place during these dark hours. Especially when the patient is no longer in front of us.

Samara Ginzburg, MD, is director of undergraduate medical education at the North Shore-LIJ Health System and assistant dean for medical education at the Hofstra North Shore-LIJ School of Medicine.



Chest Tray Chic, Too

PAUL KOLKER

Paul Kolker, MD, is emeritus chief of cardiothoracic surgery at Glen Cove Hospital, a graduate of Hofstra School of Law, and an artist whose studio, Studio601, also serves as the artist's gallery.

The Patient Doctor

The door was slightly ajar, thankfully. I slipped in – loud and awkward, my crutches banging against the doorway, clipboard clasped tightly against a crutch with one hand. “Hi,” I said, smiling. My right leg was the elephant in the room, big and obvious. I looked more like a patient than she did.

She was a woman who looked to be in her fifties, slightly plump, brown hair tinged with gray. Upon seeing my awkward entry she jumped down from the exam table and pulled her bag off the chair, motioning for me to sit down. I did.

I took out my pen and asked for her story. The diagnosis was cancer, already metastasized to her liver. A lifetime – or just a few years – ago she'd been a doctor and had worked in three different specialties across a period longer than I'd been alive. She sat back on the table, fiddling with her gown, and began to talk about her medical history. She'd been through radiotherapy. The malignancy had traveled to her bones, but she'd been able to fight it off. She spoke about her children, too. They were teenagers. The cancer had forced her into becoming a full-time housewife. It was a tough job, she said, laughing. But she meant it.

I had been a patient for over a month – I tore my Achilles tendon while playing on the college soccer team – but I knew that pretty soon, my trial would end. I would be able walk into a room to meet my patients and they wouldn't have to jump off their beds or exam tables and usher me into chairs. I would no longer be a patient.

It turned out she was in her forties; the disease had aged her. As I listened to her talk about giving up medicine, I was reminded of the lessons I'd learned in the past few months – as a medical student, and now as someone on the other side of the bed. I knew what it was like to have a needle and tubes tethered to my arm. To go to sleep and wake up needing to pee but not being able to do it. To have nurses and doctors look right through me. To feel shame, to lie to a doctor and say that I'm okay when I feel like crap. To want to please the doctors and nurses as if it would make the whole experience better.

Nothing feels good about being a patient, until it's over. And here was my patient, still sharp, funny, and strong enough to jump down to help someone, even in her condition. I wondered whether I would have seen all of this a month ago.

I was intent on becoming a doctor, but I had never been in a hospital as a patient. In a way I was more suited to my first career choice: I studied education in college, and I'd been a student all my life. As I drew close to completing my master's, though, I realized that the kind of educator I wanted to be wasn't necessarily in a high school classroom. The last years of school rapidly became filled with research, volunteer work, and medical school applications. As a doctor I could teach, do research, and see patients. It was everything I wanted and, importantly, it sounded like fun.

It wasn't until last month that I learned another side of what doctoring is about. I was playing in the second soccer game of the season when I heard a snap. I went down fast, right on the cold grass. My teammates – classmates from the medical school – picked me up and carried me to the sidelines. I couldn't walk, but there was no pain. It was Sunday; Monday was a day away. I couldn't miss class. I fended off suggestions that I go to the Emergency Room. Me? Hell no. I used to volunteer in an ER in the city, a colorful place that drew people with problems big and small. But people like me didn't go to the Emergency Room. It was just a foot, after all.

My brother pulled an old crutch of his out of the shed. He is shorter than I am, and the crutch was bent; and, of course, I had no idea how to use it. I looked very silly in class the next day, hobbling and hopping, eventually giving up and sliding around on a wheeled chair. My classmates made me see a faculty member who specialized in emergency medicine. He took one look at my right foot, asked a few questions, and gently delivered a preliminary diagnosis: "You probably have a tear in your Achilles." His recommendation was firm: "You need to go to the Emergency Room."

A few weeks prior I had shadowed a doctor in the fast track ward of the ER at Long Island Jewish. Now, wheeling in as a patient, the place felt eerily familiar. The attending physician had been one of the ultrasound faculty members at my school, and he did an ultrasound on me first thing. I saw the tear on the screen. I

was going to need surgery.

One thing I never noticed about my patients was all the waiting they had to do. Wait and wait and when the waiting feels like forever . . . more waiting. I was admitted that night and would remain there for two more days. I was scared. I didn't know what was going to happen. People weren't telling me when my surgery was. I didn't know if anyone would be there when I woke up.

A few weeks earlier I had learned about the concept of health-care as a microsystem, with patients and providers working as a team. From my bed, it was hard to notice any team spirit with my caregivers. I felt helpless and needy. People with white coats would enter my room but I had no idea who anyone was. I was alone in the crowd.

No one prepared me for what it would feel like being put out for surgery. I woke up shivering. I was bundled in seven blankets and I still couldn't stop shaking. A patient near me was moaning. I was panicked, and my leg was so heavy that the rest of me couldn't move. And then that urge to pee washed over me. The nurse said she would bring me a bedpan. I knew that wouldn't work. Peeing in public was hard enough, but peeing lying down? I'd never be able to do it.

I demanded help standing. I looked down and saw myself completely naked, a nurse holding me tight by the arm. "The sooner you pee, the sooner you'll get out of here," she said. It seemed like forever before it came. When it did, I had to look away from her. Uggghhh. I was naked and peeing in front of a stranger. I was mortified.

I was discharged without much incident, and I'm well on my way to recovery. Still, when I walk in the room my patients jump up to take care of me when it should be the other way around.

I've asked plenty of doctors what they would do in this situation. Many have said that doctors who fall ill or become disabled often stop seeing patients. I was even advised to fall back on administrative work – to stay behind the scenes – during my clinical rotations. While some doctors are able to continue doing the work they love (one of my teachers told me his children's pediatrician has one arm), many more seem to end up giving it up.

My patient was one of the doctors who had to give it up. After a distinguished and exciting career fighting illness in the wards, she is now fighting a much more personal battle at home. “I loved being a doctor,” she told me. “It was hard giving that up.”

Not long ago, I might not have understood her plight. Now, as I reached for my crutches, clipboard clasped tightly against one with my right hand, I understood what she was going through. I will be completely healed in a few weeks, but I hope I never forget the lessons I have learned.

Joshua Bloom is in the inaugural class of the Hofstra North Shore-LIJ School of Medicine.



At Sunrise, Cappadocia, Turkey

FAIZUR CHOWDHURY

Faizur Chowdhury, MD, is an attending at Southside Hospital.

Paul

All it took was a glance to his left. The patient’s eyes had a sort of longing in them, reaching out from beneath upturned eyebrows and the dark bags that encased them. Ben stopped his brisk walk down the hospital hall and poked his head into the small emergency department room, pulled aside the floral-patterned divider, and let himself in.

The guy’s hair was a mess of brown. He looked to be on the shorter side, with a stocky build and graying stubble dotting his tired face. Now Ben had to make sure he was comfortable. As he moved in closer, he got a better look at the man, who couldn’t have been much older than 40, but had a much older-looking face — probably ravaged from years of drug abuse. A thin white hospital sheet covered his left leg as he lay on his side watching Ben walk toward him.

“Hey doc, my foot’s pretty effed up,” he said, not giving Ben time for any sort of introduction. “Sorry that I’m using that language — you don’t mind, right? But it’s just that I think I can say what I want to say and no one can stop me from saying it. Like if I went to college and became one of those supreme...,” he paused for a second, turned his eyes to the wall, and actually looked rather pensive. “What do they call them? Them court guys?”

“Supreme Court Justices?” Ben offered.

“Yeah, yeah, them guys. Like if I went and got all my lawyering stuff and had my own courtroom, I could cuss and be like if you don’t like it then you can just leave my damn courtroom. ‘Cause it’d be mine and all and I could make all the rules. And I could tell them all about my First Amendment rights. You know what I mean, doc?” He seemed to be posing a question, but he didn’t pause for an answer before continuing. “Yeah, I think I could do that then, just tell everyone to shove it if they didn’t like it.”

The guy took in a quick breath and as soon as Ben started to open his mouth, he started up again: “You know, doc, I went to college but I had to drop out ‘cause I got arrested and put in jail.” He looked at his arm briefly, then showed it to Ben. “You see all these here?” as he pointed to the tattoos on his arm. “Did ‘em all myself. Even the ones on my right arm. And I’m right handed. Learned a

lot of useless crap in jail, but the one thing I actually still use is drawing tattoos. I used to work in a parlor, actually.”

