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contents

6 **The Queen with the
Blackened Toes**

By Stephanie Tran
Florida State University College of
Medicine

9 **Autumn of the Scalpel**

By Tiffany Jenkins
University of Washington School of
Medicine

10 **Signs**

By Daisy Bassen, M.D.
Child Psychiatry

11 **At the Loom**

By Arany Uthayakumar
Pegasus Physician Writers at Stanford
University of California, Berkeley

18 **On Being**

By Lauren Knowlson, M.D.
Obstetrics/Gynecology
Mountain Area Health Education
Center

20 **Breathless**

By Emily Podany
Baylor College of Medicine

23 **Forgiveness**

By Michelle Schmidt, M.D.
Internal Medicine
Baylor College of Medicine

26 **A Sharp Lesson on
Becoming a Patient**

By Atsuko Yamahiro, M.D.
Internal Medicine
MetroHealth Medical Center
Case Western Reserve University

contents

28 The Net

By Alexis Ramos
University of Texas Health Science
Center at San Antonio

30 Love Thy Neighbor's Specialty

By Monique Mun
Wayne State University School of
Medicine

32 Genesis

By Denise Go
Duke University School of Law

33 Becoming a Physician

By Natasha Gibson
Indiana University School of
Medicine

34 Weird Doctors

By Shaili Jain, M.D.
Psychiatry
National Center for PTSD
Stanford University

42 Where Roads Take Us

By Soumitri Barua
The Warren Alpert Medical School of
Brown University

44 On the Other Side

By Lara Slesnick
University of Texas Health Science
Center at San Antonio

47 Dr. Babineau-My Mentor, My Friend

By Jessica Churchill
Eastern Virginia Medical School

the queen with the blackened toes

BY
STEPHANIE TRAN

It's her gangrenous toes, black as soot and hard as stone. She comes to us a cripple—just another patient lost to follow-up. Forget the insulin shots, the uncontrolled HgbA1c, and the deteriorating kidneys that worry me. Her neuropathy is so profound that as the surgeon examines her phalanges, exposing bone to air, this hardened woman with diabetes doesn't bat an eyelash.

Talks about amputation, preserving her ability to walk, broad-spectrum antibiotics, and an extended stay in the hospital are not her priority during this witching hour.

Do what you gotta do, doc. I just need to know if I'll be able to wear my flats for Sunday church.

The surgeon tries to explain her treatment after the procedure, the importance of blood sugar control, vigilance against future foot ulcers, and that her shoe options would be...limited. She nods along, eager to show her cooperation before she motions to a crumpled bag of her personal belongings. Nestled inside a royal purple dress is a pair of tattered black flats.

My shoes, doc, they make me look real nice. You gotta look your best for Sunday service.

With a slow nod cued from the surgeon and a tight smile, we say our goodbyes from her room. We'll see her tomorrow morning for the procedure, so get some rest! Don't forget, no food after midnight.

Closing the door behind us, the surgeon's exasperations can be summarized with a frustrated shake of the head coupled with a few words coated in disbelief: Patient's priorities, eh?

She waits for us, tethered to bags of fluids and wires of vital sign monitors—entangled in the lifeline of the preop room. The surgeon is not here yet, running late, they say. I fumble through the charts of informed consent, drug allergies, and previous surgeries; my mind reviews the compulsive steps of the procedure when she breaks my nervous reverie.

Do you like shoes, young lady?

My thoughts revert to that pair of worn out black flats, similar to a comfortable pair I own. I smile at her, sharing this fact as she grins heartily. This simple fact finds us common ground—our shared humanity found in a pair of shoes. A conversation starts, slow and hesitant before she is overflowing with words, coated with a Southern accent, cool as a glass of ice tea. She regales me with a story of a loving husband she recently lost, the hard relationships with her siblings, and the heroic dedication of her son all miraculously connected to her love of shoes.

That pair—I bought them on sale at Dillard's. You should pick up some of your fancy doctor shoes there next time.

I chuckle at her suggestion as things get quiet. She looks forlornly at her battered feet and sighs.

As I struggle to grasp at the words to say, the surgeon arrives.

The operation is swift and efficient. Her toes crunch off with the bone clipper, revealing the necrotic microvessels beneath. They adamantly struggle to perfuse the tissue as we scrape away the decay. The sutures I place are snug but loose—a soft embrace of the living tissues that cover the bone.

I use gauze to wipe away a single tear of red blood, a sign to the surgeon that, maybe, she'll get to keep the rest of her foot.

I come to her in my worn white coat, pockets blotted with ink pens and the collar ruffled from long hospital hours. She rests soundly and startles at my

knock. Though smiling tiredly at my greeting, she eyes me warily as the bandages come off, twirling around my hand. Her flesh exposed to the cold air, she chokes at the sight of her missing toes.

Will my Sunday shoes still fit?

I think about the oath from my first day of medical school to: Do no harm. To be a patient is to suffer. To be a doctor is to serve with compassion.

But, as doctors, we can't heal everything. The ravages of chronic diseases and the hardships of life can leave a patient trapped in pain and misfortune. We reach out to those who that suffer and offer comfort as we can. Amongst the vastness of medical records, vital signs, and laboratory studies, the face of the patient can be lost—until we recognize their distress and feel our own empathy move us toward action.

And yet, what comfort could I give that would be both compassionate and right for her?

Instead I tell her that her feet are lovely and alive, that the surgery was successful in saving the rest of her body at the sacrifice of her toes, but that doesn't mean the loss won't hurt. I tell her that there's always the threat she could lose more, so she'll need to work on managing her diabetes and going to physical therapy. She'll never wear those same shoes from Dillard's that her late husband loved so much, but she'll get to

dance in her Sunday dress with her son.

And I offer her that instead of dressing her feet in worn out black flats, how about some soft white bandages—the color of clouds?

She is quiet as she stares at her toes and the package of Kerlix I hold to her eyes—a decision turning in her mind. I wait for a moment to regard her with a soft calmness and acknowledgement of her strength and concerns. Nevertheless, whether she accepts these bandages as "shoes" or not, I can't leave her feet unprotected and open to the elements.

Just as I pop open the bandages, she whoops out a belly laugh and gives me a knowing wink.

Come back here, when you finish your schooling sweetie. I'd love for you to be my doctor. Or take you shoe shopping, you hear?

Smiling, I gently wrap her feet in their new pair of lovely, snow white bandages.

autumn of the scalpel

BY TIFFANY JENKINS

Webs of fascia melt
beneath the touch
of the scalpel blade
–as we unveil
woven sheets of muscle
ending in iridescent
tendons shining so beautifully
it takes my breath away.

It's our first day holding
a scalpel, its handle heavy
in our hands. We cut gently
as we remember the once
rhythmic rise and fall of the
chest beneath our fingers.
Outside, vibrant orange
and yellow leaves sway
in the chilled autumn
breeze, dusting the edges
of the brick hospital wall.

It's the changing of a season.
The inevitable fall of leaves
from the bough, that unveil
the fruits that will nourish
the next generation. It's our
first time touching death,
our first time unveiling the
mysteries of life, whose secrets
lie ripe beneath our fingers.

signs

BY DAISY BASSEN, M.D.

Those old delusions were so elegant—
Made of glass, of butter, of straw,
Likely to burst into flame, full scarlet,
With the sun's faintest effort.
There is some little help now.
Small beer, wafers offering
Connection with the utterly effable.
The priest's cassock castoffs
In favor of my cashmere turtleneck,
Lap cross-hatched with RxRxRx.
And for what: robots, lasers asterisked
From die-cut eye sockets, in woods So
dark, regular with malevolent pines.
No resin, no reason, news at eleven.

at the loom

BY ARANY UTHAYAKUMAR

I. The psychiatrist

Warm chestnut wall tones simmer about the crown molding, as do the swirls of my morning tea. Neutral as the decor may be, little in my office doesn't remind me of Sri Lanka.

My eyes glance at the array of volumes next to the desk, a counterargument to the aforementioned neutrality of the room. And what of us? protest those books, in exuberantly tropical hues of citrus, lilac, and turquoise. Lined up on the shelf, with book holders reminiscent of wrought iron gates, the novels and handbooks could be the loud houses in the town of Jaffna—unabashedly colorful, and unapologetically impossible to ignore.

I strum through the pages of my planner, looking through the day's appointments. My first patient will arrive soon: Yaalini Mohan. The familiar syllables of the Tamil language roll off my tongue with ancestral ease.

I glance through the bio, only out of habit. I've read and reread the details of her case, and internalized anything the initial patient note could tell me, as well as what I've added to it since.

Yaalini is a 23 year old woman of Sri Lankan descent, and a refugee who came to America after the country's civil war ended. She has some extended family in the area, but at present, she is living on her own.

Currently, she is a graduate student at Berkeley, but has taken some time off, due to exacerbation of recurring episodic flashbacks of sexual assault from her time in the refugee camps. Likely diagnosis from the initial consult: seems fairly evident that Yaalini is struggling with post traumatic stress disorder.

There are still a few minutes before she arrives, but the energy I had seconds earlier dissipates without any control. I lean back in my chair as my eyelids flutter anxiously. To be honest, I'm nervous. It's been difficult to establish a rapport with Yaalini. It's not just that she is understandably reserved, because I can work with reservations—I'm used to them.

The people I see aren't usually thrilled to meet me. I hope that in time, their distance will evolve into genuine trust, and even a warmth of sorts. That happens over the course of a tenderly maintained relationship between patient and doctor, though, built gradually with time and trust. I care deeply

about my patients even before they walk in that door, but sometimes, it takes them a while to believe that for themselves—and that's okay.

So initially, I'm familiar with being likened to an unwelcome relative whom they've been ordered to pay an unpleasant, but supposedly necessary visit. And I mean, I understand—I'm not here to offer encouragement, or to make them laugh. I'm here, to be present for them in their time of misery. I can give voice to that which they don't understand, and listen to what they need heard. But for me to listen, more needs to be said.

