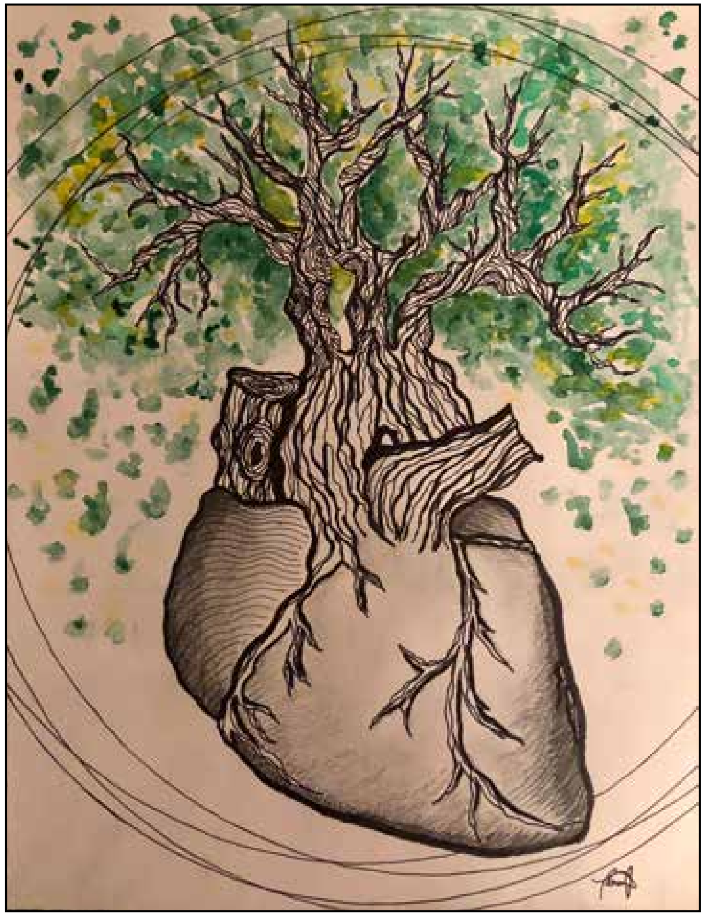

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THE DONALD AND BARBARA ZUCKER
SCHOOL OF MEDICINE AT HOFSTRA/NORTHWELL

ART & LITERARY REVIEW

ISSUE EIGHT 2019

# Narrateur

## REFLECTIONS ON CARING

THE DONALD AND BARBARA ZUCKER
SCHOOL OF MEDICINE
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# Narrateur

REFLECTIONS ON CARING

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## Front: Training the Next Generation

*Ron Israeli, MD, is a clinical assistant professor of surgery at the Zucker School of Medicine at Hofstra/Northwell. Nationally known for his work in breast and abdominal wall reconstruction, Dr. Israeli has recently begun formal instruction in oil painting, studying with Long Island artist David Peikon. He is currently creating a series of oil paintings depicting scenes from the operating room. The front cover painting, his first in the series, depicts John Procaccino, MD, the director of the fellowship program in colon and rectal surgery at Northwell Health, operating with Jason Lei, MD, a recent graduate of the program.*

## Back: Tree of Life

*Tanim Jain is a third-year medical student at the Zucker School of Medicine at Hofstra/Northwell. She draws her inspiration from nature and enjoys experimenting with different media. "Tree of Life" was created using ink, watercolor and graphite. The tree of life is found across many cultures, a symbol of immortality and interconnectedness. This piece was inspired by the strength of the human heart and its ability to grow and flourish.*

# From the Dean of the School of Medicine

Welcome, everyone, to the eighth edition of *Narrateur*. This journal allows the wide array of caregivers from our medical school and health system to use literature and art to display the special aspects of humanism that are part of the care of virtually every patient.

In this issue we are excited by the broad and diverse content that has been submitted by our medical community. Just to point out a few pieces you will encounter, there is a remarkably imaginative narrative of the life and death of a simple endothelial cell that captures the magic of the millions of sophisticated working parts that make us the humans that we are. A poignant story about the effect of being a family caregiver for one's own parent reminds us of the importance of these responsibilities and the lasting memories that change the very essence of who we are. The sadness of aging and dementia — the slow fading away of the person who once was — is wonderfully captured in the metaphor of "Fading Colors." Finally, let me bring your attention to "The Chaplains of Lenox Hill," which discusses the interplay among medicine, healing and religion. This piece helps us understand the many varied ways that people with different backgrounds can come together to relieve the suffering of those who are so very ill.

I hope that you enjoy this issue — and that next year you consider submitting something of your own.

Lawrence G. Smith, MD, MACP

Dean, Zucker School of Medicine at Hofstra/Northwell

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

# From the Editor-in-Chief

We launched *Narrateur: Reflections on Caring* with the first school of medicine class, of fifty students. This is our eighth issue, and our biggest year for submissions. They came from all corners of the Northwell Health system, the school of medicine and Hofstra University. I am proud to listen to the young doctors-in-training who submitted to the 2019 issue. Their stories, photographs, poetry and artwork reveal insights that confirm my belief that we are creating a reflective and compassionate group of physicians who will be using these skills in their practices for decades to come.

Our submissions from others in the health system and Hofstra also capture a universal theme: that we want to share experiences that make us who we are in the world. I love opening up a new submission and having the story unfold across the page. (Photos and art tell deep stories, too, and you will love our handpicked selections.)

We have a terrific team of SOM editors who vote for the pieces that are in every issue. The issue is put together by a small group of amazing people: Bob Keane, our managing editor, who was my managing editor at *Newsday* for decades; Wayne McLean, our talented designer who magically makes so many submissions come together and look perfect; Thea Welch, a brilliant copy editor; and this year's SOM managing editor, Maya Alexandri, whose extraordinary talents are so appreciated. We are also fortunate to have Phillis Levin, a professor of English and poet-in-residence at Hofstra University, who has been our guide in all things poetry since this journal began. A shout-out to her latest book, *Mr. Memory & Other Poems* (Penguin Books, 2016). And always, warm thanks to Dean Smith for his continued support.

Jamie Talan, MPH

Editor-in-Chief

# A Conversation with Oncologists Nagashree Seetharamu, MD, and Anna Levy, MD

*In Issue Seven of* Narrateur, *Adam Lalley wrote "A Conversation with David Elkowitz," an interview with the associate dean and pathology professor at the Zucker School of Medicine at Hofstra/Northwell. At the time, Dr. Elkowitz had recently been diagnosed with poorly differentiated squamous cell thymic carcinoma.*

*In the course of that interview, Dr. Elkowitz described his oncologist: "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."*

*After I read those words, I approached Dr. Elkowitz to discuss the possibility of a follow-up interview with his oncology team. I was curious to know more. Dr. Elkowitz is an extremely knowledgeable, dynamic, proactive physician. Inspiring his trust and alleviating his depression are advanced-level skills. In addition, the delivery of care to patients who are also physicians seems to be an underexamined dimension of the physician's experience.*

*Dr. Elkowitz was enthusiastic about the idea. He emphasized the importance of developing skills to treat physicians-as-patients, as well as to connect with their families.*

*In the interim between our initial discussion and the interview in January 2019, Dr. Elkowitz was diagnosed with a metastasis* *of the thymic carcinoma to his liver, as well as a second primary tumor, in his colon. During fall 2018, he underwent a remarkable treatment schedule that allowed him to continue teaching. By December 2018, his scans showed no evidence of disease.*

*Dr. Elkowitz's oncologists, Nagashree Seetharamu, MD, and Anna Levy, MD, graciously agreed to take the time to speak with me about their experience treating him. Dr. Seetharamu is an oncologist at the Monter Cancer Center. She is a specialist in head, neck and thoracic cancers and is also involved in resident and fellow education, as well as research. Dr. Seetharamu treated Dr. Elkowitz for his thymic cancer.*

*Dr. Levy is also an oncologist at the Monter Cancer Center. She specializes in gastrointestinal malignancies, with a focus on hepatobiliary tumors. Dr. Levy is also involved in research. She treated Dr. Elkowitz for his colon cancer.*

***Maya:** Please talk about the rewards and benefits of providing patient care, as well as some of the challenges.*

**Dr. L:** Caring for cancer patients is very complex. Treating a cancer patient involves addressing the patient's physical, psychosocial and spiritual needs. In addition, it is important to incorporate the patient's family in this process. For all of us, seeing a patient do well with treatment is incredibly satisfying. On the flip side, I've seen patients not do well, and that is always hard.

**Dr. S:** Oncology is really a complete marriage of art and science. The science is advancing so rapidly, and that's one reason why we subspecialize — we focus on one disease. Each week new material is being reported in the literature, and it is important to use that knowledge prudently and tailor it to the needs of any individual patient.

Oncology is a bit of everything: cancer science, psychiatry, palliative medicine, internal medicine, fused with hope and a lot of good wishes. That's the art. While it is challenging, the whole process is rewarding. I cannot imagine myself doing anything else.

***Maya:*** *Have you had patients as doctors before?*

**Dr. S:** Actually, I myself have been through this process as a patient. I was treated by excellent providers — wonderful people — who guided me on the right path. We think, as doctors, we shouldn't be getting sick. But we're not immune. We're people — it's kind of reassuring to know that we are people.

When physicians are patients — there are two different people in one body. One is the layperson who really wants to hear about treatments and hear about his or her cancer. And then there is the doctor trying to be the second consultant. It's an internal struggle, and it's also challenging for the physician because the patient is making suggestions, which may not be appropriate at the time. You want to honor their knowledge and expertise, but at the same time you don't want to assume that they know everything. So, the best strategy is to start from the beginning just as you would with a normal patient, but at the same time tailor the information to the physician patient's level of education.

**Dr. L:** The shared decision making is different with a physician patient. With a non-physician patient, the oncologist gives the options of treatment A versus treatment B. But at the end of the day the oncologist appropriately makes a recommendation based on his or her knowledge of the disease process, expected prognosis and the patient's personal values and beliefs. A physician patient usually has more insight into the disease process. He or she is able to understand medical jargon and, in some cases, can interpret the medical literature. As an oncologist, I try to incorporate physician patients into the decision-making process to the degree that they desire to be involved. It's not "one size fits all." Also, managing expectations, as with any patient, is very important.

**Dr. S:** Every physician patient is different. There are some micromanagers who want to know why every little thing was done the way it was done. They want to discuss every minute laboratory detail and radiological finding. There are physicians who tell us how they think they should be treated for their cancer — “I think combining immunotherapy with targeted treatment would be better for me”— and then there are physician patients, like Dr. Elkowitz, who are definitely on top of everything but trust their doctors to make the right decisions.

***Maya:*** *Dr. Elkowitz has talked about how he was confident in his recovery because he was under your care. Could you elaborate on how you provided that care?*

**Dr. S:** He came to us with a diagnosis that is not generally associated with a good prognosis. To top that, our patient was an astute pathologist who knew everything! He was a wreck when we first met. The first meeting was really more about trying to get him composed. We then started making treatment plans. His case was presented at the tumor board. We were confident that we would need a multidisciplinary treatment plan, and that it would do a good job in terms of shrinking the tumor. I spoke to the surgeon who was chosen by Dr. Elkowitz, and I had a lot of confidence that he knew what he was doing. So I felt we formed a good team. My recommendation was to do four cycles of chemotherapy and then surgery. But then we decided to stop at two because the tumor had shown a significant response already. Dr. Elkowitz had the surgery, and that confirmed that the treatment had worked because there was less than 10 percent viable tumor left. So we decided to do two more cycles as we had planned. He completed all this treatment with grace, looking better than ever. I was hoping that the cancer would not show its face again, but I know the nature of the beast and feared that it would. But I rested on the facts that the tumor was 100 percent PD-L1 positive [a marker that predicts response to immunotherapy], and that I had immunotherapy in my back pocket ready to be used, if needed. Whenever Dr. Elkowitz went into the dark corner, we used to remind him of that. When the cancer did recur, I didn’t make a unilateral decision to try immunotherapy. It was a partnership among us as a team, experts from other institutions, Dr. Elkowitz and his amazing wife, Stephanie.

**Dr. L**: My first meeting with David was after he had had an unfortunate series of events that all occurred in a very short time period: a myocardial infarction that required revascularization with stent placement, diagnosis of relapsed thymic carcinoma and a new diagnosis of colon cancer. I saw him after his colon surgery, and he was told that he had Stage III colon cancer that required adjuvant chemotherapy. David felt apprehensive at having to start chemotherapy again, as he had had a tough experience with it in the past. So during our first visit, he was feeling very low. He had been eating very little, felt weak and barely spoke. He kept his head down for most of the visit, and I could tell he was struggling. Stephanie, his wife, was really holding everything together. My goals for the first visit were to establish a relationship with him and Stephanie and to focus on improving his symptom burden. I only briefly discussed chemotherapy, so as not to overwhelm David.

At our follow-up visit a few weeks later, he looked much better. He was recovering well from surgery, and emotionally he was in a better place. He was more conversant. We discussed chemotherapy for the colon cancer and agreed that he would proceed with the treatment. Unfortunately, after the first cycle, David had an adverse reaction to one of his chemotherapy drugs. It was a very rare cardiac toxicity that was probably exacerbated by his recent cardiac event. Following the adverse event, I met with David and Stephanie several times to determine what to do next. The offending drug was the backbone of his treatment, and there was no alternative treatment to offer. The options were to try the treatment again in a monitored setting or discontinue the treatment completely. I reached out to experts in the field and spoke to his cardiology team. There was not a consensus, and the decision ultimately fell to me. David and I met, and I asked him how he felt about the two options. The doctor in him, who understood the small benefit of the treatment, wanted to try. However, the patient in him was scared. In the end, I made the decision to abort the treatment due to the high risk for further complications. I think I expected David to put up a fight, but instead he told me, “I trust you. I trust your judgment about this, and I’m going to go with whatever you say. I would never go against you." It was such a meaningful moment to me.

**Dr. S:** It's rare to find physicians like that, who trust their doctors when they end up as patients. He has that great balance.

**Dr. L:** Because David has good insight to know the right time to be a patient versus a doctor, he is able to defer to his medical team to guide him.

***Maya:*** *To what extent was your care of Dr. Elkowitz influenced by the fact that he is a doctor?*

**Dr. S:** Because he was a physician, I understood that I had an educated patient who knows his body. Recently Stephanie, his wife, did a lot of research and asked us about a mutation for which a new treatment was just approved. I would not have generally sent the tumor out for that particular mutation. It's very rare, but it was a request from a patient and his wife who are exceptionally smart and have done a lot of online research on the topic. What they requested made sense, and so we honored their suggestion. Of course, there's no time for ego — you have to make sure that you didn't miss something.

**Dr. L:** David requested a PD-L1 stain on his tumor. It was not clinically relevant to his case, and I normally would not have ordered it. However, being a pathologist, he has full access to the pathology department. I supported the decision to obtain the stain, but before I could add it on myself, he was already on the phone with the lab supervisor.

It actually made a lot of sense. If the tumor does express PD-L1, there is a lower risk of recurrence, which strengthens the argument against chemotherapy that is risky. Ultimately, when it comes to treating David, I treat him the same way I treat anyone — with compassion and respect, trying to align with his beliefs and guiding him on the correct path.

**Dr. S:** David was not eating and was losing weight when he started taking the chemotherapy following his surgery. Right after the operation, he was going back to his dark side and fixating on what happened. I sent my physician assistant, Keara, to talk to him. I didn't have the heart to tell him: "If you're continuing to lose weight, you have to forgo the full cycle." She said it in such a plain way, and that was it! After that, he did not lose a pound. Sometimes you need the push. When I was doing treatments myself, for breast cancer, and I lost all my hair, I asked myself: "Why am I doing this? I'm not going to do the full course. It doesn't make any sense." The doctor in me asked, "What are the chances that this is going to help me?" But then the layperson in me said, "Okay, I'll do the full treatment as my oncologist wants me to." Ultimately, I did the full cycle. So I could completely understand where he was coming from.

***Maya:** What do you do as a doctor to develop your capacity to relate to patients when they need support for the spiritual dimensions of healing?*

**Dr. L:** For an oncologist it's important to be empathetic and a good listener. I've learned from my palliative care colleagues to speak slowly, pausing frequently, and ask open-ended questions exploring the patient's understanding. "Tell me more" is a useful phrase. Other questions that I frequently ask are: "What is most important to you?" and "What worries you?" The answers sometime are surprising, and they provide me with a framework with which to treat the patient.

**Dr. S:** You grab certain cues from the patients and their families and use that as a starting point to address the emotional aspects. I try to get into the patients' shoes to see where they're coming from, or the family members — where they're coming from. There may be conflicts between patients and family members, or the family members may be fighting among themselves as to what the proper care is. They may come in with a lot of anger: "This was missed" or “How could this happen?” It’s hard for patients and families to adjust quickly to the new reality. You listen to them, and try to find a common ground upon which everybody agrees. I try to get everybody on board, and show them all that I’m not giving up. At the same time, I am educating them about what palliative care is, and how we take care of people at the end of life. We have wonderful palliative care colleagues whom we always refer patients to, very early in the process. We work in partnership.

***Maya:*** *What can we do to be better physicians for our physician patients? As you said, Dr. Seetharamu, we’re human, we have bodies, we are mortal. We will be patients. How can we understand a physician identity in a way that includes being a patient at some point in our lives?*

**Dr. S:** It’s important to understand that being a patient could happen to anybody. Follow Dr. Elkowitz’s lead and put trust and faith in medicine. Just let yourself be taken care of. Be open: You are like another person. Go through your screening process. When you turn a certain age, if they recommend mammogram or colonoscopy, go through that process. Follow the guidelines. I fought with my primary care doctor about getting a mammogram. I had just turned forty, and I thought, “I’m not going do this.” And she told me, “I want you to do this.” So I said, “Whatever, but I know it’s going to be totally normal!” And it was not! So all I’m saying is: Let people take care of you rather than putting in your own two cents.

**Dr. L**: I think what it comes down to is effective communication. We frequently hear from patients and their families about multiple providers with different opinions. No one seems to be speaking with one voice. Effective communication with our colleagues and our patients is crucial, albeit difficult. However, I think that it can be taught, and with practice the skill does develop.

When I finished my hematology-oncology fellowship I thought I was an excellent communicator. My first real job was rounding in the hospital on oncology patients with whom I had no prior relationships. Oftentimes, I would need to initiate goals of care and hospice discussions. In the beginning, I was not always successful. I said the wrong things. I upset people inadvertently. But as I acquired more experience, and observed excellent communicators in real time, including with my palliative care colleagues, I became more comfortable. The bottom line is: Excellent communication is as important as the actual treatment plan when caring for any patient, especially an oncology patient.

**Dr. S**: I agree. I went to medical school in India and trained in a completely different cultural environment. When I moved here, it was a very steep learning curve for me to learn the cultural differences. There's not so much of a physician-patient partnership in India. It's really more paternalistic care there. Over the course of my career, I have made mistakes when I later felt that I had said the wrong thing to people and with very little empathy. And each time, I try to replay the scenario in my mind and ask myself, "Why did I say that? Could I have reacted differently?" I'm always thinking and correcting, and trying to improve. It becomes a habit.

**Dr. L**: You're a lifelong learner when you step through the doors of medical school. You're always honing your craft.

*Maya Alexandri, JD, is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell. She is the student managing editor of* Narrateur: Reflections on Caring.

# Into the Unknown

*David Marcus, MD, is an emergency medicine physician who is also interested in medical ethics. He is director of student education at LIJ Medical Center. This photo was taken beside the Wonder Wheel in Coney Island, Brooklyn. Watching this imposing image made him think about setting out into the unknown. And its shape reminded him of the "house of medicine, as a never-ending, thrilling carnival ride full of ups and downs, replete with flashing lights and deafening sounds. At least that is life in the ER."*

## The Chaplains at Lenox Hill

Last fall, during my third-year medicine rotation, I met a patient I'll call Ms. Arthur, a Jamaican woman in her early eighties with a self-deprecating sense of humor and a shock of bright white hair.

