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A GALLERY OF WRITING

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bloodsound (05.08.20)

*For Ahmaud Arbery, on what
should be his 26th birthday*

BY SOPHIE SCHOTT

in the beginning,
blood made a sound.
our discovery of it,
the same and different

red wombs wrapped us
as platelets ushered
our blastocysts into
our being then birth

blue gloves caught us
and cauterized maternal
flows, those tides that
bore us through childhood

where we found blood
still made sound, felt
the beat beneath milked
breasts, our own chests

we ran with green pain, grass
stained our knees and we grew
as children do, the same
yet altogether different

white privilege marked me
and mine. my mother never
had to wonder what new hail
of hate might hit me,

make my blood resound with
bullets, shooting sounds, pain
profound-obliviousness is
something I cannot tolerate now

it makes my blood sound,
inveigh against indifference.
but does it make any difference?
can we go back to the beginning?

the safe embrace of capillaries,
the steady rhythm, the warm swell
that brings forth birth from pain,
the womb, its lullaby blood sounds

but what now? spilled blood
sounds deep in georgia ground,
pain profound, everything is
altogether different.

between the numbers

BY RACHEL FLEISHMAN, M.D.

Jayden had a copper coin in his incubator. It read Operation Enduring Freedom. Most of the nurses didn't notice it was there, tucked in the top corner just under the mattress. It got lost the day he died, swept into the trash with plastic gloves and catheter wrappers and bloody gauze. The day he died was a Tuesday, his 61st day in the neonatal intensive care unit. He weighed 1377 grams that day, the day he died.

Mateo had a picture of Jesus Christ hanging at the bottom of his incubator. He weighed 846 grams at birth. His mother hung the picture before she left the hospital to go home without him, 28 weeks into her pregnancy. The doctors told her he could go home one day; he could be fine. Jesus Christ was supposed to make sure. Mateo's eyes could tell light from dark, but Mateo could not see Jesus Christ. Like every baby, he came out of his incubator, daily, so the nurses could weigh

him. 989 grams today. Gained 17 grams. A little bit more than the weight of his diaper. Sometimes, if his nurse was Catholic, she would say a Hail Mary before placing him back into his incubator. After Jayden died, Mateo's mother added a brass crucifix. It dangled from a chain beside Jesus Christ, secured to the incubator top with clear tape.

It was thick white tape that held Isabelle's feeding tube to her cheek. Isabelle was 32 weeks. The doctors don't say born at 32 weeks; the weeks of gestation define the babies. A 32-weeker, that's who they thought she was. 1233 grams at birth. Two weeks old, she was now learning to eat. The nurses called this nipping. As in, Isabelle nipped 11 milliliters. Her mother called or came every 3 hours. 8, 11, 2, 5. The nurse would tell her how much she had nipped. 5 milliliters, 20 milliliters. Sometimes nothing. What she could not nipple was dumped down a tube stuffed through her

nostril and into her stomach. It had been there since birth; clear plastic with a purple cap on the top. When she could nipple all of it, every drop, her mother understood she could go home. Today, her mother had tried to nipple her. But Isabelle refused to nipple. She slept. And her mother left crying.

The day Jayden died was the same day Isabelle moved from an incubator to a crib. Nurses hung a sign in her room. The sign had a cap and gown and the date she graduated from her incubator written with a pink sharpie. The day Jayden died, there was no sign for his 2-month birthday. No one had made one. They hung Isabelle's sign next to the photograph of her big sisters, Genevieve and Noelle, that had lived inside her incubator with her. Noelle had drawn a picture of a stick figure family. Five people, all smiling. Isabelle, much smaller than everyone else, was standing beside her sisters, waving her stick hand with five stick fingers just like the other members of her family. This picture was there, too, in her room.

Across the hall, Brady had a plastic Patriots helmet in his incubator. Named for the famous quarterback, his father

hoped the team spirit would help his son come home a winner. The helmet was from an ice cream sundae his parents shared on their first date at the beach seventeen years before. They had been married fourteen years and had had eleven miscarriages before Brady was born a 30-weeker. 1488 grams at birth, the doctors said he was big. His parents did not think he was big; they thought the ice cream sundae helmet could probably fit on his head. This was an NFC city and the nurses like to tease Brady's father every Sunday afternoon, particularly if the Patriots lost. It was meant with kindness, but when the team lost, his father worried Brady's name might not protect him.

Jayden had been next door to Brady, before he died. His mother, the only Black mother in the neonatal intensive care unit that month, kept to herself when she could. She had delivered Jayden at 24 weeks, just hours after she came to the hospital because of a three-day headache that started while she was on a business trip. Her mother brought her to the hospital; Jayden's father was in Afghanistan, in the Marines. She mentioned just once that he was away and her nurse that day, a 52-year-old woman with a perm and frosted blond bangs,

opaquely offered her assurance that when he gets released, he will be proud to meet his son. Jayden's mother had not discussed her husband anymore.

Across from Brady was Jasmyn. Jasmyn had been born on her due date. Forty weeks. Her mother was 16 and she did not know about Jayden's life or his death. The doctors had been at her delivery minutes after Jayden died. One of them sat with his mother while the others ran to save Jasmyn whose umbilical cord was wrapped around her neck on the way out. Jasmyn was not breathing when she was born on time. She came to the neonatal intensive care unit on a warmer bed with one breathing tube, one nasogastric tube, one temperature probe, and three cardiac leads. Shortly after her admission, she gained four scalp electrodes, two umbilical catheters, one IV, one cooling blanket and one rectal probe. Her mother was too confused to be scared. She really couldn't say why the doctors thought making her baby cold could help her, but she nodded lots when they talked to her, then went back to texting her boyfriend who was in geometry class.

Mateo's mother dressed up her daughters, Lucinda and Maria, in their church dresses to visit Mateo. Broad skirts, lace collars, bright cotton cloth. She was worried the nurses would not let them see their brother. She reminded them to be polite. Her husband would bring them all to see Mateo in the evenings when he was home from long haul trucking across the Northeast. The girls would sit in chairs with their hands in their laps and sing songs to Mateo while his mother held him on her chest. His father would tell them all stories about the roads he drove for work. And they would sit rejoicing at just being together. The nurses would hover in the doorway, smiling at the lovely family.

A few doors down was Owen. Owen, who still could not breathe on his own, had equipment in his incubator. The breathing tube in his mouth, the tape on his face, the angel frame to hold the accordion tubes connecting him to his life support. He had nothing extra with him. 25 weeks, 555 grams, born on the 5th day of the month. It all felt lucky to his mother who was still a patient in the hospital, who still needed medicine for her blood pressure, who still could not get out of bed. His father had been at his

his birth. But he hadn't yet left the bar after work to come see him since then. His mother knew he probably wouldn't.

