



An Exploration of Art & Literature

Volume XXIII, 2018 | UCSD School of Medicine

# THE HUMAN CONDITION

# LETTER FROM THE EDITOR

Medical students are rarely just medical students. Some are architects and prima ballerinas and philosophers. Others serve as mothers and Marines. They write code, space operas, and screenplays. Even in a room full of indistinguishable short white coats, these vibrant identities shine through.

The Human Condition is our way of honoring a small subset of these passions, by recognizing the incredible artistic and creative talent of our student body. I have been overwhelmed by the caliber of these submissions, and by the compassion, honesty and strength of their authors.

But all this talent would be for naught without a team of hardworking and diligent individuals to turn it into a publication. Fortunately, the twenty-third edition of The Human Condition was blessed with just such a team. I am astounded by what this dedicated group of young editors could produce while battling Step 1, anatomy tag exams, and the infamous Nephrology Block.

It has been an absolute privilege to read your submissions and an honor to lead this team. I hope you are as proud as we are.

Thanks,



Luke Burns  
Editor-in-Chief



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**FRONT COVER** Baby Be Free — Paige Michael  
**BACK COVER** The Planet Moon — Michael Paap

## 2018 HONORS & RECOGNITIONS:

This year we introduced awards for outstanding submissions to our magazine in the categories of photography, art, prose and poetry. The *Joyce Cutler-Shaw Artwork Award* honors our institution's distinguished artist-in-residence. We invite editors of future editions of *The Human Condition* to select other members of our medical community as namesakes for each of the other categories.

*2018 Joyce Cutler-Shaw Award for Outstanding Art Submission*  
*2018 Award for Outstanding Photography Submission*  
*2018 Award for Outstanding Prose Submission*  
*2018 Award for Outstanding Poetry Submission*

“Compassion” by Angele Labastide, MS4  
“Love” by Abdul S. Hassan, MS4  
“Living the Dream” by Samuel Paul, MS4  
“Alaska” by Simone Phillips, MS1



# ALASKA CATHARSIS

Simone Phillips, MS1 Nicole Basler, MS1

Open mouthed ice  
leans in on the ocean  
and sloughs its magnificence  
into midnight dusk.  
we are suspended on the dark ink  
of road between the two—the only  
demarcation left now  
between glacier and silvering water.  
we drove all night, you mostly,  
talking to the road  
finding comfort in sparse  
signs, the few that found us.  
we arrived late,  
too late to hear from them directly.  
at the beach we saw the remains,  
urchins all dried up,  
otters gone. even the canneries  
had been sold and consolidated.  
from the cabin we watched  
willows and brush grow up  
and we were grateful for that.

She caresses  
the ivory strokes.  
Metronome ticking  
with the beat of her heart.

*Deep breath.*

Melodic notes drift  
into a cascade of memories.

*Crescendo.*

Rage pulsates  
into her fingertips.  
Face flushing  
with anger.

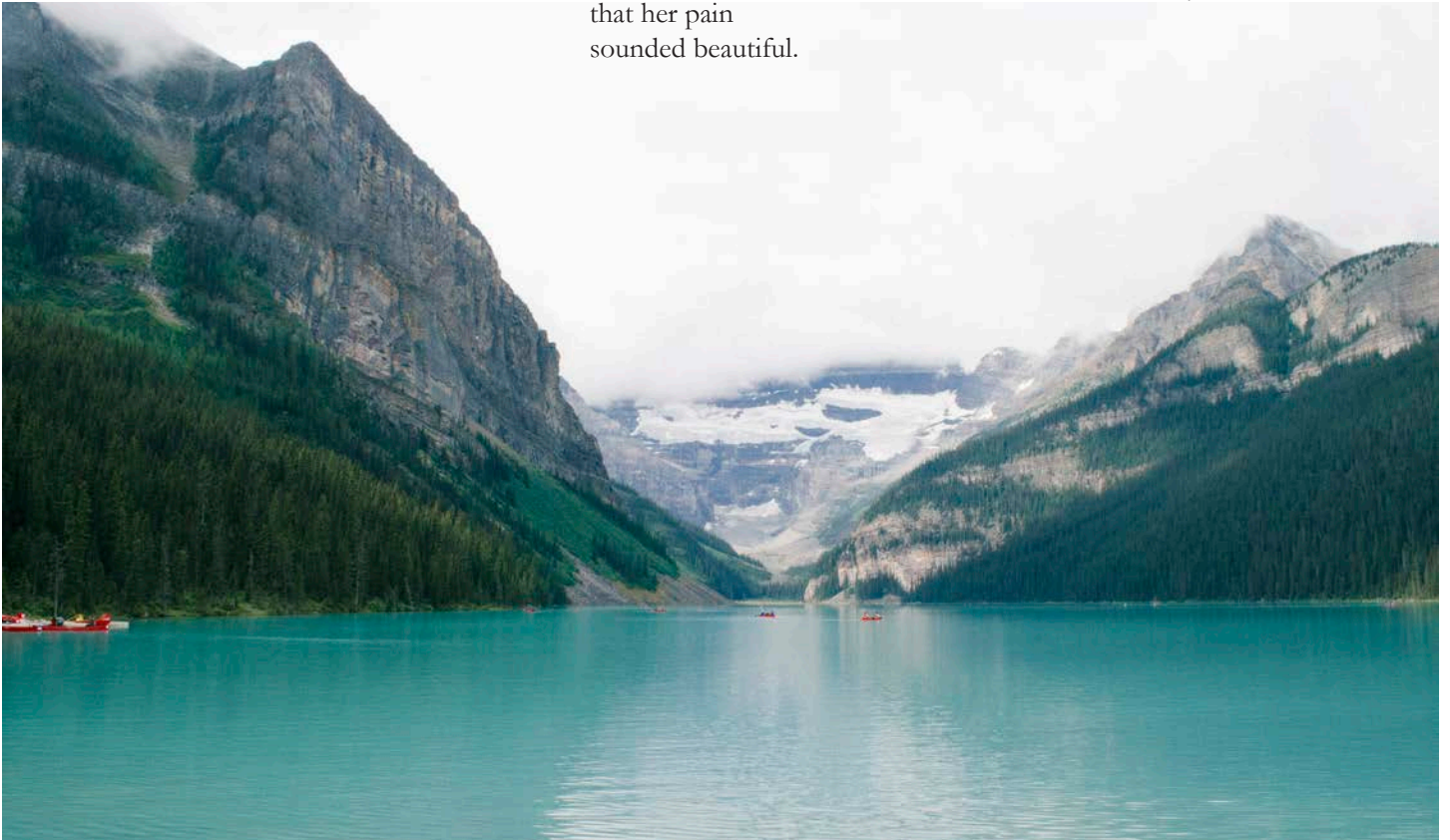
*Dolcissimo.*

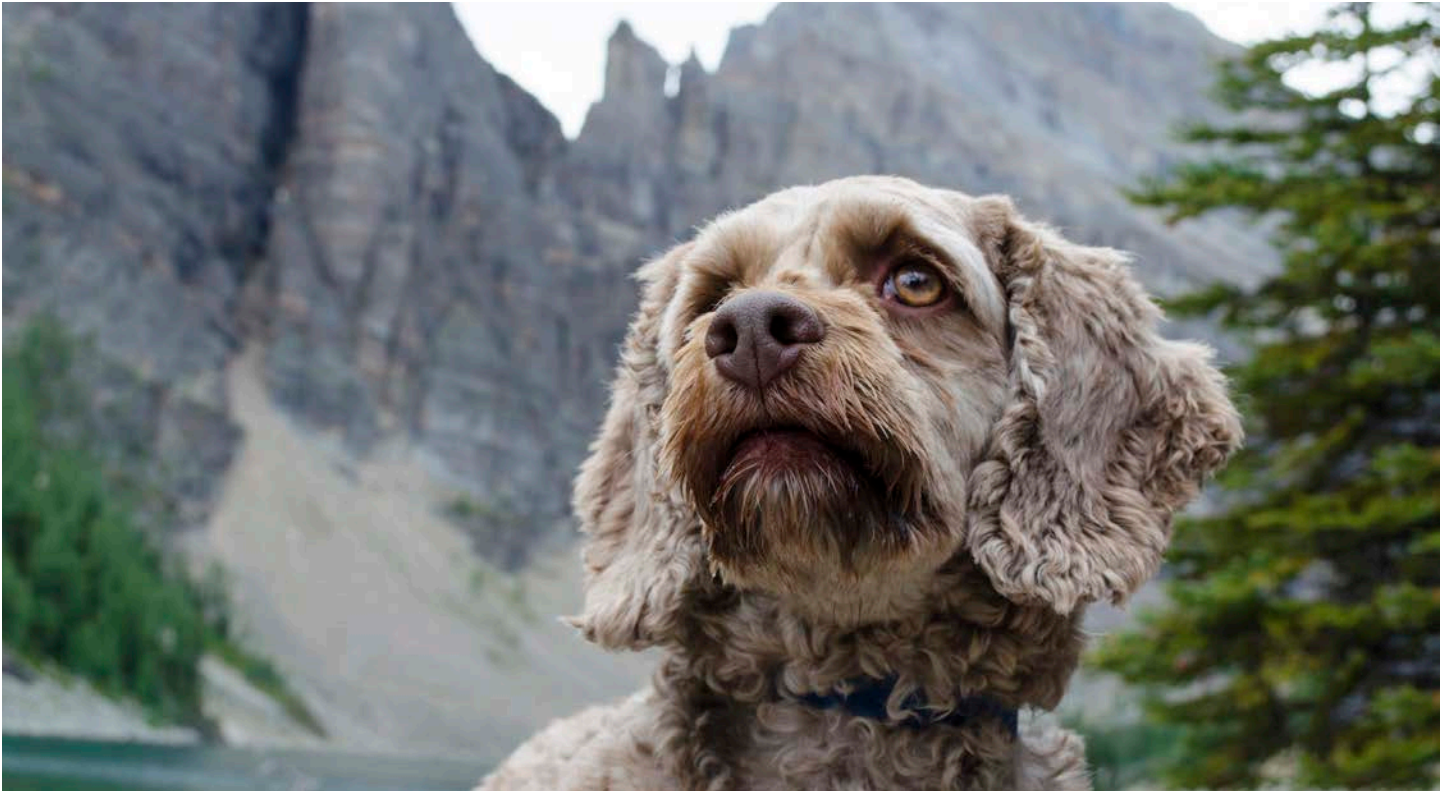
Keys glisten with tears,  
as ache and sorrow  
blend into harmony.

*Deep breath.*

She marveled  
that her pain  
sounded beautiful.

**UNTITLED** | Saatchi Patel, MS2





UNTITLED | Saatchi Patel, MS2

# GOLDEN WEEKENDS

Michael Vu, MS4

At last, two days.

It's Friday, late afternoon

Grab that someone, pack up the trunk

Amidst medical rotations, you forget normalcy

Chasing down the never-ending yellow line,

Images in the rearview mirror diminish to a horizon

Used to overcoming long distance,

Snack on crisp sliced apples and sour patch kids

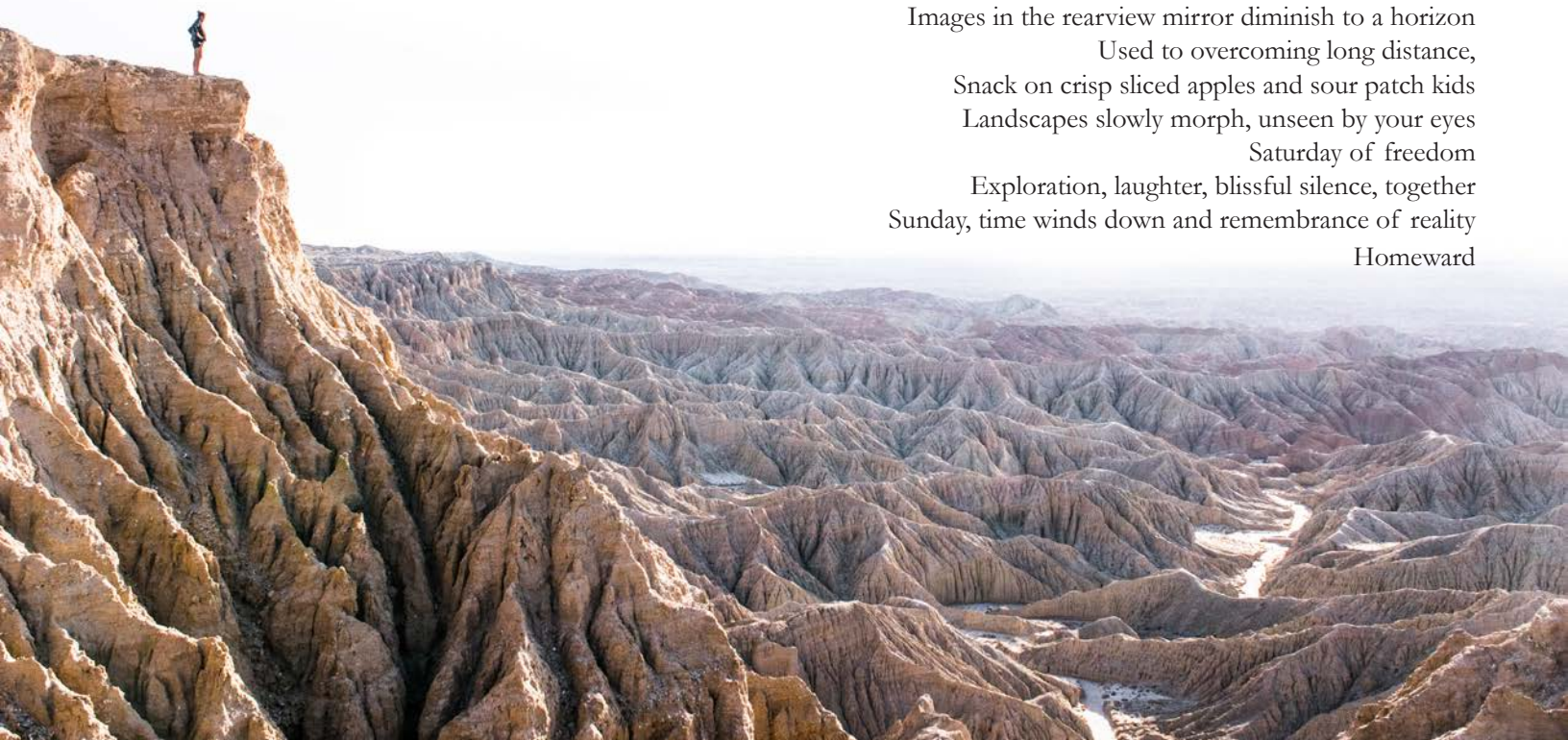
Landscapes slowly morph, unseen by your eyes

