

Narrateur

HOFSTRA NORTHWELL
SCHOOL OF MEDICINE

ART & LITERARY REVIEW

ISSUE FIVE 2016

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REFLECTIONS ON CARING



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REFLECTIONS ON CARING

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Front Cover: The Surgeon and the Sculpture

Arnold Prywes

Arnold Prywes, MD, is a clinical associate professor of ophthalmology at the Hofstra Northwell School of Medicine and chief of the glaucoma service line at Northwell Health. As a student in the inaugural class at Mount Sinai School of Medicine in 1968, he was encouraged to take some creative classes at the City University of New York. He dusted off his camera and signed up for a photography class, and he went on to become photo editor of the medical school's first yearbook. After residency, his wife, Charlotte, enrolled him in a ceramics class, where he started doing pottery and figurative sculpture. He was in the right place at the right time; his teacher was Rhoda Sherbell, whose work appears at the Museum of Modern Art, the Smithsonian and the United Nations. He says, "Sculpting has helped me to be a more complete physician. The peace that is with me when I sculpt follows me when I care for my patients." An ophthalmologist for more than three decades, he has only recently begun to exhibit his work, at Allied Artists of America, Audubon Artists of America and the Salmagundi Club in New York City. He is debuting his art collection in a one-doctor show at the Hofstra Northwell School of Medicine.

Back Cover: Morning Twilight on Machu Picchu Mountain

Chris Lu

Chris Lu is a first-year medical student at the Hofstra Northwell School of Medicine. His view of the Peruvian Andes was captured just before sunrise on a trek to Machu Picchu during the summer of 2015. "The vivid colors and mountain mist give depth and complexity to the work, highlighting the expansiveness of the mountain landscape."





From the Dean

Narrative medicine has come of age. The telling of stories and sharing of photos, drawings and paintings offer people a way to make sense of their experiences and create lasting memories that may help other practitioners come to terms with their own experiences. Storytelling is timeless and cathartic. It helps us heal. It helps us inspire. And it helps us create new generations of doctors and nurses and other caregivers who understand that the medicine they deliver is only part of the story. It is the compassion and the insight and the humanness that patients remember when they leave our examination rooms and our hospitals. It is what we remember, too.

This is our fifth edition of *Narrateur*. Over the five years we have read and viewed hundreds of submissions, selecting the best, the most inspiring, the most powerful for our literary and art review. We think that this edition is special, a physical proof that narrative medicine has come of age.

I am reminded every year of the stories that follow us like shadows and emerge in other forms to strengthen us and the care we give our patients. It is always exciting to see a photograph or piece of art or read an amazing story that stays with me for days and know that others who will be seeing it in *Narrateur* will also grow from the experience.

I am confident that you will love this issue as much as I do.

LAWRENCE G. SMITH, MD, MACP

Dean, Hofstra Northwell School of Medicine

Executive Vice President and Physician-in-Chief, Northwell Health

Letter from the Editor-in-Chief

The fifth year of a medical school is symbolic on many fronts. It means that the students from the inaugural class are now in residency programs and taking their lessons to the front lines. It means that this new class of students will have an opportunity to learn from hundreds of students who came before them. It means that the people who teach them have grown and changed. There is no question that the stories we tell about our patients and about ourselves become part of the ethic of how we practice medicine.

I loved the surprises in preparing for this issue. One in particular arrived first as a beautiful piece of art. I soon realized that it was done on an iPad, which intrigued me. The colors drew me in. The detail was brilliant. I had to learn more about this artist. I called. I listened to an amazing story about why she became a nurse, and how she was inspired to draw the picture that we immediately accepted. Then I asked her to write her story, and she did. This woman has been patient and practitioner. And at every turn in her life, she has been an artist.

There is such depth and honesty in this issue, and for that I thank all the people whose submissions fill these pages.

JAMIE TALAN, MPH



When I Grow Up

The bowel lives in my hands and between my fingers; it is so delicate and yet so resilient. The mucus of healthy bowel is smooth and flawless; the unadulterated omentum pulsates as the picture of sustenance. The tiniest puncture will cause extensive post-operative morbidity while a powerful anastomosis could serve as an indispensable link in the chain of digestion. Without fuel any mortal would soon perish.

The operating room can be a cold place; I am usually especially sensitive to temperature and can never seem to get warm. In the operating room, however, I am immune to my surroundings. I see the patient and the task at hand; nothing else exists. I don't think about things or places outside of this very moment. Everyone and everything outside are frozen in time.

I love being around surgeons. They know how to speak with levity and enjoy themselves in the operating room but they maintain absolute solemnity and concentration when called for. Sometimes I wish I didn't have to breathe. It seems as if the tiniest movement can be a distraction. Other times I find myself opening up about things I haven't shared with most people and feeling the ultimate sense of camaraderie.

The tools of the operating room are the finest of utensils, reminiscent of paintbrushes with which I always wished I were proficient. The thrill while holding one of them, scalpel or suction, instills astounding fear as well as earth-shattering confidence.

One day, I will be that surgeon.

Hannah Hoffman is a fourth-year student at the Hofstra Northwell School of Medicine. She graduated from New York University with a degree in African studies and hopes to begin a general surgery residency in the fall.

NARRATEUR





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Khokhloma

ELLEN PEKAR

Ellen Pekar is a first-year medical student at the Hofstra Northwell School of Medicine. She minored in fine arts at the University of Pennsylvania. "Khokhloma" is pastel on colored paper.

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DINA ABIRI

How Bad Is Your Pain?

Appearances to the mind are of four kinds. Things either are what they appear to be; or they neither are, nor appear to be; or they are, and do not appear to be; or they are not, yet appear to be. Rightly to aim in all these cases is the wise man's task.

—Epictetus, 2nd century A.D.

What does it mean to suffer? What does it mean to feel pain? Can emotion be studied objectively? Can we ever come to understand what anyone else truly feels? Medicine demands that we try.

We ask, “On a scale from 1 to 10, how bad is your pain?” The goal is to do something of use with this knowledge. So we learn to trace the anatomical path of pain. We call the process nociception, derived from the latin *nocere*, “to harm or to hurt.” We learn that information transmits by way of electrical and chemical impulses through specialized cells belonging to a system whose very name is fraught with anxiety: the nervous system.

So-called nociceptors send messages to allied cells, in the form of a chemical flux that we call an action potential, all along the length of the spinal cord, up to the most evolutionarily conserved part of the brain, our brainstem, where lesions mean life or death. From this elemental conglomeration of cells are signals that spread up toward our very own relay station, that which we call the thalamus. These signals meet destiny, which for pain means the cerebral cortex. Here perception of pain lies in a complex and confounding and beautiful neural code, the scope of which begs us to stop and stare and think about life, if only for a little while.

Pain is everywhere, like commuters during rush hour on the subway, jam-packed, together and alone; or like falling snow during a storm when each flake can go unnoticed unless one deliberately takes a look. It is our responsibility to look. It is the doctor's task to lessen the pain of patients and try to shield them from future pain. Yet we are only as good as the questions we ask.

Perhaps the better questions are, “What does suffering mean to you? What does pain mean to you?” For as doctors we must possess not only scientific mastery but the will to traverse the end-



DINA ABIRI

less complication of human emotion. So we ask about pain, even deduced to a scale, because only then can we open the door for our patients to unfold themselves to us. Only then can we fulfill our role as healers.

Dina Abiri is a second-year student at the Hofstra Northwell School of Medicine. She graduated from Barnard College, where she studied writing and neuroscience. After college, she pursued a master of science degree in narrative medicine at Columbia University.



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Life Giving Life

ALLISON SELBY

Allison Selby, MD, is a third-year internal medicine resident at Lenox Hill Hospital.

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ETHAN FRIED

Yellow Man

The yellow man sat in a corner of the subway car, trying hard to be invisible. He wore an ecru dress shirt, a beige jacket and a yellow hat pulled down to throw a deep shadow over his face. He hoped that the camouflage would make his glowing yellowness less noticeable. He was jaundiced.

People were inching away from him. He didn't blame them. He could take off his hat and let his yellow face speak for the rest of him. It's only cancer, people! But the physician in him tried to work on a higher plane. I am that physician.

It was 2008, and I had just come off two weeks of fever with rigors from what turned out to be a blocked bile duct. This was followed by jaundice. As a program director, I have trained hundreds of internists to maintain their composure, even when dealing with catastrophic illness. My chief resident was tall and thin, with a neatly cropped beard and a tightly wrapped turban. He was a paragon of professionalism, one of my "go to" role models. But when I passed him in the hall, his stare could have burned a hole in my skin. It lasted until I disappeared behind the door of my office.

When the fever came, I convinced myself it was just a cold. When my urine turned orange and then brown, I convinced myself that it was because I had swallowed too many ibuprofen tablets to reduce the fever. When my wife told me I was looking a bit yellow, I shrugged and told her to go back to sleep. "What does a psychologist know about jaundice?"

We had one of our division chief meetings the following morning. After the meeting, the chief of gastroenterology, infectious disease and general medicine cornered me and said, "You're really jaundiced and you have to go check it out." So I walked across the street to the phlebotomy room at the faculty practice and asked them to draw the appropriate bloods.

"Who is the ordering physician?"

"Me."

About an hour later, the chief of infectious disease and a good friend came to my door, pointed at me and said: "Leptospirosis."

"Really?" I said. I was relieved, because that is something



treatable. Leptospirosis starts as a febrile illness and ends with hepatitis.

I called my wife. “Honey, I think we figured out the whole yellow skin thing. It might be leptospirosis.”

“What’s that?” asked my wife.

“You get it from exposure to rat urine.” Two weeks earlier I spent a day cleaning out our basement.

“Then it’s not leptospirosis,” she snapped back. “We don’t have rats.”

An hour later, more blood tests came back. The bilirubin, which makes the skin yellow, was almost all direct, which means it is being successfully processed by a healthy liver but it is blocked before it can exit from the biliary tract into the intestine. What could be blocking it was anyone’s guess. There was no pain, so I immediately ruled out gallstones. When it’s painless, that could mean that the blockage has been growing slowly and silently, a cancerous ninja hiding in the shadows waiting to strike with deadly force.

I walked downstairs to the radiology suite. At the front desk I asked for an abdominal ultrasound. The clerk asked who the patient was. I handed her my ID badge. She asked for a name of the patient. But then she lifted her eyes and looked straight at me. I was a blazing noonday sun yellow in a crisp white coat. Minutes later, I was undressed to the waist, lying on a gurney. My friend was sliding a probe across my belly.

“Yeah,” he said, almost lost in the image on the screen, “the duct is dilated and there might be a mass in the head of the pancreas.” I broke into a sweat and felt lightheaded. “Really? So, that’s it?” He wasn’t sure, and he said he wanted to order a CT scan for a better look.

The CT scan was completed a few minutes later. I was putting my shirt on when my friend came in and told me that he had an important appointment and had to leave. He asked me to walk over to the “ballroom,” where someone would read the scan for me.

The radiology reading room looks more like an air traffic controller center than a ballroom. It is dark and houses a dozen



ETHAN FRIED

workstations in cubicles. Radiologists, their faces bathed in a soft glow, murmur into microphones dictating their readings, one after another.

I found the abdominal station and asked the radiologist if he could read the scan. He pulled it up and immediately said, “Yeah, this guy’s in trouble. There’s a mass right in the ampulla of Vater [a small nubbin that marks the entry of the biliary tract into the intestine – not the pancreas]. This thing’s been there for a while. He was probably jaundiced for some time but didn’t notice.”

“You should know,” I said, cutting him off, “this is actually a scan of my abdomen.”

There was a ten-second pause before I heard his voice again. “Well,” he said, “this could really be anything. It could be a stone. It could even be artifact. There could be nothing there at all.” I thanked him and went back to my office.

It turned out I would be diagnosed with biliary cancer. In time, I would forget the side effects of the treatment. But I will never forget how embarrassing it was to be sick. That emotion colors my approach to my own patients as well as the patients of the students and the residents I train. Sick people are mortified by others inching away from them on the train. Sick people, even knowledgeable ones, start to think magically. They make little bargains, like, “If I can get through the next eighteen months, which is the median survival for this cancer, then I have a better than fifty percent chance of being cured.”

Even years later, when all that is left of the sickness is an ugly scar and the need to eat carefully with the aid of pancreatic replacement enzyme, I never think about a simple fever in the same way. Every backache could be something ominous. Every bad dream could become real again. This much I know to be true. I am a different kind of well than I was before I was the yellow man.

Ethan Fried, MD, is director of the internal medicine residency training program at Lenox Hill Hospital and an associate professor of medicine at the Hofstra Northwell School of Medicine.

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Central Park Residents

HEATHER EDWARD

Heather Edward is a second-year medical student at the Hofstra Northwell School of Medicine.

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HEIDI MANDEL

I Would Turn on a Dime For You

Your roast beef and sliced avocado seeded deli sandwich
sits on my lap
Wrapped up, but slowly losing its freshness
We made it this morning as you feasted on warm biscuits
layered and sweetened
With strawberry jam and melted butter
Dark coffee with frothy cream

I promised you that I would guard every crumb
From the swarming white coats
Biting into your skin like frenzied mosquitoes drawing
fresh blood

Now your lunch is mine; I will not share
With those who strangely grab pieces of what does not
belong to them
I stand firm despite my desperate hunger

Your secret is safe with me
It is mine now and I will not share
You became a heavenly body of light

Your promise is safe with me
It's as if I never knew you. I will not share

As if all the billions of dimes are worthless
As if it ever mattered whether I met you before
We left the roast beef as a parting gift

Heidi Mandel, PhD, LMSW, is a social work supervisor at the Jewish Board and a research consultant with the Hofstra Northwell School of Medicine.

NARRATEUR



JEREMY FAMA

Be Happy

“Have you ever heard the phrase, ‘Do what you love’? Well, I think that’s bullshit.”

Was that what he meant to say? The speaker at the American Medical Association Club event, a resident, was giving a talk centered primarily on the qualities and meanings of being a leader. It was a talk that first surprised and then inspired me.

“You are setting yourself up for failure with that saying,” he continued. “How can you choose to do something you love if you are required to do it first before you know that you love it? For example ... becoming a doctor.

“You’re all in medical school now because you believe that you love helping people, using science in your career and all of those other great things that I probably also wrote on my personal statement. I’m not saying that that isn’t true about you, but that doesn’t mean that you will love being a doctor,” he said.

I couldn’t believe what I was hearing. It was close to RIA week and I didn’t need any more reasons to want to drop out of medical school. And then he made his point:

“That’s why I would like to replace the phrase ‘Do what you love’ with ‘Love what you do.’ It is more realistic, and it is empowering.”

I was amazed by how different the meaning of a flipped sentence could be, and how much it would change my perspective.

“You can spend your entire life trying to do what you love and never succeeding,” the speaker posited, “but you can love what you do at any given instant.”

For me, his message is an “It’s about the ride, not the destination” sort of thing. I do not want to rely on there being a magical point of maximum happiness that I may reach one day, because life is too unpredictable for that.

I want to be happy in what I do, and I believe that by loving what I do, being passionate about it, and being grateful for where I am, whether spending time with friends and family or buried in the mysteries of hemolytic anemia, I will be able to achieve that.

Jeremy Fama is a second-year student at the Hofstra Northwell School of Medicine. He studied public health and Spanish at Johns Hopkins University and returned to Long Island, his “favorite place on Earth,” where he was born and raised.



Insight

It was my fifth week on Psychiatry. My attending, an amiable man, invited me to the mental health court for retention and treatment-over-objection. This is a hearing where psychiatrists argue why patients should be held against their will in the hospital. The defendant, a thirty-nine-year-old woman, was undergoing her first manic episode. When I had first met her, a week earlier, I questioned whether she had a mental illness. She was well dressed in a tight-fitting white polo sweater with jeans. She was thin and stood around five-feet-five. She had curly brown hair. The way she was put together was in stark contrast to the other patients on the unit, who wore pajamas.

