

WINTER 2018 - 2019 • ISSUE 2

literary

amwa

A GALLERY OF WRITING

editorial board



Eliza Lo Chin, M.D., M.P.H.
Executive Director, AMWA

Linda Clever, M.D.
President, RENEW

Cristina Denise Go
Literary AMWA Co-Lead
J.D. Candidate, Duke University School of Law

Anju Goel, M.D., M.P.H.
Literary AMWA Co-Lead
Physician at Heal
Deputy Health Officer (Interim), San Luis Obispo
County

Preeti John, M.D., M.B.B., M.P.H., F.A.C.S.
Clinical Assistant Professor, University of Maryland
School of Medicine

Monique Mun
M.D. Candidate, Wayne State University School of
Medicine

Emily Transue, M.D., M.H.A.
Senior Medical Director, Coordinated Care
Clinical Associate Professor, University of Washington
School of Medicine

Tana Welch, Ph.D., M.F.A.
Assistant Professor, Florida State University College
of Medicine



advisory board

Rita Charon, M.D., Ph.D.

*Professor of Medicine at Columbia University Medical Center
Executive Director, Program in Narrative Medicine, Columbia
University*

Eliza Lo Chin, M.D., M.P.H.

*Executive Director, American Medical Women's Association
(AMWA)*

Linda Clever, M.D.

President, RENEW

Sarah Cutrona, M.D., M.P.H.

Associate Professor of Medicine, University of Massachusetts

Gayatri Devi, M.D., M.S.

*Director, New York Memory and Healthy Aging Services
Clinical Associate Professor, New York University School of
Medicine*

Cristina Denise Go

Literary AMWA Co-Lead

J.D. Candidate, Duke University School of Law

Anju Goel, M.D., M.P.H.

Physician at Heal

*Deputy Health Officer (Interim), San Luis Obispo County
Literary AMWA Co-Lead*

Suzanne Leonard Harrison, MD, FAAFP, FAMWA

AMWA President

*Professor of Family Medicine & Rural Health
Education Director, Family Medicine
Florida State University College of Medicine*

advisory board



Claudia Morrissey-Conlon, M.D.
U.S. Government Lead, USAID

Audrey Shafer, M.D.
*Professor of Anesthesiology, Perioperative, and Pain Medicine,
Stanford University School of Medicine
Anesthesiologist, Veteran Affairs Palo Alto Health Care System
Director, Medicine and the Muse, Stanford Center of Bioethics*

Renda Soylemez Weiner, M.D., M.P.H.
*Director, Medical Optimization Program Center for Healthcare
Organization and Implementation Research
Edith Nourse Rogers Memorial VA Hospital
Associate Professor of Medicine, Boston University School of
Medicine*



contents

6 Against Medical Advice

By Alyssa Brown
Mayo Clinic Graduate School of
Biomedical Sciences and University
of Louisville School of Medicine

12 broken hands

By Erin McConnell, M.D.
Ohio State University
Wexner Medical Center

13 The Phoenix Effect: Turning Vulnerability Into Resilience

By Hope Ferdowsian, M.D., M.P.H.,
FACP, FACPM
University of New Mexico School of
Medicine

18 Hiding Spots

By Rosey Lee
Pen Name of Atlanta-based Physician

21 Forces of Nature

By Chelsea Life
Florida State University College of
Medicine

23 Still Human

By Elise Miller, M.D.

contents

25 Gimme Shelter

By Alyssa Brown
Mayo Clinic Graduate School of
Biomedical Sciences and University
of Louisville School of Medicine

31 The Day My Daughter
Smelled Like Someone Else
By Alissa Frame
Boston University School of Medicine

34 When the White Coat
Becomes a Hospital Gown

By Michelle Lee

36 Waiting for Godot

By Emilie Transue
University of Pittsburgh School of
Medicine

41 Building a Community: My Coming-
of-Age as a Future Physician

By Pooja Suguna Yesentharao
Johns Hopkins School of Medicine

44 What I Can Do

By Kaci McCleary
University of Pittsburgh School of
Medicine

against medical advice

BY ALYSSA BROWN

In rural Kentucky for surgery rotation, we usually had relaxed call nights at home. We rarely stayed late on call nights or got called back in to the hospital on surgery rotation in this sleepy town. If we were on call for the night, we would text the attending before we left at 5pm to see if anything was happening. I texted the attending when we finished afternoon lectures. He responded with only a room number. I went to the room and asked the patient inside if she had seen the attending yet. She looked worried and said no... was she getting surgery? I apologized and skittered out of the room.

The attending had texted me the wrong number, but I could hear his voice floating down the hallway. I followed the voice and silently slid into the correct patient's room. The attending briefly turned his head to

acknowledge me. The room was dark, and the voices speaking quietly inside had the unmistakable tinge of fear.

I started to piece together the story. The patient was an 81-year-old male in acute renal failure, which is not normally a surgical problem. He had appeared in the ED eight days prior with a small bowel obstruction. He refused surgery to relieve the obstruction and left against medical advice. He returned to the ER that afternoon with fulminant renal failure and persistent small bowel obstruction. He had not passed stool in those eight days. Many patients look sick, but he looked close to death. He was thin and lying limp in the bed with a far away look in his eyes. His children were gathered around him.

The attending spoke to the

patient and family, using words like “urgent,” “tonight,” and “chances of making it through an operation.” Then his phone rang. He said he would see them after the operation, and he turned and ducked out of the room, clomping off down the hall with me trailing a few lengths behind.

I knew the gravity of the situation and the length of the night ahead, and I was glad I had hidden a Kind bar in the pocket of my white coat. As we sat in the lounge, I started to peel off the wrapper and pick at pieces of it. As if knowing that my mouth was full of granola bar, the attending turned and began to ask what fluids were most appropriate for the patient. I gave the incorrect answer of lactated ringers, and he began to berate me for picking the fluid that would kill the patient. When being pimped about a patient, it always seems as though the patient isn't real, even though they are usually on the table in front of me or someone I just visited. It feels as though they are a practice question, not a living and breathing human being.

Just as suddenly as he started asking me questions, his phone rang, “OR is ready for you.” We skittered down the stairs to join the rest of the

operative team. I could tell the attending was tense but also excited, as was I. He loved the complicated big cases, even though I could tell he was growing tired of call and working so hard at around 60 years of age. He loved his patients, and he loved ICU care, but late at night, he would sometimes mutter that he was getting too old for nights like this.

There was a palpable tension that night, like a pit in my stomach. It felt different than getting called in late for an appendix or cholecystectomy. Usually, the anesthesia team was joking or playing music when I came in to set out my gloves and gown. Tonight, the room was utter chaos. They had intubated the patient and feces came out the endotracheal tube. Feces was everywhere. It covered the patient's neck and chest. It was splashed all over the floor and over the shoe-coverless feet of the anesthesia team. I stood paralyzed. I did not know this could even happen.

The attending brushed past me and jumped into action. “Come on, we need to get him open,” He said, “Clean him up so I can throw a central line in that IJ.” The patient was cleaned and the central line was inserted, but the anesthesiologist questioned its sterility. The surgeon

threw back, “This patient needs a central line now, and if it gets infected, so be it. He is going to be lucky as hell to make it off this damn table.”