The wariness and curtness with which she talks, and her flat affect speak volumes more than what she is willing to convey to me. Distrust emanates from the recoil of her hair, tightly clasped hands, and pursed lips. The mosaic of her facial features dance in a repertoire of staged neutrality, occasionally lapsing into unrehearsed steps of anger and bitterness. These occasional windows into the mind of Yaalini are all I have. And even these, she would hide with curtains I'm sure, if she looked up to see me processing them.

I feel that she sees me as someone trying to decode what is left of her private self—that when I gaze intently at her, I look at her as something to be read, or solved.

What I hope Yaalini will realize is that when I look at her, I don't see something to be read—I see a writer at a critical point in continuing her story. I see turbulence, adversity, but above all, resilience.

I'm just here to help her write the rest of the story contained within the enigmatic crease of her brow.

II. Yaalini

Walking into Dr. Rani Kumar's office, I attempt a polite smile in the slight chance that it might leave me a little inclined to have a more productive session than the last. The corners of my mouth bravely lead the charge, but the thin lipped middle portion flexes its authority, ultimately defeating the corners in their noble quest.

Pursed lips it is, then.

The crinkles next to Dr. Kumar's eyes, normally a relaxed complement to the smile she gives me despite how sour I must look each time, seem a bit worn down today. It must be evident that I'm only here at the urging of my extended family, and not of my own volition.

When I first confessed to having disturbing flashbacks of Manik Farm, the 300,000 person refugee camp in which I had been contained, I was told that seeing a psychiatrist who specialized in South Asian women might be a good fit for me.

There would be some cultural familiarity, some mutual understanding of the contradictory picture of violent chaos and impossible tranquility that was the country from which we came. Sri Lanka, an aptly tear shaped island, was a juxtaposition of romanticized beauty, dehumanized minorities, and injustice glorified by unaccountability. Were Sri Lanka a person, it would need years of therapy and a melange of medications to treat its various disorders.

But Sri Lanka was not here to see Dr. Kumar; I was.

Coming from such a convoluted place, so divisive in its history and arguably as fragmented in its diaspora, it's difficult to find cultural familiarity with anyone outside of Sri Lankan ancestry. And even

then, the relationships of individuals to this island vary so much from person to person, that my narrative doesn't really have much in common with the narrative of Sri Lankan people I've met here in the States. Even this well-meaning psychiatrist, who I discerned was also of Tamil descent from Sri Lanka, had a very different relationship to the country than I did.

I'd like to think that I wasn't being childish about this—and I wasn't subconsciously thinking that simply because Dr. Kumar hadn't experienced what I had, she wouldn't possibly be able to help me through the difficulties I was having now. Those assumptions weren't entirely inaccurate, but I wasn't sure how much they were keeping me from gaining anything here.

I didn't dislike Dr. Kumar—I just had little faith in these sessions, or that what we discussed in this room would help me find myself in the shell I had become.

My eyes wandered to the bright fuchsia notebooks on her bookshelf, as I felt her eyes quietly monitoring my activity. Usually, our first few minutes were filled with a silence that stretched for what felt like eons. I didn't mind that part, though. I preferred silence to answering questions, which simply felt like my teeth were being pulled without the luxurious haze of an anesthetic.

The ombre shading of bright pink to deep magenta on the book covers conjured images of the limber branches of flushed hibiscus flowers that dangled freely in my childhood Jaffna home. How easily the flowers would nestle into my sister's hair, and how picturesque they made the ground upon falling daintily into the dust! I missed those flowers, among other things. I'd recently seen a potted hibiscus flower at Trader Joe's, and gotten embarrassingly excited. But even after the tender care I had given it, the hibiscus failed to blossom, dying in a week. These flowers didn't grow nearly as easily in the Bay Area as they did back in Sri Lanka.

The hibiscus had only withered away a week ago. I had started to wither long before that.

Dr. Kumar followed my gaze to the notebooks. When I started to fixate on them, something in her own face slowly lit up.

"Those were my travel journals from college," she said softly. "I used to write quite a lot."

I expected a follow-up question, something asking about my own interests or hobbies. Instead, I was pleasantly surprised with a comfortable silence. For a brief moment, Dr. Kumar wasn't seeing me when she looked at me. She was remembering a time and place far beyond the walls of this room.

In the past, therapy had felt like being held under a microscope, with unrelenting examination of every word and gesture. Returning again and again to a space of scrutiny had put me on the defensive. But the lens wasn't on me now, because this moment was velveted in someone else's nostalgia.

Something felt safer, more inviting about being on the periphery of someone's thoughts, instead of in the foreground.

This was the closest I had come to liking Dr. Kumar. Her usual questions came across as analytic and clinical. When she prescribed antidepressants, our interactions felt impersonal and systematic. When she shared this piece about herself, though, as not a doctor or therapist, but a writer, it was the first time I felt like she might be able to understand me as a person, as Yaalini.

Despite our differences in narrative, she might empathize with what it felt like to craft that story, and how it felt to internalize pain and trauma, through writing.

Something stirred within me, as I nestled into the comfort of this welcoming lull. A few long minutes after she had murmured "used to write quite a lot," I found myself mumbling "me too...well, still do."

Dr. Kumar looked at me in surprise. This was the only time I had ever initiated conversation. She normally kept her face fairly even, but there was a glimmer of excitement in her eye.

She opened her mouth in preparation to ask me something, but quickly closed it. There was something almost charged about the silence between us: pulsating with anticipation, and weighty with possibility. Anything could happen.

I surprised myself further by continuing to speak. Unsure at first, the words stumbled out of my mouth. Unused to being so forthcoming, they reverted to their staccato roots every so often.

“I’ve, um, been doing a, uh, lot of writing these past few weeks, actually.” I paused.

“What makes you feel like writing?” she asked. This may have been a diagnostic inquiry, but it didn’t feel like one. It felt like two writers having a conversation about their work.

I reflected for a bit. “It used to be anything that made me think of Sri Lanka.” My eyes closed, as I sank into a sea of images. In the hushed stillness of the room, I could almost feel a gentle island breeze.

I could sense that Dr. Kumar was intrigued, but to her credit, this quietude held no expectations or urgency. Somehow, we both knew that I would continue.

And I did. “Smells of certain curry leaves, specific plants... even faces of strangers who bore uncanny resemblance to someone I might have seen around Jaffna.” I opened my eyes, curious to see how she would respond.

Dr. Kumar nodded knowingly.

“More recently though, it’s things that trigger feelings of beings scared, or unsafe...” my voice trailed. I hesitated before clarifying, “Things that

remind me of the war, or of, um, Manik Farm.”

“And these things... they are what trigger the flashbacks?” she asked.

I shook my head, looking down at the well-groomed carpet. “Not quite. I’ll feel myself tense up in the moment, but it’s not until I...well, I mean, I don’t quite immediately experience the flashback.”

“Would you feel comfortable elaborating on that?”

I froze.

“It’s okay if you don’t feel comfortable talking about that right now,” she coaxed.

I looked up as I nodded in response (another first), so she knew I appreciated that.

In our last session, I had been a resolute stone wall to her questions. My answers were as curt as I could muster, and I hadn’t felt like divulging anything to her. She was different today, though. Now, she made me feel like talking. I took a deep breath and continued.

“Usually if class ends later in the day, and if it’s dark out, I’m pretty paranoid walking back home, especially if I have to go through that grove of trees lining the pathway in front of Center and Shattuck. I live pretty close to the Downtown Berkeley BART station, which isn’t that far from campus.

But at times, walking through that dark pathway to get home, when it’s fairly quiet, I’ll see something move. Sometimes walking down Center Street, someone might walk too close to me. Last week, I passed by a homeless man with a creepy grin luminescent on the poorly lit sidewalk. Despite the decently crowded street, for a split second, it felt like that creepy grin and I were all alone. I rushed home, and didn’t breathe until I was inside my apartment, and had locked the front door.”

I paused, reaching into my bag. I dug around for a bit before I found what I was looking for, a deep blue

moleskin notebook. I set it gently on my lap, letting it letting it balance precariously as I continued.

“That’s when the flashbacks would storm the memory gates open—when I got home. And everything... comes back.” I faltered, wrapping my arms around myself instinctively. “I resist at first, but when I can feel the memories start to overpower me, I grab a pen and start writing in my journal.

I just let those waves of anguish crash over me as I scribble away furiously.”

I look down at the notebook, and back at Dr. Kumar. “It’s.. easier for me to write about this than to just talk freehand. When I’m writing, I can just let myself experience the full emotion, and then cleanse myself of it. When I’m... answering questions, or talking about it with someone, it doesn’t feel like I can fully experience the urgency or fear of that moment... I’m just stuck in this hellish limbo of being near these awful feelings, but not inside them... so I never get to that catharsis.”

I tilted my head; I had never pieced together this realization before. A smile dawned on Dr. Kumar’s face as she watched me process this for myself.

I knew I didn’t have to, but I felt like apologizing anyway. But before I could say anything, she asked, “Would you feel comfortable reading your journal entries out loud, instead of answering questions? At least at the beginning of our sessions?”

Had Dr. Kumar asked this last time, or during our first meeting, I would have retorted back with something brusque. It was a testament to the unexpected change today had brought, that when I thought about her proposition, it made sense.

“The only reason I ask,” Dr. Kumar clarified, “is that the catharsis of writing, or even reading one’s writing, can make it easier to then talk about things.”

She didn’t say it out loud, but somewhere in there, I heard “I know it helps me” implicitly laced in the tone of her words, and the softness of her eyes.

“Actually, I’d.. I’d like that very much.”

Dr. Kumar gave me an encouraging nod. “Whenever you’re ready, Yaalini.”

I opened up the journal to the most recent entry, and took a long, shaky breath.

“Take your time,” she murmured soothingly.

“And at any point, you can stop. You do not have to read anything you do not want to,” she reminded me.