Our first minute of conversation was ordinary, not a hint of mania. The only odd thing about her was that her expression was wide-eyed and she seemed to forgo blinking. After the interview, the diagnosis was clear: bipolar I disorder. It soon emerged that she was paranoid about her husband and family locking her up; she thought she was in a romantic relationship with Jesus and was overly flirtatious with my poker-faced attending. The day before, she had been brought to the hospital following a car crash that she had caused. This point plagued me for several weeks, to the point that I did some research. I found that the increased incidence of car crashes due to mental illness is insignificant; I guess the unpredictability bothers me.

While we don't exactly know the cause of manic episodes, the course is clear. Without treatment, patients get worse, which is hard to explain to a patient who thinks nothing's wrong in the first place. These patients don't want to take medication, though it is clear to everyone around them – their friends, family, therapists and doctors – that they desperately need it. And that is why we are here at this mental health court.

The court is at Creedmoor Psychiatric Hospital. The parcel of land on which dozens of buildings stand, many now boarded up and abandoned, was made available to the state in 1908. The state's Commission for Lunacy directed that it open as a farm colony



of Brooklyn State Hospital in 1912. Creedmoor looks like a jail, double-fenced with barbed wire.

We first met with the lawyer who was representing the hospital. We convened in a small room with a single desk and two chairs. I sat on a radiator, circa 1940s, in the corner. The three of us went over the main points of the case while my patient waited with another patient and a nurse in the lobby. We went through her symptoms: impulsivity, decreased need for sleep, hypersexuality and delusions. We reviewed how she picked fights with other patients and was found lying on the floor naked one night, sprinkling water on herself in some sort of holy ritual. Finally, we went over the medications she needed, antipsychotic drugs and lithium, to reduce these symptoms.

After we finished this review, we entered a courtroom and waited for our case to be heard. The judge listened to the facts at hand and ruled to hear the rest of the case the next week. This meant that the young woman had to remain in the hospital until the hearing. The attending and I left the courtroom and chatted outside. The patient walked out alone. She seemed confused. We told her she had to stay inside with her nurse. The nurse was with another patient, so the attending went inside to look for her. I turned to follow the attending, but as I looked back I saw the patient sneaking out the door.

I followed her, and when we got outside she made a mad dash for the road. When she was about 200 yards away, she looked back at me. I raised my arms, my palms facing up, gesturing, "What the hell are you doing?" She paused for a split second, as if considering coming back, but then she kept going toward the road.

I considered running after her, but I remembered from orientation that students were not to restrain patients. I went back into the hospital and we called the police. Her husband called later in the day and told us that she had withdrawn thousands of dollars from the bank. Her escape was short-lived. The next day she was found at an expensive hotel. Police brought her back to the hospital.



A week later, we were back at the court. Again, the judge would hear about all of her symptoms, including her lack of insight and her poor judgment eloping from the courthouse. I knew the tide had turned against the medical team when the judge called the elopement an exercise in good judgment. He ruled in favor of the patient. He set her free.

I was confused and a bit perplexed. How could this patient be allowed to walk out of a mental hospital when she seemed so sick? The illness was upending her life, and she didn't have the slightest clue. But then I realized that the principles of law and the principles of medicine do differ. Physicians are charged with helping patients as much as they can, even if that includes holding them against their will so they don't break the bank or impulsively file for divorce. The law doesn't share this view. The judge only cared for the physical safety of the patient and the potential for her to commit crimes. If she was cleared on those fronts, she was free to go.

As I thought more about the judge's decision, I questioned my own resolutions. How do physicians justify treating people against their will, and where do we draw the line? The diabetic patient with uncontrolled blood sugar isn't held against his will, nor is the patient with coronary artery disease who continues to smoke and eat unhealthy food. These patients may understand their conditions to a degree, but the number of deaths from treatable illness testifies to their lack of real insight. There are no locks on their hospital room doors.

John Sadeghi is a third-year medical student at the Hofstra Northwell School of Medicine. He's planning on pursuing a career in surgery.



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Crash

DENNIS KESELMAN

Dennis Keselman is a first-year medical student at the Hofstra Northwell School of Medicine. "Crash" is more of a reflection on members of the health care community than on the patients themselves, he says. "Many in health care avoid confronting the worst possibility for patients. Often, patients present with nonspecific symptoms such as fatigue and weight loss. They might be evaluated for hyperthyroidism or anemia, but occasionally, the diagnosis is a dreaded one. Gastric adenocarcinoma. Pancreatic adenocarcinoma. It hits both the patient and the health care provider like a strong wave crashing into a boulder. All of a sudden, emotions become overwhelming and invade every thought." This photo was taken on Catalina Island, CA.

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LENA LIU

Finding My Voice

It was a normal Tuesday afternoon in my ICE Medicine preceptor's office as Dr. Carney and I walked into the exam room to see a follow-up patient. The woman was here for her bimonthly checkup to evaluate the management of her medical conditions. She had CHF and diabetes, but the unique thing about her was that she had an LVAD machine – a left ventricular assist device – to help her heart pump.

Dr. Carney explained the use of the LVAD to me in front of the patient. When she finished, the patient turned to me and said, "My heart is too weak on its own. This thing literally helps me live. This thing is my life." She had her hand on the device's battery pack, which she was wearing on a belt around her waist.

After Dr. Carney had confirmed the patient's medications, she ordered a blood test in order to check her HbA1c levels and lipid profile. Dr. Carney asked me to escort the patient across the hall to the endocrinology suite where the blood work would be done. She told me that she had spoken with the receptionist and had arranged for our patient to be seen first, since the LVAD battery pack was running low. "Make sure they take her in for blood work right away," Dr. Carney emphasized, as I was walking away with the patient.

Across the hall, I shuttled our patient to the front of the line, and when I came face to face with the receptionist, I said, "This is Dr. Carney's patient with the LVAD. Is it okay if she cuts the line as Dr. Carney had requested?"

With a look of annoyance on his face, the receptionist said, "Oh, right, Dr. Carney's patient. We're going to need her to sign in and wait just like anyone else. The nurse is currently busy with another patient."

I explained the situation clearly and respectfully, stressing that our patient's LVAD battery pack was about to run out of power, but the receptionist ignored my plea, apparently because I was a medical student with no real authority. The patient, who had been standing quietly next to me the entire time, was composed at first

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but began to lose her patience. “This is literally my life! My life is in this battery pack and my life is on the line!” she yelled to the receptionist.

At this point, other patients in the waiting room who had heard all of this jumped in to support my patient for me. “Let her in!” one said to the receptionist. “I can’t believe they’re not listening to you,” another whispered to me, shaking her head.

Finally, I raised my voice slightly and said, “Can we please have another nurse who is capable of drawing blood come and see my patient?” This did the trick, and a nurse was summoned. Unfortunately, she had to stop halfway through the process because the LVAD battery pack became critically low. The patient and her son had to rush home to charge it.

Later, Dr. Carney told me that due to her preexisting diabetes our patient would likely be ineligible for a heart transplant, in which case her LVAD would support her heart for the rest of her life – something called destination therapy.

When I explained the lab work situation to her, Dr. Carney seemed frustrated that they had not listened to me right away. But she also said, “Lena, you became assertive. I see that you’re really stepping up to the plate and defending your patients. You’re fitting in here very nicely.”

This experience tested me in ways that I wasn’t expecting, and I came to the realization that patient advocacy can make a real difference, no matter how small the efforts may seem in the moment. And I learned that sometimes it’s okay to overstep boundaries to gain small victories for the patient’s sake.

I had found my voice in medicine. Not only did it feel right, but it has encouraged me to believe that one day I could make a major difference in the lives of my patients.

Lena Liu is a first-year medical student at the Hofstra Northwell School of Medicine, where she co-leads the Internal Medicine Interest Group and the Neurology Interest Group.



Alone with My Thoughts

As a child a blizzard meant
a day off from school
shoveling snow
while Mom made hot chocolate.
Now, I watch the swirling snow outside.
The wind blew out the power.
“Please come back on,” I pray.
I got the nonperishable food, bottled water,
battery-operated radio, flashlights.
And yes, extra batteries.
The whistling wind stokes my fears:
Will the extra blankets keep Mom warm?
Will the cold house aggravate her COPD?
Will she get up at night and fall?
Then what?
Spring can’t come quickly enough.
Will the ambulance get through?

Frances Avnet is an executive secretary at the Maurice A. Deane School of Law at Hofstra University. Her works have been published in The Arts Scene, Creations, Narrateur, Bards Annual 2013, 2014, 2015 and Rescued Kitties Two.



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Where Life Begins

JOLANTA BARBARA NORELLI

Jolanta Barbara Norelli is an MD/PhD candidate at the Hofstra Northwell School of Medicine who has been painting and designing for years, continuing the passion for art that her mother infused in her at a young age. She is founder of the Art and Medicine Club at the School of Medicine and a member of the Osler Society.

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DANIEL KENNELLY

A Cross in the Darkness

Each morning as I swing off the interstate that parallels the harbor, Saint Bridget's Medical Center is visible from the top of the exit ramp. In the semidarkness, the large cross upon the medical center's dome is illuminated by the floodlights that surround it.

As I see that cross, I say a silent prayer for God's blessings upon my work that shift, and I ask God to walk with me as I do his bidding. Above all, I pray that I will not get in God's way.

And then I ask God to watch over my Maria.

I am a Roman Catholic priest, a chaplain at Saint Bridget's Medical Center. I know that there are many other Roman Catholic priests who are chaplains at Roman Catholic medical centers, but I am different.

Unlike the others, I have not just left an empty warm bed. I have also left the warm body of the woman whom I love, the woman whom I may very well have made love to the night before, the woman who had fallen asleep in my arms. I have also left the embrace of a woman whose parting gesture of love, after a soft kiss, was to trace the sign of the cross on my forehead, and to ask God to bless me and my work over the next three days of my shift.

The medical center's cross, glowing in the softly vanishing darkness, is a reminder to me that God's great love for His people will help us survive whatever catastrophe the flow of life might bring us.

And the love that I and my brown-haired, blue-eyed Maria share is a powerful reminder to both of us of how much we are loved by our God.

I know that there are many who would consider me a "bad priest" because of the love and the life that Maria and I share. I know too that there are many people who would call my Maria a "priest's whore." Maria and I know that my church would suspend me if it ever found out about us. My calling and my career would be in shambles.

But right now, Maria and I are where we have chosen to be. It has been almost ten years. We both love each other deeply and unselfishly; and we've made the decision to merge our lives into a love story that others might condemn as sinful – even though we are both at peace before our God. Maria and I know in our hearts that God, in His love for us, brought us together.

Our decision was not made casually. When Maria and I met, we



were in good places in our lives. Maria, comfortably divorced and fiercely independent, had followed her heart and had established herself as a master gardener, growing her small landscaping service into a highly regarded consultancy practice. After several years of teaching, I had followed the silent whisper of God's spirit into the Roman Catholic priesthood. I loved being a Catholic priest, and I loved being a hospital chaplain. I knew that when I walked the halls of Saint Bridget's, my clerical collar and my presence witnessed to a compassionate and loving God who walked with His people in their moments of sickness and pain.

This God of compassion and love is the God that Maria and I both believe in.

Maria knows that I love my life and my work as a priest and chaplain, and she blesses and supports me in that work. I know that as much as I miss her during my long, seventy-two-hour shift, my absences are harder on her.

"I love seeing you leave," she said to me one morning, still lying in our bed as I stepped out of the shower. "Because then I know that I get to hold you again in three days."

She was trying to smile, but in the bathroom mirror's light I could see the mist of tears in her eyes. Naked and still half-dripping from the shower, I sat on the edge of the bed and took her in my arms.

"I'm sorry that our life is so nuts, honey," I said, kissing her softly on the top of her head, her warm morning scent filling my senses.

"Go, my gentle man," she said quietly, her face in my chest, "go. God's people need a good priest. Besides," she added, giving me a playful half-shove, "you're getting my side of the bed all wet."

And as on other mornings, as the tires of my car crunched over the stones of the driveway, I looked into the rearview mirror and saw her silhouette standing at the living room window, watching as I left her for another three days.

Daniel Kennelly, PhD, is an ordained Roman Catholic priest who is a chaplain at Long Island Jewish Medical Center. He has master's degrees in education and divinity, and a doctorate in spiritual counseling.

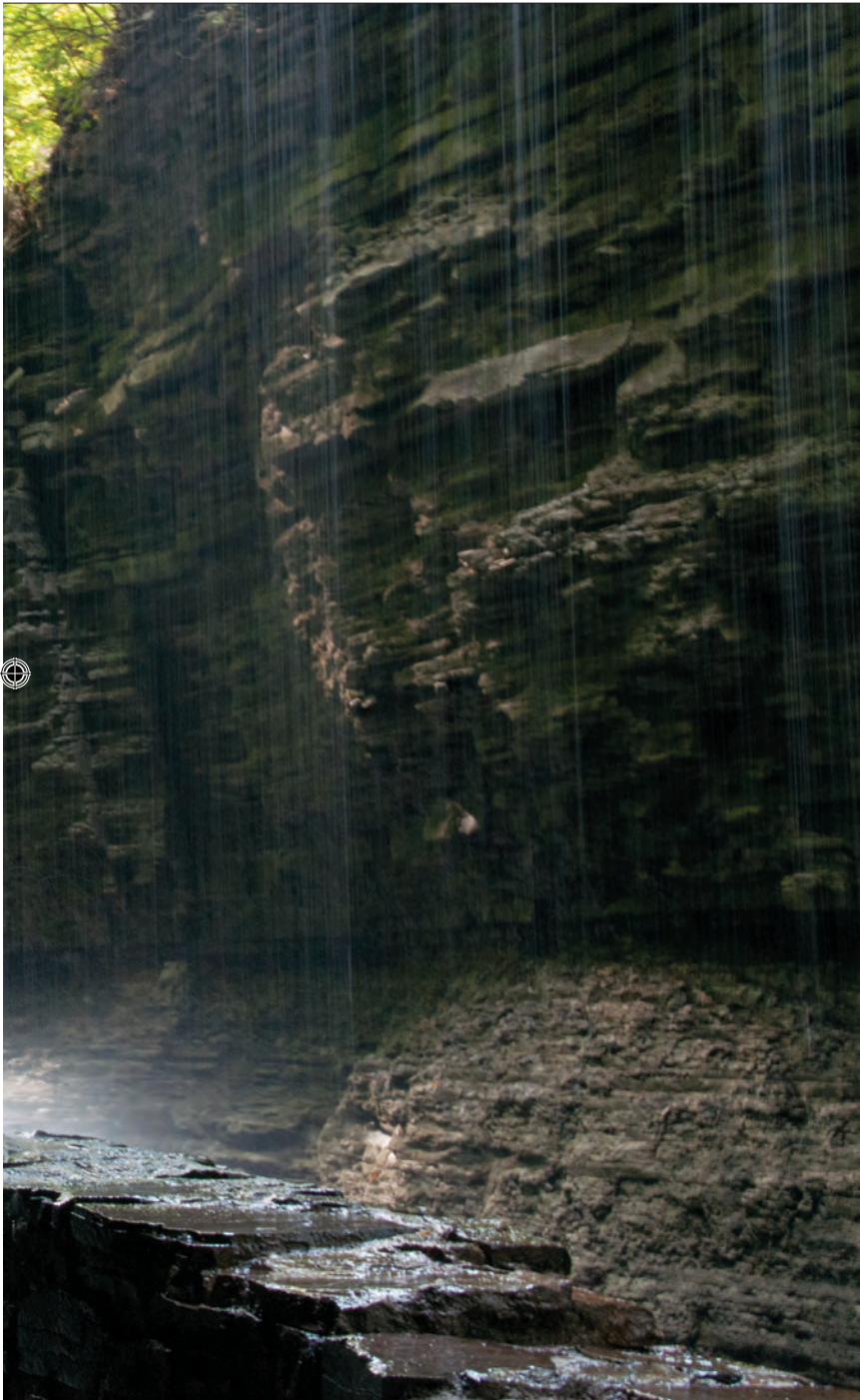


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Water Veil

MARIA RUGGIERI

Maria Ruggieri, PhD, is a scientist at the Brain Tumor Biotech Center at the Feinstein Institute for Medical Research, part of Northwell Health. She spotted this poetic scene created by a small waterfall over the path while visiting Watkins Glen in the Finger Lakes area in upstate New York.