Saturday of freedom

Exploration, laughter, blissful silence, together

Sunday, time winds down and remembrance of reality

Homeward





# The HUMAN CONDITION JOURNAL of MEDICINE

## ORIGINAL ARTICLE

### A Case Report

Jordan Stone, MS4

**Background:** During medical school, many students conduct clinical research studies involving human subjects. These projects often emerge from powerful visions of a better way to deliver care, and each vision is itself an engine propelling the unemotional, tedious labor performed in its service. Done assiduously, the day-to-day work draws out a familiar pattern of symptoms. To spend prolonged periods turning medical records into workable data, for example, entails pain behind the eyes, a headache encircling the forehead, a bridge of ache across the wrists, progressively poorer posture, and, if one is not judicious, a Spotify “Discover Weekly” dominated by “research music” (this is perhaps the most enduring of the symptoms described). In this author’s experience, the young clinical researcher develops two identities. One is the objective, dispassionate repeater of tasks; the other, the passionate, emotional humanist glimpsing the forest beyond the trees. Much has been written about the latter. Less is recorded, however, on the emotional dimensions of day-to-day clinical research.

**Purpose:** To explore how it feels to be a young medical student conducting clinical research about very sick patients in challenging clinical and life circumstances.

**Methods:** Review the charts of 250 patients diagnosed with gynecologic cancers, that is, cancers of the uterus, ovaries, and other organs along the reproductive tract. Note that these patients’ tumors all underwent molecular profiling, where the tumor is analyzed for meaningful changes in the tumor DNA. These changes enable

the tumor to grow like a wild vine or to invade far-flung corners of the body. They are also targets for new drugs, and that is the true purpose of the molecular profile, to match new drugs to critical DNA changes.

Open the chart of a deceased patient—a pop-up message asks if you are sure you want to open the chart of this patient, as they are deceased. Notice the background color of this patient’s chart interface is a much lighter shade of gray than charts of the living. Document the patient’s birthday, feel a pit form when you type the year, “1987”. Take off your headphones, go to the bathroom, wash your hands, come back, put your headphones on, click hurriedly through her chart. Open a new patient. Piece together from years of clinic notes the number of distinct chemotherapeutics she’s received. Balk when you arrive at 12. Recount them—13, actually. Gloss over the side effects: “nausea refractory to several medications”, “profound fatigue”, “depressed about hair loss”. You do not have a column in your spreadsheet for these—no sense in reviewing them.

Marvel at your own efficiency—now, you can parse 10 paragraphs of a GYN Oncology clinic note to fill 5 spreadsheet cells in under 2 minutes. Initially read notes from Social Workers, Palliative Care, Hospice, then begin to filter them out when they prove hollow for the purposes of your work. As time wears on, notice yourself disconnecting from the patient’s narrative altogether as you process each chart down to bones and repackage it into neat spreadsheet rows.

Find the molecular profile report for each patient—some have undergone the

process several times, you learn. Note when the report was issued, where in the body the tumor sample came from. Copy down the alphabet soup of DNA changes identified, the list of suggested experimental drugs printed in a box along the bottom like lottery numbers. Read the appended pages of text about each drug; realize their contents are unimportant to the experiment and stop reading them altogether for subsequent patients.

**Results:** Sample Documentation from Patient Charts:

“...Though molecular profile suggests the patient may respond to this drug, the patient’s insurance denied coverage for the drug. Called insurance company last month per patient’s request and submitted formal appeal. Insurance company sent denial letter this week. Patient is devastated, is asking about costs of drug out of pocket. Patient given out-of-pocket estimate, requests information regarding additional financial aid. Patient to return to clinic next week to discuss options.”

“...Patient discontinued drug due to intolerable side effects.”

“...Discussed with patient absence of curative options at this juncture. After lengthy discussion, patient elects hospice.”

“...Patient reports she is hopeful, as she is a potential candidate for clinical trial”

“...Patient reports relief in hearing from clinical trial coordinator this week, continues to be hopeful about the trial’s potential. Return to clinic in one week.”

“...Patient without clinical or radiographic evidence of cancer following recent treatment with Drug A, no further treatment recommended

at this time, return to clinic in 1 month.”

“...Patient’s daughter says she would like to take her mother home from the hospital for her 70th birthday. Inquires whether mother can eat a small slice of favorite cake in context of recurrent bowel obstructions. Risks and benefits discussed.”

**Conclusion:** Research is meant to be an objective undertaking, strongest when the emotional biases of the researcher are tamped down to a minimum. This says nothing of the emotional experience young researchers may face in engaging with saddening, frustrating, or even traumatic subject matter. Predominantly, it is the heady process of developing a big research idea that draws on humanistic qualities like empathy or compassion for sustenance. But, the day-to-day mechanics of research should not be discounted in their potential to draw from young researchers a spring of emotional engagement with those subjects that make us most human. More research is required to depict the full scope of this experience.

**NORTHERN LIGHTS** | Stacy Ma, MS1



**CLASSROOM** | Sarah Bassiouni, MS1

# NIGHT VISION

Noelle Van Rysselberghe, MS4

A 58-year-old woman presents with a new tremor of her right hand.

She first noted the tremor 16 months ago while undergoing chemotherapy for breast cancer. It has since become progressively worse. She thinks it is due to muscle tightness, though she sometimes worries that she has brain cancer.

I know better.

On exam, this woman has a unilateral, low-frequency, resting tremor. The tremor ceases when she moves her finger to a target, such as my finger or her nose. When I repetitively flex and extend her right arm at the elbow, I initially think she is resisting me, but no. She has rigidity in her right upper extremity. Her difficulty with right-

sided, rapid finger tapping confirms exactly where the lesion is. Deep in the posterior and inferior part of her brain, just above the brainstem, a collection of cell bodies called the substantia nigra pars compacta are not making enough dopamine.

Looking inside patients' brains... medical school taught me lots of cool tricks like this. To my school's credit, they also taught me a lot about bedside manner, about breaking bad news, and about supporting our patients emotionally as well as physically.

Medical school did not teach me how to tell my mom that I thought she had Parkinson's.

"What's your diagnosis, Doctor?" she asked, playful but also curious.

Surely I must be wrong. My mom was just starting to get strong again after chemo, surgery and radiation. She seemed so well.

I was doing an away rotation on the other side of the country when my mom called me with her diagnosis. It was late at night and I was walking home from the hospital.


"Noelle," her voice quivered like mine used to when I was scared and alone. "They told me I have Parkinson's."

I had seen the storm but could not change its course.

"Did you hear me? They told me I have Parkinson's."

Medical school taught me how to comfort patients with challenging diagnoses. I learned words to use and steps to take to make people feel less alone. I learned how to empower people within the confines of a 15-minute office visit.





Medical school did not teach me how to support my mom with a diagnosis that fundamentally changed her expectations for the rest of her life. It did not teach me how to cope with the uncertainty of her prognosis, or how to answer when my siblings asked me, “What does this mean? How fast is this going to progress?”

Following a patient over the years is a bit like watching a motion picture. Even deeply intimate shots into a patient’s life belie their struggle between appointments. We see decline—or growth—in a series of steps. We have time to recover emotionally, while they are stuck in the plot.

As I watch my mom struggle to process her diagnosis, I find myself wanting to press fast-forward. Like a clinician, I want to say: “Here, see this counselor and go to this support group. Let’s meet again in two weeks and see how it’s going.” I want to get to the part where she

says, “I’ve accepted this. I feel grateful for what I have.”

Instead, I sit with my mom. “My life is over,” she says often. “I have no control.” I watch joy fade from her face as she fights private demons, determined to keep them locked out of sight. I watch my dad struggle to support her as she turns inward; her independence makes her want to bear the whole tragedy alone. Collectively, we mourn our visions for the future. So much is unknown. All we know is that things will get harder.

Being the only (future) doctor in my family, my loved ones often look to me for answers I do not have. I don’t know what our future looks like. I don’t know how we should fill our time. How could anyone?

My family’s trust in me, though heavy, is not misplaced. I can accompany my mom to her doctor’s appointments; translate medical jargon, and advocate on her behalf. When her doctor gives her an

article to read, we read it together, me annotating in the margins and highlighting the important parts for her to understand. When she is invited to join a Phase II clinical trial, I locate the Phase I results and the animal data to help her make an informed decision.

As my mom looks at me with relief and gratitude, I see the comfort that my medical training has been able to provide. Medical school never could have prepared me to navigate us through the challenging and unpredictable waters that come with this disease. But no person who finds themselves here will be a perfect captain. Still, I can be what my mom needs. I am a small light in a sea of darkness. And I am ready to sail with her.

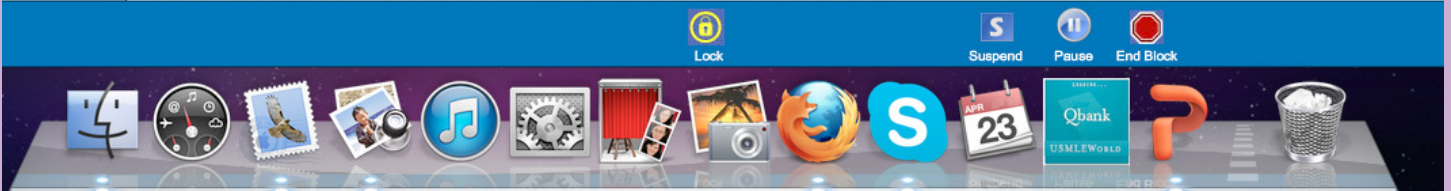


STEPHANIE USMLEOVICH

# ROSES ARE RED my allure holds you captive

The correct answer is D. 12% chose this. Based on this patient's history of a cat bite, *Pasteurella multocida* is a likely causative organism. It is associated with cellulitis around the bite site and can sometimes lead to osteomyelitis in children.

A is not correct. 5% chose this. Bell's palsy is associated with Lyme disease caused by *Borrelia*



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A WHOLE UWorld | Anonymous

## The GUT

Bojing Jia, MS1

half a billion nerves  
if I exchanged food for thought  
will I pass GI?



PYRAVID (2014) | Jimmy Bazzy, MS1

# (GASTRO) GENESIS 1:1

Andrew Park, MS2

In the beginning, there was nothing.  
<sup>2</sup> And He saw there was nothing, and said, “Let there be food.”  
<sup>3</sup> But the fridge remained empty. I mean, come on, He wasn’t a magician.  
<sup>4</sup> So He dragged himself out of His pajamas, drove to the supermarket, bought some things,  
<sup>5</sup> beer especially, and resolved to cook.  
<sup>6</sup> On the first day, He made toast

from leavened bread. And He picked off the burnt edges, spread the butter, and saw that it was good.  
<sup>7</sup> On the second day, He made cereal. Pouring the milk into the bowl of wheat-o’s, He took pride in His progress. This was His creation. Food blogs were overrated.  
<sup>8</sup> This was His.  
<sup>9</sup> On the third day, He experimented with bird fowl and creatures of the

air, including deli turkey, turkey bacon, smoked turkey, and chicken.  
<sup>10</sup> Mainly chicken. And He cracked the seed of chicken and fried it in a pan and put it on His toast. Then He cut up the breast of chicken and seasoned it with ketchup—<sup>11</sup> man’s red sauce—and ate it, and saw that it was good. So good, in fact, that He ate it every, single, day that week. <sup>12</sup> Starving? Who’s starving? Not He!