“The sun was setting. The colors exploding across the horizon, with their deep mustard golds, crimson reds, and blushing pinks, seemed to sing joyfully, ignorant of the lonely figures beneath it who were struggling to hold on to a shred of their dignity. I looked up helplessly, searching the skies for anything that could distract me, or save us, but gave up when the colors seem to glow more brightly the closer we were to our downfall.

The soldiers’ faces became blurs as everything but the maddeningly bright sky was thrown under a shroud of blacks and grays. Only their silhouettes were distinguishable. We heard their rapid, greedy breaths before we felt their hands. Like carnivores proudly running their paws over a catch before devouring it, they caressed us, savoring our screams and protests as they prepared to devour us from the inside. They peeled off the meager clothes we had, stripping away the one layer of dignity that had helped us remember we were humans, and not animals.

It was a moot point, though. Now, more than ever, it was clear that we had never been human to them.

More figures emerged in the darkness. My head was

spinning—erupting, crying, and screaming in angry agony. My eyes fought back tears, but everything was growing hazy anyway. The figures looked less like humans, as my vision played games with me. Were they two-legged? Four-legged? More of them approached us, but the only thing I could make out were their eyes, which glowed with seemingly inhuman intensity, and wide grins that bore eerily white teeth. Their lips curled back in triumph, as they let out bone-chilling laughs that resounded throughout the grounds and tingled up through each vertebra of my spine.

What raked against my skin did not feel like fingers but claws—claws that groped every inch of me and pinned me down, enjoying that I was powerless in their grip. I felt excruciating pain, as what felt like daggers pierced my very core. Again, and again, I was stabbed, but no metal or weapon could have made me want to cry as much as the ones these beasts wielded. I shrieked like a dying antelope, and each time I was met with the laughter of a hyena.

I had kept my eyes closed, hoping the darkness would shield me in some way, or at least dampen the howls, as hyenas continued to cackle into the night.

Many things made their way into my ears, passing through the fickle defense of the dark. Some of them were throaty jeers of multiple tenors—“Look how pretty you are...” one of them cooed derisively, while another mocked, “How horrible you cows smell... I feel absolutely sick.” The jeers were only interrupted by keening wails and gloating roars.

I looked up once, clenching my teeth to keep me from screaming. Multiple pairs of glowing eyes were laughing at me, framed by a bloodbath of sky.

They say eyes are the window to the soul, but I couldn't see any trace of humanity in those eyes.

The next thing I remember was waking up in a puddle of my own blood, and thinking that I had died. I felt like a hollowed carcass, and everything

within me had been eaten, chewed up, and spit out.

When we made it back to the tents, and my brother found me, he almost couldn't recognize me. The horror in his eyes made me wish I had died instead, so I wouldn't have been haunted by the purgatory reflected in his gaze. Lip trembling, and eyes threatening to burst in tears, he swept me in his arms without a word. We never spoke about it afterwards.”

III. The Intangible

We spin quickly out of her mouth, threads of an ephemeral tapestry that is woven as it is spoken. We slide amongst other shimmering shades of emotion, and knot up in unresolved holes when something isn't said.

Like a mobius strip, it is not always clear where one side of us begins or ends. There is the side Yaalini bares to the world, and the side that only she sees.

Our tapestry is constantly shifting, transient as the fleeting nature of her thoughts. On most days, we are a flux of mottled grays and mildewed greens—reserved, despondent, and withdrawn. This tapestry of our being often pulses with a secret. It is in her writing that those secrets erupt, and many of us are liberated—brilliant wisps of angry vermilion, fierce gold, and mournful sapphire. Defined streaks of color appear in the tapestry, fighting to be seen amongst the depressed and fraying threads of the other side. We demand to be recognized.

But as the daily metronome of monotonous beats, we are repressed, and begin to fade. Once glorious shades become shadows of what we used to be, joining the ranks of marbled melancholy. Regretfully, tearing older threads of the tapestry to make way for ourselves can be a rude, painful awakening. There is no established etiquette that we follow, nor any logic behind rebuilding the bonds of

this fleeting fabric. We are impulsive things who create and destroy of our own accord, but we can be tamed by one who can wield a particular loom.

At the helm of the loom, when someone coaxes us out, we are deftly chided to supplant old threads peacefully. Order is found amongst our disorder.

The loom itself, however, requires the strands of two—warp and woof, psychiatrist and patient—who wield this tapestry together. For without either, harmonious embroidery can regress into threadbare turbulence. We flit, we glide, and pirouette in a seamless arabesque of sentiments. In place of haphazard weaving that leads to violent revolution, there is instead an enduring stability between threads.

Tears roll down Yaalini's cheeks as the weightier of us tumble through, but the overtures of pain are not born from our ripping through the tapestry just to be seen. This time, the pain she feels is the nature of who we are—what we represent in our purest, unadulterated form. But to assuage the sad blues, and the seething reds, emerge soothing amethysts and comforting aquamarines. They were there all along, but they were shy at first, hiding behind the more raucous of us.

Dr. Kumar finds them lurking in the background, and tugs at them until they are brave enough to spin onto the loom on their own.

The mosaic patterns of the tapestry are fluid, but eventually, the rapid weaving loses its urgency, and shining threads inhabit their final abodes. We are a curious blend of anger, sadness, and resolution, framed with hints of a resilient silver lining throughout. Fresh off the loom, we radiate a certain heat, but we cool down enough to wrap around Yaalini, and envelop her as comfortingly as an ephemeral blanket can.

Some would say we're intangible. But as we settle on her shoulders, she feels our presence. Gentling wrapping her arms around herself, Yaalini looks up

at Dr. Kumar.

She isn't better yet, but healing is beginning.

We glimmer eagerly as a unified tapestry, as she processes what they've created, and recognizes that they have started to weave her story together, where she last left off.

on being

BY LAUREN KNOWLSON, M.D.

I never knew one could be so empty
and so full all at once.
How each day could pass with so much new
and also so much the same.
Time goes on and on with new faces
and new patients. A different day—
what day is it actually?
Their problems start to seem the same.
The questions blur and the answers fall
just out of reach.

I think often of my friends and family.
What are they doing?
Do they know where I am?
How could they ever understand?

As I ponder this, I watch a spider
meticulously spin his web outside my window.
He works quickly and with such attention to detail.

What is he thinking?
Can he see me looking out at him and wondering?
What is he doing?
Does he know I am here?

continued from previous page

Life comes in stages,
and each stage changes me in some way.
I am not who I was, nor am I who I will become.
I am just I.
Here. Now.

A blend of the person I once was—
and the person I am striving to be.
Who is that person?
What is she doing?
Does she know where she is?
How could she ever understand?

The clock keeps ticking and the spider still
weaves his web. Line by line.
Does he know that his web will not last forever?
I think no. And yet still,
he works fervently to build it—intricately.
Is the web he built today better than yesterday's?
Maybe not, yet still, he builds it.

breathless

BY EMILY PODANY

There is a moment, between the calls for epinephrine and the dull thuds of chest compressions, when I realize that I am standing next to her father.

He is wearing dark, torn jeans and is staring at the child on the trauma bay stretcher. His eyes are an empty sea. He is holding a single tiny pink sock in his hands.

"Pulse check!" someone yells. There is a pause, a vacuum, an absence of compression. The monitor overhead becomes a single, flat line.

"No pulse, resume compressions," a nurse responds from the child's head. A burly doctor takes over and the thuds resume, louder and more hollow than before.

"If she dies, what will I do?"

His voice is quiet but startling in its clarity. I turn. He is standing completely still, his eyes staring into mine. I open my mouth and nothing comes out. My white coat feels heavy and stiff on my arms. There is something in my contact lens, sharp and scratching my cornea. I resist the urge to rub it. I hold the moment tenuously between us and let myself look into the abyss, hoping my

presence is somehow enough.

"So now they're pushing more epinephrine, because three minutes have passed," my attending says, leaning in and speaking loudly over the organized chaos. The moment shatters and I turn away from the father.

"We can go now and do your presentation of the other patient; I'm not sure if there's much more to learn here," He shakes his head sadly, glancing back at the stretcher.

He walks out the door, past the father's shaking fingers and the pharmacist's row of syringes. I turn to the father, hoping for some sort of relief to come from all of this, but his eyes are back on his daughter. I stand there for a few seconds with him, shoulder to shoulder, watching a dozen strangers work to save her life. I feel the pull to stay, to have someone witness this moment with him so that he is not alone. I want to tell him I am with you but he is already somewhere I cannot reach, an unfathomable place. All I can do is watch, become a spectator in a memory that will never leave him.

I finally walk out into the hallway, leaving the moment hanging behind me. The team stands in a

circle, a flock of white coats, and I end up facing the trauma bay. "Okay," the attending says. "Let's hear your presentations!"

One by one, the other med students present a case they saw that day. Febrile seizure. Abscess drainage. Flu. There are debates about treatment plans, discussions about diagnoses.

A door opens behind me and I hear a nurse's calm voice. "They're in the middle of CPR, so there will be a lot of people in there." A young woman passes by my right shoulder, led by the nurse. She is composed, her face unknowing and calm. She meets my gaze as she passes the group, her eyes bright and sharp as needles. She holds her phone firmly in her hands.

"Do you want to present your patient?" my attending asks me.

The woman enters the trauma bay, and I watch her over his shoulder.

"Of course," I say.

The woman starts to scream. Her phone falls to the floor but the sound is lost in the chaos. She fights through the tide of doctors and places her hand on the girl's forehead. The other medical students turn and stare through the doors of the trauma bay. One puts a hand over his mouth, tears forming in his eyes.

There is a heavy silence in the group as they turn back to me.

I present my patient's history and my assessment.

The mother and father are ushered out of the trauma bay and into a small room with a social worker. I watch them collapse onto the couch, holding each other, before the door swings closed.

I present my treatment plan.

The social worker exits the room and pauses, wiping a few tears from her eyes, before she enters the din of the trauma bay once more.

"Let's see if there are any other cases we can go see," my attending says quietly.