The surgeon’s first assist stepped into the OR. She had been called in from her 40 year work anniversary dinner. I offered congratulations, but she brushed me off, saying that this case was more important than her dinner. I stepped up to the table as I had done many times before. Immediately, the first assist scolded me to re-scrub. I was annoyed. I was sure I had not touched anything, but I also knew better than to question her. She was a stern older woman. She had been around the block and ate medical students for lunch.

I ripped off my gown and gloves and ran back out of the OR to rescrub. I did not want to miss anything. I came back in just as the abdomen was fully opened. It was distended and grey. It did not look like a “happy bowel.” The surgeon told me to follow his hands. We began to run the bowel. I was not keeping up with him and I kept tripping over my hands, which I am sure he noticed, but thankfully did not comment on, besides an occasional glare across the table.

We found a small perforation and the obstruction. We squeezed the bowel like a tube of toothpaste, decompressing the bowel. The surgeon reached for the pool suction as he cut a hole into the stomach. I watched it fill the large tower it was connected to with turbid dark fecal material. I kept thinking, this patient is going to feel so much better when we get all of this feces out of him.

The surgeon removed the suction and asked the anesthesiologist for numbers—ABG, base excess, and how fast the fluids were running. I did not really know what many of those meant, but I knew the surgeon was not happy. He put a G-tube in the stomach and he began to work on closing the perforation. After putting in one line of staples, he handed me the stapler and told me to run it across the next portion of bowel. I did as I had done many times before. He did not like the way I stapled across the bowel, and he asked, “are you sure the bowel is completely closed with a stable line like that?” I muttered yes. He did not seem to agree but moved on, saying, “We need to get the hell out of this abdomen.” He placed the bowel back inside the abdominal cavity. Usually, he talked a lot in the OR, especially when we were closing,

but tonight all we could hear was the beeping of the monitors and the snap of the stapler closing the patient's abdomen. I felt the pit in my stomach slightly relax after I knew the patient was closed and would make it out of the operating room.

We moved the patient out of the OR and into the ICU. It was now midnight. I could see the quiet darkness of rural Kentucky outside. The attending looked exhausted, and we both stood there just staring at the patient. Occasionally, the attending fiddled with the arterial line and the machine connected to it. He instructed me that I needed to know how this machine worked by morning.

I knew it was already going to be a late night and early morning, and there was no way I was going to look anything up when I got home. I nodded though, wiping my bleary eyes.

We continued to stare silently at the patient for an hour at least. I kept wondering what we were looking for. Maybe he was looking for a sign of which way the scale between life and death would tilt. We eventually stepped outside the ICU room and finished his notes. He kept snapping at me because I could

not, for the life of me, spell cholecystectomy in my sleep-deprived state. We took one last long look into the ICU, bed 27, then walked silently down the long hallway back to the locker rooms. He told me that he expected me to hand off the patient in the morning to the other students. I nodded with the silent knowledge both of us would barely sleep in the meager hours between now and the sunrise. I wrote a brief note to my friend who would inherit this patient, and I told her I would meet her in front of bed 27 in the morning. I was too invested in seeing how this turned out. When I tried to fall asleep that night, I kept thinking that I might not see his name on the patient list in the morning because he had not made it through the night.

A few hours later, I was back in the ICU. His name was on the list! He had made it through the night. I felt hopeful that he had tricked death into letting him survive this episode. But I soon realized how naïve this sentiment was. Later that morning, there was a commotion outside room 27. One of the nurses announced that the patient was about to code and we needed to call the attending." I told her I knew where he was. I half jogged down the hall towards the ORs. I knew he was

going to do a cholecystectomy in OR 7, and it was going to happen very soon. I wanted to catch him before he was scrubbed. I still had some hope that he could do something to save this patient.

I caught him right before he walked into the OR. Slightly out of breath, I rushed to tell him that the patient was about to code in the ICU. What he said next shocked me: “It was going to happen sooner or later. I’m not surprised.” I fumbled for words as he headed into OR 7. I was too stunned by his reaction to properly form my own.

I turned and strode back towards the ICU. The only people the family knew were me, a lowly medical student, and the attending. I wanted him to be there to talk to the family and support them through what was going to be a traumatic experience if he coded. I felt angry and frustrated and guilty that I could not do anything to help. The surgeon arrived. He glided towards the chaos outside the room. He parted the knot of people outside and talked to the family. He came over later and plainly told me that the family was going to let him go peacefully. He said, “He died by his own hand. He didn’t want surgery until it was too late to help.” I guess in the most

basic sense, that’s true, but it served as no comfort to me in that moment.

I first wrote about this experience a year later. The patient still remains etched in my mind, and the memory of that night and day remain fresh. After some time, the memory has lost its sharp edges, like a rock gently being smoothed by the flow of a river. This is still one of my darkest moments of third year, but there were moments of light. There were miracles and deaths. This was not the first or last death I bore witness to that year. I have come to appreciate that the surgeon and family made the correct decision to let the man die peacefully. I could not see through my naïve hope that the patient would always make it through, at the time. I was so frustrated that I felt like the attending was ignoring a clearly acutely ill patient at the moments before his death. It became clear though. They let him die with dignity. They did not make the futile decision to shatter his ribs while trying to pump his heart forward towards more life. While “do not resuscitate”, is not everyone’s choice, in this case, it gave the patient a chance to say goodbye. I like to think that he understood his decision and the hand he had been dealt. At that point in the year, I did

not yet understand the power of choosing peaceful death. Even though these these memories can be painful to hold onto, I do not want to forget him, but I want to remember that he chose, and maybe going against medical advice wasn't always a bad thing.

broken hands

BY ERIN MCCONNELL, M.D.

ulcerations weep between
like interdigital islands
floating amidst
compromised flesh

sheets of tissue
peel off in strips
enough to fund
a graft
or Christmas

erythema creeps
towards dorsal
patches of
xerosis

where water
becomes fire
the epidermis
erodes
cracks and fissures

the *phoenix* effect: turning vulnerability into resilience

BY HOPE FERDOWSIAN,
M.D., M.P.H., FACP, FACPM

The following essay relates to Dr. Ferdowsian's book, *Phoenix Zones: Where Strength Is Born and Resilience Lives* (The University of Chicago Press, 2018).

As physicians, we are asked to turn toward, rather than away from, vulnerability and suffering. It is our duty, but it is not without a cost. Our patients' pain can vicariously transform into our own. The sleepless nights, despair alternating with anger, numbness, and anguish can all become ours, piling on top of an ache we may already carry.

Our patients' shared lives are also a priceless gift to us. Their hope, courage, and resilience can too become ours—lessons in healing we might not have realized we needed. They are lessons I have tried to heed.

I knew as a child that I wanted to become a doctor. My interest in medicine was not driven by scientific

curiosity, but by a desire to curb violence and suffering. Early in my life, my parents spoke often of human rights violations around the world. However, the stories they shared did not fully imprint upon me until I was nine years old and crawled up on my mother's built-in bookshelves where I found a shiny red book entitled *A Cry from the Heart*. As I opened the book and turned its pages, I read about an Iranian child who was burned to death because of his religion. A few years later, I met members of my father's extended family that were also detained by the same cruel regime. Though my father's family escaped, that tortured child's image remains singed in my brain.

Those early experiences eventually led me to others who would

surprisingly fuel my hope and optimism. Their gift of hope came at a poignant time—when I realized I had been chasing violence my entire career, absorbing the sadness and nightmares along the way.

