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Dark Star
Brian McMichael MD
Resident Physician, Emergency Medicine

The unimaginable mass in his abdomen
Pushes mercilessly through his back
Passes instantly through the hospital bed
And sinks into the center of the earth
Pinning him in position
– a specimen in a collection
   a great recumbent termite queen
   a distended and humbled, Jabba the Hut

Ballooning
Pregnant like a blister
Without shame or irony
He tells me, "I try to drink a 12-pack a day."
   Do I hide my shock?
An awkward attempt at connection,
   Or is it that I'm trying to surprise him
   right back in the kisser
By predicting that he no longer gets a buzz
   that some people drink like that
   just to keep from getting the shakes,
"Yep, and so I won't hallucinate like I did last Wednesday."

In Labor –
   ed breathing
We deliver him by
Caesarian invasion
   crossing the Rubicon into his homeland
by "tapping his belly"

He is polite and grateful
Chatting easily about his

Interesting and lost career

Cause and Effect
   Ascites fluid – Clear and golden
   Streaming into sterile vacuum bottles
   Produces a startlingly nice head,
   Usually

We fastidiously capture his
Disturbingly milky elixir
Easy blame slips away

Several liters later
He breathes easier
   While at the same moment
   The other person in the room,
   His dark star child
   Begins to grow again
   Inside his belly

"The smallest sprout shows there is really no death,
And if ever there was it led forward life, and does not wait
at the end to arrest it,
And ceas'd the moment life appear'd.
All goes onward and outward, nothing collapses,
And to die is different from what anyone supposed, and
luckier."

-Walt Whitman, Song of Myself
Lost and Found
Brian McMichael, MD
Resident Physician, Emergency Medicine

Before you were married and divorced
you lived together for a time
in an Craftsman, built in the 19-teens
in the backyard, the dirt
had chunks of ceramic and metal
bits of broken glass that time would expose
and rain would polish clean
these were dangerous for the dog
you told yourself

After a storm you’d patrol the backyard
for these antique hazards
you’d walk a systematic pattern
searching the ground for crusty jaggednesses
worrisome iridescent glints

You took to noticing the patterns that these pieces laid in
reconstructing them in your mind
into their original wholenesses
you’d imagine the people who used them
and then discarded or lost these bits and pieces
that you were mapping out over time

The ghost that haunted the breakfast nook
shuffling about most mornings before daybreak
and repeatedly opening that same window
looking out onto the backyard
was probably hunting for one of these keepsakes,
which you could never completely reclaim

Later as things were coming apart

you thought of intentionally creating your own artifact
breaking something and throwing it out in the yard
scattering all but a few, completing pieces
for those to come after

who might someday work this site
with shovels and sifters
brushing away the earth
to free the incubating relics
perhaps the only surviving traces of you

You could see her assembling that mosaic
piecing together a life in her imagination
her face would look down on these remains,
pause and smile to herself
as she understands
what she has found

"We do not serve the weak or the broken.
What we serve is the wholeness in each other
and the wholeness in life. The part in you that I
serve is the same part that is strengthened in me
when I serve. Unlike helping and fixing and
rescuing, service is mutual."

-Rachel Naomi Remen, M.D.
USS Arizona

On a warm bright spring morning we stood over the place
where eleven-hundred-seventy-seven-men
lie in darkness
in a rusted steel hull.
Promises unfulfilled,
pleasures unfelt,
future stolen.
We wept silently for these men -
mostly young - but also for those
who raised them, loved them.

Howard Fischer, MD

EITAN’S ROOM

Miriam Levine, WSU SOM Class of 2011

Ari Barak’s wife grips his hand and he tries halfheartedly to
pay attention. His eyes wander over the apartment complex. It’s a
U-shaped brown brick building, with porches and a grassy courtyard.
A bicycle leans against one wall; beside it a beach towel hosts a
family of teddy bears at tea. Do the bike and the stuffed animals
belong to the same child? Ari decides yes, probably a girl. He
wonders how old she is.

His wife Amira asks the landlord something or other about
the building’s age; Ari doesn’t care. He hates even the idea of
renting an apartment. No room for Eitan.

The landlord smiles too much. His name is Mr. Cummings,
a big-bellied man with graying hair who wears a white polo shirt and
tan slacks. He speaks quickly and energetically, and the exertion of
ascending a flight of steep stairs reddens his cheeks. Ari struggles to
translate into Hebrew to himself but is too embarrassed to ask Mr.
Cummings to slow down. Besides, he’s not interested in what the
landlord has to say.