<sup>13</sup> On the fourth day, someone left sandwiches in the student lounge. He thought they were free. They looked free, anyway.  
<sup>14</sup> And on the fifth day, He made rice. And He opened up the rice cooker and let the steam rise up to His face. With a paddle he scooped up the grains, and saw that it was good. Was rice usually this crunchy? Who cares! Certainly not He! <sup>15</sup> And rice became the new toast.  
<sup>17</sup> On the sixth day, His ambitions got the better of Him. He bought vegetables and fruits, and chopped all kinds of colorful things with his knife. Tossing them in the pan, he added beef and pork and dashed in salt and pepper and stirred as it sizzled. Soon the air became thick with savory smells and He was proud of what was to come.  
<sup>18</sup> And then the smoke detector went off.  
<sup>19</sup> On the seventh day He ordered pizza. Good Lord, He needed a break.



# LIVING THE DREAM

Sam Paul, MS4

“Living the dream.” The refrain of all orthopedic surgery residents and attending physicians. I am never quite sure if the reply is genuine, or a sarcastic quip making light of the constant responsibilities, long days, and sleepless nights they face. Perhaps it is a bit of both.

I spent the first week of my first orthopedic surgery rotation like most rotating medical students: scrambling to find my bearings. I was figuring out the intricacies of a new hospital system, locating the operating rooms, ingratiating myself with OR staff, and all the while studying, studying, studying.

Studying, so that if a question arose about anatomy, approach, technique, complications, post-operative care, or the name of the artist currently singing the song on the radio in the OR, I could respond without dishonoring my family, shaming my institution, and losing my one shot at an interview. By the second week, I felt much more comfortable and capable. I even raised my standing with the OR staff up to a 0 out of 10.

The morning started like most. I met with my chief resident, “Chief”, to go over the plan for the day. I would be shadowing an attending I had yet to work with. He was a relatively recent hire who had completed residency training at that institution. I entered the operating room for the first case with ample time to prepare. I pulled my gown and gloves, helped the scrub tech position the patient, and assisted with sterile preparation of the extremity. The attending, “Attending” walked in as we finished. He was tall, athletically built, and in his early thirties. His eyes were a pale, piercing blue. Naturally, he was white. Everyone in the room was white. Everyone is always white. That was nothing new. During my four years of medical school, I have worked with a grand total of one black attending.

You may wonder about the increased stress that being a black medical student in a white-dominated field may bring (or the isolation, alienation, pressure to dispel preconceived notions, or fear that you are being viewed negatively), but in the words of the philosopher, Maz, in the space documentary, *The Force Awakens*, “That is a good question for another time.”

Attending carried himself with a calm confidence, and the bravado common in many orthopedic surgeons. His cocksure demeanor and assured tone made me confident that the day would run smoothly. He exchanged jokes with the OR staff and Chief. I introduced myself, and he seemed genuinely interested in learning about me. After some quick small talk, and a couple more quips, Attending and Chief scrubbed in and started the case. Despite not being able to scrub in, I was excited. I was getting the opportunity to work with a young, fun attending who acknowledged my existence.

I stood six feet away from the operating table, my direct view blocked by the two towering surgeons whose combined height could rescue a cat from any tree. I watched the details of the surgery on a small screen that followed the movements of the arthroscopic camera, all the while performing mental gymnastics to identify the correct anatomy. The case progressed smoothly. I even answered a few questions correctly. The atmosphere of the room was jovial and light. Jokes were cracked. Conversations flowed. Hip-hop music played in the background. My slow, careful movements prevented the circulator from having an aneurysm.

And then, Oh snap! My jam, Kanye West’s *Gold Digger*, started playing from the Pandora station. I bopped my head as the two surgeons rapped along to the song.

“I ain’t saying she a gold digger, but she ain’t messing with no broke...”

Every black person knows the anxiety that happens in a rap song right before the n-word appears. Are your friends about to make things super awkward? Is that friend of a friend going to yell the n-word in your face and expect you to be cool with it? Strangely, I wasn’t worried. I was in a professional setting. There’s no way an attending would...

“Niggas”

All of the happy air in the room was instantly sucked away, replaced with silence. No one dared speak. No one dared breathe. I waited and hoped for someone to say something that would break the tension.

“OMG, I’m so sorry. That never happens.” “That was inappropriate. Let’s talk after the case.” “Word word word, blah blah blah.” ANYTHING. I just wanted any opportunity to respond that it was okay and not to worry.

Five seconds I waited. Ten seconds. Thirty seconds. An eternity. I waited for words that would never come. The once cheerful room now had the atmosphere of a bomb being defused. No more jokes. No more talking.

Electric pins and needles rushed into my palms and soles, evaporating with the rising heat of my blood. My stomach churned. My face burned. My hands became drenched in sweat. I was humiliated and embarrassed. Above all, I felt overwhelming guilt. I ruined the party. I ruined the fun. I had never felt so much like an outsider. I had never felt so alone. I could only imagine what Attending was thinking. Was he angry or annoyed at me for being in the room? Did he fear discipline? Did his mind race through the countless disputes sparked by race happening throughout the nation? Did he see me as a snowflake who couldn’t handle it? Was I the problem with medicine nowadays?

Every day leading up to that moment (and in the infinite moments afterward) I tried desperately to do the impossible. I tried to get residents, faculty, and staff to see past my skin color, to see me for

me. To see me as one of them. One small word shattered that possibility. It made it painstakingly clear that I was not part of the club. Although we were in the same room, we were worlds apart. Without lifting a finger, or uttering a word, I seemingly ruined my chances of getting an interview spot. Did I even want one? I couldn't help but wonder if this was a regular occurrence.

Eventually, time released its hold on the moment. The case finished. Then the next. And then the one following it. Each case drowned in uneasy silence. I remained in perpetual isolation. The once friendly staff now ignored me. They were probably too embarrassed to meet my gaze. Attending disappeared between cases, present for the opening incision and gone as soon as it was closed. Chief deflected my questions with one word answers.

At the end of the day, I assisted the staff in bringing the last patient to the PACU. Afterward, I found Chief and Attending in a small room with seating

for two. They were eating food, and enjoying a seemingly light conversation. Their work was done for the day. I walked to the entrance of the room to show that I was ready to help with the next task. I briefly locked eyes with Chief, but he did not acknowledge me. I found a spot to awkwardly stand and read within eyeshot of the room. Seen, but not heard. After ten minutes, I accepted that Chief would do nothing to help the situation. I walked into the room and informed him that I was going to the workroom to help the on-call resident. I turned to Attending, and looked him square in the eyes. Mustering all the confidence and gratitude I could, I smiled and said, "Thank you for a great day."

I found the resident workroom empty except for another away rotator. His warm greeting suggested limitless energy. His eyes told a much different story. Slumping slightly in his seat, he asked how my day went.

"Oh, you know," I said.

"Living the dream."



**GUARDIAN I** Kevin Yei, MS1

**SHADOWS I** Kevin Yei, MS1



# THE NEW KID

Daniel Kronenberg, MS4

Anyone who has been a third-year medical student will tell you how difficult it can be. Very little in the first two years of medical school can prepare you for the long hours, finding energy to study after coming home, not knowing much about the specialty you are rotating through, not understanding how you are evaluated, finding time to eat. Did I mention not knowing anything?

Being a fourth-year sub-intern adds new challenges. After a month or two on the wards, you may have grown comfortable with the workflow and may even know a thing or two about your specialty. However, “with great power [kinda] comes great[er] responsibility.” You are now expected to function at the level of an intern, managing the care of your own personal group of patients. You must follow up on labs, images,

culture sensitivities, outside hospital records. You might hold the consult pager for your service and be “first-to-call” for the patients you are assigned.

Now imagine being a sub-intern on an away rotation. Suddenly you are not only painfully inept and often ineffectual in your nascent career choice. Now you don’t even know where the bathrooms are. No longer do the nurses vaguely remember you and let you know how your patients did overnight. Imagine you just stumbled through rapid-fire rounds and you have been assigned to a case starting in 15 minutes. How will you get scrubs before the case? Where can you change? Where are the ORs?

These are the kinds of thoughts that swirled in my head long before the plane ride. Maybe it was not the best mindset to have going into a new rotation but what medical student doesn’t perseverate about the details? My mentor back home once said, “Any surgeon who isn’t a little worried all the time is probably a sociopath.”

Yet what I found during my sojourn away from my medical school for nearly five weeks, was actually very reminiscent of home.

Day one on Monday morning was a “morbidity and mortality” report-style grand rounds. Assembled in the conference room were faculty and residents of various years. There were also three other visiting fourth-year medical students. I smiled and made pleasantries but the blood left my hands and a lump hung in my throat. We were asked to stand and introduce ourselves to the group. They spoke the names of impressive home institutions. The carnage of a Mad Max-like battle royale between us played out in my head. It didn’t end well for me. The girl from the prestigious school in Philadelphia was too quick with her flamethrower.

I shook it off and introduced myself. The residents came to meet us after the meeting. They were an intimidating but smiling bunch. “Welcome! Welcome!” said one of the chiefs. “We’ll talk more later in the week about expectations. You all have cases to go to.” Then they showed us where to get scrubs, where to change and where the ORs were.

From then on, the rotation played out much like my sub-internship back home. I woke up at 4:00 every morning and I left the hospital at 7:00 in the evening. I read up on my patients, and studied for clinics. I assisted in the OR, and sewed up the skin when we were done. To be sure, I got lost. A lot. However, I eventually found the bathrooms. Some of the nurses started to vaguely recognize my face. I found the break room where the free peanut butter-and-jelly sandwiches were and scarfed them down between marathon cases. I held my patients’ hands when I introduced myself in pre-op, and apologized for tapping on their sore bellies days later on the floor.

I was surprised how quickly I began to feel at home. The faculty didn’t seem interested in trying to break me down to make their own students look good. They wanted to teach me and help me grow, even though I might not end up



PASSIONATE FOCUS | Justin Griffiths, MS1

as “one of them.” The residents were familiar with feeling foreign on away rotations. They strove to set me up for success and bought me lunch on a number of occasions. They spoke often of why they love their city and why I would too. And instead of chain-sawing each other’s heads off, the other sub-interns and I grew close. We shared cases and secrets about attending idiosyncrasies. We spent time together outside of work, joking about the arduous journey ahead and confessing how impressed and humbled we were with one another.

In the end are we just interchangeable parts, like Lego blocks? Could we be happy at any number of places? Maybe, I thought, as the sun came up over the last day of the rotation. I found myself falling for the place. Somehow it made me feel guilty: my medical school had ushered me in behind the curtain into the secret world of medicine. Could I simply pick up and move elsewhere? What about all the sweat, blood and tears—not all my own—

that had gone into making me a fourth-year medical student?

I thought long about this. Perhaps the answer is that if you work hard, and feel passionate about what you are doing and the people you do it for, “home” can be anywhere. My first away rotation was instrumental for a number of reasons and I did learn some truths. I got to meet very inspirational people and I was exposed to procedures I had not seen before. Most importantly, it took a lot of the fear out of the prospect of moving away somewhere unfamiliar for residency at the end of medical school.

As fate would have it, a couple days after the rotation ended, the 2017 total solar eclipse passed through the region where I was staying. My best friend was studying at graduate school nearby, and I joined him, his classmates, and nearly 500 students and families stretched on picnic blankets that bright morning. People lounged and gazed upward, enthralled with the slowly disappearing sun.

As totality neared, a pall swept over the now silent, grassy quad. The daylight faded, the crickets began to chirp, and the temperature dropped 20 degrees. My heart was pounding as the last sliver of sun was obscured. We threw off our eclipse-viewing glasses nearly in unison. I heard a collective gasp from the crowd. It took a moment for my eyes to adjust, but once they did, stars and planets replaced blue sky and white clouds.

And then I saw it. Where the sun had been in the morning sky, was a solid black disc. Surrounding the eclipse was the scintillating, white corona, the sun’s normally invisible atmosphere and fiery bursts of solar flares. In that single minute I was overcome with both the awe and eeriness of an eclipse. I couldn’t help but think that shimmering black hole in the sky was a metaphor for the future: full of uncertainty, and potential beauty. Until we experience it for ourselves, it will always be a mystery.

**UNTITLED I** Bradley King, MS1



# STERILE TECHNIQUES FOR ADEQUATE WOUND HEALING

Luke Burns, MS4

My entire body is rigid with tension. I am solid, unmoving, rooted to the earth like an ancient tree. Beads of sweat pool beneath my scrubs, but still, I do not move. My gloved fingers ache beautifully, wound so tightly around the medical instruments it is though I am welded to the sterile metal. I have been given a task and nothing will break me from it. Despite the pain, despite the torment, I do not yield. For I, the 3rd year medical student on the general surgery service, have been asked to retract.