The man then proceeded to pull his left leg out from under the sheet. His left foot was noticeably bigger than his right, actually swollen to almost double the size of the other. “Yeah, I’m a diabetic. That’s why my foot is so messed,” he said as he looked up at Ben, in a way that made Ben think the guy might know more about his disease than he had originally thought. “But check this one out here, I love redheads.” As he pulled up his gown, Ben saw a crudely drawn figure of a bare-chested redheaded woman on his leg. He pulled the gown back down and smiled, covering his foot with the sheet.

“Man, am I glad you came in here. I finally have someone to talk to. I’ve been up here since ten in the morning, been here all day it seems. And I just been waitin’ to see someone. Name’s Paul. Pleased to meet you, doc.” He reached out his hand for Ben to shake, now giving Ben the window to introduce himself. “So what kinda doc are you, man? What you need to know from me?”

“Well, actually today’s a day off. I was just here to help out one of my buddies with some of his research. He needed an extra pair of hands, and this is the best way out to the parking lot from his lab. Normally, I’m a medical student.”

“Well, research could mean a whole bunch of things. For all I know you could be doing research on baseball cards down the street.”

“Well, it’s stuff with DNA.” Ben paused for a moment, never having had to explain his colleague’s research before, let alone to someone who might not have a clue as to what he was talking about. “It’s basically looking to see what genes are involved with common diseases.”

Paul’s interested look disappeared. His back straightened against the pillows. “Did you know that they have a cure for diabetes? You have to know. But they just won’t let it out ‘cause the pharmaceutical companies are making too much money off it.”

Ben was taken aback by the guy’s paranoia. “I don’t know. I haven’t heard of it. But who knows, I guess,” he said.

“Yeah, I know. You’re just like my sister, she won’t talk to me ‘cause she works with the NSA and apparently she thinks I was

mixed up with the Hell’s Angels back in the day ‘cause she seen me in one little picture from when I was at a Van Halen concert in ’88. The NSA recruited her right out of high school. Haven’t really seen her since. Most of my family lives over in the graveyard down Ponca Street.”

Ben stood there, not really too sure where to take the conversation at this point, and he knew he was already late getting home. All he had wanted to do was to ask Paul if he needed anything because he’d made eye contact with him. There was a brief lapse in the conversation, and both men looked toward the wall as if they were examining the same interesting thing plastered on it. The wall was blank.

“Thanks for coming in here, man,” Paul said, finally breaking the silence. “I really appreciate it. It’s been real lonely in this damn room all by myself. You’re the first guy that’s come in here to chat with me. I can tell you’re a good guy, and when I look at you I know that there’s people out there that won’t let the whole world go to hell. So thanks, man.”

“Yeah, Paul, no problem,” Ben said, as he started backing out of the room. “I just really wanted to check in and see if everything was all right or if you needed anything. I do actually have to get out of here. I was supposed to be home an hour ago but things ran a little late and my girlfriend’s been nagging me to get home. Can I get you anything real quick before I leave though?”

“Yeah, another Coke would be great if you could.” Paul extended his Styrofoam cup to Ben with a smirk on his face, but Ben didn’t take it from him. “I’m just yankin’ your chain, bud. Nah, don’t worry about me, I’ll be fine soon as this guy’s all healed up,” he said as he pointed to his foot. “But take care, man, I really liked talking to you.”

Ben nodded and pulled aside the floral divider, leaving the dark room and stepping into the bright hallway of the hospital’s emergency department. He still wasn’t quite sure why he’d felt obligated to go into that room and talk to Paul or why he even looked at him in the first place. He didn’t understand whether he had done anything for Paul — it wasn’t as if he even said anything important to him. Maybe the guy just needed someone to listen to him. Normally Ben wouldn’t have done anything like that, especially if

he was rotating on the floor. Maybe it was just because he was still so new to everything as a third-year medical student and was still getting used to all the patient interactions. In his short time at the hospital, Ben had gotten to know his fair share of the emergency room regulars. The guy with Crohn's disease who was always asking the patient reps how much longer it'd be till he was seen when he knew damn well how long it normally took. Or the woman who always needed an extra blanket after a weekend bender and "falling down the stairs." Most often, though, Ben saw people come in with no health insurance and nowhere else to go. But he still couldn't figure out what had prompted him to stop for Paul.

The emergency exit door burst open, letting in the humidity of a Baltimore mid-summer's evening. Often after a long day at work, Ben couldn't remember what the weather was like outside. Inside, the temperature seemed to be set to below freezing and he usually had on a sweatshirt as he ventured outside into the thickness. The sun was just beginning to set, nestling itself behind streaking clouds and leaving a vibrant red hue to the evening sky just above the horizon.

He reached into his pocket and pulled out his vibrating phone. Cara was calling. He turned off his phone and jammed it back into his pocket as he reached to open the door to his Toyota, which had seen better decades. Leaving the hospital parking lot, he thought up an excuse for Cara as to why he was late again and why he didn't answer any of her calls. He seemed to be making up excuses a lot lately.

He drove down the tiny Baltimore streets that didn't seem to be built for cars, heading to his rented row house near Federal Hill, thinking about his interaction with Paul. He wondered where Paul would head when he was discharged and what clothes he would use to cover his tattooed stories. He wondered who else would be let in on his secrets and who else already had. He pictured Paul dropping his light hospital gown onto the floor and stepping outside into the hospital hallway. And finally going home.

Daniel Bulanowski is in the inaugural class of the Hofstra North Shore-LIJ School of Medicine.

A Tear in Her Eye

Taking a history requires practice, which is why there is a pretty important doctor to the left of my arm, watching. I am a second-year medical student and it's the 1970s when balcony seats at Olympia Stadium in Detroit are less expensive than a coffee and a donut. I am at Wayne State University and I am being "observed" by one of the most respected internists in the city. He is not saying a word. He doesn't even crack a smile.

My task is to take the history of a middle-aged woman in the hospital. Decades later, I will have no recollection of why the woman is there, but every feeling that I have during the exercise will become an indelible part of my memory. I will even remember the color of her hair – a dark blonde – and the track of a tear as it moves down her cheek.

That tear is provoked by my astute history taking. She's in her fifties, so I imagine that she, like my mother, has children who are venturing out of college and making their way in the world.

"Do you have children?" I ask.

She is an attractive woman, and I see the tear welling in her eye. It had not fully formed before my brain registers the same emotion – sadness – and the thought that I am staring at a patient who is sad beyond anything I have ever seen.

"I'm sorry," I whisper.

Five more tears, and she takes the sleeve of her hospital gown and wipes them away. Her cheek still glistens. She clears her throat and manages a half-smile.

"I had three children," she says. "Ten years ago, they died in a car accident."

I put my pen in my other hand and reach out to comfort her. A minute or two passes and I feel paralyzed and don't know what to say. I finally decide to break the silence with more history taking. I thank the woman and wish her well. I walk out of the room with the attending on my heels. I am very upset that I provoked such memories.

The attending is an arm's distance from me in the hallway. He must know how shaken I am, but when I search his face for any sign of empathy his features are cool like marble. Me, I am sick.

My belly hurts.

“What observations did you have?” my doctor/teacher asks.

“I’m upset. I feel terrible that I asked her whether she had children...”

Now that I have spent half my life doctoring the sick, his words remain seared into my brain: “Well, this is a good example of someone who can’t move on in life and deal with her grief.” He says something else about maladaptive behavior, but I have already checked out of the hallway.

I stand there but my mind is in lock-down. And to think, I am about to tell him how much empathy I have for the poor woman – forever a mother with no children. And I am about to say how history taking is such a privilege because it allows some patients to share stories so close to their hearts.

I must have been standing with my mouth wide open for the longest time, for the next thing I know I am alone. My thoughts taunt me. I am not sure if I am wrong to feel sadness and empathy for the woman on the other side of that door. I want to turn and go back inside, sit next to her, hold her hand, comfort her.

What if that is not what it is to be a physician? What if the attending – he is chief of internal medicine – is right? What if those deep-down feelings are wrong and a doctor taking a history should do so without emotion? Do I even have it in me not to be compassionate?

Decades later, I will still see her face and conjure up that tear in a heartbeat. “I’m sorry,” I will say to myself. I am sorry I never turned back and entered that door again.

Three years later...

I am at a busy inner-city hospital in Greenwich Village. I am an intern, and I find myself drawn to the same room every day for what feels like a month or two. Inside this room there is a man on a bed who is not moving. He never moves because he can’t. A stroke ripped through his brain and shut down the motor cortex. The signals no longer reach his muscles and he suffers from locked-in syndrome.

