

Narrateur

REFLECTIONS ON CARING



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Narrateur

REFLECTIONS ON CARING

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Compassion

ARNOLD S. PRYWES

Arnold S. Prywes, MD, was in the first graduating class of the Mount Sinai School of Medicine, where he completed his ophthalmology fellowship and residency. He is chief of the glaucoma service and associate clinical professor at the Zucker School of Medicine at Hofstra/Northwell. He is the founding partner of Glaucoma Consultants of Long Island and inventor of the XEN gel stent for minimally invasive glaucoma surgery. Sculpture has been his passion for more than 35 years. He writes, "Providing emotional support to our patients is often as important as treating them medically; it aids in our patients' healing. This sculpture evokes the feeling of compassion."

Letter from the Dean

It wasn't an ordinary lecture about prescription opioid abuse. The stage was set, with four members of the Medicine in Theater group doing a dramatic reading of Eugene O'Neill's "A Long Day's Journey into Night." The SOM students took on the Tyrone family and the addictions that were threatening to pull the family apart. A bioethics panel about drug abuse followed, and people in the audience got to talk about these vexing issues as they exist today, not circa 1950s. The next month, students had fun arranging art and photos from fellow students and faculty for our fourth annual Celebration of Visual Art exhibit. Recently, we had an emotional night of dance with people with Parkinson's disease.

There are nights when the medical school comes alive with students and doctors acting out stories of their patients' caregivers. These events are deep-rooted in the philosophy of our medical school, and there is no richer place to find the strong links between compassion and storytelling than in *Narrateur: Reflections on Caring*. The written pieces — many real, others not — and the art and photos are part of our journey to become doctors. We are part of a brave new world, with medicines and technologies that push the human clock forward but often can separate us from the healing touch of the face-to-face patient encounter. Thinking and talking about these issues better prepare us for the emotions that come with the doctoring territory.

We have a medical humanities curriculum that offers a healers art class for the first-year students and one on narrative perspective and reflective writing for students in their last year. All of these events lead us to a singular lesson: Humanness makes us the healers that we are.

LAWRENCE G. SMITH, MD, MACP
Dean, the Zucker School of Medicine at Hofstra/Northwell
Executive Vice President and Physician-in-Chief, Northwell Health

Letter from the Editor-in-Chief

Back when the medical school was just welcoming its first class, I came to Dean Smith with the idea to publish an art and literary journal. He didn't hesitate: "Yes, do it," he said. Now we are on our seventh issue, and this one seems to have nailed it on every level.

The students came out in droves to share their stories and photos and artwork. One woman shared her experience on day one on an EMS run. The driver called out that there had been an arrest. Police, she thought. Not heart.. "What's the protocol?" she asked. Surprised, he answered: "CPR."

Another student wrote a story about coming to terms with the deaths of his dearly loved grandparents. The story is accompanied by a painting of them. Faculty members wrote about their journeys through cancer diagnosis and treatment. Our SOM student managing editor, Adam Lalley, brought us a poignant interview with David Elkowitz, who tells his cancer story. One doctor was asked by another doctor to tell a friend with cancer to get her affairs in order. He did. Ten years later, she called to see if he could meet her for coffee. The lesson: Don't play God.

Another doctor offered up a brilliant translation of the poem "*Le Cygne*" ("The Swan") by Charles Baudelaire. He suffered an episode of endocarditis and a subsequent valve repair (one of the first in the country). Medication ignited a depression, and once it lifted (with a change in the medication) he began thinking about "what things in my past were worth saving." "*Le Cygne*" was one of them. Translated from the French, of course.

What a gratifying endeavor! Every issue has its own character, and every issue is wonderful. I thank our contributors, and I hope our readers will agree.

JAMIE TALAN, MPH

A Conversation with David Elkowitz

Last July, Dr. David Elkowitz was diagnosed with a poorly differentiated squamous cell thymic carcinoma. I know what this means because, before his diagnosis, he was the one who taught it to my medical school class, citing Robbins with an almost photographic memory. After his diagnosis, months passed before he gave another lecture, and when he did, he was 10 pounds lighter and had lost most of his hair from chemotherapy. The subject of the regularly scheduled lecture was anterior mediastinal masses, and here we had a patient and a doctor in one.

In the many times that I've visited his office, his desk has always been tidy. He admits to not owning a computer at home, and the desk that separates him from visitors to his office is bare, aside from a keyboard and a monitor. Behind him, beside a microscope and beneath two neat shelves of a few select volumes, he's surrounded himself with photos and mementos from friends and family, along with two signs. One says "No Whining," which he says is meant for him, not for his visitors. The other is "Essayons," or "Let's try," the motto of his alma mater.

When we conducted this interview, his hair was already beginning to grow back, and he was back to full-time work. On a few occasions, he leaned in to the microphone that was recording our conversation to emphasize a point and to be sure that readers took note. Throughout the process, he has remained a teacher above all, first teaching by example, and now teaching from experience.

Adam: Last July, you were diagnosed with a thymic carcinoma, but you were still teaching at the time. Did you feel unwell before you were diagnosed?

Dr. E: For the better part of a year and a half, I had noticed these weird myalgias in my upper body, from my pectoral muscles up, along with TMJ and temporal headaches. The fact that they were alleviated by ibuprofen made me poo-poo working them up, and I chalked it all up to the price of becoming 50. But it was definitely real. I mean, I came to work with a bottle of ibuprofen, so I knew something was wrong. At the same time, roughly, I developed a very severe case of Raynaud's. I chalked that up to some bad habits, you know, tobacco use. So over the last year, I weaned myself off of tobacco — I'm off it now — but it wasn't getting better.

Adam: So what triggered a visit to a doctor?

Dr. E: In July of last year, I had three talks I was giving around the country — two in Texas and one in Washington — and I had a day off before I was set to come back to work. So I said, "You know, I should get this checked out." I had promised my family that when I turned 50, I'd go for a colonoscopy and endoscopy, and those had both been clean, so I was on a good roll by this time. The myalgias were bad during the talks, but I felt fine otherwise. I even went for a run. So when I came back, I went for a Raynaud's workup, which was a battery of tests and a chest x-ray. I had the chest x-ray first to rule in or rule out lymphoma, which has been associated with Raynaud's. Afterwards, I was brought into the radiology suite. I saw an x-ray on the light board with a huge mediastinal mass, and I said to the radiologist, "Please tell me that's not mine."

Adam: Did you get any other imaging to confirm the x-ray?

Dr. E: A CT scan was done immediately. Then I alerted my higher-ups at the school. I needed a quarterback, so on a Thursday night, I went in to see a pulmonologist. I had a needle-core biopsy the next

day, and a pathologist made sure there was enough sample to do not only a diagnostic but also a genetic workup. On Saturday, I had the diagnosis of a high-grade, poorly differentiated squamous carcinoma of thymic origin, otherwise known as a thymic carcinoma.

Adam: That must have been a scary period of time. How did you take it?

Dr. E: Saturday afternoon, I freaked out a little bit. I had a couple of friends in the medical field support me on Saturday and Sunday. I'll admit those days after I got the diagnosis were not good, because even though I knew what the diagnosis meant, the sheer size of the mass — it was 15 centimeters, wrapping around vital structures — made me at that time not a surgical candidate. So that scared me a little bit. My whole family was over. The school was very supportive. I started to read a little bit, and I shouldn't have done that. **Don't do that. Allow yourself to be a patient, not your own doctor.**

Adam: When did you start getting treatment?

Dr. E: So on Sunday, you know, I had a couple of drinks. I settled myself down. One promise I made to myself was that I wasn't going to put myself through the mental trauma of spending another month getting second, third, fourth, and fifth opinions. I promised myself that if I trusted my physicians, I was going to trust the fact that they would find the proper information and protocols on their own. On Monday, I went to see an oncologist at Northwell. She was a wonderful human being. And she was confident. She looked at me, and I think she saw that I was depressed, but she settled me right down. She said, "We are not going for just maintaining you for a few years. We are going for a cure." And the way she said it, I trusted her. I mean, she was just awesome. Direct, truthful, knowledgeable. That afternoon, I also met with a surgeon and a radiation oncologist. I trusted all of them 100 percent. Once my team was set, I started going forward. On Tuesday morning, five days after my diagnosis of a mass, I went for chemo.



Dr. Elkowitz and his son on the morning of his first chemo treatment. "You can see in my face that I was in a great mood that morning."

Adam: And how did you feel when you started chemo on that Tuesday?

Dr. E: I gotta tell you, I was in a great mood that morning. Great mood. I have a picture from that morning that I can share with you. From that day on, positive attitude. That's not to say — like, this weekend, I started thinking again about my mortality. But all in all, I decided to fight this. I decided to go into battle instead of just going through the motions.

Adam: That's interesting, the way you phrased that. In a sense, you had to surrender being your own doctor and hand yourself over

to others. And yet you weren't surrendering to the disease. It must have been difficult to learn how to fight the right battles.

Dr. E: I never really thought about it until you just posed it that way. I knew I was going to fight the disease. And the only way I knew how to fight it was to have a good attitude and get back to work. But I had to relinquish some control in terms of what I was going to research and what I was not going to research.

Adam: It seems that you realized quickly that you didn't want to fight yourself. You just got out of your own way.

Dr. E: I knew enough about medical oncology to make me dangerous. And I decided very early on that I was not going to be my doctor. I was going to trust my doctors. That's not to say that I didn't ask questions. I asked questions. But I tried hard not to second-guess their judgment, and I really tried hard to be a good patient. In fact, when I was being treated by a lot of the staff there, many of them didn't know I was a physician or part of a medical school.

Adam: People dealing with cancer often say that they're fighting it, and it's hard for somebody who has not had cancer to imagine what that means. What kind of a fight is it?

Dr. E: The irony is that when I had this mass in me, I was running six, seven miles. I gave presentations in that month of July. I was feeling good aside from the Raynaud's and the myalgias, which were alleviated by medication. I didn't feel awful until I started treatment. So I think fighting cancer is really two things: It's fighting the side effects of treatment, and fighting this whole idea of your own mortality.

Adam: Many people fight off those thoughts of their own mortality by distracting themselves, and sometimes work is the distraction that they need. But what's really interesting about your situation is that you're a pathologist — your job involves teaching us about

cancer. In fact, the first lecture that you gave to our class after you began your treatment was about mediastinal masses.

Dr. E: The way I reconciled that paradox was very simple. My work — being around the administration, faculty, and students — was part of my treatment plan. Of course, I couldn't have come back to work at all without the mental and physical support of my wife and children at home. **But I wanted to use my issue as a tool for better understanding of the material, of what it means to be a physician, and of what it means to be a patient.** I felt that that would be the greatest gift I could give to the students. So I had no problem talking about anterior mediastinal masses when I came back; or, in the case of the first-years, using a poorly differentiated squamous carcinoma as an example of grading or staging. I had no problem doing it because, again, I really wanted to give back to the students not only the knowledge but also the insight into what it is to be a great physician — it's a lot more than just knowing your material — and what it's like to be a patient.

Adam: Do you feel that as a pathologist you were always at a distance from disease, looking at slides through a microscope?

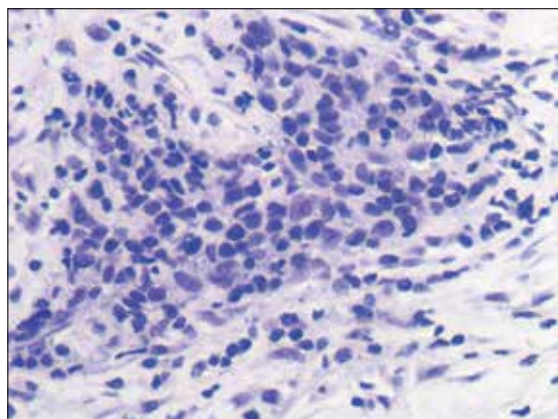
Dr. E: I gotta tell you, I've been in academics for 18, 19 years, but very early on in my career, certainly during my residency and fellowship, we'd sign out 50 to 100 cases per day, maybe 30 cancer cases. And all they'd be is slides on a tray. And I know looking back at that time, yeah, they were patients, but you never really had the time or allowed yourself to think that these people were scared. After the sign-out, it was just out of sight, out of mind. Because the next day, you have another 50 or 100 cases. And here when they signed out my case on Saturday and they gave me that diagnosis, I was shattered. I know my wife was shattered. My kids were upset.

Adam: I suppose if pathologists internalized every case that they diagnosed, they wouldn't be able to do their job.

Dr. E: They couldn't do their job effectively. Maybe they can, but I know I couldn't. I'll speak for myself. I knew I couldn't, and I didn't. But after my diagnosis it became very evident to me that **every disease that we learn about has families and patients attached to it with real feelings and real emotions.** I always felt that if you were a competent physician and knew your material well, all the other stuff made no difference. But my doctors are not only competent, they have the "it" factor. They can look in my eyes, and without saying a word ... I have full trust and confidence in them. This total rapport between us, it's awesome.

Adam: Between Thursday and Saturday — I mean, Saturday was the big day, but how did you handle the two nights of sleep before that? You talked about what happened during the days, but what was going through your mind at night?

Dr. E: Oh, this is good for the students. So remember: Everything's about a differential. From Thursday to Saturday, I was going through a differential in my mind. On Thursday, I was diagnosed with a mass. At first, with the chest x-ray, I was thinking, Okay, it's either a thymoma or lymphoma. And if it's lymphoma, it's most likely nodular sclerosing, maybe a B-cell lymphoma. Two hours later, I saw the results of my CT scan with contrast, and it showed a malignant mass, 15 centimeters, with lymph node



Biopsy of Dr. Elkowitz's thymic carcinoma

involvement. So my brain shifted gears to, Oh, thymoma is a lot less likely—it's still in the differential, but lymphoma is much more likely. And out of lymphomas, I was thinking it would be nodular sclerosing. On Friday, I went in for the biopsy, and when they woke me up after the biopsy was over, the interventional radiologist said to me, "Your mass was so fibrotic that we had to use a special needle to pull tissue out." So at that time, I was actually in a good mood, because I thought to myself, It's nodular sclerosing, with sclerosing explaining the fibrosis of that mass. By Saturday I got back the results.

Adam: That was the doctor in you. What was the patient in you thinking?

Dr. E: Saturday and Sunday were not good days. Yeah, those were not good days. Because then the hopefulness of nodular sclerosing, which has the best prognosis of any of the malignant options, was gone. Saturday and Sunday were tough. But my family was around me. I had close friends who were physicians around me. They spent time with me and my family at home and really helped me a lot. But then Monday night, after I met my team and I was comfortable with them, and knowing that I was going to start chemo on Tuesday morning, I had Chinese food and I had a good night. I went in there with a great attitude. I became notorious. I had a hundred students clogging up the waiting room, and it was awesome. From that point on, I've had bad days, but very few and far between. Even this last weekend, I started thinking — because I was getting a cough and having this shortness of breath, so I started to think about my mortality, you know, Is it back? But by and large, I've had a lot of great days since the first day of treatment.

Adam: Do you have a strategy for dealing with those thoughts?

Dr. E: Yes, I actively put them out of my brain. That's it. It takes effort. I put it out of my brain actively, and I think about something

else. It's a real active process. **And I always go back to the confidence I had in my physicians, in my surgeon in particular, who said, "You're cured, we got it." And my oncologist was saying, "It's working." I think about them.** But it's active. You actively gotta move on.

Adam: Can you talk about your decision about whether to tell the students what was going on?

Dr. E: That was never even a thought in my mind. Students, faculty, and administration are like my family at home. I spend so much time with you guys here. You guys were going to see me without any hair, drop 10 pounds, anemic, walking up the stairs taking breaks. I mean, you guys are not stupid. You were going to see that I was sick. What am I going to do? Hide it? I couldn't. Plus, I knew this was a teaching moment, a chance to make lemonade out of lemons.

Adam: From the beginning, you knew?

Dr. E: I didn't pull any punches with you guys. And the outpouring of love and concern from the administration, the faculty, the students, and the community including the health system was so intense. I had so many visitors that there wasn't enough room for other patients' families in the waiting room. It was an intense, loving response. It was very, very good. Very good. Yeah. True gift.

Adam: Occasionally there's this dynamic where the patient sometimes needs to help the caregivers to overcome the grief surrounding the illness. In other words, the patient can end up comforting friends and family, rather than the other way around. Did you ever feel like you needed to reassure other people that you'd be all right?

Dr. E: No. The students, the faculty and the administration, whenever they came to see me, were terrific. I don't think they ever wanted me to use my energy to heal their own issues. As for family, you

never know what this truly does to your wife and your children, because as they're being strong for you, they internalize a lot of stuff. They deal with a lot without trying to put the burden on you. I know my wife and my children did that and are doing that. I just want to let them know that I really do love them and appreciate that. They were incredibly strong. They had their moments, but very rarely, if ever, around me. Everyone was very strong around me.

Adam: During one of the times we talked before, you said that the experience made you a better teacher. What has changed?

Dr. E: Let me be perfectly clear. I was getting more from teaching than I was giving. I am sure of that. We have a lot of talented faculty and certainly pathologists who could have done those sessions. They may not have done it in my style, but they certainly could have relayed the content. My choice to come back was part of my own treatment. In fact, it was a little bit selfish of me, because the students had to sit there and listen to a person who had trouble projecting, who was out of breath, whose appearance might have been distracting. I don't care what you guys say, whether you disagree with me on this or not. I knew this was going to be an important part of me healing faster. **Having the opportunity to teach was just as important as the drugs going into me.** I feel very strongly about that.

Adam: Was that something that you'd always considered on your own? Or was that something that doctors or oncologists had suggested?

Dr. E: On the contrary. I was encouraged to take it a little bit slower, to get rest, to take care of myself. What people didn't realize was that my coming back and having the opportunity to do those sessions was taking care of me. It was keeping me in the game.

Adam: Last time we spoke, we talked about how illness or adversity can change your perspective on life. You mentioned that sitting in traffic used to be a frustrating experience until you weren't able

to drive for a while. And then, when you were able to drive again, you felt grateful for sitting in traffic. Were there other moments like that during your treatment and recovery?

Dr. E: There were a lot of little things that I missed, or that I didn't expect to miss. I missed mundane things like having hair on my body, having an appetite, and being able to taste food. I missed the ability to go for a run. Sitting in traffic was part of the experience of driving to work independently, and my illness made me realize that I had taken all of that for granted, even the frustrating parts.

Adam: Did it make you love and appreciate your family more?

Dr. E: Loving my family was never difficult for me. I lost my sister at an early age, when I was 24, and I still think about her a lot, so I'd already worked through a time like that. No, appreciating my wife and children wasn't hard for me to realize.

Adam: What did you do when you had all that time off?

Dr. E: I didn't have the energy to do anything. I watched movies, slept, or made the effort to rehabilitate myself, maybe walk a thousand feet. It was an ongoing struggle to even eat. It was an hour-long ordeal just to get something down. It was an hour-long ordeal for me to walk down the stairs and out the door. Everything was an hour-long ordeal, and I had to sit and rest. I mentioned this to your class, but the one thing I gotta tell you guys is that words mean something in medicine. When somebody says, "I'm fatigued," what does that actually mean? Last year, you and I could have gone together for a five-mile run, and when we came back, we'd be fatigued, but we'd feel great. It's a good fatigue. Or maybe you as a physician can prescribe me a medication where, as a side effect, I might feel fatigued. And I might say, "Yeah, I feel a little tired." Or maybe medical students studying 29 hours a day, eight days a week, are wiped out and feel fatigued, but they go to sleep and they wake up feeling okay. Or maybe you're on

chemo, and you feel fatigued. And that fatigue is like this: Even when you go to sleep, you still feel like hell.

Adam: You've often said to us that attitude is a choice. What do you mean by that?

Dr. E: I said to you that I started thinking about my own mortality. Negative thoughts. I'm human. I understand that's going to happen from time to time. But you have a choice to dwell on them or to move on. That's what I mean. Whatever is happening, there's enough good going on, and I have a positive attitude. Today I'm a little out of breath. I have this chronic cough. I don't feel 100 percent. But instead of dwelling on that, I'm here at work. I'm talking to you. I helped two students in my office with content questions. That's a privilege and a great thing. I'm in a better place now than in the morning when I wasn't feeling that great. No matter what your circumstances are, don't complain. There are people who have it worse off.

David Elkowitz, DO, is associate dean and director of the Academy of Medical Educators, director of undergraduate medical education for the Department of Pathology and Laboratory Medicine, co-director of the Structure Lab, and associate director of the PEARLS program. Dr. Elkowitz is also associate professor of science education and pathology/laboratory medicine at the Zucker School of Medicine at Hofstra/Northwell.