I excuse myself and go to the bathroom. I lock the door and press my head against the cold wood. I take one breath, then another. The lump in my throat subsides slowly until it is a dull throb. I look in the mirror and my right eye is bloodshot, so I fish out my contacts and throw them away. I have already seen what I need to see today.

When I come out, the world is slightly blurred. The trauma bay is reduced to a flurry of movement and sound. I can no longer see well enough to watch the lines on the monitor in the trauma bay, and I am grateful. I want to feel that I have learned from this experience, but all I feel is a sense of being suspended above the moment, watching time drift by in waves. Twenty minutes of CPR. Ten seconds of eye contact. One short phone call from a hospital. A lifetime ending in a single memory.

"You
are so
brave,"
I tell her.

"Just
keep
breathing."

Outside a new patient's room, I hang back for a moment to breathe. The air in the hospital is sterile and cold as it rushes through me, and though the hallway is filled with people, I feel utterly alone. Yet there is a young girl with asthma inside this room who is afraid. There is a girl inside this room who is alive. I take a deep breath of antiseptic-flavored air and step into the room.

The girl is gasping on the bed, her terrified eyes flickering back and forth between me and my attending. I hurry to her side and take her hand in mine. This time, I find the words.

"You are so brave," I tell her.

"Just keep breathing." The young girl takes a breath, and then another. She nods. She keeps breathing.

forgiveness

BY MICHELLE SCHMIDT, M.D.

When I was applying to medical school in the fall of 1990, I remember interviewing with a female anesthesiologist. She had gray hair and she spoke with the wisdom of someone who had seen seasons come and go. It was early in the interview day. At the time, I was living at home with my mother and younger brother. I had graduated from college and was working for the year while I applied to medical school. We lived modestly; neither one of my parents had graduated from college and my single mother struggled to make ends meet. She worked at a daycare center; years later while cleaning out old files my husband and I came across one of her W2 forms from the early 1980s. She made \$7000 that year. As a young woman, barely out of adolescence, I was entering into unknown waters. I couldn't imagine myself as anyone other than the daughter of parents who worked multiple jobs just to put food on our table. Before my parents divorced and during our last Christmas as a family, my mom used wallpaper (left in the hall closet from prior homeowners) to wrap the only presents they could afford: scotch tape, markers and a pad of paper.

Almost daily, I think about the advice the

anesthesiologist gave me that day. She had five children, worked full time in an academic setting and was married to a physician. It would be four years before I met my husband, but I knew that one day I'd want a family too.

I asked her how she juggled all of her responsibilities.

She told me, "You can be a good wife and a good mother and a good doctor but don't expect to be all three on the same day."

Twenty-six years later I have a deep and abiding understanding of her words. My husband, who is also a doctor, and I have been married for twenty years and we have three teenagers: two boys and one girl. I work part-time as a clinical educator to internal medicine residents in their weekly continuity clinic and I work in the triage and urgent care areas in the emergency room of a large public hospital. Many days I find that it is easier to pull a twelve-hour shift in the emergency room than to be a good parent or spouse.

Through our years of training we become

transformed without realizing that it's happened. In our medical world, we are at the top of the food chain. It's insidious, this transformation. As students and residents we are the grunt workers, everything dictated by those above us. All of our choices are closely monitored. One day we finish residency or fellowship and, suddenly, we are in the driver's seat. It's this intersection of being in charge at work and being in charge at home that has me in its vice grip. I like work because I get to tell people what to do and they do it. At least that's how it seems to me. I place an order in the electronic medical record and it gets completed by the nursing or ancillary staff. A resident signs out a patient to me and I disagree with their treatment plan and I get the last word. A patient is sick and I get to decide the work up and necessary medications and I tell the patient what they need to do to get better. A lot of emphasis is placed on your decision-making capacity as a physician because you are the one with all the schooling and knowledge and experience. For the most part, in your doctor bubble, your word is valued and respected.

Then there is real life; life outside the bubble.

When I walk through the front door or pick someone up from school or drop someone off at practice; I am just "Mom." Sure, on some level my kids might have respect for the fact that I work.

But developmentally it's all about the id with them. How I wish I could enter orders into the computer at home and find them magically completed. Or tell someone I'm not happy with a grade and hear, "I'll get right on that Dr. Schmidt!" But it just doesn't work that way. You'd think

after almost seventeen years as a parent, I'd start to realize that talking louder or more forcefully isn't the solution. The volume and tone of my voice are inversely proportional to the desired outcome. It's just like the good anesthesiologist said to me that day, it's unrealistic to expect I'll excel at everything 100% of the time.

There is nothing more humbling than raising teenagers. They are blind to your ego and sense of accomplishment and they can zero in on your character flaws like a military drone. I can't be Dr. Schmidt at home. It doesn't work. My thirteen-year-old daughter recently taught me this. The battle was silly. As the adult, I should have known better but my orders were not being fulfilled. She was supposed to go to soccer practice and she refused to go. Several practices were missed. She had a responsibility and she wasn't living up to the expectation. She was letting down her coach, the manager (another parent who volunteers his time) and her team. Not to mention that I was ashamed she was blatantly skipping practices and even a scrimmage. This was behavior not becoming to me as a mother or to our family. This type of insubordination would never happen at work. Staff would be disciplined, residents would be failed and patients would be chastised severely. I found myself getting increasingly frustrated and increasingly irrational. And then it happened. I said to her, "You know why your friends are better at soccer than you? Because they don't skip practice!" This was definitely not a good mom day. It was not even a fair mom day. It was a bad mom day. The worst part of my statement was I

knew she felt a sense of inadequacy compared to her friends because she had confided this to me a week earlier. Also, she felt like her new coach belittled her in front of her team. I behaved badly. The irony: if I had spoken like this to a colleague, ancillary staff, resident or patient, I'd have been written up as well. And no matter how frustrated I get at work, I never lose my cool.

Not like I did with my daughter, a person who I love and adore as much as anyone in the world.

What I couldn't have known that fall day in 1990 when I was interviewing with the female anesthesiologist for a spot in her medical school and what I couldn't have known by her statement - that I couldn't be a good mom, wife and doctor on the same day - was this: she'd already had countless experiences like the one I'd just had with my daughter, countless opportunities blown as a parent, a spouse and a physician. That's the reason she was so wise. There is no way to prepare for the reality of being flawed other than living. The path to wisdom is bumpy.

For the record, my daughter graciously forgave me. It was a good moment for both of us. She learned what I already knew, that parents aren't always right and they may even disappoint you.

She learned that her mom could ask for forgiveness and that sometimes humility is learned the hard way. I learned that I can't superimpose my doctor self onto my family and it gave me pause about how I conduct myself at work. Although I think I'm always courteous, respectful and polite to my patients, residents, nurses and staff, it reinforced that I am not the

king of the world.

It's a lucky job I have, wearing all these hats and balancing all these roles. I wish I could remember her name and go back and thank her, that anesthesiologist. Knowing what I know now, I'd like to go back and have a cup of coffee with her and give her a hug. Her advice was the best I've ever received.

a sharp lesson on becoming a patient

BY ATSUKO YAMAHIRO, M.D.

The ventilator delivered its tidal volume to the patient. Up and down the patient's chest rose. The orange glow competed with the room's fluorescent light for space in my burning eyes. I was finishing my last 24-hour call of residency. I felt the patient's stringy pulse ripple past my gloved index finger. This was my third attempt to get an arterial blood gas. I adjusted the needle millimeter by millimeter, and finally there it was: red liquid rising into the tube. A tension released from my back. The day team was coming in a few hours and I needed this sent off. "Was the order placed for this patient's ventilator settings?" The nurse asked. As I looked for the Band-Aid to place on the patient's wrist, my fingers trembled from the extra cup of coffee and I felt a feathery touch on my left thumb. There was a small tear in the glove. Blood trickled out of the tear.

I mechanically completed my tasks—washing my hands with alcohol, and sending off the ABG in the plastic case to the lab—before turning my attention to my own problem. This patient had a history of HIV and Hepatitis C. His blood had come into contact with mine. I washed my hands vigorously with soap and water.

The sun had just finished rising, and people were rushing to work. At the occupational health clinic, I changed into a wrinkled patient gown. A nurse took my history and drew my blood. A medical student accompanied the attending who asked me clarifying questions. The student stood in the corner of the room silently, observing my every move.

"I am a resident and not a patient," I wanted to explain. "I was just drawing a blood gas for my patient. Here is my ID badge and here are my scrubs to prove it."

"These are the medications you need to take," the attending said. Because the patient had history of drug-resistant HIV, there were five pills total, some taken twice a day.

I trained in the Yale Primary Care HIV training track. Prescribing medications to patients who had been diagnosed with HIV was second nature to me. As the patients sat nervously, I would say, "These medications are well-tolerated. But some of the side effects include rash, GI upset, and diarrhea. These may occur but should go away. It

tis important for you to take these drugs every day.”

Now the pills stood on my kitchen counter with my name and phone number on the labels. They were clunky and oval, blue and orange, plastic and chalky. They sat next to my banana, mango, and chia seed smoothies: a foreign friend to my usual routine. As I began my four-week course of medications, I forgot to take my evening doses of the medications for the first five days.

One morning, a week into treatment, I looked in the mirror and saw that my chest was covered with dark red spots. A quick survey showed that they were all over my body. My body was now a canvas of candy button bumps. Thoughts of bed bugs and scabies rushed through my mind. Was it new detergent or body wash or allergies to my cat? Could this be the first sign of HIV infection? I stripped my bed clean of the sheets, threw them in the washer, and washed them three times.

It was none of the above. I was allergic to one of the drugs in my regimen. As I picked up the new medication regimen from the pharmacy, the pharmacist asked me to sign for them. “You’re here to pick up your...” She squinted at the computer, then at my hands. “Your HIV meds?”