His wife comes every day with a large thermos of carrot juice. She is convinced it is the best medicine since there is no other medicine that we can serve up for his condition.

He understands what people say, but his eyes are the only part of his body that shows evidence that the light is still on in his brain. It is 1978 and he is in his early sixties.

His wife regales us about his swimming prowess and his venturing across the Aegean Sea in Greece. He loves Greece, she says. We’ll go back if he gets better, she adds.

He isn’t getting better, and she knows that in her head, but not in her heart. That is why I come around every day to offer an ear, a smile. I like her stories. I admire her hope. They were world travelers, and she is feeding him carrot juice to get him back on that road.

After a month of this, I hear my name on the loudspeaker. I am summoned to the room where his wife is screaming. Doctors and nurses are crowding in. These are the days before advanced directives or DNRs or healthcare proxies. Her husband is coding and she is screaming that she wants everything done to save him.

Meanwhile, social workers and nurses have been spoon-feeding her the truth for a month. He isn’t going to get better, they have said. Nobody wants him to die on their watch, and here I am – the doctor on call, the guy who loves the story about how he swam in the Aegean Sea.

We attempt to resuscitate him. It doesn’t work. After I announce the time of death, the room clears out. The woman sits by her husband’s bed, holding his hand, weeping. I put my arm around her and she falls heavily into my chest. I feel the weight of this last month and her lost love. I do not cover his face with the sheet. We just sit there for the longest time. She holds his hand and I hold hers. I am afraid that I let her down, that I let him die on my watch.

I want to say that I am sorry. I stay quiet. She begins to tell me more stories about her husband and about their travels. Then, she looks up at me and smiles through her sadness.

“Thank you for listening,” she says.

Thomas Kwiatkowski MD, is an assistant dean for education/simulation at the Hofstra North Shore-LIJ School of Medicine, and medical director of the Patient Safety Institute and the Center for Emergency Medical Services.

HIV

When I began my work with HIV three years ago I thought to myself, I will do my best to make a change, some sort of difference — no matter how big or small — in the lives of these patients.

A patient would come in without a belt, clutching his pants in his hand so he wouldn't fall down, and I would take off my belt and give it to him. Sometimes patients did not have food in the home, so I would set them up with a free grocery delivery or food pantry referral. "Keep the faith," I would tell my patients, emphasizing the small acts of kindness that were no match for the big kinds of sickness they were dealing with.

I waited for some of them to reach out to me and talk about how they were doing, but it did not happen. It frustrated me. I had hoped that my kindness had made their days somewhat lighter. It would have been nice to hear something.

And then I did. This young mother had two preschool children and a husband who was with her at most appointments. She was in and out of the hospital several times that year, and each time our doctors, nurses, and the unit social worker would do their absolute best to make sure she could get stable enough to return home to her family.

Christmastime came, and the patient and her husband sat down with me during an out-patient visit and said that because of all the hospitalizations she was not able to renew many of her benefits. Her husband, who was the only source of income, had all he could do keeping up with the household bills. "We won't be able to give our children anything for Christmas," she said.

Nothing in her voice was angry. She was sad. Tears ran down her cheeks. Her husband held her hand, softly. After they left, I worked with a team of social workers and we were able to get the family approved for our "Adopt-A-Family" program at North Shore. The children received bikes, toys, and clothes. Both the patient and her husband received gifts as well. It was the last Christmas my patient would spend with her family.

A few months later, my patient was rehospitalized and passed away. Our staff sat with the children and husband and offered what comfort we could. We also assisted the family with funeral ar-

rangements and referrals to assistance programs so that they would not have to suffer financially in other areas.

"If it weren't for you and all of the other doctors and nurses who helped us, I don't think our family could have made it," the patient's husband said, only days after he buried his wife. "Thank you."

It was then that I understood the importance of teamwork. Like family, it is not just one individual in a story.

That year, seven more patients with AIDS died and left stories behind. They have taught me a lesson of faith in humanity: how big gifts can come from small moments in one life touching another.

RunInMuun Hyman, LMSW, is a social worker in the department of infectious diseases at North Shore University Hospital.



Early Morning Along the Arno

STEVEN RUBIN

Steven Rubin, MD, is a pediatric ophthalmologist and vice chair and residency program director in the department of ophthalmology at the Hofstra North Shore-LIJ School of Medicine.

The Physical

This time she comes in quietly
without her usual Wernicke's babble
ceaseless as stock ticker tape
without an exchange.
She probably hasn't slept again.

She used to teach middle school science;
then her husband came home from Iraq
higgledy piggledy halfway to Libya
post-traumatic; attacked her
with a hammer.

Today she's snapping her change purse
open and shut. My greetings float
like happy-face balloons over a landscape
where no-one looks up.
She's in the little paper gown

refusing to put her change purse down
even while I thump and palpate,
echolocate the outlines of her organs:
lungs, liver, spleen.
Shut, open, shut.

*

It becomes a gesture
the physical: body to body
a tenderness takes place
when I touch the shapes
that ruin makes.

But today, she can't bear it.
She pushes me away, cries out

IF MY LEAVES ARE ON FIRE!
ALL YOUR TREES ARE BARE!

I sing-song a rhyme that sometimes
calms her:

Hark, hark, the dogs do bark
The beggars are coming to town
Some in rags and some in jags,

AND THE ONE
IN THE GODDAMN GOWN!

she shouts, then sticks out her tongue.
But she lets me finish the exam.

*

I cannot fathom such aloneness.

The mad solo of herself
goes on all day, sometimes all night
until a blade of light pries open
the next day—
which does not recognize her.

Have I been faithful?
Stirring ashes, making black marks
on this page?

Solitaire,
I cannot speak for you.
You speak for me—

...finish the phrase
my combustible

the bare tree in me.

Note: A person with Wernicke's aphasia from brain trauma or stroke has lost the ability to understand language, but can speak fluently, often hyper-fluently. Such individuals don't realize they make no sense. In the past, mental institutions had their share of "schizophrenics" who actually suffered from Wernicke's aphasia.

Dawn McGuire, MD, is a neurologist and author of three books of poetry, including The Aphasia Cafe (IFSF Publishers, 2012). She is a professor at Morehouse School of Medicine in Atlanta, GA.

Lessons from Lindsay

My stepsister Lindsay is an amazing person. The daughter of two lawyers and the first born in a family of four children, she is unable to speak but seems to understand everything that is said to her. She cannot initiate activity but is able to follow directions easily. And although she has an awkward gait, swimming comes effortlessly to her. Lindsay has an incredibly sweet disposition and sustains a level of inquisitiveness beyond what I've experienced in my other siblings. Lindsay also has Down syndrome.

I was 12 years old when Lindsay became a member of my immediate family. Her condition sparked both my curiosity and my interest. Several years later, during my sophomore year of high school, a rotator cuff injury left me unable to practice or compete in swimming. Having been both a competitive swimmer and a coach for the greater part of my life, I decided to combine my desire to learn more about my stepsister with my talent for swimming and began coaching for the Special Olympics swim team.

During my time working with athletes with various mental and physical challenges, the wide range of their abilities struck me as incredible. Chris, a member of the group I coached who had cerebral palsy, was high functioning in his abilities to converse and interact outside of the pool but was unable to progress in his swimming because of a severe learning impairment. Sarah and Marc both had spina bifida yet they were so different in their abilities in and out of the water that I found it difficult to comprehend that they both suffered from the same condition. While both were confined to a wheelchair, Sarah was able to complete a practice entirely on her own while Marc required a companion for physical assistance. I also coached several swimmers with Down syndrome who were fully conversant and only marginally impaired – a stark contrast to my own stepsister. The differences I experienced in my swimmers helped me understand more about Lindsay's condition, and it also incited passion to learn more about other disabilities.

As a neuroscience major at Johns Hopkins University, I learned a great deal about the biological, genetic and environmental factors that led to my stepsister's condition. Classroom sessions helped me understand the chromosomal disorder and its effect on one's cogni-

tive abilities. Each class and professor helped me discover more about myself as I learned about others. I knew at this point that I wanted to be a doctor.