Wedged between senior resident and scrub tech, I contort my body in the precise manner I know will least impede the precious work occurring on the table before me. What that work is, I am not quite sure, as my view is alternately blocked by the patient's left leg and the back of the attending's head. But no matter, for my task is plain.

It is my 4th week on the general surgery service and I consider myself somewhat of an expert by now. I have learned how best to fulcrum the hooked retracting tool into the patient's incision to allow maximum access to the surgical site. I make tiny amendments to the angle of my hand and the downward pressure of my wrist, adjustments that are invisible to the naked eye. But still I am certain the residents notice. True, nobody speaks to me or really even acknowledges my presence, but on certain days I cannot help but imagine the conversations they have about me in the physician's lounge.

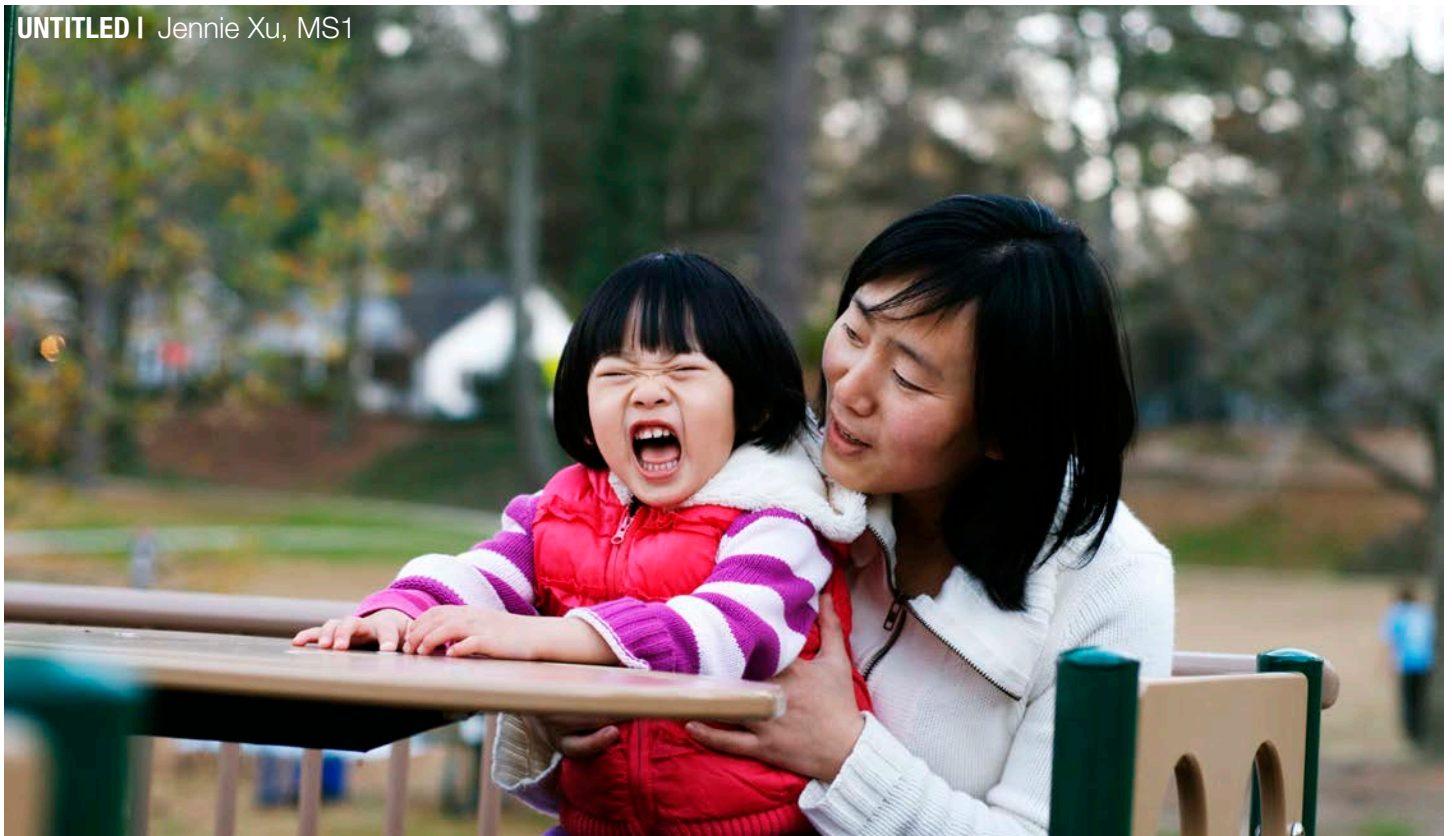
"Did you see how that medical student retracted today? Gee whiz, we finished that case in half the time because the field of view was so unobstructed. Is this the best medical student we've ever had? It may well be."

This thought comforts me today, as I

feel the pain in my hand slowly replaced with a welcome numbness. Occasionally a strong grip will readjust my wrist, changing the angle of my retraction and recruiting new, unused muscles in my thighs and cervical spine. Later I will amuse myself by reviewing in Gray's Anatomy these obscure, throbbing muscles I otherwise so infrequently have the opportunity to use.

The pain is nothing, because I know I am a vital part of something bigger. As a medical student, it is often hard to feel important. Presenting my patient's metabolic panel each morning, I diligently regurgitate the electrolyte values for the benefit of the rest of the team and cannot help but notice the residents' impatient shuffling or the attending's unabashed texting. I try so hard to have a purpose, to be of use, but it is hard when I know I am the least useful person in a room full of

UNTITLED | Jennie Xu, MS1





busy professionals. When a fax needs to be sent or a sub-specialty service consulted, the other medical students and I jump at the opportunity to be useful. But when none of us know how a fax machine works or when we accidentally page the attending physician asleep on her post-call day, we create even more work and burden.

I know one day this will change, that as a busy resident I will yearn for the carefree, halcyon days of medical school when my actions rarely had the potential to endanger lives. I will look jealously at the medical student who has entire unmapped portions of the body left to discover, who does not lie awake wondering which mistake he made that morning could be brewing into a horrendous outcome overnight.

But for now I concentrate on the task of retraction. The surgery proceeds as I diligently hold tension on the tissue. A subtle instinct tells me to make a small adjustment and I think I detect a resulting sense of appreciation in the attending's body language, maybe the way his head tilted—it is hard to tell from behind.

And then disaster strikes. The intern beside me makes a sudden movement, laterally and cephalad, and despite my weeks of diligent training as a 3rd year medical student, I do not see it coming. The unsterile portion of her gown brushes against my outstretched left arm, instantly reverting it to a useless, germ-ridden appendage. All eyes turn on me. It is though I have contracted the Bubonic plague.

The scrub tech points silently to a pile of sterile garments on a table behind him. It is no use protesting. I release the retractor. The surgery pauses momentarily while I move glumly away from the table, feeling the blood return in painful jolts to my arm.

On the table I find the item I am

after: a single hollow tube of elastic sterile material through which I will place my defiled left arm. I believe it was created precisely for clumsy medical students who contaminate themselves while in the operating room. This is the Sleeve of Shame, and I will wear it for the rest of the case.

I return to the operating table and am immediately confused. Despite my absence, despite my established role on the team, the surgery seems to be continuing without me. In fact, the residents seem a lot more comfortable huddled around the patient without me shouldering between them. The space I had once occupied has been resorbed by other sterile bodies, and it takes me a few moments to peer between them to realize what has happened.

Then I see it. Poised delicately on the edge of the incision is a single piece of sleek, uncomplaining, untiring metal.

An automatic retractor.

I turn sadly from the table and watch the rest of the case from the sidelines. The automatic retractor does fabulously.

One day, I tell myself, I will actually be useful. I will have access to Mayo needle holders and toothed Adson tissue forceps and curved Metzenbaum scissors, to an entire arsenal of sterile instruments. Like my mentors, I will invite medical students to scrub in, I will grant them an opportunity not only to discover hidden wonders of the human body, but to perform in the elegant pageantry of the operating theatre. Most of all, I will let them feel proud to play their role on the team, no matter how small.

But for now I will watch, study and admire.

And maybe figure out how to send a fax.

the river flows  
through the canyon  
cutting the edges away  
softly, softly, softly  
making way for more  
more uncertainty,  
more progress—  
more change  
in all forms.

it is painful  
to lose those parts of me  
to watch  
as they flow away with the current,  
leaving only memories  
of what once was,  
of the comfort I once found.

and yet,  
the waves lap against those rough  
borders,  
soothing my aches,  
swirling and bubbling  
bringing tales  
of what is to come,  
whispers of the joy  
just over the horizon,  
waiting to reach me  
to settle in  
to fill the parts of me I lost  
to create grooves I did not know  
could exist.

until  
they too  
will flow away  
and I will wait  
patiently  
for new waters  
to take their place.

**-growing pains**  
Harpreet Gill, MS1

# DR. ARWIN

Lillia Cherkasskiy, MS4

Dr. Arwin was a tall, thin woman with light brown hair gathered into a tight bun at the nape of her neck. She breezed past me into the physician's office without acknowledging my existence. This was not unusual attending behavior, as any medical student will attest to, but I was surprised nonetheless. She had only completed her epilepsy fellowship one year previously. I expected that she might remember what it was like to be a student.

"Hello, Dr. Arwin. My name is Lillia and I've been assigned to work with you this afternoon, if that's alright with you."

She responded without turning from her computer screen or pausing her online shopping for a handbag. "Hm. I never work with students."

This was going to be a fun afternoon.

"You may come into the patient rooms with me but do not speak."

A fun afternoon indeed.

Our first patient was Mr. Sanders. Five times per day for the last three months, he had been experiencing shaking fits. The exam room smelled of stale cigarettes and body odor. Mr. Sanders was an obese, forty-year-old male, sitting across from his father, gently fingering a tattered bowler hat.

When we entered the room, Dr. Arwin pushed her chair as far away as possible from the pair and wrinkled her nose.

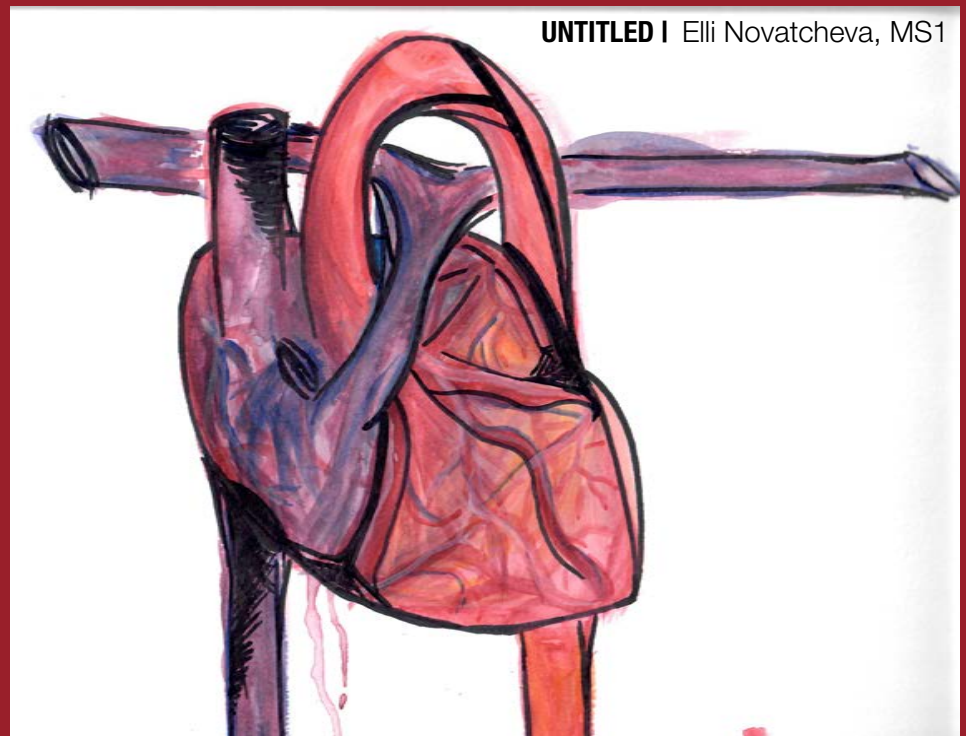
"Why are you here today?" After concluding the ten-minute visit and ordering a two-hour EEG for Mr. Sanders, she whispered to me confidentially, "Panic attacks."

Our second patient was Ms. Atkins. She was a fifty-year-old woman with watery eyes who looked ready to burst into tears. In fact, she did burst into tears as soon as we walked into the exam room.

"My seizures are getting more frequent. You have to help me!"

As Dr. Arwin launched into an explanation of how her seizures were

I was starting to get the hang of epilepsy clinic. Our next three patients also did not have real epilepsy and needed two-hour EEGs. I wondered vaguely why Dr. Arwin seemed only to see new patients and not to have any follow-up patients. In my experience in medical school, I have met quite a few Dr. Arwins. Unfortunately, I don't have any tips for avoiding them, but judging



psychogenic, brought on by stress, without any organic cause, Ms. Atkins started blinking rapidly, stiffened, and fell backward onto the examination table. For the next 30 seconds, her arms jerked back and forth and foam poured from her parted lips. Dr. Arwin turned her on her side and ordered a two-hour EEG.

from their lack of repeat customers, patients seem to catch on pretty quickly without any help.