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RICHARD SIDLOW

It Saw Me

I was a seasoned pediatric hospitalist with a dozen years as an attending in a busy hospital, and I had participated in almost twenty medical volunteer trips to South American countries. I thought I had seen or heard about everything until I met a silent thirteen-year-old girl and her angry father while working as a medical volunteer in southern Mexico.

My colleagues and I were focused on repairing cleft lips and palates. My responsibility was the pre- and post-operative care of patients undergoing these surgeries. Occasionally, I evaluated patients who came late on screening day.

On the third day of our five-day surgical schedule, a father and daughter arrived by bus from a small village nine hours away. The first thing I noticed was the father's scowl. He seemed angry about something. His daughter had an unrepaired one-sided cleft lip and palate. I gave them my full attention.

She was the oldest of three children, all of whom were born with either a cleft lip or a cleft palate. The man's younger children had had their surgeries long ago; she had been turned away every time she was brought to a surgical mission, because she had asthma, the father said. I thought to myself how unlikely this was, since asthma was very uncommon in this part of the world.

I asked him what medications his daughter was taking. He produced two slips of paper listing inhaled steroids, a beta-2 agonist inhaler and an oral antihistamine, an evidence-based and well-respected traditional cocktail for someone with persistent asthma.

And when was the last time his daughter had an asthma attack? "Yesterday, before getting on the bus," he said, rolling his eyes and pivoting his body dismissively away from his daughter.

"Did she use her inhaler yesterday?" I asked.

"No. We left them at home."

"And she got better by herself?"

"Yes!" he barked.

"Does she get a lot of attacks?"

"About once a week."

"And does she get better with the inhaler?"

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“It doesn’t seem to make a difference,” he said, making no effort to hold back his frustration, looking straight at his daughter.

I was both excited and concerned about the story so far. I knew from experience that interesting diagnoses came from stories that didn’t make sense. I continued with my questions, although I was bothered by how this father and daughter interacted with each other.

His replies were now only thinly veiling a disdain for doctors and their medicine. I turned to observe his daughter. She had not coughed once since arriving, despite having had an untreated asthma attack not twenty-four hours ago, nor was she breathing quickly or in a labored fashion. She was small for her age. She was thin and had jet-black hair and dark brown eyes. She wore a white dress that was peppered with crumbs from the cookies she was sucking on.

She never made eye contact with anyone. She looked downward, side to side, anywhere but toward the person in front of her. She did not ever utter a sound, even when spoken to. I asked her father if his daughter spoke. “Never,” he replied, his scowl deepening. At this point, I could feel in my bones he thought she was faking her respiratory issues. She was his albatross.

It was impossible to tell just from looking at her whether her muteness was due to an underlying syndrome, a developmental delay or maybe deafness, or whether she was just choosing not to speak.

No doubt, as is common for any person born with a deformity in any part of the world unfamiliar with embryology, she had been ridiculed, bullied and marginalized. So at this point in her life why would she make the effort to talk to me, or to anyone?

I asked her to remove her jacket so I could listen to her heart and lungs. Her father abruptly did it for her. I straightened out her dress, trying to be as gentle and respectful as possible while carefully listening.

Whoa! ... wait a second ... try again ... what? I forced myself to slow down and closely analyze the sounds percolating up my



stethoscope. The familiar waltz-like interplay between heartbeats and breath sounds was there, combined with a cacophonous overlay that had distinct parts to it. After five minutes of having her hold her breath, squat and breathe deeply, both with and without exertion, I was able to tease out several things. Her heart sounds were equally audible in both the right and left side of her chest, which was not normal. Between the normal lub and dub of her heartbeats and the in-and-out of her inhalation and exhalation, there was a lot of noise in the right upper part of her chest. This area sounded like a war zone: bubbles popping, wheezing at different pitches and Velcro being pulled apart, all at the same time.

Next, I looked at her hands and noticed a bluish hue to her nail beds. On closer inspection, her lips and tongue were blue-tinged as well. I knew that these were signs that she was not getting enough oxygen to these areas.

Eureka! I knew at this point that her asthma was actually an anatomic problem with her heart or lungs, or both. Now the problem was how to obtain a more precise diagnosis given the technological limitations of this rural hospital.

I tracked down the social worker and, with her help, got a set of chest X-rays.

When the X-rays arrived I held them up to the light streaming in from one of the windows. I saw that much of her heart was contained in the right side of her chest, yet the tip of her heart was still facing left? The film was not rotated, her collarbones and ribs were paired and even in orientation and she had taken a good breath to reveal the majority of her ribs, all signs of a good-quality X-ray.

So what was going on with this film? Surely this must have been an error on the part of the radiology tech, a mislabeling of the left side for the right side.

Another set of X-rays was ordered and I found exactly the same thing.

I went to the radiology suite and spoke to the technologist, hoping to meet an incompetent oaf who was laterally challenged. But she was quite competent and assured me the labeling was correct,



as was the patient's orientation during both sets of X-rays.

Upon closer inspection, I noticed that the left lung was much larger than the right, and when looking at them under very strong light, I saw that the right upper lung was quite dense. I now thought that the diagnosis had to do with a malformation of her right upper lung, shunting blood away from the rest of her body and reducing her ability to extract enough oxygen from the air. There were a number of possible diagnoses that could substantiate this theory, and luckily, one of the team members on this trip was a pediatric cardiologist. I gave him the films without any priming.

"What do you see?" I asked.

"Scimitar syndrome," he said matter-of-factly.

"Really?"

I had brought a collection of journal articles from home to pass the time between patients, and not an hour and a half before this patient walked into my life I had been reading about this very syndrome. It was the first time I had ever heard of it. The syndrome consists of a malformed right-upper-lung lobe that shunts blood away from the heart without oxygenating it. The left lung has to enlarge to compensate for the space and lack of oxygenation. This explained the X-ray findings, my findings on physical exam and the episodes of shortness of breath that were misinterpreted as asthma attacks. They were actually attacks of oxygen depletion. Most patients with this syndrome died in infancy. It was extraordinarily rare for an individual to live to adulthood with this problem unrepaired.

It seems that Scimitar syndrome saw me, but I did not see it, despite our recent acquaintance in print. The mystery was solved, and the synchronicity of these events made me shudder.

I found the social worker again, and she was thrilled to hear what we had determined. I explained to her what was needed. We did not have the ability to perform an echocardiogram or CT scan to define more precisely her heart/lung anatomy at this hospital, nor was there a pediatric cardiologist, pulmonologist or cardiothoracic surgeon locally. But these services were available at another



hospital that was only an hour's bus ride away. I asked if we could send the father and daughter to this hospital with the story and her X-rays and get her the care she needed. Then, at a future date, we could get her cleft lip and palate repaired.

"Yes, absolutely!" she said. "We can cover the travel costs and all the medical fees involved. Let them stay the night and we can arrange everything starting tomorrow morning."

We explained to the father everything that had just transpired — the incorrect diagnosis of asthma, the findings on the X-rays, her undiagnosed syndrome and the offer of support for the medical needs and ancillary costs.

He was incredulous.

"So how could all those other doctors be wrong?" he asked sarcastically.

I tried to explain that the symptoms his daughter had been experiencing her whole life were most probably transient bouts of lack of oxygen, and that today's physical findings may not have been as dramatic during previous medical encounters.

His scowl tightened. He did not like my answer, and during our whole conversation, his daughter never uttered a sound.

Our discussion ended late in the afternoon, and with a little coaxing from the social worker and me, he agreed to stay the night with his daughter and to meet with us again first thing in the morning.

That night, as I lay in bed, I contemplated what must have been going through this father's mind. Why should he trust us now when so many times before doctors had failed him and his daughter? The answer we gave him now was even harder to understand, and there was no guarantee that it would translate into the procedure he actually wanted for his daughter. He would have been completely justified in asking whether this was some form of a karmic joke.

The next morning father and daughter were nowhere to be found.

Richard Sidlow, MD, is associate director of the Department of Pediatrics and director of the Pediatric Hospitalist Group at Staten Island University Hospital. Other stories have been published in The Intima and Blood and Thunder.



Frozen

SARAH BAYEFSKY

Sarah Bayefsky is in the 2016 graduating class of the Hofstra Northwell School of Medicine. She will begin her residency in internal medicine and pediatrics at Vanderbilt in Nashville, TN. Her photograph represents last year's harsh winter on Long Island that led to many hospitalizations. She writes: "It is also a symbol of a paralyzed doctor who is unable to do what is right when it matters most. Medical school trains us to use scientific knowledge to better the human condition, but often what patients need from their providers has nothing to do with science at all. An empathetic listener, humble communicator and thoughtful comforter may be just what the patient ordered."



ELAINE ADAMS BORDEN

Her First Love

Calamity has followed me all through my life. But the path that led me under a steaming coffee pot at fifteen months and into an operating room where surgeons repeatedly grafted a toddler's brown skin for a year; to where I was hit by a car; to when I nearly drowned at eight because I didn't know I couldn't swim; and through endless asthma inhalers in my youth also led me to nursing. And here I am today, twenty-eight years a nurse.

Those amazing and compassionate women who cared for me knew just what I needed to take the pain away: crayons and pencils and chalk and brown paper bags. (We couldn't afford any more than that.) I drew flowers, millions of them, intricately laid out and colorful. My grandmother would just stare at my drawings.

It was an art teacher at my high school in Graniteville, South Carolina, who sat me down and explained that I was a mix of brightness and creativity, that my brain processed textures and shapes and proportion. It was part of my nature, she told me. Then she taught me about utilizing the page and putting shapes and textures down to make my drawings come alive.

I didn't forget. I went off to the University of South Carolina, which was just down the road from my home. During that first year my dad got sick and money for college ran out. I moved north to live with family on Long Island and ended up at the Vocational Education Extension Board to study to become a licensed practical nurse.

It had been years since North Shore University Hospital hired LPNs from the extension board, but in 1987 the hospital hired the top five of us. In 1992 I enrolled at Nassau Community College and crammed two years of work into one to become a registered nurse. Ten years later, I went back for a legal nurse consulting degree.

I always loved nursing, so my drawings took a back seat to my work and to the children I would start bringing into the world. I have hundreds of sketches of my babies sleeping.

It wasn't until three years ago that another calamity would take me down: I slipped on a puddle of coffee heading into work and landed on my back and into the wrong side of the the hospital, this time as a patient. I had several herniated discs and needed rods in my spine, and lots of downtime.

NARRATEUR



ELAINE ADAMS BORDEN

I did what any right-brained person would do to get my mind off the pain: I drew. This time, my medium was not crayons and pencils and chalk. I taught myself how to draw on my iPad with a seven-dollar app called Sketch Pad Pro. My drawings became my medicine.

I started swimming to strengthen my spine. One day I saw a flyer looking for submissions for an art show at the Freeport Library. I submitted an iPad drawing of a little black girl surrounded by flowers. The judges were mesmerized (although one thought it was obscene that I would call something art that had been drawn on a tablet).

When I was recuperating I had lots of time to draw, and I love the smell of paint and linseed oil. But it takes neither of these, and little other preparation, to create on my iPad.

I am back to nursing, and back to painting. I'm told that I draw better now than I ever did in my youth. My latest is called "Her First Love."

An apt title, I think.

Elaine Adams Borden, RN, is a surgical intensive care unit trauma nurse at North Shore University Hospital. She specializes in digital art but also turns to oil, acrylics, pastels, pencil, charcoal and ink whenever she gets a chance.

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Her First Love

ELAINE ADAMS BORDEN

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STANLEY KATZ

The Physician

A young woman had just given birth, and during the delivery her doctors had discovered that she had a heart murmur. I am an interventional cardiologist, and I was called in to consult.

The new mother with the murmur was thirty-two years old. The heart murmur was no surprise to her, she said. She was born with a heart condition, and as a young child was seen by a pediatric cardiologist who recommended a cardiac catheterization. Her father refused to have his seven-year-old child head into surgery. “Stay away from doctors,” he warned her.

She had avoided doctors and any talk about the murmur until I showed up at her hospital bedside. On examination, I could not figure it out. An echocardiogram showed that she had a single ventricle. I recommended the same procedure that she would have had as a child: a catheterization. She agreed.

This was early in my career, and I wanted to have some guidance from a pediatric cardiologist. It was the early 1980s, and there was no pediatric heart doctor at the hospital where I had been working. It was recommended that I contact a specialist down the road at North Shore University Hospital. He graciously agreed to consult on the case. He asked if he could be there for the procedure, and I was glad for the expert company.

The catheterization was a success.

I soon discovered that my new colleague lived in my neighborhood, and in fact we would eventually be colleagues at the same institution. I would see him jogging frequently. He’d smile and tell me that he was running off his fat. He just couldn’t seem to lose it. A decade later, he would have given anything for that heft. He had pancreatic cancer and was emaciated. The disease killed him within a year.

One evening, not long after he died, I was driving home from work when a problem with a tire forced me to pull into a neighborhood repair place. I was sitting in the reception area when the manager approached me.

NARRATEUR



“Are you a doctor?” he asked.

“Yes,” I said.

“Are you at North Shore?” I nodded.

Then, he asked me whether I had known the doctor who had just died.

“Yes,” I answered.

“So sad that he passed. He was an amazing doctor,” the manager said. He told me that his daughter had been born with a congenital heart defect that had required several procedures and surgeries during her first six months of life. “It was hell. But he was always incredibly supportive.”

The manager said that one evening during those first six months, he and his wife were at home with their child when the doorbell rang. It was the doctor and his wife. They said they were there to babysit. They wanted to give the young couple a night on the town, and they would not be dissuaded. So the tire guy and his wife got dressed, kissed their baby and headed out for dinner.

“When we returned later, the house was calm and quiet. They were just so kind,” he said. “And we had a fun night off.”

Listening to this story, I wished I had come to know my colleague as a friend. He certainly was a guy who understood what doctoring is all about.

Stanley Katz, MD, is executive director of the cardiovascular service line and senior vice president of cardiovascular services at Northwell Health. In his high school days, he was a professional soccer player in Cape Town, South Africa, where he surfed, ran track and played squash and tennis. Today, he's happy to follow his passion to the sky; he is an avid pilot.



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Overhead

BENJAMIN STUART

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Benjamin Stuart is a third-year medical student at the Hofstra Northwell School of Medicine. His work has been featured at the Fisher Museum of Art in Los Angeles and on the Ontario Ministry of the Environment web site.

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My First Time in Anatomy Lab

An old man gazed up at me, his face peaceful. My first thought was that he looked like someone's grandfather, the type who always offers words of wisdom and has a good joke to tell.

While his expression was serene, mine was unsettled because, after all, he was dead, and I was an anxious but eager medical student looking at a cadaver for the first time.

I timidly approached the man. I knew that he couldn't stop me, but I had some intuition that it wouldn't be right to take advantage of his lifeless body. I couldn't tell you why, but I knew he deserved some dignity.

After a few moments, I became comfortable staring directly at his anatomical features. We were soon told to familiarize ourselves with the body, so I started "poking around," as the instructor suggested. Then we were informed that the man's name was Frank and that he was eighty-nine years old. He or his family had donated his body so that future physicians could learn from it.

I immediately felt a responsibility that I had not felt before. I realized that I owe it to Frank to become the best doctor I can be so that I make his contribution worthwhile.

Elie Kaplan-Marans is a first-year medical student at the Hofstra Northwell School of Medicine.



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Under the Sea

ELISE STAVE

Elise Stave is a first-year student at the Hofstra Northwell School of Medicine.

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SUSAN RIEKERT

Rose's Beach

Rose wanted to spend her last years living by the beach, but she was sent home to die. She came to us on her deathbed, filled with so much fluid that I feared she would burst with one touch. Her two devoted sons had refused hospice and instead requested home care services despite being told that nothing more could be done for her. Her heart disease was now in the end stages. She was two years shy of 100 years old. I was her nurse.