It was not in a classroom but in an examination room at the Johns Hopkins Kennedy Krieger Center that I learned what makes a great doctor. I joined my parents for an appointment they had for Lindsay with a new physician, Dr. Capone. After a series of tests and examinations, Dr. Capone informed us that in addition to having Down syndrome, Lindsay was autistic. What Dr. Capone told us about Lindsay had not been identified in over 19 years of previous doctor appointments. Speaking with Dr. Capone made me realize that the true challenge for a doctor lies in identifying disparate facts to form a cohesive diagnosis. Excellent communication, sensitivity and critical, out-of-the-box thinking combined with a creative approach to problem solving can dramatically affect the lives of others. Indeed, it was this combination that helped Dr. Capone reach the diagnosis that has led to Lindsay's increased functioning and happiness.

At Hopkins, I also came to meet Pierre, a young boy from Haiti who was brought to America after the earthquake of 2010. Pierre was severely disabled and spoke no English. With my broken French and with the assistance of a Creole interpreter, I helped the child move through the healthcare system.

It soon became apparent that Pierre would not address the female caretakers. If I was in the room and it was a choice between me and his interpreter, his gaze would turn in my direction. Even female doctors had a hard time getting him to settle down for their examination. I became Pierre's unofficial mover, the tender of the medication, the blood pressure cuff, the showering. I was unqualified and untrained in all of these activities but it didn't matter. The agitation in the boy's face, the fear, gave way to my efforts throughout his stay.

Pierre and I made a connection in a place and situation far away from the life he knew. Away from his family and plopped into the chaos of the hospital, he was unable to communicate with anyone aside from me with my poor French. He struggled to understand

people and a world that he had never seen.

I imagine that my stepsister might have felt such a frustration had she been thrown into the world without her family.

During my work at Hopkins, my desire to learn more about my stepsister's condition intensified. I was also drawn into other medical puzzles in the laboratory. After three years of part-time research at JHU, I was offered a position at the federal National Institute of Child Health and Human Development. My lab worked to understand the roles of various genes in the development of the human nervous system. Our main project was to identify the role of a gene that regulates the development of the hippocampus, the major brain region that is selectively affected by Down syndrome.

Technical expertise is an important aspect of being a doctor. However, I believe that there are other attributes that are essential in a well-rounded physician: a problem-solving mentality, a tendency toward creative thinking, excellent communication skills and compassion. These qualities, as well as a strong work ethic, honed by years of competitive swimming, have been incorporated into the fabric of my life. The lessons I learned from my stepsister and others at the Special Olympics propelled me into medicine. They taught me about compassion and empathy and being in the moment with all of the limitations imposed on an individual, and all of the strengths.

When I accepted a seat in the first class of the new medical school, one of the major selling points was the immediate access to patients. The breadth of the experience would take me into diverse communities and cultures, from working EMT shifts in Queens to following a number of patients at Huntington Hospital over the space of a year. I would find patients needing my help on the ambulance, in the ER, in the ICU and in the catheterization lab. Every opportunity comes with a lesson about community and relationships, about family strength and individual courage, about hope and healing and the trust that people expect when they find themselves in unsettling places and times.

Alexander J. Blood is in the inaugural class of the Hofstra North Shore-LIJ School of Medicine.

A Valentine's Day Tale

Amid the pastoral splendor and beauty that is the nature of the North Fork of Eastern Long Island lies the town of Mattituck. Sandwiched between the shores of Peconic Bay and the Long Island Sound, this hamlet has been home to farmers and fishermen dating back before the American Revolution. It has also become a retreat for those who look back to a quieter time. It's a place where the days lap over each other like the waves on its sandy beaches. It is here among the farms and marinas that my Uncle Andre and Aunt Betty came to spend their retirement.

They moved into a small red brick home and stocked it with the relics collected over the span of their 45-year marriage. It became their refuge. Nestled in this bucolic countryside, they enjoyed views of cornfields from their kitchen window. From their old but steady porch, they could see shallow creeks off in the distance. This quiet home and sprawling backyard were the realization of a mutual lifelong dream. They had found a pleasant niche in this idyllic place, which was a stark contrast to the bustle of Flushing they knew so well. Their new house invited the afternoon sun every day through quaint panel windows. Uncle Andre loved to stand there, squinting, as he watched the sparkle of the sheets of snow and ice on an evergreen bough.

It is here that my tale of true love begins.

Uncle Andre was a carpenter with a distinctive Neapolitan nose that had been made even more memorable by the whack of an errant baseball bat when he was a younger man. He had a raspy voice straight out of central casting for *The Sopranos*. He was lucky in love. He had married his childhood sweetheart and spent the rest of his life adoring her. And what wasn't there to adore?

Aunt Betty wore high heels while vacuuming their living room! She took getting dressed as seriously as a surgeon takes entering the brain: carefully, slowly, and with precision. Ultimately, she would emerge gorgeous. When Uncle Andre was a working man, Aunt Betty would step into a pair of heels, grab a bag from the kitchen counter, and head for her car. She would sit and eat with Uncle Andre, pick up the wrappers, and then head back home.

Aunt Betty loved to dance.

Uncle Andre loved to build houses.

Over the years, their relationship took some health hits. His coronary artery disease required four arteries to be bypassed with repeat performances by stents and a defibrillator for good measure. Once, during a colonoscopy, he fell prey to an infrequent complication: His large bowel was perforated by the snip of the scope. Aunt Betty became Nurse Betty with compassion and no complaints.

That night, while watching Uncle Andre shivering, Aunt Betty sat him down on the sofa while she grabbed the bed sheets and comforters and whisked them off to the dryer. When they emerged warm a few minutes later, she brought him back to bed and tucked him in and rubbed his arms gently until his body no longer rattled. She did four loads of sheets before she realized that he was only getting sicker. She called an ambulance. By the time it arrived, poor Uncle Andre was almost in septic shock. He recovered after a week of intravenous antibiotics. Aunt Betty was determined to get a better dryer that could make bed linens warmer.

For Aunt Betty, the journey was different. Aunt Betty is one of those fortunate people who go through life relatively unscathed by the aging process. She was healthy, although she did have her gall bladder removed. She always looked and acted the same. Never could anyone recall a bad mood or a day without a smile and kind words.

Then, one day, I noticed that there was a different cadence to her cheery self. I reached back to medical school training and began doing a mental assessment scale. "Count backwards by seven," I instructed her. "How many nickels in a dollar thirty-five?" She smiled broadly, "Oh, Frankie, I don't know about those things. But ask me anyone's birthday. I never forget a birthday. Yours is January 16." Exam over. So she couldn't make change if her life depended on it; she couldn't tell you who the President was four years ago; and she couldn't subtract seven from a hundred without a calculator. So what! She could remember my birthday and every other birthday that counted in the world. I kissed her on the cheek. My house call completed.

For Aunt Betty and Uncle Andre, life was a duet. They were inseparable. She was at his bedside whether at home or during one

of his frequent visits to the hospital. She stopped driving her car, or should I say, she had her keys taken away from her when she continued to get lost in their little town. Even a trip a few blocks from their home to the Love Lane stores would be an excursion from which she could not easily return. That didn't matter much, as Andre had become her permanent chauffeur. She never protested. They were a team. He made sure that she was never alone. She made sure he never felt old.

On February 14, 2006, pockets of ice and frozen snow stuck to the stubble of last year's corn husks. Wide-open fields with faded orange drift barriers dotted Mattituck. Occasional shrunken squash and pumpkins were strewn where the tourists had dropped them on their way to and from roadside stands in the summer.

On this morning, Uncle Andre and Aunt Betty performed the Valentine's Day routine that had been theirs for 45 years. She prepared breakfast, and he turned on the stereo — Frank Sinatra sang them a love song.

Then their love story would change forever.

Sometime after breakfast, perhaps by ten or eleven, Aunt Betty couldn't really say, Uncle Andre told her that he felt a bit tired and wanted to lie down for a while. She joined him in the bedroom after she cleaned up the house. At midday, the telephone rang. It was their daughter. Aunt Betty told her that Dad was taking a nap. She said she would call when he awoke.

Later in the afternoon, the phone rang again. Aunt Betty answered. It was their daughter again. She asked whether Dad was up. Betty told her that Andre was still sleeping and could not be roused. By this time, their three sons also knew that there was something wrong with their father's sleeping in. While they were concerned, their mother seemed very quiet on the other end of the receiver. She hung up the phone, a smile coming to her lips because she was thinking about Andre.

Their daughter called the ambulance. Aunt Betty did not respond to the banging on the door; perhaps she did not hear it. EMS workers broke it down. They yelled to find where the patient was. From the upstairs bedroom came a faint whisper. Aunt Betty was in bed with Uncle Andre, her arms wrapped around him.