Owen's mom and Brady's mom knew each other from high school. They hadn't seen each other since graduation. Brady's mom knew Owen would go home to a trailer park, knew Owen's mom sometimes took off her clothes for money at the club on the State Highway, knew she'd been in jail at least once. In high school, while Owen's mom was the cheerleader all the boys wanted, Brady's mom had studied hard, gone to college.

But one college degree, one master's degree, one high-paying job and one marriage earned her nothing extra in the neonatal intensive care unit. Since Jayden died, Brady's mom didn't want to talk to the other mothers in the lounge, did not want to see herself in their communal worry.

Olivia's mother talked to everyone. Moms, dads, grandmas. She spent more time in the lounge than with her daughter. Seeing her daughter scared her, but she couldn't quite bring herself to say it. Nor could she bring herself to go home. So she chatted. And she knit.

Two booties, three hats, one head band. Olivia had Down Syndrome. She, too, was learning to nipple. Beside her crib, her mother's knitting lay folded neatly on display. 3642 grams at birth a week ago, she had yet to regain her birth weight. She lost weight every day. 105 grams, 86 grams. Gone. Today she weighed 3099 grams. That included one feeding tube. The day the doctors moved her from the healthy baby nursery to Intensive Care and placed the feeding tube was the day before Jayden died. It was also the day Olivia's mother began pumping her breasts to save her child. She worried that maybe, just maybe, it wasn't Olivia's fault that she was losing weight but instead her own. Maybe her milk wasn't made right, maybe she didn't have enough. Every three hours her phone chirped and her breasts started to leak. 9, 12, 3, 6. The machine was connected, sucking rhythmically, when Jayden died. Olivia's mother had had her feet on the footrest of the giant green chair, breasts strapped to the plastic phalanges, when the nurse yelled, "I need some help in here." That was the beginning of Jayden's death. When Olivia's mother heard her, she looked at Olivia asleep in her crib, looked at her nipples sucking in and out and in of the phalange, and wanted to run down

the hall with her daughter, topless.

The doctors had been standing outside Tuan's room when Jayden's nurse yelled for help. Four doctors: one in charge, the others learning. Six computers, one nurse, one parent, one dietician, one pharmacist, and one social worker were in the doorway of Tuan's room. They called this *rounds*. As in the doctors go on rounds to see their patients. Rounds are a puzzle of numbers and letters and metric units. TFL 150, AFL 147, *urine 4 ml per kg per hour*, stool times 8, *nippled 89 percent*. When the nurse yelled, "I need some help in here," Tuan's mother froze. And instead of explaining those numbers to Tuan's mother, instead of remarking on his progress, the entire team simply ran away from her. Tuan's mother stood in the doorway. She turned Tuan's small jade dragon charm over and over in the palm of her hand, the smooth cool stone calming her while more and more people went into Jayden's room. She wanted to pick up her child, feel him breathing. Instead, she stood there.

When the doctors ran down the hall to Jayden's room, Isabelle's mom was holding Isabelle. She was trying to nipple her and Isabelle was ever so slowly drinking her milk. Isabelle's

mom watched the bubbles pop up from inside the rubber nipple and float to the surface of the milk in the upside-down bottle. She saw the team rush by. The door was closed; she heard nothing. And her daughter kept sucking. One bubble at a time.

When they got there, to Jayden, his alarm was screaming. Jayden had been on life support, unable to breathe on his own since his birth. For 61 days, he had had a tube in his windpipe that was taped to his face. For 61 days, the hole near his heart would not close. For 61 days, the doctors had manipulated the numbers on his ventilator. For 61 days, they had tried everything to wean him from that machine. He could get close, but he could not get better. And that day, before he died, his breathing tube clogged. The good air could not get in if the tube is blocked. His oxygen levels dropped. Eighty percent. Seventy percent. Sixties. And when the nurse called the doctors, she had already tried to suction out the plug on her own without success. His mother was there on the couch beside his incubator. When it all started, she did not cry. For just a brief second, she glanced at the doorway. Just a glance.

And in the doorway was Luke's mother. She was there for a moment, before the secretary walked her away. Luke had been in the neonatal intensive care unit for 84 days. Originally a 24-weeker, he had gained 1801 grams in 84 days. At first, like Owen and Jayden, his incubator held equipment. Lots of it. The plastic walls opaque from humidity meant to moisten his skin. His mother tried to add a photograph of the family dog, Chewie, to his incubator, but the humidity dripped. The ink smeared. The tape meant to hold the two tubes and two catheters that kept him alive would not stick to his immature skin. At some point, his skin changed. Then, the equipment changed. One breathing tube removed, one mask added. He was 27 weeks then. 686 grams. Since then, he could breathe on his own. Since then, his mother had gone home at night and had dinner with his father because she knew, in her heart, that Luke would eventually come home to them. The day that Jayden died was the ninth time she'd left a crock pot full of chili for her husband since she'd gone home without Luke.

Luke's mother had tried to befriend Jayden's mother. They had talked several times in the lounge. Both boys were 24 weeks. Both

women had spent months coming in and out of the hospital, mothering in between the numbers of the neonatal intensive care unit. While Luke seemed to get better, Jayden did not. He grew, but his lungs would not heal. The hole near his heart would not close. Luke's mother would chat about her students. She was a math teacher. She'd tell Jayden's mother about her mathletes, about mindset, about the burden of high stakes testing. Jayden's mother, a human resources executive, kept trying to picture Jayden learning to count, but it was easier to imagine him singing his ABCs than mastering numbers. She would not talk about Jayden with Luke's mother. She did not want to compare their children.

While the doctor was un-taping Jayden's breathing tube, his mother saw Luke's mother as a flash in the doorway. *We are replacing his breathing tube*, she heard the doctor say. Everyone in the room was quiet while the head doctor asked for equipment. One blade, size 0. One handle. One endotracheal tube, size 3.0. One stylet. And while a nurse and the junior doctors scrambled to line up the equipment, the head doctor put a mask over Jayden's face and squeezed a balloon to help him breathe. She was patient, but terse.

She asked another nurse to place a second IV. His alarm kept beeping. The nurse ran out to find a special light to find his veins.

When she left, the nurse went next door, to get the light from the counter in Hope's room. Normally, she would tip-toe into Hope's room, but she did not have time. Hope started crying, jarred awake from the noise, but there was nothing to be done. Born one week past her due date, 41 weeks, addicted to methadone, Hope had lived in the neonatal intensive care unit for 19 days. Every three hours the nurses measured her withdrawal. They quantified diarrhea and shaking and screaming into a number. Two was good, 12 was not. Every three hours they gave her morphine in tiny syringes, tweaking the dose once each day at most. Hope's mother spent all day with Hope when she could. She would put Hope on her chest and read *The Hobbit* out loud. While Jayden was dying, Hope's mother was at the methadone clinic getting her dose. She was not there to hold her daughter, to stop her screaming, when the nurse left her room to go back to Jayden and stick needles into his veins.