I was greeted at the door by two men who didn't appear much younger than Rose herself. I took two steps into the main room and there she was, lying prone on a mattress on the floor. Her beautiful blue eyes shone bright in her swollen face. She'd spent weeks in the hospital, and it had taken its toll. She was unable to walk, and she was too weak to speak. Rose had another home in Florida and she had told her sons that she wanted to get back to her beach. "You have to help her get better!" her sons begged. "Mom is not ready to die." Their faces were pale and sad.

I went over and sat in a chair beside the bed. I leaned down and took her hand in mine. She softly gripped my hand and just stared up at me. My first thought was: How am I going to help this patient? I read the prognosis on the referral sheet. It said that a hospice placement was urgently needed. One of the men held his mother's other hand and his brother caressed her head. I said that I would discuss a plan of care with her doctor and that we would do all we could for her. I did not make any promises, but this spark of hope spread like fire across the terrain of this small family unit, a triangle. Rose picked up on the love and the possibility of something more than dying. Her eyes flashed like lightning. She strained to make her lips turn up. Who was I to deny them their only morsel of hope? "It will be a long journey with many obstacles," I said. "We will work together as a team."

I spoke with Rose's doctor. He had been expecting a call from hospice. After much debate, he agreed to place her in our coronary heart failure program. We agreed that we could send a doctor from our house calls program. We ordered a hospital bed,

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air mattress and oxygen. Prescriptions were written for physical therapy in the home, a health aide and social work services. But even with giving her the best care possible, I knew that the odds were small that she would get to her home on the beach. Her doctor made me agree not to offer false hope. He said to call hospice in if there was no improvement or if things were deteriorating.

Our first few days together were rocky. Her cardiopulmonary status remained unstable. I visited her daily to monitor her respiratory status, assessments and medication adjustments. Her sons followed every direction to a tee. Blood tests revealed multiple electrolyte imbalances and elevated PT/INRs. The home health aide reported that Rose was not eating. Within three days, her eyes became a stormy blue-gray. Her hand grasp was appreciably weaker.

On the fourth day, I stood by Rose's bed in the middle of the living room and called her sons over. "Tell me about Rose's beach in Florida," I said. They described the azure ocean frequented by dolphins and manatees. They recalled how much Rose loved to walk along the beach and the hours she spent basking in the sun. I shared my own love of the beach. I had hoped Rose might perk up listening to our conversation. She remained peaceful in sleep. Disheartened, I left their home and cried in my car.

The next day, Rose's son called and left a message with the secretary. Dreading the worst, I returned the call. "She's awake and sitting up!" her son cried. "She even ate a little!"

But I arrived that morning to find Rose in bed and asleep. False alarm, I thought to myself. She's not getting any better. Then, as I turned to get my supplies from my nursing bag, I heard a soft voice whisper, "So, when are we going to the beach?"

Rose is now 103 and living on her beach on the Florida coast. With the help of telehealth and the home care team, she began her long walk to wellness. With multiple medication adjustments and close monitoring, her cardiopulmonary status began to stabilize. Her edema slowly dissipated and she could walk more smoothly again. One step at a time, we would tell her. Soon, she was off



SUSAN RIEKERT

her oxygen and ambulating with a walker. Her sons, so very grateful, could not thank us enough. Our reward was witnessing Rose come back to life. Every year, her sons send a card. My invitation is an open one. I have yet to make it to Rose's beach.

Susan Riekert, RN, has been a nurse with the Northwell Health Home Care Network for the past twenty-three years. Her current role is as a nurse educator. She also teaches nursing at Queensborough Community College.

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House on Chincoteague Island, Virginia

JEANNE VASILAKIS

Jeanne Vasilakis, NP, is a pediatric nurse practitioner in the Division of Adolescent Medicine at Cohen Children's Medical Center.

NARRATEUR





BRIAN E. EMMERT, JR.

Forgetting

This fish swims in circles, day after day,
Observing the outside world.

Oh look, a woman, thinks the fish.
I wonder what life would be like as a woman.
Memory interminable, focus abundant.
The fish continues to swim in circles.

Oh look, a woman, thinks the fish.
I wonder what life would be like as a woman.
Retention, attention, recognition, and recall.
I would do anything to have the brain of that woman.
Then, I wouldn't forget my past.

What a cute fish, thinks the woman.
I wonder what life would be like as a fish.
No worries, no stress, just swimming around.
Memory short, but normal, alas.
The woman turns and stares into the distance.

What a cute fish, thinks the woman.
I wonder what life would be like as a fish.
No appearances to uphold, no need to be bold.
I would do anything to have the brain of that fish.
Then, it would be normal for me to forget.

No pressure, no pain, no frustration, no shame.
Swimming and resetting, just part of the brain.
But curse this disease, this damned disease,
Altering my mentation; oh the disdain.

Oh! Look at the fish! What a cute fish!
I wonder what life would be like as a fish.

*Brian E. Emmert, Jr., is a first-year student at the Hofstra
Northwell School of Medicine.*



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Flamboyance

MARY SUN

Mary Sun is in the 2016 graduating class of the Hofstra Northwell School of Medicine and is heading into a radiology residency.

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Silk Socks

There is a room on the surgical ICU where agonizing screams pierce the night.

She calls his name. She cries. She paces beside his body and occasionally reaches down to his hospital gown and tugs it and tries to make him move. He is still. He is tethered to machines that are breathing for him. He came in two days ago. He fell reaching over to tie his shoes. He hit his head. There was a blood clot, and now he is on life support.

The shock of it all – he was so alive three days ago, and now doctors trail in shaking their heads. They agree that there is nothing they can do. The subdural hematoma caused too much damage. He will not wake up.

She had been hoping for decades together. They fell in love and married when he was sixty. They had sixteen years. She wanted more. She can't stop chanting his name. She gasps for air. Her own tears almost choke her.

She holds his hand. I hold hers. I am a nurse on the surgical ICU. Doctors explain that he is not a candidate for surgery. Now, this wife is asked to end life support and say goodbye. There will be no more tomorrows. She wails. I hold back my own tears.

Another day passes. In the afternoon, she nods when doctors explain what will happen when the machines are turned off. She looks down. Her voice is a whisper when she answers their questions. She finally says okay, she understands. She walks out of the room.

A doctor removes the tube from the man's airways. The machine goes black. I set up a morphine drip. She returns to his bedside and does not move for another four hours. She is docile, stripped of energy. When the machines at my desk go lifeless, that is when I come back in and say only four words: "I'm sorry. He's gone."

Yesterday, his two daughters were there. They told me that they had had a falling out with their father after the death of their



TUNISA RIGGINS

mother. They spent a few hours by his bedside and said they would be flying home that evening.

After they left, his wife said that she and her husband had a solitary and loving marriage. It was empty of the tradition of their Chinese culture where family is sacred.

I give her a few minutes with her dead husband.

She comes out of the room and walks toward me. I am sitting at the nursing station and immediately stand when she stops at the desk. “Will you dress him?” she asks.

I do not understand the request. I turn to my supervisor, who nods her head. “Of course,” she says.

His wife leaves. I go back into the room and cover the body. Two hours later, she returns to the unit with a bag that contains one pair of underwear, a pair of brown silk socks, a brown suit jacket and matching slacks, a crisp white button-down tuxedo shirt, a tie and a pair of brown leather shoes. There is also a Kangol hat. Everything is new, with tags.

I take the package into the room and stand in front of my patient. His wife slips out of the room. I begin dressing him. A nurse helps with the tuxedo shirt. Another nurse had just watched a YouTube video on assembling a tie and joins in the dressing. The silk socks are put on last.

When we are done, his wife returns to the room and I see the first smile. She puts on his toupée and adjusts the hat over his head. She turns toward me and kisses my cheek. Her hands wrap tightly around my arms and back. She is crying. This time, her tears are soft, like snow.

Later that day, a resident explained that this dressing is part of an ancient Chinese death ritual. A tradition. I was, for a few moments, the only family she had left.

Tunisa Riggins, RN, is a nurse on the surgical intensive care unit at Long Island Jewish Medical Center.



ALYSSA ROTHMAN

The Patient I Didn't Expect

I usually keep my emotions in check
But that afternoon was an exception
I guess everyone has that patient
The one that can change your perception

This twenty-one-year-old's chart
Was much thicker than the rest
A horrific car accident two years ago
Had left him damaged and depressed

Two broken femurs and a fractured pelvis
Damaged vocal cords and a mangled hand
Months in the hospital and even more in rehab
I was impressed this patient could even stand

I flipped through the pages of his chart
And my jaw dropped even more
But none of this prepared me
For what was waiting behind the door

I entered the room with my preceptor
And started the visit just like any other
Except when I saw the face of the patient
Looked so much like my little brother

My brother also almost lost his life
And the memories started rushing in
I did my best to compose myself
I had a history and physical to begin

While I asked my questions
His mom's eyes were locked on the floor
I knew her painful expression all too well
Probably wishing she could do more

NARRATEUR



ALYSSA ROTHMAN

I remembered the pain my family felt
Watching my brother struggle every day
It's hard to watch someone rebuild his life
You wish there was something you could do or say

My patient expressed many concerns
About his weak voice and awkward gait
“Are these things permanent or will they improve?”
“How much longer do I have to wait?”

I remembered how my brother withdrew
From all of the people and activities he enjoyed
Watching the effect on my parents was the hardest
Every hope they had for their son seemed destroyed

I felt his mother's sadness and fear
I wanted so badly to tell her it would be okay
Her son will find that thing that brings him back
That thing to help him find his way

It took my brother many years to recover
But now I am so proud of his success
I wanted the same result for my patient
So he can feel the thrill of making progress

The appointment came to an end
And my preceptor and I said goodbye
The patient and his mother left the office
As the first tear escaped my eye

Alyssa Rothman is a second-year medical student at the Hofstra Northwell School of Medicine.

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ELAINE HOI

Let My Body Be

Let my body be my body again.
Let it assist me in my cadence
Support me in my balance
Accommodate me in my stance
Let my body be my body again.
Let its muscles lift, pull and carry me
To open plain with summer's glow
Instead of fibers torn asunder
Ravaged slowly, blow by blow.
Let its limbs lever and propel me
To places that I'm fit to go
Instead of sickly stems I tremble under
Knees wobbling to and fro.
Let its joints support and connect me
To organs big and small
Instead of mechanisms to impede me
From walking straight and sitting tall.
Let its face and hands and feet
Meet the faces that I meet
With courageous wherewithal,
Instead of timidity enshrouded
My expressions ever clouded
Praying for a curtain call.
Let its arms and neck and shoulders
Allow myself to better boulders
That another could not free
Instead of constant supplication
Wishing mind-body separation
Whispering a beggar's plea.
Please, please dear remedy
Let my body be.

I sing the body curative
Let my body
Let my body
Let my body
Be.

Elaine Hoi, RN, is a med-surg/telemetry nurse at Long Island Jewish Medical Center.

NARRATEUR



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Freedom

MARYBETH WRIGHT

MaryBeth Wright is a program coordinator for the Second 100 Weeks at the Hofstra Northwell School of Medicine.

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SONIA CABAN

Believe

It was Christmas, and I was a new nurse on the critical care unit. I was working the night shift, which meant that this new girl in town would miss holiday dinner with her husband and children.

My three daughters just stared at me as I explained that I had to build up seniority at my job before I could get holidays off. Their faces told me that they would have none of it. I closed the door behind me and climbed into my car. I felt terrible.

At 7:00 p.m. I met my first patient of the night. She was in her mid-thirties and on a ventilator. I smiled and introduced myself and told her that she could ring the bell if she needed anything. She said she was expecting her family.

From the nursing station, I saw that her family arrived a few minutes later. The monitors at my desk gave me a clear view of her room. I looked up a few minutes later and her family was gone. It seemed odd, especially given that it was Christmas. I stood up and headed into her room. She was crying.

She said she was afraid. She had been diagnosed with myasthenia gravis, an autoimmune neuromuscular disease that causes muscle weakness and fatigue. She was on a vent because of respiratory weakness. I sat down next to her bed and took her hand. I let her cry.

She said she asked her family to leave early because she did not want to spoil their Christmas. I asked a colleague to take over some of my patients so I could stay with this young woman. Her tears flowed.

She said that she had a four-year-old son and a six-year-old daughter. She was also a kindergarten teacher so had a gaggle of five-year-olds, which explained why she was surrounded by dozens of beautiful hearts on paper that her students and children had made her for Christmas at the hospital. Those shaky crayoned words – *come back soon, we love you, we miss you* – broke my heart.

She asked me if I had children. I told her I had three girls, two teenagers and a ten-year-old. I started telling how the previous Christmas I was going crazy trying to find a Christmas bell like the



SONIA CABAN

one in the *Polar Express* movie. She started to laugh and said she did the same thing that year for her children. After searching many stores and malls I finally found the perfect bell – just like the one in *Polar Express*. I told her that it was the last gift my youngest opened and she put it against her ear and rang the little silver bell. She smiled. I couldn't hear the ringing – just like in the movie! – but my husband had just entered the room and heard it just fine. My patient said that her husband had done the same exact thing. We laughed so hard that a nurse came in and said “sshhhh” and closed the door.

We just laughed even more. After a few minutes she thanked me for taking away her sad tears in exchange for laughter.

I told her she should “Just Believe,” the song from *Polar Express*. She said that was what she was going to start doing. My break ended and she lowered her bed, a smile on her face.

The next morning, the sun was up and I was heading home. I stopped in and hugged my patient. Our smiles were back and so were our tears. In my heart I just believed she was going to get better. I think she felt the same way.

On that day I learned the true meaning of Christmas, and my job: hearts blending together with faith.

Sonia Caban, RN, works in the intensive care burn unit at Staten Island University Hospital.

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MICHAEL B. GROSSO

Physician's Song

(After Whitman who was, after all, a nurse)

I CELEBRATE myself, and sing myself,
And what I assume you shall assume.
Therefore, patient, trouble yourself not
With diagnosis or prognosis.
For every atom belonging to you is my responsibility.
Hippocrates' credo, that the safekeeping of your very bones and sinews
Your beating heart,
Your inspirations and expirations
Are my affairs and dwell in the safekeeping
Of my objectivity
As I would observe a spear of summer grass
In the current season
The time and authority of Hippocrates having passed
As green leaves to dry leaves
You no longer take things at second or third hand.
You do not look through my eyes either.
I depart as air and
You are alone
With the silence of the grinding respirator
To listen to all sides and filter them from yourself.
The full force of nature is as nothing
Against the generation of consultants and tubes.
The smell of machines will intoxicate you if you let it.
Dearest sufferer
In your grief you know not who I am
Or what I mean.
If you want me again look for me under your boot-soles.
We can walk the dark woods together.
I will not lash you to myself
But let our fingers entwine.
I stop somewhere waiting for you.

Michael B. Grosso, MD, is the medical director of Huntington Hospital and assistant professor of pediatrics at the Hofstra Northwell School of Medicine.