The EMS workers ran to the room and just stared at Uncle Andre's body, which was ashen. Aunt Betty, wide-eyed in disbelief, just kept her hold on him. The EMS attendant asked her what she was doing. She kept her grip and remained silent. They asked her to let go. "I can't," she whispered. "He is still so cold."

On the day I gave his eulogy, a drizzle showered the mourners just enough to hide the streaks of their tears. His burial service was in Flushing, a far cry from the fields of corn and potatoes and the lapping waves by the marina's dock. My entire family was there. The dimness inside the gothic church served as an expression of the emptiness everyone felt deeply. I spoke of Uncle Andre's robust personality, his cheer and grace. My eyes sought out the faces in the crowd as I spoke. All were grief-stricken and weeping. All but one.

Aunt Betty's expression was one of shock. She was confused. She reminded me of a child who was told that her best friend could not come out to play. When I left the altar to return to my seat, she grabbed my arm. She whispered, "Frankie, he is so cold. Don't let him go away."

Francis Arena, MD, is a medical oncologist and voluntary attending at North Shore University Hospital, Glen Cove Hospital, and LIJ.

What's in a Name?

When I arrived at my first cardiac arrest call, the street scene was chaotic.

An ambulance had been flagged down to attend to a 52-year-old chef who had collapsed in the alley behind his restaurant. The crew determined that the man was in cardiac arrest. Someone called 911 while a Good Samaritan hailed the North Shore-LIJ ambulance I was riding on during an EMT shift.

When I jumped from our BLS (Basic Life Support) ambulance, there was emergency vehicle gridlock — a North Shore-LIJ Advanced Life Support (ALS) ambulance was on scene, as were FDNY and Nassau County life support vehicles.

Ignoring the craziness, the ALS crew was already working on the patient, putting in IVs, performing CPR, administering oxygen and attaching an endotracheal tube. We jumped right in to help. We were a small army in the cramped space of the back alley of a bar. The patient was unconscious. I imagined him only minutes ago, heading out to this small concrete alley to smoke a cigarette. There were a number of his fellow employees staring at their friend, shouting: "Wake up! Wake up!"

I had hours upon hours of training and multiple EMT experiences before I arrived at the alley to save a man whose heart had given out. I was eager to apply the skills I had learned. I wanted my actions to affect this guy's life. I wanted to save him.

At first, I was almost shy. There were so many crews trying to relay information and aid the patient that I felt I was being helpful by staying out of their way. Time is critical, and it seemed there were enough people involved. Ultimately, I was able to help transport the patient. As his stretcher was lifted into our ambulance I jumped in beside him and started administering chest compressions. As we sped away en route to the hospital, my hands were working mightily, hard, fast chest compressions. I was helping to save a life.

Meanwhile, the ambulance was careening down streets and taking corners like a race car in the Indy 500. I was swaying with the speed but I didn't lose my footing. I was a man possessed. I had to help pump this patient's blood to his tissues. The only time my

hands moved off of the man's chest was to allow an EMT to use the AED to shock his heart. Then, my hands were back, concerned with nothing but compressing the chest and keeping blood flowing. Nothing but my rhythmic task mattered.

The patient's heart kept its rhythm with the same steady pace as my hands on his chest. This was the closest I have come to a cardiac cell. I had one goal, one desire: to keep pumping. When we finally arrived, I helped transport the patient to the trauma suite. I watched myself performing ventilations, mindful not to overinflate the lungs. When we got into the trauma room, we transferred the patient off the backboard to the hospital bed. Now, the medical team stepped in and I stepped back and assumed the role of the observer.

The next few minutes were painful. The patient had been in cardiac arrest for more than half an hour. He was in ventricular fibrillation and slowly heading to asystole. The ED staff performed multiple shocks and administered one unsuccessful drug after another. IV fluids coursed through his veins. Nothing was helping.

Before I got into medical school, I studied cardiac pharmacology. I was aware of the time and energy spent to understand the heart and how to treat it. Yet as I watched the ER crew working so hard to get this one heart working again, it seemed as if we were firing BBs at an armored tank.

The chef died.

I listened as the attending physician pronounced the time of death. I wondered about the last meal that he had served up. The staff began clearing out of the room and I followed. We had to get back to the ambulance, back to the next call.

After my shift, I couldn't help thinking about the "what ifs." What if I did something wrong? What if I could have done more? What if we had gotten there sooner? What if someone else gave CPR . . . What if? After I ran all of the scenarios in my head, I came to the conclusion that sometimes it's a person's time, no matter the hard work to save a life. Every patient I see in my medical career has a finite existence; all patients I will ever see or care for will die. It seemed a cold sobering fact. We all get life, and we all lose life. The only thing I can do is to do my best and to help give others as much precious time as I can.

This chef did not know me, but he left behind many lessons for this new medical student. I felt a profound sense of rejuvenation from the

experience, no longer too exhausted to finish a task at hand, no longer too stressed to practice a seemingly impossible skill. I understood from this experience that life can end suddenly; at home, at work, on a break.

I promised myself that as I moved forward in my studies to become an EMT, I would not forget about the man who died despite everything scores of people did to save him. I was bothered by one thing: I didn't know his name. I could not remember whether the co-workers screaming for him to wake up said: "Wake up, Jimmy!" Or, "Wake up Fred!" I wanted to put a name to the man.

The next week, I got my chance. I was taking part in a training simulation on physical diagnostic skills. The doctor doing the simulation was the same man who pronounced the death and called out the exact time for the record. I asked him whether he remembered me. "No," he said, "I do not." I reminded him of the cardiac arrest and the death, hoping it would jog his memory which would spit out a name.

Yes, he said, he remembered the case well. "I remember that the patient was in cardiac arrest and that he was later resuscitated." My eyes widened. I was skeptical. "No, you must be mistaken, I heard you pronounce him dead before I left the room. The time is still in my head. It was 4:53 p.m."

"Yes," he said. "You are right. But after the room all but cleared out, a nurse noted some agonal breaths and we continued treatments and eventually got a rhythm. The man is alive."

I could barely sit still during the rest of the simulation. I had helped save a life. I still can hardly believe the turn of events, the twist to the end of the story. I learned that I had made a difference.

I want to think that this feeling of jubilation I am experiencing is for this fortunate fellow, but I wonder whether it may be validation for me. As I type this line, it sounds incredibly selfish. What would have happened if I did not learn that the chef had lived? Would my life somehow be different?

I feel lucky that I ran into the attending and that I received such unexpected news. No longer do I seem to care about the man's name – which I still do not know – but am content to know that he lives! Wake up, Dan! Wake up, Steve!

He woke up.

Brian Koch is in the inaugural class of the Hofstra North Shore-LIJ School of Medicine.

Life Support

They were far apart and a lifetime away,
They traveled different roads with the same detour,
ending up here seeking, yearning, praying for,
a way to have power over their destiny.

When the man began to articulate,
He spoke of how to preserve and defend the physical,
But they wanted, needed, desired
A way to be truly alive.