Almost thirty years after I discovered that bright red book on my mother's bookshelf, I walked toward the glass door of my clinic waiting room. There, I saw a man with a slight build and dark, graying hair. As I introduced myself, he reached out his hand for mine and then carefully released it. He was an established expert in a rare field of medicine, a man I call "Doc."

Doc is also a torture survivor from Iran. He was targeted after vocally opposing the government's persecution of his colleagues. During our first visit together, I was tasked with listening to his story and completing a forensic examination for his asylum attorney. I wrote a medical report substantiating Doc's claims of torture, and I later learned that he would not be forced to return to a nation that posed a grave threat to his life—a country he still loves and dreams of.

Today, after a long personal struggle and quest for asylum, Doc is an active member of the American

medical community. In his hospital, he mentors a variety of colleagues. He has reunited with his family, and—as he did before fleeing to America—he continues to pursue interests outside medicine. Although he still wrestles at times with the violence he endured, he has risen in a free and open society. He has also become a dear friend.

In Doc, I discerned a phenomenon I had repeatedly observed in many patients and torture survivors I met over the years. They appeared to defy their seen and unseen injuries and thrive even after indescribable trauma, much like the mythical Phoenix who rises from the ashes of her previous form. Within some circles of medicine, this transformation is called the Phoenix Effect.

The Phoenix Effect is a metaphor for how we can heal ourselves as well as the world around us. Over time, the legend of the Phoenix has evolved. Most forms of the myth reflect a basic story: after hundreds of years, when the old Phoenix feels her death approaching, she begins to collect fragrant plant life to build a nest in a sacred tree. In the better-known tradition, the sun heats the nest and ignites the Phoenix. From

the ashes, a new Phoenix arises. In literature, the Phoenix has come to represent an enduring sense of redemption and recovery.

Stories like Doc's led me to what I call Phoenix Zones—places where individuals can heal and thrive. They also hold lessons for how we can heal as a society. Phoenix Zones are bound by core principles including respect for dignity, freedom, and sovereignty, and a commitment to compassion and justice. Though often considered lofty ideals, these principles are actually biological needs we share with other animals. They are the basis for the Phoenix Effect, which hinges on whether our vulnerabilities are nourished or exploited. As Doc and others have taught me, the Phoenix does not rise alone. Resilience is not solely determined by the best or worst of our lives. Like vulnerability, it is a biological phenomenon influenced by the world we live in.

In our roles as physicians, we carry the burden and privilege of seeing patients through some of their most difficult and vulnerable moments. As a result, we must also confront our own vulnerabilities, including our relative powerlessness to conquer disease, disorder, and

suffering. But by witnessing resilience, we can also extract key lessons we need to prevent suffering and help others suffer less. As healers, teachers, citizens, and leaders, we can use these lessons to help turn vulnerability into resilience.

As healers, we can begin by recognizing principles that foster resilience as the biological needs they are. Research literature shows that treating individuals with dignity matters significantly throughout their lives. Not surprisingly, researchers have found that respect for the intrinsic value of each individual fosters wellbeing, even after severe violence or while dying. Likewise, empiric evidence supports the therapeutic effects of respect for autonomy, compassion, and justice—all of which form the basis for trauma-informed care, a treatment framework that addresses all types of trauma, including unjust societal constructs and abuses of power.

Several collective authorities such as the American Medical Association and the World Health Organization have already issued guidelines highlighting the importance of working collaboratively with governments, healthcare

organizations, and the public to meet society's health needs through a framework of justice. Though sometimes difficult, our professional roles also require that we consider how our own personal and institutional biases interfere with our ability to deliver just, equitable care to people regardless of their race, ethnicity, gender, orientation, ability, or financial means. Fortunately, there are already national initiatives, conferences, and curricula dedicated to recognizing and resolving unconscious bias, making it easier to confront prejudices that interfere with empathic and just care.

Physician educators can have an exponential impact in this regard. There are many opportunities to introduce critical principles like respect for freedom, compassion, and justice in education and training. Students and trainees are hungry for these lessons. I often reflect on my own time as a medical resident when I wondered if I had chosen the right field. At a critical time in my training, my mentors helped me form a clinic for the evaluation of asylum seekers, reassuring me that I could merge my interests in medicine and justice. That clinic still exists today, more than a decade after its inception. It

is where I met Doc, and where many students and residents sat in on asylum evaluations with me. Today, they are physicians who organize human rights conferences, help shut down immigration detention centers, and serve children who have survived physical and sexual abuse. They are creating Phoenix Zones.

Like many of us, my former students and residents realize that they are physician citizens who can magnify their voices through letters to the editor, opinion editorials, articles, and testimony on local and national issues. Just as Doc did, they remind me that we must move beyond our traditional professional roles to help address the ills within society—through the healthcare organizations we work for, the professional societies we belong to, the media organizations we speak with, and the civil society we live in. In each of these areas, we have an opportunity to ensure that policies and reforms reflect principles that nourish vulnerabilities and foster resilience—the Phoenix Effect—among individuals and within society.

I frequently recall the child from *A Cry from the Heart* and the many survivors I've met throughout my

medical career. Their stories and the myth of the Phoenix offer a powerful example of how we can rewrite our personal and collective narratives. The Phoenix Effect reminds me that together, we can reimagine our future, much like Doc has. He and others have taught me how violence can be defeated. In the zones of the Phoenix, we are capable of strength, resilience, and growth. Each zone can produce momentum for the next—where the wounded rise, and where great care is given to creating peace for those who have been hurt or borne witness to their pain. And, with hope and action, their dispersion offers space to avoid the creation of harm in the first place—a world in which every child can feel safe.

hiding *spots*

BY ROSEY LEE

“Where have you been?” I asked.

It was 6:52 a.m. and my voice echoed in the quiet corridor of the hospital’s rehab wing. I fought to contain my emotions, but I found some deliverance in the echo’s dramatic effect.

Chad stood 20 feet ahead of me, in the doorway of his mother’s room. He glanced at me, his eyes widening briefly. I became aware of the piercing click-clack of my four-inch stiletto heels on the shiny vinyl floor as I barreled toward him.

A charming grin spread across his face. What might have been an innocuous gesture under different circumstances further transformed my relief into anger. I pivoted and walked away before he could answer the question. It didn’t matter what answer he gave. I wouldn’t believe him anyway.

Click
Clack
Click
Clack

I felt empowered with each step I took.

Something had told me I’d find him in Mrs. Wilson’s room, so I stopped by on my way to work. We were supposed to have met there last evening, but he never showed up and didn’t answer my calls the entire night. Chad visited his mom almost every day. Not wanting to alarm her, I didn’t mention my concern.

I couldn’t sleep all night. I feared something terrible had happened to him. We’d finally gotten engaged but I wondered if we’d make it to our wedding. I spiraled down a path of what-ifs, imagining everything from cheating to foul play, but deep down I suspected he was fine, physically at

least. Chad had never disappeared before. It only took one time to get my attention.

Click
Clack
Click
Clack

I scurried to the adjacent Imaging Center. Approaching the rear entrance of my office suite, I quickly removed my heels and exchanged them for the quiet ballet flats I always kept in my bag. I planned to skip radiology case conference and needed to avoid announcing my arrival to my colleagues who were already gathering for the daily meeting. I felt so small at my natural five-foot height. As I sneaked down the hallway, a sense of humiliation at the morning's events weighed on me. I slid into a cluttered storage room and nestled with my iPad in a battered faux leather chair among the other cast-off furniture.