Mr. Cummings unlocks the door to the vacant apartment,
and Ari bumps into Amira when they both try to go through the door
at the same time. Inside, Ari’s impressions of the place do not
improve. The kitchenette is poorly lit by a dome-shaped fixture, but
even so it doesn’t mask the linoleum’s yellow tinge or the stain
shaped like a child’s fist near the sink. Worse, the room is too small
for proper cooking – and that’s without any furniture. Just try fitting
the pressure cooker on one of those burners! Amira won’t be able to
make a real lentil soup. Eitan’s favorite. (“With toast but NO
crust!”) Even if the burners were larger, not even half their pots and
pans would fit into those cupboards. There will be no weekend hide-
and-seek games here. Ari remembers how Eitan once hid in the cupboard under the kitchen sink for nearly half an hour and Ari couldn’t find him until the little boy started crying because “he was lost.”

“Isn’t that nice, habibi?”

Ari feels a tug on his hand. “What?” he asks, rubbing his eyes with his free hand. “I don’t catch that.” He cringes inwardly, realizing his mistake. This is why Ari hates speaking English in public: he always mixes up verb tenses when he’s nervous. Amira is much better at languages and he lets her do the talking.

“Mr. Cummings was telling us that the refrigerator is a Sub-Zero.”

The landlord nods. “Best they make. It’ll run for years and never cause you any trouble.”

“Oh, yofi. Excellent.” Ari attempts a mask of enthusiasm. It does seem first-class: a fridge/freezer combination tall enough and wide enough to hold food for an army, with stainless steel doors. But is it necessary? Temperatures in the States don’t even compare to home. During a hamsin, the temperature can easily reach forty-five.

The Fahrenheit scale will never make sense to him.

Mr. Cummings continues. “Oh, and see?” He takes something small and square from his pocket and sticks it onto the fridge. “The doors are magnetic. I’ve got the same model and I always put up my kids’ pictures on the doors. You guys have any kids?”

Ari and Amira turn toward each other without their eyes meeting. “No.”

The landlord clears his throat and coughs politely. Can he tell? “Well, it’s great for putting up recipes or invitations, too. Let’s move on.”

Ari loses himself in thought again as Mr. Cummings leads them into the living room. The landlord’s voice echoes in the empty room as he prattles on about the Venetian lace curtains and aren’t they splendid, not something you can usually find outside Italy except at an exorbitant price. Ari disagrees: he hears Eitan’s high, childish voice pronouncing the frilly material “girly.” The little boy would’ve preferred draping it over himself to make a ghost costume. At least the rest of the room is tolerable. The hardwood floor is in good condition, and the walls are white – cool and sensible like walls back home.

“Yes, the walls are in great shape,” the landlord says, his voice picking up. Ari realizes he’s complimented them out loud. “Just painted last year. I try to give them a fresh coat every seven years or so.”

Seven. Next week should be Eitan’s seventh birthday. Ari looks his wife in the eyes for the first time in days, maybe weeks. Her face has aged in the last six months. The once-smooth forehead is now wrinkled, and gray roots stand out in her customary braid of thick black curls. Is this the same woman he married nine years ago? Amira looks back at him, her brown eyes wide and a half-smile of understanding on her lips. But then her shoulders tense and she stands straight as if she’s back in the Army. She’ll see this through with characteristic iron will unless he intervenes.

“Thanks very much, we’ll think it over,” Ari says and turns back toward the kitchen.

“Wouldn’t you like to see the bedroom first?” Mr. Cummings asks. He walks toward it and continues talking without a breath so that there’s no time to refuse. “Our apartments have really lovely bedrooms. The windows look out over the park and the sunsets are just terrific.”

“Come on, motek.” Amira presses Ari’s hand. “It won’t take long.” She leads him toward the remaining room closed off by a sliding door.

Ari stands firm. “I’ve seen enough. Let’s go.”

With a glance at Mr. Cummings, Amira switches to Hebrew.

“What’s wrong with you? This place is perfectly nice.” She speaks in hushed tones.
“It’s missing something.”

“What? There’s a kitchen – a little small, but not terrible – a living room, a bedroom, a bathroom...” She talks with her hands, gesturing as she speaks. “We could make it work.”

Ari shakes his head. “We’re leaving.”