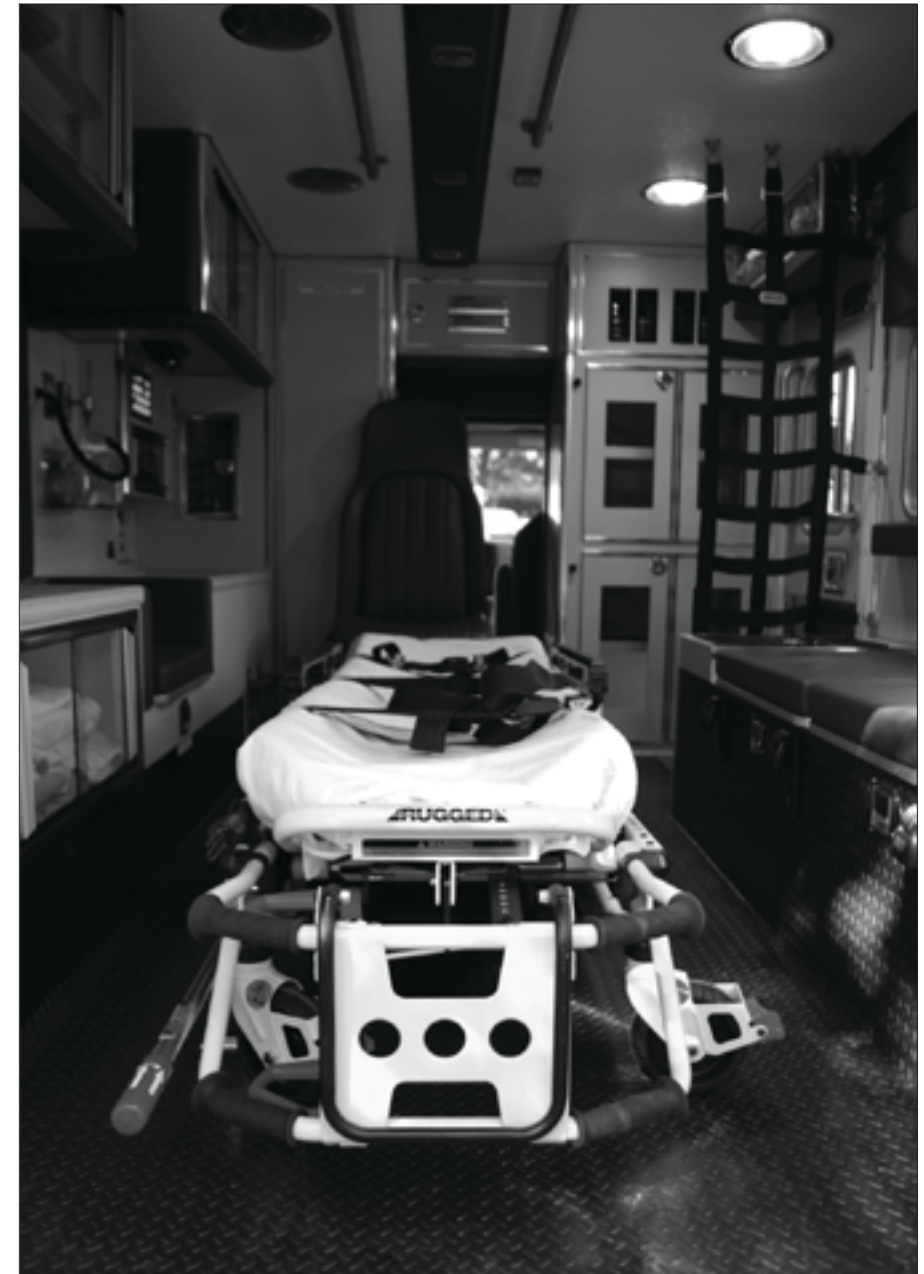
As they prepared to depart once more,
About to wander with questions unanswered,
I paced over and brought them together,
Unfamiliar no more.

Strangers in life separated by decades,
Bonded by the same complex machine,
Found comfort in each other,
As if something natural controlled the beating of their
hearts again.

This is a reflection on a patient encounter during a device support group, where a 96-year-old man and a 30-year-old man found a connection through their pacemaker experiences and their devices.

Cathy Ann Morimando, ANP, is a nurse practitioner at Southside Hospital and runs a device support group called "We've Got Rhythm."

Grant Nishanian is a PACS/RIS support analyst at Lenox Hill Hospital. He is also a lieutenant of the Larchmont Volunteer Ambulance Corps.



Stretcher

GRANT NISHANIAN

The Illusion of Choice

Max woke up before any of the other patients one Sunday and made a decision.

“Enough is enough,” he thought.

He looked outside and squinted at the bright light that bounced off the ice in the nursing home parking lot. The doctors and nurses had their winter coats on. They were scurrying from their warm cars. Max thought back to the last day he worked. He smiled and shook his head. It was 22 years ago. He figured back then that he’d be dead within a couple of years. All this stuff about losing meaning after you leave work was such rubbish. He found out that he didn’t need much meaning to have a happy life.

Max was surprised to learn since then that he was a simple, quiet man. Not simplistic, just simple. He was pleasant and sweet and he lived peacefully with the other patients and, unlike most of them, he coexisted with the intimidations of aging.

Many of those other patients sucked the life out of the nursing home staff, like Molly, who screamed and clawed every time a nurse’s aide would try to bathe her. But Max gave hope to them all. “If Max can cope with the declines of aging,” the staff would think, “perhaps I could, too, one day.” The nursing home staff loved to describe Max to their friends. “I have a patient who taught himself how to use a computer!” his nurse Susan once bragged. Max spent hours researching stock trends, and he’d give tips to any doctor or nurse who would pause to listen. “I can predict the future,” he would say, half jokingly. That was three years ago.

That’s why they were surprised and confused that cold, crisp Sunday when Max woke up and declared, “I’m not going to have food anymore.”

Max had been fed through a tube in his stomach for the two years, after developing myasthenia gravis, a neurologic disease that made it impossible for him to coordinate his throat muscles. When he swallowed, portions of what he’d been eating would travel to his lungs. This process, which doctors call aspiration, caused Max to choke.

A century ago in the United States — and in many undeveloped

countries today — people with myasthenia gravis would have aspirated so often they would die of aspiration pneumonia. Not a terrible death as deaths go. Pneumonia was called the “old person’s friend” — it was thought that if you had to die, the progression from pneumonia to death in a week was a lot better than lingering for years through prostate cancer or a series of strokes.

Today it’s possible to give many people with swallowing problems the nutrition they need while decreasing their risk of aspiration pneumonia. Surgeons or gastroenterologists install a synthetic feeding tube through the abdominal skin, fat, and muscle into the stomach. Chalky nutrition was dripped into Max’s gastrointestinal tract, bypassing the swallowing process.

For two years, Max seemed to take this as a simple inconvenience. That is, until that Sunday morning when his nurse Susan began the ritual of hanging the plastic bottle filled with food on Max’s IV pole. That’s when he said, “Don’t.”

Susan paused.

“I’m ready to die,” Max said.

“What do you mean?” Susan asked him.

Max replied, “It’s time.”

Susan tried to convince Max to take some nutrition that morning, but he remained opposed. Susan paged the physician on call who came to speak with Max, but he was steadfast.

“No more food,” he said.

The next morning I received a call from David, the medical director of Max’s nursing home. He asked me to meet with Max. I’m a psychiatrist, and David wanted an opinion about whether Max had the mental capacity to refuse food. David emphasized the urgency of this meeting. “He’s getting dehydrated, and I don’t know if he’ll be able to speak with you clearly if we wait until tomorrow.” I broke away from what I was doing at the hospital and drove to the nursing home.

David and I met at the nursing station. “I’ve never seen anything like this,” David told me. “Max doesn’t seem depressed or confused, and there isn’t anything new going on medically. I don’t know what to make of it. I let him know you’d be coming to see

him.” I told David I would try to understand Max’s decision and see whether he had the cognitive capacity to refuse food. I walked down the hallway, neat and antiseptic, and I turned into Max’s room wondering who and what I’d find.

Max studied me when I entered his room. He was awake and alert. He looked cozy, with the covers of his bed pulled up to his chin. I was expecting to find a gaunt and sallow man, but his eyes shone and his skin was firm and ruddy, studded with scruffy, salty whiskers.

“Mr. Rubin?”

“Yes.”

“I’m Dr. Weiner, one of the psychiatrists here.”

“I know. I was expecting you.” I extended my hand and he shook it firmly.

“May I have a seat so we can talk for a while?” I asked.

“Of course, please do.”

Max’s speech was garbled from weakness in his vocal cords, which also caused his swallowing problems. I pulled a chair up close to his bed and looked into his eyes while I sat down. They were focused clearly on me.

“I heard you made an important decision yesterday,” I said.

“Yes, I’m ready to die,” he responded without blinking.

“Tell me about it.” I said.

“I want you to know that I’m an educated man. I have a doctor of jurisprudence degree. I know how to make decisions. I’ve thought about this for a long time.”

“But why now, Max? What’s causing you to make this decision now, as opposed to a month from now or a month ago?”

“I just know it’s the right time,” he said. “I’ve lived long enough. Everyone has to die.”

“Are you in pain?” I asked.

“No,” he replied.

“Any physical complaints?”

“Nothing I can’t handle,” he said, smiling.

“Are you suffering in any way?”

“No,” he said.

“Is there anything the staff can do to make you more comfortable or your life more pleasant here?”

“No,” he said. “Everyone’s been great.”

I asked a series of questions that assessed symptoms of depression, anxiety, memory loss, and problems with reasoning. Although his thinking was a little slower than it probably was years earlier, there was nothing wrong in the psychiatric sense of the word. I explored his family life. He had one living brother with whom he was not that close, and a great-niece whom he loved. He spoke about his niece with much pride. She was a successful artist and a good person. At the same time, Max did not have a desire to continue living just to see her life blossom.