Jayden's mother watched the color in his face turn darker. His

arms stopped wiggling, went limp. The screaming from the monitor took on a different tone as his heart rate dropped. Eighties, seventies, sixties, fifties . . . Louder, harsher, even harder to ignore. *Start compressions*, the doctor said. Hands wrapped around his chest and started squeezing. *One and two and three and breathe. One and two and three and breathe.* The doctor moved the mask from his face. *Pause compressions.* She lit up his mouth, slid the tube over his tongue and into his windpipe. *It's in. You, resume compressions.* She pointed at the nurse whose hands were poised around Jayden's chest. *You, call for X-ray.* She pointed at the most junior doctor. The monitor was still screaming. Jayden's mother was frozen. *One and two and three and breathe* and blood filled the inside of his breathing tube. Jayden's mother and the doctor looked at each other, four eyes locked across the room, when the blood filled the tube. And the doctor kept on fighting with everything she had.

While the team was fighting for Jayden, Brady's parents and Hope's mother stood in the lounge buzzing the door to come into the neonatal intensive care unit. No one came, so they buzzed again. Jayden's room was in the back, away from the main

door, and they did not know he was dying. Brady's father started to bang on the window. He wanted to see his son. When the X-ray technician rolled the machine past them and opened the doors, they walked inside and stood side by side scrubbing their hands at the sink just as they had been taught. They could not hear Jayden dying. The sign over the scrub sink read that scrubbing should take 60 seconds and that it takes 60 seconds to sing the alphabet. Brady's father often did sing, silently, to himself.

The counting begets a rhythm of its own. *One and two and three and breathe.* Again. And again. Fifteen minutes of CPR meant a doctor squeezed his chest 1,800 times. Three doses of epinephrine into his veins so his heart would keep beating, one large dose of epinephrine poured down his breathing tube to help stop the bleeding. Twenty-eight milliliters of normal saline pushed through an IV and one blood transfusion of 21 milliliters was started but did not have time to infuse. The team did every last thing. They could not save him.

The doctor gestured for Jayden's mother to come closer and she did. The doctor took Jayden's mother's

hand and placed it on Jayden's head. *Stop compressions,* the doctor said. And all four doctors, three nurses, one respiratory therapist, and one social worker were silent. The doctor listened to Jayden's chest and while she did this, she closed her eyes. The nurse kept pressing buttons on the monitor because it would just not stop beeping. *Time of death, 10:34 a.m.*

Before she knew what was happening, Jayden's mother was sitting on the couch again with her child in her lap. Having endured 61 days of battle with his body, he was finally freed. A blue hat was placed on his head. The quilt that had covered his incubator now wrapped his body. And the doctor sat beside his mother, silently, while everyone else disappeared. There were no numbers anymore. There was only Jayden.

That was three days ago. Since then, Olivia's mother added a sweater knit from pink bamboo yarn to the shelf in Olivia's room. Jasmyn had replaced Jayden as the sickest baby in the neonatal intensive care unit. Luke had weaned off all of his oxygen; for the first time in his life, he had no prongs in his nostrils. Hope's morphine dose was a little bit less; her mother bought tiny pink

stars and dangled them like a mobile over her daughter's crib. Owen's mother had gone home without him, riding the elevator beside a married couple and their fat baby boy cooing in his car seat. She had left a pair of tiny, blue, leather-soled shoes in his incubator. Mateo and Brady had each grown one diaper size larger. Isabelle still could not take a full bottle. And Tuan was ready, finally ready, to go home.

sink or *swim*

BY LEAH JONES

My first swim lesson: I was one of a dozen or so six-year-olds in the pool. I tried desperately to mimic my instructor, hoping for some word of praise indicating that my flounderingings were an acceptable approximation of her graceful stroke.

My first time teaching a swim lesson: as life marches on, I found myself on the flip side of the student-teacher relationship. Three years ago, I started to teach my co-workers in Guatemala how to swim. The women in that lakeside community are raised to be afraid of the water. While the little boys are off splashing at the water's edge, the little girls will often stay home. Given the all-too-frequent drownings, I offered lessons. In addition to my newfound role as swim coach, my work there was also as a teacher, instructing the traditional birth attendants in a maternal and child health education course. That said, and as most

who work internationally will attest, I learned much more than I taught—about the Mayan customs, about the patient-provider relationship, about myself, and about being a white visitor in an indígena community.

This year, my first year of medical school, I tried to hold on to the idea of a two-way relationship. Reflecting on my experience in Guatemala (in every relationship there was a give and take of learning and teaching) amidst the top-down environment of attendings, students, and patients, things seemed upended. I felt the medical encounter dynamics should be inverted, with the patient as the captain and the providers as the crew to reach the safe harbor of a patient-defined healthy life.

Among the Tz'utujil Maya, the lake is respectfully regarded as live-giving and life-taking. It is sacred, but deadly. People cross the lake

every day to go to work, and it is the quotidian realm of the men who fish. Yet on any day, the Xocomil winds can capsize the small boats. For those who live at its shores, it is well known that anyone daring enough to swim in the deeper waters risks capture by the souls that dwell in its depths. It is said that every so often, the “ahogados” or “drowned ones” will hold a ghostly parade through the town drumming and yelling someone’s name. That person will soon perish.

Like the yin and yang of the lake, as a source of both life and death, there is a duality to the medical profession. Beyond the cradle and the grave, medicine is also about learning and teaching, pain and relief, the impact we can have on those still living and the impact those who are departed have on us.

I hope I can continue to process my work and relationships in Guatemala as I progress from my first year in medical school to the second. I don’t yet feel ready to go back to Santiago. My mom worked in Ecuador for three years in her twenties and has never been back, though she always refers to it as the most formative time in her life. To some degree, it bothers me that she’s never been back because it

feels like a loose thread, a half-read chapter. And yet, living in a different country and building strong, but time-stamped relationships, is such a whirlwind that it feels like getting caught up in the Xocomil winds themselves. Similarly, in this new world of medicine, its culture and customs, my first patients, first instructors, and first mistakes have been equally as tumultuous, influential, and instructive in my learning how to swim.

mourning sickness

The grief of a physician mother experiencing miscarriage

BY LEALANI MAE Y. ACOSTA, M.D.

miss

doctor

mrs

menses

missed menses?

conception

reception

relation

elation

thickening

quickenning

sickenning

contentment

complacent

placenta

displacement

miscarriage

carnage

rage

mourning

sick

bear

bairn

barren

bore

tissues

issued

fingers

toes

feet

us

me

him

we

weeping

wailing

ailing

railing

kneeling

healing

an *eye* for visual observation

BY ABIGAIL LUMAN

Two weeks after my first year of medical school came to an end, I developed cellulitis and an abscess over my right temple that was uncomfortably close to my eye. I was eventually ushered to the emergency department and was kept there overnight to ensure my vision was not compromised. When I looked into the mirror in the hospital bathroom, I didn't recognize myself. My right eye was erythematous, and the surrounding edema was pushing my eyelid closed. Puffiness eliminated the familiar symmetry of my face. This abnormal portrait of my face—which serves as a centralized location of my identity—became the manifestation of a clinical diagnosis.

