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A GALLERY OF WRITING

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a bustling *other*

BY JOANA ANDOH

Bustling in the ED
I wore my glasses today
As a kind of glossy shield
Too tall in my clogs
Too green in my scrubs
With a high ponytail, excessively long
Tinges of black and maroon
Full of twists I did myself
Myself, I try to make small
Bustling in my short white coat
Noticeably a med student
Noticeably a woman
Noticeably black
Black, the color of a man I pass
Wearing a suit
Hospital ID dangling from his lapel
With a wave he stops me
Compliments my hair
And says
“It’s good to see people like you in these spaces.”
An exhale
A nod
And a smile I don’t try to hide

the *power* of a label

BY ODEYA KAGAN

We are taught to be objective. 24-year-old female presents with intermittent sharp suprapubic pain (10/10 on the pain scale) around the time of menstruation. We report a history, conduct a thorough physical exam, and discuss a differential. Endometriosis, Adenomyosis, Ovarian cyst, and the list goes on. How would your thoughts change if instead a chart read: “24-year-old female with past medical history of bipolar disorder presents with intermittent sharp suprapubic pain (10/10 on the pain scale) around the time of menstruation.”

In medical school we are taught to be complete, stating pertinent positives and information we believe to be essential to one’s medical care. We spend time with our patients getting to know their unique life stories as we build rapport and may even feel a sense of pride as we exit the room knowing that a patient felt heard

and not reduced to mere symptoms or diagnoses. We may have the best of intentions, it’s why we chose a path in medicine, but when it comes time to type out the first sentence of that HPI, we go back to that initial template, the basics, adding that seemingly objective diagnosis, except when it comes to mental illness.

Years of stigma, fear and bias absorbed into our subconscious without our permission or awareness, has tainted our ability to truly be objective. As much as we hope or say otherwise, bipolar disorder, unlike purely physical ailments such as cancer, comes with ingrained assumptions, prejudice, stigma, and even shame. It’s inherent in our own vernacular. She IS bipolar, he HAS cancer. And while we in our personal interactions may do our best to break the cycle, we must be equally aware of the words and intentions we choose in our documentation.

What is the next physician going to glean as they quickly skim my notes before even meeting my patient? Are we unintentionally misleading them? Giving emphasis to just one part of a patient's story that may color the rest of their care. And what about the patient, with a newfound access to their medical records, who internalizes the negative stereotypes of their illness in the form of self-stigma?

There's no perfect answer and no one is to blame, but we must do better. Because this time our 24-year-old college educated, white patient may evade the consequences the label of mental illness may have on her medical care. But can the same be said for the young black male who walks into your ER in the midst of a sickle cell crisis? Or the homeless female with schizophrenia presenting with signs of diabetic ketoacidosis?

We have a responsibility to document a full history, and by no means am I saying to omit such diagnoses. All I ask is that you take a second to think of the power you hold as you type that first sentence. The sentence that will guide that patient's future care. Will this responsibly inform the physician in this patient's future care? Or will my

words set off a cascade of assumptions, redirections, and even mistrust by those who treat them next?

carrot cake and covid

BY MOLLY UHLENHAKE, D.O.

I quickly scanned my Inbox messages in between seeing patients on a busy clinic morning. One message stopped me, a death for one of my long-term patients.

I last saw Roscoe in the clinic just six weeks ago. Over the fall, he had three back-to-back admissions, first for fatigue, next for confusion. The final hospital admission was two weeks ago and that was when the metastatic pancreatic cancer was discovered. I spoke with his daughter before his last discharge and we discussed plans to go home with hospice. The oncologist had given him one week to live. I struggled to find the right words. I was so sad to hear of his rapid decline.

I felt it when he passed. I was out on an evening walk with my family when I suddenly I thought of Roscoe and my mind shuffled through memories of when I first met him, years ago.

Roscoe came to clinic religiously; every three months, always accompanied by his wife, Lucinda, and his oldest daughter. He never missed an appointment. Roscoe was a tall man who looked like a giant in comparison to petite Lucinda. He always wore blue overalls and a crisp baseball cap. He sat patiently and quietly on the exam table for most of the appointment while Lucinda talked.

Roscoe and Lucinda were married for seventy years. Lucinda was an exceptional cook. She took his glucose intolerance very seriously and spent years monitoring his blood sugar, even when I said it was not necessary. I spent one visit reassuring them that it was okay for him to have dessert a few times a week. Every visit, Lucinda provided a detailed handwritten log of his blood pressures and blood sugar. Her penmanship was perfect. She also organized his refill requests,

managing his health like a professional.

His daughter called him a “hushed” man, saying he only spoke when necessary. I intentionally reserved the end of each visit to hear from Roscoe himself. Most days, the conversation steered away from medical issues and towards life events: his childhood on the farm, his latest house project, his newest grandchild.