In the days before her admission to the inpatient wards, she had noticed her stool had become darker, and one day she felt tired, a little short of breath. She took a shower, hoping to refresh herself, but soon felt even weaker. She started sweating and sank to floor. That was when she decided to go to the hospital. In the emergency room, as a doctor was taking her history, she vomited a liter of blood and clots into a disposable pink bin.

Nothing like this had ever happened to her before, and there was no obvious cause. She didn't have a history of stomach ulcers, drink coffee or alcohol or take painkillers. She hadn't changed her diet or started any new medications. Two endoscopies and a colonoscopy found nothing remarkable, and there seemed to be nothing she could do to prevent another episode.

Over the course of the next few days, and after a few transfusions, she began to feel stronger, and she never vomited blood again. But the lack of a diagnosis still troubled her. What if it was the first sign of something more serious? What if one day, without warning, she passed out in the grocery store or in the street?

Without a physiological explanation, she turned inward for religious clues. Was she being punished? What was God trying to tell her?

The office of Lenox Hill's Pastoral Care Services is in one of the oldest wings of the hospital compound, and on an afternoon in February, I sat down with Rabbi Simcha Silverman, Father Anthony and Diane Dreher, a student chaplain, to hear about the kinds of conversations they have with patients. I was surprised to learn how much overlap exists between our roles as medical providers and their roles as spiritual counselors.

As Rabbi Silverman explained, the hospital identifies twenty-one religions in its census — a reflection of New York City's own diversity — but most patients still check the boxes for "unknown," "none," or "other." So while much of the work of the chaplains involves meeting religious needs like prayer or rituals, a large part of what they do is simply talking to patients using the same tools of empathy that medical students learn: reflection, legitimization and exploration.

"Illness strikes a chord with people. When you're hospitalized, you're in a moment of transition," Diane explained. "You're out of your regular life, whatever that is, and stuff bubbles up." Listening sounds like an easy task, but it can be hard to resist the temptation to fix a patient's problems, especially in a hospital setting.

Among the stories we shared that afternoon, Rabbi Silverman told me about a man in his mid-seventies with advanced COPD who felt that he was being punished. The rabbi asked him what he felt he was being punished for, and the man recounted something he did in high school against his parents. "This man had been walking around with this burden for over fifty years. If I had tried to reassure him and said, 'No, God doesn't punish like that,' it could have ended the conversation, but he might have carried this burden on his shoulders for the rest of his life." Instead, what they do as chaplains is to unpack it all and ask: What do you feel you're being punished for? What was your relationship like with your parents afterward? Do you think they held this against you until the end of their lives? What can we do to help you reconcile yourself with what you did?

Pain and suffering are often lumped together. In my time on the wards, I have seen that they are different, though they can coexist. During my OB/gyn clerkship, I witnessed extreme pain as women labored — at times, I could hear it all the way down the hallway. But these patients expected the pain, knew it would be temporary and accepted the reason for it, so there was very little suffering. In contrast, some of the psychiatric patients I've met express no pain at all but experience intense suffering.

Often as physicians we treat only the pain, but any caregiver can mitigate suffering. Rabbi Silverman shared another story of a nurse administering a medication to a patient who asked, "Will I survive this?" It was a vague question, and the nurse could easily have answered it in its narrowest sense, “Will I survive this drug?” Instead, she interpreted the patient’s question in its deepest implication, “Will I survive this disease?” The nurse responded, “We’re trying everything we can for you. You’re getting the best possible care.” They talked a little while longer, and the following morning the patient passed away. She was awake almost until her final moments, and as the rabbi reflected, “It’s very possible that the last person to have given her some sort of emotional support was this nurse who almost chanced on it.”

In Islam, as in some other faiths, one of the requirements for conversion is a verbal profession of faith. In both marriage and legal testimony, we say out loud, “I do.” What is the power of speech beyond the meanings of the words themselves? Where does it come from?

The well-known Christian pastor Joel Osteen, who starts every sermon by inviting his audience to recite a short mantra, says, “Words have creative power. When you speak something out, you give life to what you’re saying. When God created the worlds, he didn’t just think them into being. He said, ‘Let there be light,’ and light came. His words set it into motion.”

We may not have answers to all of our patients’ questions. We may not even be able to diagnose every problem. Sometimes the best we can do for our patients is to explore. As with the therapy that comes from journaling, when patients speak aloud, they externalize their thoughts, hear the transformative power of their own words and encounter themselves in a different way. By turning patients’ internal monologues into dialogues, we allow them to draw upon their own spiritual strengths.

“It’s sometimes easy to tap somebody on the shoulder and say, ‘It’s going to be okay.’” Rabbi Silverman added. For many patients, it won’t be okay, so those words sound shallow. “We’re not there to give them a quick fix. Instead, we want to journey with our patients through their suffering or through their experience, even to celebrate with them when things go well.”

A few months later, I called Ms. Arthur at home, and we talked for a while. She told me that photographs downloaded from the tiny capsule she swallowed just before discharge later showed no signs of the source of bleeding, and she hasn't had any more episodes of vomiting. She still worries about what happened to her last autumn and waits to see if it will recur. She prays that it won't. Otherwise, she says she is doing well. It was great to hear her voice on the phone. We promised to talk again.

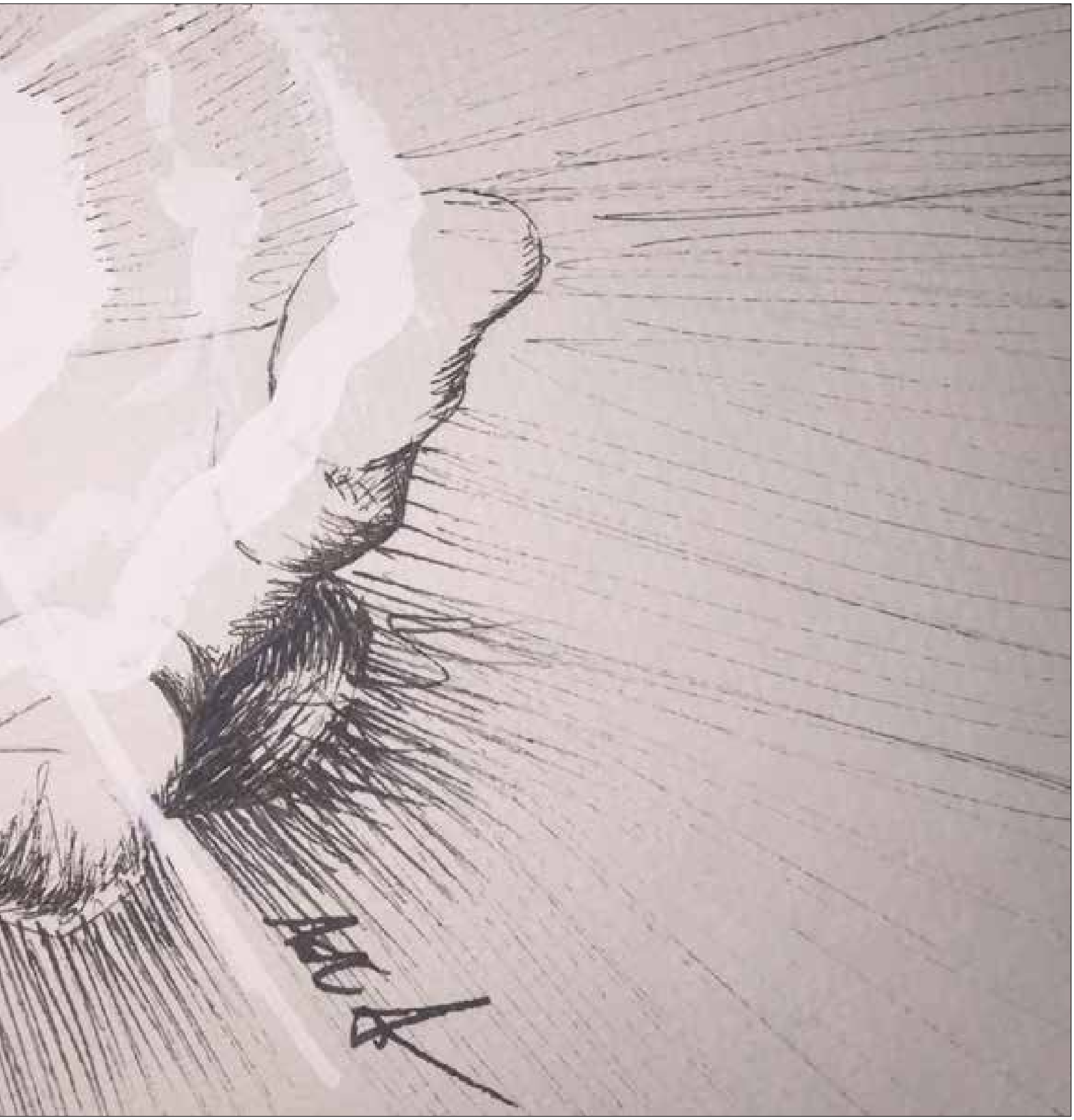
*Adam Lalley is a third-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He is a winner of the Michael E. DeBakey Medical Student Poetry Award, hosted by Baylor College of Medicine, and the William Carlos Williams Poetry Competition, hosted by Northeast Ohio Medical University. His poetry has been published in the* Journal of Medical Humanities.

**Arcadia**

*Jolanta Barbara Norelli is a seventh-year MD/PhD candidate at the Zucker School of Medicine at Hofstra/Northwell. She is pursuing a career in diagnostic radiology after graduation. She is the founder of the Art and Medicine Club and enjoys spending free time painting and designing costumes.*

## Star

*Amanda Lastella is a third-year fine arts and psychology student at Hofstra University. She plans on pursuing a career as a creative arts therapist for early childhood and elementary schools. She wrote: "As I've progressed through psychology, I've repeatedly met with themes surrounding how your internal state, such as your thoughts and feelings, can affect and influence your external*



*state, or your physical body, and vice versa. In this piece, I wanted to pay tribute visually to those internal states in the form of the light source at the center of the hand. It's meant to show how when you care for those internal states, your mental health and emotions, and let them shine, you can begin to positively affect your physical health as well."*

*Students at the Zucker School of Medicine at Hofstra/Northwell study the human body in Structure, a curricular component that combines anatomy, embryology, histology (microanatomy), pathology and medical imaging. Students learn skills of clinical observation, explore anatomical relationships and practice surgeries and other techniques. The body donor's gift helps provide a complete picture of the structure of the human body in health and disease.*

*Making an anatomical gift is what people commonly call "donating one's body to science." Donors sign up for the registry and tell their loved ones about their intent to donate. After death, the whole body comes to the medical school and is used for medical education. This differs from organ donation, in which certain body parts may be transplanted into living recipients.*

*— Robert V. Hill, PhD, director of the anatomical gift program at the Zucker School of Medicine at Hofstra/Northwell*

## A Life Is Forever

It took me a moment to realize that there was an actual person in front of me. It was a surprise at first, mainly because I had never seen a body in such a way. Her name was Reema. I needed a bit of time to get accustomed to the situation. Finally, my hands reached down to touch her. I analyzed every part of her body. There were small details — manicured nails, freckles, veins — that had marked this woman in life. Matching polish painted on her hands and feet. She cared about her appearance. Beyond the physical body, I was seeing who she was and what difficulties she had to go through medically. She was overweight, and I began to think about the lifestyle decisions she had made, and how they might have commingled with the events that took her life. Instinctively, I attempted to piece together a story that surrounded the donor body.

Normally, you get to know people by interacting with them. Through various discussions and experiences, you learn about their lives, character traits and interests. Here, I learned about Reema by searching for pieces of information that could give me a clue into her life. Initially keeping an eye out for medically related issues, I began to understand the dead woman before me. She had a story, and getting to know Reema by examining her body was a remarkable encounter. I was seeing her in a particular moment, but I couldn't help but wonder about all of the events in her life that led up to it.

A person is not defined only by skin and tissue and bones. Rather, a person is a collection of experiences, values and morals that guide behavior and beliefs. Being able to discover certain clues about Reema's life was a valuable endeavor that allowed me to appreciate this person. I wondered about the events leading up to her death and the path she and her family followed that led to the challenging decision to donate her body. It exemplified the type of a person Reema was — someone who desired to help others. I have a belief that every person contributes something special to the world. Even after they are physically gone, their actions have an impact on other people's lives. Reema's gift to me was what I could learn from her; she has given me the opportunity to gain knowledge, intuition and compassion, which I in turn will use to benefit others.

*Joshua Burshtein is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He was born in Queens and grew up in Rockland County and northern New Jersey. He spent fifteen years playing soccer, reaching the highest level in U.S youth soccer. He taught himself to play piano and enjoys playing and singing for his family and friends.*

ANGELA LIU

## To Rest in Peace

I wasn't prepared for her face to look as realistic as it did. Before touching her, I had to first uncover her, and I started by just unveiling her face. It looked as if she were just sleeping. And then, as I continued down, I saw the stitching and the blood and the feet. The feet were the least alive. And then I touched her, and I felt the stiffness of her skin, of her joints, of her limbs, and the last hint of doubt dissipated. I was touching a cadaver.

I eventually started cutting into her. I remember my gloves being covered in fat. That surprised me, although looking back perhaps it shouldn't have. After all, I have worked with raw meat when cooking, and I am often left with oily hands. But perhaps unconsciously, my mind strayed away from connecting this person in front of me with what was essentially a slab of meat.

I remember thinking: Would Reema (the name of our body donor) be mortified that we were digging through her layers of sebaceous tissue? Exposing her fat for all the world to see? I wonder if body donors understand what they are signing up for, if they know what exactly will happen to them after death,

I was struck by her nails, how even postmortem they were perfectly done. After the lab session, the incongruity of open flaps of skin displaying her fat and blood vessels juxtaposed with those pretty nails, matching on fingers and toes, really struck me. And I remembered a question, inspired by a half-forgotten passage read long ago: Is it ever possible to die with dignity?

What about dignity after death?

Toward the end of the session, I saw a piece of paper with the symbol for female and the letters *s-e-a* on it. I remember wondering what that meant, and asking a doctor present. He said he didn't know, either. He went to ask another doctor, and then another, and I stood there vaguely embarrassed, wondering if my question was really all that important anyway. But the doctor came back to me, enthusiastic and excited, and said that he had found the answer. The letters meant that the donor requested to be buried at sea.

I was really glad I had discovered this piece of information, about this woman who once lived in this body that I had just dissected and will further dissect. And then I wondered: What about all the globs of fat we pulled out and disposed of into the biohazard bin? Those will never rest in the sea. And what about the organs that we will find and study in her? Will we put them back?

When will this body rest?

*Angela Liu is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell. She wrote this piece following her experience with her body donor and her first dissection.*

# Donor

Standing in the anatomy room
With its silent occupants
And air heavy with preservatives
Reminds me of the poem “The Giving Tree.”
I wonder what would have happened
If the boy in the poem had wanted to be a botanist.
“Look,” the Tree might say,
“The rings of my trunk tell a story
Of changing seasons, of
Years of climate patterns,
Of history itself.
My leaves trap the intangible sunlight
And give it form.
My branches have welcomed birds
To their nests
And provided shelter from the rain.
If you examine my bark, you will see
Signs of adversity that has shaped me.”
The boy points to a lesion in the tree.
“And this?”
“That,” the Tree says,
“Is why I had to leave.”
The boy stands alone where the tree once grew.
There is only forest
And sky
And silence
Weighted with unspoken promises.

*Yuna Choi is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell. She enjoys writing and painting, and she is interested in the intersection between medicine and the humanities.*

## Chemo Love

He used to sing me
Frank Sinatra songs
as we danced on
New York City rooftops

He used to kiss me
like a schoolboy
lost and giddy

He used to hold my hand
wet and clammy
in the front seat
as we drove up the FDR
listening to our favorite songs

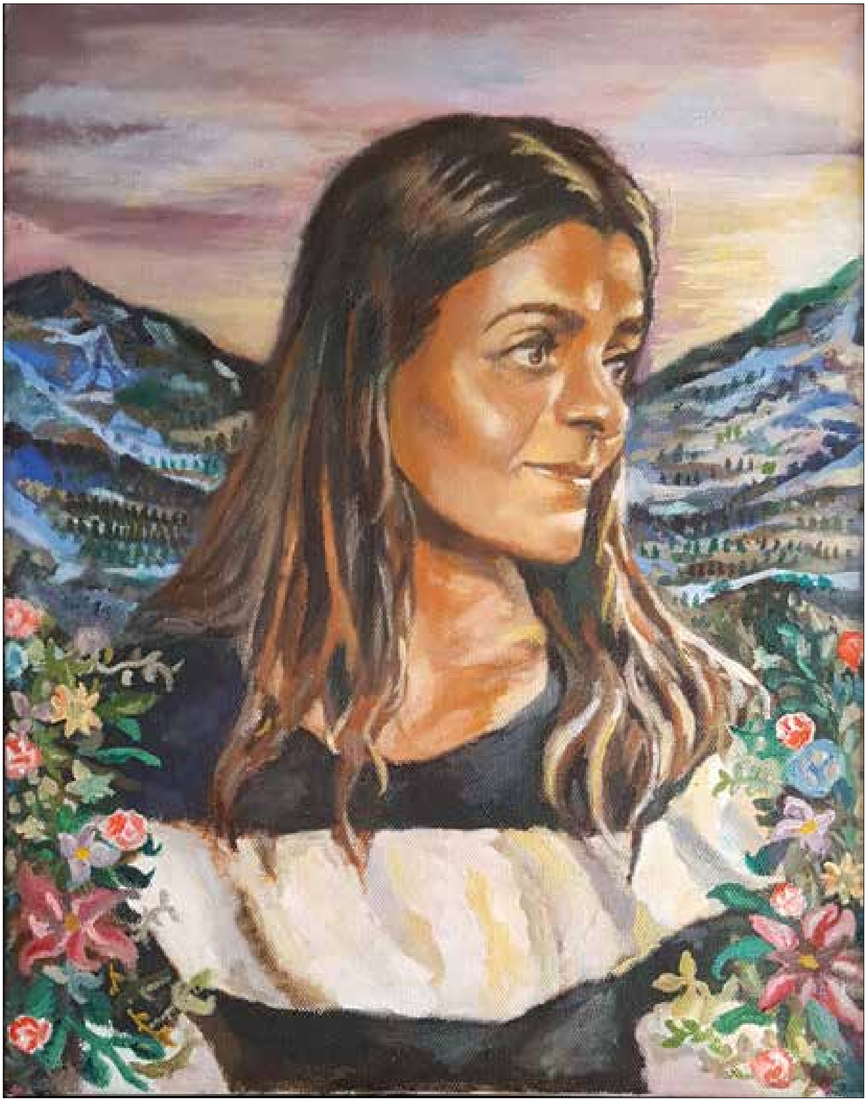
Now he holds my hand
when my line goes in
on chemo days

He sits with me
and looks up statistics,
trying to find a path
to answer the questions:
Why me?
Why now?
How can we survive this?

I love him as deeply
and surely as the breaths I take
to distract myself from the red
liquid seeping into my veins
as he tells me his findings
on recurrence rates,
survival numbers, and
the likelihood of complications

These are the things we talk
about now
lying in bed, whispering,
This data
our new love language.
"You really do love me,"
I say, laughing.
"I really do," he says as he
wraps his arms around me,
cupping my breast.

*Saema H. Khandakar, MD, is a pediatric hospitalist at Cohen Children's Medical Center and an assistant professor at the Zucker School of Medicine at Hofstra/Northwell. She is a breast cancer survivor who enjoys writing in her spare time. Her writing has been featured in the* New York Times.



## The Only Patel in the World

*Wilhelm Chang, DO, is a PGY-1 internal medicine intern at Lenox Hill Hospital. His real name is William, but when after an exhausting day he switches his white coat for his artistic hat, he transforms into Wilhelm He aspires to be both a Renaissance man and an enlightened Chinese scholar of antiquity, well versed in all aspects of life: social, artistic, spiritual, intellectual and physical. He said: "Art is a love for life and fosters compassion so important for a young doctor in training."*

## Farmhouse

Mamie Gall, a student in my poetry writing class at the Jones Institute, told me that her family once owned a dairy and vegetable farm that extended between the railroad tracks and Union Avenue, from the Westbury station to New Cassel.