It still bothered me that, despite the fact that Max was coherent, I had no clear picture from him why he wanted to die, nor did I understand why he wanted to die now. If I decided that Max didn’t have the mental capacity to make this decision, we had the right to feed him against his will, even by tying him down.

“So, you just know that it’s the right time to die?” I asked.

“That’s right,” Max replied.

“What would make it the wrong time, then?”

Max thought for a while. He said, “I saw Jack Dempsey once.” Jack Dempsey was a fierce boxer who held the heavyweight title from 1919 through 1926. I was expecting Max to tell me a story about a prizefight he attended and how Dempsey, known as the “Manassa Mauler,” beat up a worthy opponent.

Instead Max said, “Dempsey was in a wheelchair, all bent over. He was in his eighties. He was being pushed by a lady, a nurse, I guess. I want to go out in one piece. Not with a stroke.”

“What was that like for you to see Dempsey that way?”

“It’s the worst thing in the world. When you can’t do things for yourself any more, what’s the point? You’re not a person.”

“Did something happen last week to make you feel this way?” I asked.

“No, I’ve just been thinking about it for a long time, and I don’t want to let it get to that point. Now is a good time to die.”

I was quiet for a bit. Then I said, “Most athletes retire after their skills decline. Very few go out at the top of their game. It sounds as if you want to go out on your own terms, close to the top of your game.”

“That’s exactly right!” he said. “I want to go out without being

pushed around.”

Max wanted to control when and how he would die from natural causes, and he had the right to do this. In 1990, the Supreme Court in *Cruzan v. Director, Missouri Department of Health* supported a person’s right to refuse life-sustaining treatment — provided he or she had mental capacity to make that decision.

“It sounds as if you really know how you want to live out your life. I’ll let the staff know you have the ability to make this decision.”

“Thank you,” he said.

“I hope your journey is peaceful and comfortable, Max.”

“I hope you have a good life, Doc.” We shook hands. I stood up and left the room.

I paged David to the nursing station and he came quickly. “He definitely has capacity to make this decision,” I told David.

His eyes turned a little red. “I was hoping someone could convince him to change his mind,” he said. Then he added, “I’ll try one more time.” He walked down the hall toward the patient’s room. I stayed in the nurse’s station to write my long note, documenting for clinical and legal purposes how I arrived at my decision, using patient quotations, and wondering as I wrote, “Should I have tried to change Max’s mind?”

Max’s social worker came by. I told her about my discussion with him. She said, “Yes, he’s devoted to this decision.” The word “devoted” struck a chord. It implied something conscious and philosophic. People can be devoted to their marriages or careers or religion. Right then, Max was devoted to living life only under certain acceptable terms.

I left the nursing home to return to the main hospital where I did the bulk of my work as a psychiatrist for the medically ill, and although I thought about Max during the day, I also became wrapped up in a series of intense interactions with anxiously ill patients who had all made implicit decisions to fight and live on. Still, I wondered about Max over the subsequent few days. I assumed he had since died. But it wasn’t until the following week that I called David to find out how he was.

David said, “It was fascinating. Max decided to allow us to feed him the next day.” I was surprised. I thought about how Da-

vid’s effort to change Max’s mind might have had an impact. I felt a twinge of guilt. Maybe I should have tried to influence Max’s thinking rather than simply understanding it and abiding by it. Maybe Max was not so clear about his choice to die. If so, what did it mean that day for me to say he had capacity to choose? I had a choice in this, too.

But then David said something even more surprising. “Max died the following day.”

I’ve thought much about Max since then and how on that cold, hopeful Monday, a psychiatrist with much to live for shared a warm moment with an old man who had lived just enough. Perhaps what Max and I chose together that day was the illusion of choice, because regardless of what he, or I, or David wanted, one truth rose above all others.

It was, after all, a good time for Max to die.

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consultation liaison
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Hospital.*

Augenblick in Aruba

Sharing the innate draw to the source of our cells,
 our isotonic birthplace,
 on this heavenly morning,
 I watch the perched pelicans perform their ablutions,
 whitlocks glistening in the sun.

The bronzed apples stroll by, outnumbering the pears.
 Some with zippered chests, on their second chances,
 sport gleaming talismans around their necks.

But what of the tall thin man, toes in the water, spider fingers at his side
 and – a quick glance confirms – the caved chest?
 Will he live to have his thorax splayed?

I share Cassandra's ancient gift and curse...
 and with a moment's hesitation, walk by.

With permission from Annals of Internal Medicine, Vol. 154, No. 12, 20 June 2011; 837.

Editor's Note: The poet identifies the tall thin man with spider fingers in the blink of an eye (*augenblick*, in German) as likely having Marfan's syndrome, a genetic disorder of connective tissue. Manifestations include a tall, thin build; "arachnodactyly" (long fingers and toes); and chest wall deformities. Aortic aneurysms may require surgery to prevent sudden premature death. In Greek mythology, when Cassandra spurned the love of the god Apollo who had given her the gift of prophecy, he turned it into a curse – that no one would ever believe her predictions.

Robin Dibner, MD, is the internal medicine residency program director at Lenox Hill Hospital.

*Looking Forward*

LORY DIAZ

*Lory Diaz is manager of the
 audiovisual department at
 the Feinstein Institute for
 Medical Research.*

No More Flowers

He had a twinkle in his eye as I entered the room. He sat quietly, a bit reserved but not withdrawn, a baseball cap perched slightly askew upon his gray-white hair. Actually it was not really a baseball cap, for instead of a team logo the words "101st Airborne" were boldly embroidered. A black cap with white stitching — he always wore it. His service in the great war of his "the greatest generation" defined him. He always talked about it, and today would be no exception.

As I entered the small exam room, I noted that he and his wife always took the same positions. He sat in the chair to the right, his hands resting on top of his cane upright between his legs, while his wife sat in the chair to the left, at a 90-degree angle to his, their knees almost but not quite touching. They said nothing to one another and it didn't seem as if my entrance had interrupted any conversation. I slid through the narrow space between them and sat on the rolling stool near the exam table, at a diagonal approximately three feet away.

He always let me speak first. Though he was 83 and I was 51, his generation believed that proper etiquette dictated that the doctor always be accorded respect. His wife, looking weary and drawn, obeyed that unspoken rule as well.

"So how are you doing?" I looked him in the eyes when I asked him.

"You tell me, doc." He always had the same response. His last score on the mini mental status exam was 21. That was three months ago, and the test indicated that he was on the border of mild to moderate dementia.

His wife answered for him: "He is pleasant enough, never gets angry or yells, but it's the same questions over and over. The same war stories all the time. He really hasn't improved any since the last medication change and now he is having almost daily incontinence."

We discussed how he spent the day, whether he was eating sufficiently, carrying out his daily activities. He could still wash up, shave, even bathe with assistance but needed help choosing his clothing. He never wandered and there were no side effects from

his medication. He spent most of the day looking at old war photos and his medals and watching TV or sleeping.

I repeated his MMSE; it was now 18. He was firmly in a moderately severe dementia.

"You're right, Mrs. Griboff. He has declined despite the switch to Mendicept. However, there is a new medication, just recently FDA approved. It is called Exodyne and it works differently from the others. It removes the amyloid plaque from the brain of Alzheimer's patients, and that seems to enhance memory and cognition." I purposely framed my words in semi-med-speak, partly to sound more authoritative and partly because I knew that Nancy Griboff had been reviewing the literature on the Internet and was well versed in amyloid, tau, cognitive function and memory, NPIs and ADL. She was smart, resourceful and desperate, willing to grasp at anything as long as it was safe and had some putative medical rationale behind it, if it would bring her husband back.

"What do you think, Mr. Griboff, you want to try it?" I directed the question to him to preserve his dignity and sense of choice, although I knew the decision would be made by her.

"Sounds good to me, doc."

I looked at her and saw her nodded assent.

"Okay, we'll start at 25 mg and increase weekly to a maximum of 100 mg in one month. Call me if you have any problems." I said all this as I wrote out the prescription. As I looked up to hand it over I saw he was itching to tell me something.

"What is it, Mr. Griboff?"

"Doc, did I ever tell you about our last bombing mission over Germany? We had just flown out of France, this was about early '45."

I looked over at his wife, who said, "Oh, Charles, the doctor has plenty of patients waiting and no time and besides, you told him this story already."

"It's okay, Mrs. Griboff. I have a couple of minutes."