At our first visit many years ago, he proclaimed, “The only problem I have is that my hip hurts sometimes.” He was strong and made aging look easy. He coasted into his eighties, active as can be. Roscoe was a retired carpenter and even in his eighties, he was still working. Each visit, he described his latest project: fixing a niece’s deck, painting a neighbor’s house, mowing a friend’s lawn. Once, he fell off a ladder. After that, his wife and daughter restricted his jobs. When we first met, he reported a regular evening drink: “Bourbon whiskey straight 100 proof.” The drink seemed to match him perfectly—pure, not watered down. Later, he backed off the whiskey and his only vice became nightly dessert—his favorite carrot cake.

I loved that his name was unique: Roscoe. I had never met a Roscoe. He grew up in the rural Midwest on a farm. He talked about his parents, his siblings, and the origin of his name. He discussed his childhood and growing up as a Black man in the heart of this country. He started drinking coffee when he was twelve years old. He told stories of hopping on trains and riding horses. It was fascinating.

I brought up Advanced Directives multiple times over the years. He never completed any of the forms. Both Roscoe and Lucinda always said, “It is in God’s hands. Our kids know what to do.” When the time came, everything fell in line smoothly, just as they reassured me it would. There was no hesitancy. There was no bickering. There was no indecision. There was acceptance and love. It was simple and straightforward: he would go home to die, and his family would care for him.

I vividly recall our last clinic session. Lucinda casually mentioned Roscoe seemed tired and described an odd incident when he suddenly became confused. She found him putting on his pants incorrectly, which was unusual for him. We were not yet alarmed. Instead, the whole

family considered that he might be depressed.

In fact, his daughter thought both parents were down because of the pandemic—they were shut in and isolated. Lucinda was no longer grocery shopping and Roscoe stopped going to Home Depot. We spent the majority of that visit mapping out a plan to get them both back to their favorite places. His grandson would pick him up early on a weekday morning and take him to Home Depot upon opening.

“If it is too busy or feels unsafe, you just go home,” I instructed. He would wear a mask and gloves and take hand sanitizer. This appeased him, but I sensed he had other concerns. When I inquired, he revealed his ongoing frustration with diet restrictions. Roscoe asked for more salt and regular dessert. I gently reminded the family that he could have a slice of carrot cake after supper. We all smiled as they left.

As a primary care physician, I sign up to doctor patients through life. I am prepared to face death with them. It is never easy. Every loss causes me to reflect and remember. This particular goodbye was drastically different due to the pandemic.

Out of town family members struggled with decisions on whether or not to travel with the rapidly rising numbers of cases and I was unsure on how to advise them.

There were strict visiting rules that separated families during critical illness. Pre-pandemic, if a patient of mine was in the hospital, I visited them regularly.

I pondered if it was reasonable to show up on the wards and expose others or potentially expose myself. I did not want to use the scarce resource of PPE. I would not be able to sit at the bedside and hold his hand. I could not give Lucinda a hug. I thought about going anyway, and just standing at the door, but then hastily decided against arriving in person. I called using the hospital operator, but the phone rang and rang.

A funeral was not safe or possible. I grieved for the family, navigating the loss of their patriarch in the midst of a pandemic. I never got to say goodbye to my patient, my friend. Instead, I dropped off a carrot cake on his front porch, my face covered by a mask. Lucinda and her daughter stood on the porch as I waved from afar, doing my best to say a loving farewell.

an *observational* interview

BY CHELSEA KARSON, M.D.

As a medical student, I rotated at a state mental hospital. The hospital was enormous, sprawling, and old. It once housed thousands of patients suffering from any condition, ranging from psychosis to developmental disorders to criminal insanity. Now, it was underfunded and crumbling. The hospital's units and programming were currently limited to treating mainly those who were deemed "destitute" and "dangerous" by the state. While at the hospital, I worked with Dr. S, a fearless psychiatrist who was determined to teach the principles of psychiatry to any medical student with whom she crossed paths.

Dr. S was fond of saying "Pay attention! Recognize the signs. Lazy doctors expect patients to speak and diagnosis themselves. 'I am depressed. I hear voices.' Pay attention! You should be able to diagnose a patient from the doorway!"

Before beginning an exam, she would tell students to observe the patients in the day room and study their behavior. The snarkiest among us questioned whether this method proved the paranoid patients right—that we were watching them for secret motives. I laughed at the joke, but thought Dr. S had a point. When I looked out across the room, it became clear: Dr. S wanted us to see the physical signs of mental illness.

Half-collapsed on the couches were the physical manifestations of depression—hunched, tearful, scarred, and despairing. The patients were trapped in their thoughts, ignoring one another, and focused entirely on their private battles.