I'd never felt inclined to check Chad's phone or email in the two years we'd been together. But I needed information, and Chad's email account and calendar were easy to access. We had exchanged email passwords after our engagement, but I felt nauseated

admitting to myself that using them might reflect a larger problem.

Chad's email account was chaotic. Usually meticulous and organized, he hadn't arranged his read messages into folders in months. Even when his mom was rushed to the hospital last month with a heart attack, Chad checked email and responded to urgent messages in the waiting room. But he hadn't opened any messages or taken any meetings for the past two days.

I pored over Chad's calendar and noticed weekly evening appointments labeled "Mary" during the time Chad had told me he was at the gym. The same address was listed as the location for each appointment.

My hands trembled. Contemplating the purpose of these meet-ups, I took three deep breaths and said the Serenity Prayer. Then I said it again—slower this time, the end of each line punctuated with an increasingly intense breath.

I Googled the address and was stunned to discover that it wasn't a hotel or some random woman's home. It was a mental health facility.

Chad and I had talked about our health histories, including his bouts of depression. His symptoms had been managed with counseling, but he'd stopped going after his longtime therapist moved away last year. Now I realized he wasn't coping as well as I thought.

I was overcome with guilt that I'd missed the signs, including ghosting me last night and taking a week off work last month with no real explanation. Tears poured down my face as I played everything over in my head. I cried the tears I was too afraid to cry the night before and too angry to cry this morning. I cried imagining the pain that had driven Chad to isolate himself from the people who loved him the most. I cried from the relief that I hadn't lost him to someone else. I cried because I wanted to fix this for Chad, even though I knew I couldn't.

The rehab wing was busy when I returned. A mixture of footsteps, talking, and elevator bells muffled the click-clack of my heels as I approached the room for the second time that morning. Chad didn't hear me when I walked up. I stood in the doorway and watched him. His body slumped in the chair beside the bed. His hands covered his eyes. He

looked defeated, like he was about to collapse under the weight of what he was hiding.

"It's gonna be okay," I said.

He lowered his hands from his eyes and sighed. "Yeah, Mom just went to physical therapy. The doctor says she's coming along on the cardiac rehab program," he said. He picked up the magazine beside him and pretended to peruse the pages.

"No, I mean you," I said. I grabbed his hand and sat next to him.

Chad sat erect in the chair and tensed, bracing for an argument. He tried to pull his hand away, but I wouldn't let go. I expected him to look up at me, but he avoided eye contact.

I rubbed his hand gently. "It's okay if you need space. I just need you to tell me," I said.

He relaxed. Then he squeezed my hand. "Thank you, babe," Chad said. He closed his eyes and laid his head on my shoulder.

forces of nature

BY CHELSEA LIFE

One woman faces discrimination,
staring up at her glass ceiling.
She knows the odds are up against her;
the prospect leaves her reeling.

Another struggles to balance it all-
care for her kids, finish the manuscript on time.
She clutches onto her third cup of coffee,
convincing herself she can meet that deadline.

A girl marches in Washington,
making her voice heard.
She holds up her sign and shouts for equal rights-
the freedoms all women deserve!

continued from the previous page

A woman rings the bell in a hospital,
celebrating her improved condition.
She knew she could beat cancer, and here she is,
rejoicing in her newfound remission.

Throughout our endeavors, we question ourselves,
“Am I equipped to handle this strife?”
We push ourselves forward, trudging ahead,
seeking the most we can get from life.

Sisters, we are strong,
unstoppable forces of nature.
Let us join hands and stand together!
United, we will forge our future.

still *human*

BY ELISE MILLER, M.D.

Mauve fingernails picked absently at invisible fuzz on her jeans. Her wrist bangles jingled as she worked; pick, scratch, rub, repeat.

Her blue eyes smiled up at me from behind thick-framed glasses. “I remember you,” she said when the doctor introduced me. “Ironic,” I thought, given that this patient was here for evaluation of memory loss. While my words and smile said “likewise,” I was trying to place this 80-year-old woman in the sea of elderly patients I had seen in the last month as a medical student on my geriatrics rotation.

Two daughters accompanied the woman. The older daughter reached for the free notepads and pens at the center of the table and handed one of each to her mother. “Here, Mom,” she said. “We are at an important meeting, and we are going to take notes.”

The patient studied the pen intently, twisting, turning, and ultimately setting it aside. The notepad was flipped through, turned over, and pushed away. She smiled at me and winked from across the table.

It was time to discuss the patient’s test results. Her doctor handed out graphs, one to each daughter and one to the patient. I hadn’t seen the graph prior to entering the room, and I was surprised by the steeply negative line before me. Every category on her cognitive testing was marked as severely below average.

The younger daughter began vigorously writing on a notepad. The doctor said, “You don’t have to worry, we are going to go over this thoroughly and give you copies of all of our notes and instructions to take home.”

The doctor thoroughly went through each category on the graph with the daughters and the patient. She explained what terms like “visual-spatial reasoning,” “processing speed,” and “delayed recognition memory” meant. At the end of her commentary, she paused and looked directly into the patient’s eyes.

“What this means,” she said gently, “is that you have dementia.”

The younger daughter again wrote vigorously, head down over her notepad. The older daughter simply nodded a few beats and looked at the shredded tissue she’d been wringing in her hands.

The patient pushed her glasses back up the bridge of her nose with the tip of her mauve fingernail, looked at her doctor, and smiled.

Her younger daughter glanced up from her notepad, skeptically stared at her smiling mother, and finally spoke. “Are you alright with that, Mom?”

“Alright with what?” her mother replied.

She smiled and winked at me

again from across the table, like she was playing a game and having a lovely time. Like perhaps this was all a joke, and she was just tricking everyone into thinking she was losing it. That’s when I placed her. I remembered that wink from a few weeks prior when I was shadowing in the same clinic. During her cognitive testing, whenever the questions became tricky, she would look back at me, smile and wink.

People often develop coping mechanisms, whether conscious of them or not. This gesture seemed to be our patient’s way of smoothing the ruffles in this new world in which she lived: disguising her disease, compensating for her deficiencies, and diffusing the tension when people looked at her with concern. While the gesture in itself was meaningless, it was the most meaningful thing she was able to say.

I’m still human.

gimme shelter

BYALYSSA BROWN

“It’s just a shot away, it’s just a shot away,” blared the music in the OR. Music makes the OR feel special, magical. There was a flurry of hands and spurts of blood, but I’ll start at the beginning of the story. I hate to say that there is something exciting about getting called in to the hospital in the middle of the night. Logically, I know that means something bad is happening to someone else, but it makes my heart beat a little faster and my adrenaline rush. I had been following a surgeon at Baptist Hospital all Saturday. We didn’t have any cases so we both went home to rest at 3pm. We agreed that she would call me if anything came in. She always rolled her eyes when I asked her to do

this because she thought I should probably just get some sleep and enjoy my weekend. I got a text from her at 8pm, and it said, “Seems like a quiet night, so unless something changes, let’s meet at 8am to round.” I decided to go to bed early in case something came in.

At 1 am, I sat straight up in bed; my phone was playing a loud jangling tone. I didn’t recognize the number, but I went ahead and picked it up after rubbing some of the crust out of my eyes. “We have a case. You don’t have to come in, but if you do, come through the ED, and I’ll prop the door open so you can get up to the lounge. Be here ASAP if you’re coming, this case needs to go fast.”