"Well, you see, doc, we were flying out of Calais, a group of 13 in our squadron. As we approached the target over Bremerhaven, we came under attack by Luftwaffe fighters. We lost an engine and

got quite a few holes in the tail but we limped back. The smoke was fierce. I found out later we were the only ones in the squad who made it back.”

“And who was your CO?” I asked.

“Pierce ‘Red’ Benchly,” he quickly replied. He couldn’t remember what he had for breakfast that morning, but he remembered his commanding officer’s name from over 60 years ago.

I didn’t speak to them for a month but they called in dutifully, reported to my staff that Mr. Griboff was tolerating the medicine, increasing the dosage by 25 mg weekly until 100 mg. They came back about a month later — same exam room, same seating positions, same black cap.

“Let’s try the MMSE, Mr. Griboff, and see how you’re doing.”

“Call me Charlie,” he said.

“Okay, Charlie. I am going to give you three words to remember — *shoe, brown, honesty*. Repeat these and remember them because I am going to ask you them later.” He repeated them.

“Now spell the word *world*. Now spell it backwards.” No problem. “What were the three words I asked you to remember?”

“*Shoe, brown, honesty.*”

I was astounded.

At the end of the exam his score was 25. A 7-point increase in his MMSE in one month. This was remarkable — in fact, unheard of.

“This Exodyne is pretty good stuff, eh, doc?” I stared. For the first time since he was afflicted with memory loss, Charles Griboff was showing insight into the fact that he even had a memory problem.

“You know, doc, I was telling Nancy the other day that the house really needs painting. I told her I’d call Bernie, our son, to come up with the grandkids and give me a hand doing it.”

Nancy had a barely contained smile on her face; she looked as if she were ready to explode. “Doctor, it is incredible. He is remembering things and talking about doing things he hasn’t done in years. You heard him just mention the grandchildren. Last time, you recall, he couldn’t remember he even had grandchildren, let alone their names. Charles, what are our grandchildren’s names?”

He replied quickly and without hesitation. I don’t know who

was more excited, Nancy or Charlie or I.

“Increase the Exodyne to the maximum, to 150 mg, and I want to see him back next week.”

“You got it, doc. Oh, by the way...”

Here it comes, the perennial war story, the repetitious hallmark of his dementia. “Yes, Charlie?” I said, my enthusiasm somewhat dampened.

“I just wanted to say thanks.” That was it. No war story. He didn’t even bring up the war.

I floated through the next eight patients. My head was spinning. This was reportable. I couldn’t wait until Charlie returned in one week.

I was not disappointed. At Charlie’s return he was more kempt and the black cap was conspicuously absent. His speech was clear and exact but retained its familiar, friendly quality. He still called me “doc,” and he scored a 30 out of 30 on his MMSE.

“Charlie, you are doing great! I think we are experiencing something historic here. Stay on the 150-mg dose and I’ll see you in a month.” We shook hands as we always did at the end of a visit. Charlie’s grip was tight, painfully tight, and he bared his teeth in a tight smile.

“See you then, doc, early August. You know, I am so lucky to have met you, doc, but I’m really lucky to have a wife like my Nancy. She really is beautiful, doc, isn’t she? I know other men would love to have her.” Then he laughed.

“Yessir, Charlie,” I replied, and I laughed, too, a bit uneasily.

A month went by and the Griboffs called (actually Charlie himself) to cancel his appointment. They were taking a long overdue vacation and would come and see me in September instead. Things were going great, Charlie insisted; he felt better than ever.

Two weeks later, a phone call from Nancy. They were in Arizona. “Doctor something is not right. Charlie’s memory seems okay, but he is acting funny. I am so frightened. He wakes up in the middle of the night and starts wandering around, doesn’t say anything, starts looking under the covers, checking closets. Then he walks out of the motel room, wanders up and down the hall, even going outside to the car once, mumbling ‘I’m gonna get you, I’ll find you, you bastard.’ He then returns to the room, looks at

me with an icy stare and says — and, doctor, I'm so embarrassed, but I must tell you — he says, 'You whore,' and then he gets into bed and falls asleep. In the morning he gets up and acts as if nothing has happened. This has already happened three nights in a row, and I haven't said anything to him because he doesn't recall anything about it the next morning, and in every other respect he is fine. I don't know what to do."

"Look, Mrs. Griboff, as long as he has not harmed himself, you or anyone else, just continue doing what you're doing, get home as soon as possible and bring him in and we'll see what's going on."

Two days later Charlie was in my office. He looked good; tanned and relaxed. I was relieved to see no 101st Airborne cap. I gently asked about any unusual behavior, directing my question to him, not to Nancy, who looked on apprehensively.

"Nope, nothing, doc." He didn't report any of the strange behavior Nancy told me about in her frantic phone call.

We did the MMSE: 28. He had dropped two points — day of the week and what floor my office is on. Could be jet lag, fatigue or the medicine failing. Charlie helped me answer the question. "You know doc, I have noticed my mind slipping a bit. The other day I had a little trouble adding up the dinner bill and I confused our airline gate. I kept thinking C3 but it was gate C8."

"Charlie, I'd like to get an EEG, do some blood work and repeat an MRI, if you don't mind. We'll check things out."

"Sure, doc, no problem. By the way, I'd like to speak to you alone for a second. Nancy, can you wait in the waiting room please?"

Nancy dutifully complied to his request and repaired to the waiting room, giving me a furtive and worried glance.

The door closed. Charlie said, "Doc, you don't think I saw that look she gave you? Is that why we came back so quickly? Are you porkin' my wife, you bastard?" I sat there looking at Charlie's tanned and weathered face. If it weren't so dreadful it would be comical. He is suspecting me of making advances on his 77-year-old wife.

"Charlie," I said softly, reaching for his hand.

"Oh, doc, doc, I'm sorry. I don't know what's wrong with me. I have all these crazy thoughts. I think she is with other men, wants other men. I know it is not you. And doc, the memory, I'm losing it. I was feeling so good. It was really working. I was clicking again.

What's happening?!"

We did the MRI, the EEG, the lab work. The EEG and labs were essentially normal. The MRI showed some nonspecific white-matter ischemic changes and modest amount of atrophy, identical to his MRI from a year ago. We did another MMSE, a week later. He was down to 26. Charles and Nancy were in despair. They both looked at me searchingly, aching. Why, doc? Although they were asking why it was happening, I took the "why" as an accusation: Why did you do this to me? Why did you bring me back, give me my memory back only to take it away? Why did you make me feel this pain of loss all over again?

I was reminded of the novella *Flowers for Algernon*, which I read when I was in eighth grade and which was made into a movie. It was about a mouse named Algernon and a mentally handicapped man named Charly, subjects of a medical experiment to enhance their intelligence. Both became "super-intelligent," but alas, the effects were only temporary, and the pain and the alienation it caused were ultimately unbearable. Algernon dies and is buried in the backyard. Charly's last request of doctors is that someone remember to put flowers on Algernon's grave.

The irony that the man in the story was named Charly was not lost on me. Like Charly, my Charlie had been in a state of blissful ignorance, yanked out by scientific experimentation and given hope for a better life only to be pulled back into the abyss.

The MMSE continued to drop, to 23, to 19. *Shoe, brown and honesty* were all gone. Spelling a word backward was a non-starter. Charlie no longer recalled his grandchildren's names. And yet he was more content. No more paranoid delusions. No more anger. The black cap was back. The lines on his face softened. He remembered none of his ordeal, mercifully oblivious and unaware. Nancy, on the other hand, was painfully aware.

We stopped the Exodyne.

"I'll see you next month, Charlie."

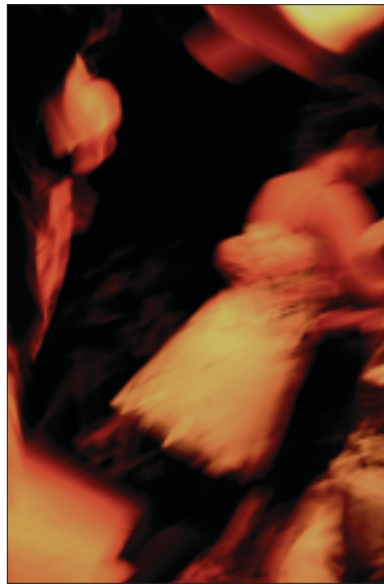
"You bet, doc. By the way, did I ever tell you about our last bombing mission over Germany?"

Alan A. Mazurek, MD, is a voluntary attending (neurology) at North Shore University Hospital and has been involved in the care and treatment of patients with Alzheimer's disease for almost 30 years.

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 the 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 twice 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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