Adam Lalley is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He is a winner of the Michael E. DeBaKey Medical Student Poetry Award, hosted by Baylor College of Medicine, and the William Carlos Williams Poetry Competition, hosted by Northeast Ohio Medical University. Adam is the student managing editor of Narrateur.

From the Sea

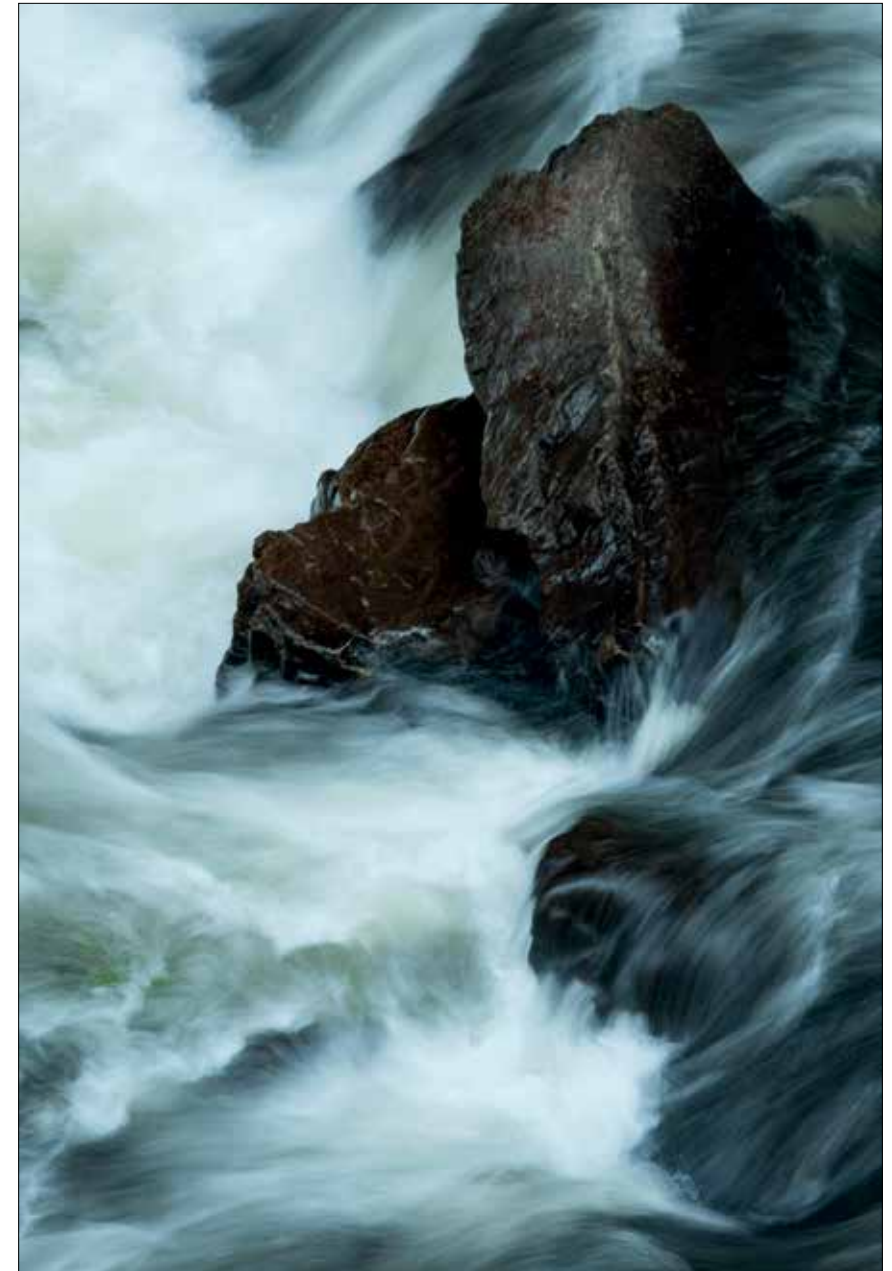
1.

Being born at 22 weeks is incompatible with survival. It is compatible with a soft, downy head, hair extending down to meet eyebrows. It is compatible with perfectly shaped fingers, toes, arms bent with palms up in offering. We stood around this breathless doll to understand its circulation, how it survived in an aqueous environment. Then we moved on as a group to a sturdier donor to see how this one survived on land.

2.

I am taking note, a scribe to pain and hope. My OB preceptor specializes in high-risk pregnancies. A woman sits in his office, tears streaming down her face. This week there was no heartbeat. She will try again, and again, until there is nothing left. She hopes that the ocean is plentiful. She prays that the seawater that flows in her veins will produce another being from its depths and deliver it to her shore.

Victoria Fort is a third-year medical student at the Zucker School of Medicine at Hofstra/Northwell. She grew up in the mountains of Tennessee. She wrote this poem during her first year in medical school while sitting near the ocean in Long Beach.



Water Rush

MARIA RUGGIERI

Maria Ruggieri, PhD, is an associate professor at the Feinstein Institute and at the Department of Molecular Medicine and Radiation Medicine at the Zucker School of Medicine at Hofstra/Northwell. She writes: "My love for nature leads me to look for different perspectives to experience moments of awe."

Perception

In a world where everyone had some sort of minor power or skill that manifested in early adulthood, Mira woke one day with the newfound gift of perception. To her, on the spectrum of skills, it was closer to a curse than a superpower.

Many boasted increased hand-eye coordination, a slightly faster gait, a minutely better sense of smell, or maybe increased visual acuity. Some could detect an untruth; others had been granted the ability to perfectly reproduce a painting or photograph. Mira had been given the gift of keen insight into a person's physical well-being simply by seeing him or her.

Every rash, discoloration, change in normal physical build of a person's anatomy as visible from the outside suddenly had another layer of meaning. And as she continued to glean additional knowledge about people, she found herself a little uncomfortable with the intimate look it gave her into their lives.

There was an old man who read the local newspaper every morning at the coffee shop on the corner of Mira's street. She stopped by most days before work to get her daily dose of delicious caffeinated beverage, and she had come across him many times. She would wave a hello and he would give a gruff nod of good morning, with a hint of a smile. He reminded Mira of her grandfather.

On the day she woke with her new power of perception, Mira saw him in a different way. She noticed the large purple bruises on the man's hands, the word *purpura* coming to mind unbidden. Then she saw the swelling of his ankles beneath his rather cheerful blue pinstripe socks where his khakis rode up as he crossed one leg over the other. His wet cough into a shockingly yellow embroidered handkerchief startled her out of her thoughts as she left a minute later with her cup of steaming coffee in hand. But even the aroma of her favorite drink couldn't shoo away the unease that she felt when she realized that her new power had given her a clear picture of a man in congestive heart failure.

When she walked into the office building where she worked and passed the security guard's desk, her new power brought her attention to a patchy red and white plaque of skin on the guard's elbows. She could almost feel the intense need to scratch along the skin as the guard, a middle-aged man who had shared endless cake recipes at their last holiday party, gave her a pleasant smile. The bags under his eyes and a nick on his skin at the angle of his jaw informed her of his sleeplessness and stress as he juggled two jobs and coped with a new baby at home. Mira smiled back as she scanned her ID card and walked into the elevator.

As the doors to the elevator closed, Mira took a deep breath, grateful to be alone for just a minute. This power was providing too much information.

The elevator chimed twice, opening at the second floor and admitting a harried young woman in a suit dress, lugging a large business tote stuffed with documents. She hurriedly looked at her watch and Mira could not keep from seeing the woman's hands. The joints of her fingers, especially at the junction between finger and palm, were enlarged and pink-purple, and the fingers were bent away toward her pinkies. As the woman looked up from her watch, she gave Mira a small smile, as if to share her predicament. Mira couldn't miss the wince of pain as the woman grasped her purse with those swollen yet lovely hands.

As she approached her cubicle, Mira sighed. She booted up her computer, took a long sip of coffee, and closed her eyes, tired despite a restful night's sleep. She reflected briefly on the depth of information merely observing a person could provide. A shiver ran down her back in the chill of the office and she took another sip.

Maybe she would visit her doctor later that day and discuss options for dealing with her unsettling new power. Then, opening up an internet browser, she quickly typed "skill-inhibiting medications."

Pratiksha Yalakkishettar is a third-year medical student at the Zucker School of Medicine at Hofstra/Northwell. She is interested in health policy and primary care.

Marvin

“He’s turning 90 this year,” his wife told me, “so I’m going to throw him a big party. We’ve been together over 60 years,” she said. I glanced down at Marvin’s chart and saw his birthday was another three months away. She must have noticed my eyes dart down to the chart, then back at her. Though I tried to conceal my skepticism, she too must have known that Marvin’s prognosis was grim. But she didn’t want to hear it. “He’s a fighter,” she said, her voice taking on a firmer tone. She put her hand on his shoulder, and then said, in a gentler voice: “He always surprises the doctors...don’t you, Marv?”

Marvin’s eyes remained closed; his mouth hung open. She leaned over and kissed his forehead, navigating her way around the many wires that connected her husband to monitors and machines that seemed to take turns beeping. The nurse would come in every few minutes, press the “silence alarm” button, check for tangled or blocked tubing, or hang a new bag of fluid. Marvin was not a surgical candidate, and no further interventions were being offered. His melanoma, which had already infiltrated his lungs, had now metastasized to his brain, precipitating the bleed that heralded his rapid decline.

His wife was not ready to discuss prognosis. She spoke of the more superficial consequences of the situation, voicing future-oriented concerns that allowed her to remain hopeful. “He hasn’t been out of bed in so long. He needs to stay active,” she insisted. “He needs to see physical therapy.” Then came the questions: “When will you feed him?” “Has he gotten his Coumadin?” I started to explain to her that anticoagulation was being withheld because of the bleeding in his brain, but she stopped me before I could finish. Her questions had all been rhetorical, I later realized. “It’s too much information for one day,” she said. There was a pause; in that silence, I felt the enormity of her suffering crash into me like a giant wave.

“You’re right. I’m sorry,” I said. “What are you thinking about right now?”

“I’m thinking...so many things,” she started. “I can’t go back to my apartment alone. What will I do without him there? It’s just going to be so lonely.”

I wasn’t sure if she was referring to that night, or to all the nights that would follow. I said nothing, having realized that the best thing I could do in the moment was to listen.

“I don’t usually cry,” his wife said, “I never cry, actually...but this is too much.” I felt helpless, wishing I could provide her with some hope, something reassuring — anything to stop her sobbing. But I knew there was nothing else we could do.

“Don’t apologize for anything. This is a lot,” I told her. I knew that nothing I said would take away the pain she felt in that moment.

“Will you take care of him?” she asked me, with a look in her eyes that may have been despair, or may have been hope — I wasn’t sure. *Oh, no...she thinks I’m a doctor,* I thought. *If she knew the truth, she wouldn’t let me go near her husband.* But I didn’t have the heart to break this to her in that moment. She needed one thing: reassurance that her husband would be cared for. It was the least I could give her. “Of course we will,” I said, “I promise.”

We talked about goals of care for her husband. She seemed to understand the situation and agreed that comfort care was what he would have wanted. “He was always independent, so sharp and so with it. He wouldn’t want to be like this,” she said. But when the time came to actually move him, she resisted vehemently and begged for him to stay in the ICU. “One more day here,” she said. “He needs one more day here.”

His nurse was frustrated by the wife’s refusal at the last minute, after the paperwork had been put through and transport was to arrive any minute. From behind the nurse’s station, I saw the commotion and went to speak to her. She looked happy to see me, and I knew she was hopeful that I would agree with her. I acknowledged her concerns but told her the arrangements had been finalized and reassured her that this was the right thing to do. I again started to explain the logic, the futility of aggressive interventions and the benefits of comfort care. She cut me off, and I realized that I had

again fallen into the trap of trying to use logic to overcome emotion.

“You don’t understand,” she said, sounding angrier than I was expecting. “I know you can’t save him, but we are very social people,” she said. “I like having all the people around here...the life...the energy on this unit. Please just let us stay one more day.”

This was a request I had never heard. The ICU is far from a social place, I thought to myself, but I supposed that the fear of her husband’s death had forced her to search for hope anywhere she could. To her, the ICU was a place where Marvin had a shot at life.

I wanted to comfort her, to provide just a little bit of hope, but not too much.

“Moving there doesn’t mean he’s dying,” I started. “Necessarily,” I added quickly.

There was a fine line between critical care and comfort care, between truth and compassion. I held out a little box of hospital tissues, and she took one and then grabbed a handful more, frustrated by how quickly the thin hospital tissues disintegrated as they became soaked with her tears.

I held the swinging door open as the transport team wheeled Marvin from the ICU to the Palliative Care Unit. Even as it was happening, she cried, begged, bargained, negotiated for one more day in the ICU. She would not walk through the doorway with me to the Palliative Care Unit. “I just feel like this means it’s close to the end. I’m not ready to say goodbye yet.” We both knew it was too late for negotiation. She would never be ready to say goodbye. I didn’t try to provide logic this time; instead, I just let her talk. I listened; and in that moment, I felt needed.

Before leaving that day, I stopped by Marvin’s room with my attending, and for the first time, I saw him alone. I was surprised that his wife wasn’t beside him and wondered if she had left. And if so, why had she left so soon?

“Marvin?” I said. There was no reply.

“How are you?” I asked. Still nothing. “Can I get you anything?” I stood there for a few moments, not knowing what to say

or do and feeling completely useless.

“Are you in any pain?” I asked. Still nothing. His eyes were staring straight ahead, and he seemed to see straight through me. I turned around to see if someone stood behind me. But there was nobody, nothing at all behind me. The sound of silence was deafening, as he lay in bed facing nothing but his own mortality. Perhaps this is why his wife had left. Perhaps it had simply been too much for her to face.

Then, catching me off guard, he spoke in a monotone: “My leg.”

“Your leg?” I asked. “Which leg?”

I stepped toward the foot of the bed. “This leg?” I said, putting my hand on top of the blanket over his left leg. I looked at his face for a sign of affirmation, but I got nothing. After a few moments, I moved my hand to his other leg. “Or this one?”

“It hurts,” he said.

“Which leg? What kind of pain?” My mind immediately started to race. He probably has a DVT, I thought, and I felt a sudden urgent need to take care of him, as I had promised his wife. “I’m going to look at your legs, okay?”

I put on a pair of gloves and peeled back the blanket. The inflatable purple compression devices covered his pale, white legs — no redness, no warmth — good signs, I thought. I hesitated for a moment before taking off the SCDs. I felt a wave of relief when my attending entered the room. I told him, somewhat frantically, about Marvin’s leg pain. “I’m not sure which leg it is, though,” I said.

“What kind of pain are you having?” he asked Marvin.

We looked at Marvin’s face, waiting and hoping that he would speak.

After a few more moments, he did. “Charley horse.”

“I can take a look...?” I said, phrasing it more as a question than a statement and then looking at my attending, who nodded, indicating his approval. I placed my hand on Marvin’s calf, tentatively at first. I pressed lightly on a few spots. “Does this hurt?” I asked him.

He didn't reply, so I placed my hand on the other leg and began to apply light pressure. "Yes," he said abruptly.

I stopped on the spot, and gently rubbed it, my eyes now focused on his face, looking for any expression. "Does this make it feel better?" I asked hopefully.

"Yes," he said.

I rubbed the spot a bit more, wanting more than anything to end his pain. If I could do that one thing, even something so little, perhaps I wouldn't feel I had lied to Marvin's wife. Maybe I really would have taken care of him, in my own little way.

"Yes?" I said, excitedly. "It's feeling a bit better now?"

"Yes," he said again. This time, Marvin and I made eye contact. He looked comfortable. But it was the last thing I would hear him say. I felt my eyes fill with tears, quickly wiping them away with the back of my hand, embarrassed that I was crying, and vowing to myself that I would be braver next time.

The next week, I purposely walked through the Palliative Care Unit every time I came and went from the ICU. Sometimes his door was closed, other times it was open, and I would see him peacefully resting. I spoke with his wife, who told me they were planning to place Marvin in Parker Jewish, a subacute rehab facility not far from their retirement community. I was surprised, but I believed her, perhaps because I wanted to believe that she had been right, that Marvin had rallied. Perhaps he really had surprised us all, just as his wife said he would.

Later, I realized that when death is near, human beings cling to any semblance of hope. The next Friday, when I went to visit Marvin, I found his door wide open. The room was empty, and his bed was freshly made with clean white linens. Had he gone home? When I opened his medical record, I saw the answer, but not the one I wanted. "Discharge Note for the Expired Patient." My heart sank. I read the note, but it was simply a documentation of the time he stopped breathing spontaneously, and the time he was pronounced dead. It said his daughter had been notified. There was no mention of his wife. I read each note, in reverse chronological order, looking for something that would give me closure.

What I found only left me feeling worse. It was written just hours before he passed away:

12:43 PM- Pain- yes.

Onset- days.

Location- right leg.

Character- unable to characterize as patient is nonverbal.

Radiation- unknown.

Alleviating/aggravating factors- unknown.

Timing- unknown.

So many unknowns. I wondered what had ultimately taken him. I wondered if his wife was beside him. I wondered if his wife had clung to hope that he would rally until the last moment, or if her hope had been gradually replaced by acceptance.

I lingered in the hall of the Palliative Care Unit for a few moments before walking down toward the double doors that led back to the ICU. Just one week prior, I had walked with Marvin's wife in the opposite direction, promising her that I would care for her husband. I thought about the juxtaposition of palliative care and critical care continuous units, connected only by a set of swinging doors. I knew then that we had done the right thing for Marvin. I had cared for him in my own little way, and he was no longer suffering. As the door slammed shut behind me, I felt closure.

Anjali Narayan is a fourth-year medical student at the Zucker School of Medicine at Hofstra/Northwell. She is excited to start her residency in July 2018. In her free time, she enjoys running, writing, reading, painting, and playing the violin.



The Yellow Pumpkin

ALAN SLOYER

NARRATEUR

Alan Sloyer, MD, is an associate professor of medicine at the Zucker School of Medicine at Hofstra/Northwell and a gastroenterologist practicing on Long Island. He travels the world with his camera. This image was captured in Naoshima, Japan. Naoshima, previously a sleepy fishing island, has been turned into one of the most remarkable art and architecture destinations in the world.

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An Unknown Soldier

Flying in the darkness:

At night, every sense is amplified, especially when you take your helmet off. The vibrations of the helicopter beneath you seem to shift your internal organs. The vibrations of the engines rock you to sleep. First, in preparation for the long cross-country flight, you remove your rucksack, helmet, and rifle, which are looped through your tie-in — all to protect you and others if the aircraft were to crash. You sit on the metal floor, biding time, feeling the floor rings under your legs, and the uneven, raw edges of the interior skin of the aircraft on your back. Across the small aircraft several teammates are splayed out, as if tanning on a beach. You wait for takeoff. Up and away.

As the sun sets, the water beneath glistens through the back of the aircraft's open ramp. Once the sun is fully down, the nose takes over. The overwhelming stench of burning JP-8 singes the nasal cavity, leaving a gasoline taste in your mouth. Somewhere else in the cabin, the pungent smell of wintergreen floats through the air. Someone is packing a lip. You feel the aircraft moving from hover to fly to hover, as it slows and speeds up, playing tricks on your mind. Finally, the aircraft slows, and you feel the beast of the machine hover again. Time to kit up: helmet on, ruck up, night vision goggles on. And suddenly, the world once again is visible, through an amber-green hue that is only partially in focus.

The ramp opens, off you step, and the mission continues.

Healing:

“Hi, I’m calling to get the name and identifier of a man we dropped off on our last mission to the KAF [Kandahar Airfield] Hospital,” I say.

“Call back on a secure line,” the voice snaps.

I walk across our clapboard, plywood, dust-laden operations center no bigger than the bedroom I grew up in, grasp the red phone, and call back.

“Call the morgue, they have the information. That person died,” he growls.

I dial the morgue. “Hello,” an airman answers, “how may I help you?”

“I’m looking for the name and identifier of a soldier we dropped on a recent mission,” I say, giving him the number.

“Oh,” the morgue airman replies, “you mean the soldier who died on the helicopter on the way here.”