I quickly woke out of the fog. Before I even responded, I was pulling on a pair of scrubs. I grabbed a pair of diet cokes and a granola bar before half-jogging out the door.

It was pouring rain and there was a chance of the roads flooding that night. I didn't think about it as I tore down the road, probably a little too fast. My mind kept rifling through the possibilities of the case. She hadn't revealed any details, but I knew that it probably wasn't an appendix, which is usually not a middle of the night emergency operation. It was definitely not trauma because it was at Baptist Hospital and they didn't handle traumas. I thought maybe a gallbladder, but that can usually wait until the morning as well. I whipped my car into the ED parking lot. I walked into the front door of the ED and past all of the security and staff, and shimmied through a door into the staff elevator. It always shocks me how much you can get away with in a hospital if you have a white coat on! I slid through the propped open door on the second floor to get into the PACU and down the hall to the lounge. I took a deep breath before walking into the lounge.

I found the surgeon curled in a

chair, covered in a blanket fresh from the warmer. She was reviewing the patient's chart. I handed her the diet coke that she didn't remember that she needed. She was scrolling back and forth through a CT scan. She told me to throw my stuff in her locker and look at the CT. I wadded up my white coat and crammed it into the top of the locker and hurried back out. Without turning, she said, "What do you think of this CT?" My brain was still foggy with sleep, so I wasn't sure what I was looking at, but it looked like there was a lot of bright contrast sitting in the peritoneum, which I knew wasn't good. She began to fill in the details to add color to the black and white CT scan. The patient was a 75-year-old female who fainted after dinner that afternoon. By that night, a CT scan had been done in the Emergency Department, and blood was visible in the abdomen. Radiology reported a possible splenic artery aneurysm that had burst. That's when the surgeon had gotten called. It was her turn to try to make this patient better.

She looked at me, and said, "We are going to get in there, get out, and pray that we can patch it up enough for her to make it through the night." As if on cue, the intercom

screached to life and said, “We’re ready for you.” The surgery floor always seems to be so full of life during the day, but at night, it almost seems haunted. There are empty beds, empty carts, and you can only hear your own breath and sometimes the hum of a rogue machine. We walked down the hall towards the OR. I had seen her work her magic before, but not on a case like this. She was usually bubbly and talkative as we strolled to the OR, but tonight she was quiet. She knew that the odds were not in her favor. She was the last chance to save this woman.

We scrubbed in, which is a process that we can never quite speed up. The patient was moved into the room seamlessly. The gloves and gowns seemed to appear on the surgeon, like a quick costume change, and everything seemed to quicken. The surgeon strode over to the table and stepped up onto two step stools. As I stepped up to the table, my mind began to wander. I thought to myself that this could be my grandmother, or someone else’s. It is easy once the face is covered to not think of these more emotional details of the patient. It is easy to keep distance when they are just a case or just an anonymous patient

on the table.

Before I got too deep into these thoughts, the surgeon called for a blade and traced it down the middle of the patient’s abdomen. The suction was shoved into the fresh wound as we went. Blood began to run down the sides of the drape. When we could finally see the abdomen open before us, there was dark red, firm blood pooling throughout. Everything and everyone was at the ready. Hands seemed to just know exactly where to go. Nothing was fumbled. There was a steadiness to the surgeon’s voice, with urgency but without harshness. The aneurysm of the vessel was hiding within the yellow clumps of fat. It stubbornly did not want to give away its position. The surgeon began to pack the abdomen with Raytecs. She was shoving them down into the crevices and cracks of the abdomen to soak up any extra bleeding. We would leave them there. The patient would be closed another day., but for today, she would leave the operating room with a new vacuum sealed abdomen. The surgeon asked for lab values. The anesthesiologist recited them to her, and I could see her begin to frown even from under the mask. They did not sound good, but we had done all

awe could do for the night. The nurses would keep pushing fluids and blood products after surgery.

We stepped out of the OR and peeled off our blood-covered gowns. I looked down and realized that blood covered my clogs because, as usual, I had forgotten to put on shoe covers. It was 3am. One of the nurses brought us back down to earth: the roads were flooding and we needed to be careful on the drive home. We agreed to meet back at 7am to round and check on the patient. The surgeon decided to crash at the hospital, and I decided to try to make it home on the flooded roads. I was exhausted. I was also worried that the patient would not make it to the morning. She was in a precarious state, and I was not sure if we could pull her back from that cliff ledge. The rain was hard and pulsing. The roads were thickly covered in water. On the way home, the interstate started to flood, but I kept plodding forward to steal a few hours of sleep before heading back to the hospital. I came in and kicked off my clogs and fell asleep in my scrubs.

The sleep came quickly, but the alarm came quicker. In the morning, the rain had slowed but not stopped

as I made my way back to the hospital. I was already tense about seeing the patient. I wandered through to the OR lounge where the surgeon was still staring at the CT from the night before and some new lab results. I could tell, from her expression that it was not looking good. She didn't turn to me when she said, "We're taking her back to the OR." She stood and quickly paced down the hall, I didn't ask where we were going because I knew she did not want to be bothered.

Eventually, we ended up in the family room of the ICU. About five family members were standing there clutching coffee and speaking in hushed whispers. They quieted more when we appeared. The surgeon said, "We are happy she made it through the night, but she is going to need another operation this morning to keep her alive. I cannot promise anything. Her chances are not good, but we will do the best we can." Somehow, the family did not look surprised, or maybe they were still in a state of shock from the night before and hadn't yet absorbed this new information.

We moved out of the room, and the surgeon began to assemble the

team. She listed them like a batting order—her surgical partner, a hematologist, a critical care specialist, anesthesiologist, and a first assistant. The patient was full of tubes, hoses, and wires, so it was difficult to move her to the OR floor. We crammed into the elevator and hoped that nothing bad would happen on the way there. Once in the OR, there was a flurry of activity. Things were going to go quickly again. The critical nature was weighing heavily in the room, but everyone there knew that it was a Hail Mary, and this team was the final chance the woman had to live. There is nothing quite like a surgeon in a critical case. There is nothing wasted in their movements or words. The team worked like a machine. It was like everyone knew what the other would do before they did it. The wound vacuum came off, the staples were removed, the abdomen was opened again. It seemed as though time stood still. It was only 8am.

“The floods is threat'ning, My very life today, Gimme, gimme shelter, Or I'm gonna fade away,” wailed Mick Jagger. It sounded like someone had turned up the volume. I could see the surgeon clipping vessels and saving this woman on the table as

the song seemed to get louder as the two surgeons worked together to fix this. I cannot quite describe how magical this moment was. There are sometimes indescribable moments in the OR that don't seem quite real—a suspended disbelief, where miracles seem to appear out of the ether. I thought for a second, there is no way that she isn't going to make it off the table, not with the feeling that was that was filling the room. The room collectively sighed as the surgeons began to navigate the patient back from the brink. The bleeding was controlled, and everything was working perfectly. Before I knew it, the case was over. The bubble of magic had burst, and the patient had survived another hour. As we all began to strip off our masks and gowns, someone pointed out that it was an all female team. I tried to hold back the feeling that that might have been the reason that everything went so well. There were leaders, but it was a group effort rather than a single person who saved this patient's life, at least for a while longer.