NARRATEUR



BRYANA VALVERDE-DEBARTOLO

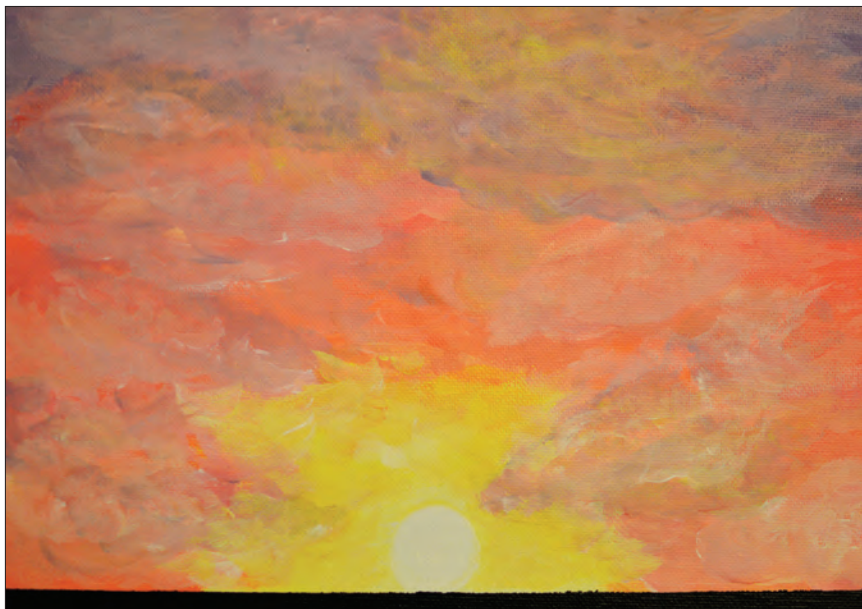
Tie Box

— *for Grandfather*

You like to wear ties to church.
I bought you a pink silk one
well, actually, I forgot to bring it,
and only wished I had.
Invisibly marked,
still boxed
on the closet floor.

Bryana Valverde-DeBartolo has recently completed an MFA in creative writing at Hofstra University. Her poetry explores diverse themes of hybridity, identity, politics, feminism, nature, love, loss, life and transformation against the backdrop of textured Trinidadian and American motifs. Several of her pieces collectively tell the story of journey, and the spaces of transition in between cultures.

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Life

ZANETA CHEN

Zaneta Chen is in the 2016 graduating class of the Hofstra Northwell School of Medicine and will be heading into an internal medicine residency.

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SARAH GUTMAN

Letter to Abraham

I can't really sort through what's going on in my head right now, so I'm just going to write what happened and see if that helps.

I went to the crib against the wall and asked Joanne, a translator, to ask the mom why she brought the baby to the hospital. I started taking notes. I think that was my first mistake; there was a baby dying right in front of me and I started taking notes. *From the Congolese refugee camp, two months old, boy. Breathing fast for five days. Treated for pneumonia with antibiotics for four days. Sent here last night because not improving.*

Then I got distracted. I don't remember by what – another patient, maybe, a phone call? A text? Anyway, then I was talking to the resident and I told her there was another new admission, but when she asked me how he looked I realized I couldn't tell her because I hadn't actually seen the baby.

When we went back to check we unpacked his little blanket burrito and he stared up at us, belly huge, eyes huge, everything else tiny. Sick. Dehydrated. Started fluids. Pneumonia? More antibiotics. But his belly was so huge, and it just kept getting bigger by the second.

We put on a nasal cannula of oxygen. When it didn't change anything and I went to adjust the nose prongs I realized there was a fluid coming out. Brown? Black? Green? Out of his nose and out of his mouth, and still he just stared at me with those big eyes. He stared and stared as the nurse put in the nasogastric tube and sucked more fluid out, but only kind of sucked it out because none of the syringes fit the tubing, but nothing in this hospital seems to work when you need it to. And the resident and my attending, and now the Ugandan attending, are all deciding that he needs to go to a bigger hospital with an operating room, and we're loading him onto the ambulance and Joanne and I are going with him, and now the baby and I are staring into each other's eyes as the ambulance goes flying through the streets and I'm trying to keep a good seal on the mask I'm using to bag him

NARRATEUR



SARAH GUTMAN

because the oxygen can't come with us but I don't squeeze too hard because his belly is still so swollen and more of the brown-black-green stuff is coming out.

We brought him straight to the OR, but there wasn't any oxygen there and no pulse ox for a baby, so I stared at him some more while people went to get them, and I thought about how I was doing nothing. And when I finally left him with his new doctors and went into the hallway his dad was crying and he told Joanne to tell me that he's worried, and I just told Joanne to tell him that I'm worried too.

And then Joanne and I rode the ambulance back to our hospital.

A few hours later, I overheard someone tell someone else that the baby had died in the OR. And I felt tired. And I wished I had opened the blanket burrito sooner.

Note: This letter was written to the author's husband while she was on a rotation in Kisoro, Uganda. Since this experience, she has had time to reflect but still often feels the way she did that day – that she can't fully sort out what's going on in her head. "It is impossible to fully grasp the injustice of the health disparities between the rich and poor places in the world. There are many more eloquent and informed writers than I who have written about poverty and global health, so I won't attempt that here. I'm just grateful to have had the opportunity to learn from the talented doctors who dedicate their careers to trying to make a dent."

Sarah Gutman, MPH, is a fourth-year student at the Hofstra Northwell School of Medicine. She attended Harvard University and the Johns Hopkins Bloomberg School of Public Health before starting medical school. With interests in women's health and global health, she will be starting a residency in obstetrics and gynecology.

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JOHN F. DECARLO

Dis-Ease

Biological inquiry is cordial in its social discourse
but a bit rough and edgy around the cellular membranes:
You think doing the tango with an excited electron is taxing?
Try enticing an ever-evasive evolutionary virus
into a vaccinating embrace

Knocking on the door of Nothingness...
It's no cosmic joke: It's the existential bloodsucker of perplexity!
And not the "nothingness" of the quirky quantum-field theory
which is really nothing but oscillations of variable variables –
a quasi-religious science, striking up an expose pose

To really knock on Nothingness
is to venture what one will hear within the void,
when no – physical or energetic – thing or entity
seems to be even frowning back at you...
Do you dare to believe in the nonexistence of belief?

*John F. Decarlo teaches in the Writing Studies Program at Hofstra University.
He is also the poet in residence with the Long Island Philosophical Society and
recently received the Chancellor's Award for Teaching Excellence.*

NARRATEUR



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The View

SANJAY KIRTANE

Sanjay Kirtane, MD, is a cardiologist at Northwell Health. He comes from a family of doctors and has been in practice since 1982. In his younger years, he played professional cricket in India. He has recently returned to the cricket field in the U.S.

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SAMUEL ALPERIN

How Can I?

How can I tell this new mother in room 1 that we will do everything we can to treat her kid with SCID (severe combined immunodeficiency), when the mother in room 2 won't even vaccinate her kid for fear of autism? I can't. How can I treat and help my patients with their anxiety when I grapple with my own anxiety about friends, girlfriends and life in general? I can't.

How can I tell the single mother of three that everything will be okay after breaking the news to her that she has stage 4 lung cancer? I can't.

How can I properly treat my patient with mental developmental issues for his hypertension when his sister, his only caretaker, insists that he will take his pills but he doesn't want to? I can't.

How can I know to trust all of my colleagues and their diagnoses and findings except for the time one of them is wrong? I can't.

How can I live with myself knowing that if only I had listened more closely in lecture twenty years ago perhaps I would've caught this patient's rare disease and he wouldn't have died? I can't.

How can I learn everything there is to learn about the wonder that is the human body, heart, lungs, kidneys, liver, brain, so that I can rest assured that I have treated my patients the best I could? I can't.

How can I? I can and I will. Because I want to. Because I have to.

Samuel Alperin is a third-year student at the Hofstra Northwell School of Medicine. At the hospital, he often finds himself awed by medicine, his patients and their stories.

NARRATEUR



Sunset Over Pristine Place

CHRISTOPHER
FAZIO

Christopher Fazio is the admissions coordinator at the Hofstra Northwell School of Medicine and is working toward a master's degree in business administration at the Zarb School of Business. He enjoys traveling, baseball, piano playing and songwriting. He has captured this palm tree at sunset over several years. It grows outside his mother's house in Florida. Pristine Place is actually the name of her gated community.



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EDMUND MILLER

The Owl

The owl perches on high, protected by her surroundings. She is at rest, watchful but calm. It is not time to sleep or hunt. She is not fully hungry. She waits, relaxed, yet fully aware of her surroundings.

The man sits, sipping his double-shot, skinny, extra-foam, crème brûlée latte, staring anxiously at his smartphone, adrenaline flowing, unaware of his surroundings.

The owl tweets, blissfully unaware of social media. She is finding who is in the vicinity, and notifying others of her presence. Relaxed, but vigilant.

The man takes a photo of his coffee and brownie and posts it on Facebook so that all his contacts will know this important feature of his life.

A twig snaps and the owl reacts, checking to see if this could signal danger or food, important issues both.

There is a crashing sound, but the man is oblivious. He is unaware of any signals of danger or the need for help. He is just not listening. He is focused on getting to the next level of a game.

The owl responds to life's rhythms, developed over eons, and is tense and aware when appropriate and relaxed but aware when safe.

The man responds to modern life, being ever active, focused, anxious, texting, mailing, gaming, but all the while unaware of real life that surrounds him.

I wonder why they call her “Wise Old Owl”?

Edmund Miller, PhD, is head of the Center for Heart and Lung Research of the Feinstein Institute for Medical Research at Northwell Health.

NARRATEUR



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The Owl

EDMUND MILLER

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BURTON ROCHELSON

An Old-Fashioned Doctor

A few months ago, I had to call a young doctor into my office because of a failure to follow a safety protocol. Fortunately, the patient did not suffer any consequences of this breach, but she might have. I was discouraged by the physician's response.

The doctor did not like practicing "cookbook medicine." Evidence-based medicine — the use of the literature to guide you — just wasn't necessary. Reading and lifetime learning were esoteric, irrelevant, ivory tower exercises. The "art" of medicine is when you are using judgment, experience and what you had learned from your older partner — that, and kindness, would be enough.

"I like to think I'm an old-fashioned kind of doctor," the thirty-four-year-old physician told me.

At that moment, I coincidentally (perhaps) turned and saw the graduation picture of my father's medical school class that hangs on the wall of my office. Underneath it is written: University of Vytautus the Great. Kaunas, Lithuania, 1939.

Months after my father's graduation from medical school, the Germans invaded the town of Kaunas. They moved all of the Jews from their homes and placed them in ghettos, and all of their assets were taken. My father, his wife and their young son, eight years old at the time, were taken to the Dachau and Auschwitz concentration camps. The year was 1944. When the war ended on April 29, 1945, my father was liberated. Sadly, he soon learned that his wife and son were gone.

Thousands of sick and dying refugees streamed into displaced persons camps near Munich. In May 1945, my father and a few other refugees, also doctors, began a hospital in Landsberg am Lech, a displaced persons camp for thousands of survivors of concentration camps and, ironically, a former prison where Adolf Hitler had written *Mein Kampf*. Within days, the hospital had 600 inpatients, with thousands more



presenting to the outpatient clinic, suffering from starvation and illness.

My father came to America in 1946. He was fluent in six languages, but English was not among them. He spoke the language of medicine. He passed his medical boards, having more trouble with the English than with the medicine. But finally, he was a doctor in America. That saved his life. He met my mother and they began a family, which is where I come in.

Everywhere my father and I went, he would make a diagnosis. “That woman over there, she has thyroid disease. That man we just passed — congestive heart failure.” This was as much a part of my father as the stethoscope he carried around in the right pocket of his suit jacket. Even now, when I look at photos from my childhood, I see that stethoscope peeking out at every wedding, at every dinner party.

Because, “Well,” he would say, “you never know.”

My father retired in poor health in 1983, and he died a year later. When I went to my parents’ home to clear out his things, I found two large closets in the attic completely filled with old and new copies of *Chest* and the *American Journal of Respiratory Diseases*. On his desk was the latest issue of *JAMA*, opened to an article that he must have been reading when he died.

Many years later, I met a man named Natan. He lived in Brooklyn. When we met, he stood in front of me, tears running down his cheeks. He hugged me tight. “Rochelson,” he said. “Your father, the doctor, he saved my life.” When I asked how, he told me this: “He sat down with me. He looked into my eyes. Right into my eyes. I was only fourteen years old, and I had lost everyone to the Nazis. And then he told me: ‘You are going to be all right. You are going to be all right.’ And that was the first time that I believed it could be true. He saved my life.”

My mind drifted off as I gazed at my father’s graduation



BURTON ROCHELSON

photo. There he was, the day he officially became a doctor. Before everything in his life would change.

My attention turned back to the young doctor sitting across from me. Yes, I thought. Sit down with your patients, look into their eyes, and tell them that it's going to be all right. And then many years from now, when it's over, die with the latest journal opened to a fresh page of medical insight. That's an old-fashioned doctor.

Burton Rochelson, MD, is chief of maternal-fetal medicine at Northwell Health and director of obstetrics and gynecology at North Shore University Hospital. He is a playwright, producer and actor and is one of the founders of the Medicine in Theater group of the Osler Society at the Hofstra Northwell School of Medicine.

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Flame Tree

ALICE FORNARI

Alice Fornari, EdD, RD, is professor of science education, population health and family medicine and associate dean of educational skills development at the Hofstra Northwell School of Medicine. She is also assistant vice president of faculty development at Northwell Health.

NARRATEUR





JOAN M. SCHAEFER

Healing Hands

Lord, grant to me your human touch.
Hands that comfort heal so much!
I'm merely mortal, made to wait
Your creation sealed my fate.

From sky and sea my blood does flow;
Your blueprints etched upon my soul.
From stone you fed them wine and bread
Your love's the guide inside my head.

Breathing deep within my chest,
You inspire hopefulness.
Let silence be a gift to me,
Transform the noise to harmonies.

That with my hands all pains may hush
Lord, grant to me your human touch!

Joan M. Schaefer, RN, has forty years of experience in the operating room, labor and delivery, home care and for the past twenty-two years, the Emergency Department at Long Island Jewish Medical Center. She is an amateur photographer and a published poet who thrives on creating palpability from possibility and poetry from perception.

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KEVIN TRINH

T'ang Poem: Rehab Life

Sweat tears pain push might
Hands hold lift step right
Rest wipe smile deep breath
Laugh cry strength good night

Kevin Trinh, MD, is chief resident in the Department of Physical Medicine and Rehabilitation at the Hofstra Northwell School of Medicine.

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Hawaiian Sunset

STEVEN RUBIN

Steven Rubin, MD, graduated from snap shooter to photographer during his first year of medical school in the 1970s. He is currently vice chair of ophthalmology and assistant dean (for respectful culture) at the Hofstra Northwell School of Medicine.

NARRATEUR





Remember This, Healer

Remember this, Healer,
Break not the identity of the person
Behind the disease
Remember always our hopes,
And wants,
Dreams and sorrows,
Softly spoken to loved ones behind strong eyes
that hide shrouded fears,
Remember to speak truth,
But also leave time for silence,
Our hands have grasped at so many,
Help us hold on to what we hold dear,
Act as guides through the winding roads
of pathologies and treatments
With knowledge and compassion in the face of difficulty,
Light our way through the crossroads we may face,
Remember always that we are more than statistic,
We are life held in fragile bodies,
Intricate and delicate
Filled with an energy that cannot fully be explained,

We are a baby's first laugh,
A mother's sigh,
A lover's warmth,
A father's cry,
The pain of a paper cut as blood bubbles to the skin's surface,
And the bittersweet twinkle in a grandmother's eyes
as she recounts the numerous memories that she
holds dear and the regrets from her long life,
Remember this, Healer,
We are sparks of flame that live but briefly,
Yet how resplendently bright is our warm light

Pratiksha Yalakkishettar is a first-year student at the Hofstra Northwell School of Medicine. She is interested in health policy and primary care and loves to write as a way to engage with the community and to share the humanistic side of medicine.



DAVID STATMAN

Headed for the River

I headed for the river today
I headed for the river today
I don't know whither, I shake and I shiver
I headed for the river today

I raised my face up to the stars
I raised my face up to the stars
It's been too long, I've been so far
I raised my face up to the stars

And I don't know why I cry
Don't know why I cry
Wish I knew the reason why
I don't know why, know why I cry

It looks like a long way down
It looks like a long way down
It'd be all right if I'm not around
It looks like a long way down

I take a mighty breath
I take a mighty breath
And all at once, I know for sure
That I'm not ready yet

But I don't know why I cry
Don't know why I cry
Wish I knew the reason why
I don't know why, know why I cry

I press my face into the earth
I press my face into the earth
I can smell all the life in this dirt
I press my face into the earth

I picked myself up off the ground
I picked myself up off the ground
I once was lost and now am found
I picked myself up off the ground

NARRATEUR



DAVID STATMAN

Still I don't know why I cry
Don't know why I cry
Wish I knew the reason why

I don't know why, know why I cry

David Statman, PhD, is a psychology fellow at Cohen Children's Medical Center. This blues song, written on a vintage mandolin, was inspired by David's clinical training at Zucker Hillside Hospital bearing witness to his patients' suffering from suicidal thoughts and behavior and their experience of healing. David's other creative outlet is in the kitchen, and he blogs about his experimental cooking as A Jew's Bouche.