The stubborn medical student in me didn't want to admit that I was nervous about how this illness could alter my appearance. I didn't want to see how uncomfortable, embarrassed, or vulnerable I felt.

Could this impact the way my future patients perceived me? It was only three months earlier that I had been in this same room of the emergency department, conducting my very first history and physical exam. From the same bed that I now found myself in, my patient shared intimate details with me about how her cancer had taken over the entirety of her identity, and how her missing hair impeded her ability to hide her disease from the outside world. My father now sat in the chair that I had perched in during that patient encounter. My vastly different experiences in this one room prompted me to further dissect the interplay between learning how to visually interpret a patient encounter during medical school and what this means for a patient experiencing illness.

Since starting medical school, I have learned and discussed repeatedly the importance of visual observation. Learning

various physical exams translated into looking at strangers, friends, and family differently. The bruised red marks laden deep within a man's antecubital fossa that traced down his anterior forearm became a sign of intravenous drug use and an indication of the suffering that comes hand in hand with addiction. The rounded face of a stranger raised the question of chronic steroid use. My peers have asked me about the 4 cm scar that lines the side of my right thumb, a reminder of a ski injury that required prompt surgical intervention. These observations, by myself and others, became difficult to ignore once the physiological meaning behind them was explored in a classroom setting.

My observational skills were further stretched during our first-year medical anatomy course. The optical challenge of the facial nerve dissection was particularly strenuous. My group went on a search for wisps of tissue which had once offered our donor the ability to communicate pure emotion with the raise of an eyebrow, a hint of a smile, or tear-stained tissues. The facial nerve, split into its many delicate branches, was a wonder of an anatomical item. I recall standing in awe as I considered that electrical signals once passed through this

beautiful structure to offer physical affirmations of joy, suffering, or curiosity by our donor. It once helped produce physical manifestations of who she was as a person; a portrait of her deepest feelings. During this course, we were trained to see these nerves as a slightly more off-yellow color than the surrounding connective tissue. This was something my undergraduate artistic training called me to describe as strands of sandy warmth behind a background of tusk white fibrous tissue.

I remember my drawing professor in college vigorously pointing to the leg of a table in class. He was explaining how to focus one's mind on the subtle linear patterns created by light striking the metal rod at an exact angle. He pushed us to transfer this visual information to paper exactly as we perceived it, which required reflecting fuzzy lines of mental projections into physical, tangible form with our pencils. Later as homework, I oriented a desk lamp to create a distinct shadow under a pair of scissors that I had placed on a white sheet of paper. The plastic handle morphed into stacked, curved lines of varying shades which created depth, shape, and texture. I focused in on the proportion of the handle to that of the bilateral metal

blades. Photons cascaded into my retina and were eventually coded into movements of my right hand through a series of what I can only describe as beautifully biologic events. Mirrored reflection emerged between the scissors sitting on the desk in front of me and the scissors I had drawn.

Learning how to visually deconstruct objects like this during my artistic training changed the way I saw the world. I will never be able to look at how light reflects off objects the same way. Bright spots appear as a set of tools that can be used to communicate the depth and shape of a tangible item. The exact location of a shadow beneath an object offers hints at the location of the light source that created the juxtaposition of light and dark. Learning how to draw was akin to learning how to use my senses differently. Patterns, shapes and linear information that had been there the entire time simply had to be brought to my attention by my drawing professor, who was trained in teaching students how to effectively replicate visual information with writing utensils.

Art conveys human emotion and serves as an outlet for pain, suffering, joy and happiness.

It serves as a physical manifestation of what it means to be alive. When emotions are too complex to communicate with words, we let them out of the cages of our minds with color, shape, and the action of creating. Meaning becomes layered into pigment, graphite, charcoal, and clay. This meaning is transferred from artist to observer and takes on the shape of a new mind like wine being poured from its bottle into an open glass.

This is akin to medicine because just as the motion of texture in a painting can communicate a story, outward visual signs of disease can communicate pathology that exists at a cellular level.

Teaching visual literacy to medical students within an artistic framework has been found to improve the sophistication of physical exam description.¹ Patients ask us to take this further and truly see their humanity beyond the confines of their illness. I argue that exploring the deeper meaning of stories conveyed by visual art as a medical student could offer insight into the humanity of the patient story. However, this cannot be achieved without excellent visual observational skills. Are scars a sign that someone has received x, y, z

disease?

What if we took our observation further into seeing the background information conveyed by visual details? Under that framework, perhaps scars reveal strength, trauma, and stories that are inevitable due to existing in a perfectly imperfect world. Hospitals are more than gallery spaces for illness and disease—they are spaces interwoven deeply within what it means to interact with the systems people have created to care for one another.

An electronic portrait of my distorted and swollen face is now permanently attached to my medical record. The infection was resolved with oral antibiotics, and the contour of my eye and face returned to its familiar form. A tiny scar over my right temple from an attempted incision and drainage that evening is obvious only to me now. Occasionally, my makeup brush smooths over this small crease and I am reminded of the evening I was a patient, instead of a medical student.

1

Reference

1. Naghshineh S., Hafler JP, Miller AR, et al. Formal art observation training improves medical students' visual diagnostic skills. *J. Gen. Intern Med.* 2008;23(7):991–997. doi:10.1007/s11606 -008-0667-0.

the *death* exam

BY JENNIFER CAPUTO-SIEDLER, M.D.

The intern handbook was a document created by the residents who had come before us. It was sent out at the beginning of the year, to be printed, folded into pocket size, and to serve as a guide for common scenarios we would be called about during our rotation as house officer, the intern covering the internal medicine teams overnight. The handbook was how I knew to order vancomycin and cefepime when called for neutropenic fever and to order 0.5 mg IV hydromorphone for the rigors that patients experienced during blood transfusions at our cancer center.

One of the pages of the handbook covered pronouncing the death of a patient. It outlined the exam to perform and gave a sample note of how to document the death exam in the chart. *No response to verbal or tactile stimuli. Pupils fixed and dilated. Absent heart and breath sounds. Patient pronounced dead at xx:xx. Attending notified. Next of*

kin notified. It was this page I referred to when called to make my first pronouncement.

But the intern handbook did not cover how to handle the situation with James.

As the overnight intern, I did not meet James until after his death. He was a young man, near my age, with a rare aggressive cancer. According to his medical record, he had tried multiple treatments, but none had slowed the cancer's progression. He had become acutely ill the week before and been admitted to the ICU with sepsis. I wasn't there when he developed multiorgan system failure. I wasn't part of the conversations with him and his family about the grim prognosis he faced. I wasn't there when the decision was made to transition to comfort measures and minimize his suffering.