I manage to squeak out a “yes” in response to this. The soldier who died, died in my arms a few hours ago. Our team had scrambled to a helicopter, responding to a convoy of American vehicles that had been obliterated by a massive IED (improvised explosive device) in the Horn of Panjwai. This place was a death valley, littered with mines and IEDs. We ran to a helicopter, our pilots powering it up, as we quickly prepared blood tubing, warm blankets, airway devices, drawing pain medications, sedatives, antibiotics, and TXA. We jumped off the aircraft, finding an absolute mess on the ground: five critical patients for five of us to treat on two helicopters on the way back. Three men were single or double amputees. Quickly, we loaded two of the most severe patients on our helicopter with three of us. Two of us took one patient apiece, with the third member shuttling gear back and forth.

The soldier I was treating was around 21. He sported a short military cut. His face was coated with mud. His legs were mangled. His skin was gray and cool. I checked his pulses and tourniquets. Tourniquets were good. Pulses were not. I started CPR while screaming over the loud whine of the helicopter's engines to my teammate: “Get the PRBCs [packed red blood cells] ready!” He took over compressions while I was drilling his shoulder, slamming PRBCs the best I could — anything to restore his blood, which was now pooling on the ground in Panjwai, our helicopter, and me. *Throw in a tube*, I say to myself, out loud. *Shit. I don't have enough hands! Damn it. Keep on with the compressions. Blood. Warmth. Epi. Blood. Warmth. Epi. This guy needs bright lights and cold steel.*

We touched down at the airfield. Medical workers rushed toward us. “Stay back!” I shouted. We lifted the patient off the helicopter and got him into the ambulance. It sped off to the hospital. I was still by his side, performing CPR. My body armor rattled with each compression. I felt hopeless. Worthless. We placed the soldier on the cot. At the hospital, a physician yelled to be heard: “What’s going on here?” I explained. The docs cracked open his chest and massaged his heart. *Holy shit*. The words came out in a whisper, even in my head. The extent we go to to save a life. We push forward with everything we’ve got. I sat in the background watching everybody running by me. The soldier’s heart wouldn’t tick. He was not breathing. The doctors called it. We failed him.

Back to the phone call. The airman gives his name and identifier. It has taken up permanent residency in my brain, as does the image of his lifeless body bouncing in the back of the helicopter. And the stench of the burning flesh and explosives at the site. And the rudeness of the damn airman at the morgue. His response still baffles me. I was the guy who went out there, helped carry him from the wreckage, and treated him. The soldier took his last breath in my arms, staring at me. All I wanted was his name and identifier.

I got it, and a lot more . . . inconceivable to those who have not lived it. Only in the presence of a few do we feel comfortable talking about these experiences, which might explain why the wounds and questions linger. We haven’t figured out how to fully heal, but we hope that in time we will.

Christopher Petersen spent eight years in the military performing search and rescue duties and treating injured service members and civilians — both in combat zones and through humanitarian mission sets. He is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell.

Alternate Terrain

He replied, “I live in a crater on the moon,
where dust covers the tears from my sunken eyes”
I sit across from him in the institution
fluorescent lights beam onto pale olive walls
He sits on a melancholy cot, his arms dangling
Through the open window, I gaze at the moon and the man
who begs the moon to
take him home,
a shadow of who he once was,
a hero with light years of laughter
standing tall as a rocket ship turbo-charged with hot delirium
I am bereft, a widow of damaged goods,
cast out from the dabble-dabble of the crowds
I am faceless, hollow, flinching with fear in his presence
I promised him angels delivering warm blankets
A soft landing
But I cannot wipe away the soot
nor neutralize his fumes

Heidi Mandel PhD, LMSW, is a social work supervisor at the Jewish Board and a research consultant with the Zucker School of Medicine at Hofstra/Northwell. She is also pioneering narrative social work in a new book entitled Narrative in Social Work Practice: The Power and Possibility of Story.

Billy

There were the runny noses and coughs, and then there was Billy. He was only days into being a teenager — he'd just celebrated his 13th birthday — and he arrived at the doctor's office trailing on the heels of his mother. His doctor and I entered the room, and no sooner had the door shut than the mother started speaking: "We had a really bad night last night. Something is going on with him."

Her son was nearly failing his eighth grade classes. He was behind on his assignments, and the trouble was spilling out at home, too. Over the weekend, she'd taken away his phone and made him sit at the kitchen table and complete his schoolwork. He's a bright kid, she said. She thought she'd finally broken through. But later that week his guidance counselor called and said that there were other classes and more work that needed attention.

She found him in his room and recounted the call, word for word. He let her finish and then exploded with an anger that had been building for months. "I hate you. I hate you!" he yelled. "I don't give a shit about you. I'm miserable! Sometimes I just want to kill myself." He saw the shock in his mother's face and immediately took back his death wish, but it was too late.

His mother started sobbing and wondered what to do. She thought about driving him to the emergency room right away but decided to call his pediatrician. An appointment was scheduled for the next day. She'd heard enough stories about young people killing themselves.

Sitting in the exam room, Billy looked down at his feet, embarrassed. "I didn't really mean it, Mom. I told you that at the time. I shouldn't have said that."

"I know you didn't, and I'm not mad at you, but these are the kinds of things that you tell a doctor." Then, turning to his doctor: "He's my only child, so I don't know. Is this normal for

a teenager, or is something wrong with him? Sometimes I feel I don't know who he is any more."

Billy protested from where he sat with his feet dangling off the exam table. "I'm fine. I don't need to see anyone, really. I'm fine." His voice was steady, every word delivered in the same bland tone.

The doctor turned to Billy and asked him what was going on in his life. Although he had addressed the question to his patient, it was the mother who answered. She had divorced Billy's father a decade ago. His father rented an apartment close to them and saw him every day, but he had moved to Canada a few years ago. Billy had visited him last summer, and they had been at each other's throats the entire time. He felt that his father was treating him like a child.

The mother had recently lost her job and subsequently her apartment, so they were now living with her elderly parents. As her story continued, it seemed quite reasonable to me that anyone in Billy's situation would be having a difficult time.

I listened to the pediatrician offer some thoughts about what he'd just heard. I felt as if I shouldn't be in the room. It felt too personal, almost voyeuristic. But then I thought: *This is my job. I'm here to learn. I'm watching this encounter so that I can learn what to do when I'm in the doctor's position.*

I wish I could say something. I want to reassure the mother that one angry outburst from her son does not mean he has changed as a person. How many times at that age did I yell at my parents, say things that I knew would get a reaction out of them, even when I knew in the moment that I didn't mean it? I want to tell Billy that it's normal to see a therapist if he needs one. He's probably not even aware of how many others in his class are getting help through therapy or medication.

I want to say all of this, but it's not my place. My role right now is as an observer. The pediatrician's job is to talk. One day I'll have patients of my own coming to my office, and I will be the one listening and giving them the answers they so desperately need.

My inner monologue ended as I heard the doctor ask Billy, “What do you think we should do?” Questions like this separate a good doctor from a great doctor. Giving Billy autonomy and control in this moment when his well-meaning mother wouldn’t even let him finish a sentence was exactly the right thing to do.

Patients are not often cured in just one visit. The doctor wrote down some phone numbers for psychiatrists who might have availability. The mother would have to call and find one who took her son’s insurance. Billy was still behind on school-work. His mother was still out of a job. But something had changed. That family walked into the exam room looking for answers, and although no answer is perfect, they had gotten one. They had reassurance from a doctor who had known Billy since he was born and who had sat and listened attentively and without judgment. He had struck the right balance. He’d given the mother and son options. Most important, he was there.

This encounter jolted me out of the endless loop of cough-runny noses-microbes-medicines-flu shots that I had found myself in for the past several weeks. It reminded me how meaningful patient encounters can be and what I’m pushing myself toward. I know that I won’t have all the answers. I know that sometimes I will tell patients things they don’t want to hear. Sometimes they won’t trust me, they won’t listen to me, and maybe they won’t even believe I have their best interests at heart. But sometimes there will be patients who come in seeking something more than medicine for a fleeting cold, something they can’t even name, and I will be there. Just there.

Danielle Cohen is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell.



The Singular Rose

KISHEN BULSARA

Kishen Bulsara is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He writes, “This image captures the beauty of a singular red rose found in Prospect Park, Brooklyn, on a rainy autumn afternoon. The rose is a symbol of love, a sign of coming together and unity. The petals form a cohesive whole, much like a team of physicians, nurses, physician assistants, and students who work together to provide care.”

The First Day of Chemo

Sleep doesn't come. I open my eyes. Time has stopped. Only one minute has passed since the last time I opened my eyes. Finally, it's the moment I've been dreading. It's my first day of chemo. This needs to be done if I am going to reduce my odds of dying. My cancer is aggressive, and my oncologists say it can spread to my lungs. If that happens, I will most likely die. No one knows if chemo will reduce the odds, because so little is known about this rare cancer. My oncologist thinks if there is even a small chance to reduce the spread of the cancer, why not try it.

Why not indeed? This decision wasn't easy for me. Another oncologist I consulted thought that chemo wouldn't do any good at all. We had the get-your-affairs-in-order talk. And prayed. Another oncologist thought that I should pursue a very extreme form of chemo. He warned it might kill the cancer cells but could also trigger heart failure, shut down my kidneys, and make me susceptible to leukemia. There was more, but my brain shut down. I stopped listening. My children insisted that I do something to beat this beast. I chose to stand on ground somewhere in the middle.

I am a statistician. Numbers is my game. I understand odds ratios. As chief of clinical quality, I monitor hospital errors and near misses. I collect data about mortality and failed procedures. This is my first time on the other side of the bed, so to speak. I have to develop new routines to cope. My position, my education, my knowledge — all irrelevant when the internal clock is ticking. What seems relevant to the challenge of chemotherapy is that I had been a soldier in a war. This time, so many decades later, cancer is my enemy.

I am weak from surgery and radiation. I need to be on time at the infusion center. I force myself to get up. I am used to directing my own life. That control is no longer mine. My wife — my rock — insists that I move forward. People are behind me, she says. The light is green. Go forward.

The doors to the chemo suite open. A smiling escort calls my name. My stomach lurches. I look at my wife. No U-turn allowed. I remind myself that this is my decision. This is what I determined to do: to beat cancer. To add more years to my life. "Name? Date of

birth?" She's got the right person. Can I have a room with a window? "Of course," she says. There is a plant on the windowsill. It is alive.

The nurse can't find the vein. She apologizes and keeps poking. I almost pass out. My wife tells her to stop and find someone who can do this right. A new nurse comes in and has no trouble finding a vein. I read. I look around. So many people with so many stories, some confused, some determined, some broken, others not. This is my new community. How dreadful! How lucky that it may work! Hours go by. It's finally over. For today.

Yosef D. Dlugacz, PhD, is senior vice president and chief of clinical quality, education, and research at Northwell Health. He has championed improving quality for clinical and operational processes, educated health professionals on quality management philosophy, tools, and techniques, and published four highly praised textbooks on health care quality.



Blue

ELISE STAVE

Elise Stave is a third-year medical student at the Zucker School of Medicine at Hofstra/Northwell.

Charlie

Cries of a younger brother
Drowned out by the stream
of Fox News. Four sets of freshly pressed

Sunday's best hang near Jesus,
the cannabis, and a dusty mitt.
In the beginning, his eyes started crossing,

And there was still time for road trips,
Promises of ice cream, solace
From a beast and his beauty. When you wish

Upon a star, you cry, but it's just the medicine
Working. The exposed beams of his father's eyes
Supporting an eroding edifice, unsure

Of how long they can bear the weight.
A sun setting through ponderosa pines
Eventually finds empty pill bottles,

An alb now hanging in the closet, and a weathered
brown leather sofa, the only pew.
A sweeping oiled thumb seals the final act.

"I'll pray for you," the priest says,
and Charlie, "I'll pray for you, too."

Dominic Pappas is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He grew up on the West Coast and took a few years off before medical school to travel. One of his goals is to climb Denali.

**Saba**

ALICE FORNARI

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

Wide Open

“Though your symptoms are inconclusive with the pain that you’ve been experiencing, the ultrasound and CT scan testing did show us some things that are somewhat concerning.”

Silence.

“There are some ‘spots’ that the images showed us on your liver and some abnormalities seen on the CT scan that lead us to believe that there may be tumors on your colon.”

Again, silence.

Painful silence.

“These images are not definitive, but they are concerning in that they suggest possible colorectal cancer.”

She said it — the ghastly “c-word.”

Take the most basic definition of the word. It simply means a disease in which abnormal cells grow and destroy body tissue. But it’s not so simple. It’s so much more than merely the destruction of body tissue. It destroys people, not just the victims of the cancer itself, but also the victims’ families and friends. It breaks hearts and shatters souls. It instills fear in its most potent form, and it raises the question of faith.

I stared straight ahead at the IV fluids racing quickly into her blood.

Wide open, we call it, when we allow the IV fluids to freely drip in at an uncontrolled rate. Wide open, like my tear ducts. I looked at her and then back at the physician, waiting for someone to break the deafening silence.

Finally, the physician spoke. “I know that’s a lot to take in. Do you have any questions for me?”

She shook her head.

The physician stepped out.

She dropped the bomb, asked a shaken patient if she had questions, and then turned and walked out. I could have followed, but I didn’t.

In nursing school, we are taught a great deal, but not enough. Everything comes from textbook protocol. Did these books and

classes teach me how to recognize the signs and symptoms of colorectal cancer? Sure, but these were also the same resources that taught me to respect each patient’s intimate zone (0 to 18 inches) and to be sure never to intrude on that zone without first obtaining the patient’s consent. This always struck me as unrealistic, but it wasn’t until I was in this moment that I learned how truly impractical the idea was.

Nursing school also teaches how vital it is to demonstrate compassion, yet they deter us from displaying any sort of emotion about a patient’s condition. The world of textbooks and PowerPoint presentations is quite different from the realm of clinical practice. I stood up, and, disregarding much of what I was taught in nursing school about the nurse-client relationship, I said, “Would you like me to stay with you?”

She nodded.

Without asking for her permission, I held her hand and listened to her talk. I started to cry, but then I quickly grew embarrassed enough that I turned around and began fiddling with the blood pressure cuff, cardiac monitor, IV tubing, and anything that would hinder her from seeing the tears welling in my eyes. With just a few minutes left of my shift, I told her I would be back after I gave a report to the oncoming nurse. I’m sure the patient thought it was an excuse for me to leave because my shift was over.

I walked out, and a colleague, who had noticed the look on my face, asked if I was okay. I told her how I thought I had messed up by allowing my emotions to get the best of me in front of a patient. My colleague, who had lost her mom to cancer two years before, told me that what I had done was far from shameful. In fact, she said, it was beautiful and something the patient would probably never forget. I trusted her.

After giving my hand-off report to the day shift nurses, I went back into the exam room and sat with my patient. I listened to her some more; I heard stories about some of her most difficult times, such as the sudden loss of her husband a year ago when he went to the bank and never returned because he suffered cardiac arrest.

Then she talked about some of her happiest and proudest

moments, such as times spent with her mother, children, and granddaughter. I watched her face light up as she pulled up photos on her cell phone to show me.

She then went on to ask me if I was working the following day. I was. Knowing that she was being admitted to the hospital and she wouldn't be in the ED when I reported for my next shift, she asked if I would visit her.

"Sure," I said, and I smiled — another choice of mine which nursing school would strongly disapprove of.

Nursing school did teach me something quite valuable and something that continues to resonate as I go through each shift as a novice nurse: The most I will ever learn throughout my nursing career will be in clinical practice, especially during my first year.

I was warned that even with all you have learned in school, there will be moments when you reach a crossroads, unsure of which route to take. I have learned that what to do in certain situations cannot always be taught, but rather you must rely on instinct.

Nursing school didn't prepare me for the moment when I was going to cry with a patient after she had been given perhaps the worst news of her life, nor did it teach me how to love a patient during her weakest and most vulnerable moments.

As a nursing student, I was cautioned that there could be a day when my decision might be the only thing standing between a patient and the grave, but I was never told that there could be a time when I would be the only person standing between the very delicate, almost nonexistent, margin of space that separates a patient's sense of dignity from her feelings of worthlessness.

When I returned home from my shift that morning, much later than usual, my mom inquired, "Why are you so late today? I couldn't imagine that you hit traffic now; the roads must have been wide open."

They were, but so were my arms and heart.

Zabella Simos, RN, is a nurse in the Emergency Department at North Shore University Hospital. Outside of nursing, she loves soccer, exercising, the beach, traveling, and spending time with family and friends.



Calm Before the Storm

JENNIFER RAHMAN

Jennifer Rahman is in her third year of a psychiatry residency at the Zucker Hillside Hospital and Northwell Health. She will be starting in the New York-Presbyterian Hospital Child and Adolescent Psychiatry Training Program in July 2018. This photo was taken in Flamenco Beach, Culebra, in Puerto Rico.

Decade of Asclepius[Excerpt from *A Sonnet's Soliloquy*]

Sonnet LXXV

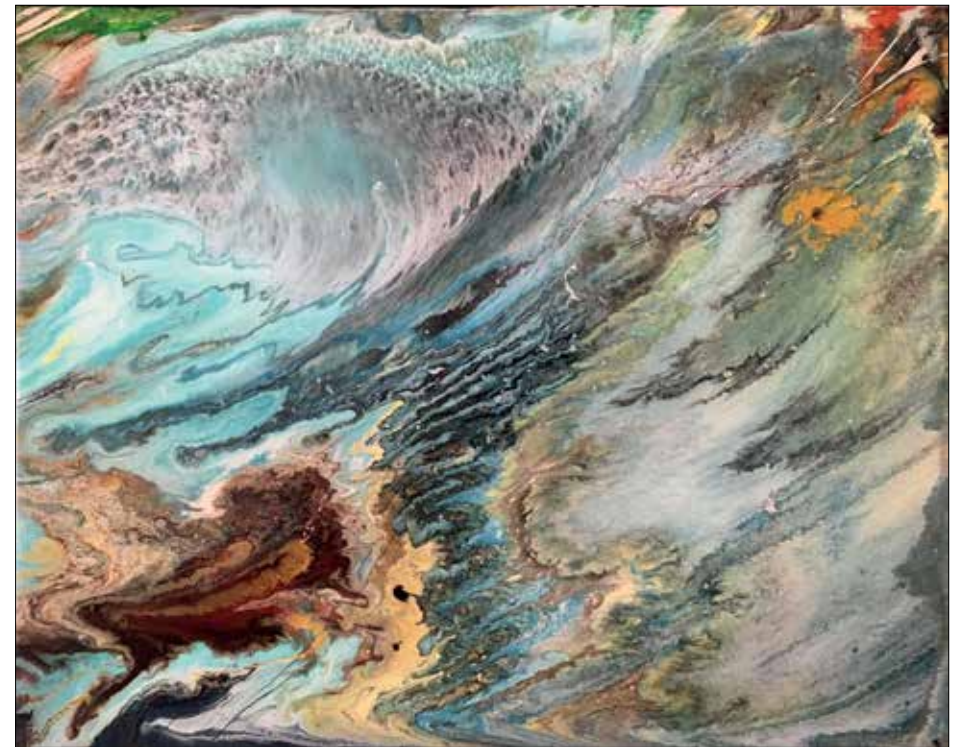
The majesty and beauty of our craft
 Is echoed in the gruesomeness it wears,
 A badge of courage worn by warriors staffed
 In battle 'gainst the suff'ring mankind bears.

No conflict ever knew a broader field,
 To touch all living souls in every land,
 Nor any other enterprise could wield
 All human motions firmly in its hand.

For beauty is not found in pleasantries
 Or struggles where the ends are quick and clear,
 But rather glory is complexity,
 And grace, the taste of solace earned from fear.

Still, no man is as fortunate as I,
 To labor in this craft, boundless as sky.

Robert Pena is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He is a lifelong Long Island resident and attended Cornell University where he received his bachelor of science and master's in engineering degrees. He is an avid writer and is currently working on a historical fiction novel, a high fantasy trilogy, a book of sonnets, and other small projects.

**Awaiting the Storm**

ELLEN PEKAR

Ellen Pekar is a third-year medical student at the Zucker School of Medicine at Hofstra/Northwell. Her painting is fluid acrylic on canvas.

Perfection

I rode the city bus home after high school baseball practice. I always sat in the last row by the window. I knew that when we turned onto Bainbridge Avenue, the bus passed a building with metal grates over the windows. On the sidewalk in front of the building stood a man with his tongue thrust forward, white foamy spittle on his chin, his shirttails out of his pants, whirling his fingers and talking to himself. A woman stood next to him, rocking frenetically to an unheard beat. She clapped her hands. She took long drags off a cigarette. Their bizarre appearance and behavior disturbed me. I didn't understand why they looked or acted that way. I thought what they had might be contagious. I looked away.