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Morning Meditation

LISA B. MARTIN

Lisa B. Martin, JD, is the coordinator of the Humanities in Medicine Program at the Hofstra Northwell School of Medicine. "‘Morning Meditation’ captures the serenity of the ‘calm after the storm,’ and, at the same moment, the ‘calm before the next the storm,’ immediately after a 5:00 a.m. phone notification that schools would be cancelled for the day."

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KATHLEEN DOLAN

The Present

He struggled every morning
With the shirt that she put on him
A skeleton of a man
She still saw as proud and strong...
And gazing out the window
At the world they used to share,
His reflection tried to pity him
But his smile wouldn't dare...

He said, "Tomorrow is never promised.
Yesterday's but time well spent.
Today is a welcome gift
And I'll enjoy the present."

Grandchildren running 'round him
Replacing work routines
That once kept him too busy
To enjoy life's little things.
Confined to his easy chair
Storybook in hand,
The love in his grandchild's eyes
Touched this grateful man.

He said, "If I never see tomorrow,
I had this day with all of you...
And I wouldn't change a moment
If I had it all over to do..."

I watched my father through the years
Transform before my eyes,
Not just his ailing body
But the hero deep inside.
Who made hearts dance with laughter
Though he could barely stand...
And only bid the devil good morning
When he had to shake his hand.

NARRATEUR



KATHLEEN DOLAN

Remember...
Tomorrow is never promised
Yesterday's but time well spent
Today is a welcome gift
Please enjoy the present.

Kathleen Dolan, RN, is assistant director of quality management at Glen Cove Hospital. She is also a singer, songwriter and musician who plays nine instruments in a band with her two brothers.

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Monkeys

MICHAEL MARCHESE

Michael Marchese is in the 2016 graduating class of the Hofstra Northwell School of Medicine and is starting a surgical residency at Northwell Health.

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MUSTAFA H. GHANEM

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9-22-01

the bee hums a familiar rhythm
not to be undone
by shock or incision

there was a time when
the bee scoured fields for nectar
to feed her family
every sister and sister

On 9-22-01

the winds led the bee to a toxic flower
manic, she stung her own hive
& her sisters returned no better

the bee was not herself that day
she was instilled toxins galore
she is alone at present
the bee wants sugar no more

Mustafa H. Ghanem is a second-year medical student in the MD/PhD program at the Hofstra Northwell School of Medicine.

NARRATEUR



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Waves of Gravel

MARC SYMONS

Marc Symons, PhD, is an investigator and the co-director of the Brain Tumor Biotech Center at the Feinstein Institute for Medical Research, part of Northwell Health.

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DIANE J. POWELL

The Clot

As a long-time registered nurse and a mother, I knew this about pregnancy: It can be the most wonderful – and dangerous – time in a woman's life.

I was thankful that my thirty-year-old daughter had brought her first child into the world with grace, much as she has done most other things in her life. Her delivery was natural, with no anesthetics, and the baby was born in a little over two hours, as the sun started to peek out on a new day. Speaking as a first-time grandmother, I'd say the boy was a miracle, better than magnificent. Life couldn't have been sweeter in those hazy post-labor-and-delivery days.

Then one morning, after two weeks of round-the-clock nursing and little sleep, the new mother was ready for some me-time and a nice warm shower. Her tall claw-foot tub called out to her. She slipped off her clothes. Petite and still fit, she lifted her leg over the tub's high side. As she held the sides of the tub, she felt a pang in her groin. Funny, she thought, she had felt the same sensation two days ago when out walking with the baby and her husband near their apartment in Williamsburg.

Intrigued and a little concerned, she reached for a towel. She stood looking at herself – would her body completely return to its former self? she wondered – and saw that her left thigh looked just slightly reddish-purple and seemed a little swollen from the knee to the groin. She reached for her cell phone and snapped a photo of both legs. And she did what any good child does, no matter the age. She sent her worries to her mother.

The photo arrived by text. I was at a nursing meeting off site and stepped out of the conference room to call her. I had just gotten a smartphone so I could receive precious photos of my grandson. I didn't even know how to enlarge the photos yet, so it was hard to tell if there was real swelling and redness. Still, the first thing I wondered was whether it was a clot.

I called my daughter, who said that she'd probably pulled her groin muscle walking, or stretching while climbing into that huge tub. I suggested she call her ob/gyn, whose midwife had



brought her son into the world. She spoke to him, and his first reaction was that it probably wasn't a clot. If it were, she said he reasoned, the swelling and redness would likely be in the calf or in the back of the knee, where many clots show themselves. This slight rosiness stretched from her left knee up to her groin. Just in case, he told her, if she continued to be concerned, she could go to the ER to have it checked.

Her mother-in-law, a neonatal intensive care nurse, came by to visit the baby and took a good look at my daughter's leg. It was a little later in the day and the leg was neither red nor swollen, so no, it seemed as if there was no clot there. Still, my daughter and I agreed that she would call a vascular surgeon who had previously helped both our families with surgical and vascular issues; surely at his office he could do an ultrasound right on the premises.

She called the office immediately, but he had just left for the day. Reaching him by phone, she described what she was looking at. After asking a few questions, the doctor told her that he did not have an immediate concern about a clot. An appointment was set for the first thing the next morning. He would do an office exam of that troubling left leg.

That next morning, the ultrasound sounded an alarm: There was a large clot and the DVT (deep vein thrombosis) was blocking the iliofemoral vein, from the knee to the belly button. The surgeon had one comment: "She needs to go to the hospital and have this clot taken out."

The doctor sent us to the nearest hospital, which was right down the road. In the ER, they repeated the ultrasound, confirmed the diagnosis and brought her down for CT scans – chest, abdomen and brain – to make sure there were no other clots. Heparin was started in the afternoon. We met the vascular surgeon that evening in her room. He had pondered her situation and said that he was concerned that a surgical intervention might be too risky, since she had given birth only two weeks before. He advised the conservative route – no surgical or in-



terventional procedures, IV heparin with a bridge to oral anti-coagulants – which she followed for the next eight days in the hospital.

“But how is the clot going to go away, and what will it do to her leg?” I asked. He stuck with his decision. But I kept asking questions, of NP colleagues, nurses, physician assistants and physicians I worked with and trusted in the ICU and on the clinical units at LIJ Medical Center. I combed the medical literature for options and lined up ideas for second opinions, just in case.

Three days after discharge from the hospital, my daughter spiked a fever. I called the doctor and was lucky to reach him on a weekend morning. But he said that if we brought her back to the ER, her course of treatment would not change. Clots can cause fevers.

That day I got to church early – it was Sunday – to pray for guidance about what to do next and spotted a friend whose husband is a surgical physician assistant. Years ago he had met and worked in the OR with a physician who is now at North Shore University Hospital, a vascular surgeon. He knew him so well personally and professionally that he called him at home. He told the physician, Kambhampaty Krishnasastri, MD, chief of vascular surgery, about my daughter’s case.

Dr. Krishnasastri called me back and was very kind and concerned. He asked a few questions, including whether it was her right or left leg. When I described the location, the extensive swelling and discoloration and the postpartum timeframe, he conjectured that it was May-Thurner syndrome. I wrote it down, because I had never heard of that condition before. We were set to see him first thing Monday morning.

But her leg wouldn’t wait. By night, it was heavy and swollen and looked nothing like its twin. We all headed to the emergency room at North Shore shortly before midnight. The tests were repeated once again: ultrasound, CT scans. The clot was as angry as ever. Circulation was at stake. She was admitted and we stayed through the night.



Dr. Krishnasastry stood at the foot of her bed the next morning. He'd already seen the scans and examined the leg. "We're going to get this clot out," he said quietly, firmly. He told us there were parameters for removing this type of clot. You need to get it out in about two weeks, and that window was closing. We heard this for the first time and realized that, thankfully, we were in that proverbial right place at the right time.

My daughter was still on Coumadin, but the North Shore doctors stopped that immediately to prepare her for surgery. They ordered four transfusions of fresh frozen plasma. They put a catheter in the back of her knee, and now that she had been moved to the surgical ICU, interventional radiologist Daniel Putterman began delivering clot-busting medication into her femoral vein. The staff put her at an angle; she would stay in this position for three more days of clot-busting medication and interventional radiology (IR) procedures. Dr. Putterman needed to place a stent into the vein to keep it open. All the while this beautiful, exhausted mother pumped breast milk so she could nurse her baby when she got home.

Dr. Krishnasastry confirmed the diagnosis: a congenital anomaly called May-Thurner syndrome. This can be a silent condition that many of us unknowingly walk around with, but with iliac vein compression, it can cause pain, swelling and a blood clot or DVT in the iliofemoral vein. Compromised blood flow in the leg can lead to the formation of collateral veins, which can help the leg get blood flow, but the DVT can be accompanied by a dreaded post-thrombotic syndrome, which includes tingling, numbness, a lifetime of leg swelling, and sometimes chronic leg ulcers. She had a large DVT that required thrombolysis and stenting.

Her pregnancy and delivery had set in motion a perfect storm: May-Thurner syndrome, the weight of the baby in pregnancy pressing on the iliac vein and the hormones of pregnancy, which sent her into a hypercoagulable state.

She was discharged home in time to celebrate her son's



fourth week of life. They had her on oral blood thinners again. Her life returned to new-baby normal, and we thought she was out of the woods. Then, twenty-three days after discharge, despite the Coumadin, another clot emerged in the same leg.

She was admitted again, directly into the surgical ICU, and she underwent five more clot-busting procedures over five days. She was in rough shape but still somehow smiling. At one point, Craig Greben, chief interventional radiologist, paged my son-in-law in the hospital. Alarmed, we sprinted to the IR department.

Dr. Greben directed his words to my daughter's husband of two years, who was her health care proxy. "We need your permission to put in another stent," he said.

My son-in-law turned to me and grabbed my hands. "Look me in the eye and tell me I am doing the right thing!" he demanded. I nodded. He nodded in the direction of the doctor, who turned and with great speed headed back into the IR surgical suite. He would have to thread the catheter up her right leg and across her abdomen and down into the clotted vein in her left leg. He knew the stent would allow her to get better blood flow to her leg.

After my daughter's discharge, my son-in-law spent the next six months giving her twice-daily injections of Lovenox, an anticoagulant. She had to wear a surgical support stocking from toes to thigh for two years.

This team of doctors saved my daughter from a lifetime of pain and disability, and perhaps something worse. At the first hospital, I asked a lot of questions but never felt satisfied with or reassured by the answers. When I realized that the care, clinical expertise and compassion we needed were to be found in my own health system, I felt as if I were waking up after a very scary dream in Dorothy's Kansas. *There's no place like home. There's no place like home.* And I thought about how the standard of care has such wide latitude, and outcomes depend on where you land.



DIANE J. POWELL

I found Dr. Krishnasastry through a friend, someone who had never even worked at North Shore. I found this health system's expert on anticoagulant therapy, Dr. Alex Spyropoulos, because two years earlier one of Dr. Spyropoulos's nurse practitioners was presenting at a meeting and I took her card. On it, I wrote the doctor's name, and I put the card up on my bulletin board. Dr. Spyropoulos consulted with IR and guided my daughter through the months after her last discharge to educate her about post-clot rehabilitation and adjust the dosing of the anticoagulants that kept her clot-free. She now takes a daily baby aspirin.

My daughter returned to the art and science of mothering and breastfeeding. My grandson thrives and is better than magnificent. We have learned that family extends beyond family to the place we come to every day to make a difference, one patient at a time.

Diane J. Powell, RN, ANP, MA, MBA, is a nationally certified case manager who has worked at Long Island Jewish Medical Center for fourteen years.

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Sea of Cabbage

AMY COOPER

Amy Cooper is in the 2016 graduating class of the Hofstra Northwell School of Medicine. She will be starting her residency in psychiatry at Zucker Hillside Hospital this summer. Her photograph was taken in the market in Kisoro, Uganda. Kisoro is a dis-

NARRATEUR





trict in southwest Uganda a short distance from the borders of Rwanda and the Democratic Republic of Congo. She writes: "During my fourth year of medical school I lived in Kisoro for a clinical rotation, and worked in the male ward of the local government hospital. Market days are an important part of life in Kisoro, occurring every Monday and Thursday. On these days people from near and far descend upon this farming town to sell everything from fresh fruit to fabric, transforming this quiet community into a chaotic and vibrant destination."





HANNAH SPELLMAN

My Brother's Keeper

"Congratulations on your beautiful new boy!" said the nurses, obstetrician and pediatricians who delivered Jacob into the world on that snowy January day.

A nurse handed the newborn to his beaming parents. "Does he look kind of blue to you?" Jacob's father asked the pediatric resident, remembering his older daughter's rosy coloring upon birth. "Nah, that's just because he's a newborn," the resident said. The team of doctors and nurses left the room and the young parents fell in love with their son.

A few hours later, Jacob's father still felt something was off. He went into the hall and found one of the labor and delivery nurses. "Hmm, maybe he does look a little purple-y," the nurse said, and she went to ask the head nurse. "Hmm, yeah, I see what you mean," the head nurse said. "We can get someone up from peds to take a look if you'd like."

The neonatology fellow from Boston Children's who was on rounds at the small community hospital was about to head out the door. He made one last stop on the labor and delivery floor to check out the newborn. As soon as he saw the baby he knew something was wrong. He quickly listened and said to the boy's father: "Your baby has a heart murmur. He needs an echo."

The neonatologist, followed by Jacob's father, went down to the NICU. The results were worrisome. "We need to transfer him to Boston Children's. I'll take him with me. Don't come right away; meet us there in a few hours."

Jacob's father went back upstairs to see his wife. She was entertaining their daughter, Jacob's sister and her own sister. Jacob's father sent them out of the room and burst out crying as he told her about the baby. "This is the worst thing that's ever happened to me in my whole life," he sobbed.

A few hours later, he arrived at the hospital to see his new purple baby hooked up to dozens of wires and machines. "We need to do open heart surgery," said the pediatric cardiology fellow. "We're getting everything ready now."

Jacob's father was horrified. He called a local rabbi to see if he had



any contacts at the hospital. This rabbi made some calls and connected Jacob's father to the chief of pediatric cardiology. Shortly before Jacob went into surgery, the chief called it off. "His chance of surviving the surgery increases significantly each day he grows older. He's doing fine enough now that we can push off the surgery. We just have to watch him closely."

For a month, the parents spent each full day in the NICU watching their new baby, tethered to innumerable wires. In the evenings, they spent a few hours playing with Jacob's sister and tucking her into bed before they returned to stare at Jacob for a few hours. Finally, the chief said, "He has stabilized enough to go home. But he needs to get checked every day." Jacob's parents took him home until, a few months later, the chief said: "Now it's time. We can't wait any longer for the surgery."

The surgery was a success. When the parents saw their son, Jacob's father exclaimed: "I have never seen him so pink. I didn't even realize this was the color he was supposed to be." His mother breathed a sigh of relief and said: "Finally, my baby is at home, with no more machines and needles." Jacob's sister went to her nursery school and announced: "I had a brother with a broken heart, but then the doctors fixed it."

A year passed, and Jacob was no stranger to doctors. Jacob's pediatrician told his parents they could call any time. He told them there was nothing to worry about. They liked the accessible pediatrician, who had helped them adjust to parenting Jacob's sister. The cardiologists all said that now Jacob was just like any other kid, and they should treat him as such. Jacob would need a follow-up surgery, but there was no rush; it could wait until the following winter. A year after Jacob's surgery, I was born.