I became involved in James's care when I was called around 11:30 pm one night to pronounce his death. I reviewed his chart, gathering basic information about his hospital course. I re-read my signout, which stated that James's death was imminent and the family had made the decision for comfort care and knew he had, at most, days to live. I consulted my intern handbook so I wouldn't miss any of the necessary steps to make and document the pronouncement correctly.

Confident in my ability, I arrived at the room to find James surrounded by family, seven or eight people encircling his hospital bed. The lights were off and the room was quiet. I hesitantly entered, introduced myself, and gave my condolences, "I am sorry for your loss."

"Please don't do this," James's father pleaded.

I was taken by surprise and unsure of how to proceed. In my hesitancy, James's father went on to explain. That day was James's daughter's birthday and the family did not want this day to also forever be the day her father had died. They asked me to declare his death after

midnight, once her birthday had passed.

At first, I didn't say anything. Many thoughts ran through my mind. *But he did die on her birthday. Even if I said it was the next day, wouldn't they always know he had died on her birthday? Is it illegal to put the time of death after midnight? Could I go to jail? Could I get kicked out of my residency program? I know what it's like to pass the anniversary of my father's death each year, how would I feel if it was on my birthday? Should I call my attending?*

To buy myself time, I told his family that since I was already there, I would go ahead and do the necessary exam and then give them some time alone with James. I approached James, lying in the hospital bed. His youth was apparent despite the bloating of his limbs and abdomen and the yellow-gray tone of his skin. I shined my penlight into his eyes. Fixed and dilated. I placed my stethoscope on his chest. No heart or breath sounds. I subtly applied nailbed pressure to his fingertips under the sheet. No response to physical stimuli. I looked at the clock; it was not yet midnight.

I stepped back from the bed.

I looked at James's father and told him what I would do. I again gave my condolences and left the room.

anatomy of humanity

BY ANGELINE AJIT

Veins of grace and eyes of hope,
We were born among the brightest stars.
Starting as infinitesimal atoms and cells,
Passion brought us to where we are.

We are matter and molecules recomposed
To choose between scalpels and scopes
To heal bruised hearts or anxious souls
And mend delicate, broken bones.

Skilled, gloved, healing hands
Make gentle incisions with steady breath.
But underneath are calloused fingers,
Scars from intimacy with frequent death.

How beautiful the lives we protect—
Footsteps chasing uncertain grounds,
Arteries flowing with limitless empathy
For people in pale paper gowns.

No mechanical heart made up of gears
We are only human after all.
No pumped oil and artificial heartbeats,
Like humans, we can fall.

And at last when we cease,
Our light falls away.
Yet through the patients we save,
Our stardust will stay.

a reflection on grief and supporting the grieving

BY MAYCEE GIELOW

"Bekk?"

"Yeah," he recalled with a weak smile, "that's what they all called me."

I had just finished reading the letter my grandfather had been attempting to write for the past two days. The letter was addressed to his sister-in-law, my grandmother's last living sibling, and it was signed "Bekk", short for Bekkedahl—the last name he shared with my grandma for nearly 70 years. It had been painstakingly typed on the old type-writer in his office.

"It's nice. This is a really nice letter, grandpa." I said, trying to hold back tears. It was all I could muster.

We both sat there, tears in our eyes, not saying anything. The letter detailed the last few months of my grandmother's life. She passed away

the week prior and we were beginning to tie up loose ends. Yet there we sat, deep in the trenches of a grief so strong it was nearly palpable.

"70 years. I don't know what life is without her."

That night, those words stuck with me. I lay awake thinking of how I was in over my head. I foolishly believed that my two years working as a nursing aide and now a second-year medical student somehow qualified me to be a comforting presence to my grandfather who was consumed with grief. As a nursing assistant, I was trusted to care for patients at their most vulnerable. Throughout medical school, we were always reminded that patients are people first. Yet somehow, when I was confronted with such an intimately personal loss—those lessons all fell short.

I had always had a special relationship with my grandpa. We, however, only saw each other once or twice a year growing up. Even less frequently as I got older. It wasn't until my grandma entered hospice that I made it a point to visit more frequently again. Who was I to think he'd even want me there? What could I possibly do?

Throughout the next week, we visited restaurants that my grandparents frequented. Through tear-filled eyes, I watched as my grandpa bravely explained to the servers why my grandma wasn't there. Some people seemed to know intuitively how to respond, while others stumbled through a simple, "I'm so sorry for your loss." I envied the former, sympathized with the latter.

People often shy away from those who are grieving. We don't know what to do. We are afraid of saying the wrong thing, reopening the metaphorical wound. But the thing about grief is that people reach a point at which they need to talk. It may take a weeks or months, but eventually, we talk about our loved ones because we still cannot fathom life without them. We talk about them so we don't forget—as if we could. We talk about them to

acknowledge that the life that we built around them was real and good and meaningful.

The time I spent with my grandpa was such an impactful time in my life because I was brought face-to-face with immense loss and learned that so much of supporting a grieving person is showing up. I learned to sit in comfortable silence. I learned to ask questions. I learned to let people tell their stories. I learned to be brave and embrace this stage of mourning because it was a path to healing. I learned that not all questions need an answer — sometimes it is enough to know that someone heard you, remembered that you are still hurting, acknowledged that life as you knew it is gone.

The week after I left, my grandpa told me that he was incredibly grateful for my presence in the days and weeks following my grandmother's death. That he didn't know how he would have made it through on his own. Through this experience, I began to consider that I may have a skill set to work around loss and end-of-life care. I don't presume to be any kind of expert in grieving, but I do know that I can show up for people. I can fight for them, ensure the end of their life is

spent how they want it to be, and I can be a comforting presence during what is likely the most difficult time in their lives. As I move forward in my medical training, I will take this experience with me as I care for my own patients with even more empathy and understanding.

If you know someone who is grieving, I would encourage you to reach out to them. Your mere presence may encourage and support them, even if they aren't ready to talk. Acknowledge their feelings of their world being turned upside down, while the rest of the world seems to spin on as usual. Send them a gift. Invite them to coffee and let them tell their stories. Listen. Even if you feel like you aren't the right person for the job, you never know the difference you could make by simply showing up.

For more information on grief and the grieving process, here are some books I have found particularly impactful:

Good Grief by Granger Westberg

On Grief and Grieving by Elisabeth Kübler-Ross and David Kessler

Being Mortal by Atul Gawande

A Grief Observed by C.S.Lewis

lessons from *lucy*

BY REBECCA MACDONELL-YILMAZ, M.D.

The fish was promptly named Lucy by my preschool-aged sons. Gifted by our nanny, it had the same indigo hue as her own fish, which was also called Lucy, and so there was no need for discussion; the choice of names was clear. For a few weeks following her arrival, the boys eagerly introduced Lucy to everyone who entered our home. At two and four, they weren't old enough to feed her or refresh the water in the small tank that now sat on our kitchen counter, so the task of remembering fell to my husband and me (but mostly to our nanny).