My hands felt heavy as I signed the log. The multi-layer make-up that covered the boils on my face, my ears, my lips, and my neck seemed to dissolve. I saw a movie flashing in the pharmacist’s mind. The protagonist, me, with IV drugs, shooting heroin until I passed out or having unprotected intercourse with many partners. This was the

diagnosis, the bumps and boils that proved those high-risk behaviors. I sensed the others waiting in line for their medications take a step back. I wanted to announce: “I am a doctor. I got a needlestick injury. My rash is from my medications!” Instead, I grabbed the paper bag of medications with my rash-speckled hands, and scurried away.

As a patient, I had missed multiple doses of my medications, felt frightened by the side effects, and hid under the label of a physician in order to avoid the stigma of HIV that had been placed on me.

As a physician, I would often attribute an HIV-infected patient’s detectable viral load attributed to medication non-adherence and lecture the patient on the importance of taking medications as prescribed. When giving new medications to a patient, I would blaze through potential side effects so that I could get through my check-list and the patient’s visit. I would shrug off a patient’s need to come to the HIV clinic through the backdoor as a little paranoid.

I knew now how it feels to be on the other side of that checklist.

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the net

BY ALEXIS RAMOS

There was a specific day in winter when, even though snowflakes were not yet falling, I fell. I fell for a boy that seemed sweeter than nectar. The lure of his inciting ways entrapped me. The catching was his game, as if I were a butterfly and he was the net swooping for my attention. He caught me that winter, tangled me inside his net. Never had I felt the clichés of heart skipping a beat and butterflies in my stomach until I became reduced to an insect myself.

I could always sense if his days were bad by the way he walked inside, slamming the door so hard that even the windows would wince in pain. I'd close my eyes dreaming of open spaces and the wind in my face. My first mistake was not setting the table the way he liked—a cup in the upper left corner with two forks and one knife on either side of the plate. The suffocation began slowly. He wanted to see how far the net he placed around my wings could stretch—testing its elasticity, testing its patience, testing its ability to snap.

“You’re not good enough,” he’d jab.

“Why are you so stupid?” He’d blow.

“You need me,” he’d kick. I could feel the net tangled around my wings, and wished that I never left the safety of my cocoon.

A buzz trickled out of my phone—mistake number two.

“Who is that?” He demanded furiously. My schoolmate texting what time class began tomorrow almost ablated the chance I’d ever see another sunrise again.

“It’s a classmate,” I’d stammer. I could feel the strings of the net tightening with tension.

“You’re a liar.”

He smacked the phone across my face. No longer did his sweet presence take my breath away, instead it was his hands.

“I’m sorry,” I choked out as he squeezed tighter.

“It won’t happen again.”

I was an insect that could not find its way out of a

bad situation, and he knew that. His apologies and excuses were binding. They were words spoken so sincerely that I didn't notice the hold they had on me. It was a Tuesday morning in Spring when he put a bushel of flowers on the dining room table—a kind of surprise that signaled abuse from the day before. The cracked blinds in the kitchen let in a stream of sunlight. I closed my eyes and imagined open fields filled with living flowers. The flowers I imagined in my mind were rooted far into the ground and were not a symbol of guilt.

“What am I doing?” I said out loud. I'd been reducing myself to a bug when I'd already grown into a butterfly. The process of metamorphosis had given me wings. I chose to break free of this net because I could. The empty silhouette I had become was not compatible with the self who had once flown in clear blue skies. Throwing the dead flowers on the floor, I searched for real ones.

love thy neighbor's specialty

BY MONIQUE MUN

Now, at the end of my third year of medical school, there is something about the culture of medicine that doesn't sit well with me. At the beginning, it seemed benign and provided some good laughs; but now, it has become more personal, even toxic. I refer to the demeaning and dismissive comments from one specialty made about another specialty. I am not overly sensitive, and I understand these comments can be made out of frustration or to provide comic relief. However, for an impressionable medical student, these comments begin to stick, producing a new set of doctors who will echo the same sentiments.

We must understand that although people who pursue medicine have some commonalities with each other, such as commitment, drive and an interest in helping others, there are far more differences among this homologous group. It is these differences that make each one of us uniquely fitted for each specialty. I, for one, have chosen to pursue psychiatry. My personality, love for patient interaction, and interest in mental health make me well-suited for psychiatry. However, another student who likes working with her hands, seeks immediate improvement,

and enjoys utilization of instruments, may go on to pursue surgery. While the idea of being in the OR all day and doing procedures terrifies me, likewise, talking to patients all day who are depressed or anxious might terrify a surgeon. There is a valid and sometimes personal reason why we choose the specialties that we do. Making derisive comments about another specialty can undermine someone's personal motivation and the unique talents they bring to that specialty.

I distinctly remember one comment made to me while working one-on-one with a resident while suturing a patient's abdomen. She asked me, "You're the one that wants to do pediatric psychiatry, right?"

I hesitated for a second, and confirmed, "Yes."

She then replied sarcastically, "Good for you. Someone's got to do it, sounds miserable."

At first I was shocked at how derisive the comment was and how it made me feel. Was I being too sensitive? Or did this cross the boundary of professionalism? How can you say such things when this is the profession that I am

fervently pursuing, and that I feel is my “calling” in medicine? At the same time, this is the same resident that admitted to me that if her daughter came to her claiming she was depressed, she would tell her to “suck it up”. As you can see, words do carry weight. And it seemed to weigh heavier because I was afraid to defend myself and the specialty, especially in a profession like medicine where seniority is akin to superiority. I certainly did not have the confidence to respond when she had my clerkship evaluation hanging over my head.

Yet, this aspect of medicine is not just damaging to the personal psyche. It also leaves an impression on young medical students. They can form preconceived notions about a specialty, affecting their experience on the rotation and even patient care. For example, on my internal medicine rotation, I made the mistake of assuming that my residents and attending did not care for the psychiatric history of patients. I was afraid of being interrupted or stopped if I mentioned it during my patient presentation. Thus, I neglected to ask one of my patients about his psychiatric history while taking a history and physical. Turns out, my patient endorsed thoughts of suicide and was battling with depression. It became pertinent when the patient started to refuse treatment because he was feeling hopeless. I was embarrassed when I, an aspiring psychiatrist, was not the one to find that out because I did not even ask.

Is this aspect of medicine ever going to change? Maybe not. But I think we should start with choosing our words differently. Instead of saying,

“Psychiatry? You’re going to be miserable - just dealing with crazy people all day,” perhaps you should say, “Psychiatry? I do not have the patience to treat psychiatric patients.” Speak in a way that is respectful towards another specialty, acknowledging that your opinion is just that - your opinion. Just because you had a miserable time on a certain rotation does not mean that everyone else who goes into that specialty will be miserable too. Our experience of medicine is subjective, and rightfully so. The different avenues medicine offers allow each one of us to pursue our individual interests and utilize our unique talents for the common goal of taking care of patients.

genesis

BY DENISE GO

Your name is Génesis, like Eden's pressed beginning—a common christening for this half of what the First World calls the bitter earth. You color spaceships in Crayola, pink chalk powder dusting your slim-framed glasses as you tuck your hair to jam stethoscope tips in your ears.

They always speak heartbeats—some talk acoustics with body politic. Did I tell you empires could make a Jeepney bloodmobile from our thread-words: como barrio y baryo, corazón and Corazon Aquino?

Manila, Managua—to my American Spanglish (*nod for translation*) prayers. The priest bows his head for Padre Nuestro as blushed cream plumeria petals float from open doors of the cloister during Mass. Today, they read

the Book of your namesake. Your skin is brown like mine like yours; I hate describing their shade as coffee or chocolate, as if we were meant to be consumed. But I love this linoleum floored church-turned-clinic, four electric standing fans for white noise:

gentle under hot banana leaves as you read from books on Curie and Einstein with bright pictures. We will play hopscotch and fútbol after your mother's checkup, watch suns become love—you insist it's science, not magic.

becoming a physician

BY NATASHA GIBSON

Be nice, but not too nice. Be bold, but not too bold. These are common messages we hear as women in today's society. Be everything; but be careful because you might be too much of everything for someone. Moreover, when you are too much, you are expected to be less for their sake. Do not let anyone tell you that you are too much. It is important to remember that situations and times are not dictated by what makes everyone else feel warm and fuzzy, or powerful. Many will question your sanity at taking on the difficult task that is studying medicine, but it is well worth the reward.

Seek out those who will build others up and seek to follow their example. With every push backwards, you have to take two steps forward that challenge only makes you stronger. Individuals working to support and grow one another fill the field of healthcare. From personal experience, I can say that your work will be checked and double-checked to ensure you have not failed. However, I have

always found gems along the way that give me hope. From my male counterpart immediately deferring to me for the care of a patient when in the patient's verbiage I was "the female aide". To fellows who support my studies and encourage me to keep going always providing me with new resources and guidance, to attending's who seek me out to mentor and guide me in my learning. Support of one another has always been the strongest foundation for growth, and in small steps of taking leadership roles, teaching roles, and mentoring roles the women of medicine supported by those surrounding them have found a new foothold.

If you look carefully, you will see that women around you are fighting the same battle. So be kind, for the struggles you face are theirs as well. Remember, you are not a doormat and you are not everyone's idea of perfect. So do not let anyone tell you that you are not enough or are too much. You are just right.

weird doctors

BY SHAILI JAIN, M.D.

Milwaukee,
Wisconsin, USA

Liverpool,
Great Britain

“What if you hospitalized God?” my pulmonologist friend asks, his boyish face breaking into a smirk. We are guests at a holiday party, he is tipsy, and I have an uneasy sense about where this conversation is headed. His voice rises to compete with Bing Crosby’s crooning flowing from mounted speakers. “You know? A guy comes in claiming he is God, and you diagnose him as delusional, medicate and commit him. I mean, it’s not as if you have a blood test to prove he’s delusional. Wouldn’t you feel bad about locking God up in a psych hospital?” I rapidly proffer insights as to why this would not happen, but he is not interested, and this leaves me feeling miffed.