"My house is long gone. But right there, I grew up on a farm there. My father owned it. So did his granddaddy."

Mamie held her pencil above her paper. I encouraged her to think about food. Later, she volunteered to read her poem aloud.

The house is clean, the furniture is sparse,
the table is laden with simple fare:
peas, potatoes, bacon and eggs, and butter freshly churned.
There is fresh honey, and the scent of cured ham fills the air.
Welcome neighbors, to this simple fare, the food of life.

What neighbors? What friends? I found out more each week about the "food of life" in this building of broken furniture, rank toilets, taped windows, rattling pipes, asylum-grim walls and unpainted hallways.

The Jones Institute was a waystation for poor, homeless and emotionally disabled individuals. In 1978, I volunteered to teach a poetry writing class once a week for two months, a proposal met with suspicion by the administration. Even after showing the director my two published books of poems, it took several months and several phone calls before she agreed to allow me to teach the class.

The dayroom where we met was rarely set up; I needed to open bridge tables and find chairs for the dozen participants. I brought my own paper and pencils. Twice the dayroom was locked, and no one could find the key to open it. Since there was no other place to meet, I had to cancel class. Another time a window couldn't be shut as a storm raged, and once the floor was flooded from a burst pipe.

In one session Palma, another student, wrote:

My father had a gas station.
I lost a kid brother in the war.
I was brought here because I was sick.
Now that I'm well, I feel better.
I'm waiting for my husband to take me home.

Palma didn't show up one morning. The staff never told me that a resident would be absent. If I found out anything, it was through another resident. I knew that Palma and Mamie shared a room.

"Where's Palma today?" I asked. "Is she okay?"

"Yesterday morning her chest of drawers was empty. She's gone."

"Did her husband come for her?"

Mamie shook her head. "Her husband passed many years ago," she said.

Mamie handed me a poem she had written on her own.

Yesterday we sat here.
Today you've gone, and I sit here alone.
I see you in the books I used to read to you,
In the music you listened to
And in the walks we took together.
No, Palma, I am not alone.

Mamie was my favorite student, I suppose because she was the most outgoing and articulate. She often returned to her life in Westbury. My doubts about the accuracy of her memories disappeared as she revealed more. She had been at the Jones Institute for more than twenty years, a fact the director confirmed.

"I was born in Westbury. I had six brothers and one sister. My father died in an accident. He was driving a wagon back from the coal yard when was hit by a train."

Coke-bottle glasses rested on her nose. She wore her wiry hair swept back, revealing small ears and a broad forehead free of furrows and wrinkles. Her hands were smooth but ashy. Mamie was the staff's favorite. She had a perpetual smile and took care of her basic needs. Once a year, department stores donated clothes to the institute, and the staff gave her first pick. While they encouraged her to take whatever she liked, she said, “This is all I want.” She wore a spotless white dress with pale yellow circles and a triple strand of plastic beads.

Most residents wore clothes that hadn’t been stylish in decades, stained, worn, smelling  of age. One day I asked Mamie why others didn’t have fresh clothes, as she and Palma did. Mamie’s lips tightened. I had touched on a topic she would rather avoid. I didn’t pursue it any further. We began to work on the day’s theme, “Animated Animals.” Her smile returned.

I stood by the edge of the pond
Watching the ducks swim among the lily pads.
Some were white and some were brown
And seemed not to be aware of their surroundings.
To them, all was right with the world.

More than fifty people lived in the forlorn stone building, on a thirteen-acre plot. Where once the residents grew their own food, the land was now weeded over, crossed only by residents on an occasional walk to the gate on West John Street. “This was ours, from the station all the way here,” Mamie remembered. “It was my grandfather’s, then my father’s.” She rolled the pencil between her fingers.

“Do you want to write this down? Is this a poem?”

“No, I want to tell you about it. From the Westbury station all the way here. It was big, maybe the biggest around,” she repeated. “All the way here.” She saw my skeptical look. “You don’t believe me?”

“Poetry is about not what is true but what you truly feel,” I said.

“This isn’t a poem. The farm once stretched from the coal yard by the train station all the way to here.”

“Maybe we can make it into a poem,” I said.

Half an hour later, when I returned to her after having worked with other students, she had written:

How I miss the little wooden schoolhouse
Set back from the road.
The building is old and the pictures are all gone.
In this place I still see faces of girls and boys
Eager to get on with their lessons
And learn more about the world.

At the last class Mamie handed me a shoebox filled with sheaves of papers upon which she had written some of her memories and a family prayer book. “I don’t know what else to do with these,” she said. “No one else is interested. But I think you would be. It is information about my family’s history. I’m afraid that they would be lost if I didn’t give them to someone who would keep them safe. There is always a bible for me to read. I’m fond of this one, but every bible is a comfort.”

Over the next several weeks I read them carefully, checking some of the information against records I found at the Westbury Historical Society. I confirmed most of Mamie’s information and filled in some pieces for the historical society.

Mamie was born in 1900, in Grantville, the African-American section around the Westbury train station, a name given to the neighborhood in the eighteenth century when Quakers began granting property to their manumitted slaves.

In Mamie’s prayer book I found the names Tamero and Oyo. In old-fashioned handwriting that had faded, two words were written: Old Calabar and Barbados, most likely their last stop in Africa and first in America. The list continued with Tamero and Oyo’s son, Obium, who married Rose. Nero and Bridget were their children. Many names in the book weren’t legible, but I could read Richard, Cato, Elkanah, Hannah, Cloe, Jupiter, Benjamin, Peni, Ruth, Nancy and Sarah. Altogether, the names seemed to represent at least six generations born on Long Island, most enslaved, some born free.

Mamie’s great-grandfather had aided runaway slaves on their route to Canada. Over the years, each generation sold parcels of land. By the end of the nineteenth century, the farmland was gone. The first parcel went to an African-American women’s group, which established a summer residence, the Garnet Memorial Home, for black women and children from New York’s tenements. Subsequent parcels were bought by Italian and Polish workers from the Gold Coast estates in Old Westbury. By the time Mamie was born all that remained was her father’s two-acre plot, the last black-owned dairy in Westbury. She remembered several cows staked out in the field creating circles in the grass as they grazed, and a smokehouse to cure meat.

After her father’s death, Mamie cared for her mother and worked as a washerwoman at Hesse's Hotel near her farm. When her mother died intestate, Mamie's siblings fought over the land. But probate court agreed with the town to foreclose on the house because of unpaid property taxes.

Mamie rented a room at Hesse's Hotel, but when the hotel changed hands, she lost both the room and her job. That summer she worked at the Garnet Home, but when winter arrived, she was jobless again. The charitable volunteers at Neighborhood House arranged for her to live at the Jones Institute.

Several months after classes ended, I returned to the Jones Institute. "Can I see Mamie Gall, please?"

The woman behind the desk, the same one who had given me the sign-in sheet on previous occasions, looked at me scornfully.

"I taught the poetry class here."

"I know who you are," she said.

"I'd like to say hello to her."

"Does she know you are visiting?"

"No."

"She needs to know in advance."

"I didn't know that."

"Did you call?"

"No."

"You need to call before visiting."

"Can you call her for me, please?"

"You need to call yourself."

"Okay. Can I have the phone?"

She stared at me and moved to keep the office phone out of my reach. "There's a pay phone in the hall."

"What's her phone number?"

"She doesn't have a phone."

"So how do I call her?"

"Call the facility and leave a message."

"Do you mean that I need to call to talk to you, so I can leave her a message?"

The conversation continued this way for another minute, until finally the secretary said, "She isn't here today."

“Where is she?”

“I can’t tell you that.”

“Why not?”

“It’s confidential.”

“When will she be back?”

No answer.

“Is the director in?” I asked, knowing that she was rarely in before noon.

Growing visibly irritated, she shrugged her shoulders, rose from her seat and went into the back office. As I turned to leave, I noticed the dayroom’s door was ajar. Mamie, her head on her chest, sat in a chair, immaculately dressed as always.

Mamie,” I called.

On her lap she had a copy of *Sunflower Splendor*, a book of Chinese poetry I had given her.

“Mr. Dobrin,” she said as she opened her eyes and lifted her head.

“I’m happy to find you,” I said. “The office said you were out for the day.”

“I’m here,” she said.

“So, Mamie, how are you doing?” I said. I took her hand as I pulled over a bridge chair next to her.

“I’m fine. But I’m moving out soon.”

“Really? After all these years? Where are you going?”

“I don’t know.”

“Why are you leaving then?”

“It’s being sold. There’s nothing special about Jones, but it’s nice to be part of it. I expected it to be open forever. They didn’t tell me where I’m going. Everyone I know is gone already. They said there is a nice nursing home for me.”

The following week *Newsday* ran a story about shuttering the Jones Institute.

During the early years of operation, the residents were commonly referred to as inmates, and those able to work farmed the property to help sustain the facility. Sale of the property became necessary to close the deficit between operating costs and income. The residents were placed elsewhere.

Trustees of the institute said they closed Jones in anticipation of a two-million-dollar sale of the thirteen-acre property to King Kullen Supermarkets. They said that the sixty-nine-year-old structure had become too expensive to operate and that the residents' monthly Supplemental Security Income checks were not enough to cover costs.

I called the *Newsday* reporter and asked if she could tell me where I might find the former residents. She directed me to the Brush Hollow Nursing Home, a single-story building much like a motel. It was a mile from my home. The lobby smelled foul. Among the several people in chairs, some staring, some sleeping, I noticed my former student Abe.

"Abe."

He didn't turn his head.

"It's me, Arthur."

Still no response.

"The poetry class."

He didn't acknowledge my presence.

"What do you want?" a woman behind the reception desk shouted.

I left Abe in the chair and walked to the desk. I began to explain my visit but didn't get far when she admonished me: "You can't come in here and start talking to people."

"But I know him. I've come to visit. To say hello."

"You need permission to talk to someone."

"So I'm asking."

"We don't need troublemakers here. Get out."

"This isn't a prison."

"If you don't leave now, I'm calling the police."

"Are there others from the Jones Institute here?"

"Get out!"

"Let me leave a note for them. They can call me."

I scribbled my phone number on a scrap of paper I pulled from my pocket. She didn't even wait for me to leave before she tore it into several pieces and tossed in a wastebasket beside her desk.

I made several more attempts to visit, called, sent letters, to no avail. Within a year, the Brush Hollow Nursing Home was shut, and when it reopened it had changed names and had become a private assisted living facility. The Jones Institute had reopened on the tony

North Shore as the Jones Manor on the Sound.

I drove to Bayville to look for Mamie or anyone I knew from my class. The receptionist was pleasant but puzzled when I asked about residents from the Jones Institute. She had never heard of the home. This was a private nursing home, she explained, part of a California chain.

In the lobby were people neatly dressed and well cared for, mostly animated, some even cheerful.

Where was Mamie? I would never find an answer to that question.

*Arthur Dobrin, DSW, is professor emeritus at Hofstra University and leader emeritus of the Ethical Humanist Society of Long Island. He is the author and editor of twenty-five books, including four novels and five books of poetry. He served as a Peace Corps volunteer in Kenya.*

**Riptide**

*Lena Liu is in the 2019 graduating class at the Zucker School of Medicine at Hofstra/Northwell, and will be heading into a neurology residency. She wrote of her painting, "The turbulent waves hitting the shore represent the unpredictable waves of emotion we feel as care providers throughout the ups and downs of a patient's course."*

## Fractured

Months ago, I was called to the bedside of a 101-year-old woman who had fallen and fractured her hip. She was soft-spoken and a bit frail, but nothing in her medical history suggested that we shouldn't operate. Everything about the break and the location made me comfortable that this was something I could mend. After all, my job is fixing bones.

A hospitalist and a cardiologist examined her and signed off on the surgery. I discussed the benefits and the risks of hip surgery, and she and her daughter agreed that it would be good to be able to walk again, and without pain. I gave them a crash course on hip fractures. There are risks at any age, but certainly an aging body is more vulnerable to problems: bleeding, infection, nerve damage; or the bone or wound might not heal as well as it would in a younger person. Of course, there is a one percent chance of losing your life on the table. And in older people, mortality within one year is around twenty-five to thirty percent. They seemed to understand. To do the surgery, her daughter had to temporarily rescind the Do Not Resuscitate order. Consent forms were signed and we put her on the OR schedule that day.

I have operated on over 570 patients since my orthopedic residency days. Now, I was teaching a new generation of residents. With me that day in the operating room were two residents, and I guided them through the procedure. Three screws traversed the fracture site, and the bone was fixed. The X-ray looked fantastic. By any account, the surgery was a success.

The next day, I visited my patient. She was chatting away and doing well. She thanked me. I smiled. I had been excited about the case. She was my oldest patient, so far.

A day later, the call came. One of the residents informed me that my patient had passed away. He had found her unresponsive, and her DNR was back in the charts so they had not attempted to resuscitate her. I was devastated. This was the first person I had taken to the operating room who died.

I called my patient's daughter. The phone rang and rang, and it finally answered with a beep. *Leave a message...beep.* I reintroduced myself on the tape and offered my condolences. “Please call if you need anything. I am so sorry for your loss,” I said. I wanted to help mend her heartbreak.

The call was never returned.

*Adam D. Bitterman, DO, is an assistant professor of orthopedic surgery at the Northwell Health Orthopaedic Institute at Huntington Hospital. He is a foot and ankle specialist.*

## Alone

A black dotted line of ants attaches, as if glued,
to the outside of the cabinet door,
in the grimy kitchen
of a very old woman

The ants point to a pile of dishes, unwashed and chipped,
assembled with stuck-on food, on the Formica counter,
as if this collage was her last creative act.
Stale air. No air.  An empty oxygen tank idles solo,
The woman is alone
By choice –
Ninety-eight, and feeble, she offered thorns to those who came close,
and retreated with lowered eyes.
Her body, a gnarled tree trunk shrunk and splintered,
hollowed out from lack of nourishment.
Even the ants withdrew.

The clock stops its mission and darkness diffuses the room,
The air hangs,
It masks the scent of urine in soiled diapers
tossed on the floor
in the sad bedroom.
Though her younger journeys
opened panoramas of sky, land and sea
They will end today in a perfect pearl
of a full moon.

*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 a pioneer of narrative social work, with a chapter in* Narrative in Social Work Practice: The Power and Possibility of Story.

## A Day in my Country

I woke up on this beautiful cool morning to the sound of a rooster reminding us it was time to greet the day. The familiar sights and sounds of my country at dawn:  the *pasolas* (mopeds) roaring to life and gliding seamlessly between the vans and trucks; the smell of Santo Domingo coffee; the calls of the street vendors, with their wide, toothless smiles, beckoning walkers with their vine-ripe avocados, coconuts asking to be cut open to reveal their sweet milk and creamy pulp;  my people greeting with a kiss and generous smile, going out of their way to wish everyone *buenos días*. This was my view of the morning. The nostalgia was almost overwhelming but altogether comforting.

We arrived at the hospital to present to the residents, and again I was filled with pride as I watched my classmates navigate a case and educate others. We had the opportunity to work with Dr. Ruth Rivera, who is the kind of person who will awe you and restore your faith in humanity with just a few witnessed interactions. She introduced us to her patients as her colleagues from the U.S. with respect and allowed us to take part in her physical examinations.

We attempted to auscultate fetal heart tones with our stethoscopes as she does daily, and she smiled from ear to ear while thanking us as we gifted her clinic a Doppler to enable her patients to listen to their babies along with her. We then got to tour a public hospital that had recently undergone renovations. The walls were brightly colored and the rooms large, clean and well lit. The medical director took time out of his busy day to show us around and answer all of our questions. He graciously told us about all of the donations and mission work that have helped make the hospital what it is today. They see 500 to 600 patients on an average day in their ED for no charge.

Something that struck me was the number of women in medicine. I inquired if this was specific to this region and was told that the vast majority of medical students throughout the country are females. These physicians are truly remarkable human beings.

They work tirelessly, smile through it all and make such a difference with so few resources. Perspective and gratitude for this trip are part of my every day.

A mantra I've been saying to myself in my tougher days of intern year is "not every day is a good day, but there is good in every day." The more memories I make with my co-residents, the more I learn that no matter what a day brings, there is always good in my day.

*Hennessy Skehan, MD, is a resident at Phelps Hospital in Sleepy Hollow, New York, a part of Northwell Health. Dr. Skehan's family is from the Dominican Republic, and as a child she spent six months of every year there. In January she took part in a medical outreach program to the Dominican Republic sponsored by Northwell. "A Day in My Country" is an entry in her journal. Another participant in the program was Khristina Booth, DO, whose photograph is below.*

## A Church at Alaman Batay

*Khristina Booth, DO, is a resident at Phelps Hospital in Sleepy Hollow, New York, part of Northwell Health. This January, she took part in a one-week medical outreach program to the Dominican Republic sponsored by Northwell Health. The group traveled to Pedro De Macories, where they volunteered at the Jamie Oliver Pinot Hospital.*

## Cohort ID 1325

I had been working with Cohort ID 1325 closely for months. She was the most popular serum vial in the cohort. I found her in the right corner of the third rack from the top of Sub-Zero freezer #16. I knew her demographics by heart. By chance, we were both twenty-four. I never needed to enter the database for her numerous comorbidities. Her main disease – the one that had taken down her young body – was lupus. There was nothing slow about her case. Lupus was the runaway train in her body.

Her serum was so popular that it had helped develop multiple monoclonal antibodies. I could not wait to see her face to face in clinic and let her know what a contribution she had made. Perhaps her disease was not currently under control, but the possibility of remission was not far off for her and others, thanks to her willingness to reliably provide serum every three months.

But my chance to speak with her never came. When I went to check her medical history in the record, I was confronted with the gray screen that signified a deceased patient. Her last few days were filled with fluids, pressors, broad-spectrum antibiotics, multiorgan system failure and multiple goals-of-care conversations; a common narrative in every hospital.

I thought of Cohort ID 1325 often throughout medical school. During my first years, I thought about her when we covered the multiple complications she lived with. I continued to contribute to projects in the hopes of using clinical research to assist other patients years down the road. Maybe entering this data would show statistically significant differences to provide clues to disease pathology. Perhaps this retrospective cohort would provide evidence in support of new treatment guidelines.

I had come to know her so well that there were times that I missed her.

During my third year, I saw her in almost all of my patients. I saw her when I described how hypertension can damage kidneys and why something with the word hemoglobin is actually more pertinent regarding the sugar in blood than the blood itself. I saw Cohort ID 1325 in every code blue.

I knew the quality of my chest compressions, my ability to work as a team member and my medical knowledge could alter a patient's course. I was aware that I thought of her often because of the research I participated in. However, I started to consider that perhaps I remembered her so often because she is the type of patient that I gravitate toward: the patient who is complex and warrants careful recall of basic pathophysiology in order to balance multiple comorbidities with various medications, each with its own set of contraindications and adverse effects; one whose care requires input from multiple specialties, explanations of disease management and discussions of lifestyle modifications to prevent future complications.

I spent four years reading Harrison's textbook and memorizing pages of first aid to learn diseases as individual entities, almost in their own vacuum. I want to spend the rest of my years seeing the faces behind these diseases and how their occurrence and management can be intertwined with and affected by changes in socioeconomic status, access to quality health care and the environment that surrounds the patient. One might say it is difficult to work closely with patients knowing you will have, at most, a few days together during their hospitalization. And if we meet in clinic, these visits last a mere hour or less. But it takes a certain amount of unconditional acceptance to greet patients at the emergency department or clinic with empathy and interest regardless of poor genetics, choices or luck. It is easy to look at a room full of physicians and say that we spend too much time staring at screens. But I would argue that it takes compassion to know that every click has a consequence; an opportunity to improve a patient's condition or his or her access to timely, quality care.

Four years after "meeting" Cohort ID 1325, I still think of her often. But now I also think of my sixty-three-year-old patient who needs to control his blood pressure so he can continue to deejay in his Jamaican community and my ninety-three-year-old patient with newly discovered atrial fibrillation whose only concern is getting back to her Kiwanis club activities. My interest in medicine began with a 30cc serum vial, but it continues with every patient.