# HOMETOWN

Simone Phillips, MS1

The furniture was almost believable enough to be the wicker it suggested. We sat in it anyway. We drank white wine from smudged glasses and gazed at the empty kiddie pool. More plastic, this time in the shape of a turtle. The newspaper drifted in and out of conversation. She fetched the New York Times at one point, not to read from, but to wave as a prop.

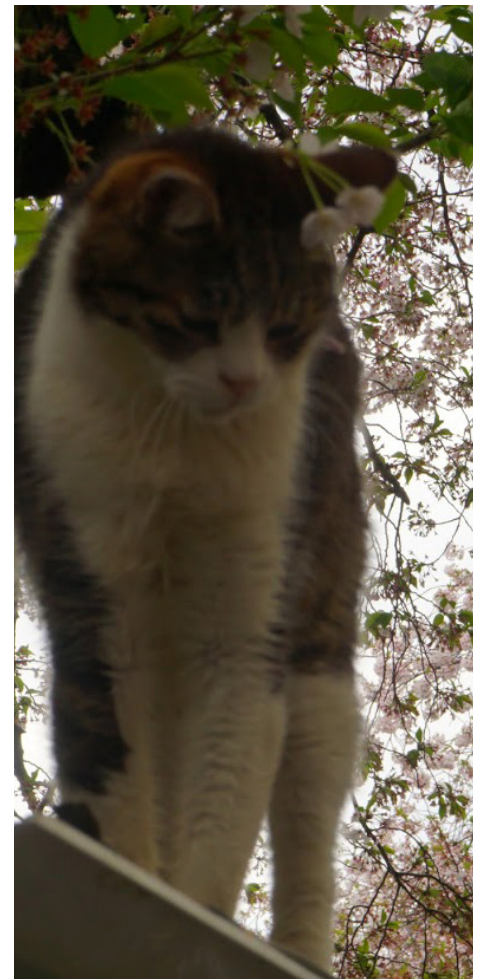
It was the week after Charlottesville, and to prove our

erudition we quoted politicians' racist remarks with disdain. It was hard to tell if the women's death genuinely shocked, or if it was the least risky thing to speak about.

After dinner; several glasses of wine; a rising moon. Talk shifted to our own histories. She and her sister both married wealthy men. Her sister's sons now managed orchards, ordered Mexicans, El Salvadorans. Last week her nephew arrived at the neighbors' wearing only his underwear and a shotgun.

Something about a run-in between the dogs.

The story went on loops. She held up photos of her nephew's daughter proudly showcasing a pig she had raised in 4-H. "Black," my friend remarked. "She's black," as though we might have missed this from the photographs. My friend clung to her words like a prize. As though having a black child in her family exempted her from Charlottesville.



CHAT ET SAKURA | Jimmy Bazy, MS1

# WHAT ELSE DO I HAVE?

Sandeep Prabhu, MS4

Mr. Sweet was immensely friendly and pleasant (even when I woke him up early in the morning before sunrise), which is all the more commendable given that he had liver failure and was admitted with an acute exacerbation. I found no known cause listed in his chart, so I dug a little further and asked him as well. I learned that he never used intravenous drugs, didn't drink alcohol, was not obese and had no known genetic predisposition to liver disease. I finally came to the same conclusion that other providers before him had: his cirrhosis and liver failure was cryptogenic, with no known cause.

Furthermore, his kidneys had failed and he was getting regular dialysis. He was listed for a liver and kidney transplant and lived at home with his wife, making 3 weekly dialysis visits and periodic drainage of fluid that would build up in his belly. Given his tough scenario, I was surprised to see Mr.

Sweet's optimism.

Every morning when I pre-rounded on him, he was pleasant and optimistic, answering my questions patiently, complimenting me on my tie and reminding me what a great day it was. Over the course of the few days he was in the hospital, I visited him frequently and got to know him well. I asked him directly once how he managed to be so positive despite the seriousness of his condition. He chuckled, stating that his daughter had asked him the same thing, and replied, "Well, of course I'm hopeful and optimistic about the transplant. Because if I don't have optimism, what else do I have?"

His profound statement struck a chord in me. Despite all the odds stacked against him, he didn't give in. His will power was not only ironclad but he also exuded positivity despite having a condition that could very well limit his life to weeks. His attitude

towards those few days I cared for him taught me two important things.

First, a person's inner strength has no limits, despite being pushed to the brink. This is an important lesson for life as we all face what seem to be insurmountable odds. Being steadfast in trying to tackle them is only part of it, as he showed, but striving to be positive makes the challenging process a more positive one for us and those around us.

Secondly, the importance of comfort in end-of-life care was illustrated well by his case. Those last few weeks or even days are priceless to patients like him and his loved ones. After he was stabilized in the hospital, he insisted on going back home where he could still maintain a good quality of life.

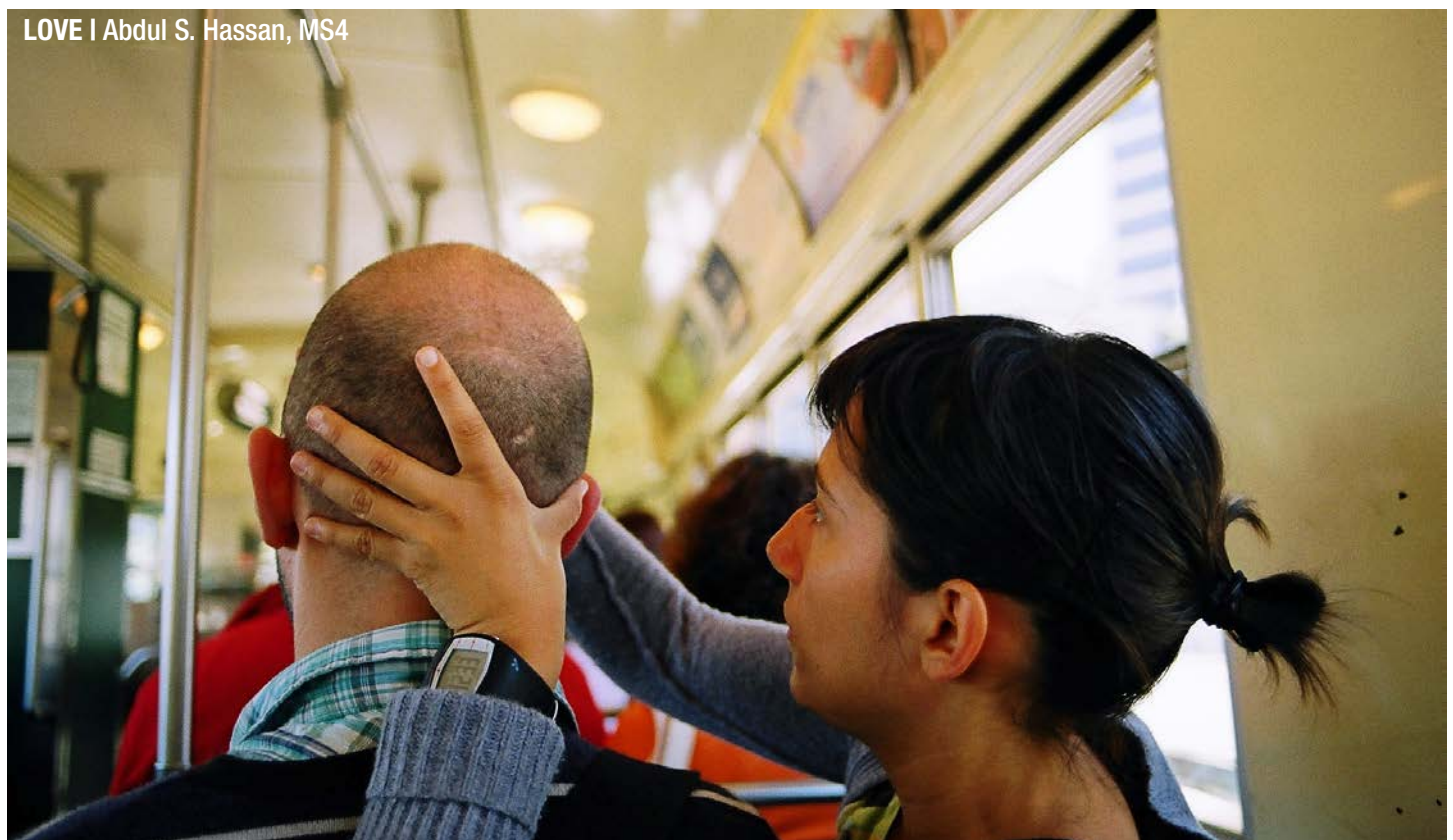
I left the service a few days after he went home. Unfortunately, he was readmitted a few weeks later. This time, however, his condition deteriorated further and he spent many weeks in the

CHALKY OUTLINES | Courtney Chen, MS2



ICU. I later found out that despite all efforts, he passed away in the hospital. He never got that liver and kidney. He didn't even have a chance to be at home when he died. I never got to see him during that last admission, but I would like to believe he was positive even when he knew the end was near.

Mr. Sweet may have passed on but he taught me to be constantly grateful for all the things I often take for granted and to reframe my momentary frustrations by looking at the bigger picture. He also showed that no matter what challenges one is facing, one can still radiate infectious positivity to those around them. And at the very end, that may be all that really matters.





# SOMETHING FOR THE PAIN

ANDREW PARK, MS2

## Part I: 1988

Bed 23 wants more applesauce for the dried turkey and congealed gravy

Bed 34 wants her daughter to visit

Bed 25 wants more T cells

Bed 2 wants quiet because the ward is too loud and he can't hear President Reagan on the television

We do not have applesauce or T cells or family

We do not have extra hands to simmer the noise or tune the quiet.

But we do have morphine.

## Part II: 2018

He rolled into the trauma bay at 0200 in agony, mouth frothing, face pallid, eyes bloodshot. They rushed him through the double doors, medics on both ends of the gurney, one clamping down to control the bleeding. In my thirty years as a nurse, I had seen plenty of blood—but this was too much.

He wasn't half full; at the rate he was bleeding, he was a far cry from half empty.

The medics gave the report while Dr. Shepherd listened: entry wound, yes. Exit wound, no. The bullet had entered his belly at close range, liked what it saw,

redecorated the place, and had shown no signs of wanting to leave. An IV line was initially acquired on the field. Fluids were pushed. The patient was calm and alert. But when they tried to administer morphine, he flipped.

"Yanked the line right out," said the medic. "After that, we couldn't do anything."

The man needed an emergent surgery, an exploratory laparotomy. For that, he needed to remain still.

We tried to get an IV, but he thrashed with such force to hold us at bay, gnashing his teeth, flailing his arms.

"No, pain, no, pain!" he exclaimed, over and over, as if it were some ethereal blessing, some palliative mantra.



UNTITLED | JASON CAFFREY, MS2

I raised my voice. “Sir, you need to stay still.”

“No! Pain! 24!” The man wrenched his arms and wrapped them in a self-embrace.