Amira glares at him, but he doesn’t let go of her hand until they’re on the stairs. All she can do is stammer a quick apology to Mr. Cummings, who’s been shifting from foot to foot and studying the cuffs of his pants during their conversation – Ari’s a little overtired and he hasn’t been himself lately. She doesn’t speak to her husband the entire car ride, staring instead out the passenger window. Stores and restaurants blur together as the couple speeds home; Amira has never seen her husband drive so fast. He slams the car door when they arrive and marches into the house, hurling the car keys onto the kitchen counter on his way to the library. “Motek?” she calls after him. “What’s going on?” She joins her husband in the library.

He’s standing behind the old wooden rocking chair, pushing it so vigorously that it nearly tips over. “I can’t do this. I can’t leave this house.”

“Now what’s so bad about the apartment? Remember how dirty our first place was, the one with the cockroaches? This is almost palatial.”

“It doesn’t have a room for Eitan.”

Amira looks at him with pity and gentleness. “It’s been six months. It’s time to move on.”

“No. I won’t abandon him.” Ari turns away. His eyes fall on the bottom shelf, the one with Eitan’s books: a few are longer, but most are picture books. One with a green spine sticks out and Ari bends down to push it back into place. It’s The Giving Tree. Ari loved reading it to Eitan at bedtime, even though the little boy didn’t understand the story’s message. How could he, when he wasn’t even as old as the boy in the story? It was the tree Ari loved. Instead of putting the book away Ari leafs through it. When he reaches the end he looks up. Amira stands behind him, on hand on his shoulder.

“And the tree was happy,” they finish together. Amira tries to close the book and take it from him. He resists.

“Let’s put it back on the shelf.”

“Just like you want to do with Eitan – put him away,” Ari accuses. “That list.” The list she’s pressed on him for two months to try and demonstrate the advantages of moving.

Amira’s face loses its color. She drops the book and grabs Ari’s wrist. “Let me show you something.”

Ari follows mutely. He’s seen his wife a different shade of red for every degree of anger, but never so white, not even when she had the flu last year. She leads him to the living-room sofa. There’s a brown leather photo album Ari doesn’t recognize on the coffee table. Amira sets it in Ari’s lap, then sits down beside her husband. She opens the album.

Inside are all the photographs of Eitan that they’ve been meaning to organize for the past seven years, labeled and in chronological order: Eitan newly born, Dr. Ben-Josef cutting the umbilical cord, the bris, and each of Eitan’s six birthdays. So this is how Amira has spent the past several weekends. He’d glimpsed her on his way to the basement to paint: curled up on the sofa, nestling against the ultrasuede and resting her feet on the coffee table. There was a mess of something on the rug but it had disappeared and Amira was always in the library with the door shut when he came back upstairs.

Ari knows what the final picture will be. Father and son stand outside the garage, Eitan wearing his brand-new helmet and proudly displaying his shiny red two-wheeler. (“No training wheels for me, Imma! I’m a big boy.”) The walnut tree frames him on the left and his child-size goalie net stands on the right.

Ari remembers that afternoon well. How excited Eitan had been! Amira’d been on the phone with her cousin, but Eitan grabbed the portable out of her hand before Ari could stop him had and tried
to call Sabha and Savta, disregarding manners and the time difference. He’d relinquished the phone reluctantly and climbed up on the utility-room counter to reach the camera shelf. As soon as Amira hung up the phone, he’d dragged her and Ari outside to take a picture of the prized possession.

Amira turns the last page and the real picture is before them. “Look,” she says. “Here’s a picture of you teaching him how to ride a bike.”

“You found my favorite picture.” It had disappeared sometime within the last few weeks.

Amira smiles. “I took it to get an enlargement. I didn’t want to tell you.”

Ari asks what the extra copy is for.

“For that problem spot in your painting.”

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"When you look back on a lifetime and think of what has been given to the world by your presence, your fugitive presence, inevitably you think of your art, whatever it may be, as the gift you have made to the world in acknowledgement of the gift you have been given, which is life itself...That work is not an expression of the desire for praise or recognition, or prizes, but the deepest manifestation of your gratitude of the gift of life.”