You spend the first two years of medical school studying thick textbooks with monastic fixation. Once you have proved you can do this well, the gateway is opened for you to meet the city’s people in their role as patients. From their mouths come the illness scripts that infuse the textbook data stored in your brain with meaning. These hours spent with patients, engage your eyes and ears in a way a book page cannot - and so begins your gradual transformation from student to doctor.

The challenges and ambiguities of the medical world enthralled me, and professors suggested I become a surgeon or specialist, career paths

scarcely available to my minority predecessors. I had considered gastroenterology, a thoroughly respectable medical subspecialty, but then close to graduation, during an obligatory clinical rotation in psychiatry, something happened that changed my mind.

I was shadowing Dr. A, a consultant¹ psychiatrist, during his Tuesday morning clinic in Southport, a seaside town located 20 miles north of Liverpool. As a “student doctor” my job was to observe. After the patient left, Dr. A dictated a note and, if time allowed, threw me a question to test my knowledge or to point out a golden nugget of clinical information. Through this on-the-job training, I came to know that seizures are a rare side effect of antidepressants; what the symptoms of pathological jealousy, commonly known as Othello’s syndrome, are; and how to distinguish between a hypomanic and manic patient. I also scribbled notes on topics to read up on later at home, or looked up a quick fact in my pocket-sized *Maudsley Handbook of Practical Psychiatry*.

The next patient, Sarah, had a pudgy face framed by mouse-colored hair, beady eyes, and thin lips clumsily smothered in pink lipstick. Her smell of rainwater mingled with cat hair lingered in the air of the office space. She acknowledged my presence as the “student doctor” with a tight smile. Sarah appeared accustomed to the setup and started talking right away. Things seemed unremarkable, and I was starting to wonder why she was here—then it came.

“Who can deal with the smell of shit round the clock?” Sarah’s stocky frame leaned in toward Dr. A, who did not flinch.

“I hear them, next door, talking about me at night. They smear shit on the walls and call me a bitch!” Tears welled in her anguish-filled eyes.

I sat holding my breath, fascinated at this twist in her tale. She had gone from docile to crazed in thirty seconds.

“How long has the smell been back, Sarah?” Dr. A intervened.

“A few weeks.” She was peeved at having her rant interrupted.

“Your brother called. He said you stopped your medication. Is that true?”

Sarah glared. “They make me sleepy. I have to stay up at night so I can hear what they are saying.”

She sheepishly added, “Anyhow, I don’t think I need them.”

“How about we compromise and lower the dose?”

“Okay. I suppose we can do that,” she shrugged.

“Come back next week?” Dr. A leaned over with a prescription and a smile.

She got up and obediently took the prescription, briefly nodding in my direction before leaving.

¹ Consultant is the British term for attending physician.

Sarah's chart was thick, some of the older notes just thin sheets of cream paper typed with an old-fashioned typewriter. She had been diagnosed with schizophrenia at age twenty-seven and suffered paranoid delusions that triggered episodes of bizarre and violent behavior requiring her to be hospitalized against her will. In recent years she had been more stable, taking medications and attending appointments. But six months prior, her mother, with whom she had lived, had died. Her chart referenced a brother as her only living relative; I recognized his name as that of a prominent local physician.

This was not the first time I had seen a patient who was also the relative of a physician. It was the absence of the red carpet treatment for Sarah that piqued my interest. Why was she not seen for her appointments at the fancy teaching hospital in downtown Liverpool, by the department of psychiatry's chief? Why was no family here by her side? I recalled a physician's wife who had found a breast lump and the team of doctors who had descended to ensure she received a fast-tracked work up. Another night, on call, a retired doctor came in with chest pain. He was seen by the attending physician, typically unheard of, at an hour when only junior house staff roamed the hospital corridors. These incidents had all struck me as being such a departure from the snail's pace so typical of the British National Health Service.

It dawned on me that severe mental illness was unique in the way it infiltrated a patient's life. I could imagine Sarah's bizarre behavior, the chaos,

and exhausting resistance met by her loved ones. It must have been trying dealing, day to day, with a harsh psychosis that left Sarah inclined to believe that the whole world was conspiring against her rather than accept she was the one misperceiving reality. I imagined it was complicated for her brother to have her seen at his workplace. Perhaps it was easier for him to stay connected from a distance and in the more comfortable confines of his role as a professional. What stayed with me, though, were Sarah's eyes, full of anguish and fear and no different from those of other patients. But she was here alone and, ironically, the very organ she needed most, to understand her illness and make decisions about her healthcare was the very organ that was sick, leaving her exquisitely vulnerable. A good psychiatrist would have to master the art of advocating for her patients—especially those who had no one to advocate for them. Something about this realization moved me to the core and made me consider psychiatry as a specialty I should pursue.

Psychiatry was different from other specialties in the world of medicine. To begin, most psychiatric hospitals are separated from the wards of a regular hospital and, to limit the damage suffered by patients experiencing suicidal urges to jump, are rarely built higher than two stories. They have euphemistic names like "Broadoak" and "Northbrook," and the grounds tend to be greener and prettier than the typical hospital campus, perhaps in an effort to thwart the attention of unsavory nicknames like "loony bin" or "mad house." Also, psychiatric patients use

their hospital beds for sleeping only; they don't wear hospital gowns and can often be seen outside the hospital entrance, taking a cigarette break.

The complaints of my fellow medical students were ubiquitous: "the pace is so slow"; "psychiatrists don't do anything other than listen and talk"; or "the patients don't even get better – no sooner do they get discharged than they are back in again, as if the hospital entrance were a revolving door." No doubt, many medical specialties are mocked by students for all sorts of reasons. Doctors who choose to become anesthesiologists (or pathologists) only like patients when they are asleep (or dead). Plastic surgeons and dermatologists only became doctors so they can make mounds of money. Still, I could not shake the feeling that the criticism of psychiatry was fueled by a belief that it was, somehow, separate from the rest of medicine in a way that made it "make-believe" medicine.

I planned to share my dilemma with my parents during a weekend visit home. The grind of medical school had encroached on other parts of my life so trips home were fleeting, infrequent, and often consisted of simple things like sleeping in, eating home-cooked food, watching a Bollywood movie, or taking a long bath. On Saturday, after sleeping in, I followed my parents' voices to the kitchen. Moments later, sipping scalding Tetley tea, I shared with Mum and Dad my enthusiasm for psychiatry and how I was contemplating pursuing it as a specialty. Dad looked up from the orange he was peeling and turned to face me head on;

his eyebrows were arched in disbelief, eyes wide and jaw slightly dropped. I felt my body tense and recoil in response.

"Why would you want to be a psychiatrist? That would be a waste of your training!"

I turned to Mum, the voice of reason:

"Why would you want to be around crazy people all day? Is it even safe?"

My heart fell at their reactions. Devastated, I stared at the floor as Dad lectured me about why psychiatry was such an absurd choice. Mum backed up his statements with supportive mutterings. Their lack of a favorable response to my announcement was jarring; my life, to this point, had been full of a variety of choices that had elicited only encouragement from their lips.

I thought again about why I was drawn to psychiatry. Sarah from Southport was only one of many patients I met during that psychiatry rotation. Like Sarah, these patients also had severe mental illnesses like schizophrenia and bipolar disorder. These illnesses had affected every part of their lives, interfering with their capacity to love, create, and work. They were incapacitated not by poor lifestyle choices, moral weakness, or character flaws but by a complex and delicate interplay between biology, genes, and their environment. I found their symptoms of absorbing interest, and caring for them left me feeling gratified.

I was filled with a reassuring sense that psychiatry was where I was meant to be. With newfound gusto I interrupted Dad's lecture but, to my dismay, my mumbles lacked conviction and made me realize that, oddly, I still did not have the words to fully describe the hold this specialty had over me. I was overcome with an uneasy feeling of sadness and loneliness. This was all unfamiliar territory.

Several months later, I was sitting in an office on the seventh floor of the Royal University Liverpool Hospital. Across from me was my boss, Dr. B. He was an internist, tall with boyish looks and an easy smile. His relaxed manner lay in contrast to his eyes, which were intense and inquisitive. He was technically outstanding and always professional— just the kind of doctor I wanted to be. His office offered a bird's-eye view over Liverpool—concrete chimneys billowing smoke into the grey sky, car parks filled with vehicles of every color and size sitting in the drizzly rain, and row upon row of red brick terraced houses separated by narrow streets. Far below us the city's inhabitants, affectionately called Scousers,² walked along worn streets past news agencies selling lottery tickets and the evening edition of *The Echo*, bakery windows filled with trays of Eccles cakes, éclairs, and jam donuts, and a corner pub that served warm pints of Guinness in a smoky sanctuary. I was awaiting a review of my professional performance as an intern. It had been a grueling year but a prerequisite for all new doctors to complete before proceeding to specialty training. The year was intense with a frenetic rotation through different medical and

surgical wards. I had become adept at diagnosing failing hearts, livers, kidneys, and lungs. My nose, routinely flooded by the smell of death emanating from pus-filled wounds and necrotic skin tissue, was now desensitized so I no longer gagged at the sight of frothy urine, bloody stool samples, or bile-streaked vomit. I had been up at all hours of the night, for many nights, replacing low potassiums and magnesiums, catheterizing stubborn bladders, culturing the bugs responsible for spiking fevers, and setting up morphine pumps for cancer pain and insulin drips for patients with diabetes. Through all such tasks my mind had lingered on my patients' back-stories, which I believed crucial to understanding them. My mind often lingered on patients' back-stories, which I believed crucial to understanding them. My patient Allan had liver failure and would come into the hospital every few weeks to have the fluid from his abdomen drained. With hollowed cheeks and a terse face he would lie flat, stripped to the waist, waiting patiently for me to insert the drain. Taking in Allan's skin, daffodil yellow with jaundice, the ruby red palms of his hands, and his belly, so swollen with fluid that he looked seven months' pregnant, I wondered how Bell's Scotch whiskey had come to hold so much influence over his marriage, children, and job. I busied myself organizing the contents of my procedure tray: sterile gloves, antiseptic wash, local anesthetic drawn up in a 5cc syringe, drapes to cover the rest of his tummy, a wide bore cannula, and a urinary bag roomy enough to collect the drainage. As I felt the "tug" from the needle puncturing his abdomen and watched the straw-colored fluid gush out, I wondered what was so compelling a

² Scousers is a colloquial term for the local inhabitants of Liverpool and a reference to their fast and unique way with the English language.

bout the amber-colored spirit that he had drunk more and more of, year after year, until his liver became shriveled and irreversibly destroyed.