Then one day at work, I received a text from our nanny that the fish wasn't looking so good; she wasn't eating and had white spots on her fins. She and the boys brought Lucy back to the pet store, where they were told she might have an infection and were given something to sprinkle into the water — some type of fish antibiotic, I could only

assume. But it didn't help. Several hours later, our nanny texted again to tell us that Lucy had died.

At that point, I began to panic. Suddenly, my kids were being exposed to death, a confrontation I had felt sure was tucked safely in the distant future. Their grandparents are not infirm, nor are any of our neighbors or close friends. Death and dying were conversations I was glad to postpone. Because as much as I believe in being honest with my children, in fostering grit and resilience, deep down I never want them to feel sad.

As it happens, I am in the business of sadness. I am a pediatric oncologist and a hospice and palliative care physician. My colleagues in each of these specialties find their own field uplifting and the other terribly depressing. I occupy the niche where they overlap, where everyone

emphatically agrees that grief resides. So I am used to talking about death. To delving into discomfort. I grow frustrated when patients, families, and even my coworkers, slink around it. I see each discussion as a quest: my task is to unearth a patient's beliefs and desires surrounding the end of life and, once I understand them, to guide them toward the care that makes the most sense for that individual.

I have often returned to the advice I used to dispense to parents during my pediatrics training when they were reticent to talk to their teens about sex: if you wait to bring it up until you feel ready, it will already be too late. The same is true in end-of-life care: if patients and families wait to talk about care preferences and code status until they feel ready, the window of time in which these wishes can be acted upon may already be closing. As Thomas Lynch wrote, "Maybe it is so for every generation — that sex and death are the required lessons."¹ Perhaps each lesson must be learned twice: once for one's own understanding and again in passing on that knowledge. I felt nowhere ready for this second step.

1. Lynch, T. (1997). *The undertaking: Life studies from the dismal trade*.

When I returned home, the boys greeted me happily, swarming around my legs and into my arms. They shouted bits and pieces of their day: stories they had read, games they had played, how well they had or hadn't behaved.

At some point, my older son said, "Our fish got sick. She died."

His little brother chimed in: "She's in the ground!"

And there we were, in it. I said what I felt: "I'm sorry that she died. That was very nice of you to bury her."

We hugged. They went back to playing, apparently unscathed, while I sat with the discomfort that my patients and colleagues must so often feel.

These discussions proved prescient when I miscarried later that year. My husband and I had shared with our boys the news of a baby brother or sister earlier than was perhaps wise, given the nature of these things and my advanced maternal age. Forced to explain that a baby would no longer arrive in the fall, I returned to a concept we had

already visited: “The baby died,” I told them. “Sometimes that happens; it’s nobody’s fault. It’s very sad. But we can feel sad together as a family.” They asked questions — does everyone die? Would they die? — and I did my best to answer simply and honestly.

It’s still uncomfortable to talk about death and my miscarriage with my kids. But I know that I need to keep doing it, that it puts me in the shoes of my patients and their families as they face discussions that they never wanted to have. Six months later, my boys continue to announce to friends: “There was a baby in Mommy’s tummy but it died,” and periodically ask, “Can you put another baby in your tummy?” I tell them that we can’t predict the future, but together we can hope.

bicarbonate *swirl*

BY MARCIA GLASS, M.D.

Standing here,
outside this hospital room,
listening to you talk about bicarbonate,
I notice a painting on the wall
in the shape of a swirl
going round and round —
almost to infinity.

And,
in those two or three seconds,
I feel stillness.

But, looking back,
I see your mind is running
because this patient's heart
is also running.
And the EKG
will soon be running,
next to the oxygen,

which is still running,
and the IV fluids,
which have to keep running.

And, down the hall,
the surgery team
suddenly starts running
because someone's life
is running

out.

Right now,
I wish you could stop and look at this painting.
Just for two or three seconds,
notice this swirl
going almost to infinity.

But, instead,
I stare at you intently
and nod my head.

in search of **heaven**

BY MICHELLE MATVEY

Michael sat with his head down. His hands were folded neatly in his lap, and his eyes were wide open, fixed upon the worn blue carpet beneath his feet. He was mummified in his stillness, save for the rhythmic, tic-like clearing of his throat. I tried to read his body language and assess his willingness to participate in group therapy today. He was polite and composed, visibly mustering an effort to blend his towering frame into its surroundings.

The nurse practitioner started us off: “So, I wanted to ask how everyone’s week is going so far?” She glanced around the room, expectantly.

Michael raised his hand. This weekend, he explained, he read an uplifting passage in the Bible: “Salvation was possible even for those who had sinned.”

I processed Michael’s anecdote and struggled to see an opening for the group’s focus on symptom management of schizophrenia. Surely, Michael was expressing some sort of relief that his past actions did not seal his fate. Logically, this could be related to his lived experience of mental illness.

But, how could I weave this thread tactfully? How could I reroute the direction of the story he vulnerably shared towards a discussion of his disorder, without being overly reductive?

Michael was revealing a private solace in his relationship with Christianity. Perhaps immediately pivoting to a therapeutic prompt was too sudden a leap, and risked minimizing Michael’s contribution.

I glanced at the nurse practitioner. She bit down on her lip and tried to find the appropriate

words, as her eyes darted down at her notepad and up at the ceiling.

The psychiatrist, quietly observing, gently sprang into action: “So, what I’m hearing is, this passage suggests the possibility of repentance, and you found that hopeful. Is it possible you had this reaction because you think you’re damned?”

Michael responded: “Yes.”

“And might that have something to do with your diagnosis of schizophrenia?”

“Yes. Yes, it does. I’ve done some things I’m not proud of. And I do think my actions were related to my disorder.”

As the session continued, Michael spoke with increasing openness and a remarkable degree of introspection. I learned he had a history of violence, which weighed on him greatly. He attempted to articulate the moments leading up to his past outbursts, when his psychosis got the better of him. He painted a picture of quiet tension with rapid crescendo: the unsuspecting switch from calm, internal peace, to white-hot fireworks in the brain, urgent need

for release on someone or something, and finally, a climax of searing, irrepressible rage.

“It feels like my head is going to explode,” Michael continued, “It takes over. I get angry, and I can’t make it stop. Maybe I’ll break something or take it out on the person closest to me. I caused my family a lot of pain. And I’m trying to heal from that.”

“It sounds like you feel remorseful of this past pattern of behavior,” the psychiatrist responded.

Michael nodded. He struggled to grapple with the cause and effect of his brain’s inner workings, at the mercy of a process whose daily mysteries eluded him.

“I was wondering: if I were to get an MRI or some kind of scan, would they be able to see where the schizophrenia is located?” he asked.

“Not exactly,” the psychiatrist replied. “Schizophrenia is a complicated group of symptoms, and it’s not necessarily located in a particular region of your brain. We have theories about this, but they’re not diagnostic.”