Jacob was a wild kid who would climb on furniture, make messes and pull the hair of anyone in reach. "That was the best summer of my life," my father would tell me when I was growing up. "We had just bought the new swing set for the house, Jacob and his sister were playing beautifully, we drove cross-country on vacation and we were all happy. You were born healthy. Everything had turned out okay."



As the leaves were changing colors and falling from the trees, Jacob got a cold. He was feverish and cranky and pushed away all of his food. Jacob's parents were concerned, but two-year-olds get colds, so they told themselves to calm down. Then Jacob started vomiting. My parents were more concerned, but they didn't want to overreact. "Why don't you call his pediatrician?" a friend suggested.

"Don't worry about it, kids get sick sometimes," Jacob's pediatrician comforted Jacob's parents. "Just make sure he doesn't get dehydrated. Spoon some Pedialyte into his mouth while he sleeps. He'll be fine soon. If he gets worse, you can always call me again."

The next night, my father awoke to a scream. "Is he dead?" he blurted out without knowing where that question came from. The only response was my mother screaming again, standing over Jacob's crib. Their son was blue again.

A 911 call was made and the local rabbi summoned. The ambulance took Jacob away, and the rabbi came over immediately. The rabbi planned the funeral and burial while sitting with Jacob's body in the morgue, in keeping with the Jewish custom to stand guard over a body from the time of death until the burial. Jacob's parents sat unmoving in their room. The lights were still off.

The day after Jacob died, his pediatrician came to the house. Crying, he apologized to my parents. "This is a one-in-a-million occurrence. I never imagined that this type of thing could have happened. I'm so, so sorry."

My parents just stared at him. They would never forgive this man – this doctor – for the death of their son. My dad would also never forgive himself for not asking more questions or getting a second opinion, and for not rushing to do the follow-up surgery. "I later learned that vomiting is a sign of heart failure in children," he once told me.

My mom would also replay giving Jacob the Pedialyte, wondering whether it had something to do with his death. (The pediatrician later denied instructing them to feed him in his sleep. Perhaps he feared a malpractice claim.)

Decades later, my older sister spent much of her first pregnancy



HANNAH SPELLMAN

in fear — even after a fetal ultrasound signaled a healthy heart. And I entered medical school afraid. I anticipate going through residency, fellowships and life terrified of making a mistake or unknowingly misleading a patient or a parent. I think about my family's experience, and I remain petrified by the thought of inadvertently causing death, and paralyzed by the knowledge that I would never be able to forgive myself.

Hannah Spellman is a first-year student at the Hofstra Northwell School of Medicine.

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The Symbiotic Friendship

DAHLIA HASSAN

Dahlia Hassan is a third-year medical student at the Hofstra Northwell School of Medicine. She enjoys traveling when her schedule allows it. This photograph was taken at Petra in Jordan. "With temperatures over 100 degrees in an arid desert landscape, the only source of shade for the feral dogs who live there was the Bedouins' donkeys, who were gussied up and ready to carry tourists up the mountain. Almost every donkey had a dog enjoying its shade and company."

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JUDY RICHTER

Goodbye, My Sweet Boy

I am a social worker in the emergency room. It is my job to observe and to offer emotional support and guidance to patients, their families and friends. I love what I do.

On most days I can separate my professional life from my private life. I may sympathize with people in distress, and I may empathize with a parent dealing with an ailing child, but there is a degree of separation between us. But one spring day last year, something happened that changed that. It still haunts me.

I drove to work, winter thankfully over, and a voice on the radio promised me a beautiful day. A promise not kept.

The early part of my workday was uneventful. People charged at me in frustration with a litany of complaints: *My loved one is in pain – do something! How long must we wait? Where is a doctor? Where is food? Where is help when I need it?* I did my best to patiently answer every question, and I was feeling rather good as I saw the relief in their faces as they departed.

It was then that the call sounded on the ambulance radio. For a moment, everything stopped in the bustling emergency room. A twenty-three-year-old male had been found unresponsive at home. He was in cardiac arrest, and the ambulance was speeding to the hospital. The EMT's voice was shaky. They were delivering CPR, but things didn't look good.

We cleared a room and stood by, ready to help.

The crew crashed through the double doors, panic on their faces. Two men were pushing the gurney. A third medic was on the gurney, straddling the patient, continuing to perform CPR. The young man under him did not move. His skin was already the color of the spring sky.

A medic called out the patient's vitals as they rushed the gurney into the room we had prepared. He was lifted onto a bed. A team of doctors and nurses began to work furiously. There was no time. The man was near death, or might already be dead.

By this time we knew his story, or part of it. The EMT who had delivered CPR and was now walking toward us panting and



JUDY RICHTER

sweating said that man's mother had found him unresponsive in his room. He was supposed to be up for work, and she went in to check on him. The EMT team found drug paraphernalia on the side table by his bed.

"His parents are on their way to the ER," the medic said.

In 2013, Long Island lost 144 people to heroin. This number was unprecedented. Three years earlier, thirty-eight heroin deaths had been recorded. Today, people can buy heroin for about the cost of a pack of cigarettes.

Twenty minutes of chest pounding and paddles and powerful medicines designed to work against heroin did not help. The people charged with trying to save lives walked out of the room shaking their heads. Some of them had grown children. Others were only a few years older than the man on the table.

The time of death was called: 10:30 a.m. The young man had arrived at the hospital without a pulse or a heartbeat, but the team had been hoping for a miracle. It did not come.

I live in a small harbor town on the Long Island Sound. I stood at the nursing station and looked at the young man's name on a form. I knew the name. His mother and I probably shopped the same stores. He was the same age as my daughter.

My trance was broken as the young man's mother came running toward me. I recognized her. The social worker in me stepped forward, arms outstretched to embrace her. Our eyes locked. I called out her name, but she turned toward the security desk and started walking quickly to the exit. I called her name again and started to follow her. "Please, stop and come back," I said. My pace quickened to keep up with her. A man was approaching, and she fell into his arms.

I was two paces behind her. "I am John's father," the man said.

"Please come back inside," I urged. "The doctors want to speak with you." He gently took his wife's arm and followed me. I led the way through the doors of the ER, past the security guard and into a small room. "Please wait," I said. "The doctor will be right in."



JUDY RICHTER

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A few minutes later the doctor who led the team that had tried to save their son entered the room. "I am so sorry. We did everything we could . . ."

The woman jumped out of her chair. She ran past the doctor, frantic, like a mother whose toddler had gotten lost in a department store, looking everywhere to find him. A nurse in the hall pointed to the room where his body had been covered with a sheet. The mother went in, pulled back the sheet, looked at her son and cried, "How could you do this to me?"

I was standing in the doorway. A small crowd of my colleagues had gathered in the hall outside the room. We watched as she gently kissed her son on the forehead and then said, "Goodbye, my sweet, handsome boy. I love you."

Her husband was at the door, too. She turned to him and said, "Come on. We're leaving. Let's go." Before he could reply, she continued: "No one can know about this. We will not have a funeral." Then the couple walked down the hall in silence.

I remained in the room with their dead son. I now recognized his face from the high school. I remembered his striking blue eyes, now closed forever.

"Wow, that mother was crazy," said a nurse who had entered the room as I was standing at the foot of the bed. "I have never seen anything like that. Obviously, there is something wrong with her. She didn't even cry."

Still staring at the body of the dead young man, I said, "You never know what people are going through."

Nurses and aides who entered the room to prepare the body for the morgue were equally harsh. "That mother is weird," an aide said. "They won't even have a funeral for him?" Another young woman answered her question with a shrug: "Well, he did it to himself."

The social worker in me had nothing to say. Neither did the mother in me. I turned and walked out.

This wasn't our first death to heroin, and it wouldn't be our

NARRATEUR



last. Where was the compassion that we learned during our training? Every life is worth living. Every death is worth mourning.

The next day my daughter learned through Facebook that someone she went to high school with had died of a drug overdose. “I am so sorry,” I said. We talked about the growing epidemic of heroin addiction. It was good to feel my daughter’s compassion. Later that day a friend called and asked whether I had heard about John’s death. “Yes,” I said. “My daughter told me this morning.”

“I feel so sorry for his parents,” my friend continued. “Did you know this is the second child they lost?” I did not, I said. She told me that they had a child who died of an illness when she was in elementary school. John was a few years younger than his sister.

The mother’s grief and her reaction made more sense when I heard this. Who knew this family’s struggles? There is nothing weird about how a mother acts when her heart is broken.

It took me a long time to process the insensitive words of my colleagues. None of them had any idea what that family had endured. I do know this: They loved their son.

I thought about John’s mother for a long time – in fact, I still do. The events of that day led me to start a hospital-based drug task force. We work to help people with addictions. We try to make loved ones more aware that addiction is a disease, and we counsel staff on the importance of “parking stigma at the door.” Stigma affects how we treat our patients and their families.

On the day of John’s death I had to call his parents to see what they wanted us to do with their son’s belongings – the clothes he had on when he went to bed. John’s father answered the phone. “I am so sorry that you lost your son,” I said. “Would you like to come pick up his belongings?”

“Of course,” he answered.

Judy Richter, LMSW, is a social worker at Huntington Hospital and chair of the hospital’s drug task force.



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Time

JESSICA MAY

NARRATEUR





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Jessica May is a third-year student at the Hofstra Northwell School of Medicine. She traveled to Paris and Rome recently and was transfixed by the images of death in the catacombs of Paris, as death is an ever-present part of life in the hospital. In "Time," she says, young seemingly healthy tourists are shown in full color, positioned with a clock and time as the ultimate backdrop.

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TAMAR HAREL

A Simple Medicine

As alarms chimed and dinged in the ER, red lights flashed and blinked discordantly, monitors and alerts vied for attention and patients hollered in the halls, one patient stood out. With her brassy British accent and her warm, vivacious spirit, Mrs. K seemed larger than life, impervious to the chaos of the ER. As nurses and doctors marched through her room, she greeted each one with ease, like a gracious hostess warmly welcoming them to her elegant home. Although she was obviously ill, her eyes sparkled and crinkled as she responded with quick quips.

Her complaint was a simple and common one: diarrhea, something often treated over the counter. Her course, however, was complicated. Her chemotherapy, the very thing shrinking her tumor, was irritating her bowels, making each day a misery. Cancer had blocked her esophagus, preventing her from swallowing even a sip of water. Relying on a feeding tube, she declared that she would die happy if she could simply have a single scoop of ice cream just once more.

Diarrhea continued to take its toll. Each day in the hospital, she seemed to wither and wane. Her hair, so neat when she first arrived, appeared like wisps of cotton candy, white flyaway tendrils that exposed a balding scalp. Her posture, once erect and graceful, became huddled. This woman, with such a large and expansive spirit, suddenly seemed small. She began to shroud herself in blankets, covering her head like some high priestess. Because she was unable to drink, her voice became hoarse and thin. She needed to gargle some mysterious blue liquid to regain enough of her voice to whisper even a few words.

When she did speak, it was about death. She had come in for diarrhea and was expected to leave, but she seemed to plan on leaving more than simply the hospital behind. All my other patients were terminal, so when the day came to write her discharge note, I happily recorded her course of treatment, the need for follow-up and a proud description of how her illness had resolved. Shortly



after I wrote her note, however, she vomited, aspirating fluid. That morning she died, oxygen mask on her face, eyes closed, her children at her bedside, denied that final scoop of ice cream.

Over the next few days, I asked myself what more I could have done to make her more comfortable, to help her in her final days. What further kindnesses were available, what chance did I miss?

A few days later, I was assigned a new patient, with another simple disease: a nineteen-year-old with uncomplicated pyelonephritis. She was lively and happy, friendly and warm. She would not fade as Mrs. K had; her discharge note would not be replaced with a death certificate.

This new patient, however, was disappointed; she was stuck in the hospital on her birthday, missing a zip-line-themed party. After taking her history and performing a physical exam, an intern and I went to get her a type of treatment not found in the pharmacy or the hospital supply closet. We went down to the cafeteria and purchased a red velvet cream cheese cupcake, returned to her room and sang “Happy Birthday.” It was a simple thing. The IV would restore her fluids; the antibiotics would clear the infection. The cupcake, made of flour, sugar and food coloring, had no medicinal value. That day, however, seeing her brighten as she took a cupcake selfie, I felt as if a part of me had healed.

I realized that although medicine can be difficult and distressing, the cure is not to distance yourself from the patient, to shield yourself from possible pain. It is healthier to care for the patient and look for those small extras. Rather than regretting what could have been, asking what more I could have done, it is better to look to the future and be proactive in the present, and always ask what more can I do.

Tamar Harel is a third-year medical student at the Hofstra Northwell School of Medicine.



BRUCE HIRSCH

Describe Your Place of Work

The welcome mat is the greeting.
The doorway – the introduction.
“How are you feeling now?” is the hallway.
The story of the illness proceeds inside the living room.
And sometimes (only sometimes)
We get to sit around the kitchen table to talk about
What it feels like to live in this house
On this street.

Bruce Hirsch, MD, is an infectious disease specialist at North Shore University Hospital.

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Light

ASHLEY BARLEV

Ashley Barlev is a first-year student in the MD/PhD program at the Hofstra Northwell School of Medicine.

NARRATEUR





FREDDA S. PEARLSON

The Body Electric (Heart Sounds)

now the heart snaps
like a rubber band
now a limp empty bell, no longer
that shining pumping muscle
crisply beating, little metronome
now just jumping, thumping
a wild exhausting dance
losing power, flow, warmth
quivering, shivering
drowning in its own red ocean
gasping for air
now grabbing any impulse
and pushing it through
to any of the four sad rooms
and out the microscopic doors
another sudden beat, filling
a bit of the lumpy sack
all the tiny cables, unfeeling arteries
now hanging like limp threads
no time for lament
or prayer or thanks
every organ, every cell still
vibrant, expectant
the connections still unbroken
along the wires
of the body electric
the silent colorless instinct
for one more beat
two more seconds
on this side of the abyss

Fredda S. Pearlson, RN, is a cardiovascular telemetry nurse at Lenox Hill Hospital. Her poetry has appeared in numerous literary journals including The California Quarterly, The Wisconsin Review, The Centennial Review, Panoply, Helicon Nine, The Feminist Renaissance, Chrysalis, Stone Country, The Little Magazine, The Dolphin's Arc: Poems on Endangered Sea Creatures, Connecticut River Review, Common Ground Review and Miramar. This poem was previously published in Common Ground Review.

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VICTORIA FORT

Magic Is Real Here

The man was standing alone on a blanket next to the road. His hands shot around his body in a circle and thrust something long and green into his mouth. He pulled it out and leaned forward, exploding in an angry scream, his shoulders forward and down, his mouth wide open, his eyes fixed on mine as we drove past.

I grabbed the arms of the men on either side of me in the truck. “Was that a snake?” I wrenched around and stared at the man. His pants were torn and ragged, his beard thick. He was still watching us, glaring in our direction. “A green mamba, yes. Magic is real here.”

I watched the side of the road dip into a ravine lined with stalls made of bamboo and thatch, where women stood over piles of discarded clothes from the Western world. The thick green leaves of banana trees hung heavy over the paths that crisscrossed this informal market.

I sat between the driver and a hospital procurement officer. We were in Blantyre picking up drugs for the mission hospital in Mulanje. Then they would take me to get a bus to Neno, the most remote district in Malawi. Riding in the bed of the truck was a ten-gallon jug of liquid morphine. It occurred to me that the people here are so poor that they can’t afford to abuse injectable drugs. That same container would be worth a fortune at home in the United States.

Newspapers over the last few months had recurring headlines about the same three stories:

Woman in Mulanje gives birth to a stone

*Man tried at high court for abducting children
and flying over the town in a basket*

Mysterious disease clutches Neno

Yes, I would have to agree that magic was real here.
The ob/gyn I lived with had investigated the stone birth, ac-



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accompanied by a geologist. They agreed that it was unlikely that the stone had come from the woman — it matched the stones found in the parking lot. Still, the sister-in-law had been accused of witchcraft, and all accusations must be investigated.