I saw the track marks and tattoos. The faded ink crawling up his arms, occasionally broken by pockmarks and pop holes. I assumed the worst, my mind wrapping its dendrites around the “A” word:

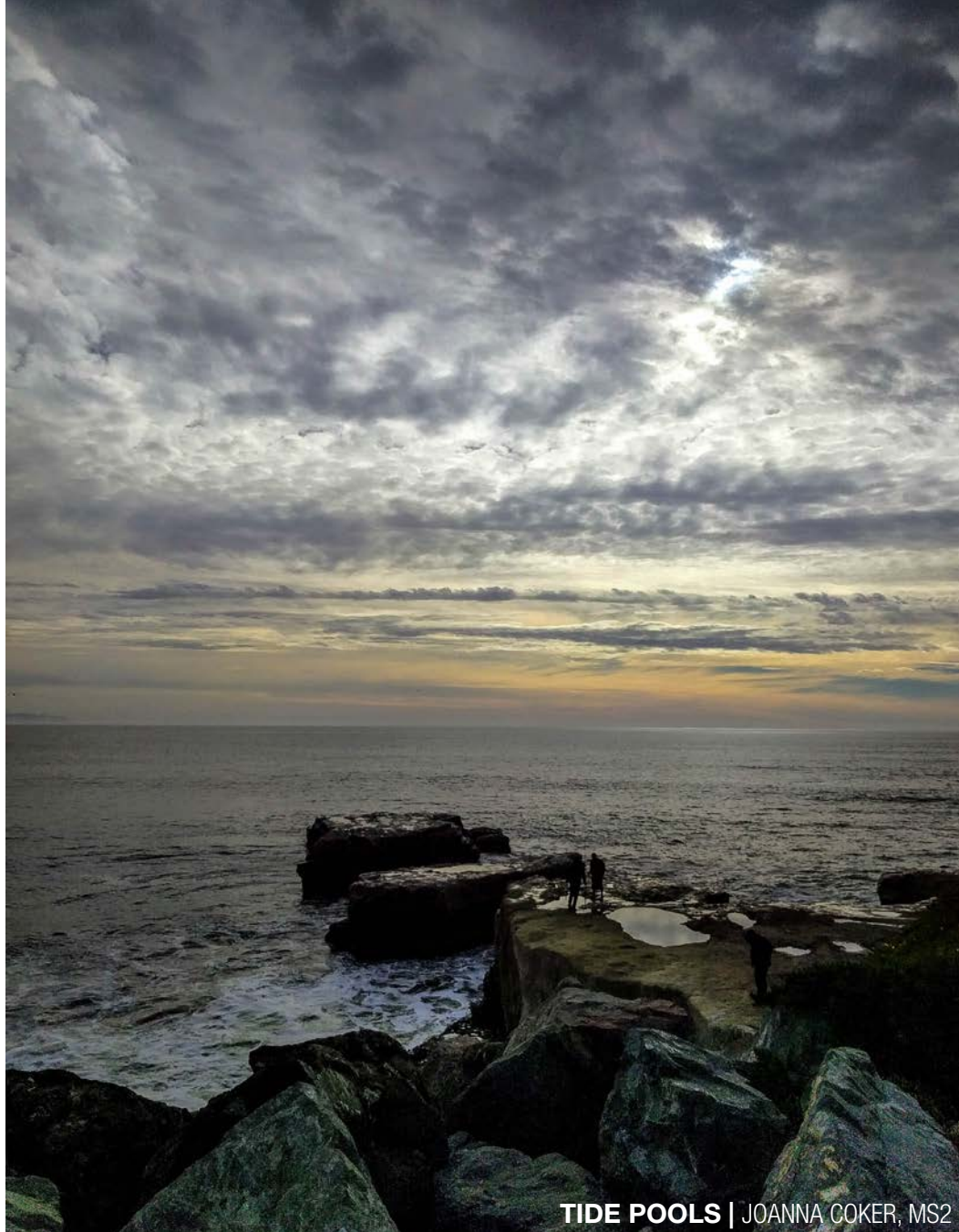
*Addict.*

“Sir, we can’t help you if you keep moving.”

“No, pain. 24 d—”

“Sir, we’ll give you pain meds, but we don’t dose Dilaudid that high.”

The man trembled, then his arms went limp. “No pain,” he pleaded. “24



TIDE POOLS | JOANNA COKER, MS2

days.”

By this point, we had fentanyl at the bedside, and were ready to administer intramuscular Haldol to sedate him. I raised an eyebrow at Dr. Shepherd, waiting for the okay.

Dr. Shepherd held up his hand. Quietly, he walked to the patient, knelt forward, and mouthed something into his ear, out of our hearing range.

The man calmed. We got the line.

“Hold the fentanyl. Only Haldol.”

The patient was stabilized and sent to the OR.

\*\*\*

He didn’t make it, we found out the next morning. The blood loss was too great, and his body couldn’t compensate

for the shock, no matter how many red blood cells they infused.

Later, when asked what he whispered that had calmed the man down, Dr. Shepherd said this:

*No Dilaudid, no morphine, no fentanyl. No opiates, I promise.*

“You administered him nothing for his pain?” probed the M&M panel in the coming week.

*No Dilaudid, no morphine, no fentanyl.*

“So, in other words, you provided him nothing?” queried the malpractice letter in later months.

*No opiates, I promise.*

The patient died on his own terms, liberated from his demons; free. That’s not something you can give with a needle.



DOLLS | ELLI NOVATCHEVA, MS1

## SOMETHING I CAN'T EXPLAIN TO OTHER PEOPLE

STACY MA

### September.

Our first time in the room with 160 bodies, 130 of which are living. A single sheet of paper tells us the bare minimum: 93 year old female, coronary artery disease, deceased in June. We open the covers and let the sight of the naked cadaver sink into our eyes, the smell of formaldehyde into our scrubs. I've seen isolated body parts in my undergrad anatomy course—a leg, an arm, a thorax—I thought that was wild. We are too scared to lift the black bag that hides her face.

### October.

We have to flip her over? For a little lady, I imagined her to be lighter; wouldn't being void of life do that at least? Here's a good technique to

remove the skin, we accept without question. Then all 5 of us are at it, and once again I wish she were even smaller. I can hardly eat my dinner that night.

### November.

One transverse and one sagittal—how kind of them to make the cuts for us. I walk in and I turn my eyes to anything else that might be less horrific. Is this supposed to feel normal by now? (I answer myself: no.)

I hold her lung in my hands. It is remarkably pink and soft for having breathed a life of 93 years. I think about the air that filled this lung and how much more pure it was than ours, where she lived and what she did and whether it was hard. It wasn't long ago that I held her heart the same way and wondered what, or who, it had raced for. I wonder now how my lungs compare.

### February.

We chat over a table that looks like a war zone, joke about the double-edged nature of our newfound knowledge, laugh to cut through the morbidity. For the most part, it works. The black bag cast aside for good, she is exposed. This is what we were scared of, this is what makes her real. We find all the parts that once governed even her slightest change of expression. If I could express to her how I feel, to have learned from her in the most intimate of manners, I would tell her that I've held every part of her and respected each one.

How do I explain what I've done, what I've seen, and what I've felt here to anyone who's never stepped foot in a room like this?

This is just the beginning.



# DEATH OF A MEDICAL STUDENT

ANONYMOUS

I saw you stand and swing your hand  
To swear to *Tread with care in matters of life and death*  
As we stood and smiled at our parents from the stage  
I heard you speak that oath that came so easy then  
To our bleach-white hearts buttoned tight and hard  
The rub of rubber on my neck and  
Bell against my chest  
And then they brought us back inside to scour off the glow  
We were colleagues now and here to learn, you see  
Some days my mind would feel so full,  
Brimming like a fishbowl, I would press my bowing temples  
Just to blur the fizzy hum, just to stop from spilling over

At dinner I tell my parents how they  
Tell us how they want us to give bad news  
With uncrossed knees and open faces  
And platitudes  
I am spilling over  
But as my coat grows darker, longer,  
I cannot help it, I cannot scrub the carmine sleeves, cannot wipe free the hands  
Of the blistered boy who reached out from his  
Hospital bed and asked, *What is the worst thing in the world it could be?*

We are all far too young  
And when they called us on a Sunday with bad news  
And we came pouring  
From the wards, from the lecture halls and libraries  
I felt the rim slip loose from both my hands and  
The weight within my pockets drag me  
Deep, down and woven in the darkness  
And when I looked up from the sand  
Dark bodies slid between the light and me  
And you were lost





# THE POWER OF OTHERS' EXPECTATIONS

**NIKHIL V. KOTHA, MS1**

Every moment we are in the presence of other people, we are affected by their expectations of us. Some are affected more than others. Most are affected more than they are aware. Which category do you fall under?

Although this process is a combination of conscious and unconscious mechanisms, we are constantly changing ourselves as a result. This is to be expected. After all, a single relationship has numerous facets and effects; a network of numerous two-way relationships will create a dynamic society of interweaved mental selves. This dynamic society is the basis of the Looking Glass Self Theory, developed by sociologist Charles Cooley. In his work, *Human Nature and the Social Order*, Cooley describes his theory as having 3 steps: how one

imagines one appears to another; how one imagines the subsequent judgment of the other; and how one reacts to perceived judgment.

In addition to these implicit expectations, voiced expectations are commonly present in everyday life. The form of the voiced expectations varies from an overt comment, such as “I expect you to not have done that”, to a more subtle comment, such as “Why would you do that?” It has been found that fulfilling both of these types of expectations is an innate response of modern day humans.

Expectations of any kind, especially from meaningful people in our lives, tend to make us think that we are supposed to naturally fulfill the desired qualities or actions because that is who we are, or are supposed to be. Thus, expectations influence one's self-concept, an overall perspective of who one actually is. Satisfying expectations

tends to at least partially satisfy both one's social relationships and one's self-concept.

I was born in a rural village in central India. Most of my family is still there. I don't want to bore you with my personal statement but in essence, my annual visits and immersion into these surroundings contributed significantly to my drive to become a doctor. I want to be clear: no one forced me to be a doctor. No one in my family is a doctor. In fact, my family actually partially discouraged it.

Referencing my emotional sensitivity, the long journey, or some other reason, they tried to convince me to be a stereotypical ‘Indian engineer,’ to settle down with a career and family by the ripe age of 30. But once it was clear that I wasn't budging, their words changed. Their expectations changed. Suddenly I became the man to serve the people, the one who would help everyone and open



a hospital back home in India. Half of it was joking, half of it was serious. It took a while to reconcile this additional burden on my shoulders. I know their intentions were good. At least, I choose to believe so. But for me, amongst the craziness of this medical school chapter of my life, this additional burden and pressure was unneeded.

For now, I've put it on the backburner. Although it's hard to not satisfy those who you care about, I realized I was not being true to myself. After all, I barely know who I am at the ever-so-young age of 21. So when I talk to my family now and these expectations arise, I laugh them off and kick the can down the road. Only time will tell if I can fulfill them. But there is no doubt in my mind that I act in order to try and meet these expectations and be the 'hero' that they envision. They have changed my personality already in more ways than they realize. In many ways, I am thankful as their expectations are helping me become a

better person. But the big challenge and fear is ensuring I am true to myself in the process. Maybe that's not who I am meant to be. Maybe that's not who I want to be.

Even in my nascent career, the phenomenon of being changed by those around me has already occurred numerous times. The most notable came when I was shadowing a pediatric surgeon. As the mother of the patient guided her child into the OR, I noticed she was crying. Tears streamed down her face as she realized the operation was actually going to happen. Keep in mind that this was a simple operation with little to no chance of adverse outcomes or impending risk to life. Appallingly, the surgeon offered a half-hearted word of encouragement and proceeded with his duties. After the mother left, he laughed at her reaction and joked about it with the operating team and me.

I still don't know exactly why, but I laughed with him. Even though I had

contradicting emotions of sympathy and empathy for the mother, I still laughed with him. As I questioned my actions later, I realized I succumbed to the inherent hierarchy present within the medical system and the inherent philosophy of appeasing those above you. But maybe my parents were right: I am too emotionally sensitive. Maybe after 10 years of practice, I might have the same reaction as the surgeon. But I know as of right now, I caved in to expectations and the desire to be part of the system. What scares me is that I did it without a second thought.

Every moment we are in the presence of other people, we are affected by their expectations of us. Some are affected more than others. Most are affected more than they are aware. Which category do you fall under? I know which one I currently fall under. But I also know which one I want to fall under, hopefully sooner rather than later.



STUDENT BY WINDOWS | ELLI NOVATCHEVA, MS1

## MENTAL STATUS EXAM

AYAN KUSARI, MS4

Where were you when the president was shot?  
Where were you when the towers fell?  
What is the similarity between  
an apple and an orange?  
What is the similarity between  
a clock and a yardstick  
and a man in a white coat?  
We are measuring devices  
See how I map  
the rooms of your mind

Blue daisies on your cotton gown  
He was a tyrant, she says on the phone  
His drinking was bad

Was, was!  
See how your own flesh flings you to the past!  
Your sister sniffs  
A cruel man

You have no self-summary  
No defense or argument

How old were you on your wedding day?  
How many children did you raise?  
Does the world seem sometimes untrue?  
Do you float above your body  
and see yourself from afar?  
Do you know why we keep you here?  
Do you know you have been a danger to others?  
Do you know you are a danger to yourself?  
Steady now.  
Count back by seven from one hundred.  
Do you know who you are?

# WILDFIRE

HARPREET GILL, MS1

we are props  
to be decorated, paraded, admired—  
silently.

we are to be pleasant, modest, obedi-  
ent—  
unflinching  
in our acceptance of our fate  
decided by the superior minds  
of brothers, fathers, husbands.

is it not painful to realize  
that your womb may give life  
but you may not take charge  
of your own?

rise  
and break free of their age old shackles  
inside you is power, beauty, knowl-  
edge—  
fire.  
a form that does not conform  
to their outdated ideas of purity.

you burn too brightly  
for their liking,  
and you set their mold for goodness  
ablaze.  
you are more  
than they are capable of understanding  
and for that,  
they demonize you  
as hellfire.  
in truth,  
your flame serves as a beacon—  
a guiding light  
for your sisters  
to find a way  
to their own salvation.



Ashley Ott  
26

# INTERWOVEN

E.B. DEVORE, MS2

I  
On a wooded hill, between the trunks of old trees, there sat an unmoving rock. And inside the rock, the rock wasn't rock anymore, no--it had melted, the way wood melts into nothing as it rots--but it was a less nutritious nothing than the wood, and nothing new could grow inside the stony shell--an empty unfertilized egg that could not divide and multiply and make more of itself, nor feed a better something into being. And so the roiling mess swirled around in its own nothingness, malcontent--a stone soup with nothing in it but stone, a worthless elixir--for what is a rock if not strong and solid? Nothing.