--Stanley Kunitz
A friend of a friend was shot
Jennifer Curtis, MD

wake up boom.... boomboom
knowing women all over the city
join me
wondering
is it my son?

because the orange clad properties of state
are not mere primates
or topics of endless debate
by scholars so far away
they don't know...

she knows...
his favorite soup is tomato
with government grilled cheese
the baby mouse that he tries to free
the classmates he sags and swears to please
and he walks...

as i walk through this abandoned lot
with broken glass
boys like him pass me
glance at me
glare at me
stare at me

i stare at this abandoned land
in my mind plant flowers in this sand
clean trash and repaint homes

and pray like Elijah for this valley of bones
to BREATHE freedom from oppression
for hard hearts to BEAT with compassion
for Muscles to SEETHE from constructive exhaustion
and for eyes to SEE

your son

***

“There is no medicine like hope, no incentive so great,
and no tonic so powerful as expectation of something better tomorrow”
- Orison Swett Marden
The Woman Who Left Her Husband for a Hat

I wrote my wife a love song
then she left me for a hat.
We’d been through trying times before,
but she’d never stooped to that.

A hat?! Why not a pair of shoes,
a flat-screen TV or a hypoallergenic cat?
I wrote my wife a love song
then she left me for a hat.

You pity her: “That poor woman—it must have been an awful song.”
But you cannot rightfully believe
the discord justifies the leave.

I will admit I’ve made mistakes
(though not all the fault is mine)
and she may not have left me for a hat
if she had been of sounder mind.

Also, though I am not pleased,
there is one redeeming factor
in the midst of my absurd
and sudden sadly-ever-after:

The hat is a marvel of woven straw
trimmed with silk, chiffon, and velvet roses
of purple, white, mulberry and green.
It’s the finest hat that I ever have seen.

And when she wears it,
I see years upon years of bygone joy
wash over her face like a morning sun.
I can hardly bear it.

I wrote my wife a love song
then she left me for a hat.
But I guess I’m okay with that
if a hat can do what a love song can’t.

Alok Sachdeva

“Woman in Hat” - by Alok Sachdeva, WSU SOM Class of 2011
Time Ticks Away
Nishant Tageja, MD
Resident Physician, Internal Medicine

time ticks those moments away
wat passed out again..a wasteful day
stare into empty spaces..n th drunken bay
sun will shine someday..& show me th way.

lay in th moonshine..bathe in th lunar sway
me th novice and my lunatic ways..
away into the sleepy hollows ,
the dancing alleys & the dreamy greys..

wat will They think, wat will They say
Running past cold cedars..how i vaporised these days
jus a wild thought,you think i care..huh?
Damned be they...

mendin my loony looney ways..
I might as well run someday..
chase away th setting sun
& its blustering rays

till that moment,i procrastinate
raging like a river,every moment
each day...
My vernal desires..
growing older...
time ticks away !!

Blood
Jennifer Curtis, MD

“My daddy drank when I was born, It’s in my blood line”
He shouts burning black eyes fatally blind
To the hope contained in her kind-ness

“My daddy drank too nigga
Now get outta my house with that liquor!”

Pools of water pour from her bloodshot blue
Like rain able to restore withered to new
But his black is unfertile, cracked, hard, cruel.

The door slams, rap booms amplifying his mistakes
Leaving a trail of car alarms in his wake

And a huddled up woman crying
Trying
To rebirth through bloodshot tears

But water is not the life carrying capacity flood
It’s Blood

Woman only have one chance to transfuse
The man while he’s incapable to refuse
For nine months she is his deliverer

Women consent to give birth to creatures who will one day die
After birth our blood is useless, so we open our thighs
Hoping to take this man in and redeliver him

But the blood of a man is needed
The blood of one man is needed.
It’s late, on-call-tired
we dash into a third floor room
for a cross-cover page
as always both ceiling-mounted TVs are on
tuned to separate too-loud channels

we whisk past a preoccupied mother
the boy standing there with those foreboding
sparse wisps of hair
infused with too many lines
running from as many IV bags
hanging starkly on a wheeled pole

we round a curtain to find
a squad of posed action-figures
resolutely standing guard
strategically placed by their leader
to ward off the enemy

slumped rag-doll side-ways
a pale, pale, thin boy
with dark-crusted, cracked lips
blood slowly seeping from purple little bumps here and there

The shiner he sports
you wish
was from getting punched
but it’s not,

from the rock-bottom platelet count
from the chemo
from the cancer
from the chromosome
from the mutation
from the virus
that wriggled and jiggled and wiggled inside him

the mom calmly consents to the platelet transfusion
which along with everything else tried through the night
will not save him from bleeding out
even till morning

Photo by Andrea Barbieri, WSU SOM Class of 2009
Doing Something By Doing Nothing
Adam J. Rosh, M.D.
Department of Emergency Medicine

He is going to die by the end of my shift, I think to myself as I examine Mr. Brenner. His wife of 41 years, a daughter and a son surrounded him. I knew Mr. Brenner was deathly ill when I saw that he was recently discharged from the hospital after complications from his metastatic prostate cancer. The chart said he was diagnosed nearly three years ago. He thought it was in remission, but the cancer showed its ugly face again 6 months ago when Mr. Brenner started having lower back pain. His pain was not due to all the years of lifting bags full of concrete as a construction worker, as he thought, but instead to the collapse of one of his vertebra.