After the surgery, we continued to make rounds, but kept coming back to the patient. We kept wandering by her room to talk to her family and update ourselves on how

she was doing. By the afternoon, she continued stabilize. She was not awake or out of the woods, but her lab values and vital signs were becoming more normal. This was my last day on the rotation. I finally went home.

I woke up Monday and started my first day of a pediatrics rotation. I kept thinking about the weekend patient, though, and I was worried. How was she doing? I was afraid to ask. I was afraid to hear that she had passed. I thought of texting the surgeon, but I did not want to bother her after an arduous weekend.

That night, I went to grab a beer with friends after work. I heard my phone buzz, but I didn't think much of it. I finally checked, and it was from the surgeon. My heart dropped into my toes. I was afraid to open it. I knew before reading it what it would most likely say. It said, "She went into pulseless electrical activity this afternoon, and we never got her back." I responded that I was sorry, and I knew she had done all she possibly could. She had given it her all. She responded, "thank you." For one of my first times during third year, I felt like the physician had the same feelings about the patient's death as I did. We were both hurting.

I could tell she was grappling with what she could have done differently. She didn't blame the other team members. She assumed full responsibility.

Losing a patient hurts more than it maybe should. I had lost other patients during my third year of medical school. I thought by this point that I would be able to distance myself or maybe it would hurt less, but it never has. Writing this, it still hurts when I think about her. Maybe that's a good thing.

the day my *daughter* smelled like someone else

BY ALISSA FRAME

*WINNER
OF THE 2018 LINDA BRODSKY MEMORIAL ESSAY CONTEST*

I decided to quit the day I realized my daughter smelled like someone else. It was my first day back after maternity leave from the Boston University School of Medicine, where I had finished two years of medical school and two years of graduate research. I expected to spend four more years in the MD/PhD program - two in the lab and two in clinical rotations.

I stayed up that night to wait for my husband to come home after a long shift. He was an internal medicine intern, a glimpse of my future, and I needed his advice. I thought about what I would say, how I would ease him into the conversation. I would tell him how

my interest in my dissertation project had faded long before I even knew I was pregnant, and how the students and postdocs who sealed my decision to join my advisor's lab were leaving or already gone. I would explain that I couldn't leave a daughter I loved to do something I barely liked. I would remind him how little clinical experience I had and how removed I felt, two years into my graduate research, from a future as a practicing physician. I would remind him how, as an intern, he often left the house before our daughter woke up and got home after she had fallen asleep. How much harder would that be when she was old enough to really know him, want him, ask for him? How

much harder would it be when I traded the flexibility of research training for the rigidity of clinical rotations and residency- when I was the one missing everything? And I would tell him how she smelled like someone else when I picked her up from daycare. I wanted her to smell like me.

We sat down. I took a breath, thought about where to begin. “I want to quit.”

After several weeks, we made a plan. I would give it my best effort for two months, to make sure that my decision wasn't made rashly during a transition that is difficult for mothers in any career path. If I still wanted to quit after two months, I would change labs, to make sure that my decision wasn't based simply on a poor fit. If I still wanted to quit after changing labs, I would drop out of the graduate program and return to the clinical rotations in an MD-only track. If I still wanted quit then, I would.

Our conversation stretched out over days. It grew to include not only me and my husband but also our support system- our families, our friends and peers, our mentors and role models. More reasons to quit surfaced. There was the daycare

tuition check that eclipsed my monthly stipend. The nagging fear that an MD/PhD program cannot be completed during daycare hours. The possibility that I would miss out on four years of snuggles only to find out that I didn't want to be a doctor, after all.

But there were reasons to keep going, too. There was the obvious affection the daycare teachers had for our daughter. The payback obligation I had incurred over four years of tuition and stipend paid out by our privately funded program. The fear that our daughter would look at my decision as evidence that she has to choose between a career and a family. The values I held that had driven me to pursue medicine in the first place.

After several weeks, we made a plan. I would give it my best effort for two months, to make sure that my decision wasn't made rashly during a transition that is difficult for mothers in any career path. If I still wanted to quit after two months, I would change labs, to make sure my decision wasn't based simply on a poor fit. If I still wanted to quit after changing labs, I would drop out of the graduate program and return to the clinical rotations in an MD-only track. If I still wanted quit then, I

would.

Two months later, I had a difficult conversation with my advisor. He understood immediately and made a call to a professor whose research field and lab environment were a far better fit, and I switched into his lab the next day. In the following weeks, I found a project I was passionate about. I was genuinely excited to drop my daughter off each morning and head into the lab. I found myself talking about my research with my family and friends, something I had never done in my original lab. I began to draw connections between my research and the clinical work I wanted to do when I graduated.

That was two years ago. As the two months passed, my commitment to the program and to a career in medicine strengthened. My daughter began walking, talking, running, and singing, and every day she reaffirmed that a demanding career and a happy family are not mutually exclusive goals. She came home from daycare with songs I didn't recognize and games I didn't know, and I was thankful that she was learning more than I could teach her. She told me that she loved her teachers and friends and I was happy she had a community beyond our family. She formed an intense and adorable

bond with my husband despite his challenging schedule and I realized that my return to medical school and residency wouldn't destroy my relationship with her.

I recently returned to the lab after another maternity leave. I smiled as I handed my second daughter to the woman who had cared for my first, and then I cried in the car on my way to the medical campus. I spent the day catching up with colleagues and making research plans with my advisor while I counted the minutes until I could leave. I smiled again when I picked my daughter up that evening, and then I kissed her head. She smelled like someone else, but I didn't mind.

when the white coat *became* a hospital gown

BY MICHELLE LEE

*PLACING SECOND
IN THE 2018 LINDA BRODSKY ESSAY CONTEST*

It was a beautiful fall evening in New York when I was told I should leave medical school. I was a well-appearing 25-year-old, but the tell-tale symptoms I had been brushing off for months finally imploded. I still remember trembling behind a white curtain as a patient in my own school's emergency room, in pure disbelief as the doctor informed me of my diagnosis. Ironically, I had just studied the diagnosis for a medical school exam earlier that year, but I was genuinely shocked to experience the illness firsthand.

Thus, began the single most transformative year of my medical training—the year I became a patient. I could tell the doctor felt sorry as he patted my arm, but he

might as well have been a hundred miles away. My mind was blank and could not gain traction past the fact that I would miss school. I was near the end of my second year of medical school, and incredulously asked what of my plans to meet up with friends and study a few days later. When he brought up the fact that he wasn't sure when I would be able to return, I completely lost it.

I resisted giving up my white coat as long as I could. With scheduling accommodations around treatment and appointments, I was able to finish the year's exams only a few weeks after my classmates. Although my dean and doctors were uneasy, I soldiered on. I'm still high-functioning, I kept saying, and

objectively, I was. But running myself into the ground far past my physical and mental limits, rather than accept my disability, ended up prolonging my healing process and eventually necessitating a longer than intended medical leave.

I had preferred to hide behind a white coat and throw myself into helping others for as long as I could than to face my diagnosis. I feared the depression that would follow if I left school, which certainly did happen and was not pleasant. I had always believed that you could achieve and overcome anything with pure will and hard-work. I was the girl who was the first in my family to graduate college, worked 3 jobs and got into an Ivy League medical school. I was the girl with 10 research publications. I was the girl who developed De Quervain's tendonitis from repetitive hand movements during countless late nights and weekends of research.