A few years later, a friend told me he worked with developmentally disabled adults, and the organization needed lifeguards. I was looking to make money during college, and although I wasn't sure if I could work with disabled adults, poverty was a motivator. I told him I'd go check it out.

He said, "They're fun, like big kids. They love swimming, and they'll love you unconditionally once they get to know you, and you know them."

I rounded the corner onto Bainbridge Avenue for my interview, and I was 17 again, on the bus.

I walked through the doors and into my new job. A week later, I drove the clients to a swimming pool at Bronx House. In the summer, we drove to Pleasantville. I learned that the clients' movements and sounds had meaning. I discerned the differences among the sounds people made; speech clearly enunciated but harried, grunting for joy or dismay, and at times, the grinding of teeth due to tension. I grew to love the way they greeted me with hugs and joyful hellos. They'd say, "Hello, Beel." Caroline, one of the clients in my care, was in her thirties and had large expressive eyes and luxurious brown skin. She liked her hair in cornrows and carried her pocket-book under her arm like a football. She greeted me with her hand under her chin, palm up, her other hand on her hip telling me, "I'm in a good mood; I'm in a good mood, Bill McCabe." Joey skipped

and hopped over to me, his undulating utterances greeting me hello. Michael spit his rap, "My name is Michael, my name is Sweet, I rock to the body, I rock to the beat. Ronald Reagan counting all his money," his voice trailing off into silence as he lumbered away, his giraffe-long legs taking him down the hall.

The clients were in their thirties and forties, no longer children but still childlike. I thought of them as kids despite their age. They interacted with the world with such innocence, and they could care less that they were invisible to the world around them.

My wife's belly was growing, and at 18 weeks her doctor delivered the news that the baby had Down syndrome. She called me crying. I couldn't understand what she was saying. Her crying got louder, and she took a deep breath and said, "The baby's got Down syndrome." I wished I were home with her. We were both crying now.

On my drive home, I thought about Caroline and Joey and Michael. My wife and I fell into each other's arms. We held tight, and we didn't want to let go. We knew enough about how life can change in an instant. My wife was a police officer, and I was a paramedic. This was our moment.

We didn't consider not having our child. We discussed the diagnosis with family. My in-laws thought we should abort the baby. "Who's going to care for it?" my father-in-law asked. My parents said we had to keep the baby. "Abortion's a sin," my mother said.

When Nunzi was born, family and friends offered condolences rather than congratulations. "Why are you sorry?" I asked. They couldn't see beyond her diagnosis to her innate beauty. I wished they had been with me during college when I fell in love with my clients. In their fear, they couldn't imagine Nunzi having a joyous life.

Doctors described Nunzi in terms of her Down syndrome. "She has low-set ears, her hands have a simian crease, her tongue is unusually large, her heart has a large hole and is missing a valve, and of course she's not going to be able to live like a regular child."

My wife and I saw past our daughter's diagnosis. We loved the way she felt in our arms. We loved the way her tiny hand fit in our palms. We loved the way her blue eyes looked up at us. We were opti-

mistic for her, even with her medical challenges.

At six months old, Nunzi underwent open-heart surgery to correct the large hole and create a valve. During the months leading up to the surgery she required regular doctor and emergency room visits, and a stay in the ICU. We brought her to her doctors' visits and slept overnight in the hospital when she was admitted. We had bruised bags under our eyes. Emotionally, I had trouble balancing my role as father and paramedic. Each day caring for her posed new hurdles: a feeding tube at three months, transient fevers that baffled her doctors. Then, there was the open-heart surgery. More than once, I parked the ambulance outside our own house to replace the feeding tube dislodged by Nunzi's coughing, or stop her from pulling the tube out of her nose. Gradually, my world became smaller and smaller. My roles were difficult to differentiate. I became numb to my emotions, the way I did at work when I was confronted with successive tragedies. But as wasn't the case with ambulance calls, I couldn't walk out of this situation. I was terrified of losing her.

Thankfully, the first year of her life passed. I was glad it was behind me, although she still had some health challenges in front of her. Despite the challenges, I never second-guessed our decision to have her.

I've never second-guessed because Nunzi is my butterfly. Everything she does lightens my mood and brightens my day. When I picked her up as a baby, her little hand patted me on the shoulder instantly a sense of calm passed over me. Today, when I arrive home, she runs to greet me, "Dad Bill home!" She gives amazing hugs. Her laughter floats through my home like a symphony. Other times, she sits pensively, learning her words or trying to figure out a puzzle. Her spirit lightens mine and rests in me. She is now 21-years old.

I often recall what a friend said when I worried about her learning. "She's not here to learn, she's too evolved; she's here to teach."

William J. McCabe, RN, is a registered nurse with experience in pediatric intensive care and emergency nursing. He is currently retired and actively involved in caring for his daughter, Nunzi. Professionally, he is focused on writing narrative nonfiction.

Migraine

My grave has been dug
and the shovel is bashing
my skull to pieces.

Mia Herman received an MFA in creative writing from Hofstra University in 2013. Since then, her poems and essays have appeared in numerous publications, most recently the Bellevue Literary Review and Minerva Rising. She is the outreach director for Tethered by Letters (TBL), an international literary nonprofit and independent publisher. She is also the creative nonfiction editor for F(r)iction, TBL's triannual print publication.



Chasing Sunsets

ANUP SONTI

Anup Sonti is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He is an avid outdoors enthusiast and in his free time enjoys nature photography, stargazing, hiking, and backpacking.

Foggy Day

BARBARA HIRSCH

Barbara Hirsch, MD, is an endocrinologist and partner at North Shore Diabetes and Endocrine Associates, and a clinical assistant professor in the Department of Medicine at the Zucker School of Medicine at Hofstra/Northwell.

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Saying Goodbye to Elizabeth

Elizabeth died in a snowstorm. I remember that day very clearly. There was a threat of a blizzard, the coolness of snow lingering in the air. I had a feeling of uneasiness, as many of my home care patients were depending on me to care for them that day. My car was already stocked with medical supplies, along with a shovel, a blanket, snow boots, an extra hat, and a pair of gloves. There was also a case of water. As a veteran home care nurse of 25 years, I knew how to prepare for an emergency.

I carefully examined my list of patients. I had Elizabeth scheduled for late afternoon. I called her mother to make sure that it would be okay. She was stable, for now, her mother said, and she promised to contact me if there was any change in her status. Glancing at the time, thermos in hand, I set out to start my day.

Traveling from one patient to the next, I was rewarded with their expressions of gratitude simply because I had shown up. I was helping them, not only with their wounds, medications, or a listen to their hearts. I was there holding their hands, offering warmth on a cold winter day.

Finally, in mid-afternoon with five inches of thick snow packed on the ground, I was in my car and headed to see Elizabeth. I planned it this way so that I could devote the remainder of my day to her. I knew that I would not be leaving her side until the end of the storm.

Elizabeth was a 43-year-old patient who had been battling metastatic breast cancer for several years. I had been caring for her for a year. I was with her through chemotherapy, radiation, and multiple rehospitalizations as the disease cursed her body with a slow, torturous deterioration, yet, in the midst of it all, a surge of immense spirit and strength emanated from throughout her person. She did not waver, not Elizabeth. She loved life, that much I knew about her. I saw her strength and spirit every visit. She was a true warrior. When doctors wanted to

put her on home hospice, she said no. I knew it wasn't because she was afraid of dying. I knew that she wanted me to keep coming. She was facing an ending and didn't want any more beginnings, especially with a nurse who would be tending to her during last few months, then weeks, then days. And when that day was upon us, she had her mother call and simply say: "It's time. Please come."

My car had been stocked with supplies for the living. Now, I would need resources to help my patient say goodbye to those in her world, including me. Elizabeth was my hero. She showed me what it is like to be courageous and compassionate. I knew this would be the end of our journey.

I was at her front door, and already my knees were giving way and I wanted to cry. I greeted her mother. We hugged as she shook in my arms, allowing her tears to flow. She brought me to her daughter's bedside. I reached down and embraced my beautiful, dying patient. Releasing my grip, I realized she had fallen into a heavy, peaceful sleep. Her bed was surrounded with flowers and her favorite stuffed bear. The soft rise and fall of her chest gave me solace in knowing that she had truly waited for me.

I touched her cool hand, gentle like mist. She knew I was there. She did not open her eyes but weakly squeezed back and turned her lips upward in a soft smile. I thanked her for waiting and continued to hold her hand for a long while, guiding her to move toward the light. As her breaths became shallower, holding her close, her mom and I coached Elizabeth to look for the family members that would be waiting for her. Gasping her final breath, she fell back softly. There was a look of tranquility on her face, an aura that left no doubt Elizabeth was at peace.

Her mother and I waited for the funeral director to come. A foot or more of snow had fallen, and I knew I needed to be on my way home. Quickly retrieving my shovel from the car, I began to clear their walkway. I was glad that Elizabeth's mom could only see my back from her window as I shivered, not

from the bitter cold, but from weeping as I grieved for a soul taken way too early in life. The cool snowflakes dissolved as the hot tears flooded my face — tears that flowed throughout the last 12 hours of the storm.

Susan Riekert, RN, is a nurse educator at Northwell Health at Home. She teaches nursing at Queensborough Community College and has recently been accepted into the PhD in nursing program at the CUNY Graduate Center.

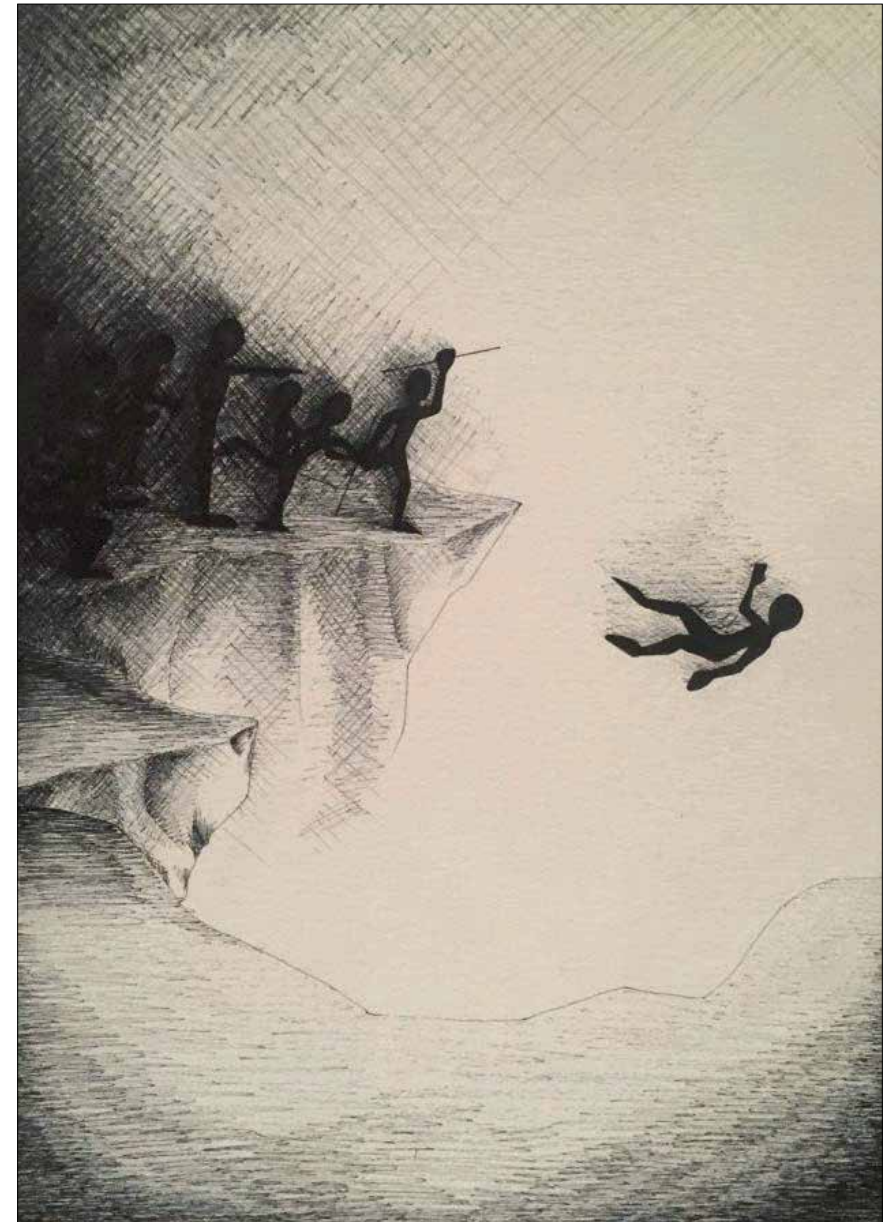


Nighttime in Shanghai

WENJING CHEN

Wenjing Chen is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell. She was born in Shanghai, China, and moved to America when she was eight. She majored in economics and minored in biology at Dartmouth College, and she spent two years conducting research at the Clinical Center of the National Institutes of Health before entering medical school. She enjoys painting in her free time. “Nighttime in Shanghai” was inspired by one of her recent visits.

NARRATEUR



The Dive

AMANDA LASTELLA

Amanda Lastella is a second-year undergraduate student at Hofstra University. She plans on pursuing a career in creative art therapy. She writes, “‘The Dive’ is based on a short piece I wrote a few years ago. It’s meant to demonstrate the difficulties of letting go of past events or problems, along with the importance of moving forward despite obstacles in your path.”

The High Priest of Xango

It was a cold and damp December when I took the call from the daughter of one of my patients. Her mother had had a series of severe complications, and she was now a permanent guest in the Intensive Care Unit. She'd been with us for over 18 months, and she remained critically ill. There had been so many setbacks, including coding events that had led to several CPR saves. She was a fighter, and she had let it be known that she had signed on for our all-inclusive package. Try everything, she said. And we did.

The therapeutic short list did not include a High Priest of Xango. "Can I bring the High Priest of the Xango Rite to pray for my mother?"

The family and I had a strong rapport. She'd been my longest patient on the Critical Care Unit. I knew by the vibrant costumes worn on occasion by family members that they practiced an ancient African discipline. Somehow, religion and medicine came together on that dark December evening. The two danced around us during a conversation on advanced directives. She asked that question. I said: "Why not?"

The following day, the high priest showed up at the nursing station. He was casually dressed. I introduced myself and said that I was expecting him. (I wasn't.) His voice was very gentle. He asked for permission to change into his priestly attire and enter the patient's room. "Of course," I said, nodding. He took out a long red and white robe and put his arms through it. Within seconds, he was incarnated into a monk from the Dark Ages. He picked up a weathered suitcase, walked to the room, and disappeared inside. Five minutes later, I followed his tracks.

The air was thick with the smell of cooked okra and fruit. An altar had already been erected with red and white colors, assorted pictures of saints, fruits and vegetables, and palm oil. I was about to be part of a ritual, and it seemed like the right thing to do. The patient was in her bed. Her niece was by her side. Rose, a physician assistant, was standing with her mouth open by a wall.

Maria, a nurse, was inching close to Rose. Maria's face was hardened like a cast.

I thought Rose looked too uncomfortable and could get in the way of this religious offering. I asked her to leave. Maria, who had clocked 25 years on the ICU, turned to me and said curtly: "Do not touch my patient. I am leaving to take care of sick patients. In all my years..." She made a sound of disgust.

The priest and the niece started humming a melody, which then turned quickly into chanting. They started singing and dancing. The ceremony finished with praying and saluting the deity by lying face down on the floor with arms extended at their sides, still singing.

I stepped out of the room as their singing was getting louder. I thought about the time a family member had lit incense in the ICU and caused a small fire, which set off an alarm. Her husband's airway collapsed, and I later had to explain to the chief resident why this intern (me) had allowed incense on the ward. On this new day, I said a short prayer of my own to the High Priest of Xango.

Please, I shouted in silence, no incense.

After a while, the niece came out of the room, and announced that the priest had achieved ecstasy, and would require some time for meditation. I was happy that the chanting, singing, and dancing were over. I welcomed the silence. The nursing staff remained understandably alarmed and started asking questions: "What's going on?" "What's all the racket?"

There was an excitement to the discussion. We talked about how this patient had coded many times and had always come back stronger and able to talk immediately after the event. Although we were very proud of our resuscitation efforts, it surprised us that she always came back to normal, seemingly with no complications.

The priest emerged exhausted and gaunt. He asked to speak to me privately. I was intrigued by how dancing and singing in the ICU could make someone so tired. He was spent and pale, as if he'd just finished a marathon.

He attempted to answer a question I did not ask: “I know my disciple has died a number of times and has always come back from the underworld.” I began praising the nurses and staff for their interventions and resuscitation efforts. He said in a deep and tired voice: “You are wrong! The reason she cannot die is because she has two souls!”

I pretended to understand, assuring him that it’s normal for a patient not to die in the ICU when he or she has a metaphysical problem of this sort. He continued to calmly explain that her body had been the home to a second soul since her sickness, an evil soul. This evil soul did not allow her to die.

His next words almost took me to the ground: “We need to perform an exorcism, now!”

The unit was not busy. It was night and the weather was awful. I admit I was curious. An exorcism? I agreed on the condition that there could be no shouting or disturbing other patients. The priest and the niece left the unit. An hour later, they returned, dressed in red robes. The priest had another well-worn suitcase. They walked into my patient’s room, and the priest tied a red string around the hospital bed, which he said was “to hold in the good soul and protect us from the evil eye.”

I stood in silence in the back of the room. Singing began. Bodies contorted. Arms and legs seemed to have a life of their own. The priest opened the suitcase and extracted a turtle, a chicken, and the head of a goat. They sang over these animals and the patient. I felt embarrassed being there. I was, after all, a doctor in the middle of an exorcism. I thought it was time to leave. As I got to the door, I turned and reminded them not to forget to take the chicken, the suitcase, and the altar with them when they left.

A few minutes later, the robed couple appeared and asked if there was a grassy area nearby. I directed them to a door at the back of the ICU that opened onto the street. They walked toward the exit. Maria remained silent and distant.

They returned together the next day. I was informed that three days from now they would have to complete the exorcism. When

I asked if live animals would be necessary, both answered at the same time: “The animals are dead and buried.”

They explained that they were now required to “unbury” the animals, and only then would they be able to initiate the second and concluding part of the ritual. I was on call that day and worried about what would happen during this part of the ritual. Still, I nodded my head.

At midnight three days later, the niece and her priest showed up with their robes, a suitcase, and a bag. Maria was on duty that night, taking care of the patient. She looked me in the eye and offered me one challenge: “Don’t you dare mess up the bed.”

The red string went up. The two of them lay down at the edge of the bed and began chanting. The goat’s head appeared. With circular motions to the rhythm of a song that sounded like a samba, they proceeded to place the goat’s head in the leather suitcase. The heads of the chicken and the turtle lay there waiting for the third head.

“The deed is done. Our beloved sister has one soul. She can rest now,” the High Priest of Xango said.

I stood in the back of the room, thinking about what had just happened. As the priest walked out the door, the patient died.

Rafael Barrera, MD, is director of the Surgical Critical Care Service at Long Island Jewish Medical Center and associate professor of medicine at the Zucker School of Medicine at Hofstra/Northwell.

The Last Place on Earth

Her hand grasps the white rumped sheet
 I notice the paleness
 Her eyes open when I say her name
 but they don't look anywhere
 Her lips seem to form words
 but the words are inaudible to me
 Does she know where she is?
 Does she know where she's going?
 My presence feels like an intrusion
 on her last days and hours
 I touch her hand and say goodbye

Eva Turel, RN, is a palliative care manager at Glen Cove Hospital.

Blue Numbers

They faded into her skin like ink on wet paper.
 Etched with disdain, they echoed a dark shadow,
 an evil tattooed upon our consciousness.
 I take care as I glide my hand over them,
 feeling shame and great sorrow.
 Stories forever silenced, but not forgotten.
 Tears well in my eyes for this stranger
 as I wash her body, brush back
 her silver hair, and seal the zipper shut.
Baruch dyan ha-emet
 It is her time.

Jean O'Connor, RN, is a nurse in the PACU at Northern Westchester Hospital. She is married with three children. She is pursuing her master's degree in nursing education and loves to write in her free time.



Context Clues

DENNIS KESELMAN

Dennis Keselman is a third-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He is interested in languages, the humanities, and the mind. He is from Staten Island, New York, and attended New York University for his undergraduate studies. He writes, "Overcoming sickness teaches us about ourselves and what we value most. This Norwegian glacier is fighting its own sickness, struggling to stay alive high in the mountain. But as it struggles, its illness is causing it to send nutrient-rich glacial water to the surrounding environment, creating an even more beautiful and lush dimension to its existence."