II  
And outside, on the surface, stress spread like moss. It grew, hairier and greener, spun into elaborate knots by passing storms--and the knots stopped unwrinkling themselves, and nothing could fly past anymore--everything got caught up in the wild tangled mess, soot, severed butterfly wings, seeds that did not sprout but were swallowed, sand that worked its way down through the long threads of moss to the surface of the rock, where it sat and itched at the rock's skin. And the rock sat there, untouched by anything but its deep blanket of moss, for days, weeks, months--a few lizards passed by, and a bird, but everyone knew this species of moss was dangerous. Like the rock, nothing could grow from this moss. Unlike the rock, this moss was resilient.

III  
Up in the clouds, small seeds bloomed into fat wet drops, and the rain began falling, slowly at first--and the moss welcomed it, the moss that was always growing--but the rain began to pour out of the sky, as if a bucket had tipped over, or a bathtub, or an ocean, and then fell in pellets of ice like bullets. And the moss was ripped apart and stripped from the rock, and washed away--and the rock sat bald and exposed, a thin grey nothing in the middle of curtains of water, unaware of the ice that ricocheted off of its newly clean surface--until the hail fell hard enough that one piece cracked the rock open. And slowly the insides spilled out, that useless elixir, and slipped down the side of the hill in a silvery stream, and hardened there--and when the rain stopped and the sun began to warm the earth, drawing clouds of steam from the dark wet dirt, the silver rippled with color like an abalone shell and thousands of rainbows were reflected into the forest.



## À LA FOLIE

SARAH BASSIOUNI, MS1

“do not drive into smoke”

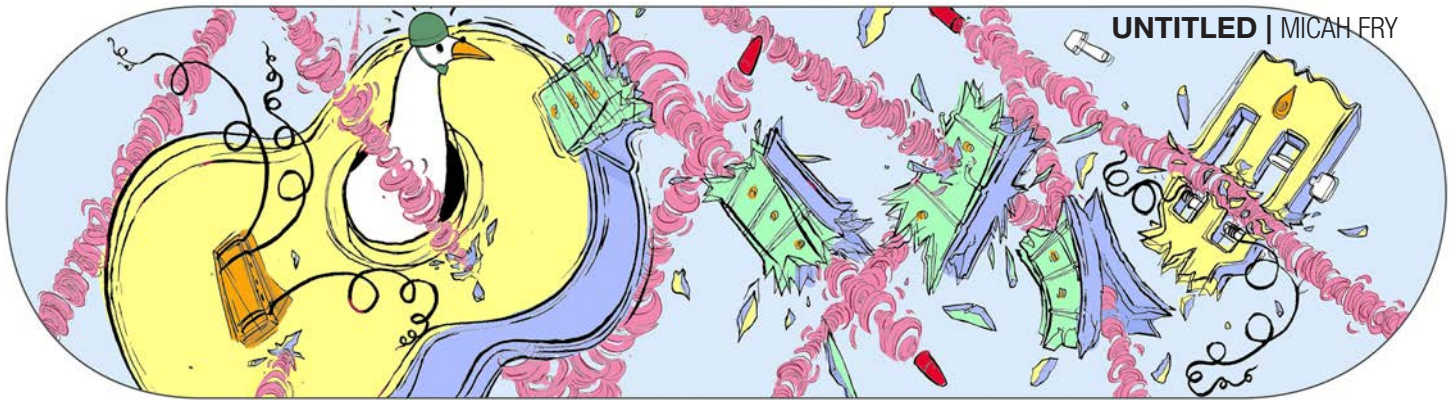
oklahoma.  
that's where she first saw  
the sign;

1469 miles later,  
it was  
(still)  
carved into her mind.

prescient.

she should have  
listened.

PATTERNS AND PERSPECTIVE | JUSTIN GRIFFITHS



## INSIDE

SCOTT NOMURA, MS4

This past year, beeps and buzzes sometimes interrupted my talks with patients. The former came from my pager, the latter from my watch, alerting me to a new text or email. To my chagrin, I could not silence my pager. But I often debated whether or not to put my watch to sleep: would the patient consider it disrespectful if I didn't? Would it be best for my own privacy? Maybe it would startle someone and trigger an event? Ultimately, I chose not to touch it. And I'm glad I didn't.

**Watch: "Move! 3721 steps left"**  
**Patient: 8 year old girl**

"Lauren, what are you doing? Sit still, the doctor needs to listen to your heart."

"Mommy, his watch told me to move!" Lauren continued to wiggle along the length of her bed, like a snake with a checkerboard grin, with little bits of applesauce peeking out.

"Lauren, please. You look like a worm."

"It's ok, I'm your pretty worm, Mommy...Mister, are there other watches like yours? I want one, but yours has cooties already."

"Of course there are! Maybe your Mommy or Daddy can get you one for being so good?"

"Umm...I don't know. Daddy used to be rich, but now he's not."

"What happened?"

"He married Mommy," Lauren giggled.

**Watch: "noReply@aamc.org"**  
**Patient: 72yo man with dementia**

Current and recent 4th year medical students applying to residency programs know the nervous excitement when receiving an email from this sender. If the contents relay good news (an interview invite), the scramble to sign up for an interview date begins, and you might see a classmate run "to the bathroom," phone in hand, with ERAS/Thalamus/other interview scheduling software open. If the contents are less ideal, there may just be a quick glance at the message, a pause, then a slow slide of the smartphone out of sight. Mr. R noticed me in this situation, and though he usually spoke off-topic on account of his dementia, this time he shouted a perfectly-timed statement:

"THE MICROSCOPE WAS INVENTED BEFORE THE TELESCOPE!"

After a quick bedside Wiki search, I was astonished to find that most historical accounts do agree that the microscope was first built in 1595, while the first telescope was invented in 1608.

"How weird," Mr. R's neighbor said from a nearby bed. And with all the cosmos towering above mankind, it is interesting that minuscule building blocks may have attracted our magnified eyes first. Yet the more the fact stewed in my mind throughout the day, the less "weird" it seemed. Perhaps especially amongst medical students, minds can get lost in minute details and forget the proverbial big picture: the well-being of both the patient and themselves. Medical school is a satisfying time of exponential growth but can also be constricting at times, a simultaneously expanding and collapsing universe. With so much to learn, it's easy to forget about life

outside of medicine if not for gentle reminders like the outburst from Mr. R. I thanked him for helping me remember what was important, hoping he had enough clarity to receive the gratitude. As I walked away, I could faintly hear once more, "How weird."

**Watch: "Incoming call: Mom"**  
**Patient: 62 year old man, waiting for hospice**

This patient noticed I ignored my Mom's call while our team talked to him and later expressed his displeasure. As a former writer, he addressed this issue with a poem about his own relationship with his mother. With his permission, part of it is shared below:

*"...I always hung up saying, 'I've got to go, I've got to go, I've got to go.'*

*Until finally the place to go was home,  
And face the face I had disowned, thrown  
Away to 'To-do's' of tomorrow, 'I love you,'  
'Happy Mother's Day,' 'Are you okay,' all  
delayed.*

*You were there for my first steps, I should  
have been there for your last,*

*To catch you before you collapsed  
Under the wait, too much to bear  
Atlas, at last time to rest.*

*I filled a fountain with liquid lament  
Collecting, cradling pennies for my wish  
Of connecting once more by cord to you.*

*I would give it all back, for one minute.  
Please, to amend my one regret?*

*Take my arms so that I may feel your  
embrace,*

*Take my eyes so that my tears can flow  
freely,*

*Take my ears so that you may hear, 'I miss  
you'*

*And leave me deaf to ignore those words,  
'Darling, I have to go.'"*

# WORDPLAY

**NICKY HERRICK, MS4**

My first day of medicine wards my resident assigned me to Ms. R. “She’ll be a great learning case, autoimmune hepatitis on the transplant list. But, she’s Spanish speaking only, is that okay?”

I was working on my Spanish, Ms. R on her English, but neither of us were very good yet. I used a translator for the daily medical questions, but we practiced with each other on everything else

“Mi hija esta visitando hoy,” she said one Saturday morning with a big smile. We laughed together when one morning I called her liver helado (ice cream) instead of higado.

As my weeks caring for her progressed, I discovered her life outside of the hospital – she was a loving mother, sister, and wife. I met her husband, daughter, three sisters, and two brothers-in-law. Her husband told me how they would spend half the year in Alaska, making their living on a

fishing boat. These were her precious few months at home, and Ms. R was desperate to get out of the hospital and spend time with her 15-year-old daughter.

I relished my new responsibility as the primary contact between Ms. R and her family. I finally felt like I was the doctor. She and her family listened attentively when I explained what our next steps were, how the new medication worked, and what our long-term goals would be. We shared in the joy when she made progress and maintained hope when she had a bad day.

I will never forget Ms. R and her family, but it was her husband, Mr. R, who taught me the most important thing I learned in medical school.

My fourth week caring for Ms. R, she decompensated. Two days prior we were discharge planning, then suddenly she was encephalopathic, febrile, and maxed out on antibiotics. I talked to Mr. R about how we were looking for a source for her infection, trying to make her strong enough for transplant.

He looked down, took a breath, and quietly asked, “She isn’t strong enough to wait for a transplant at home?”. I explained how it was safer for her in the hospital and that we still had a lot of progress to make before she would be strong enough to go home.

I went back to check on Ms. R later that afternoon. Her husband was there, but not in his normal chair next to her bed. He was holding her leg mimicking the exercises the physical therapist had performed the day before. The realization hit me that just a few hours prior I had explained to him that she needed to get stronger before she could go home. Now here he was, doing what he could to help her get stronger.

Mr. R taught me more about the power of our words in that moment than a lifetime of reading could have. As physicians, patients look to us for guidance and support, and I hadn’t fully appreciated until then that they often take what we say at face value. When I said she needed to get stronger, I meant everything from finding the source of and treating her infection,



**EVENING BATH | ANGELE LABASTIDE, MS4**



**COMPASSION | ANGELE LABASTIDE, MS4**



to improving her mental status, to removing the Foley catheter, and finally getting her strong enough to get out of bed. But, what I said was ‘stronger’ and to Mr. R that meant to make her muscles stronger, something he could help with. My interaction with Mr. R taught me firsthand that what we choose to say, and how we say it, matters.

The moment was equally beautiful and heartbreaking, and moved me to my core. The next few minutes were spent in the stairwell crying. I collected myself and went back to thank Mr. R for his help with her physical therapy and talked to him in more detail about the many hurdles that she was facing.

After 4 weeks caring for Ms. R, she was transferred to the ICU the day I was off-service taking my Shelf exam. Three days later, surrounded by her family, Ms. R died peacefully.

I always smile and think of her when I see an Alaska license plate or yet again mistakenly ask a patient about a painful helado. Though her case was emotionally and mentally challenging, it was a privilege taking care of and knowing Ms. R and her family.



**GOLDEN HOUR** | JUSTIN GRIFFITHS, MS1

## INTERWOVEN

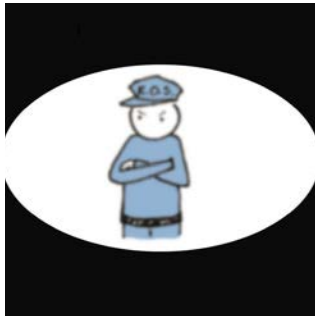
**E.B. DEVORE, MS2**

When I look at you  
I see the whole tapestry  
Threads running over each other  
Glistening under the light  
Some more visible from oblique angles  
The darkness of others drawing the eye  
Loose ends I want to run my fingers over  
And piece together one at a time  
To understand how you were made  
So why, when you look at me,  
Do you see just one thread?



**ADORNMENT BLOOM** | ANGELE LABASTIDE, MS4

# the MS1 NIGHTMARE by gauri



"You there, halt!"

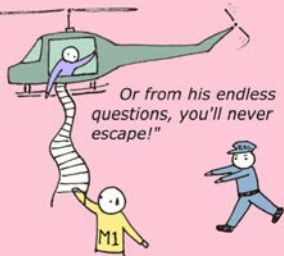


"Answer some questions for me."

Why is it I only recall  
branches of the biliary tree?

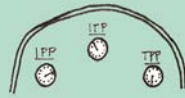


"Quick, over here--before it's too late,



Or from his endless  
questions, you'll never  
escape!"

What kind of helicop--



"Get to the back at once,  
our co-pilot's not well!"

There aren't any heart sounds,  
as far as I can tell...



"Your stethoscope is backwards



and the diaphragm, reversed!"



Wait, hold on--

"Haha! I've got you,



And there's more answers I require!"

How could you have  
caught us  
with so little time  
transpired?



"Trust me, with that smell,



you were not difficult to seek."

Oh, of course! The scrubs that



I should have washed last week.

The world began closing in,  
with a sudden



And from then on,  
I resolved to get (at least)  
7 hours of sleep.