*Ana Valle is in the 2019 graduating class of the Zucker School of Medicine at Hofstra/Northwell and plans to go into internal medicine. She was born in Panama and raised in Pennsylvania, and then she moved to Baltimore to study public health. She enjoys reading, barre classes and her cat, Phillip McAllister.*

**Burmese Balancing Fisherman - Inle Lake, Myanmar**

*Alan Sloyer, MD, is an associate professor of medicine at the Zucker School of Medicine at Hofstra/Northwell. He is a gastroenterologist practicing in Great Neck, Long Island, and travels the world with his camera.*

## A Simple Endothelial Cell

He lived a simple life. As a simple endothelial cell, he spent his days doing typical endothelial cell things.

Every hour started with maintenance of his lipid bilayer, followed by routine checkup of functional proteins and ending with an ATP generation push. The most exciting thing he ever did was release cytokines whenever anything suspicious bumped into him from the bloodstream.

Then *she* rocketed into his life, literally. With a crash, she, a recently matured red blood cell, unceremoniously ruptured his perfectly symmetrical lipid bilayer. Cytokines spilled out, attaching to the offending erythrocyte and signaling *OUCH*.

*Sorry!* she signaled back. *I just matured. Haven't gotten navigation down yet! Beautiful border though!*

He did a double take. Were these messages meant for him? Red blood cells smashed into his borders all the time. No erythrocyte had ever bothered to send an apology before. Endothelial cells out this far out in the periphery were normally ignored.

He quickly gathered some signaling peptides to send back, but she was already out of his range. All he saw was the flash of her pale central pallor and then she was gone.

He kept a lookout for her. As he dutifully repaired his membrane, he scrutinized every blood cell that passed by for the specific curve of her dimple. He started wondering if he had imagined the whole thing. Then, as suddenly as last time, she came careening into range. *Hey!* he shouted out, waving his transmembrane receptors. He watched her angle out of the main flow and get closer to the vessel wall.

*Hey?* she signaled back. *Oh! You're that endothelial cell I ran into a bunch of circuits ago.*

He quickly sent out his reply. *Yeah! Just wanted to say hi!*

The moment he released the cytokines, he wanted to bring them back in. Could he *be* more lame?

Her response was instantaneous, *Well, hi!* she said. *Your repair mechanisms are really good. I can't even tell something had happened.*

He was slow to get his reply out, but he was getting used to the pace of signaling. *I've had a lot of practice*, he said, feeling witty.

Then he hurried to add, *I've never signaled to an erythrocyte before.*

*Do you often talk to endothelial cells?*

She was right in front of him now, crawling along at a snail's pace. He could see the cytoskeleton that held her curves and the pleasant red hue of her rounded edges. At his question, she turned, shaking some oxygen molecules loose.

*Not really,* she admitted. *It's too much effort to signal when the flow is so fast. But apparently I make exceptions for the kind ones.*

Was that a compliment? He couldn't think of anything to reply with, and she was already nearing the edge of his range. *Does that mean you'll stop by once in a while to signal?* he blurted.

She turned again as if trying to see what kind of cell she was actually talking to, and as more oxygen floated away, she lightly replied, *I like your directness, thelio cell. See ya 'round!* And then she was gone.

*See ya 'round*, she had said. He added some extra receptors to the newest batch of membrane proteins, just in case she had a hard time spotting him on her next circuit. For some reason, adding one amino acid to another didn't seem as dull as it always had.

Over the course of hours and then days, they grew to know each other. They realized they had a lot in common. They both followed a precise routine that was boring yet reassuring. They shared a curiosity about what other cells were up to. They both felt a certain discontent with existence as they knew it.

He shared his frustration with being stuck to a basement membrane, unable to know anything other then the nanometers of signaling range that he was given. All his life, he repaired, built and generated ATP. What was the purpose? he wondered.

He learned about how unsettled she felt, always whirling around, constantly displaced and never having a quiet moment to just sit and contemplate. All she wanted was to be still for one second rather than having to go with the flow. When would she be free of that constant force? she had asked one time. He didn't have an answer.

The best part was the stories. Because he was stuck, she told him stories about the coronary passageways that moved in patterns he couldn't imagine and epic tales of osteoblast warriors who fought a never-ending war against the osteoclast bullies. She made him feel vast, alive.

One day, she came with an exciting story from the gastric vessels. They had noticed an increasing amount of VLDLs being shuttled through and had an insane conspiracy theory.

*Okay, what's the theory?* he asked, settling in for a good story.

*You'll get a kick out of this one,* she said. *So you know how VLDLs lead kind of a sad life?*

*No,* he replied.

*Oh, okay, well, they're the ones who go around delivering triglycerides, getting smaller and smaller until they disappear back into their birth cells. You know, honorable and self-sacrificing and all that, but also kind of sad.*

*Got it,* he replied.

*Yeah, so GI cells think that the VLDLs have been plotting their revenge for eons and one day, these lipids will band together and stop the current.*

*What do you mean, stop the current?* he asked

*Not sure, they just said the lipids have some ability to stop this flow I'm in. Can you imagine? Maybe there is hope that I won't be constantly pushed and prodded like this forever,* she said, with brightness in her dimple.

He thought about it. He had heard from the lymphopolice that if his membrane ever became damaged it would accumulate something called platelets, and those might attract things called lipids. He had always been told that if lipids ever came near him, he had to sound the alarm and it was a dire emergency. They never explained why, though. No one ever did. Everyone just assumed endothelial cells out here had no thoughts of their own. Everyone except for her.

*It sounds as if the GI cells are generating too many reactive oxygen species and going radical,* he replied, a plan forming in his head. If lipids could stop the current, and membrane rupture attracted lipids, maybe he could give her the one thing she wished for the most. He returned to the conversation. *But for your sake I hope they're right. Maybe these lipids do have some magical superpower we don't know about.*

She didn't reply for a bit, lost in thought, drifting. *Maybe,* she said. *And maybe if I'm especially lucky, I'll get to stop right here, so we can talk for a little longer before the end of existence as we know it.*

*Yeah,* he replied. Then he paused. He felt as if this was the moment. This was when he should tell her how much he enjoyed their conversations, and how he wished she could stay right there forever. This was the moment he should tell her he didn't hate being stuck on this basement membrane any more, because if he wasn't stuck, how would she ever find him? She had turned the part of him that he hated most into his greatest strength, and she had showed him that no matter what kind of cell he was, he could have the kind of life he had always wanted, one that was filled with experiences, even if not first hand. He wanted to tell her, but of course, she was gone.

As time passed, they kept up their microsecond-long conversations, and he secretly let his bilayer get more and more frazzled. Lipids, platelets and cholesterol started accumulating. He didn't see how this would affect the current, but he did notice that she was able to stay longer in the shadow of the growing tower. However, she never stayed long enough for him to work up his courage to tell her how much she meant to him. *You mean so much to me. You make me a better cell. You are my world.* If only they had more time.

Then, when he felt as if he was going to go crazy, a large blob of yellow touched the top of the plaque tower and got stuck. The current pushed against it, but it remained in place, blocking the artery. Everything paused.

*Catch ya lat*— she had started saying before the current had stopped carrying her signals. She hung in the fluid, suspended in serum. For the first time in her existence, she was still.

*The current stopped,* she thought, amazed. *Could this really be happening?*

He wanted to signal that his plan worked, that he had stopped the current just for her, but he suddenly had trouble generating ATP. He started to panic. Where did the oxygen go? He felt nuclei shutting down and peroxisomes start to undergo apoptosis. NADH and FADH2 accumulated on the inner mitochondrial matrix, waiting for a final electron carrier that would never come to take their electrons.

Above him, she shivered, releasing bubbles for him to use. Oxygen diffused in all directions, with a small amount coming through to him. With that and the last of his ATP, he generated one message to send out into the still serum, hoping it would somehow get to her.

She hung in the silence and felt her glucose stores depleting. She felt the presence of glucose all around her, but there was no force to push the monosaccharide to her GLUT1 receptors. *Please,* she thought, *let me move again.* With a gush, the plaque tower dislodged. As the fluid started shifting, she got his last message.

*I didn't know what this would do, but for you I would do it all again. Be still, and thank you*, he said.

She looked back at the macrophages as they engulfed the endothelial cells that had undergone necrosis. Soon, they would be replaced with identical copies and the border would be as smooth as can be. She herself would make a trip to the spleen. The current would continue and new red blood cells would circulate. It was a silly dream to “be still,” and there would be no record of what transpired between a hopeful erythrocyte and a lovesick endothelial cell. And yet, she too would do it all again, because he was right. Without a dream, without love, without mistakes, without purpose, without wonder, without taking chances, what is an existence?

He lived a simple life, yet one that was not simple at all.

*Dee Luo is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell. This is her first time writing fiction, but she hopes to expand upon her world-within-a-body idea in the future.*

## I Have a Dream

*Kishen Bulsara is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell. In his free time, he enjoys listening to music, watching movies, cooking and traveling.*

## Letter from a Small Someone

*Dedicated to every medical student who has ever felt small but has found joy along the journey*

I am proud to wear my rose-colored glasses.
I have spent years polishing them. The smudges wipe away, some scratches remain, but what they reveal is still beautiful.
They are mostly given, partly nurtured, partly earned.
How silly that you think they make me blind, when they show me with such clarity what the naked eye cannot see.
Through these lenses
a once daunting skyline becomes a million tiny bright windows into the large world that exists beyond medicine,
an inconvenient interruption at the public library is a reminder of how real and interesting the people behind those windows are,
an unpleasant subway car becomes the brief intersection of dozens of stories that will never meet the same way again,
each failed experiment becomes a chance to renew focus, bringing me one step closer to new knowledge,
every anxious moment of self-doubt becomes a flame in the fire that will forge my future.
When I witness happiness and success and think "those things are not for you," these lenses help me envision a unique future full of things I cannot yet fathom.
It is these same lenses that show me
a frightened warrior in the stoic face of a patient's wife,
true wisdom in the gaze of a psychiatrist as he peers past empty eyes into the mind of his patient,
and the wholehearted love and dedication in the quick half-smile of a curt surgeon.
These glasses cannot change or heal.
They cannot make sense of death.
They can only help you appreciate life and face death with grace.

*Elena Brindley is a fourth-year student in the MD/PhD program at the Zucker School of Medicine at Hofstra/Northwell. She is from Downingtown, Pennsylvania, and is passionate about family, faith, fitness, food, science and all things Notre Dame.*

## A Mother's Love

One fall morning, two decades ago, I arrived at the emergency room before the sun. The unit was already bustling with sick people. I was a new attending, and within days I felt as if I had come home. Everything about this place made me want to be there: the adrenaline, the organized chaos, the opportunity to meet new people. Most days, even with the sick patients I tended, I was happy there. But there is that moment, which most of us know, when the world shifts under us, the day that lasts forever as a lesson and a scar, the day when a patient leaves his or her legacy in your hands. This was my day.

My patient was Sean. He was acutely ill. That was the first thing I noticed when I walked into room 10. Shortness of breath was the chief complaint. This was typical fare in the ER, I remember thinking. He was sitting crossed-legged on the stretcher.  I thought this was odd.

He was a small man with a soft, gentle voice. He was cachectic. I introduced myself. "Hi," he said. His gaze was downward and fixed. An older woman sat by the stretcher with a look of concern.

He was already hooked up to a cardiac monitor and pulse oximeter. I attempted to take a history, but his words were faint. He motioned with his hand to the woman sitting there. It was his mother.

A nurse had already implemented orders — oxygen supplementation, IV insertion, phlebotomy, electrocardiogram. She was prepping him for a STAT chest X-ray. Meanwhile, I asked Sean's mother to tell me his history. He had muscular dystrophy, she said.  He was complaining of shortness of breath.  This was not an unusual complaint for him, but this time it was different, more severe.

Then, I understood why he sat in that unusual position. Sean was diagnosed with Duchenne muscular dystrophy at two years old.  He was now nineteen and wheelchair bound. He could no longer straighten or move his legs. After finishing his history and physical, I talked with Sean and his mother about the severity of his condition, along with the possible treatment options.

I was beginning to discuss resuscitation options, including intubation, when suddenly Sean gently raised his hand. In a barely audible voice, his gaze still fixed downward, Sean responded: "I don't know." His hand moved in the direction of his mother. He was orchestrating his fate.

She responded that he did not want to be intubated or resuscitated. This took me by surprise. He was only a teenager. Perhaps there could be a chance, a glimpse of hope that he could make it through this episode.

I pleaded with him to think about it further. They asked for a minute to talk privately. Respecting their request, I left the room. Upon my return, his condition had worsened.

I turned to the mother, pleading that we needed to work fast to resuscitate him. She lifted her own hand. “No,” she gestured, and then her words came out calmly. She had thought about this moment for thousands of days. Her voice was soft and compassionate: “Hasn’t he suffered enough? This is his wish. We have had this discussion many times. We knew this day would come, and he is ready.”

My eyes filled with tears. I knew she was right, and I felt pain recognizing how difficult the decision was for her. I asked her if I could call someone. “A priest,” she said. “And just make him comfortable.”

We focused on allowing Sean to be as comfortable as possible. We adjusted pillows behind his back against a wall. The priest arrived, and he did God’s work. He delivered last rites. The room was filled with prayer.

Over the next few hours, I was constantly in and out to check on Sean. I ached for this mother and her son. Enough. He had suffered enough. She knew. He knew.

At last, I watched this small, strong woman lean over him, her hand touching his face. She kissed his forehead. He quietly closed his eyes and took his last breath.

In death, his lips were parted in a gentle smile. He had a look of tranquility on his face that we recognized with humility. We stood at his bedside in silence. His mother was the healer in the room. She turned to me and wrapped her arms around my shoulders. She thanked me for listening and making sure her son spent his last hours well cared for. We sat, talked and cried together. Later, she left to make arrangements for his funeral.

On the ride home, I cried. The tragedy of a mother losing her son was overwhelming. I was awed by the strength they both possessed. For seventeen years, she had known his prognosis. Over the years, he understood that, too. They knew a slow, crippling death was inevitable. They were prepared. I had witnessed the grace and acceptance of Sean’s decision. I knew they were right. I admired them.

But I wasn’t ready to accept it.

I have had two decades of doctoring, and I now know that the day Sean died was when I realized the beauty of a mother's true love. She had acted with the utmost kindness and selfless love. At the time she and Sean came to my emergency room, palliative care was not common, but they asked us to provide them, essentially, with palliative care. I am grateful to them for giving me the opportunity to listen and support them in accordance with their wishes. They allowed me a chance to contribute to the alleviation of Sean's suffering by caring for his whole person, including body, mind and spirit. Being in the presence of the courage and love Sean and his mother showed each other made me a better physician. I realize now that I was a healer in those moments, after all.

*Annabella Salvador-Kelly, MD, is associate chief medical officer and vice president of medical affairs at the Zucker School of Medicine at Hofstra/Northwell. She is also an associate professor of medicine.*

## Reflections on Aging

*Cassie Gross is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell. She spent time abroad in China and Taiwan and is interested in holistic and alternative health care. She credits her artistic instincts and creativity to her grandmother, who informally taught her to play with all sorts of mixed media – both in life and on canvas. About her work, she said, "These are two portraits of a grandmother experiencing both the joys and the darker reflective moments in her life. As she has aged, I can sense her inner struggle as she comes to terms with the purpose and meaning in her life after her husband has passed."*

## *"L'Albatros"* by Charles Baudelaire

*Translated by Eugene B. Friedman*

Oftentimes, the ship's crew, for their own amusement,
Corner albatross, vast birds of the ocean's sweep,
Escorts of the long sea voyage, those indolent
Consorts of vessels gliding 'cross the bitter deep.

Scarcely have they been deposed onto the planking
When these kings of the Azure, clumsy, stripped of pride,
Sorrily surrender, their great white wings hanging
On the deck boards, like paddles dragging alongside.

This winged traveler, how spineless, gauche and weak!
So ugly!  What a buffoon! He's handsome no more!
One sailor jabs his short-stemmed pipe at the bird's beak,
Another limps, mocks the cripple who used to soar!

The poet is so much like this prince of the clouds
Who haunts the storm and targets bowmen for taunting,
Exiled on the ground, surrounded by jeering crowds
His giant wings make the smallest steps too daunting.

*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. *In college, he used to read French poems in their original versions, and he decided to return to these poems and translate them.*

## Trust

I awoke that morning and put on dress clothes: a dark floral blouse and black dress pants that were neatly ironed. I combed my hair and donned more makeup than usual. I selected my fancy but comfortable shoes. I made sure I resembled…well…an adult.

I arrived early, well before any student would even consider getting to school. I walked into MET201 but didn't take a seat. I went straight toward the center, placed my belongings on the podium and looked out at the stadium seating before me. The hall was silent and motionless. I felt a thrilling fear surrounding me.

As the students began to file in, the room buzzed with conversation, laughter and the distinct aroma of hot coffee. I briskly moved to a seat in the corner and reviewed my notes, certain that I needed every second of preparation.

"All right, guys, let's get to it." It took a moment for the students to realize that I, a young student playing dress-up in adult clothes, was about to start class. As I waited for everybody to settle down, I looked out at those who were ready. They stared back blankly, half hidden by their computer screens, faces lit by the glow of technology.

I had that moment — you know, the one where your stomach instantly drops and you feel light-headed, only to recover with an unsettling abdominal sensation. I was standing there, at the front of the hall, ready to facilitate information, to convey knowledge and to help consolidate learning.

I share a common goal with the students, to enhance comprehension and elevate the level of education. But do the students trust me? How could they trust the girl standing at the wrong place in the hall?

I am a student, not a teacher. In fact, I have been a student for over twenty years. The hat I am accustomed to wearing is small, and it signifies the constant drive to absorb information that is presented to me. As I complete my fourth year in medical school and a two-month-long medical education elective, I realize that my student hat is being replaced by a new one, that of an educator. Was I ready for this? There went my stomach again.

"All right, everyone, here is your first slide. We are in the esophagus. If I told you that this was abnormal, please tell me in which layer the pathology lives. You should work with a partner." That was my first prompt to the hundred students staring back at me, expressionless.

Over the past month on my medical education elective, I have learned that the cornerstone of education is trust. Trust is a bilateral adventure; trust is given where trust is received. Trust is seeded in the commitment to shared goals. During my first moments in front of the class, I had a trust crisis. Did the students trust me to teach them? To ask the right question? To challenge them? Did I trust the students to answer the question properly? To have completed the pre-reading? To even listen to my question?

I was convinced that I had prepared flawless questions, but while the class stared at me for what seemed to be an eternal fifteen seconds, my stomach took a nosedive. Thoughts rushed through my head: "They don't trust me. I don't trust them." Finally, the room started to buzz with conversation about the question I had posed. In that instant, with just a sliver of trust from the students, I reciprocated with even greater trust. I listened in on some of the conversations that they were having — some correct, some incorrect, some with novel insights I had not even considered. I learned that if students are given trust by the educator, both can achieve a desired outcome

As I transition into residency, as I realize that I will be a physician soon, I know that the trust that I have established with my students can be translated into building relationships with my future patients. Trust will be the cornerstone of my patient-physician relationships. Trust will allow me to guide my patients through their journey, teaching and educating them about their health and their ailments.

As I doff my comfortable student hat and trade it in for that of educator, I know that, even as a physician, I will be a lifelong learner. The personal connection I develop with each patient will drive my intellectual curiosity, knowing that every new detail can lead to a positive outcome for a very real human being.

I have come to understand that teaching does not just come from the person standing at the front of the hall or auditorium. Teaching also comes from the person sitting on the examination table in front of us, the patient.

To my patients I will forever be a student, yearning to learn and to understand their conditions, their feelings, their lives and their thoughts, while striving to guide them toward their individual health goals.

"Okay everyone, great job. Please reach out to me if you have any questions." And, in the blink of an eye, an hour had passed, my slides had reached the end and I had finished my talk. As the room began to buzz with conversation and the students scurried out, I trusted that they had gained something from this interaction, just as I had.