This naiveté about hard work led me to learn the hard way that our bodies did have a physical and mental limit, and that medicine was not advanced enough to bring us back on track from certain diseases fast enough, or at all. I was not superwoman, and I was getting

myself into trouble pretending to be one.

While I made an excellent recovery during my leave, I also became frustrated with medication side effects, delays, and knowledge gap between doctor and patient. Even though I was a medical student and should have known better, I still got pill esophagitis, an avoidable medication side effect. I also developed the utmost respect for social workers, who smoothed over the practical and socioeconomic aspects of my health insurance and said "the right thing" more often than my doctor did.

After my leave, I was able to put on my white coat in good health, indebted to my treatment team. My rueful dissatisfaction with medical advances and healthcare system made me run head-first into all that had to be lived for, just as before, but this time more wisely and strategically.

Unwittingly traversing the five stages of grief through my recovery gave me a mental steeliness that my younger, more excitable self didn't have. I was smart before, but now I was wise. Although I didn't see at the time, that year made me the doctor I

needed to become. I also realized that patient advocacy and long-term care were extremely important to me.

Living with a temporary disability gave me the courage to be assertive and excel in crises. I didn't hesitate to speak up loudly anymore and ask questions anymore. I was surprised to be able to reach patients, sometimes better than fellows, and address their frustrations with misdiagnoses and delays, because I too was acutely aware of the practical issues in medicine.

Doctors were not infallible—they are overworked, make mistakes, and a small delay can disrupt a patient's work or school week tremendously. Part of this dissatisfaction fueled my desire to get a certificate in business leadership and decision to get a joint MBA in the future so I could learn how to improve the inefficiency of our healthcare system.

Feeling strongly about clear doctor-patient communication, I also became a stronger community health and patient advocate. With each and every patient I sit with, I always make sure they understand their diagnosis and medications, and I encourage them to write any

further questions if they think of them later.

Looking back, I'm extremely grateful that I had these lessons as a nascent yet-to-be formed doctor. Though painful, these very same life experiences helped develop an additional skillset in leadership, community advocacy, and patient education I wouldn't have otherwise. It made me into the woman I am today, and the physician I will be tomorrow, and I wouldn't have it any other way.

waiting for godot

BY EMILIE TRANSUE

*FROM THE 2018 LINDA BRODSKY
MEMORIAL JOURNAL*

**Words whispered to me in the quiet
of confidence:**

“I’ve been repeatedly misgendered. There’s nowhere to indicate my preferred pronouns to our administration. I feel this place is a hostile learning environment.”

“I have to repeatedly ask for my accommodations. I have to repeatedly explain my health status and why I have decided not to undergo intensive surgery right now to ‘fix myself’.”

“I have had to independently orchestrate an elaborate system of childcare to cover the three times of day I am expected to be on the wards.”

“I am a patient. I have been hospitalized during medical school for wanting to kill myself.”

“I am afraid of being stopped by the police. I worry about waking up to the shooting of my sisters and brothers on TV.”

“I can’t breathe. I want to demonstrate my anger with protests, with change.”

“I am tired. I need to take online classes, research months, and time off. My passion for patient care is not strong enough to outweigh the dread of this place.”

Things lectured to me in our academic halls:

“Suck it up”, said the director of our Internal Medicine rotation at Medical Education Grand Rounds. “That’s my viewpoint on wellness.”

“Those protests are damaging to your reputation”, said the anesthesia attending. “You should be careful of having such photos of yourself.”

“Don’t wear your Black Lives Matter Pin”, said the Human Resources Department. “Don’t wear your LGBTQ Pride Pins. Too political, we don’t want to make anyone uncomfortable.”

“Mandatory group sessions would also make me want to kill myself”, said the director of our Internal Medicine rotation at Medical Education Grand Rounds.

“An applicant asked me about the mental health support for our trainees”, complained the psychiatry Program Director. “I think twice about an applicant who asks me that kind of thing.”

“Women in medicine should get married to a man who makes money”, said the Chair of the Department of Medicine. “This way you can spend more time at home and relieve your guilt of being a career woman.”

“It pains me to think of students out there suffering”, said the Chair of the Curriculum Committee. “It pains me to think we don’t know about it.”

Things we have said in response:

“But, this learning climate is hurting us. The traditions of medicine are capitalist, heterosexist, patriarchal, and racist. This culture assertively promotes obedience to authority, conservatism, and assimilation. We see our patients and our hearts being burdened by these oppressions. Is that not suffering?”

Wait. Said the Vice Dean. Wait for when the curriculum is changing.

Wait. Said the Advisory Dean. Wait until you have completed your studies.

Wait. Said the Assistant Dean for Student Affairs. Wait until you are really a doctor.

Wait. Said the Associate Dean for Faculty Affairs. Wait until you are an attending with authority. Wait. They said.

Wait.

"For years now I have heard the word 'Wait!' It rings in the ear of every Negro with piercing familiarity. This 'Wait' has almost always meant 'Never.'"

Things said in a group debriefing session:

"I can learn to wait. I will learn to justify the time between now and then, between now and that time when I might have the power to make a difference."

Staring at my residency application, I said:

Maybe medicine isn't the place for me. It has placed a hundred ton anvil on my bursting soul. I am losing the love of learning, the love of service. I am losing the ability to care for our communities because in this ivory tower, I am transforming myself out of belonging. I am no longer the brother or sister of patients, I am the overseer and auctioneer of health. I must learn "cultural competency"

because I am systematically forgetting my own. I must re-learn to practice empathy because my shameful emotional vulnerability is hidden deep within. I am losing the ability to honor the humanity in others because I am killing it within myself.

And yet,

I have touched humans Who Still Rise.

I have cried with humans who have invited me to heal within their grief.

I have read Roxane Gay write brokenly about working to love her abused body and passionate soul. I have seen Angela Davis tell her stories of collectives, feminism, and activism.

I have heard Bryan Stevenson call to keep the drums beating for justice. I have visited the grave of Dr. Martin Luther King Jr. and he said to me:

We must use time creatively, in the knowledge that the time is always ripe to do right. Now is the time to make real the promise of democracy and transform our pending national elegy into a creative psalm of brotherhood. Now is the time to lift

our national policy from the
quicksand of racial injustice to the
solid rock of human dignity.

**On September 15, 2017, I submitted
my residency application. For I
deserve better.**

My classmates deserve better.

Our communities deserve better.

**We all deserve the solid rock of
human dignity. Now.**

building a community: *my coming-of-age as a future physician*

BY POOJA SUGUNA YESANTHAR

FROM THE 2018 LINDA BRODSKY MEMORIAL JOURNAL

Joshua* leans back onto the sterile examination table, his skin damp with perspiration and his cotton shirt sticking to his sweaty ribcage. The cloth pulls itself from his skin to billow outwards with each gust of air from the fan I had set up in the corner, revealing emaciated arms which clench into fists as he slowly pulls up his shirt. A couple of minutes later, it is over: the stitches and his feeding tube are removed, and after three weeks in the ICU, he can finally eat food again. To a normal person, feeding through a tube would be unimaginable. To him, it is life.

My research fellowship in thoracic surgery was supposed to be a highlight of my medical school research career, but little did I know that my interaction with Joshua

would encapsulate my own love and frustration with a career in medicine. I entered medical school with a penchant for surgery. I spent much of my undergraduate and graduate career working with my hands, first while completing my Bachelor's in Biomedical Engineering and then while doing my Master's in Statistics. Thus when I was awarded this research fellowship, I was beyond excited to join the surgical team in the OR, the clinic, and in the research lab.