I narrowed my focus to one patient: a skeletal woman whose hospital-issued gown had slowly slid down her emaciated shoulder

as she curled into herself, crying quietly into a handful of tissues. The hands holding the tissues were attached to thin wrists crisscrossed with scars—some were red and fresh while others faded souvenirs of failed attempts to escape an unhappy life or possibly self-inflicted. They were the result of a physical pain to distract from an emotional pain.

This patient bore other, less obvious signs of depression. The flimsy, extra small hospital gown she wore could have easily fit three women her size. Her face was skull-like, skin stretched tight over bone, and I could count the vertebrae of her neck.

Later, I would be shocked to learn that she was nineteen. Depression took her will, took her appetite for food and life. The hollow eyes were purple and fatigued. During her interview she would tell me “I can't ever sleep, even though I'm always tired. I just can't...” The physical manifestations of depression had aged and eaten away at her, leaving nothing but bones and battle scars.

Back in the day room, a young man with wild, multi-colored hair

was striding back-and-forth, speaking loudly to an exasperated nurse. At first glance, mania seemed beautiful. The young man appeared so vividly alive, waving his arms animatedly, in constant movement. A closer look revealed that the young man was not so much vivid or animated, but frantic and desperate.

His moods were too large to be contained. He spoke at an impossible rate and moved at an exhausting pace. His clothing was bright and loud, but dirty and threadbare, as if it too lacked the energy to keep up with its wearer. The patient's bright hair was messy, a partially completed dye job featuring chunks of his natural color blended with purple and red and blue. The patient's eyes, though bright and intense, were unfocused and red-rimmed, as if he had not slept for days. His face and arms were speckled with bruises, not self-harm scars per se, but evidence of likely out-of-character risky behavior and unfinished projects, hallmarks of bipolar disorder.

One did not need to speak with the patient to suspect he had bipolar disorder and was currently manic, it was possible to suspect the diagnosis from the doorway. I later learned

that the patient was a college student pursuing a degree in physics. He had begun staying up later and later into the night to study and then stopped sleeping at all and poured his endless energy into his solutions for world hunger and pollution before being arrested for breaking into a convenience store. He needed supplies for a new project.

I eventually decided after peering around the day room that psychosis was an easily identifiable shapeshifter. Psychosis varied in appearance but was consistently disorganized.

In one corner of the room, a young woman with ragged, tangled hair, pulled at her hospital gown, twisting it between her fingers as she quietly argued with an invisible opponent. Her lips were cracked and bleeding; she occasionally relinquished her tight grip on her gown to pick at them, with nervous fingers.

As she argued, she paced the room, slowly and deliberately, wearing a slipper on one foot and a sock on the other. It was impossible to see her eyes through her hair as she walked with her neck and back

bent, like standing upright took too much effort.

Various tattoos of elaborate symbols and words in foreign languages covered one of her arms. The other arm was less decorated, sporting only a small black rose. During this patient's interview, we learned that her tattoos protected her from demons and that she herself was an angel. All "rose people" were angels.

Another patient, a middle-aged man, sat with his ear pressed against the TV, occasionally scribbling notes onto a piece of paper in his lap. He smiled and waved at our group, then quickly returned to his work. At first glance, he did not fit in with the other patients. His behavior was only slightly bizarre. The psychosis revealed itself when we walked over to him and saw his notes were a mess of symbols and numbers.

During his interview, we learned he had been brought to the hospital after police found him squatting in an abandoned hotel, using a radio and magazines to decipher messages sent to him by secret government agencies. His work was

futile. He sought to crack a nonexistent code.

Dr. S's lessons in observation have served me well, from the remainder of the rotation and now, as I complete my first year of psychiatry residency training. Psychiatrists are considered to be the master interviewers of the medical world, but when we listen to our patients, we need to "pay attention" and "recognize the signs" to genuinely appreciate how mental illness has impacted their lives. Psychiatric illness may live in the brain, but it impacts the whole person.

But the world has changed since I was first introduced to Dr. S's lessons and the physical signs have become more difficult to observe. COVID-19 has challenged physicians, including psychiatrists, in endless ways, particularly in how they approach the patient interview.

How is a psychiatrist to "recognize the signs" in a world in which social distancing and virtual visits are necessary to protect patients and healthcare providers from the COVID-19 virus? What expression hides behind the

patient's mask? Does she have battle scars on her arms which are outside the view of the laptop's webcam?

Even master interviewers struggle to adjust to the "new normal" of the healthcare world: masks and virtual visits. Without meeting a patient in-person, how is one to see their nervous twitch, the Bible they carry to ward off demons, or their feet encased in winter boots in July?

These details are vital clues to diagnosis a patient and understand the severity of their illness. Dr. S's goal for each student was for them to be able to diagnosis a patient from the doorway. Now psychiatrists face a new challenge: how to "recognize the signs" of psychiatric illness from a computer screen and behind a mask.