Delirium

“Hello.”

He nudges the patient sleeping in the bed before him. “Sorry to wake you. Sorry. I hate to wake sleeping patients, but I have to talk to you.”

He nudges him again.

The patient stirs, stretches.

“Yes? Who are you?”

“I’m Dr. Martin. I’m the consulting psychiatrist. I have to talk to you.”

“Really?” the patient answers. “I’m Dr. Martin. Are we the same? I don’t think so.”

“No, not really,” the doctor answers. “I’m Dr. Martin and I’ve come to interview you.”

“Where am I?” the patient asks.

“You’re in a hospital and you’re ill. I’m a consultant. I’m a psychiatrist. I have to ask you a few questions. Sorry to wake you.”

The patient mumbles something.

“Yes, what did you say?”

“Nothing important. You say you’re Dr. Martin? You have the same name as mine? What is the matter with me?”

“You’re in delirium.”

“I’m in delirium? Really? How do I know that? How do you know that?”

“Well, I’m a psychiatrist and I know delirium when I see it.”

“How do you know we’re both not in delirium?”

The doctor laughs. “Yes, I suppose we both could be, but I’m standing here before you and I’m going to ask the questions. Will you answer them for me?”

“I can hardly refuse. You’re doing my job, except this time you’re the doctor and I’m the patient.” He pauses. “Am I dying?”

“No, not at all. You have low sodium, your BUN is elevated, and there are some minor liver issues. All of these have given you delirium, but I think the medical team can correct these things.”

“So, I am dying. At least, my death is proximal . . . or nearly proximal. Yours may be more distal. You are dying, too.”

“Don’t be pessimistic, Robert. You’re not dying, just delirious. However, this proximal distal thing; interesting.”

“Here’s the first question. Where are you?”

“I am in the land of illness and confusion.”

“Now, don’t be clever. I mean, what is the name of this place?”

“I know it’s not my house. I know it’s not my school. I know I’m in a bed but the bed can be anywhere. It must be in a place that’s normal for beds. How’m I doin’, doctor?”

“So you don’t know this is a hospital or the name of the hospital?”

“Oh, of course. I’m in a hospital. I don’t think I’m competent. I do think I’m dying. Delirium equals death, no?”

“No, no, not at all. Delirium is not death. Far from it.”

“Well, then are you me and am I you? I mean, does delirium make all equal? In this sea of my confusion is some kind of humanitarian equality finally achieved?”

“This has nothing to do with equality, just a doctor and patient in a consultation.”

“Okay, I’m in a hospital. I’m in a bed. I must be ill. I am you and you are me.”

“Hardly. We may have the same name, but that does not make us the same. I need to ask, though: What day is today?”

“I don’t have a clue. There are seven days. This may be any one of them. If you already know I’m in delirium, why are you asking these questions? The answer is before you. I can’t answer them. I’m delirious.”

“That’s true. I suppose I don’t need to ask any more questions. The answer is apparent.”

“Doctor, may I ask a question?”

“Certainly. What would you like to know?”

“First of all, do you really have the same name as myself?”

“Apparently. It’s just a coincidence, but it’s still somewhat confusing.”

“And you are not delirious?”

The doctor laughs. “No, not at all.”

“Then, do you know where you are and what day it is?”

The doctor stares at him blankly. “No, actually, I don’t.”

Robert D. Martin, MD, is a consultation psychiatrist on staff at Long Island Jewish Medical Center. He teaches in the ICE Program. “Delirium” is a story about events that he often experiences as a psychiatrist on the medical floors. The mystery centers around the question of how we know the reality of who we are, and certainly what happens when we are seriously ill.



False Idols

CHRIS LU

Chris Lu is a third-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He has been photographing landscapes and people for almost a decade, with his technique and eye evolving as his destinations and subjects do. He is fascinated by the sun and the effects of its light, reflected in many of his works. He writes, "In the middle of the Salar de Uyuni, a vast expanse of salt flats in Bolivia, there are the remains of an ancient island called Isla Incahuasi, inhabited by a quirky collection of cacti, resembling a gathering of devoted worshipers praising a rising sun."

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Not a Surgical Candidate

She must have known this was coming. She was sick. Cachectic, a doctor would say. Eighty pounds, sallow skin, sunken eyes. Death permeated the room like a noxious cloud.

"I don't understand," she said. "I felt fine just a couple days ago." Supine on the gurney, she looked as helpless as a worm caught on the pavement after a rainstorm.

"You have options," said the young resident beside me. The patient must have been 40 years older than he, but his voice was the one with authority. She looked up at him with wide eyes, hopeful.

"Options?" she asked, her voice catching. "I'm not dying, am I? I don't want to die. I'm not ready to die."

She was negotiating with the ferryman at the Styx.

"Ma'am, you're very sick," said the resident. He stared into the distance. I knew he was thinking about the next patient we had to see. This dying woman was the first of several consults we had to make in the ER. She was a smoker. She had cancer. She had been on chemo. She must have known this was coming.

Her belly was taut, distended like a balloon about to pop. It cruelly protruded from her midsection like a pregnancy, but this would take life away, not create it.

"I don't understand," she repeated.

"Ma'am," said the resident, "you have an obstruction in your bowel. As I just told you, you're very sick." He paused for effect.

"An obstruction? Can't you fix that?"

The resident stared into the distance. I sensed he was frustrated. He did not want to be the one who told her that she was going to die.

"You have a choice right now. If you want, you can choose to have a surgeon operate on you. It would have many risks. You are very, very sick. You might not survive the surgery.

You might not wake up from anesthesia. It's an option."

"That doesn't sound like much of an option."

"I understand, ma'am."

Tears fell from the corners of her eyes and she let out a single cry. She had no family or friends present. We had no understanding of her journey before she showed up in the ER this morning. If her life was a novel, this was the last page, and our role was to let her know that it was ending.

"What is my other choice?"

I wanted her to acknowledge how sick she was; I wanted her to accept her fate. It was a sobering, jarring thought. Some day, would people be wishing the same things for me?

"Your other choice is to not have surgery. You don't have to go through all that. You don't have to suffer."

"What happens then?"

She must have known this was coming. "We make you comfortable," the resident said. "We give you pain medication. You can see your family. No stress, no pain."

"And then?" She turned from the resident and made eye contact with me, the medical student, for the first time. "Then what? I don't want to die. I can't die here like this, not right now. My mind is sharp. I was just out to lunch two days ago." Her eyes searched mine for any sign of hope.

She was lying on her back because her bowels were so inflamed that the slightest movement sent agonizing pain throughout her belly. Two days ago she was out to lunch. Today, she is dying.

"What would you do?" she asked me.

I looked to the resident and he looked right back at me. *Careful*, he seemed to impart. *Careful*.

"What my colleague is telling you is that you are very sick and the only way to fix the obstruction is with surgery. He's saying that it's your choice what happens next."

"That's right," the resident said, nodding to me. I hoped I had not overstepped my role as a medical student.

“But I don’t want to quit!” she cried, summoning a life force that had lain dormant during our visit so far. “I’m a fighter. I’m still strong!”

“I can see that, ma’am,” I said.

“I’m going to fight,” she said with a determined set to her jaw. “I want the surgery.”

The resident sighed softly. “You understand that there will be risks? If you choose to do this, we need to take you to the operating room within the next half hour.”

“I don’t care. I want the surgery.”

The resident nodded. Beneath this end-of-life conversation there flowed a silent river carrying the real message, one that was too harsh for her ears. She had not accepted it.

As the resident and I turned to exit the room together, the door opened and the attending surgeon strode briskly in, nodding at us. He introduced himself in a clipped sentence. “I’ve just read your chart, ma’am. Do you understand what is going on?” He walked up beside her and gently probed her belly, eliciting a gasp of pain. His eyes turned to the monitor reading out her vital signs. Her respiratory rate was high, her blood pressure low, her heart rate high, her temp high. She was becoming septic.

“The young doctors said it was an obstruction,” she said, tilting to look at the attending. “And we decided that I am going to have surgery.”

The resident made eye contact with me and motioned that we should step further back. I followed, and the noise of the ED became noticeable through the door.

“You’re right,” the attending offered. He pulled a chair to him and sat down beside her. His voice softened and he placed his hand on her shoulder. “It is an obstruction. But we’re not going to do the surgery. You’re not a surgical candidate.”

And there it was.

“So am I going to die?” she asked, the words clanging in my ears.

“Not right now,” said the doctor, “but sometime in the next few days, unfortunately, yes.”

The room became quiet, and I wondered if the woman was reflecting on her life. Was she well traveled? Did she speak other languages? Did she have children? I hoped she had accomplished goals that made her proud. I hoped that her thoughts were filled with those happy moments. Were there also things left unfinished, dreams unfulfilled? There was no more time for them now. It wasn’t fair; it was cruel, bleak, and sad.

She stared at the ceiling. Terrified of death, exhausted, lonely; I did not know what she was feeling. I worried I had given her a moment of false hope. Was I too uncomfortable with this woman’s fate to give her the one answer she needed, the truth?

It did not matter if she knew it was coming.

Kristoffer Strauss is in the 2018 graduating class of the Zucker School of Medicine at Hofstra/Northwell. He will be starting a psychiatry residency at San Mateo County Health and Recovery Services at the San Mateo Medical Center in California.

Blank Slate

It was 40 minutes after noon,
My preceptor was running late,
So I stood by the nurses' desk,
Making small talk during the wait.

Twenty minutes crept by
Before the doctor finally arrived.
"Sorry," he said. "Plenty people
Out there can't drive."

Our patient was already prepped.
We'd get dressed and in we'd go.
It'd be my first surgery
But not his first rodeo.

We strolled into the locker room.
He tossed clean scrubs my way.
I wondered what it must be like
To do this every day.

We donned our scrubs together
And walked into the OR.
The surgical team was there —
All was going well so far.

The patient was on the table
With only her belly exposed.
I didn't see any movement.
She was sleeping, I supposed.

"Go say hi to her," he said.
I paused and looked at him.
"She won't bite," he reassured,
Then he tapped her lower limb.

Her head was behind a curtain.
I didn't realize she was awake;
Leave it to a medical student
To make such a novice mistake.

"Congratulations," I said to her.
She was happy, that was clear.
Her husband was by her head,
She wanted him to be near.

When I got back to the other side,
The surgeon stood me to his right.
"Don't worry," he said with a
wink,
"I won't let you out of my sight."

The procedure was soon under
way.
It began with one smooth cut.
And that is when I started to feel
The emptiness in my gut.

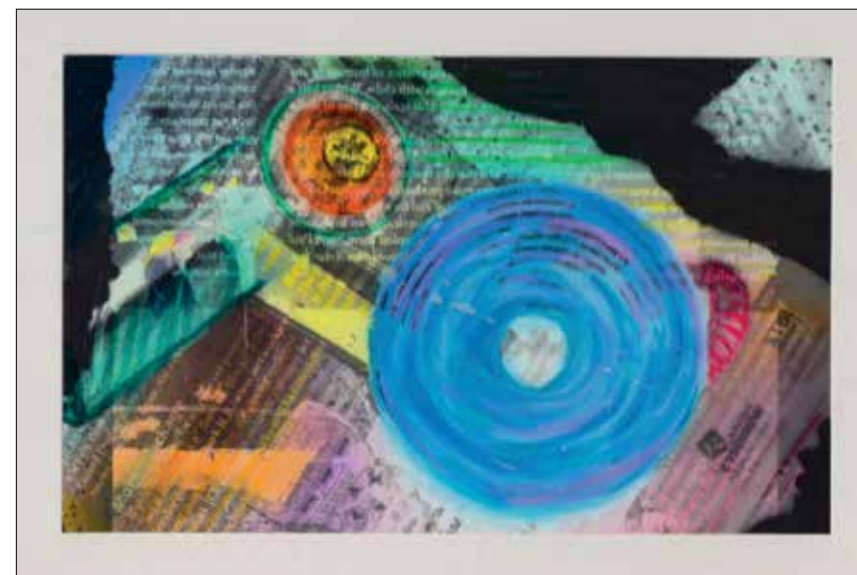
Skin and vessels were cauterized,
Muscles and fat held at bay.
Soon before my very eyes
The baby's crown was on display.

The doctor took hold of the head
And with a turn and pull and twist
The baby was out of the womb —
It could easily have been missed.

The moments before surgery
Felt longer than surgery did.
It was quick but violent,
The birthing of a kid.

I could tell why this was important
For a medical student to see.
But if that's going to be my
every day,
OB is not for me.

Roshawn Johnson, from the island of Jamaica, is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell. In elementary school, he was taught to experiment with rhyming schemes, and "Blank Slate" is a return to these earliest lessons.



Engine

JOLANTA BARBARA NORELLI

Jolanta Barbara Norelli is a sixth-year MD/PhD candidate at the Zucker School of Medicine at Hofstra/Northwell. Last August, she defended her doctoral thesis on the repair of Achilles tendon defects, and she plans to pursue a career in plastic and reconstructive surgery after graduation. She is the founder of the Art and Medicine Club and enjoys spending her free time painting and making costumes. This piece was created using multiple exposure methods with black and white photo paper, newspaper clippings, oil pastels, and color markers.

Ghost Limbs

An angel had been sighted on the ward. The reports had come on consecutive nights, from different patients. We do not normally concern ourselves with the patients' visions of the otherworlds. The epidemic patients are often delirious. But one of the patients had endorsed a visitation from the Angel of Death.

We were at the table in the canteen, eating breakfast, when the ward director found us. "He says it has wings," the ward director reported. "Or possibly many arms that move up and down speedily like wings."

The camp director sipped his coffee.

"Is he agitated?" the head of security asked.

"The patient is not agitated," the ward director answered. "He says the experience induced a kind of bliss. The creature hovered over him very close, as if inspecting him, and the patient declares himself now so ready to die that he is almost disappointed to find himself alive."

"Did it do anything besides hover?" the pharmacy manager asked between bites of sorghum porridge. The canteen door slammed. The cook clomped into the canteen, his arms laden with the mangoes he had picked.

The ward director hesitated. "He said it emptied his bedpan. It was overflowing."

The camp director made a clipped laugh. "Did it also clean up the spill?"

"Yes," the ward director nodded. "With its wings, or possibly many arms."

"How can it be the Angel of Death if it did not kill him?" the head of security asked, scraping a spoon along the skin of half an avocado. He licked the buttery fruit from the spoon.

The ward director shrugged.

"You have confirmed that it was not just a vision? It did something?" the camp director asked, a crease furrowing his brow. "Was it not the work of your staff that changed the bedpan?"

"No." The ward director looked down and shook his head. "The bedpan was empty when the medical techs came on shift this morning."

The ward director's reply prompted a pause. In the quiet, we all of us had the same thought: we need more staff. We are not in control of the funds available to our quarantine camp. Even at the meager amounts paid for our salaries, we are unable to stretch the budget to accommodate night staff. We tried 24-hour shifts, but the days off between shifts were not enough, and we at the camp are also human: We need sleep. Better, it was decided, to have the whole of the staff awake most of the time, then none of the staff fully alert ever.

"There is more." The ward director was nervous. His eyes shifted to the corner of the canteen. "Dressings have been changed. Pain medicine has been administered."

The pharmacy manager looked startled. "Narcotics?"

The ward director nodded. "From the safe. The correct amounts. Intravenously." He took a deep breath. "Charts have been updated. Unsigned," he added.

The camp director placed his coffee cup on the table.

"All this happened last night?" the head of security asked.

"Yes. Over the last two nights, perhaps. We, of course, did not take seriously the report from the first night, but after last night, I made a survey of the status of all the patients and found" He stopped, looking puzzled.

"The work of a real angel?" the head of security suggested with a smile.

"I do not know what," the ward director replied.

"Ah, but the patients must be frightened," the head of security reflected. "One patient claims readiness to die, and the rest will panic. You know how rumor affects them. We must calm them. They require an environment suitable to healing."

We all of us nodded. The susceptibility of the epidemic patients to believing the most fantastic stories was well known. They many of them hailed from villages with schools of poor quality. Some had never heard of a virus; the cause of their

hemorrhagic fever was a spell cast by a neighbor who is a wizard. Other patients insisted that the government had infected its own population with the virus to steal the funds intended for the villagers' benefit. Our doctor was accused of being a servant of death. With each influx of epidemic patients to quarantine, our ward staff was again charged with complicity in conspiracies to murder patients through the administration of nursing care.

Of course, we understood. Our patients were prey to a virulent plague. It is the nature of humans to witness the hands of gods and devils both in the experience of plague.

"Our camp will be closed if we fail the narcotics audit," the pharmacy manager said flatly.

"The investigation starts today," the camp director declared. He placed both his palms on the table. Amidst the collection of empty juice glasses, porridge bowls, and teacups assembled on the tabletop, his hands appeared powerful.

The head of security and I kept watch in the ward that night. He selected me because I am a survivor of the epidemic. I am immune. The head of security is not immune, but he is a man who experiences no fear. As specifications require of those not immune who enter the ward, the head of security wore gown, gloves, and face mask, and of course he touched no patients. He was protected, but also uncomfortable.

Perhaps for this reason he remained awake while I fell asleep on my watch. I slumbered peacefully in my chair for some hours. It was before dawn when the head of security woke me with a hand on my shoulder. Seated as I was, I was covered with a light blanket. I know not how it came to be there. But I had no opportunity to investigate the blanket's mysterious appearance because the head of security gestured with authority that I should follow. I was still groggy, but I thought I saw a patient getting into bed on our approach.

It was at this patient's bed that we stopped.

Her eyes were closed, but she was not asleep. Sensing us at her bedside, she opened her eyes. The expression on her face betrayed no surprise. She knew why we were standing over her.

Though, of course, I did not.

The head of security gestured again. Quietly, so as not to wake the others, she rose from her bed and followed us off the ward. Once outside, the head of security radioed to the camp director.

The patient walked between us to the camp director's office. I noticed that she walked with her arms stiffly held against her sides. Her upper body movement was most unnatural.

We stood outside in the predawn twilight under the setting stars and among the sounds of animals scuffling and a periodic rooster cry. Shortly, the camp director strode into view. He carried under his arm a chart. He wore a face mask, and a gown was slung over his shoulder. He was donning gloves.

"No, no, Effendi," the patient addressed him respectfully. "I am not contagious."

The camp director stopped abruptly and sized up the patient. Her facial expression was sincere, and her posture was sorrowful and apologetic. After a pause, he held up her chart: "Your rapid response test is positive."

"As it is for all who are immune," she said.

He frowned but peeled off his gloves. "Come in," he said, walking past us and unlocking his office.

The camp director waited for the head of security to take off his gown, face mask, and gloves, and for us all to sit, before he spoke. "Our head of security saw you doing things on the ward," he said. "I think the patients have seen you, too, isn't it correct?"

She nodded.

"You have accessed the narcotics."

She nodded again. "They were in pain. It was prescribed."

The camp director stared hard at her. No sign of arrogance or defiance was apparent. She seemed penitent and also seeking approval. It was a presentation recognizable among village females. They were often beaten.

"And you say you are immune." The camp director paused. The patient's eyes were very large, and trembled. The camp director's voice was concerned, sharp with his confusion, but

not unkind, when he asked, “Why are you taking a bed from an epidemic patient who needs one?”

“No, no, Effendi,” she protested softly. “Yes, perhaps to you it seems so, but no. I am here not doing such bad things as you say. I am a good servant. So much is not my choice it is as if nothing is my choice, but I choose to be a good servant.”

Her reply was curious. We understood that the patient, like all of us, spoke at least two languages, and that English was not her first. But her English might be very bad from lack of education. Unfortunately, the patient’s village was home to a tribe that spoke a language different from any we spoke.

The head of security attempted to clarify: “Why did you come here if you are not sick?”

“I was sick,” she said. “I lay on the woven mats in my family’s home hot with fever like desert sand at the highest sun, and my whole family, mother, father, sisters, brothers, aunts and uncles, and their children, all lay beside me, feverish, parched, weak and leaking and wracked with pain, and then bleeding, and then the quarantine officials came and transported us to the camp where they all —”

“— which camp?” the camp director interrupted her.

“Beyt Dakaatra,” she answered.

The camp director nodded. “Continue.”

“They all died,” she said simply.

We all of us inhaled. The death rates from the virus vary at different quarantine camps, as high as 90 percent in some. Much depends on the care provided to the afflicted. At Beyt Dakaatra, it was known that almost all died.