“I see. So, there aren’t any tests I can do to see where the damage is?” Michael persisted.

“I’m hearing an interest in more precisely understanding your diagnosis. But I want to focus instead on what you shared earlier. Is it fair to say you feel ashamed not only of your past actions, but more broadly, of your illness? That you feel defined by it?”

Michael nodded again.

“Who else among the group has felt ashamed of their diagnosis, even ostracized at times?” the psychiatrist continued.

Everyone raised their hands, almost in unison. As we went around the room, patients volunteered personal parallels and tools for coping. The session ended in handshakes, embraces, and even a few tears. I was in awe.

The psychiatrist could not provide definitive answers to Michael's questions, but he could refuse to rest on the reductions and assumptions associated with this exceptionally complex mental illness. He could resist the urge to write off

Michael’s anecdote as a disorganized contribution, rather than a legitimate starting point. There was no need to dance around the challenges and stigmas of schizophrenia, either. He was assertive, nuanced, and unflinchingly sincere.

Michael sought some sort of external, objective clarity, but the psychiatrist, realizing the limited therapeutic purpose of clinical terminology, rerouted the conversation. By framing Michael’s experience as shared rather than isolating, he created space for compassion, interpersonal connection, and patience with the self, instead of frustration.

Before that otherwise mild, uneventful Tuesday, I considered myself a good listener. But in that moment of feeling truly stumped in front of a patient, in watching the psychiatrist nakedly take the plunge and navigate fearlessly, I realized genuine therapy rests on courage. We all could use a bit more of that.

o v e r t i m e

BY HARIKA KOTTAKOTA

my skull was stuffed
with marbles
rolling in honey,
thumping off-beat
behind my temples,
& thudding against
tympanic bone,
in mock earnest

& in the grim company
of office spiders,
I hunched upon
the cold leather,
spine arched
in perfect lassitude

& inside my sturdy fortress
of manila folders
coated in sheets
of fine dust,
my wrists were
loose iron bolts
barely glued together
with gum

& my fingers stumbled
over the black
plastic keys
like intoxicated dancers
trying to pray

the deepest lavender
light kisses the
silver skyline,
staving off Night
if only
for a moment

everything I need to know to be a good doctor, I learned from my mother

the emergence of a softer face of medicine

BY OVINI RODRIGO, M.D.

*FIRST-PLACE WINNER OF THE 2020 SUSAN
LOVE RESIDENCY WRITING COMPETITION*

My mother is not a physician. She spent a significant portion of her adult life as a homemaker and now runs a successful business. However, long before I graduated medical school and added those two sacred letters to the end of my name, my mother taught me some of the most valuable skills in becoming a competent and compassionate doctor.

Lesson #1: Being organized is the first step to success. As a child, my toys were tidily stored in brightly-colored bins long before everyone got organized with The Home Edit. Even in elementary school, my folders and notebooks were color-coded by subject, and all

my homework assignments were neatly recorded in my planner. These meticulous habits that my mother instilled in me from a young age translated to the detailed information-gathering in taking a patient's history and identifying pertinent positive and negative findings on a physical exam.

Lesson #2: Always ask why. My parents always encouraged me to question everything and refuse to accept statements as fact until I had gathered supporting evidence. In medicine, we should always question why a patient is presenting with a particular constellation of symptoms and continue to ask why until we reach a satisfactory

explanation rather than attempting to fit a patient into a neat diagnostic box when there is conflicting evidence.

Lesson #3: Lending a sympathetic ear is a powerful gift.

My mother is one of the most calming and encouraging people I know. She will spend hours listening to friends as they unburden the trials and tribulations of their lives and offering quiet words of comfort. As a resident, I am often the face of the medical team to a patient, which may translate into becoming the punching bag when patients and their families are upset. Though I might not have the power to fix systemic problems in the healthcare system or the knowledge to answer some of their questions, I have often found that giving my patients the time and space to express their frustrations and communicating my understanding of the difficulty of their situation can be one of the most therapeutic interventions I can offer.

Lesson #4: Practice compassion universally. One of the central themes of my childhood was that practicing compassion and kindness in every interaction is key to having a positive impact on society. It is easy to be kind to those who look

like us or belong to the same communities. If we practice compassion in every patient encounter, we can build the foundation for a stronger therapeutic alliance with each of our patients.

Lesson #5: Love yourself before you love anyone else. My mother would say this every night as she tucked me into bed. I didn't fully understand what she meant by this when I was a child, but I gained a new appreciation for this sentiment as I got older. My mother meant that you have to take care of yourself before you can be of service to anyone else. It's the same principle as putting on your own oxygen mask on an airplane before assisting others. As physicians, we have to remember to take time to care for ourselves so that we can be at our best to help our patients.

These lessons have served me well through medical school and into residency, providing a solid foundation from which I could strive to become the ideal physician. These non-clinical skills have become invaluable, given the person-centered evolution that has slowly transformed the field of medicine. A substantial fund of knowledge and sharp clinical acumen will always be

highly prized traits in the medical field. Yet, as we move further and further away from the image of a doctor as a paternalistic upper middle class white male in a starched white coat to a more diverse and inclusive healthcare workforce with physicians — of every gender, race, socioeconomic background, sexual orientation, religion, political affiliation, and so many other defining features — clad in embroidered Patagonia fleeces, I am happy to observe a deeper shift occurring. Pure intellect and clinical brilliance are no longer the only characteristics we expect from a doctor. Physicians should have an approachable, pleasant bedside manner. Medical students are now taught to see their patients as human beings with full, rich lives aside from the medical conditions that forced them to seek a doctor's care rather than a faceless pathophysiologic mystery. Across all specialties, physicians have begun evaluating for biopsychosocial causes of illness in addition to physiologic etiologies, and social workers have become a more central component of the healthcare team. In recent years, we have started to talk more openly about imposter syndrome, work-life balance, and physician burnout. These concepts did not even exist fifty years ago.

I believe that this evolution can be attributed largely to the increasing presence of women in medicine. In my own medical school, we were acutely aware of the fact that the senior faculty were generally white males and the younger faculty tended to be women from a variety of cultural and ethnic backgrounds. There was a stark dichotomy in their approaches to being a doctor and their visions for the medical field. Fifteen years ago when Grey's Anatomy first premiered, the title character was a stoic, reserved white female entering the male-dominated, cutthroat field of surgery; she embodied many of the stereotypic male personality traits. Over the years, as the show continued to evolve, Meredith Grey and the other characters began to soften and embrace fundamental changes in the practice of medicine. The show reflects the emergence of a softer face of medicine — led by women doctors — with an emphasis on the holistic well-being of both patients and physicians, which can only have positive reverberations to our society as a whole.

building each other up *one woman at a time*

BY SELENA PARK, M.D.