*April Slamowitz is in the 2019 graduating class of the Zucker School of Medicine at Hofstra/Northwell. She wants to specialize in pediatrics.*

## Time for Breakfast!

*Steven E. Rubin, MD, graduated from snapshooter to photographer during his first year of medical school in the 1970s. He is currently professor of ophthalmology at the Zucker School of Medicine at Hofstra/Northwell and a physician advisor in revenue operations at Northwell Health.*

## Brooklyn Bridge

*Barbara Moran is an operations manager at the Zucker School of Medicine at Hofstra/Northwell. This photograph was taken on one of her many strolls across the Brooklyn Bridge.*

## The Sharpie Tattoo

Dear friend,

When we met, we were in middle school. We were just two young girls from a couple of small towns in Massachusetts, and when we outgrew them, we ventured into Boston, unearthing miles of city, sifting for treasures and claiming each corner of it for ourselves.

That one time after our twelfth grade trip, we trekked from Boston to Arlington on a mission to visit as many thrift shops as we could before stopping at our favorite hot pot place.  It was our city, so we took on all those places as if they were our own. But in Denver, we didn't belong to anyone or anything except to each other. I still hold Denver most fondly in my memory.

It was 2014. What would have been our college junior year was your sophomore year. You were finally back in school as a transfer from Bates after taking a year off. At Gordon, you were now surrounded by people you knew in a place that was closer to home.

Back in high school, you thought Bates was your dream school, and I thought it was lost somewhere in the middle of Maine. I guess the dream ended and you lost some of yourself in the middle of Maine, too.

When I saw you on break a year earlier, at the beginning of your year off, your limbs looked like a skin-colored imitation of the skeleton Ms. Campbell kept in her classroom, the same classroom where you turned around and told me I would embarrass myself singing and rapping in Korean in front of the whole school (and you were right). Somehow that performance seemed to make you more anxious than it made me.

I could never have seen the signs back then, but it makes more sense now.

We FaceTimed in September of 2014, and you lifted your wrist to the camera on your phone to show me the eating disorder recovery symbol that you had drawn in Sharpie on your skin, laid to fit snugly on your wrist. You always knew the perfect place to lay your paints on canvas, and I wasn't surprised that this superpower remained the same regardless of the tool in your hands. Your eyes beamed as if it were your trophy. It was proof of your battle and triumph — proof that you had gained back a few pounds and more. You said if you ever got a tattoo, it would be this.

But your recovery was as permanent as your Sharpie tattoo, so they had to send you away. I couldn't understand that a battle wasn't the same as a war and a few pounds wasn't the same as recovery. The dissonance tore through me as I'm sure it did you, but at least you could choose from a list of facilities.

You were a mountains and woods and ponds girl, daily sporting Patagonia fleece and L.L. Bean duck boots, so we all thought a ranch in Arizona with equine therapy would be the right place to put you back together. You flew to Arizona mid-October, and they took your phone and your belongings as if you were some prisoner they had to brainwash, with no access to horses until you made the "progress" they expected of you.

Your mother flew out after you were finally granted permission to make a call, and she took you home the next day. They transferred your case to a recovery center in Denver, which you didn't end up hating — at least not too much. You were certain you would be able to spend the holidays at home.

I remember I was always the crier in our friendship, when I told you of my conflicts with my coach, my misunderstandings with my parents through all my teenage years, my stupid boy problems. You hated crying, and you never really needed to cry since your beautifully strung words were enough to express how you felt.

But on November 6, 2014, my phone rang. Weird, I thought, you never called unless we scheduled a FaceTime, but, of course, I picked up anyway. This time, your words weren't enough. You had to stay until the week after New Year's, and crying was the only way you could tell me how much you were hurting.

We hung up and I booked a ticket to Denver for winter break.

We were apart almost half of the time we were in the same city. You had to spend most of the day at the recovery center, so I spent that time on my own form of healing after a semester in Philly. I didn't mind the high altitude, the moments of solitude while wandering around an empty city or wildlife reservation, or that thirty-some-year-old JetBlue pilot I ran into in my hotel who gave me his contact information, misconstruing my gratitude for a safe flight for an invitation for a date. It was worth it when you and I finally got to spend time together, to keep going where we left off.

We drove to Boulder, or more accurately, I drove and you crocheted next to me as we both breathed easier the further we went. We found a restaurant for lunch and I watched you try to decide what to eat. Each ingredient listed on the menu seemed to tumble through your head as you struggled to reconcile how you wanted to eat and how your nutritionists told you that you should eat. The number of calories was listed next to each offering in a tiny font. I watched you choose the dish with the lowest number, and I tried to convince myself that it wasn't the reason.

We took on downtown Denver, claiming parts with the stakes of our memory, enjoying the almost-empty city. We speculated that most people were gone for the holidays, so they handed the city to us for safekeeping.

Later that night, we chose to have dinner at Whole Foods. You told me your nutritionists encouraged you to go to places with prepared food in cases, to teach you to exercise your choice. For thirty minutes we walked up and down the cases — grilled chicken breasts, potato salads, roasted Brussels sprouts. Numbers were not there to help you this time, but I still saw calculations tumbling in your eyes as they read the labels. I pretended I was indecisive, too, because I didn't know how else I could help but walk with you up and down the cases.

We drove back to your dorm at the recovery center. "My fingers just feel like fat sausages sticking out of my sausage arms," you said. I glanced away from the empty road and looked at the fingers and the arms you were holding out in front of you, yellow-gray under the street lamps. Sausages? My mind couldn't comprehend why you thought that. Sausages weren't slender or strong or skilled, able to transport any beholder into different worlds through paint on canvas or words on paper. Sausages couldn't do that.

I asked you why you felt the need to be skinny. For the past ten years, I had been jealous of how easily you charmed others, how well you integrated into whatever group you were in and how you had retail employees inviting you to model for their brand. And then you told me the greatest lie — your personality wasn't enough, so you had to compensate with your body. It was the only thing you had to offer.

No amount of persuasion could have convinced you otherwise until you embraced it for yourself, so all I could do was deny your lies and pray you would find the truth. Eventually you did, and I keep praying that you hold on to it.

With so much love,
Carina

*Carina Zhang is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell.*

## Freedom

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

## Keeping Patients Whole

While I was on the pediatric surgery service at Cohen Children's Medical Center, I loved rounding on the cute NICU babies and the sweet PICU patients with my team every morning. I loved how each patient room had lounge chairs for nervous parents to sleep in, allowing them to be nearby during what can be a scary time for the family. I loved seeing Child Life in my patient's room playing music and making him laugh. Cohen has the warm and welcoming environment that is so crucial for sick children.

One morning, a new patient was added to our consult list. He was seventeen, just barely eligible for admission to a children's hospital. He had been run over by a car and suffered multiple injuries, landing him in our PICU. When we arrived outside his room during rounds, I was surprised to see a police officer stationed beside the patient's bed, reading a newspaper.

This patient looked so different from the other children on the unit. He had tattoos up and down his arms and around his eyes, and he wore a bitter expression on his face. There were no family members in sight — the police officer was his only company.

Later that day, I learned that the person who had run him over had done so after the patient had threatened him with violence and tried to steal his car as he was seated behind the wheel. The driver accelerated forward, knocking him down and running over him. The patient was arrested, but his injuries warranted a trip to the hospital before his fate could be decided by the legal system.

Over the course of the week, I witnessed the stark difference in the way hospital staff interacted with this patient and with the other, more accessible, more sympathetic children on the unit. One of the attending physicians had a habit of poking fun at the patient's failed carjacking while we discussed the case on rounds, likely hoping to make light of a situation that was so disturbing.

Staff seemed reluctant to enter the teen's room. There were no friendly smiles or comforting gestures, which I had seen exchanged so often there. It was easy for me to understand why they avoided the patient. We shared the same sense of unease in his presence.

This patient sparked a lot of questions that I have not been able to answer. Could we, and should we, have tried to connect with him to help us to understand his circumstances and learn why he resorted to violence and crime? Is it our responsibility as health care providers to intervene for the sake of his health? How might the discomfort — even the contempt some felt — have affected his care? Is it fair? Is it unavoidable?

Most providers would put in any amount of effort to help an innocent NICU baby. But how should we approach the older, possibly aggressive or violent children and adolescents? They may be in even greater need of compassion and care.

If we treat only the physical injuries of patients and leave the complicated psychosocial aspects for someone else, can we consider our job completed? After all, there are providers in other disciplines who have more experience in addressing a patient's home life or substance use.

This raises a significant issue. When providers compartmentalize and separate biological health from psychosocial health, we can often miss the "why" underlying a patient's disease.

Can a cardiologist properly treat a patient if she doesn't learn that the patient's finances often require him to choose between buying healthy food and buying his medications? For this cardiology patient, working to get him on an affordable medication regimen may be more useful than another lecture on the importance of medication adherence.

The existence of more specialized professionals — social workers, nutritionists and psychologists — should not absolve us of the responsibility to treat our patients' medical conditions in the context of their lives. We may not be able to fix all their problems, but we can be a resource, an advocate, a partner in their health.

*Christine Grosso is a third-year medical student at the Zucker School of Medicine at Hofstra/Northwell. She said that writing is her favorite tool for processing difficult experiences and conflicting emotions.*

## Caring for My Dad

My dad has been sick since I can remember. There were stretches of my youth when my mom would take my sister and me to the hospital to visit. We could tell he was exhausted, but he would focus whatever energy he had left on the three of us. He was upbeat and loving and never let on that sickle cell anemia was winning out over his body.

The sickling of his blood cells means that the abnormal crescent-shaped cells can’t travel easily through blood vessels, and they get sticky and stuck. There are flare-ups that are extremely painful and cause tissue damage. His bones are brittle, too. My dad has been a dreamer ever since I can remember. A day never passes that he doesn’t say how blessed he feels to be alive and how grateful he is for how God has taken care of him.

He’s had seven or eight serious episodes in his life. Other patients can have it much worse. Sometimes, he is in such pain that he can’t speak. But I have never heard him moan. We would never know if he was down for the count; he made sure of it. In spite of his pain, my father always modeled what it looked like to have a good attitude even during a tough situation. My dream of becoming a doctor started with my dad. To our family, to me, physicians mean a place of safety. They were the people that comforted my dad on his worst days.

In June, my dad had a bad fall. There were several broken bones and another long hospital stay. His liver is also badly damaged from cirrhosis, and he will probably eventually need a new one. I wanted so badly to be home to help take care of him. It felt strange to be studying about how to take care of other patients when my parents could have used the support. But again, this angst was coming from me, and not my parents.

My dad has such positive energy that it is hard to debate something that has a negative spin. When I question whether I should complete this year in medical school when he is so sick, he flips the transcript. He convinces me to see it through his eyes. “Trust the process of life,” he tells me. “It has ups and downs. Put all your focus on your studies. I am fine."

Despite his positivity, I have always struggled with this idea of caring as deeply as I wanted to for my dad and still having the resolve to keep moving through life. For him, when he has an episode life stops. But the world does not wait for illness, and for the rest of us, life keeps going. It felt that in order to "trust the process of life" and "put all my focus on my studies," I had to build a wall and compartmentalize my emotions so that I could keep going. I have felt as if I had to do this during so many periods in my life that it has made me question whether, in order to care for ourselves and maintain our sanity, we have to distance ourselves from caring too deeply for our patients.

I want to believe that I will be able to stay fully human as a physician; that I will be able to put my heart and soul into every patient I interact with; and that the empathy I entered the profession with will not be dimmed over time. But what if caring becomes too much to bear at some point? What if the only way we can ever really, truly care is by not caring at all, by tucking our hearts away and relying on our brains to help us make it through to the end of the day? What if the anger at never really being able to control or to cure what God designs to be unchanged consumes me until my lack of caring is all that is left?

In navigating how to live my life away from my dad when he is sick, I found myself questioning whether as physicians, we are simply conduits: the passageways of love and pain and healing and death; the vessels meant to carry and drop off emotions, those of our own and of others; the ships that sail just close enough to the human condition to appreciate the reality of death while we shield our eyes enough to believe we can change the fate of illness. I found myself questioning whether we are meant to measure our hearts in doses; to swallow the pain of others in small sips; to sprinkle a piece of our hearts here and a piece there so that we can save just enough for ourselves to wake up the next morning to heal again.

Learning how to care for my dad the best I can taught me that there will never really be concrete answers to these questions for physicians. This question of whether we are charged with fully caring or caring just enough to survive will always encompass an area of uncertainty that we have to live with. This tension is an in-between that we must make our home. My dad has taught me that instead of getting wrapped up in the what-ifs, we must do what we can control. He taught me that the only thing we can control is to have hope.

We must trust that carrying the weight of the patients we cannot save will not overwhelm us; that our belief in the goodness of human life will never be fully destroyed by the illness and death that surround us. My dad helped me learn that the only way to wake up the next morning and try again, to care unconditionally but to maintain our sanity, is to have faith: faith that surpasses understanding; faith that goes beyond science, inspires art and clings to hope; faith that gives us confidence that tomorrow will be better; faith that embraces the heartache and destruction that come with truly caring.

My dad's body is broken, but his spirit isn't. His disease is catching up with him, although he has never hinted that it is hard to manage. His optimism makes everyone around him believe that everything will be okay.

My hope is that I am the kind of doctor who will tend to who my patients are – and not just what they have. I want to be that place of safety for my patients and to comfort them on their worst days. I want to have the courage to care, have hope and have faith, even when it is hard. This is my father's legacy.

*Danielle Howell is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell.*

## The Petroglyph

I carved my father's name into these rocks,
Though never did I learn to write my own.
On black basalt I emblazoned
Those forms that meant the most to me:
The sun – that fulgent, searing disk,
The lizard – furtive, slight, and swift,
The fire – comfort embodied,
That struck fear in the coyote.
Now as I scratch lines on paper,
Machines incise my father's land.
Transparent lines I cannot cross – the guilt!
My own hand on the paper set it thus.
Their lines erase my name, my fire, my sun
My marks were never so indelible.

*Robert V. Hill, PhD, is an associate professor of science education and director of the anatomical gift program at the Zucker School of Medicine at Hofstra/Northwell.*

## Mother Hen

*Zerryl Bernard, BSN, RN-BC, is a staff nurse on the clinical decision unit at LIJ Medical Center.*

## The Garden

Decades ago, before I became a microbiologist and a geneticist and before I started thinking about the business of medicine, I found myself in an abandoned hospital in my home country of Austria. The hospital, weeks away from demolition, served as the grim backdrop to a play in which I would perform.

The story involved a grieving mother who had just lost her infant. Set designers did their magic and turned empty hospital rooms into dank and scary medical scenes. In one room, a surgical table and tools were lit by a single bulb from above. People who came to see the play became part of it, as they walked from room to room.

The mother wailed, brokenhearted.

My role was to play the organ in the hospital chapel. The music I chose was as dark and dismal as the sets and intended to invoke hopelessness. It was hard to watch as the mother worked through her trauma. Her baby was gone. She floated through the hospital like a ghost.

My fingers came down hard on the keys.

I think back on that play and how scary medicine felt for everyone in that abandoned building. Gone were all those who were saved or died there. What was left was the shell of a building as empty as the new mother’s soul.

Medicine was a scary business, but does it have to be?

As a teacher, I want to create a new language in medicine: a relationship between doctor and patient that is built on hope and triumph over the challenge of being human — being sick, getting well, not getting well; a relationship that strives to make medicine more soothing, even joyful.

If I could take myself back to that makeshift stage I would abandon the dismal setting and place the music in the hospital garden. There the audience would walk outside holding the young, grieving mother to show her how things can grow again. My music would be soulful. The garden would offer the poignant message that we can create beauty and hope.

I have come to see my garden as a metaphor for the teachings of medicine. It doesn't work when you leave it alone. You plant and nurture and watch it grow. It changes over time, and sometimes it gives you what you need and other times it doesn't. We eat from it. We share its beauty with visitors. We watch it die, but even that doesn't feel entirely hopeless because we know we can do it all again — and we do.

*Elisabeth Frieda Maria Schlegel, PhD, MSc, MBA, is associate professor of faculty development and medical education research and co-director of the medical student as teacher elective at the Zucker School of Medicine at Hofstra/Northwell.*

## Last Light Before the Afternoon Rain

*Andrew Simpson is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell who is interested in global and public health. He picked up photography to connect with his grandfather, who taught film classes for several decades. Andrew and his parents traveled to Guatemala every summer for twelve years to volunteer in a local hospital. This photo is a famous arch in Antigua, Guatemala, that is one of his favorite spots.*

## The Wedding

It was hard to tell where the whiteness of the sheets ended and the pallor of her skin began. She lay in her bed, in a white gown, flowers all around her. The occasion was a celebration: Maria and Luis were renewing their wedding vows. There they were, the loving couple, in Maria's room on 11-West. This wing was always referred to as "the AIDS floor."

I had gotten to know Maria and Luis during her multiple hospital admissions. I was a second-year resident, and she was a woman in her early thirties with transfusion-associated AIDS. These were the "bad old days" of the late 1980s when our therapeutic choices were limited to a single antiviral with three letters for a name, and whatever we had to fight the infection of the week. Our patients would come and go on an unrelenting downward spiral of illness, culminating, almost always, in death.

I first met Maria early one morning, when the ER attending summoned my team to admit "a female with AIDS with shortness of breath and a widened A-a gradient." Those admissions became rote, with variations in demographic particulars from patient to patient. They were mostly in their twenties. Rarely, we would meet a patient two decades older. Most with AIDS would never reach the forties milestone.

They had a variety of maladies, illnesses that should never have become routine. In those days, PCP did not mean primary care provider. Rather, it was how we referred to the parasitic pneumonia that was so common. We saw Kaposi sarcoma, which we'd learned in school was a malignancy of elderly men, ravage people in their thirties. We learned to treat cryptococcal meningitis, and how to perform a lumbar puncture to see if our hunch about its presence was accurate.

We learned to confront stereotypes, and to face our biases and preconceptions. It was foreign, especially to my colleagues from outside of New York, to see so many gay men in one place, and to know that what they had in common, more than their "gayness," was the disease that would march them inexorably to their graves. That was a fact that was driven home to me in a conversation I had with a man who actually made it to his forties, with the virus. Being forty, and with AIDS, seemed like a miracle to me. But then he sat me down, looked me in the eyes and said, “You know, they’re all dead.” He was speaking about his friends, his lovers, his circle of strength and hope and resilience. They were all dead. And his parents, along with the rest of his family, had disowned him, not because of who he was, but because of how they perceived his “gayness.” Two weeks later, he joined the ranks of those who had died.

We learned, because of the remarkable hearts of people who will forever be my role models, that those for whom we cared were, first and foremost, people. Sunday mornings, after having been on call, after admitting multiple patients for whom our admit notes read: “This is the tenth 11-West admission for this twenty-eight-year old-male with AIDS....” all we’d want to do was go home. Shower. Eat. Sleep. Try to forget the sounds and smells. But our attending, the director of the program, had a Sunday morning ritual. He made “donut rounds.”  He’d go from room to room, distributing donuts of every description, to every patient who could swallow. Attending medical rounds wouldn’t start until the last donut was handed out. And I learned that a simple act like that could do more than the medications we could prescribe.

How I hoped I wouldn’t be on call the day of Maria and Luis’s renewal ceremony. I wasn’t sure how I’d deal with the wrenching reality that the ceremony was part renewal, mostly farewell.