“I do not remember the camp,” she said. “I was in a coma for days, and when I woke up, my family was dead, and I had all these ...” her voice faded. We all of us watched her intently. “Effendi,” she swallowed thickly, “do you believe in witches?”

The camp director looked startled but answered without hesitation: “No, my child. There is no witchcraft in this world.”

“And if it were that I was a witch without intending so, would I be safe here in this camp? If it was the virus that made

me the witch?”

The superstition animating this question is common among villagers, and we are careful to withhold judgment from those at the camp. The camp director again answered briskly and without doubt: “Put your mind at ease,” he assured her. “We have no witch hunters here.”

“I woke up with all these arms,” she murmured.

We all of us required a lapse to comprehend her sentence. It was so unexpected. Accepting that we had heard her correctly, we scrutinized her. She had two arms. She wrapped them around her trunk, as if in a desperate hug.

“I see two arms,” the head of security said. “The normal number.”

“There are nine on each side,” she said with absolute resolution and, for a person who speaks with such conviction, it is so. “The staff at Beyt Dakaatra could not see them, either. I begged and begged: ‘Saw them off!’ Nobody wants a woman with 18 arms! A monster is such a thing! I pleaded with the doctor there, but he called me crazy, and because my fever broke he sent me away. I walked all the way back to my village, but they did not want me there. To them, all who contract the plague die. Those who return might be ghosts or demons.”

My heart contracted at her words. I have known the same rejection. It is like the sting of an acid scorpion. It corrodes for a long time.

“And” She looked around her, almost as if evaluating an escape. “And.” She looked at the camp director pleadingly, as if he might be able to help her say this difficult thing. He made an expression inviting her speech. It seemed to prompt her. “And the arms demand things. You understand. I have no family now. In my village, I carry water. But the arms do not accept that. They are capable. Strong arms. They call for work that is worthy. And I am immune now. I may care for the afflicted without risk. So I walked to a village where the plague was new. When the quarantine transport came, I played a patient, and it brought me here.

“I sleep at day so I do not trouble the staff, and I wake at

night to tend to the patients. This is the service the arms require of me.” She addressed the camp director in a piteous voice: “Please do not send me away, like the last camp. Let me serve. Give my bed to an epidemic patient. I will sleep on the floor. It is enough for me.”

The patient hung her head, and the camp director looked past her to share a knowing glance with the head of security and me. We are used to the delirium of the epidemic patients. This patient was not sick with the virus, but perhaps a habit of delirium had taken root. Our training is to respond to the person, not the delusion.

The head of security made a start: “Why didn’t you apply for a job here? Why did you pretend to be a patient?”

“I cannot read,” the patient answered. “I have no education. No training. Before the epidemic, I never left my village. I could never get a job here.”

Although females in the villages often cannot read, her answer perhaps had surprised the camp director. He was unusually emphatic in his objections: “But you make notations on medical charts. Administer narcotics correctly intravenously. You change dressings. You are a one-person night staff for the entire ward.”

“It is the arms,” she insisted. “They can do what I cannot.”

At her answer, we all of us felt the grip of frustration. Ignoring her delusion was a poor strategy; against our protocols, she was forcing us to respond to it. And while it is true that we live with the baobab tree in our midst, the “upside down” tree that plants its branches in the soil and stretches its roots to the sky, what succeeds for the tree is no example to emulate: turning the world on its head is not for us.

And, even as that resistance congealed into thought, now it was that I saw unfold, there, where she sat, wings. They were enormous, perhaps a half meter in length, and they were positioned oddly, affixed not to her shoulder blades, as angel wings should be, but growing out from her shoulder joints, from which her arms hung, because — I saw now — the wings were arms, gliding rapidly up and down, making the motion, almost, of

wings in flight. The exertion of these many limbs caused her own, two, human arms to unwind from her abdomen and fall open at her sides, while her sternum arched forward and her head tilted back, like she was the Nike of Samothrace embodied. At the sight, I felt an upwelling of joy, as if I had been absorbed into the ecstatic embrace of all my many 10 thousand years of ancestors.

An inexplicable demonstration it was, and of a piece with her other incredible feats, her tending to the patients with such impossible competency, and were of a nature to inspire the kind of trust that is called faith. The camp director it seems experienced the same revelation. Because what he said next was, “Owing to our budget shortfall, we can pay you only a stipend that will come as a share from my salary —” He held up a hand to stem her protest. “I will arrange it with our accounts manager. And I will make some accommodation with HR. You can begin work today but will attend the next medical tech training.”

The camp director then looked at me with a commanding expression that signaled his intention to task me with some responsibility. Without knowing what it was, I nodded my assent.

The camp director turned back to the patient. “And our logistics manager will teach you to read.”

Maya Alexandri is the author of the novel, The Celebration Husband (TSL Publications 2015); her short stories have been published in The Stockholm Review of Books, The Light Ekphrastic, Adelaide, Dime Show Review, and many others. “Ghost Limbs” will appear in her first collection of short stories, The Plague Cycle, which will be published by Spuyten Duyvil in 2018. She is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell.



Horseshoe Bend

EMILY CEN

Emily Cen is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell. She enjoys traveling and photographing natural landscapes.

A Lesson on Dying

Full disclosure: I am afraid of death. Yet I find myself aspiring to a career in medicine, a field where death is ever-present. Entering medical school, I realized there was a total shift in culture toward death. Death is commonplace. It is built into our weekly routine. One day a week involves hours of examining death in anatomy lab. We encounter dying patients during ambulance shifts. We perform CPR on patients who will most likely succumb to their injuries. We lose patients in our ICE offices. I thought that all of these experiences had made me numb to the pain of death. In fact, I really thought I was used to the idea of death.

But then both my grandparents were admitted to the hospital. And they were both dying. Being with them made me understand that despite our talk about death, we never learn how to process it in medical school.

My knowledge of medicine did not help me one iota when my grandparents were dying in the hospital. In the end, it did not matter that I knew the mechanism of action of the drugs that were fed to my grandparents to ease the process of dying. It did not matter that I knew the locations and relationships of the various organs of the body and their vascular supply. It did not matter that I knew the flow rates of nasal cannulas and non-rebreathers. I was terrified as I watched them pass away. They were not only family, but they were my first patients. I had taken them to their medical appointments; I had arranged their medications in their pillboxes; I oversaw their physical therapy at home; I called insurance companies on their behalf. I cared for them. I loved them.

I know losing family members is natural. And eventually, we will all lose patients. But witnessing the process of dying was so shocking to me. In the moment, a numbing hollowness crept up within me. I felt so incredibly small and frail, as if I were shrinking. I was surrounded by medical personnel and family, but I was alone. The sounds of the monitors and emer-

gency signals of death were so loud, clear, and ominous. My eyes welled up with tears that would not stop. Gone were the smiles that used to greet me every time I walked into the room. Gone was the warmth of my grandparents' hands that used to give me so much strength and protection. Gone was the sparkle in their eyes that were once filled with wisdom, mischief, and love.

I was faced with the empty husks of the two people I loved most in this world. I had lost my two favorite patients because I could do nothing to save them. I was utterly powerless.

Afterwards, the fear of death and that guilt consumed me and weighed on me wherever I went. In anatomy lab, I was no longer amazed by the complexities and intricacies of the human body. Dissections became painful reminders of what death looks like up close. Seeing ambulances racing on the road no longer filled me with curiosity about the patients' presentations and treatments. Instead, I could only visualize their suffering and the despair of their family members. Whenever I encountered an elderly patient in ICE who reminded me of my grandparents, I would no longer smile especially warmly; instead, I would struggle to hold back the tears. Stepping foot into the hospital became a new experience, because I was no longer enamored of the power of medicine and only saw its weaknesses. I could only focus on the death that permeated the wards. I felt I had lost the person who wanted to be a doctor his entire life. I was simply going through the motions. I too had become a husk of the person that I once was.

But after months of reflection, I realized that I had made meaningful contributions to their medical journeys — despite my limited training.

First, I assumed the identity of a doctor with whom my grandfather could openly discuss his fears about death. As my grandfather was dying, it was the very first time that he spoke to anyone openly about death. This went against every value in a traditional, superstitious Chinese household. In his

mind, I was no longer an innocent grandchild who needed to be shielded from the harsh reality of the world. I had become his confidant. At the time, it felt as if an immense burden had been placed on me, and after his death it weighed me down. Looking back, I hope that I shouldered some of my grandfather's anxiety and partially eased his transition into the next life. He told me that humans are like cars. No matter how much you love the car and care for the car, eventually it starts to fall apart. At first, bumps and scratches are easy enough to fix. The tires wear out, so you replace them. But once the engine starts to go, you have no other option but to junk it. He praised me for trying everything to fix the family's beloved car, but cars simply do not last forever. In medical school, we often talk about changing roles and taking on a new professional identity. I fully appreciate that now.

Second, I employed my empathy skills to help my parents and brother through their grief. Before medical school, I would not have had any idea how to approach such difficult conversations, but now reflecting, legitimizing, and exploring have become instinctual. I also realized the power of a physician's hand on the patient's shoulder. As I watched my grandmother pass away, her physician placed her hand on my shoulder. In that moment of desolation, I felt a spark of warmth and connection. So, as I explored my family's grief, I also established that connection with them. Furthermore, I used my medical knowledge to help translate the doctor's medical jargon so that they understood what was going on. Even though my limited medical knowledge could not change the outcome for my grandparents, at least I could help my family by removing the fear of uncertainty. I understood the power of the knowledge that we have acquired in medical school. In class, it can be difficult to appreciate what we have learned, but we have acquired an impressive arsenal of tools that can be useful in even the most demanding situations.

Death is just one of the certainties of life. But that does not necessarily mean that medicine is a futile pursuit. Over

the years, we will acquire such incredible knowledge and the skills to improve the health and lives of so many patients. But I realize now more than ever that our lives will intersect with the lives of our patients at their most difficult and challenging times. There will often be a limit to what we can do, at least medically. However, even in the face of incredible obstacles like death, we as physicians have so much to offer in terms of empathy and compassion. My grandparents taught me this invaluable lesson: There is strength in not being afraid of dying. Even when I can no longer treat or cure my patients, I have the incredible power and skills to comfort them and their families. And this art of medicine can make a world of difference.



Grandpa Grandma

JASON WONG

Jason Wong is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He is in the Art and Medicine Club.



Angry Lioness

JANA GALAN

Jana Galan, MD, is a faculty member of Glen Cove Family Medicine and loves traveling with her camera.

Foundation

Tears well in my eyes. It isn't even my cancer diagnosis. I am not giving this mother of two young children the devastating news. Observation is my only task. The breast surgeon warned me that this is a tough case. I think he tells me because he wants me to stay behind. He wants me to face the same nightmare doctors and patients face every day.

I stare at this temporarily broken young woman hunched over on the exam table in spasms of grief. I was not there when she was diagnosed with breast cancer. I was not there when she had one breast separated from the rest of her body. I was not there when she had a muscle from her back sliced and rotated into her chest in an approximation of her former resplendence. But I am here now.

It is one week after the surgery, and the pathology report indicates that her tumor is worse than everyone thought. Bad news does not wait for wounds to heal.

Quiet fills the room, punctuated by the low sobs of a mother worried about not being there to see her children grow up. Her husband sits by her, appearing stoic, but every few minutes rattling off questions, trying to determine what will happen next. One month is a long time to wait to wait to operate on the other breast, he says.

The surgeon is holding his patient's hand. His grip is soft and reassuring. He is more friend than surgeon. He says something, but it is too low for me to hear. He lapses into a pensive silence. He watches the raw emotions take over her body. He tells her that he is not giving up and neither should she. He will do whatever it takes to get her home to her children. At the end of the day, he will go home to his own two children.

Nature is not on this woman's side, but he is. At the end of the visit, the young mother lets out a timid gasp: "Thank you," she says. It comes from deep inside, with a power all its own. Her doctor tells her she needs chemotherapy. Again. She is thankful. I am thankful, too. Medicines and operations treat patients, but compassion heals them.

Countless numbers of patients receive shattering news from physicians every day. This woman has lived through it twice. The surgeon has lived through it — how many times? He is still battered by the ones he can't control. I watch this doctor. He doesn't crumble. He wants me to watch and listen. He wants me to dig deep and start building my own foundation so that I will not crumble.

Ryan Kaufman, MD, is a PGY 1 psychiatry resident at the Zucker Hillside Hospital. He wrote this piece during his third year of medical school, after a rotation with a breast oncology surgeon.



In Sickness (I Will Hold You)

IRINI TSOUNAKAS

Irini Tsounakas is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell. She writes: "This is a photo of my grandparents holding hands when my grandfather was in the hospital after having a small stroke. I thought it was a beautiful moment because it reaffirmed their love and showed what it truly means when a couple says the wedding vows of 'in sickness and in health.'"

A Shift in Perspective

Four. That's how many days had passed since I started medical school before I picked up my first EMT shift. Looking back, I'm not sure more time would have prepared me for it, but being so new to med school certainly didn't do me any favors.

I remember buckling myself into the one-person seat in the back, the crackling of the radio as it came alive, and the feeling of anticipation as we went speeding down the highway to our first call. It's a surreal experience being in the back of an ambulance—you almost feel removed from the world around you as the cars part to make way for your speeding vehicle.

Still in a daze from this new experience, I heard one of my partners yell from the front seat, "We've got an arrest!" I assumed he meant a police arrest and I yelled back, "What's the protocol?"

I remember him half turning to look at me, wondering whether he'd heard my question correctly, and then hesitantly replying, "Um, CPR?" Oh! A cardiac arrest.

I sat nervously in the back of the ambulance, kept company only by the anxious thoughts in my head. Would I be asked to step in while at the scene? Would I physically even be able to? What if I froze or had an adverse reaction and couldn't keep it together?

In what felt like seconds, we arrived at a small apartment complex where we spotted the girlfriend of the patient standing outside, crying and jumbling her words as she tried to explain that her boyfriend wasn't breathing. I watched as my partners calmed her down and asked her to lead them to him. I numbly followed them into the apartment, feeling as if my legs were propelling themselves. And then just like that, we were inside.

Time seemed to slow down as I took in the scene in front of me: papers scattered on the table, clothes on the floor, dishes piled ceiling high. A snapshot of the life of a couple who had no idea today was going to go the way it was going. Interrupting my thoughts were warm licks on my gloved hand. I looked down to see a black Labrador furiously wagging her tail and looking up at me. I couldn't help but feel a twinge of pity as I met her innocent

eyes. Did she have any idea what was happening to her owner, and why all these strangers were in her house?

I stepped into the patient's room, where he lay, already starting to turn a different color, his eyes bulging slightly and his body rhythmically moving from the force of the ongoing compressions. Every bone in my body wanted to turn away, but I stood there with my feet planted, shocked by my initiation into life as an EMT.

The basic life support (BLS) provider applying compressions indicated that he needed someone to take over. Then I heard my partner yell to me, "You said you learned how to do compressions, right? Take over compressions!"

The team members in the overcrowded room began to rearrange themselves to allow me to reach the patient, which pulled me out of my shock and spurred me forward. I positioned myself on the floor next to the patient and started compressions, the entire time very aware of this dying man's face less than a foot away from my working hands, his unmoving eyes fixed on the ceiling.

I felt the sweat collect on my face and body as I worked to keep the compressions at an even rate, intently aware of the other EMTs and the advanced life support (ALS) team, which had arrived minutes earlier, working around me to start a line and do their part to save the stricken man.

While we continuously rotated compressions, the patient was loaded onto an ambulance for transport to the hospital, at which point we handed off our duties to the members of the ALS team. I stepped back, watching the ambulance doors shut.

As I climbed up into the back of my own ambulance and into the one-person seat, I couldn't help but sense the difference in me from when I had first sat in this seat, a mere hour ago, more nervous and anxious than I had ever been.

As I silently watched the curious neighbors return to their homes, I now felt the challenge and burden of our duty, but also the immense privilege of the responsibility I had accepted the minute I put on my uniform. Above all, I was humbled by how much everyone had given in that moment to try to save the patient, all doing their parts in battling time to save the man's life.

Suddenly the radio crackled and a voice pierced the silence: “Four-6-George, we just received another call for you.” As the ambulance pulled away, siren blaring, I clicked my seatbelt and sat back, ready to see what the next hours would bring.

Amitha Kapyur is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell who was born and brought up in Southern California. She is passionate about social activism and majored in disability studies at Hofstra University.



Toucan

AMANDA FERRARO

Amanda Ferraro is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell. She is an art enthusiast and leader of the Art and Medicine Club. She writes, “‘Toucan’ is inspired by the contradictory nature of how bright colors are somehow soothing to incorporate into a piece.”

NARRATEUR

Healers

“We are going to Manhattan,” is what I said. I was on the phone with the EMS crew and ordering an ambulance to head west into the unknown, hours after the Twin Towers crashed to the ground.

I was chairman of the Emergency Department at Long Island Jewish Medical Center and medical director for our Center for Emergency Medical Services. We were eight physicians and nurses sitting in silence and trepidation as the ambulance cruised down what seemed like an abandoned Long Island Expressway. The city was stunned. We all were. We had no idea what we would see when we got there. We didn’t even know where there would be. We prayed.

As we left the expressway the city was in such chaos that we were forced to drive west. At Sixth Avenue we were stopped and directed to the Chelsea Piers in lower Manhattan, but I knew that was not where we should be heading. “Let’s go to the scene,” I said.

Very slowly, we made our way downtown toward what we soon would be calling Ground Zero. As we did, the clear, blue, sunny sky gave way to smoke and dust and the darkness of an early evening. It was little past one in the afternoon.

When we finally arrived at the Brooklyn Bridge, we carried what medical supplies we could and set up our humble emergency camp. Then, we waited for what seemed like an eternity. The streets were eerily empty except for a few uniformed officers. Where the towers stood, all we could see was a ball of fire.

Not long after we were settled, we heard a thundering crash and instinctively started to run. We had no idea whether we were running to something or running away. Streets were covered with sheets of white printer paper and an occasional shoe. The eight of us wore face masks but the dust cut through anyway. Amid the tumult, a lone boy on his skateboard sailed down the sidewalk, seemingly unfazed.

As far as my eyes could see, windows had been blown out. I looked at Brooks Brothers and remembered when I had shopped there. The lamps in City Hall Park had turned on, casting a somber glow.

We walked back to our station. A few firemen came by, more

for solace than for aid. We waited in silence for people to show up and need us. No one did. At about 11:00 p.m., we packed up our supplies and headed back to our hospital. The ride was so quiet I could hear my colleagues breathing. I kept thinking of June, a nurse in the ED, whose husband hadn't called her at 9:00 a.m. He always did. He worked at the World Trade Center.

I barely slept for days. People in my small Connecticut town closed their blinds and locked their doors. No one felt safe. We wondered whether we ever would again.

A week later, trying to regain some sense of normality, I set out for an art fair in a nearby town. There, I saw a man standing on the corner next to his painting of the Twin Towers. I wondered when he had painted it: before or after. No one would look at him. They turned their eyes from the towers. It was too painful.

I walked up to the artist, handed him some money, and carried away the painting, embarrassed but compelled to make it mine; I felt I should honor those who fell and died and all the people I couldn't and didn't save by possessing it.

As a doctor, I felt that this was my job, no matter what. I felt that I somehow had failed. I was despondent. When I got home, I put the painting in a corner of my living room. I cried. I am a physician, and there was nothing I could do to help. The way I felt was not unlike the way physicians feel when a patient is dying and we have exhausted our medicines. All that we have is our apologies, our goodbyes. It is not enough. It is never enough.

Damn, I am sad. Angry. I cry. I stomp my feet for social justice. We stood at the ready with our training and our supplies and no one showed up. It reminds me that there will always be times when we will have so much to offer and it won't matter. It will be just too late.

Dear students and colleagues and readers, never give up. We are healers. Work for a just society. Let that fire in your heart take you to the scene and harden and soften you to fight. Be ready to heal or just hold. Someone will always need you.

Thomas Kwiatkowski, MD, is professor of emergency medicine, medical director of the Patient Safety Institute, and assistant dean for education/simulation at the Zucker School of Medicine at Hofstra/Northwell.



Serenity

MARC SYMONS

Marc Symons, PhD, heads a research group and is co-director of the Brain Tumor Biotechnology Center at the Feinstein Institute for Medical Research. He likes to travel and is an avid photographer. This picture was taken at a sanctuary close to the entrance of Tenryu-ji temple in Kyoto, Japan.