Another patient, Dot, dreaded the winters, for they brought the threat of influenza -- a danger for someone with lung disease. On good days, even mild exertion rendered her gasping for air, but an infection was really bad news and often had her return to the hospital in need of intense oxygen treatments and antibiotics. During a harrowing night, with nicotine stained fingers and a face tight with worry, she whispered to me in a husky voice, "I'm not afraid of death, Dr. Jain, but the thought of suffocating to death terrifies me." Was this horrifying thought making her panic? Was panic aggravating her breathing even further -- making her hyperventilate and dangerously depleting her already-low oxygen levels?

And then there was Melody, a young patient from Toxteth, who had a nasty compulsion to insert paperclips, thumbnails, and sewing needles into her bodily orifices and skin. She was famous in the hospital as half the medical staff had, at one time or another, arisen from deep slumber to come and evaluate her on one of her many visits to the Emergency Room. Melody would sit in her hospital bed, her chestnut brown hair straggling over broad shoulders, and pick at the dirt in her fingernails, as the drama unfolded around her. Mysterious complications in her treatment, to which she reacted with a peculiar indifference, often lengthened her stays. Her condition demanded the attention of many specialties: one or more from urology; ear, nose, and throat; and gastroenterology, depending on which orifice (or

orifices) she had assaulted; plastic surgery, for her wounds caused by the repeated puncturing of her skin; infectious disease specialists, to ponder over which antibiotic should be used to treat the superbugs making their home in the deeper layers of her skin; and, of course, psychiatry. Meeting Melody confirmed my suspicion that severe mental illness was complicated and, if left untreated, became time consuming and expensive to treat. Moreover, any inclination to believe that these illnesses were imagined or "all in a patient's head" was confounded by the physical impact of Melody's disturbed behavior on the medical system.

For patients like Alan, Dot, and Melody, their mental conditions were intricately interwoven with the outcome of their physical illnesses, shaping how they lived and dealt with disease and ultimately, the quality of their lives. For me, this brain back-story held the most meaning, and that realization strengthened my resolve to pursue psychiatry. By now Mum and Dad too had submitted to my choice of specialty with tentative blessings, and I applied to a local psychiatry training program.

Back in Dr. B's office, he proceeded down a checklist of the goals expected of me as an intern, the vast majority of which, he was pleased to report, I had met very well, and he congratulated me on being a valued member of his team. We settled into pleasant chitchat, and then he leaned back, casually rocking in his chair, and asked:

"So, I hear a rumor you want to go into psych?"

“Yes, I’m in the process of applying for a position.”

“Well, I think you should stay here with us. You could do well in internal medicine.” His finger spun a pen on his desk as he added, “They are not like us, you know. They are *weird*.”

It took me a few seconds to realize that his insult was directed at psychiatrists. My face began pulsating with heat and my mouth became dry. I was filled with a mixture of anger, fear, and confusion. Instead of demanding an explanation or stating my own case I mumbled something to the effect of “I’ll think about it” and got up to leave. He stopped rocking and offered a fake smile, leaving me with an impression that choosing psychiatry would mean losing his favor.

Disapproval from such senior quarters left me shaken. I was part of the medical establishment, but it appeared that becoming a psychiatrist would diminish the quality of the medical membership I had fought and sweated for. Nonetheless, psychiatry would cause me to rebel. I was compelled to become one of those “weird doctors.”

Many years later and comfortably established in my psychiatry practice, I have come to accept that psychiatrists are in fact different from other physicians. We rarely wear white coats and tend to avoid touching patients. The legal power we have to hold the severely ill in a psychiatric hospital, against their will, introduces strains of fear into our relationship with some

patients, a contrast to the reverence often enjoyed by other physicians. But I readily gave up my stethoscope and the ritual “laying on of hands” for the challenges of examining patients in a different way.

Psychiatrists typically have limited diagnostic tests or procedures at their disposal, so our history and examination have to be impeccable, with meticulous attention to detail. Becoming a good psychiatrist meant honing my powers of observation to inspect paranoid, mistrusting, or anxious patients for the signs of psychomotor retardation, tremor of thyrotoxicosis, or pallor of anemia without them feeling scrutinized. Listening for breath and heart sounds was replaced by mastering the clinical skill of listening to what patients do and don’t say and how they say it. This skill can, if used expertly, yield volumes of critical information. Palpating spleens and livers was replaced by cultivating a sixth sense about the dynamic between myself and the patient, monitoring my own feelings towards the patient, however distasteful to my own ego, and using that to gauge the progress of treatment. Far from weird, what drew me to psychiatry was the sheer artistry involved.

Milwaukee, Wisconsin, USA

So now, almost a decade later, my pulmonologist colleague has posed his tongue-in-cheek question which, at its heart, once again questions the legitimacy of my specialty. My initial irritation at his razzing eases as I realize that beneath the teasing lies his own discomfort with psychiatry's emphasis on raw emotion. Experience has taught me that, for many physicians, dealing with raw emotion clashes with their own need for the more measured, concrete, and precise chapters of medical science.

You understand that you work with a diagnostic system that is imperfect, yet know that that does not make such a system invalid when used properly. You offer a diagnosis knowing that some may find it meaningful and be filled with gratitude whereas others might be insulted and hate you for it. You understand that psychiatry is in the midst of a revolution, hurtling toward a time when it will diagnose with blood tests and brain scans and offer tailored treatments, but you also accept your duty to heal the pain of those suffering today, suffering caused by illnesses documented since Hippocrates lived in ancient Greece. Good psychiatry only takes issue with bizarre behaviors or divine proclamations when they come with unusual pain, devastating dysfunction, or disabling burdens on the lives of the proclaimers or those living closest to them.

A decade after meeting Sarah in Southport, I am still very troubled by the way that Psychiatry is segregated from the rest of the medical profession but, by now, I have accepted the truth for what it is. I am a physician but also belong to a weird specialty struggling for legitimacy in the world of medicine.

where roads take us

BY SOUMITRI BARUA

WINNER OF THE 2017 LINDA BRODKSY MD ESSAY AWARD

Simple everyday errands, such as buying groceries, were a challenge for my family while I was growing up. My mother loved to cook spicy Indian food, and my father, younger sister, and I relished the flavorful biryani and chicken tikka masala she prepared. Every month, we would drive two hours to Buffalo, where the nearest Indian grocery store that stocked the necessary ingredients for our home cooked meals was located. The trek was worth the payoff, and these long car rides filled with lively discussions with my family are some of my most cherished memories. But, sometimes I wished that we didn't have to sacrifice our entire Saturday just to buy spices. Born and raised in a small town in rural New York, I did not have the same educational opportunities as my peers who lived in more populated areas across the country. Despite bestowing upon me a geographic disadvantage, living in my quaint town of Olean, NY, gave me a unique perspective on the challenges of life. In a town of only 15,000, many residents had to travel two hours to the nearest major city to access advanced medical resources and life-saving treatments. My personal experiences and understanding of my remote community inspired me to become a doctor so that I may be able to give back to medically underserved communities as a physician.

Lack of accessible resources affected my educational experience in high school, but I learned to overcome those obstacles and make the best of the situation to achieve my goals. From ninth grade onward, my dream was to attend Brown University, the Ivy League school in Rhode Island that prides itself on its open curriculum. I knew that Brown's academic freedom would allow me to craft my own curricular path and choose any class that satisfied my intellectual curiosity, be it human physiology, public health, or ancient Egyptian archaeology. My understaffed, rural high school, however, did not offer any of the necessary Advanced Placement (AP) courses that schools in bigger cities take for granted. Nor was my high school equipped to send students to selective schools. New York State has one of the best public education systems in the country, but our small school lacked most of the tools that connected students to higher learning. My thirst for learning, especially in the field of biology, had yet to be satisfied through my high school courses, so I decided to self-study for the AP Biology test during my sophomore year. My peers often ridiculed me for going beyond our curriculum and studying more than what was necessary to pass the high school course. course. Once, when I was quietly studying the difference between type 1 and type 2 diabetes during a free period, my classmates

mentioned to me that I was only pretending to study in order to “get attention” and labeled me as an “overachiever.” While the comments hurt, I learned to ignore the negative words. I recognized that I could not allow such remarks to interfere with my goal to get to Brown.

After successfully completing the exam, I persevered in my search for opportunities to expand my knowledge of biology. The sleepy town of Olean is not exactly a research hub like Cambridge or San Francisco, but in my quest, I met Dr. Hens, then-Assistant Professor at St. Bonaventure University, which is only minutes from my home. She mentored me as I worked in her breast cancer research lab. As I learned about the scientific aspect of cancer, I became more curious about the social aspect of health and disease.

My hometown only had one oncologist, Dr. S, who allowed me to shadow her at her private practice in Olean. For many, receiving treatment at Dr. S’ practice was the only available and affordable option. Some patients even travelled to Olean from the surrounding, yet distant hamlets to undergo chemotherapy several times a week. For more severe cases, traveling to Buffalo once again became necessary. Buffalo is home to Roswell Park Cancer Institute, which serves many cancer patients living in Western New York. When the Olean chemotherapy location could not satisfy the severe needs of sick patients, the closest option was to travel to Roswell in Buffalo.