At the intersection of cancer, critical care medicine, and thoracic surgery, my research project focused on long-term pneumonectomy outcomes. This is how I met Joshua. He suffered from such an advanced case of mesothelioma that an

*The patient's name was changed for privacy reasons.

extrapleural pneumonectomy was indicated. At the time I had already gone through a year of medical school, but practicing clinical interviews with standardized patients or patients in the ambulatory primary care clinic I worked at did not completely prepare me for working with patients like Joshua, who were in such advanced stages of disease. I was taken aback at how disease had ripped apart not only these patients' lungs, but also their lives, their families, and their entire identities. Standing in the OR as we cut out their lungs, I could not help but wonder what else we were cutting out: their ability to run after their grandkids in the park, their ability to go on that skiing trip, or their desire to even take those few extra steps to the mail box.

In a medical anthropology class I took during undergrad, we learned about the distinction between a "disease" and an "illness," where the latter involves more than just pathophysiological processes and also incorporates the patient's life circumstances. While working with these patients I became acutely aware of the distinction between these two terms. After the first procedure I felt incredibly proud and

happy that the lymph nodes and margins were clear, and we had seemed to have completely excised the disease. However, my feelings of immense joy and accomplishment were shattered when I talked to the patient after surgery and found out that he could barely live the life he had. He was largely confined to sitting, and he could no longer live the life he had so enjoyed.

Alongside the emotions I had to come to terms with when working with such sick patients, I also had to struggle with the realization that the department was heavily male-dominated. There were no female surgeons in the department, and there was only one female resident. I had been in such situations before, as the only girl in my Math Honor Society in high school, then again as the only girl on my senior design team for my capstone engineering class during undergrad. However, it still was a shock when, upon expressing concern that I did not feel confident taking patient histories because I did not know how to read chest x-rays, I was told that I just had to "chat with the patient and look pretty."

These experiences eroded the layers of confidence and certainty I

had built up since high school: I was sure that I wanted to be a surgeon after watching a cesarean section in the 10th grade. The raw emotions that came with being a surgeon, however, truly shook me to my core. How was I supposed to uphold my promise to heal my patients when life after surgery is only half the life they used to have? How was I supposed to go through another stage of life where I was one of the few women in the field?

As a child, my tennis coach told me that though tennis seems like an individual sport, I always had a team.

Despite my experiences during my research fellowship last summer, my decision to make a commitment to serving patients for a lifetime came when I realized that, like my tennis coach said, I had a team in medicine to support me. I sought advice from the female resident in the department, as well as other female physicians who I looked up to, on how to assert myself as a female medical student. I was taught how to respectfully but confidently communicate with my colleagues and my patients. My team also consisted of my surgical team – the attendings, residents, and nurses – who I talked to about how to best

serve advanced or end-stage patients, and how to come to terms with less-than-ideal clinical outcomes. My team even consisted of physicians who were not directly present – from Dr. Paul Kalanithi, the author of *When Breath Becomes Air*, I learned that as a physician part of our job is not to always promise patients for their health, but to help patients come to terms with changes in their lives brought about by disease and to help them find meaning in their lives even after an illness.

As I have entered my second year of medical school, I have realized that my healthcare team expands every day: a community that I can not only rely on, but also contribute to, creating a continuum of support and commitment to serving people and promoting patient health.

what i can do

BY KACI MCCLEARY

*FROM THE 2018 LINDA BRODSKY
MEMORIAL JOURNAL*

It wasn't the long nights spent coating whiteboards in unpronounceable drug names, hoping to at least recognize them on the morning's test. It wasn't the inbox bulging with student loan emails, seemingly. It wasn't the morning I learned my classmate had committed suicide, although I can no longer drive up that parking ramp without imagining him jumping off. It wasn't the message about a second classmate's suicide that brought us all together while, somehow, simultaneously pulling us apart. It wasn't even the day we learned of a third student...I knew what it would say before I opened the email. Failing tests, missing meetings, dozing off in class; all the standard struggles seemed surmountable when considered in isolation.

What finally got to me was the culture of wards. In the pressure-cooker of hospital medicine, simple annoyances became crushing threats to my dignity and control. Gone were the didactic days of watching lectures online, replaced by cold, sunless morning rounds that seemed designed to clash with my natural circadian rhythm. Committing to anything in advance became more dependent on prayer than planning, as we never knew our schedules until the first day of each rotation. I wanted desperately to help my overburdened residents, but being a team player actually means getting out of the way when teaching takes as long as doing it themselves. I'd come to clinics excited to finally learn through experience, yet my notes were non-billable, my physical

exams had to be repeated, and my time felt less valuable than the nitrile gloves we burned through on rounds. Every interaction became a stinging reminder of how little we knew.

There is a certain Ivory Tower romanticism to studying through the night in the early years. We're doing this for a purpose; for our patients, we persevere. The cause is noble and we are proud to make the sacrifices it asks of us. But in clinics, when even bathroom breaks are doled out by superiors, the sacrifices were no longer mine to make. Suddenly, I wasn't staying late for the good of the patient; I am there because I need a good evaluation. When I stand by the operating table for hours, it is not out of concern for the person in front of me, but rather to meet my attending's expectations. All choice had been smothered by obligation, and I brimmed with resentment. It felt like being in high school again.

After being bullied throughout my formative years, severe depression and anxiety have been constant companions. I struggle not only to be the best possible version of myself and live an authentic life, but to have the self-confidence to believe that I deserve happiness. Each year had

been a little better than the last—a difficult but steady climb up to the edge of the emotional setback known as clerkships. Especially in the first six months, the thought of quitting was my constant companion. It was not a daydream, a pleasant stroll into escapism when a surgery dragged on and on; it was a nightmare. To carry on felt impossible, but to quit? I couldn't bear the thought of giving up on my patients and myself.

As I struggled to choose between my goals and my mental health, I had the fortune of rotating with a few people who were working to solve the exact problems I was facing. Their simple acknowledgement of the toxic culture in medicine allowed me to step back and reassess my situation: certainly, at that moment I felt powerless, but it wouldn't always be that way. As a doctor, I would be in a position to advocate for change. Even as a medical student, I started finding ways to fight back against the strict, emotionless culture of the wards by talking about doctors living with mental illness.

With a few other students, I helped found a chapter of the National Alliance on Mental Illness (NAMI) at our school. Wellness, while important, was not enough for us;

failure, and struggle as a common ground for medical professionals to support each other. Additionally, I started a personal project collecting stories of physician and medical student struggles with mental illness and suicidality. I stopped wasting energy railing against what I couldn't control, and channeled it towards what I could.

Confidence trickled back in with every rotation I passed, until finally I hit my stride in advanced clerkships. There were so many other healthcare careers I could have chosen, so many other things I could have done with my life... but once I was back in my specific field of interest, neurology, the endless questioning seemed almost silly: Can I do this? Should I do this? Of course! I love medicine; the current system of practice is my primary frustration. Part of wisdom is accepting that there are things I cannot change, while maintaining the desire to change what I can. Today, what I can change is still small, and control over how I use my time is limited, but it will continue to improve with training. By focusing on what I can do rather than what I can't do, I have found both day-to-day satisfaction and the patience to continue working for the practice of medicine I love.