*SECOND- PLACE IN THE 2020 SUSAN LOVE
RESIDENCY WRITING COMPETITION*

On a sunny spring April morning, I walked up to my mailbox to see if I had received any college acceptance letters. I anxiously shuffled through the envelopes and found a letter addressed to me from a combined BS/MD program that I had applied to a few months prior. I can vividly remember walking inside and seeing my grandma on the kitchen floor folding in dumpling fillings. She glanced up as I opened the letter — I had been accepted.

“What does that mean?” she asked.

I explained that it was a seven - year program where I was accepted into three years of college and four years of medical school at the same time. I jumped in excitement. I was finally on the road to becoming a doctor which was all I had ever dreamed of since I was a little girl.

My grandma responded, “Women do not become doctors.” And that was the end of the conversation.

Since then, I have thought about that conversation with my grandma, or lack of conversation really, for many years. No — it didn’t seep into my mind and leave a permanent tattoo that unforgivingly reminded me daily of that moment. However, once in a while, whenever I felt like it was tough being a woman in medicine, I did have flashbacks to that exchange. When I was at my medical school orientation and my school proudly announced that exactly 50 percent of this year’s class was made up of female medical students, I thought about how my grandma would react. Would she say, “That’s too many?” What I thought at that moment was, “Why not more?” When I was in the operating room as a third-year

medical student with an older male surgeon who boasted that he trained during the toughest times when women were not allowed in the operating room, I felt like an outsider. Why did my being a woman have to be a topic of conversation at that very moment? I have grown much since then. I have found my calling in the field of Obstetrics and Gynecology, a field that I was attracted to because it was dedicated solely to women's reproductive health. Now, I am a second-year resident finding my voice as a female physician. I have the privilege of working with other female physicians who are strong, independent, passionate, and proud. I have met many admirable women who I have seen come together to learn how to carefully navigate these hard times through an unprecedented pandemic. Although we as women have jumped leaps and bounds in medicine, there is still a long road ahead. We must continue to fight for our voice, our equality, and our place at the table. We have to further our presence in the field of medicine which can only be done together.

Over time, I have come to understand what my grandma had meant by her comment. She had only

graduated elementary school, not because that was what she had wanted, but because she was never given the opportunity to dream bigger than that. She was placed into a mold during a time and place where women were encouraged to not get an education but instead become housewives. But we are not in that world anymore, and I too, can now stand proudly in the operating room. My hope is that day by day, we can each do a small part in furthering equality and opportunities for women in medicine by building each other up, one woman at a time.

the *unwritten* rules of women in medicine

BY ALYSSA BROWN

*FIRST-PLACE WINNER OF THE 2020 LINDA
BRODSKY MD ESSAY AWARD*

“You could try being less of a bitch.” We were in the student workroom at the rural hospital – taking a brief refuge from the hectic morning. It was fall of my third year of medical school. The room wasn’t much, a converted supply closet with a couch and computer. The room was our hiding place to bemoan the rotation. There were just six of us on the rural surgery rotation and only one male student, Austin. I had been paired with Austin, and we rotated with the various surgeons. I never expected him today anything like this to me. He was just so nice, but I should start from the beginning.

That morning, the attending assailed me for not remembering the replacement rate of potassium for a patient. I was used to the

surgeon expecting a lot from me, but that day, it stung to get reprimanded so early. I had been in the hospital until 2 am for an emergency case, and I had returned to the hospital at 5 am for pre-rounding. I had barely slept. I wanted so badly to impress the surgeon because I aspired to be a surgeon. Austin and I worked well together. We were seamless on the team; we knew our roles and performed them. During the morning, he had not gotten berated by the attending for his mistake. He, in fact, forgot to check on one of the ICU patients. Austin’s mistakes and missteps had been accruing for the entire rotation. It seemed as though, the surgeon didn’t mind when Austin faltered, but I was always harangued for seemingly less egregious offenses. I took it in

stride, but that day, I decided to ask Austin if he had noticed this difference. All the students were sitting on the couches eating lunch. I asked him, “Do you think the surgeon treats you differently?” I clarified slightly that I did not think he should have gotten yelled at that morning, but it seemed like I got reamed over minor errors, while he was free to make them. He responded that he hadn’t noticed. I wasn’t shocked that he hadn’t, even though I hoped he would have. The next thing he said though stopped me, “You could try being less of a bitch.”

I am rarely silent, but how do I even respond to that? The room fell silent. I felt my face flush, and I fixed my eyes on the floor to prevent the tear forming in the corner of my eye from being seen. It felt like a punch to the gut and the air knocked out of my lungs. No one came to my defense or said anything. It instantly made me feel like I was no longer welcome. He tried to explain it by saying I can be competitive, bossy, and over-protective of my patients. I was running a list of our interactions. Was I a bitch? I always pulled his gown and gloves, I kept him updated on patients, I kept us on track and on time, I covered for his mistakes, and I even offered to

split my granola bar from my locker when we missed lunch. This isn’t to say I was flawless. I can be stern when my concentration is broken. Our personalities were opposite— he was often lost in thought, while I was more intense. I was focused on doing my best for the team and patient. “You could try being less of a bitch.”

This rang in my ears and echoed in my heart. I spiraled; does everyone else see me this way? It was a heady mix of sleep deprivation, anxiety, and malignant thoughts. I felt alone. I felt betrayed that no one stood up for me, and I felt embarrassed.

When the day was finally over, I got in my car and just drove. I had texted a friend, so she expected my call. I fondly referred to her as the brain in our friendship, while she called me the heart. I wear my heart on my sleeve, but she can translate my emotions into words when I fail to. She was on her surgical rotation too. She picked up on the third ring. Her response surprised me, “Alyssa, you are a bitch. It’s a good thing. You know what they call a man who’s a bitch? A go-getter. The frame is different for women. It’s seen as a negative, while in men it’s a positive.” I had never thought of it that way. It never crossed my mind that I would

be judged by a different standard for being a woman in medicine. It was like I was finally let in on a big secret. As we talked, I realized there was an extra standard for women in medicine. You had to be: kind, sweet, soft, quiet, not too quiet, know everything but not act as such, look perfect, but nothing too tight or too low cut, be very friendly, don't be too eager to volunteer over a man, put your makeup on in the morning, never come in with wet hair, don't ever complain, don't be sensitive, never be too confident, and this could continue indefinitely. It's a hefty list all due to gender. It is more than I can ever be. I thought I just had to be empathetic, work hard, and be dedicated to the patients. I thought I could be myself.

“You could try being less of a bitch.” After reflecting, I promised myself that moving forward I wasn't going to be less of a “bitch” to make someone else feel more comfortable. I want and demand the same respect. I should not be treated differently because I am a woman in medicine, despite the unfortunate reality. Together, we have to start dismantling the thought that there are an extra set of rules for women in medicine. These unwritten rules aren't making us better doctors. If I get called a bitch for working hard

and caring about the patients, so be it. If that's the case, I'll be a bitch.