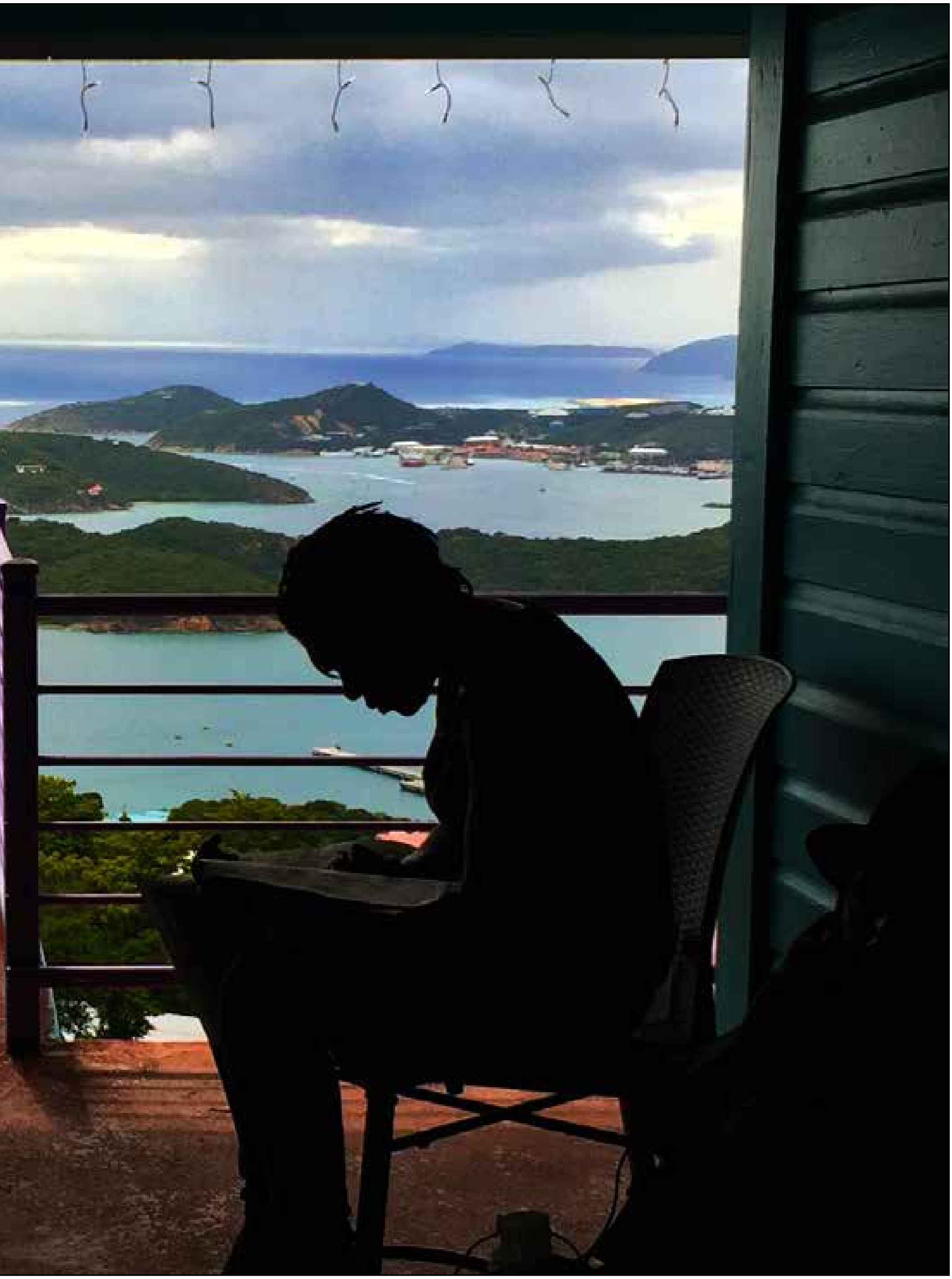
But off went my beeper. It was Janice, the head of AIDS social work, calling to tell me that the ceremony was beginning in room 1121, and they needed me there.

I responded to the page to 11-West, this time not to intubate someone, not to get consent for a spinal tap. Not to pronounce someone dead. I went to participate, to stand by their door, to weep uncontrollably. And to witness the power of personal strength and love, even in the face of impending and eternal night.

*Eric C. Last, DO, is an attending physician at Northwell Health Physician Partners/Internal Medicine in Wantagh.*

## Thursday

*Chris Lu is in the 2019 graduating class 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 wrote of this shot: "How quickly we get used to things – a testament to humankind's ability to adapt to its surroundings, yielding resilience in times of hardship, but also losing the marvelous and magnificent to the mundane."*

## The Doctor Will See You Now

I was alone the first time I visited Dr. Stephen Cowan. I was searching for a doctor for my son, Andreas. Diagnosed with cerebral palsy when he was one, he was nine at the time of this visit.

Dr. Cowan made me a cup of tea and asked about Andreas. “Start at birth and take me year to year,” he said. The pediatrician listened to Andreas’s story with compassion. The visit lasted over two hours. The only time he took his eyes off me was when he looked down at his note pad. He chronicled my son’s challenging life.

Andreas was conceived through *in vitro*. His twin brother moves through the world easily — no disability stops him from running, playing sports or talking with his friends. Andreas is nonverbal and uses a wheelchair. I had sought the meeting with Dr. Cowan, a developmental pediatrician, to get his insight into Andreas’s condition and to pursue ideas that would best serve my son.

Andreas accompanied me on the next visit.

As Dr. Cowan and I talked, Andreas watched the leaves blowing outside the office window. Dr. Cowan directed my gaze to my son: “Look at him in this moment. There is no cerebral palsy present. He is completely at ease. It is only when he attempts to do something with his body that the cerebral palsy presents itself.”

By this time I had encountered many doctors who could not see past the cerebral palsy label and, therefore, could not see Andreas. They saw the disability, nothing more. Without truly seeing my son, they had little to offer us.

Now here was Dr. Cowan, watching my son enjoy the autumn leaves. When you change how you look, you change what you see.

The doctor had chosen to look at Andreas in the restful moments, when his body and mind were completely at ease. He did not judge him as disengaging from the conversation, nor did he invoke the initial diagnosis to explain away every symptom and every concern, as so many others have.

Andreas is not his disability. Dr. Cowan was able to see through the disability and embrace the moments of ease when the disability is not present. While cerebral palsy has no cure, healing can occur when treatment extends those moments of ease.

Dr. Cowan saw Andreas, and he saw me. He told me that he may be the physician, but I am the one who has a degree in Andreas-ology.

This man has the wisdom to recognize that everyone comes to the table bringing experiences and questions that are unique to him or her. All of us — doctor, patient and parent — have something to contribute.

Dr. Cowan showed me that it is possible to find doctors who can see. He respected my son. Andreas may not be able to speak, but he was able to pick up on the language and tone of our exchange.

I have seen others treat Andreas as if he were an inanimate object. Subsequently, I have seen him become lifeless.

My son meets challenges that few will ever know. While it is often hard to navigate Andreas's world, I have come to learn that there are people who can see him and who do understand.

I hope that I always look for the Dr. Cowan in others.

*Janet Farrell Leontiou, PhD, is an adjunct associate professor in rhetoric and public advocacy at Hofstra University.*

## Adrift

*Danielle Llanos is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell. Her painting is a rendition of the open sea, depicting its turbulence and vastness.*

# Sky High

*Dylan Tan is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He enjoys taking spontaneous pictures of dogs, travel and people. This photo was taken in Seattle, and it reminded him that "there are so many amazing things happening around us all the time. We just need to remember to look up (or down) and appreciate them."*

# Birth

A
Birth has an order that starts with
Contractions that lead to
Dilation a cervical action.
Effacement occurs as the cervix is thinning, the
First of three stages of labor beginning.
Get up, take a walk, or a shower or bath
Heed your instructions from childbirth class.
Initial excitement is normal at first,
Just remember don't panic should your water burst.
Keep calm, call the doctor, active
Labor has begun,
Make your way to the car for your hospital run.
Now here's the hard part, and it takes a long time,
Often know as transition, or labor half-time.
Panting through pain, don't
Quit…rise to power.
Remember
Stage 2 is the magical hour. It's
Time to start pushing, bear down, concentrate…
Uterine contractions exacerbate!
Vaginal tissues stretch and make room, as the baby descends
from out of your
Womb.
Xenagogue guides the final egest, then places
Your newborn on top of your chest.
Zeal fills the room
(wait…it's time for stage 3, the afterbirth, placental delivery).

*Jean O'Connor, RN, works in the post-anesthesia care unit at Northern Westchester Hospital in Mount Kisco, New York. She is pursuing her master's degree in nursing education at SUNY Polytechnic Institute. Her passions include family, writing, running, baking and teaching. This is an abecedarian poem that was inspired by a beautiful eighteenth century training doll for midwives, created by a French midwife.*

## Antarctica

*Elise Stave is in the 2019 graduating class at the Zucker School of Medicine at Hofstra/Northwell.*

## Full Moon

*Zaeem Nazir is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He's been taking photos for nearly a decade and focuses on making the most of the technologies underlying modern photography.*

## Doctor Patient

"One seventy over one ten," he told me. This reading did not come from a resident about a patient she just saw, or a student about a case they studied, or a nurse about a patient I was about to see. No, the *he* was my husband, and he was telling me my blood pressure.

My first thoughts were this: Could it be happening again? Could something really be wrong with me? A decade ago I was on a gurney in the emergency room of the same hospital where I had been an intern. One day I was fine, the next day I wasn't. Just like that, I became a patient.

First, the denial. I went to work, not even recognizing a problem despite feeling too sick to drive the two blocks from the hospital to the clinic. Then, the admission, the realization that something was seriously wrong. The physical exam came screaming back: Abnormal. Very abnormal. The neurologists said that there was something really wrong with me but they didn't know what it was. They needed more tests.

It was Christmas Eve, and I knew it would be another two days before any tests would be ordered, so I declined hospital admission. The ER team gave me strict instructions to return immediately if symptoms worsened.

For a full day, time stopped for us. I had never been sick, and my husband and I were so scared that we couldn't speak. We just cried, a lot, assuming the worst-case scenario. Fatal thoughts would not leave me. I thought I was going to have brain cancer and I would be dead in a year. My eyes couldn't focus. Everything I looked at bounced up and down. I was facing my mortality and I didn't even have a name for it.

The fear was paralyzing. I couldn't move.

The next day, after fighting with my insurance company for an hour to approve a test I knew I desperately needed – an MRI – I finally succeeded in arguing my case. I barely made my appointment on time. Soon after, the specialist suggested hospitalization, a welcome relief for me, as I couldn't fathom continuing to struggle to navigate my own health system and coordinate my own care as an outpatient when I was feeling so debilitated.

Once I was hospitalized and scanned, our initial fears were put aside; there was no insidious mass in my brain. But there was evidence of a chronic neurologic illness. I was actually happy to accept such a surprising finding. I needed to undergo several more tests, but they diagnosed me with possible multiple sclerosis. (A few years later, an MRI scan showed more lesions and the diagnosis of MS was confirmed.)

I spent a week in the hospital. The hardest parts of my stay were all of the experiences that I had in between those tests: the vulnerability of being a patient, of not being in control of anything, of being addressed with zero recognition. No one referred to me by name. I was not recognized for characteristics that make me who I am – *me*. More surprising, I had been an intern there for about six months already, and in that role I was very comfortable with the hospital and my colleagues. Now, as a patient, I felt lost and alone.

I found myself in a turf war with a nurse who wouldn't bring one of my medications before the breakfast hour so that I could take the pill on an empty stomach. I had to wait until 10:30 every morning to eat because they administered the pill at 10:00 a.m. She actually said: "You aren't going to be treated any differently than any other patient just because you work here." Had she labeled me a demanding patient?

Nights in the hospital were so lonely. I was left in silence with my own thoughts, and they were not pretty. I wondered if I would ever return to the life I had just a week before. Would I ever be able to see normally again? Continue driving? Would I be able to work again?

I opted to keep one aspect of my body under my control: my clothes. I refused to wear the hospital gowns. In my mind, I automatically associated them with a risk of contracting *C. diff* or MRSA. Instead, I wore my work scrubs. I desperately wanted to maintain the divide between me and "them," doctor and patient. I was fighting to accept the fact that my illness had forced me to switch sides.

A week and a half later, after high doses of IV medication I self-administered daily at home (after being taught by the nurses how to prep my own line), my symptoms almost completely resolved. My body was still trying to find its normal rhythm. I was so lucky. I recovered, went back to work as an internal medicine resident and picked up where I left off three weeks earlier. With passing time, more medical tests, more doctor's visits, my initial event ultimately transitioned into a chronic condition, with no further major setbacks, but instead with a myriad of intermittent, transient symptoms that send the type-A, high-functioning control freak in me weekly reminders that I have to slow down, that my body is the one in control, that there are limitations to what I can and cannot do.

At the time, I only focused on how quickly I could get back to work. I did not realize the profound effects my initial medical experience, or the subsequent ones, would have on me. A few years into practice as an attending primary care physician, the patient in me was able to see through the facades my patients would hold up, dealing with the labels given to them by other health care professionals that came before me. I could resonate with their deepest fears because I knew them well. I understood the challenges of becoming a patient, of enduring the suffering. I recognized that a patient often wasn't difficult or demanding but just wanted to grab some remaining control. I learned that reassurance is just as valid a treatment as insulin for diabetes. I discovered that talking to patients as if they were family friends not only lowers their blood pressure but makes them comfortable enough to want to return. My health experiences gave me the gifts of understanding, of connection, of joy in practice – I'm a much better doctor for them.

As for my own 170/110, I will put a call through to my doctor and do what it takes to return to my new normal.

*Jennifer Verbsky, MD, is a primary care physician in the division of general internal medicine at Northwell Health, and associate program director for the internal medicine residency program. She is also the site director for one of the internal medicine ambulatory clinics.*

## Just One More Bite

*Elma Skopljak is in the ambulatory electronic health care records department at Northwell Health. Her piece is composed of mixed media — newspaper, ink, pencil and paint. This variety of materials combine together to create one unique visual language that represents togetherness as one.*

## *Lev Echad*

They were a young, naive couple. But as unworldly as they were, they were determined to prepare as well as they could for the upcoming birth of their eagerly awaited child.

Susie did everything I suggested. She took a childbirth preparation class, she was careful with her diet, and she scheduled her various tests at the appropriate times. I anticipated a good birth experience for her.

Then late one night my sleep was interrupted by a terrifying phone call. A volunteer paramedic, who had responded to an urgent call from Susie's husband, explained that when he arrived at the Queens apartment he'd found Susie unresponsive and blue, lying limp on the bed. He was able to intubate her and was in the process of getting her onto the stretcher and into the ambulance. She'd been seizing, according to Susie's husband. Had I suspected that she was developing preeclampsia? the paramedic asked.

"No," I responded quickly, but I silently worried. Could I have missed subtle signs of preeclampsia – mildly elevated blood pressure, protein in the urine? Neglected, preeclampsia can blossom into full-blown eclampsia – with seizures and all – in a heartbeat.

"Her blood pressure could be elevated just from everything that's happening right now," the paramedic said. "I'm just trying to rule everything out. Actually, she was in the process of using a device called Epi-no when she stopped breathing and started seizing. Are you familiar with it?"

I felt faint. I was very familiar with Epi-no. Designed to stretch out the vagina for impending childbirth and reduce the possibility of stitches, it's a device that includes a deflated, contoured balloon. A pregnant woman inserts it into her vagina each night in the last month of pregnancy. She inflates it with a connected hand pump. Each night the user inflates the balloon to the point at which she just starts to feel uncomfortable, and she leaves it in place for twenty minutes. Over time, the balloon size increases, until it reaches a diameter of three to four inches – presumably ensuring an easier birth and fewer stitches. It seemed a safe enough device – actually, quite clever. I'd started recommending the device to my patients, who quickly discovered that they were commercially unavailable.

I'd always resisted selling products to my patients, but I managed to find one of the only Epi-no suppliers in the U.S. and started selling the devices in my office, albeit reluctantly, because I wanted my patients to be able to procure them easily. It seemed like a good idea. Only now – I may have killed a woman and her unborn child.

I was wide awake for the rest of the night, speaking by phone to the doctors and nurses who were taking care of Susie at the hospital in Queens. A crack OB team was working that night, and they knew exactly what to do. They rushed her to the operating room, where they delivered her baby by emergency cesarean section. The baby came out crying.

Susie had suffered a large pulmonary embolus and was taken to the SICU in very critical condition. She was kept alive with sophisticated equipment, including an oscillator. I visited her that day and the next. Looking at her frighteningly edematous face, her tongue so swollen it didn't fit inside her mouth, I barely recognized her. I wondered if I'd be able to continue to deliver babies and take care of women if Susie died.

She slowly got better. She was weaned off the respirator and finally discharged from the hospital. Soon after her discharge, the paramedic who'd saved her life called me. He'd been bothered by this case, he said, and was determined to figure out what had gone so wrong.

The paramedic asked the couple if he could visit them, study the Epi-no that she'd used that fateful night and interview them about what had happened. In examining the device he discovered a hole in the balloon. He learned that each night, instead of simply pumping up the balloon and letting it remain in place for twenty minutes, they were continuously blowing up the balloon with the air pump just to maintain the inflation. It never occurred to them that this was not correct. The catastrophic air embolus was simply a matter of time.

Susie continued to see me in the office. I marveled at her ability to forgive me. I'd clearly steered her wrong when I sold her the Epi-no, but she never brought it up. Susie's husband suffered from significant post-traumatic stress disorder, and Susie wasn't herself for a long time. But at least she was alive. I was so grateful for that, even as I suffered profound remorse for having sold her the defective Epi-no.

It didn't help that the doctors who took care of her during her hospitalization published a case report in *Obstetrics & Gynecology*, the most prestigious journal in our field, concluding that no equipment with such potential risk should be so casually used. I felt the sting.

I suffered from the unintended rebuke of that journal article for two years. Of course, I got rid of all the Epi-nos I had in stock and swore I'd never sell anything else again. How I wished I could redo the last two years and avoid getting into the Epi-no business.

Then, one day, Susie came to my office for a regular checkup. It suddenly occurred to me that I'd sold her a defective device and had never reimbursed her for it! After the exam, I asked her to get dressed and remain in the room. I quickly stepped out of the room, took $200 out of my pocketbook and then reentered. I handed her the money. "I owe you this," I said. "I sold you a defective Epi-no and I never reimbursed you."

She looked at me quizzically. "What are you talking about?" she asked. "You didn't sell me an Epi-no. You never even mentioned the name to me. I got my Epi-no from my sister in Israel. I guess I should have bought it new; look what it ended up doing to me!"

I had had nothing to do with my patient's near fatal embolus! My self-flagellation had been baseless. But it was a life changer. It taught me an important lesson. I promised myself to always do my best to keep my patients safe. And I thanked G-d for letting me remain without blood on my hands.

We physicians know how heavy the mantle of responsibility can be for those of us who have devoted our lives to taking care of people. I pray daily that I don't hurt anyone.

*Jessica R. Jacob, MD, clinical assistant professor at the Zucker School of Medicine at Hofstra/Northwell, is an obstetrician-gynecologist at Northwell Health.*

## Polymathic Healers

They comb through the fibers
Of ancient thought

Stylishly teasing out connections
With contemporary issues.

They filter through the data
Of scientific ideas — scrutinizing and evaluating

Till they synthesize a valid
And fitting approach.

They carefully stitch words together,
Elucidating meanings of terms and experiences

While using instrumental concepts
To interrogate the weavings of words.

They chafe and sand away
That which is rough and extraneous

Concretizing and making plain what is
Elusive to the unfocused mind.

They display the colors of life
Across the earthly palette

Highlighting brush marks —
Flushing out depths sublime.

And when left to their own devices
They, of myriad minds and methods

Serve a dish of healthy wisdom
Digestible for everyday consumption.

*John F. DeCarlo teaches in the writing and composition program at Hofstra University and serves as the poet laureate of the Long Island Philosophical Society. He has published two books of poems.*

## Art As Medicine

Morning rounds. I was told there was a young lady I needed to check on. I found Jenna sitting in a chair. The sixteen-year-old was listening to music that was being piped through her headphones. She seemed content. She was drawing. I am an art therapy intern, but anyone could tell she had an eye for it.

Art therapy supports a patient's personal and treatment goals, using psychotherapy and the patient's creative process of art making to improve and enhance physical and mental health and emotional well-being.

I introduced myself to her and then greeted her mother. "Nice drawing," I said to Jenna. She told me that she had never had a lesson. She seemed to have no interest in working with me.