Boxcars

They arrive at my exam room every four months, in their usual order. David walks ahead of his wife, Sarah, and greets me warmly. She is always an arm's length behind her husband, and he always holds her hand. She smiles but rarely has words for me, or anyone. It has been a long time since Sarah talked to the world. The day she lost her words was the day a Nazi soldier killed her sister and niece with one pass of a bayonet. She is on thorazine, which is still supplied for her courtesy of the German government.

David and Sarah have been patients for several years. Like his wife, David is a survivor of the Holocaust. I also knew him from temple. I saw David when we attended services, which, for us, was typically on the High Holy Days and for the occasional bar or bat mitzvah. David, though, was a regular figure at synagogue. He attended services twice a day, every day. He wore the *tzitzit*, as is commanded for Jewish men. He said his prayers, donned his prayer shawl and *yarmulke*, and followed Jewish law to the letter.

David and Sarah had their medical problem lists filled with the usual litany of diagnoses — hypertension, diabetes, hyperlipidemia, arthritis. Sarah's ailments were remarkably controlled and she was doing well, at least medically. David was also fine, with well-controlled blood pressure and lab work that was perfectly acceptable, until one day he told me, "My blood pressure medicine just doesn't agree with me any more."

He complained of abdominal pain that he experienced "every time I take my pill." He was so convinced that his symptoms were medication related that he refused my advice to check some labs to ensure nothing else had changed. We agreed to change his medication to one from a different class. I asked him to come back in a month.

"Doc, it just didn't help. Can you change it again?" he asked. I ordered a different medication, and there was still no improvement in his abdominal pain. But now he *looked* ill. His weight was dropping, and he was suddenly getting full after eating only

a small amount. "Maybe I don't eat so well," he confessed when pressed. I knew I needed to do a complete workup, even if that was the last thing on David's calendar.

He agreed to some tests. His labs revealed iron deficiency anemia, and his CT scan revealed a gastric mass with surrounding adenopathy. An upper endoscopy confirmed the presence of a large, aggressive gastric cancer.

His medicine wasn't making him ill. His cancer was.

I sat down next to him. I told him that he had cancer, and we discussed what we could do to treat him. When we had exhausted our words, he simply said: "Let things happen the way they will." He did not want treatment.

Two weeks later, he was lying on my exam table when he looked up at me and asked: "I'll bet you think I'm a religious man, don't you?"

For me this was questioning a basic truth. Does the sun rise in the east? Does the heart pump blood? Is David a religious man? "Of course you're a religious man."

"No," he said, "I'm not. In fact, I don't even believe in God."

"How can that be, when you pray every day, you wear the garments, you follow the commandments?"

"I am not religious, and I do not believe in God. And the reason is that if you saw what I have seen, listened to what I heard, smelled the ghastly odors of the camp, you would also know there is no God."

"But why do you do all that you do, attending synagogue, fulfilling the commandments, and observing like a religious Jew?"

"Because," he answered, "when we were in those boxcars, being taken God knows where, we each looked to our left and our right. And we swore an oath that whoever survived, for the rest of our lives, would say *kaddish* for the rest of us that died. And so, I do what I do to honor them and to keep my word. And not to honor a God I know doesn't exist."

Kaddish, the prayer for the dead. He said it every day, to keep his word, to his family and those he did not know who died during the war.

I saw David a few more times, and then he stopped coming. He wouldn't leave home, wouldn't answer the phone, and wouldn't come to the door.

He died within a year of his diagnosis, in his home and on his own terms. Knowing David, I know he continued to say *kaddish*, every single day, until he was unable to muster the strength . . . until *kaddish* was said for him.

Eric C. Last, DO, is clinical assistant professor at the Zucker School of Medicine at Hofstra/Northwell and practices at Northwell Health Physician Partners Internal Medicine in Wantagh.



Music and Medicine

ERICA NEUREN

Erica Neuren is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell.

NARRATEUR



Startled

EDMUND J. MILLER

Edmund J. Miller, PhD, is professor of medicine, molecular biology, and surgery at the Zucker School of Medicine at Hofstra/Northwell. He is also head of the Center for Heart and Lung Research at the Feinstein Institute for Medical Research. He writes: "The look on this bird's face reminds me of how people often feel during a physical exam."

Keppy

I can see you in this picture, swirling
around your mother's uterus,
punching her bladder and kicking

with webbed toes. They curl into the sand,
waves lap over your ankles
like a dog. Coquina clams dig beneath

our soles. And the sun scorches your keppy
and I douse it with lotion. It's just us

today, and Mom, setting
up the blanket close to shore. It is 2018,
40 years since Vang Pao, 60
since Marie-Benoit, and one year left of

medical school. Until then,
I will worry about your keppy

David Pflaum is a third-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He lives in the Rockaways, Queens, New York, with his wife and son.



PoPo's Hand

AUDREY LIU

Audrey Liu is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell who enjoys doodling, drawing, and just about everything art. She writes, "'PoPo' means 'grandma' in Cantonese. My PoPo ran a restaurant for years, and the physical stress exacerbated rheumatoid arthritis. Her disease was so severe that she had to close her restaurant. It is largely controlled now, but it permanently changed the shape of her hands. She often tells me her hands are ugly now and that she used to have very beautiful hands when she was young. I don't think they are ugly, so I thought I would paint her hand so that maybe she can look at them in a new light."

The Girl Like Me

I followed the oncologist into the room. It was morning, and the California sun was streaming in through the large windows. Three people stood in a corner across the room. Their smiles were bright and their moods positive. Sitting on the exam table was a girl, her legs swinging lazily. She shared the same calm demeanor as the adults who had brought her. She smiled, at everyone.

The doctor introduced me and asked if it was all right if I observed the visit. The girl responded, “Oh, I’m a college student, too. Of course, it’s okay for you to be here if I can contribute to your learning.”

With the introduction out of the way, the father commenced to talk about the reason for their visit. With a quick clap of his hands, he asked in a sunny tone, “So, doc, what’s the plan for getting rid of the cancer this time? Dr. S. sent us over. He said the tumor was too big to operate on right now so he wanted to try to shrink it with some chemotherapy, maybe some radiation. After it gets small enough, then he would feel more comfortable taking it out.”

I knew the story. Earlier, the oncologist had told me that the girl was diagnosed at 12 with osteosarcoma, a bone cancer. The treatment worked, at first. A few years later, her doctor discovered it had metastasized to the lungs. One of her lungs was removed. “She is still able to lead a normal life, but as you can imagine she can’t overexert herself with heavy exercise since she only has one lung. Today we’re going to see her again. It seems that cancer has come back again, showing up in her remaining lung.”

Now, in the room, he stood over his patient. He was serious, and his expression showed it. He leaned on the counter and crossed his arms. In a gentle but firm tone, he delivered an agonizing opinion. “I know that Dr. S. told you the tumor will shrink with chemotherapy and radiation, but based on my experience and what we now know, it is really hard for chemotherapy and radiation to penetrate a bone tumor. Dr. S. has been with you all since you were 12, and I don’t think he wants to lose a patient that he has known for so long. I just want to prepare you in case the treatment plan doesn’t work out.”

Her aunt hid her face in her palms and cried. The mother just stared

down at her hands, frozen. Her father’s smile faded. The girl like me no longer swung her legs. Her happy-go-lucky air evaporated, and what remained was a look of resignation. “I’ve beaten cancer two times. Can I beat it a third time?”

“It’s possible. Just know that starting chemotherapy will be draining on your health, and there is no guarantee that the tumor will shrink. I know I have said a lot, and I’m sure there are many things you must consider before you come to a consensus on what to do.” The doctor discussed the side effects and what to expect if they did decide to start chemotherapy. He laid out the best scenario, and the worst.

At the end of the visit, the family stood up. The father reached out to hug the doctor and thank him for his time and honesty. The mother and the aunt thanked us. The patient turned to smile at me. “I wish you the best of luck on your journey to medical school.”

The visit lasted 15 minutes. The lessons have become as powerful as the California sun that burned through the window that day. Strength. Resilience. Family. Honesty. Hope. Fear. Decisions. Respect. Courage. Sadness. Joy. Kindness. Empathy. Humanity. Love.

As I walked down the hall to see the next patient, I wondered if I would ever be strong enough to deliver such sad news. To say goodbye to hope. To be so honest that it hurt. Could I even do that? Would I lie or tell a half-truth to protect my patient and the family?

I never found out what happened to that girl like me. We were both college students, brimming with life and dreams. We were ready to leave the safe nest of home and go out into the world. She may not have lived long enough to dream big, but she has contributed to my life with lessons books can’t possibly teach. She still lives within me, this girl like me. She never knew that she taught me well. I am a better daughter, friend, and mentor, and I know that I will be a better doctor.

Julia Su is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell. As someone who wants to advance her leadership skills, she is the co-chair of four different clubs at school: the Latino Medical Student Association, the OB/GYN Interest Group, Medical Students for Choice, and Translation Medicine. She enjoys giving back to the community and created a new scholarship fund as the co-director-elect for the Northeast Regional Board of the Latino Medical Student Association this past year. She is constantly inspired by the amazing peers and faculty around her and hopes to make a difference in the world, one small action at a time.

Transparency

Mom, in an eighties Gap jean dress, photographed organs split underneath glass cases. She would splice cells, chromosomes, ventricles with a toothpick and painter's hands, creating watercolor replicas out of pieces of people, even manifest a whole being out of buckets of ice-cold kidneys, gray as bruises, lifeless in her hands like a squid pulled from wet sand. I'd shuffle through slides, hold them up against the light of the attic, the static spots fading to reveal flipped negatives of swirled tissue and platelet constellations. I would run my eyes along the edges, following the parts like watching pieces of a kaleidoscope drop.

Now, I bring her toast. Two white pieces, buttered, a bit of sugar over top, placing it on her nightstand while she lies in Old Navy PJ's, blinds half open, biting her nails, a morning show turned down low. She is fading into an imitation of herself, thinning, as if I could fold, crease, and slip her into an envelope, mail her back to 1986 and let her swim in muscle tracts, get lost in an aortic cave, press her arctic palms against the heat of the glass.

Sophie Herzing is an MFA student at Hofstra University with a concentration in poetry. "Poetry and I have always had a special connection," she says. "My poem revolves around the graphic design work of my mother in the eighties. She worked as a medical photographer in Pittsburgh. Looking at these slides in my attic, I came to admire her work. From that, I started contemplating what her life would be like if she lost that passion for creating. In this poem, I explore the life my mother never had in contrast to the vibrant life I see her live every day."



Lila Diáfana

ANDRE MAURI

Andre Mauri is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He writes, "My photo captures a pair of diaphanous pacific sea nettles abutting the radiant lilac display of a Kreisel tank in Ontario. I like to reduce subjects to a monothematic state, devoid of distraction. My subjects range from indigenous textiles and umber terrains to motifs hidden in nature and architecture. With the uniformity of each piece, I seek to offer viewers focus and visual respite."

“Le Cygne” (“The Swan”) by Charles Baudelaire*Translated from the French by Eugene Friedman*

To Victor Hugo

I

Andromache, I think of you! That shallow stream
Was but a sad blurred mirror which in long past years,
The immense grandeur of your widow’s grief made gleam;
That false Simois that was deepened by your tears,

Just now impregnated my fertile memory
As I was walking across the new Carrousel.
The old Paris is gone, consigned to history
(Cities change faster than the heart of a mortal!);

My mind’s eye alone can see that camp of barracks,
Those heaps of rough-hewn shafts and columns, the wild grass,
Those giant blocks, puddle stained green, the bric-a-brac’s
Reflection off the panes, the cluttered jumbled mass.

There, once, long ago, a menagerie was open.
There one morning, I saw at the hour when ‘neath fair
Cold skies, Labor stirs itself awake and workmen
Sweep their somber sandstorms into the silent air,

A swan who’d freed himself from his cage and escaped.
His webbed feet were scuffing up the bone-dry pavement,
His white plumes trailing behind in the dirt they scraped;
Near a dried out rut, his beak open, his neck bent,

Nervously bathing his wings in the dust, he spoke,
His heart filled with longing for his dear native lake,
“Water, when will you rain? Won’t you roar, thunderstroke?”
I still can see this sad, strange ill-fated myth shake,

And occasionally stretch his convulsive neck on high,
The very neck that held his yearning head erect,
Like Ovid’s man, towards the ironic cruel blue sky
As if he addressed his rebukes to God direct.

II

Paris may change, but my melancholy holds fast;
New palaces, scaffolding, old neighborhoods, blocks,
They’re allegory to me, symbols of time past,
And my dear memories weigh heavier than rocks.

In front of this Louvre, a certain image piles
Stones on me. I think of my great wild swan anew!
Ridiculous and sublime, as are all exiles,
Gnawed at by endless longing; then I think of you,

Andromache, from your entombed spouse’s arms ripped,
Debased chattel under high and mighty Pyrrhus,
Stooped in bowed ecstasy, next to an empty crypt,
Great Hector’s widow – but now! – wife of Helenus!

I think of the Negress, consumptive and wizened
Treading in the mire and searching with haggard eye
For her superb Africa’s lost palms without end
Behind the giant wall of fog, immensely high.

Of all who have lost something they may not retrieve
Ever, ever again! Of those who suck sorrow
From that kindly she-wolf and who tearfully grieve!
Of gaunt orphans parched like today’s blooms tomorrow!

And so, in the forest of my mind-in-exile,
An old Memory sounds a full horn-note of yore!
I think of shipwrecked sailors stranded on an isle,
Of captives, of the vanquished – of so many more!

Eugene Friedman, MD, is a pediatrician and a member of the Board of Trustees of Northwell Health. He is the co-author of The Strange Case of Dr. Doyle: A Journey into Madness and Mayhem. Of this poem, he says, “When I was about 57 years old, I had an episode of endocarditis caused by a faulty valve. Five months later, I had one of the first valve repairs – instead of replacement – in the country, and I was put on medication for the first time in my life. I sat around the house in a state of depression, watching TV, unable to read – I had lost the desire. I think the beta-blocker I’d been taking may have contributed to my depression. It lifted when I switched to another medication and went back to work. The experience made me want to figure out what things in my past were worth saving. What came to mind were some French poems I’d read in college, in their original versions. I decided to return to these poems, and I bought a French dictionary to try to understand them. I looked back first at ‘The Swan,’ a poem about coping with change.”

The Golden Oar

Rowing is a sport of transitions. Your role is determined by the eight other bodies in the boat. It is an orchestra. You do exactly what the coxswain calls you to do. On your own call, you adjust your stroke to fit the needs of the boat. Sometimes you need to snap your legs down faster, sometimes you need to roll up more slowly, and you always need to pull harder and move more water. With each stroke, you adapt to each other.

It was a privilege to be a part of this uniquely fierce yet fragile balance of teamwork. Though years have passed since I last held an oar, one day on the St. Joseph River continues to provide me with the lessons for life as a medical student.

It was a snowy November day in northern Indiana. Several of our coxswains were sick, and I was the only rower short enough to fit in the coxswain seat. I had listened to coxswains make calls countless times, yet when this role fell on me, I was near speechless. I could not even properly voice the commands to have the rowers pick up their boat and get it out of the boathouse. I struggled with the microphone, took forever to launch the boat off the dock, and almost crashed us into several bridges.

It was the first time I had been in a boat without an oar in my hands, and I felt completely powerless. Halfway through practice, it began to hail, and I could hardly see 30 feet in front of the bow of the boat. In the middle of a tough section on the river — as I struggled to steer through a bridge span — one of the rowers looked up at me, exhausted, and breathlessly asked if I could count strokes for them. In this moment, I realized that my new role in the boat came with serious expectations. My teammates were counting on me. Sitting in this new seat for that last painful hour, I tried to be what I had expected of my coxswains so many times before.

My memories of the St. Joseph River have followed me almost every single day of medical school. In every long night studying, every difficult case discussion, and every uncomfortable patient encounter, I am reminded that I have a new role on a new kind of team. I know there will be many even more daunting transitions.

There will be many moments when I will not know the answers, when I will be trying something for the first time, when it will feel as if I am being asked to do the impossible, left in a boat without an oar, yet I will be expected to fulfill my role. If I could capture what I learned from each stroke on the St. Joe in a message to my future self, and to doctors in training everywhere, it would be this: Be adaptable, relentless, selfless, forever grateful, and expect more from yourself than what is comfortable. Whatever boat you find yourself in, and whatever transition you find yourself facing, life has handed you a golden oar. The rest is up to you.

Elena Brindley is a third-year MD/PhD candidate at the Zucker School of Medicine at Hofstra/Northwell. From Downingtown, Pennsylvania, she is passionate about family, faith, fitness, food, science, and all things Notre Dame.



Anna's Hummingbird

MUSTAFA H. GHANEM

Mustafa H. Ghanem is a fourth-year MD/PhD candidate at the Zucker School of Medicine at Hofstra/Northwell. This photo of Anna's hummingbird was taken by Fisherman's Wharf in San Francisco in early 2018.

Don't Be Afraid to Call a Rapid!

We typically do not prescribe antihypertensives, nor do we create a patient's diabetes regimen, but that does not mean we are not physicians. As a psychiatry resident, I have almost as many months of practicing general medicine as an internal medicine intern, an anesthesia prelim, or even a budding plastic surgeon.

This experience should have bred confidence, but that internal trust did not present itself on Martin Luther King Day 2016 on a day of psychiatry call when I was an intern.

I was making normal psychiatric rounds on a locked unit when one of the nurses told me an 82-year-old man had been having abdominal pain for the last 24 hours that was not being well controlled. I went to see the patient, and he looked sick. He was groaning and unable to answer the typical questions we ask: "Where is your pain?" "How long have you had it?" etc. I tried to find a pulse (something I had done on more than 300 patients) but I could not find it. I tried to get a manual blood pressure (something I'd done on more than 300 patients) but I could not find it. I called a rapid response.

The rapid response team came to the unit, checked his blood glucose, deemed him to be hypoglycemic, gave him a squeeze of glucagon, ordered basic labs, wrote their note, and then patronized me before leaving the unit. The hospitalist was then called, and I worked with her to try to figure out why the patient was not doing better once he received the glucagon. One and a half hours later, a code blue was called for that same patient. CPR was started, and eight minutes later he was pronounced dead.

Later, I reflected about how this experience would affect the way I would practice medicine and psychiatry during my residency. I asked myself whether the outcome would have been different if I had called sooner.

It may seem obvious to most people that one should call that initial rapid. Unfortunately, it was something I debated. I thought about how I would be judged by the other internal medicine residents who would respond to the rapid; I feared judgment from

other psychiatry residents who might not have made the same decision; and I feared judgment from the nursing staff, which would only reaffirm my lack of confidence in medical decision making.

Ultimately, I was commended for my quick decision making and for knowing when to ask for help. There are different ways to prove your worth during residency. It's not all about writing notes, deciding how to dose insulin, identifying the appropriate incision points; it's also about learning the material, learning to work in a team, and learning how to medically treat people.

People come to the hospital when they have no other options. They are at their most vulnerable and crave attention, empathy, and care. Treating people is not an independent process. Yes, it may require knowledge, but it also requires open communication and humility. Admitting that you do not know something about a patient or diagnosis may make the intern or resident seem unprepared, but asking for help with something you do not know can be one of your greatest assets.

Daniella Bannikov, DO, is in her third year of residency in psychiatry at the Zucker Hillside Hospital. She was born in Toronto, Canada, to Russian immigrants, and moved to New York City almost eight years ago to pursue a medical degree. She is passionate about community outreach, bringing awareness to mental illness, and ensuring people have access to mental health resources.

I Have Cut Open a Dead Man

I have cut open a dead man.
 They handed me the scalpel.
 I made the cut.
 They showed me his ligament of Treitz.
 I ran my hands over his dead guts.
 They told me to close him up.
 I made the stitches, clumsy but careful. It took forever.
 They told me the appearance didn't matter.
 The surgeon said out loud: "I'm sorry."
 I don't know who he was sorry for.
 We waited with the dead body attached to a ventilator.
 I feel as if we didn't try hard enough.
 The room reeked of rot.
 I never got to meet his wife.
 I held his hand before he died and told him it would be okay.
 I'm working on believing in my team.
 I'm working on forgiving them.
 I'm working on forgiving myself.
 I'm working.

Bonnie Bentson is a third-year medical student at the Zucker School of Medicine at Hofstra/Northwell. Bonnie is interested in pursuing a career in internal medicine or pediatrics. In her spare time, she enjoys playing and coaching soccer and visiting with dogs.



Alive in Ko Phi Phi

YUJIE (RICHIE) SUN

Yujie (Richie) Sun is a third-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He grew up in Minnesota and loves fishing, hiking, cooking, and traveling.