[But would that be sufficient time  
For my brain to come up with better rhymes?]

GAURI SHASTRI, MS1

## PATIENT OR DOCTOR?

SANIYA KISHNANI, MS1

When I imagined my future as a doctor, one of my dreams would be to show kids newly diagnosed with type 1 diabetes my insulin pump. To show them that this disease, though life-changing, doesn't have to hold you back from doing anything you can dream of. I spent so many years feeling different from my friends and classmates, that I wanted my future patients to know that I understood them. I wanted to be a doctor because I was a patient first.

The day before medical school orientation as I was leaving Best Buy with the last few purchases for my apartment, I received a call from my endocrinologist. The results of my recent thyroid biopsy were back. It was cancer.

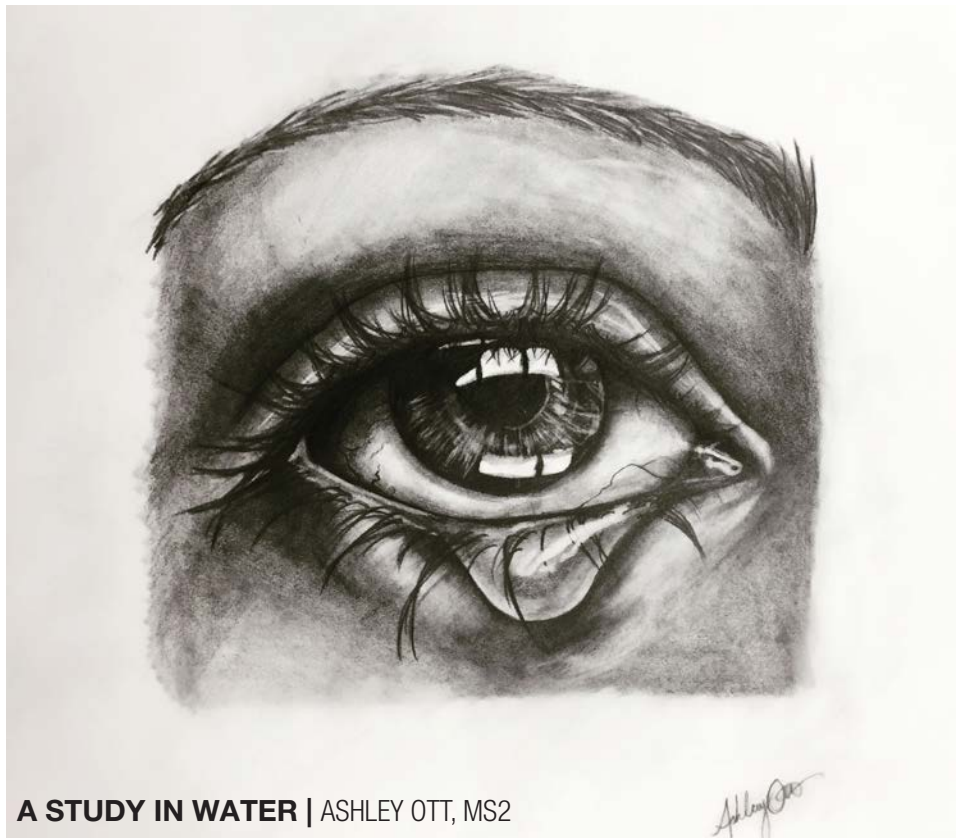
My parents wanted me to defer medical school for a year. I just wanted to cry.

How do you say, "I have cancer" to new classmates, advisors, and deans, people you don't know or trust yet? How do you say, "I have cancer" to your closest friends, the ones you just moved away from? How do you say, "I have cancer" to yourself and believe it?

How do you learn about cancer biology a few days and weeks after being told you have cancer? How do you reconcile learning more about the mutated cells inside of you while feeling their weight in your throat?

Somehow, day by day, you get through it. You learn to look at a thyroid in anatomy lab and feign ambivalence. You learn to avoid volunteering your neck for ultrasound practice. You learn to put the cancer in a box at the back of your mind so you can learn enough to get through your first quarter of medical school.

This is not my first time as a patient, but now I hold the new status of "medical student." Through this second round of being a patient, I also felt like one of the doctors in the room. At my appointment with the surgical oncologist, I was taught the Chvostek sign, shown my arytenoid cartilages



A STUDY IN WATER | ASHLEY OTT, MS2

and vocal cords, and identified my own carotid arteries on ultrasound. I couldn't help but be excited by the application of my newfound knowledge and the doctors couldn't help but teach me as if I was just a student working with them.

But at the end of the day, I was still the patient. I was the one with the steel rod in my throat while the real doctor held my tongue out for video laryngoscopy. I was the one who underwent multiple sticks for the second and third biopsies. And I was the one who had to decide if I wanted surgery or not.

The one silver lining I saw from my cancer diagnosis was that maybe it would make me a better doctor to my future patients. Maybe I would be able to empathize with them more. But this experience has only made me more afraid for my patients, and all patients. I was able to access, read, and (mostly) understand my pathology reports because I am a medical student. I was given direct contact information from my surgeon because I am a medical student. I was able to have a pre-anesthesia appointment over the phone—and not have to travel

to Northern California for a twenty-minute appointment—because I am a medical student. I was able to convince my anesthesiologist to take my continuous glucose monitor into the operating room and to put me on an insulin drip, against her initial judgement, because I am a medical student. What happens to a patient who isn't one of us? Is she heard? Is her experience and judgement valued? Does she fully understand what is happening or what she is agreeing to? Medicine is inherently a power hierarchy, one where the physician is at the top and the patient at the bottom. As I try to navigate this system for myself, I can only vow to always remember and advocate for my patients, just as I was able to advocate for myself.

Between my nearly invisible chronic disease and my very visible surgical scar, I find myself thinking back to the initial question of whether it's possible to think and feel like a patient through all the training and demands of being a doctor. If it has to be one or the other, I wonder if I can ever fully think and identify as a doctor, because I will always be a patient before I am a doctor.

# A CHICKEN RECIPE FROM MY YOUNGER SELF

GRIFFIN TYREE, MS3

I made pasta last night and it was depressing. It was the most depressing thing. Two hours of shopping, chopping, and cleaning burnt carbon off a tinny stovepot produced nothing but a sticky abomination of clumped capellini and mediocre sausage cubes that looked up at me and said “remember you are dust, and to dust you shall return.”

Tick tock, it whispered, squirming against my fork, tick tock.

For my part I would like to spare you that experience, dear reader, though I know even the most long-armed and able-bodied parent could not steer their child clear of calamity, for pain is as common to life as blood and respiration.

Not that bad pasta is a big deal. It's fine. We're fine. Moving on.

Here is a recipe for chicken that I made the other day.

## Ingredients:

Chicken legs – maybe six or seven; skin retained. Note: I prefer chicken because I often find myself working with cadavers and chicken is the most dissimilar form of land-meat to the muscle structures of the human anatomy. But beef and sometimes pork and especially those thin flank strips you get at Hibachi restaurants, those are the spitting image of your trapezius. They could have been inside you.

Onion – red onion; not white, not yellow, and certainly not sweet onions. Maybe a bulb, maybe a bulb and a half. Cut it as many times as you are satisfied with; who I am to tell you what size to make your onions? You do you.

Balsamic Vinegar – if you don't know what this is stop reading immediately. Step back from the computer and experience life. Visit the shoreline, make a friend, watch a sunset.

Soy Sauce – You will need as much soy sauce as balsamic vinegar; balance is a keystone of the human experience.

Cooking oil – This goes without saying. I, just now having had to write this here, am disappointed. In myself, in society, in all of us. Three tablespoons.

## How to cook this thing:

1 – Put oil in the pot and heat up the pot and take your onions, putting them in the pot. At medium-high heat, stir them to make sure the oil gets all over. Suffocate them in oil. Show no mercy.

2 – Continue cooking the onions until they are burnt enough to be flavorful. This is a fine line, stare at the pot until you see it reaching this point. Don't ever stop staring at the pot in this time period. Once they have faux-caramelized, take them out of the pot and store them on the side. Stare at the pot some more and realize what has just happened. Good work, congratulate yourself; we all need affirmation now and then.

3 – Put the chicken legs in the pot with some oil and let their leaking essence mingle with the memories of the onion. You want to sear them against the hot metal surface until the skin is brown and crispy on the sides. People go to restaurants and pay good money for that brownness, and you, eminent among the crawling creatures of the earth, you can make it in your own home.

4 – Turn the heat down to medium-low. Make a half-soy sauce, half-vinegar mixture, enough to fill up half of a small bowl. Pour this sauce into the pot, put the onions – your old friends – into the pot as well and cover. Let this amalgam simmer.

5 – You want the sauce to bubble and turn in some kind of viscous Francophile 'glase' while it steams the chicken legs to maturity. If you don't see this, perhaps you have put in too much liquid? But not all is lost; redemption is available to all who seek.

6 – Turn the chicken legs periodically to coat them. Ensure the sauce permeates their existence.

7 – When the chicken is cooked, take them from the fire and plate them. Many cultures mark the transition from child to adulthood with a special ceremony; this has been yours.

You will want to eat these this chicken thing with a side of some sort, maybe potatoes that have been artfully heated in a pan. You know how to make this, yes? I don't have to teach you? You know how to make this.

## Ingredients:

Potatoes – the small red and gold kind. I don't use many because I have small pans; this is a perpetual problem. But I am working on it, just as I am working on my multiple character flaws.

Cooking oil – Again. Again.

Rosemary – I have a small rosemary plant on my patio that will remain there until it becomes so grand and untameable (like the ocean) that the Homeowner's Association will make me chop it down and recycle it into firewood. A tablespoon.

Salt and Pepper – to taste.

Cut the potatoes and sear them over medium-high heat in a pan with cooking oil. Again, the brownness. Put rosemary in the pan. At a certain point, you will cover the pan and turn the heat down and the potatoes will cook through. Only you know when this point will be. Before the time of your birth it was etched into your heart and now it sits there, waiting. Listen to that voice.

Serves one person and thirteen ghosts of your childhood ambitions.

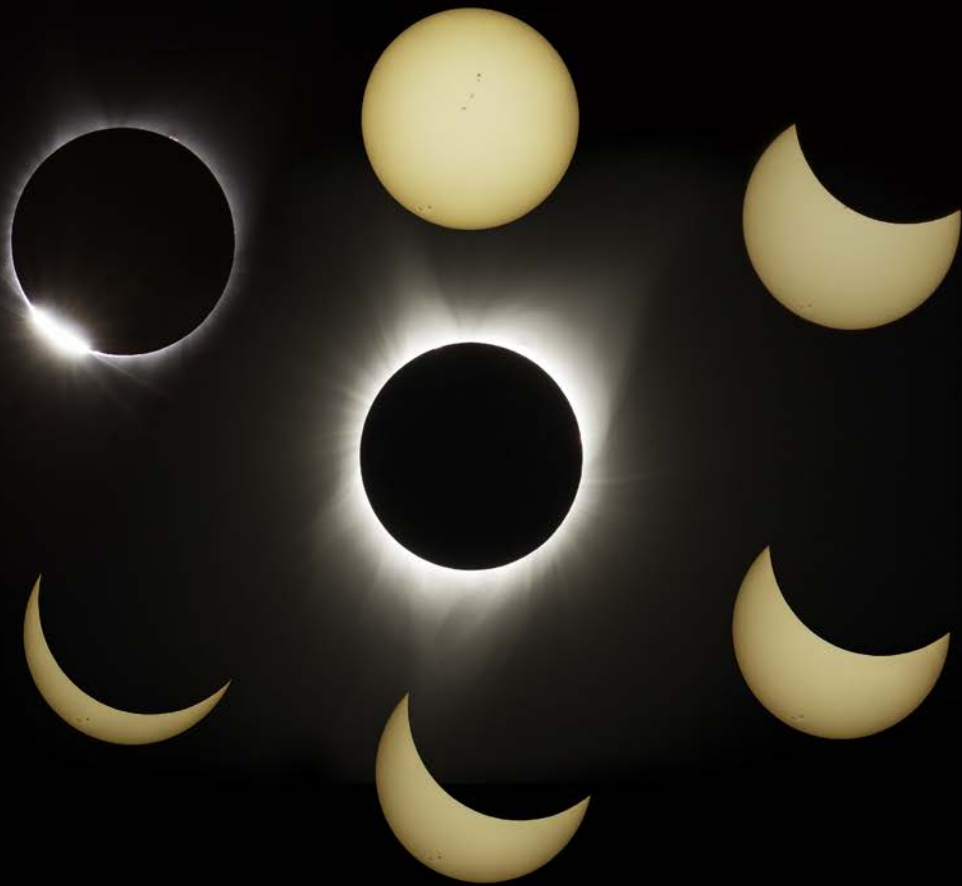
*Dedicated to Vicky Le.*

*Apart we would be two crumb-bums*

*Trying to have it all in the big city.*

*But together we are superfriends*

*Fabulously gay in opposite directions.*



**50**<sup>TH</sup>  
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