Every day, I would wander into Jenna's room and drop off some art supplies. Our relationship evolved into a few minutes of sarcastic banter — on her part — and listening on mine. In that way, I was able to help to make the hospital setting a bit more palatable for her.

One day toward the end of my rotation, I stopped by her room accompanied by a Child Life specialist and another patient. I asked her whether she wanted to take a walk around the unit with us. She nodded and followed us out the door.

In the hall, Jenna pulled me aside. She said that she was feeling really bad. She had yelled at one of nurses. I explained to her that the nurse would understand her frustration. After all, she had been in the hospital for over a month. No one likes to be in a hospital. "You don't understand, I really yelled at him. I just want my counts to come up so I can leave this place. Should I apologize to him?"

There was a shift in our relationship that day. She was sharing something much deeper, about the trouble she was having with being sick — and being sick in a hospital. As I drove home that night I pondered what I could use to give Jenna an outlet for her feelings. I thought about an altered book, which uses mixed-media artwork to change a book from its original purpose into a piece of art. An altered book can be used as a sketchbook that also contains journaling.

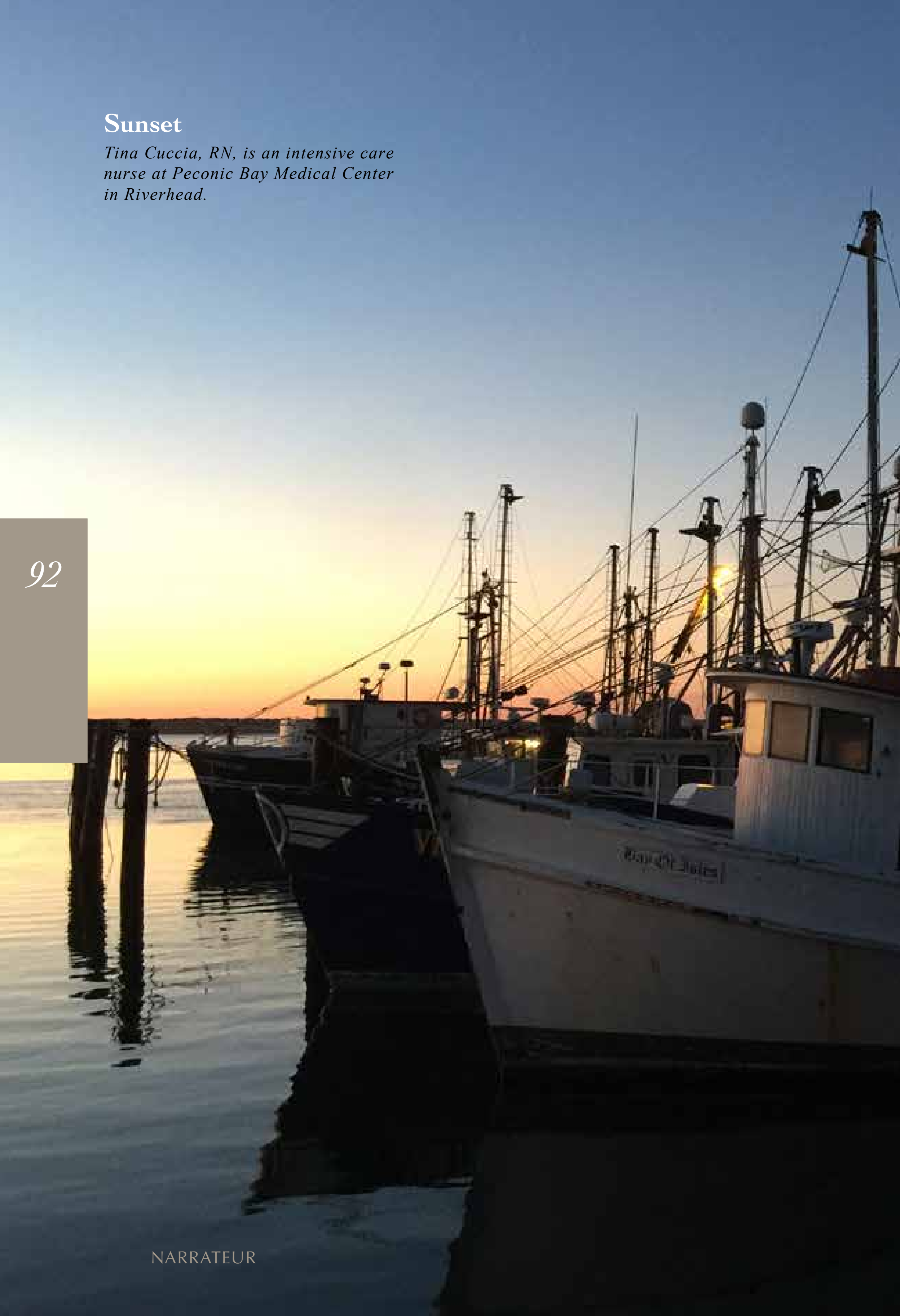
The next day, I brought in my personal altered book, along with two books for her to use as altered books. I allowed her to look through my book, even though it made me a bit uneasy since it was filled with art that had been created by me to make sense of the events unfolding in my life.

Still, I wanted Jenna to see that her journal could offer her a safe place, too. She loved the idea and quickly got to work. The next day, she was right at my side, showing me what she had done. This continued for days. The therapy was helping.

Jenna and I found a way to meld art and medicine, and it would change the way she accepted her story as a sick teenager. Adding words to art became her medicine, and mine.

Inspired by Jenna and my experiences as an intern, after graduation this spring I plan to work as an art therapist with children — especially those with special needs — and adults in the acute psychiatric setting.

*Kerry Dollard is a graduate student in the creative arts therapy and counseling program at Hofstra University. She has had extensive training in fine arts and is pursuing a career helping children with special needs and adults in psychiatric facilities through art therapy. Her picture is entitled "Emotions." She graduates from the program this spring.*



## Sunset

*Tina Cuccia, RN, is an intensive care nurse at Peconic Bay Medical Center in Riverhead.*


MARY ANNE

## The Jewel

Mom died when I was so young that my memories of her now are mixed up with all the photographs I pored over, and the stories that Dad and my other relatives repeated to me. I know that. And I know I saw her halo. Of course, there's also a photograph of Mom meditating, sitting with her *zafu* against the wall, the pillows piled up to support her back, and a round yellow pillow propped behind her head, like a sun rising around her peaceful face. But I know I saw her halo.

Mom and Dad met at a meditation retreat. After they got married, they meditated every day in our living room. The meditation nook had a square rug that fit into a corner and cut a diamond shape out of the rectangular living room. Only meditation could happen on that diamond.

Dad liked to say that the diamond was a reminder of the triple gem. Meditating is taking refuge in the three jewels of Buddhism: Buddha, Dhamma and Sangha, the qualities of enlightenment, protection of the rule of law and support of the community.

Dad says that even when I was a baby, I never cried during the meditation hour. He loves to recount how, when I was two, I toddled onto the meditation diamond and sat, resting my head against Mom's body, and later snuggling up with him.

When I was around four, Mom and Dad taught me to meditate. I sat with them as long as I could — probably about a minute. Then I sneaked off and looked at a book or played. Whatever I did, I was quiet. When Mom and Dad were meditating, there was peace in the house — as in the presence of an angel.

I know I saw Mom's halo because she used it to take care of me. When it was Mom's turn to help me take a bath, she washed me off with her halo. Actually, first she turned the halo into a round yellow sponge, and then she washed me with it. But I knew the sponge was special. I could never find it in my plastic tub of bath toys, which held my other washcloths and sponges. And when Dad helped me bathe, he used one of the sponges from my plastic tub — he liked the purple one shaped like an octopus. I was always cleaner when Mom bathed me. I think her halo sponge probably converted the regular water into holy water, which has different and better cleansing properties.

Mom used her halo to get me to eat vegetables, too. She shaped the halo into a yellow bowl, and she'd serve me broccoli or Brussels sprouts, or some other unpleasant plant product, from the bowl. And I ate the vegetables willingly. I picked them out of the bowl with my fingers, put them in my mouth and chewed, and I didn't get disgusted the way I got when Dad tried to feed me carrots or cauliflower from my blue plastic kids bowl. I swallowed the chewed-up vegetables, instead of pushing the masticated mess out of my mouth with my tongue and letting it slide down my chin. Dad had a memorable expression on his face when I did that. I remember it because there's a photograph of him, looking exasperated.

He told me that every time he'd ask Mom, "How did you get her to eat zucchini?" — or whatever vegetable — Mom would just laugh. Of course, she couldn't tell him to use her halo to feed me. Mom was the only one who could use her halo.

Mom's halo kept me safe when she was driving me to nursery school and kindergarten, or when she took me along on errands. She wrapped the halo around the steering wheel like a yellow fabric cover. The steering wheel didn't have a cover when Dad drove it. It glowed yellow under Mom's hands, and her halo guided us clear of accidents and police cars. Actually, Mom didn't need to avoid police cars. She worked for the police department as a clinical social worker. The police loved her. But maybe the halo thought it was better for Mom not to meet her work colleagues while she was driving with me.

Dad, on the other hand, got pulled over when I was in the car after Mom died. Once the policewoman realized that Dad was Mom's widower, she was really nice and thanked Dad for Mom's service instead of giving him a speeding ticket. But she also asked him not to speed with me in the car.

I remember feeling bad. I didn't want anyone to criticize Dad. He did a good job taking care of me, especially since he did it by himself. He was a teacher, so he spent his whole day with kids, and probably coming home to another kid was tiring. I didn't blame him if he wanted a break. But he never made me feel that way. He always made me feel safe. Even when he was struggling, he was protecting me.

When Dad told me Mom was dead, he was crying. I've thought a lot about what it must have been like for him. She died in her sleep because of a heart defect nobody knew about. He woke up next to her body. What the shock was like . . . every time I try to imagine that scene, I go blank. He was crying when he told me.

He's told me so many times what I did next. I put my hand on his cheek, and I said, "That's all right, Daddy. Mommy was a hybrid, like our car." Because Dad obviously did not understand, I said, "She was already part angel."

Dad did not meditate again for a year. The diamond was still in our living room, with Mom's *zafu* set up next to his and my nest of blankets and pillows against the wall, so I could meditate with them. I sometimes found Dad in the living room, standing in front of the diamond, contemplating it. But he didn't sit down to meditate.

I looked for Mom's halo. I knew that only she used it. I knew it was just for taking care of me. I knew that she was wearing it now that she was a full-time angel. And I knew that I was no angel. But I still looked for it because I needed it to take care of Dad. He was so sad when he stood in front of the meditation diamond looking as if he didn't know what to do. He was like a cross between forlorn and alone: forlone.

For a few weeks, I was on a mission. I scoured the bathroom. I examined every bath toy. I unfolded and refolded the towels. I scrutinized all the toilet paper rolls. I looked inside the toilet tank. I checked the faucets. No halo.

In the kitchen, I stood on a chair to sit on the counter to open the cabinets. I removed every bowl. I turned them all upside down and shook them to see if I could get the halo to fall out. I even stuck my head into every pot, just in case.

And when Dad and I got into the car, I searched all the pockets, floor mats, cup holders, dashboard recesses — and the trunk, when Dad opened it — to see if Mom left her halo there. I could see that Dad was working to be patient. "We have to go, Gioia, get settled," . . . and then, a minute later, when I hadn't listened and was burrowing under the front seats, "Seat belt time, Gioia!"

"Just a minute!"

"Why are you always tearing the car apart? Can't we just get in the car and drive?" he finally asked.

I gave up the search.

But when I came home on the first day of first grade, I was feeling very big. While Greg, the child development graduate student whom Dad hired to be my after-school babysitter, made my snack in the kitchen, I put Mom's *zafu* in the closet, and I moved my blankets and pillows over to where Mom's *zafu* had been.

Greg had no idea about my initiative. But Dad noticed right away when he got home. He stopped in front of the diamond and stared.

I actually remember saying what I said next. Dad's told the story to so many people that I'm sure I remember him repeating my words, but I also remember what I felt like when I said it. I was like a child in a fairy tale unlocking the door to a treasure chamber. I knew that opening the door was going to be good! At the same time, I feared that maybe I shouldn't be unlocking a locked door. But I was feeling very big.

"We used to meditate as a family," I said. "We're still a family."

Dad looked down at me. Now that I'm sixteen, I know he's not tall. Actually, I'm taller than he is. But then I was six, and he seemed tall. His expression was curious. His dark eyes glittered. His square jaw flattened, as if he was clenching his teeth together, and his black eyebrows cinched his forehead. He almost looked the way he did when I used to spit out my vegetables.

"Are you mad at me?"

He shook his head and exhaled audibly. He squatted down so we were eye to eye. "No, of course not. You're right. But…" He paused. "I will cry," he said. He wiped his eyes. "I can't meditate."

I didn't understand. "What's wrong with crying?"

Dad thought about my question. "Will it upset you?"

"Me?" I was surprised. "Aren't you supposed to cry? Are you upset when I cry?"

"Yes," he admitted. "I know sometimes you have to, but I never want you to cry."

"But, Dad, I cry all the time. Don't be upset."

Dad made a small, sad smile. He scooped me in for a hug. "It's normal to cry when your mother dies. I know that." He deposited the words gently, right in my ear.

Pressed up against the side of his face, I said, "You cry, too. Then we'll both cry, and we can both not be upset."

He inhaled and exhaled the way he does when he's accepting something. "Okay," he said. "Let's meditate."

He cried. He made no noise while we meditated, but the tears welled up from the seams of his closed eyelids and left their glistening tracks along the ridges of his cheekbones. I didn't see him crying because I was meditating, too — my eyes were closed. But when we were done, his eyes, wet with tears, sparkled like diamonds. He rose to make chai.

I followed him into the kitchen. He added milk, black tea, sugar, cinnamon, turmeric, black pepper and star anise to a pot and put it to warm on the burner. Wordlessly, I helped by putting away the ingredients.

When the chai was ready, he served me in a small teacup. "Gioia Roshan," he said, using the formality of my first and last name in mock seriousness to express his affection, "how did you get so wise?"

"I'm not," I assured him.

He didn't seem to hear. "Refuge in the triple gem was there the whole time," he murmured, almost to himself. He looked at me. "I was the one who left."

Sometimes I ask Dad if he remembers saying that, and he shrugs his shoulders. "Not especially." And then adds: "Though it's true."

But I remember. I remember because I knew then that Mom had not left us alone. She had not abandoned us. She was still taking care of us, me and Dad both, just as when she'd lived with us. When I sat down to meditate with Dad, on my first day of first grade, and as I've done every day since, I focused all my attention on the sensation of my breath as it passed to and from my nostrils over the skin above my upper lip. With my concentration focused, my eyes closed, and the sensation of my breath filling my awareness, I found what I had searched for: my mother's halo. I found it where she had left it, inside me — her lambent gold, suffusing my inner vision, embracing my heart.

*Maya Alexandri is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell, and a second lieutenant in the U.S. Army. She is the author of* The Plague Cycle *(Spuyten Duvil 2018), a short story collection, and* The Celebration Husband *(TSL Publications 2015), a novel. Her short stories have been published in* The Forge, The Stockholm Review of Books, The Light Ekphrastic*,* Adelaide*,* Dime Show Review *and many others. She is the student managing editor of* Narrateur: Reflections on Caring.

## Whistler

*Brian O'Donnell is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He worked in financial services before completing a post-baccalaureate course and starting medical school. He said, "School, work, people... hiking is a great way to clear the head. This photograph was taken near Whistler Mountain in British Columbia."*

## The Continental Divide

*Derek Mumaw is a third-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He picked up photography during his undergraduate years as a way to motivate himself to explore, intentionally pursue new experiences and appreciate the beauty all around him. He described his photo: "The clouds slunk across the landscape, catching their tenuous feet on only the very highest peaks, delicately curling away as they did. The scene was utterly and completely*

*still. From this vantage point at the base of the Titcomb Basin in Wyoming's Wind River Range, one can see nearly four miles of the Continental Divide. To the right stands the jagged Fremont peak, and to the left it drains into the Gulf of California. Everything over the horizon drains into the Gulf of Mexico. In all this enormity, it did not allow even a whisper."*

## Otis the Otter and the Vulnerable Strength

I am sitting in bed. “Plea from a Cat Named Virtue” by the Weakerthans trickles out of nearby speakers. My glassy black eyes shine in the overhead lights, and the brown polyester coat holding in my uneven stuffing appears thin but unbroken, just like you. You are sitting at your desk, steadily tapping away at your computer. You strain against the almost tangible weight of classes and exams. More insidiously, your fear and self-doubt grow silently in all the corners of the room that only I can see from my vantage point on your bed. I am a small thing, but I exude tenderness from every inch of my stitching. I only wish you could hear me when I say, “I know you’re strong.”

We first met when you were just beginning your journey. You were eighteen, and we were both young and full of life. You took me home from the Georgia Aquarium — you always loved otters. I am a child’s plaything, but when I came into your life, I knew that I had a bigger purpose. We are similar in that regard. Lifted up from obscurity, we are hoping against hope that one day we can be there for someone in need of strength.

I got glimpses into that side of you. Some mornings you would pull back the covers and expose my frizzy felt to the cool morning air as you pulled on heavy boots and hastily packed a stethoscope in your pocket. When I heard the ambulance wail, I thought of you. In the later years, you even took your work home. All the hours of the night, the radio wailed, and your steady voice came through, ready to provide backup. I was so proud of you those nights because I knew you were strong.

I saw you when you came home defeated after a day at work. You took a shower and pounded the tile while my paws opened to embrace you. I caught snippets of words you exchanged with your lover, strong words like *failure* and *death*. The outpouring of your grief was real and so fundamentally human that even I, your loyal cotton friend, was moved. I knew you had done everything that you could. Even though it probably did not feel like it at the time, I know that it made you more resilient and readier for the challenges ahead.

You continued to grapple with the nature of meaningless death and destruction, a world in pain. You worked at a hospital in the city, that much I knew. Sometimes you came home after days spent in the operating room or emergency department shaking your head at the violence that one man can inflict on another. The bed was your refuge, but you were not content to hide under the covers. You went back to face the world. You tried to make it better. I knew that you were made of sterner stuff than you had ever been before.

These memories drift through me as you work late into the night. Your short white coat, spotless and new, hangs in your closet. It marks this new era: a journey, all-encompassing and liminal, the transition of roles in four short years. As the music fades, I reflect on the times that we have had and the sacrifices you have made to get where you are now. I have never doubted you, and I wish you did not doubt yourself. I know you are strong.

*Peter Leistikow is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He enjoys writing about comedy, ethics, medicine and wellness.*

## No Peace in Storms

*Ellen Pekar is in the 2019 graduating class at the Zucker School of Medicine at Hofstra/Northwell. She used an acrylic pour technique on canvas to represent the beauty and the fury of waves during a storm at sea.*

## Polka-Dot Lunchbox

I walk across the crosswalk
Behind a lady in scrubs carrying a polka-dot lunchbox;
She walks purposefully forward – an unwavering strength in
    every step.
As the raindrops hit pavement with the tap-tap of restless
    fingers on the countertop
Or the soft taps of a hesitant student gathering courage on
    a patient's room door
They wake me
Faster than the sun ever would,
Though the fluorescent lights of the hospital will finish the
    job nicely,
I can't help but hope
That the meal inside the lunchbox
Will be eaten on time,
And not salted by tears.

*Pratiksha Yalakkishettar is in the 2019 graduating class at the Zucker School of Medicine at Hofstra/Northwell. She is going into family medicine. She said of her poem: "I remember appreciating everyone's purposeful walk toward the hospital even in the rain, and the juxtaposition of the mundane (lunchbox/meal) with the reality of a hospital setting, where a meal is sometimes accompanied by tears brought about by a difficult situation or a loss."*

## Bamboo Grove

*Marc Symons, PhD, is an investigator at the Feinstein Institute for Medical Research and loves nature photography.*

## The Bicyclist

We could hardly see the road as we made our way to the airbase five miles from Taichung. The car's lights were visible but not bright enough to help us avoid the many ruts and holes that peppered our path. It was 1968, and pavement was a thing of the future in rural Taiwan, then a third world country.