By interacting with the many patients at Olean’s oncology clinic, I realized that additional travel time for life-saving treatments was inconvenient and stressful for many patients and their families during the emotional process of chemotherapy. I watched patients as they progressed through their treatments with emotions ranging from hope to despair. When meeting an anorectal cancer patient named Myrtle, I understood her anxiety and resignation when she refused further travel to Buffalo for treatment and despondently remarked

to Dr. S, “Just let me know when my time is up.” She explained she wouldn’t have to put her family and herself through more suffering and travel to Buffalo several times a week. Through these events, I started to comprehend how social determinants affect disease. If these patients had lived closer to Buffalo, where there is more than one oncologist and one hospital, access to medical treatments would have been less burdensome for patients and their families. Even though I had fewer academic resources compared to my counterparts at elite high schools, I managed to improvise with my available tools and take advantage of all the opportunities offered in Olean, my hometown that I have come to cherish. I fulfilled my high school dream of attending Brown University, and I will be attending Alpert Medical School of Brown University this fall as part of the eight-year Program in Liberal Medical Education. I have had the opportunity to delve into my intellectual interests by taking a multitude of courses in both the sciences and humanities while majoring in public health, which has allowed me to explore both the scientific and sociological causes of disease. My inspiration to pursue medicine came from witnessing and experiencing the struggles of patients in rural America, who, like Myrtle, often felt resigned and desperate because of the lack of resources. My first-hand experiences of living in an underprivileged area, where daily tasks like grocery shopping and important necessities like medical treatment were difficult to perform and obtain, have motivated me to return as a physician to medically underserved towns.

Although I realize that a single physician cannot repair the geographic and systematic barriers to medical care, I envision myself crossing all racial and socioeconomic boundaries to bring hope to a diverse group of people.

on the other side

BY LARA SLESNICK

FROM THE 2017 LINDA BRODSKY MEMORIAL JOURNAL

As medical students, we are taught about pain. We know from lectures that the microbe *Streptococcus* will cause a sore throat, while Rotavirus will cause abdominal discomfort. However, as young and healthy medical students, we never really experience pain. Most of us have never undergone childbirth, or broken a long bone. For me, the closest thing I experienced to pain was breaking my right fifth toe, or maybe my two shoulder surgeries after 20 years of competitive swimming. This is why, after years of learning about pain from working in the Emergency Department, to helping patients through painful dermatological procedures, I thought I knew pain.

The first time I really and truly experienced pain, was after a sneeze at a potluck at my house. A searing pain at the base of my skull exploded out of nowhere. My body tensed and my neck automatically craned my head up to the sky, as if I was saying a silent prayer. However, the pain receded quickly and I shrugged it off as a fluke. I knew I had been stressed, as we were in our Mind, Brain and Behavior module, and hours of staring

at myelin stains had left my neck aching. However, episodes of the searing pain continued. Every time I sneezed, coughed, yawned or laughed, my eyes would water with pain. The time that it took for the pain to recede grew longer and longer, and eventually never went away. The headaches were debilitating; every cough became misery. My hands grew weaker and weaker, and eventually I could not hold a pencil to take notes in my classes. The words on the PowerPoint slides slowly became a muddle of watercolor gibberish, one word spilling into the other.

After an appointment with my primary care physician and two MRI's, I was sitting in a neurosurgeon's office. He calmly explained that I had a cyst in my spinal cord due to a rare congenital skull deformation. For most, this congenital anomaly was silent, mostly picked up on scans by accident. The cure?

Neurosurgery.

There are few times in a person's life where he/she comes face to face with his/her own

mortality. As medical students, residents and physicians, we slowly learn to look death in the eye daily as we treat our patients. Whether it is a woman with COPD, or a man with metastatic testicular cancer, all physicians face death. However, how often do we face our own death?

It seems to be easier as an 89-year-old with end-stage renal disease, congestive heart failure and diabetes. As a 25 year old, I had never even considered my own mortality. I had been absolutely sure I would die at 79, as most individuals in the United States do, after having a successful career as a reproductive endocrinologist, and 3-5 children of my own.

So here I was, in a neurosurgeon's office, as he spoke to me about the procedure. As a medical student, I knew about the surgery. In fact, we had learned about it the month before and I had chosen the correct answer about it on my final the previous week. Nevertheless, the surgeon explained the procedure using skull models, his finger, the scalpel, bone saw, and suture. He rattled off statistics about success, chance of infection, and cure rates. I asked questions about survival, adverse outcomes, hospital-stay length, and, vainly, the amount of hair I would lose. The visit concluded, but it seemed like my new reality was just beginning.

My blurred vision, markedly weakened grip strength and debilitating headaches made it nearly impossible for me to continue the grueling hours of medical school. Driving became difficult, such that I could not see stop signs well enough to feel comfortable behind the wheel. With that, I

could not see stop signs well enough to feel comfortable behind the wheel. With that, I could no longer attend class even when I wanted to. The deans of my school gently told me the only solution was to take a full year off from medical school, and through tears, I agreed.

My whole life had changed in a matter of six weeks. I had gone from a half-marathon running, healthy medical student to a sedentary, medical patient who could barely bathe herself. All I could do was sit at home with the TV in the background as the train of thought roared in my head. 'What if this isn't causing my symptoms? What if I become paralyzed or the surgery doesn't help?' It was as if a part of my core identity was being stripped from me by my illness.

However, as I processed my diagnosis, condition, and surgical plan in the weeks prior to neurosurgery, I came to the following conclusion. Without a doubt, the outcome of the surgery aside, this experience would make me a better physician. Every struggle I had overcome, every struggle that I had yet to conquer would help me relate to my patients. As I faced my own mortality, I came to the realization that most of my future patients would, at some point, come to this exact same impasse where I was standing. My patients would look me in the eye and tell me that they were no longer who they used to be, simply because they were ill. Before, I would've had a genuine sympathetic answer for them; and now I have an empathetic emotion with which I can connect with them. Even though this conclusion did not make the infection risk decrease or my surgeon's hands steadier, this regenerated me.

I grew slightly braver.

It was with this newfound bravery that I grabbed my small bag of comforts to make my ICU room feel like home. I shut the car door, took a deep breath and walked in.

dr. babineau—my mentor, my friend

BY JESSICA CHURCHILL
WINNER OF THE 2016 LINDA BRODSKY MD ESSAY
AWARD

A founding member of the Western Tidewater Free Clinic, the Medical Director of the EVMS HOPES Clinic, the Director of EVMS Service Learning, and the Assistant Dean of Student Affairs, Dr. Teresa Babineau, or Terri as she insists people call her, strikes an imposing figure. From outside of her impressive orbit, I listened to her lectures from the safety of the back row and blurted nervous hellos when I encountered her in the halls of HOPES, the student-run free clinic of Eastern Virginia Medical School. I did not officially meet her until the summer of my M1 year when I worked alongside her at a Remote Area Medical Mission in Wise, VA.

There she was, with all of her fancy titles and responsibilities, sloughing through the ankle deep mud in beat-up tennis shoes, her hair in a casual ponytail. Little did I know that she would become one of the most influential people in my life. Fast forward to now, I am almost finished with my M3 year and closing out my tenure as one of the Co-Directors of HOPES, where I worked closely with Dr. Babineau and our relationship took flight. I found a mentor in Dr. Babineau in a way I had never experienced before, and although I was not

She has taught me more than I could ever put into words, but three main lessons will stick with me forever:

1. You are only as great as your team.

Despite being incredibly accomplished, Dr. Babineau is the first to recognize the hard work of her colleagues. She has taught me that the best kind of leadership comes from a place of equality rather than superiority. You can often find her working side by side with her team, for no job or task is below her. Always available with a kind word, her leadership style inspires her team to go above and beyond for her. She shows her appreciation for her colleagues often in the simplest of ways, ending every email with an iteration of “Thank you for all that you do – it is surely recognized.”

By endlessly encouraging and lifting up her team, she builds lasting relationships and fosters collaboration. She has shown me that very little can be accomplished without the support of others and that a cohesive team will always be

stronger and more effective than an individual. By being a living example of compassionate leadership, she taught me to play to the strengths of my team members, making each person feel unique and essential while increasing productivity and results.

2. Be a bulldog.

The world of free clinics teems with roadblocks and pitfalls. There are never enough resources. Every story is touching, and every person deserves healthcare, shelter, and basic comforts; however, the world is not fair, and many go without one or all of those things. Dr. Babineau has devoted her life to a fight that she knows she cannot win, but that does not stop her from fighting fiercely each and every day for those who cannot speak for themselves. From the beginning of our relationship, she has encouraged me to “be a bulldog” as she always says. She has shown me how to never take no for an answer and to push forward despite insurmountable odds. In fact, she has taught me that odds don’t even matter. She throws her heart and soul into helping the underserved, and her energy is frankly intoxicating. Through her mentorship and guidance, she has taught me to never apologize for being aggressive and to always speak up for what is right and just. Because of her, I will always have a strong voice, and I hope to someday do even half of what she has done for those in need.

3. Everyone has a story; everyone has a past.

I would be lying if I said that I didn’t come into medicine with certain prejudices and misplaced ideals. Before meeting Dr. Babineau, I would have never considered working in a free clinic setting. In my mind, it wasn’t hard to get health insurance – you get a job, work hard, and get insurance. I’m not sure where this twisted and naïve view stemmed from, but it was a cornerstone of my social belief system. The idea that the medical disadvantaged were without access due to a failing of work ethic flies directly in the face of everything Dr. Babineau has built with her medical practice and her life. She could easily have shamed me for my opinion, but instead, she humbly showed me her world. She invited me to grow at my own pace and discover the world of the underprivileged in my own way. Very few people in this world are truly without judgement of others, but Dr. Babineau is one of those people if I have ever met one. She taught me how to listen without judgement to the stories of those I served at HOPES, for you can never treat the entirety of a person without understanding where they come from and what they have been through. She showed me through example that the greatest honor in medicine is to be trusted by those who have been failed by all others before.

Through her grace and intractable energy, Dr. Babineau has touched my life. Because of her, I have grown as a person, and I will take her lessons with me as I move forward with my medical career. Through her mentorship, she has shaped the physician I will soon become and ignited in me a new passion for the field of medicine. I am lucky to call Dr. Babineau not only my mentor, but my friend.