I learned that in this region being sterile was a curse worse than death. In the language and tradition of Chichewa, a girl does not become a woman until she has a child. For many infertile women the answer is monthly trips to the hospital for medicines that they hoped would change their fate.

I got on the bus to Neno and settled in for the long ride along one of the two paved roads in the country, stopping every half hour for people to get off and for women and children to rush at the windows, selling small dried fish, oranges, fried crickets and sometimes fried mice. After a few hours we turned onto a dirt road. The houses became huts that had been built into the mountain. The road became pitchy and bumpy. Great stacks of charcoal lined the road. I was later told that this was one of the last forest reserves in Malawi, and people were cutting it down to make charcoal while they still could. It was quick way to make a little money.

Partners in Health, a nonprofit based in Boston, had built a hospital in Neno. They had partnered with the Ministry of Health to be sure that staff positions were held by locals and that the hospital would be part of a more sustainable system. I had been invited to go out with their village health workers to observe a training program. I started out early the next day in a car loaded with people, food and two crates of Fanta. We were going to a village health worker training in the village where a “mysterious disease” had broken out. It was the most remote village in the district, impossible to reach during the rainy season (November-April). It was still winter in July, and the road was dry and deeply rutted. At one point we drove up a sheer cliff. I made a short video of the trip, mostly consisting of the camera being thrown around and a soundtrack of loud African music and glass Fanta bottles clinking in their crates.

The village health workers greeted me kindly. We gathered in an open auditorium with rows of cement benches and a chalk-



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board at the front of the room. The trainer spoke in Chichewa. The people seemed engaged. When the trainer asked questions, the workers in attendance stood up and provided long responses.

He reviewed for them the steps to take when they see something that is not right. For example, he described walking into a hut where one might see a hole in the roof and the family members huddled on one side of the room to avoid the rain. Then, he described the symptoms of the mysterious disease spreading through Neno. The symptoms matched a diagnosis of typhoid, but it couldn't be confirmed. The U.S. Centers for Disease Control and Prevention had sent several experts from Atlanta to do the testing, but it would take weeks to get the confirmation. Meanwhile, the village was freezing and its people were sick. It was high on a mountain range, dips and peaks spreading out for miles. People were huddled together to stay warm, and it was clear that louse-, tick- and skin-borne conditions would be easy to spread.

It turned out it was typhoid.

Victoria Fort is a student at the Hofstra Northwell School of Medicine. Four years after her first trip to Malawi she returned to the region as a Centers for Disease Control analyst for African disease surveillance systems. She was assisting the Malawian Ministry of Health with a surveillance system strengthening exercise. She looks forward to another trip to the magic of Malawi when she finishes her medical degree in 2019.



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Ships at Sea

BARBARA HIRSCH

Barbara Hirsch, MD, is an endocrinologist at Northwell Health.

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BRITTANY DAVIS

How to Interview Well

My typically unbrushed, unwashed hair was conditioned and blown dry, my exhaustion suppressed with two cups of coffee and my nervousness disguised by a lipstick-enhanced smile. I sat stiffly in my overpriced and underworn suit, pretending that the only thing in the world that mattered to me was the next ten minutes in the admissions office.

Up until that point, the medical school interview had gone well. Quite well. But then the dean of admissions threw out a hardball of a question: “What is the biggest challenge you have faced in life, and how have you overcome it?”

I stalled for a moment, debating whether to tell the truth. Instead, I lied. This was a theme in my interviews: lying. Unfortunately, the truth was just not “interview appropriate.”

I thought back to the previous night. It was 7:00 p.m. I had just settled myself into a hotel room on Long Island, laid out my suit for the next morning and read through my notes on the school where I’d be interviewing, a new medical school with a mouthful of a name: Hofstra North Shore-LIJ. I shaved my legs while waiting for some Chinese delivery. These were sham acts of normalcy given my tumultuous last few months, but I was determined to perfect my poker face. Then the call from the police came.

The officer on the phone was Sabrina Wood, a young but dedicated member of the joint Yale/New Haven Police Department. She was in charge of the Special Victims Unit and a saved contact in my phone. As her name lit up on the screen, I felt a familiar surge of panic. What now? My mind went blank as I reached for the phone with a shaking hand.

“Hey,” I whispered, no formalities required at this point.

“They bailed him out,” she responded. “I’m so sorry. They paid the \$50,000, so he’s back out. He’s been out for four hours, but I was only just told. Where are you right now? Are you alone? You need to get someplace safe.”

“I’m on Long Island,” I said, my voice shaking. The chaos in my chest was a stark contrast to the paralysis of my other senses.

NARRATEUR



“Who posted his bail? I talked to his parents and they told me they weren’t going to pay it. They told me that they were going to leave him in there after everything he’s done,” I continued, my voice filled with a twisted mixture of anger and anxiety.

Officer Wood exhaled. “I don’t know. I’m so sorry. I think it was his family though. Families lie all the time they just can’t believe their sons are capable of these things, even when they see it with their own eyes.” Her tone was bitter, betraying a history of similar phone calls. “Are you alone? You need to be with someone.”

I instinctively glanced at the door. The dead bolt was turned.

“Yeah, I’m alone, and I will be until my interview tomorrow. My parents are both out of the country, but even if they weren’t, everyone I know lives in Rhode Island.”

“Does he know where you are right now?”

I was silent. My throat was burning and my eyes stung. I constantly asked myself this question, but I always knew the answer.

“I’m sure he knows where I am. I don’t know how, but he always finds me.”

Now the panic was setting in. He was out of jail. He was angry and he was going to try to find me. The last time he found me, he tried to run me down with his car.

When the trouble first started, I couldn’t believe it was happening. I was not the stereotypical domestic violence victim, and I never thought of myself as vulnerable. Friends, family and co-workers would describe me as strong, outgoing and confident. I prided myself on being able to read people. But the thing about abusive men, or women, is that many are sociopaths. They lack the ability to feel empathy, but they have a cognitive understanding of it that enables them to conceal themselves behind layers of charm and feigned caring.

I met Sebastian through mutual friends at Yale, all of whom vouched for how wonderful and kind he was. When we first started dating, I, too, found him to be respectful, charming and loving. He was an undocumented immigrant, however, which made things a bit more complicated.



I felt bad that he had to struggle so much more than any citizen, so I tried to help as much as I could. This ultimately made me vulnerable to him. I cosigned an apartment with him, I opened a shared bank account and somehow I joined our lives together. And as soon as I had entangled myself with him financially, legally and emotionally, he pulled off his mask.

We were out with friends the first time he blew up at me. I disagreed with him about a restaurant. He said it was terrible, and I said I thought it was pretty good. He grabbed my arm and dragged me to a back room in the bar, away from the group, and then he screamed, “You only try to disrespect me – you don’t care about me, and I’m the only one who loves you like this!”

At the time, I wondered if there was a cultural component to his behavior. I decided to wait it out. Maybe he would calm down as he became more comfortable with the way couples interact in America.

Of course, it continued. I couldn’t do anything without asking permission or it would turn into a fight. While at dinner with friends one night, I told him excitedly that I had registered to run a marathon in a few months. He responded by throwing a chair across the room of the restaurant, shouting that I had disrespected him by not asking for his permission to do so, and then he stormed out, leaving our two companions shocked and speechless. I was mortified. Later that night, he screamed at me for two full hours.

I never bought into his verbal abuse. I thought he was completely out of line, and eventually I came to realize this was a display not of machismo, but of a pathological desire to control me. I wanted to break up with him, but I knew that would set him off like nothing else, and I had the MCATs coming up. I was retaking them after doing poorly on my first try at the test, and so I was under pressure to excel the second time around. If I wanted the peace of mind and time to study for them, I couldn’t break it off until after I walked out of the testing center.

So I endured more insults, more two-hour blowups. Finally, on the night of September 1, 2012, I told him that we were finished. As I had anticipated, immediately things got worse.



The night I broke up with him, I had told him we could talk more the next day, but Sebastian could not live on someone else's terms. He drove to my apartment and threw rocks at the window, screaming for me to come outside and face him. I called his cell to tell him I wouldn't talk because he needed to calm down, and he broke into my apartment building and tried to crash open the door to my apartment. When that failed, he went back outside and resumed trying to break my window with rocks.

I called the police, but I didn't press charges, and I told him after the incident that I would need a few weeks away from him before we could talk again. I figured that by then he'd be calm enough to have a normal conversation, and I could explain to him that our relationship had failed because he did not treat me with respect and civility. I was wrong.

Sebastian was suddenly everywhere I went. He would wait along the route I walked to work and try to drag me to his car, or he would push me into the side of a building and whisper threats. He said he'd "make me pay" if I didn't go with him "to talk." At first he'd walk away if a passerby approached, but he got bolder as time passed. He progressed to grabbing me in front of strangers and pushing me. When they'd stop and ask if I needed help, or if that man was bothering me, I was too afraid to say yes. If I made him that angry by doing nothing, how angry would I make him by telling a stranger he was stalking and harassing me? What would he do then?

I never felt helpless in the moment, but looking back, I realized how much I isolated myself and jeopardized my own safety during this period of my life. For days, I could not tell my friends or my parents how scared I was. I was afraid to acknowledge how bad things were, and it was that fear that helped perpetuate his abuse.

His stalking escalated. He began waiting in the parking lot of my apartment complex, darting through an open door when someone left or entered the building and then picking the lock on my door to enter my apartment. Twice, I woke to find him standing over me, looking down at me and reaching out to grab me. He



exploded with rage, screaming about how he was going to kill me, kill my coworkers and make us all pay.

Months after we had broken up, I invited two male colleagues in my lab to a dinner party at my apartment. He had been stalking me, as usual, peering through the windows of my kitchen, and when he saw them sitting at the table, eating and laughing with me, he descended to a whole new level of fury.

Later that night, he yanked me out of bed by the throat. As I struggled to get away, I managed to grab my phone to call 911. He yanked it away from me before I could finish dialing. His face was contorted with rage as he threw my phone against the wall, sending pieces of plastic flying. He pinned my shoulders to the floor with his hands and my legs with his knees and yelled at me for thirty minutes as I looked up at him expressionless, trying to deny him the pleasure of seeing my fear.

Initially, I was afraid he might actually kill me. Then I realized he was too smart to do that — what he wanted from me was submission and fear. He wanted to control me. He knew that legally he could do more damage with words than with physical violence. When he realized I was not yielding to him or apologizing for breaking up with him or “cheating” on him by having dinner with my co-workers, he broke into tears, manipulatively sobbing that he just loved me and that I was hurting him. Why did I want to hurt him so much when he had done nothing but love me?

That was the pattern. When he grabbed me, it always started with threats and anger. Why wouldn’t I talk to him? Why hadn’t I answered his thirteen calls when I was at work? Who was I cheating on him with? Then he would break down and profess his love. He would leave bruises on my arms from where he restrained me, but he prided himself on the fact that he had never thrown a punch. That was proof that he had “never hurt” me.

After three months of this, I finally called the police. The restraining order was a joke. In order to file one in New Haven, the plaintiff and the defendant must sit in a room together for several hours before being seen by a mediator. He made use of his time there to whisper threats: He would ruin my life and he’d kill my



co-workers and my family if I went through with the restraining order. I went through with it regardless, and so he waited for me outside the courthouse when I left. In broad daylight, he grabbed me by the throat and told me that no restraining order scared him, and that he was going to make sure I got what was coming to me.

My constant fear was paralyzing, but so was my guilt. Many incidents went unreported prior to and after the restraining order. I felt as if I must have been inadvertently leading him on during the relationship, and that perhaps cultural norms explained some of his unhinged behavior. I felt as if I owed him some protection as well. He was an illegal immigrant, as was the rest of his family. If he was arrested and charged, he could be deported, and I would be responsible.

But the failure to report every incident was also partly due to my delusional belief that things were not really so bad. After all, he hadn't hit me. Despite the decline in my job performance, my sleep, my feeling of safety, I convinced myself that the situation really wasn't intolerable. I wasn't being punched, kicked, burned or raped. And I was embarrassed. How could a Vassar grad, medical school candidate and blazing feminist get involved with a psycho like Sebastian?

When he tried to run me down with his car, I finally snapped out of my denial. I called the police and pressed charges, as did the state, laying out five separate first-degree domestic violence charges against him. I was relieved when I found out his bail was set at \$50,000. For the first time in months, I'd be able to sleep. Unfortunately, Officer Wood's call the night before my Hofstra interview shattered my delusion of safety.

I had guessed an interviewer would eventually ask me about the greatest challenge in my life. Medical school is filled with adversity, and admissions officers want to find candidates who triumph over adversity. So I prepared a repertoire of lies, neatly packaged "challenges" with just the right amount of seriousness to show that I could handle the stresses of medical school.

The truth is it's difficult to tell a stranger that you are living in hell, because few people want to hear such a hard story, even if it is



a testament to how resilience is achieved. There are few challenges in medical school that require you to fight for your life as someone tries to squeeze the breath out of you. No angry attending could fling as many awful threats as Sebastian could. But to tell my story would cast me as mentally and emotionally unstable. What kind of woman gets herself into such a mess? Only one who is weak and unable to see the reality of her situation, and such a woman should never be allowed to be a physician. Unfortunately, these biases against victims exist, and the medical world too often abides by such prejudices.

Medical professionals seem to live under the laws of an alternate universe, where they must perform to the best of their ability every second of the day. Things can get bad but they never get ugly, because doctors are not just human; they are superhuman. They suppress fatigue, fear and vulnerability to carry out the sacred duty to heal. There is no room for personal narratives. There is no room for the truth, if the truth betrays weakness.

“The most difficult challenge?” I said, clearing my throat, aware that the pause I’d let hang there was awkwardly long. “Well, I had Lyme disease at the end of senior year.”

Postface: Sebastian was tried and submitted a plea deal. I pushed for imprisonment, but I was told by my public prosecutor about the plea deal: “Ultimately, it’s not the victim’s choice – it’s the prosecutor’s choice.” Her statement haunts me to this day. But that is another story for another time. For this story, at this time, Sebastian’s plea deal was accepted and he self-deported to Argentina, vowing never to return to U.S. soil. If he does, he will be arrested for violation of the plea deal, which is essentially a national restraining order. Still, it’s been four years, four address changes, a new telephone number, and I still feel a cold fear rising in my throat when I see someone who looks like Sebastian.

Brittany Davis is a third-year medical student at the Hofstra Northwell School of Medicine who enjoys writing and editing in her spare time.



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Acoma Pueblo, New Mexico

ADAM COOPER

Adam Cooper is chief medical photographer and manager of medical media at Northwell Studios. He has been with Northwell Health since 1986. He is also the director of conferences for the BioCommunications Association. He enjoys traveling on photo excursions and cruises with his wife, Elena.

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Capturing Kili

ALAN SLOYER

Alan Sloyer, MD, is an attending gastroenterologist at North Shore University Hospital and an associate professor of medicine at the Hofstra Northwell School of Medicine. He is a member of North Shore Gastroenterology Associates.

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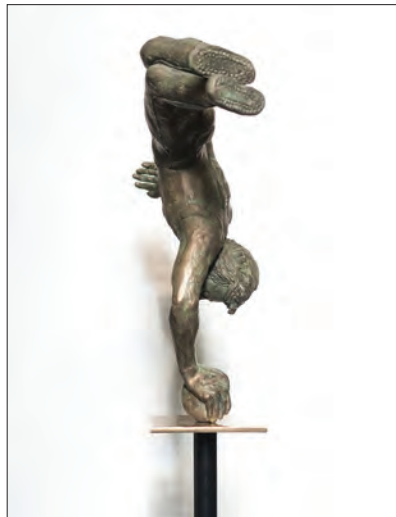




Submissions

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

Submissions are open to Hofstra Northwell School of Medicine students, faculty and staff as well as employees of Northwell Health and Hofstra University. For more information on submission guidelines visit our web site at www.narrateur.org. Or contact editor-in-chief Jamie Talan at jtalan3k@aol.com.



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