We were not late, Lisa and I. It was a dance with a buffet, not a seated dinner. I was a mere captain, just another doctor from the states assigned to the Air Force base. It wouldn't be noticed if I arrived late to the officers' reception, particularly if it was because I had to drive slowly in the Stygian darkness on a muddy, crater-riddled road.

"Thirty kilometers an hour. Does that seem too fast?" I complained to my companion.

"It's so dark, maybe you should go slower." Her apparent sarcasm betrayed her inability to convert to miles per hour, and I took exception.

"I'm only going about eighteen miles an hour, Lisa. Give me a break."

My wife of five years would often become silent when my temper flared, however mildly. For a long stretch, the only sounds that we heard were the rattling shocks of the car as a hole or rut would send us bouncing into the night air. It was a relief to come down safely.

Suddenly, something appeared immediately in front of our car. My lights hit on the bicycle and rider just as I applied the brakes and simultaneously heard the crunch of my vehicle hitting metal. Strangely, I did not hear the rider cry out, but I did hear Lisa. "Oh my God! Is he dead? Oh, terrible. Terrible!"

I thought to leave the lights on as I shut the engine and got out of the car — I had the passing fear that this might have been staged to rob us. But there he was, lying beneath his own wheels. He was a common man, one like so many other Taiwanese.

He looked at me with suffering eyes. I reminded myself that I was a doctor and went to check his pulse. He didn't speak, but he made a gesture that I should back away. He waved his hand from side to side, suggesting he was not seriously hurt.

“Name?” His English included that much. Out of the darkness, other people emerged. A sensible-sounding male voice intervened: “I speak English. He wants your name and phone to call. Can you give him that? We will take him to the hospital. Okay?”

I went to the car and rummaged in the glove compartment for a piece of paper. I wrote my name, my military position and my phone number and then tried to hand it to my victim. Before I could, the man who came from the darkness grabbed it from me and said, “I give it to him. He will go to hospital. He call tomorrow. Okay?”

Was it okay? What else was I to do on this dark road? Will he be safe without me? I wondered. Maybe I should take him to the hospital. The car would be faster.

I felt the man from the darkness looking at me. “No, no. This bad road. Two roads meet. This happen many times. We know what to do. You go. He call maybe tomorrow, maybe next day.”

During all this the bicyclist was sitting in the mud beneath his bike, showing no sign of significant suffering. I was clearly out of my element and was being dismissed. I felt I could do little more.

I got back into the car and held Lisa’s trembling hand for a moment of reassurance.

“I guess we’ll go on. He says he’s all right. I’m not sure where the hospital is or what we’ll be able to do there. Clearly, he is not in an emergency situation. Frankly, Lisa, the whole thing makes me very uncomfortable. I feel I should see this through, but the guy who took my information acted as if he’d done this before. I don’t want to be the Ugly American, but I think we should just go.”

Then it occurred to me. “Wait!”

I hurriedly got out of the car and called to the bicyclist through the crowd that had surrounded him: “What is your name?” I don’t know who answered, but I heard it clearly announced, “Chang.”

As I returned to the car, I called out, “All right, Mr. Chang. I hope you will be fine and look forward to helping you more. Get in touch with me, please.” I used all the earnestness at my disposal. I was trying to assuage my guilt as well as I could. This was hard to do as I rode off to the reception in my red 1968 Datsun.

Lisa and I were quite shaken by this incident. Nothing like this had happened to me before. I wasn’t sure I was guilty of poor judgment or poor driving, because I convinced myself that I was being very careful. Also, Mr. Chang could see me, but I could not see him. How did he come to be crossing the road just as I came by? I shared these thoughts with my fellow officers. Eddie, in particular, had a jaded view of the whole affair.

"These things happen here all the time. They set you up for a minor accident and make a few bucks. I wouldn't worry about it. Just play along."

I didn't know what to make of Eddie's suggestion and mentally swerved between using it to shake off my sense of having committed a crime or leaving the scene and not adequately helping a fellow human being.

The next day I heard nothing. By the third day I began to believe the entire affair had been lost in the mist of misidentification and poor information. Then, I got the note. The adjutant wanted to see me.

"Sit down, Captain." I did. "Do you know anything about an accident between you in a vehicle driving on the road to the airbase and a Mr. Chang riding a bicycle two nights ago?" I did. "Well, we don't want these things to get out of hand. So, you have to make restitution."

I said defensively and with some heat, "You know, I was driving eighteen miles an hour, my headlights were on distance and suddenly Mr. Chang darted out in front of me. I think he's the responsible party here!" I was instantly ashamed of my outburst. "Sorry. I'm very bothered by the whole thing."

"You need to appreciate, Captain, that we've had a number of these incidents. Fighting these people gets us into an entangling mess. It could drag on and even affect your discharge schedule. The best thing is to give restitution and show your remorse."

"Restitution and remorse?" I calmed down quickly and decided a more cooperative manner was more useful. Besides, the lawyer was treating me well and really only wanted to get this behind us, me and the Air Force. "Restitution comes to one hundred dollars. Remorse means it's best you visit him in the hospital and make a gesture, showing sadness and regret over the entire matter."

Lisa didn't want to come. I was told by the adjutant where the hospital was and how to get there. Surprisingly, the dilapidated building had an information desk. “Mr. Chang?” The man did not say a word but wrote down 3D on a piece of paper. I went up the three flights before me and found 3D. I hesitated and then walked in.

There before me in a rumpled bed was my victim. Here I was in uniform. Eight or nine men, women and children were sitting on the floor. When I entered everyone stood up.

A woman who might have been Mr. Chang’s wife came and clasped my hand with a grateful squeeze. I bowed and gestured sadness. I went up to the man I presumed was Mr. Chang and wiped his brow with a cloth I saw next to his bed. He pointed at his arm, which was in a cast. I pointed at his arm in acknowledgment. Orange peels were strewn on the floor amidst bowls of food. Clearly hygiene was poor.

The clothes worn by those in attendance were those of farmers and field workers. The feeling in the room, the emotional atmosphere that I don’t think I misinterpreted, was that of gratitude to me. I walked over to Mr. Chang and put one hundred dollars in his other hand. He bowed his head in thanks. His family and I were in a tacit agreement of understanding and forgiveness. Mr. Chang had suffered to help them, and I was going along as if everything was as it was presented to be. I put my hand over my heart to show affection and concern. Everyone bowed to me. I made a small bow in return and left the room.

I never heard anything more about the matter. I finished my tour of duty months later. I was not presented with any papers to sign regarding Mr. Chang.

No further demands were made.

*Robert D. Martin, MD, is associate clinical professor of psychiatry at the Zucker School of Medicine at Hofstra/Northwell and lends his skills to the ICE program. Aside from the piano, writing is a passion he has enjoyed since his years at college. He said of “The Bicyclist” that it considers the problems of helping someone medically when the idea of helping is outside of the usual doctoring. Patient motivation plays a role in how matters turn out. Dr. Martin has a book of short stories coming out soon. In addition, he has written “The Sensible Life,” a philosophical essay on living, as well as several novels.*

## Limitless

*Caitlin Whelan is in the 2019 graduating class at the Zucker School of Medicine at Hofstra/Northwell and is excited to start her internal medicine residency this summer. She said that this image reminded her of “strength,*

*resilience and positive growth, with countless arms reaching out to serve many purposes. A tree and a health care provider are one and the same."*

## In Memory of Memory

I held your hand the day you died,
But before, you had not been the same,
Your fingers clasped around mine, cold…
And you did not know my name.

Those twenty-some-odd years that passed,
Our spirits intertwined,
Were blown off on that selfish wind,
Which carried off your mind.

Your neck still showed some sign of pulse,
Your chest still rose with air,
But both your eyes were faded, dulled…
God, how I loathed your stare.

Your stare of recognition lost,
Your stare of meaning, robbed,
You stared so blankly, childishly
As you wondered why I sobbed.

For why would this poor stranger
Who sat next to you and cried,
Carry on with such a clarion
For someone, as if they'd died?

You are no more the man I knew,
Who clutched to me since birth,
Who held my hand and walked me through
The wonders of the Earth.

Who taught me what it means to love,
And that living is an art,
That I am to place my treasure carefully
And closest to my heart.

For where your treasure lies, they say,
Your heart will also be…
Well, you have gone and walked away,
And stolen it from me.

I kiss your forehead, pat your arm
In the hopes of waking there,
Some memory, some lasting glimpse
Of moments that we shared.

Just one more laugh, dear God, just one,
And I'll cry through all the rest.
Just crack the door, that's long been shut
And give back what once was wrest.

Do I wish you dead, bereft of breath?
Do I wish your suffering ended?
So that I can leave your side at last,
And my own heart can be mended?

For I cannot begin to heal myself
Until you've let me be,
Until your eyes stop staring,
And the quiet sets me free.

Or do I cling to every tremor
And twitch within your hand?
In hopes that this will be the time,
When at last, you'll understand…

You'll hear my voice, you'll know my name,
You'll realize why I cry,
And yes, at last, thank God, at last,
I'll get to say goodbye.

Goodbye, I'll say, I love you,
And that's all that it will take,
But that will mean the world and more,
As my heart begins to break.
For though it falls to bits and ash,
Melting as I watch you go,
I can then rebuild, begin to mend,
As I know that you still know.

For buried under all that sick,
All the pain and hurt and woe,
There still is something beautiful
That's remained since it was sown.

Your love for me, my love for you,
Though obscured, is a flower shorn,
Of all its color in winter-time,
But in spring is yet reborn.

So as you fell to tranquil sleep,
Awaking nevermore,
I rose from your most fragile side,
And walked right out your door.

For I can salvage nothing more,
As you have left me naught —
A moment, glance, or whispered word
Which is all that I had sought.

And though I turn my back to you,
No, just the shell you've left behind,
Please understand, I never left,
As you live on in my mind.

For your wit might flee from out your flesh,
And your memory decline,
But know you're carried on in pride,
In the company of mine.

For the burden that is the hardest love
Is a love saddled down with pain,
It is one that presses upon your heart,
And leaves an eternal stain.

But a stain is meant to be washed outright,
And forgotten all the same,
But you, I swear, I shall not forget,
Though you forgot my name.

Yet still, if you must ascertain
If your love for another's true,
Then watch them from the world depart,
And all its color, too.

*Robert C.F. Pena is a second-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 of 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.*

**Vibrant Dusk**

*Julia Coyle is a fine arts student at Hofstra University with a concentration in design and a minor in creative writing.*

## The Truest Act of Kindness

I have never watched someone die. I've seen dead bodies and performed compressions on a man with no life in his eyes, but I've never seen someone in his final moments, watched her take her last breaths. So I was surprised when I knew immediately that Winnie was dying.

She was ninety-five, and until a few days before had functioned mostly independently. She had been at the opera when she started to feel short of breath and EMS was called. Now in her hospital bed she was barely able to open her eyes and breathing at a rate of forty, even on high-flow oxygen. I didn't need to see her vitals, though. I knew instantly from her open-mouthed gasps that she was near the end.

In the hallway I whispered to my intern, "Is she dying?" He replied, "Oh, yeah. Hours left, maybe. Which is sad because her daughter is flying in from Colorado tomorrow."

As far as deaths go, this shouldn't be such a sad one. The woman had lived a long life and had made her wishes for comfort care only explicitly clear. She had family that was involved in her care and supportive of her decisions. Yet, there was something about seeing a person so close to the end of her life that affected me. I suppose we are so removed from death in today's society that it is jarring to see it so close.

Watching the woman's agonal gasps, I thought of a patient I had never met alive that I had helped to pronounce dead. How clearly different he was from a live human. I couldn't stop the morbid thoughts that entered my mind while looking at Winnie, still alive and breathing, but so close to becoming a motionless, cold body. I wondered if the woman sitting in bed today would be lying in a coffin tomorrow.

Judaism has a concept of *hesed shel emet*, a true act of kindness. It describes a kindness done with no ulterior motive, no possibility of being repaid by the recipient. It generally refers to deeds performed for those who have died, such as burying them and comforting their mourners.

I would like to think that much of what doctors do can be called true acts of kindness, with no compensation expected for that extra moment taken to hold a patient's hand, to show kindness and concern, to let the patient know that his or her fears are heard. This isn't like taking in your neighbor's mail or bringing food to a sick friend. Your patients can never return the favor. They aren't going to tip you for great service. There is no ICD code for "provided emotional support."

I believe that we spend the extra time, take a few minutes to go beyond our call of duty, because there is no feeling that warms you from within like knowing you have held someone's hand in his time of need, or helped her breathe a little easier.

As a medical student, I find that taking that extra time is easy. I know that I have no real responsibilities. Anything I can do can be done by my residents, and probably more efficiently. Holding a patient's hand, getting water or listening to a life story, is the least I can do, and it makes me feel useful. I imagine it's not as easy when you're an intern scrambling to cover eight patients, getting paged constantly, running on four hours of sleep. That extra fifteen minutes spent with one patient is time you could spend catching up on documentation, putting in orders or finally getting the chance to eat.

Yet, knowing how busy my intern was, I watched him go above and beyond his responsibilities for Winnie. He squeezed her hand and spoke directly to her even though she was barely conscious. He noticed her dry lips and went to get a sponge to wet her mouth, held it to her lips as she certainly didn't have the strength to do it herself. He called her daughter from the bedside and, without explicitly saying it, allowed her to say goodbye.

In that moment, I knew I was witnessing the truest act of kindness. This patient will not have the strength to say thank you. The doctor won't win an award or even be commended for how he treated her. No one else on the team even knew he was here. I was the only witness to his compassion.

I try to replay that moment in my head over and over so I never forget how important those gestures are. I hope to be — no, I will be! — the doctor who takes an extra moment to bring water to a dying patient or make a phone call to loved ones. These actions don't lead to raises or promotions to chair of the department, but they truly show the character of the person performing them.

*Danielle Cohen is a third-year medical student at the Zucker School of Medicine at Hofstra/Northwell. She is interested in pursuing a career in obstetrics and gynecology.*

## The First Year: My Journey with Grief

I get out of my car and walk back into my childhood home. The steps are wet – or is it my eyes? My dad walked on these steps not twelve hours ago. He will never walk on these steps again. I open the door. My sister is on the floor weeping by my mother's feet.

Reality is beginning to sink in. He is gone. A relative calls and tells me to pull myself together because we need to go to make arrangements. A car arrives in a few minutes and I am taken to the funeral home. The questions come at me like bullets to my heart. What size room would I like? What kind of wood do I want for the casket? Which color flowers do I prefer? How did I end up being the one making these decisions? Somebody please get me out of here! Just twenty-four hours earlier I was sitting in dance class with my kids, happy watching their small bodies jumping across the floor. Now, I am making decisions for my father's funeral, his last rites.

I want to cry, but I don't.

I return home to a house full of relatives, friends and colleagues. News has spread that Paramjeet passed away. Shock waves are palpable within our Sikh community. My children arrive. My seven-year-old daughter, the old soul, walks into the house without a word. She always has lots of questions and is hungry for answers. My son, just three, runs from room to room searching for Nanu.

"Where's Nanu, Mama?"

How do I tell this little child where his beloved Nanu is? I want to find him, too.

The initial wave of calls and texts is overwhelming. Each person wants to know what happened to Dad. I don't have it in me to repeat the events, which immediately bring me back to the moment. People say the most inappropriate things around death. "You need to be strong for your mom and your sisters." Really?

How can I be strong for anyone else when I need crutches to hold up my own wobbly legs? I stop answering the phone. Slowly, slowly, the voicemails and texts fade into yesterday. "Let me know if you need anything." I feel like saying: "A hug? A shoulder to cry on?"

The days pass, and the house starts to empty out. Family returns to their normal routines, and we are left wondering, "Now what?" I can't wait to get back to work. I think it will be just the fix for my grief! Isn't that how it works? I remember returning to work and seeing cards and flowers on my desk, I remember sitting with the lights off. It is dark, and I want it that way. I don't want the lights on because my own internal lights are off. I can't get my smile going again. I am struggling to understand if this response is normal.

In that moment, I think I will never come out of that dark place. I feel as if a part of me died with my dad. A colleague bumps into me in the hallway and says, "You're back? Are you sure you're ready?" As the weekend comes around, I start to feel sick to my stomach. Every Saturday, I relive the events of that dreaded Saturday. By Monday, I can breathe again. This goes on for months.

My Dad lost both of his parents, who lived with us, but I don't remember him grieving the same way. Am I just too emotional? Am I depressed?

It is now one year since my dad died. I have come to understand that my grief is normal. It is my normal. It is neither my mother's grief nor my sister's pain. Our relationships with him were different, and so is the mourning process unique for each of us. This is the wisdom I have gained this year.

I have come to the realization that this universal experience is understood best by the ones who have also lost someone close to them. I learn to heed their advice: "Cry when you need to cry. Don't fight the wave of emotion." That normalizes it for me and gives me permission to feel every emotion that comes my way. My children even develop a protocol for when they see me upset. One runs for tissues, while the other holds me tight. I start to realize that is all I need. Their quiet presence resonates much louder than any words. I feel supported.

They say time heals, but does it really? The first Father's Day I spend without my dad brings the pain back front and center. This sadness returns with every holiday and special occasion; and of course, the day he would have turned 62, and the first anniversary of his death. The tears and heartache come, but they recede much faster as this life moves on. My internal lights are on again. I can smile. I can appreciate the life my father had – and the one he so beautifully gave me. This is the journey of my grief.

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

# Sympathetic Response: Kandahar

*Christopher Petersen is a second-year medical student at the Zucker School of Medicine at Hofstra/Northwell. He graduated from the University of Notre Dame in 2007 and spent eight years in the U.S. Air Force before starting medical school. He said of his photograph: "This was taken in Kandahar Province, Afghanistan, with our feet dangling out of the helicopter, air hitting our faces; this was our commute to work. There were no ambulances, no vehicles; just our team sitting in the back, preparing to treat Americans and Afghans injured by war. The title, "Sympathetic Response," is what we felt when called to help the gravely wounded. However chaotic the intercom communication systems sometimes might have been, we learned to control our own self-responses. Views such as this helped bring to light a world we would likely never see again. In those moments when our mouths became dry and our palms sweaty, appreciating where we were, with the opportunity we had to help others, was a blessing."*

## Fading Colors

He chooses orange from the paint tray. He smiles as his brush, heavy with color, sweeps across the page. What follows is blue. At times the colors intersect, and he is pleased. I know this much because he's laughing and whistling. What I don't know is what brings about his joy.

This is our routine each time I visit. He identifies another color. With equal enthusiasm, he covers the paper. He sits back and observes his work. "Are you done?" I ask. A smile and one word: "Yes." The art is set aside and saved.

On my next visit, the paint tin, paper and brushes sit in front of him. He doesn't know what to do. I ask if he'd like to paint. I ask about color choices, which have been narrowed to just a few. I place my hand over his and we move it across the page, but today there is little in the way of color, movement or enjoyment. The art is set aside and saved.

Upon my next visit, no paint, no smiles and few words. I set up his past brightly colored art pieces, next to the fading works that followed. It appears that he recalls the joy they brought. Maybe this is what I want to believe. He stares out the window and says he sees a man. There is no one there.

On his nightstand there is a picture of his wife, son and daughter. "That was a terrible thing," he mutters. He seems to be recalling the loss of his daughter. He no longer remembers names, but my hope is that he still knows they are his family.

At each visit I watch his colors fading, and I know that one of those colors is me.

*Sheryl Stern, LCAT, LMFT, is an adjunct professor in the school of health sciences and human services in the department of counseling and mental health professions at Hofstra University. She is a licensed marriage and family therapist in private practice, as well as a licensed creative arts therapist, when communication is aided by creative expression. The artwork is her brother's.*

**Dahlia**

*Maria Ruggieri, PhD, is an investigator at the Feinstein Institute for Medical Research. She loves taking photographs of nature at its best. She described this photo as a dahlia opening up its heart.*

# 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.

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## Over There

*Ginnie Jeng is a first-year medical student at the Zucker School of Medicine at Hofstra/Northwell.*