Who Shall Judge?

I have a close friend, an anesthesiologist. She called me yesterday to meet for coffee. About 10 years ago, she was presumed dead.

For a few days back then she hadn't been feeling well. It could have been her schedule. It was a busy one. She divided her time between the operating room and intensive care. And then there were her three kids. And did I say she was a single mom?

A blood test instantly changed her life.

Her white blood cell count was off the charts. She had leukemia. And not just leukemia, but a bad subtype of a bad form of leukemia, AML or acute myeloid or myelogenous leukemia. Things were bad, real bad. But they could always get worse.

Despite being at a hospital center with a renowned specialist in leukemia, the chemotherapy crapped out. She had all the side effects, lost her hair and couldn't eat, but the cancer cells kept multiplying.

Plan B: bone marrow transplant.

Unfortunately, there was no plan C.

The one thing she had going for her, besides her will to live, was her two siblings who might qualify as donors. No go. The match was bad.

Meanwhile she got sicker, to the point that the major transplant centers in the country didn't want to treat her. The thinking was, "Who shall judge when you're going to die; we don't want to kill you." Of course, no one said that, but it was understood.

Did I mention her will to live? I would visit her in the hospital, and she wouldn't be in her room. I'd find her, with a face mask and hospital gown on, gaunt and frail, doing laps around the nurse's station. I'm talking power walking.

But the renowned oncologist who was treating her knew better. He knew that this was the last hurrah.

He pulled me aside. "I know you're a good friend of hers. Make sure she gets her affairs in order," he told me. He had no choice. But he didn't tell her. Not in those terms.

He was a humble and measured man with a world of experience. He was not given to frivolity. His judgment was reasoned. The writing was on the wall. In large, bold letters.

Respecting his judgment, of course I spoke with my friend. I had to.

The trick is to be realistic without crushing all hope. That's just not fair. And we just don't know. Life is a crap shoot. We play the odds. In medicine, we do what we can to increase the odds of success. We can quote statistics, but that's where it ends.

Humanity and humility go hand in hand. She listened and moved on. The daughter of a Holocaust survivor. Did it matter?

Through the intervention of her brother, she was grudgingly accepted for a bone marrow transplant. But pickings for a donor are slim for a Jew, with a European heritage..

Through an organization called Gift of Life, which runs donor drives and established a donor bank, she was hooked up with an anonymous donor. The match was less than optimal. But beggars can't be choosers. Neither can people dying from leukemia.

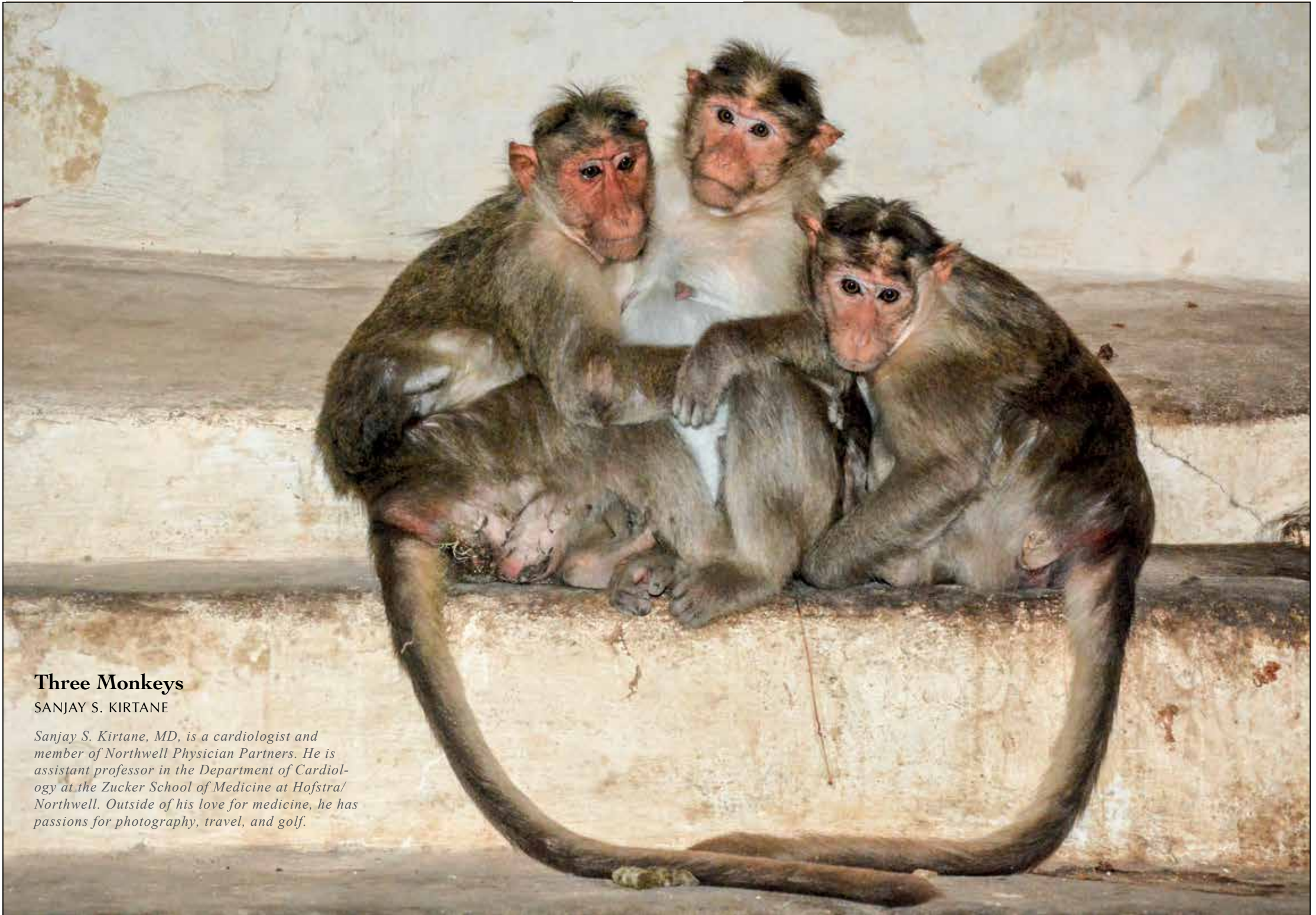
Bone marrow transplant is all or nothing. They wipe your native bone marrow out and wipe the slate clean. If the donated bone marrow is rejected, you say your final goodbyes.

Well, you know how it ends. She called me yesterday to meet for coffee.

Why do doctors never say how long a patient has to live? Doctors have an imperative to prolong life, quality life, while never losing their humanity and without destroying hope. And with feet planted firmly on the ground.

It's one thing to have a healthy ego, quite another to play God.

Robert I. Gluck, MD, is an upper-extremity surgeon who has worked at Long Island Jewish Medical Center for over 35 years.



Three Monkeys

SANJAY S. KIRTANE

Sanjay S. Kirtane, MD, is a cardiologist and member of Northwell Physician Partners. He is assistant professor in the Department of Cardiology at the Zucker School of Medicine at Hofstra/Northwell. Outside of his love for medicine, he has passions for photography, travel, and golf.

Irony

My father called me “Doctor Daughter.” In his forties, he was diagnosed with diabetes. He was so private about it that he never even told my mother, even though she was the love of his life. By his fifties, he had had a series of heart attacks that he couldn’t hide from the family and also suffered a stroke during one of his hospitalizations. A couple of years ago, his doctors inserted a cardioMEMS into his pulmonary artery to wirelessly monitor his congestive heart failure. He was 61.

We never stopped watching and worrying about him. It was his Doctor Daughter who always got the first call. Then, with a nudge or a stronger demand, he would contact his health care team. (He never seemed to care that my training is in pediatrics.) I have always been anxious when it came to my father’s medical problems. What I learned firsthand from him was that he could nosedive in a span of a few minutes. There was no obvious arm or chest pain. He vomited. Then, things went bad instantly. I didn’t want things to go south on my watch.

My father vomited on January 10. My mother called me. But he also had diarrhea. I called his doctors and we agreed that it was probably a gastrointestinal infection. His doctors prescribed hydration, and we carried out the order. A day later, he seemed better, but I was a mess and I had no idea why. I cried while sitting in on a meeting with my colleagues at the medical school. I never cried like that. I couldn’t stop. I checked in on my father and he was in better spirits. Doctor Daughter? Is that you?

On Friday, I stopped by my parents’ home on the way to work. My father said he was feeling very weak. “Dad, did you call your doctors?” I asked. “You need to tell your doctor when you are not feeling well. I should not be your first call. Call me right after you call your doctor.” My father had been resuscitated twice — at home by my middle sister. One time, he was the color of a summer storm, blue-gray.

My mother called on Saturday. Dad was short of breath and panicky. I packed my kids in the car and we headed over. He was unsteady on his feet. The ambulance had been at the house too

many times, and that day I decided to get him into my car and drive to the ER. My mother would watch the kids. At the door, my three-year-old grabbed hold of his grandfather’s leg and wouldn’t let go. My kids finally said their goodbyes and were coaxed into my mother’s arms. My little sister came with us. When we got to the car, dad had difficulty putting his seatbelt on. I reached over and buckled him in.

We arrived at the hospital. I retrieved a wheelchair. The triage nurse took his vitals, and everything was ER normal. But I am a genius at his vitals, and I thought his blood pressure was very low and he did have some quick-paced breathing. But my dad just looked at me and smiled. He was relaxed. We even used FaceTime to call my mother. She got a smile, too.

We waited patiently for an hour. He needed to go to the bathroom, and I walked him in. I waited outside the door. His eyes were having a hard time focusing. His legs were still wobbly.

The triage nurse finally came back to fetch my father. He was still in the bathroom. When he was done, they wheeled him into an exam room. They asked him to get undressed. He was too weak to pull down his pants. I helped him. A stream of nurses came in to help find a vein for the intravenous fluids. Dad said that he was hungry. We found some ginger ale and it worked to satisfy him. A resident came in and told us that he probably had some fluid in his lungs. He left and we waited.

Then, my father said that he needed to go to the bathroom again. The nurse had handed me an orange cup, and I handed it to my father and told him to pee into the cup. He gave me a deep gaze. I asked him if he understood, he smiled and nodded, and my sister and I headed to the hall to give him privacy. A nurse approached us and said that events on the cardiac monitor were troubling. I told her she could check on him. She went inside, and then we heard:

“Oh, honey, did you vomit?”

We knew what that meant. We rushed in and saw my father in the bed, completely blue. I gave a calm command to my sister: “Go call a code blue.” My baby sister ran out to the nursing station,

screaming, “Code blue! Code blue!”

The resident ran in and started doing compressions on my father’s chest. I was strangely calm. There was chaos around me. My sister was hysterical. We were asked to leave the room, and the triage nurse escorted us to a tiny family room on the opposite end of the ER. I called my husband and told him Dad was blue and he needed to pick my mother up from home and bring her to the hospital immediately.

My mom called me in a panic. “Why am I being picked up? Is Dad okay?” I told her to listen to the calm in my voice and reminded her that I am the first one who panics when he gets sick. I told her everything was “fine.” Deep in my heart, I knew nothing was fine. I continued calling all my close family members. I wanted everyone who loved Dad to be there with us. Then, my sister and I waited, again.

About 45 minutes later, a nurse came to the room holding two white plastic bags. She placed them on the chair next to me. In the bags were Dad’s clothes and personal belongings. I calmly asked her, “How’s my dad?” She was backing out of the room. “The doctors are coming to talk to you now,” is all she said.

Moments later, the resident and an attending walked into the small space, and in unison they bent down on one knee so that they were at eye level with us. The attending glanced over at the resident and with a slight nod prompted him to speak. The resident then said: “I am sorry. He died.”

Chaos. Disbelief. Anger. Grief. “What are you talking about? How could he just die?”

Then, the calm came over my shoulders like a blanket. This is the day I have been worrying about for all these years, and, what, you say he is dead? How can this be true? My father, who was smiling at me just an hour ago and told me he was hungry?

I suspect I was numb. I don’t remember anything the doctors said after that. I walked the same hallway back to his room, and I didn’t get any gesture of comfort from the staff who took care of him in his last few minutes. Not even a single glance. I was hoping for the soft touch of a hand on my shoulder or maybe even “I’m

sorry for your loss.” I got nothing.

There was so much irony in this, all of this. I always thought I would get the call that Dad had passed, but little did I know that I would have to make that call. It is ironic that I train medical students to deliver large doses of compassion and humanity to their patients and their families and received close to none. My father was always nervous when he had to go to the hospital. This time, it was different. He smiled in the waiting room. He was calm, and for the most part I was, too (strikingly different from the usual emotional wreck I became when he would fall ill). I remember thinking this was the perfect story for *Narrateur*. I would write about this experience and how the last few days played out and how ironic it was that this was the moment my father died. I would call the story “Irony.”

I would later learn that they worked on his 61-year-old heart for 30 minutes. Doctor Daughter would have to break the news to her mother and everyone else in the family. I called our priest, who arrived and prayed over my father’s body. The nurses went about their late-night tasks as if death and grief were as common as dinner, while my world had just turned upside-down.

We arrived at my parents’ house around 3:00 a.m. My dad’s slippers were on the floor, and his belt and pants were on their bed. That was it. He was not coming home. My world had changed forever. I fell asleep in the house that I grew up in. I woke up at 7:30 in the morning and wanted to just scream. The calm was gone.

I went out to the street, climbed into my car, and screamed until there was nothing left in me. Then, I had to become a daughter again, a mother, a sister, a wife, a teacher, and a doctor.

Taranjeet Ahuja, DO, is an assistant professor of science education and pediatrics. She is a pediatrician and full-time faculty member at the Zucker School of Medicine at Hofstra/Northwell. She is the director of the Initial Clinical Experience (ICE) and Advanced Clinical Experience (ACE) Continuity Clinic programs.



Kurt

DANIELLE LLANOS

Danielle Llanos is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell. She writes, “‘Kurt’ represents many personalities, and the emotional highs and lows we each experience throughout a day, a week, a month, a year.”



Pulsating

DANIELLE LLANOS

“Pulsating” is an observation of movement meant to capture the pulses of heartbeats through color.

Dubious Dublin Becomes a Caretaker

Dubious Dublin, captain of the pirate ship Black Pool, valued his human landlubber friends. The black tabby had an especially soft spot in his heart for the widow Fiona.

Fiona lived in a farmhouse on the Tralee Road, and she always had plenty of fresh milk for Dublin and his shipmates whenever they made port. The good woman even let the piratical cats sleep on the hearth in front of the fire during December's icy storms.

Dublin took it hard when he came to Tralee to spend the winter and found that Fiona had taken a serious fall and had not fully recovered. To walk, Fiona now needed wooden crutches. He watched every painful step she took to make sure she didn't fall again. As long as Fiona was awake, Dublin's eyes followed her. Never again would he nap during the day when he visited her.

When Fiona settled into her chair by the fire, he would jump on her and knead her upper arms, for Dublin thought they must ache from holding the crutches all day. At night, Dublin and a couple of his crew would snuggle against Fiona, giving her extra warmth.

Fiona's daughters, Catherine and Ashley, would come by to help her manage the farm and keep the farmhouse in order. Dublin watched them closely. As a pirate, he would always be suspicious. He wanted to be sure that the younger women treated his friend well and didn't purposely trip her to take over the farm.

One day Fiona left with her daughters. Dublin grew frantic as the day wore on and Fiona had not returned. But as night fell he heard people coming up the walk. He ran from the hearth and sat in front of the door. When it opened, he was relieved to see the daughters had brought Fiona back. Ever the cool pirate, Dublin merely got up, rubbed the chair leg, and settled himself on the hearth again.

As the winter grew colder, Dublin would wait at the door

each time Fiona left.

When she was home, Dublin's vigilance never faltered. He would set himself on the kitchen windowsill and watch Fiona's every act, moving only to knead her arms and to curl up with her at night.

When spring came, Dublin bid farewell to Fiona.

He was glad for the freedom of the sea. He had watched all winter the drudgery of Catherine and Ashley, cooking, cleaning, giving Fiona medicine, reading to her for entertainment, keeping her company, and then having to go home to look after their own hearth, all for no pay and with little complaining.

As he shouted orders and the Black Pool set sail, Dublin watched Tralee grow small in the distance. He vowed that when he returned he would give some portion of his plunder to Catherine and Ashley, a small token of his gratitude for the care they had given to his favorite landlubber.

Frances Avnet is an executive secretary at the Maurice A. Deane School of Law at Hofstra University. Her works have appeared in The Arts Scene, Creations, Bards Annual 2013, 2014, 2015, 2016, and 2017, Rescued Kitties Two, and in previous issues of Narrateur: Reflections on Caring.



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Metamorphosis

CAITLIN WHELAN

Caitlin Whelan is a third-year medical student at the Zucker School of Medicine at Hofstra/Northwell. This photograph was taken in Maui. She writes: "Metamorphosis" represents our evolution from medical students to caring and competent physicians, and the change in our patients as they take control of their bodies to make more health-conscious choices.

Submissions

Narrateur: Reflections on Caring is published by Northwell Health and the Zucker School of Medicine at Hofstra/Northwell. 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 Zucker School of Medicine at Hofstra/Northwell 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.



Cover

THE SECRET
GARDEN
ZAIN MEMON

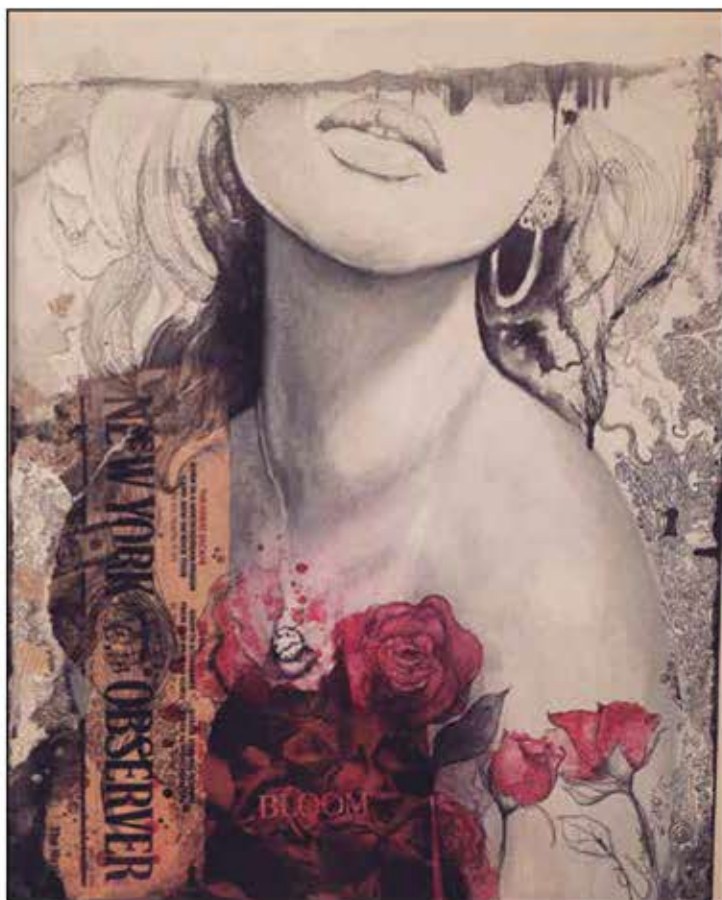


Back Cover

BLOOM
INTERRUPTED
ELMA SKOPLJAK

Zain Memon, DO, is an internal medicine resident at Northwell Lenox Hill Hospital. He enjoys traveling and photography. This photograph was taken at the Keukenhof Tulip Festival in the Netherlands. He writes, "I once treated a patient who had many different malignancies and chronic disorders. After all she had been through, what she remembered most was the nurses and other staff and their small acts of kindness. The patient reminds me that though we can cure disease sometimes, we can relieve suffering always, often with nothing more than a kind word, a gentle touch, or a warm smile. Sometimes it's important to get lost in the 'secret garden' to understand a patient and the offending disease process."

Elma Skopljak is part of the ambulatory electronic health care records department at Northwell Health. She writes, "I have been involved in different forms of art since childhood. However, painting is my favorite medium with which to explore space and different dimensions of life and spirituality. This piece involves different textures and media that create one dynamic composition. "Bloom Interrupted" represents an individual's life journey, in different form and textures but still well balanced."



DONALD AND BARBARA
ZUCKER SCHOOL of MEDICINE
AT HOFSTRA/NORTHWELL