I peer at Mr. Brenner’s vital signs. His heart rate is 115 beats per minute—al least 15 beats per minute too fast. He is sitting up in the bed, legs straight out in front of him covered by a white hospital sheet. His arms lie flat on each side of the hospital bed gripping the rails with the last of his strength. A hospital gown covers his chest. His eyes open and close slowly, like he hasn’t slept in days. His skin is sweaty and blue, and a mask covers his mouth and nose, forcing oxygen into his lungs. Each breath is a struggle. I listen to his lungs and hear faint sounds of air entering the alveoli – this is likely due to an effusion - fluid accumulating in the thorax that diminishes sound from his lungs. I place my stethoscope on his heart hoping not to hear a friction rub – a sign that fluid surrounds his heart. It sounds normal and I am relieved. I gently press on his distended abdomen attempting to localize an area of tenderness. My Brenner doesn’t budge; I can tell he is focused on breathing. I glance at his family; they are silent, waiting for my response.

“Your husband is very sick,” I say, directing my message to the wife. “His cancer has spread throughout his body. His breathing is labored and he will not be able to keep it up much longer; eventually his muscles will fatigue and he won’t be able to take a breath.” “He is going to need a breathing tube,” I explain. “This means we would have to sedate him and he will not be able to speak with you. I don’t think the breathing tube would ever be removed.” I move closer and ask her if any one ever talked to her about what she would like to do if he ever got to this point. “No,” she replied. I was stunned, considering the advanced nature of Mr. Brenner’s cancer. “Well,” I said gently, “unfortunately, now is the time.”

For the next 45 minutes, I discussed the options the Brenner family had. Some families choose to take a very aggressive route, I explained, the “do everything” choice. And some understand that the end has arrived and try to make their loved one as comfortable as possible and be at his or her bedside in the final moments. I tried to be unbiased. I felt the most important thing was to be truthful. I’ve had this conversation before, but not often enough to make it routine. I am by no means an expert at end-of-life care.

The family asks me how long he has to live. I tell them he is very sick and will likely die within a few hours if he is not intubated. And if he is intubated, they ask? Well, I cannot say for sure, but I don’t think he’ll ever be able to breath without the tube. As they think about their choices I start to question myself. Am I doing the right thing? Should I just go ahead and start treating Mr. Brenner aggressively: intubation, central line, antibiotics, pressors. It is the easy thing to do. Who am I to sway a family into not medically treating their loved one? Am I hastening the death of this man? Have I done something wrong?

After ten or so minutes the family comes up to me and says that they don’t want any further intervention. They simply want to be at his side, to hold his hand, and tell him they love him. Please make him comfortable they say.
It is at this point that I realized I am doing the right thing. Having to explain to the Brenner family all of the options and scenarios took time and patience. Telling a family that their loved one is going to die is challenging. It is the last thing the family wants to hear. But being able to talk about it in this situation is crucial. Allowing them to make an informed and comfortable decision greatly improves their last moments together.

Mr. Brenner was admitted to a private room on one of the medical floors in the hospital. His wife, son, and daughter, each grasping an arm rail, wheeled his stretcher through the hallway of the ED towards the elevator. This would be his final journey.

As emergency physicians, we are trained to always intervene, to try and stop death in its tracks. We spend years studying the pathophysiology of disease, perfecting the art of the history and physical exam, and the precise interpretation of laboratory tests. We practice the technical skills needed for life-saving procedures – placing large IV’s into veins, tubes into the trachea, and even “cracking” a chest to hold a patient’s heart in our hands to give compressions. But I’ve learned that sometimes we have to let death take its course. This can be the most difficult lesson. We are not being weak or doing the wrong thing; rather we recognize that sometimes the best treatment is to do something by doing nothing.

"In the treatment of disease, oftentimes to do nothing is to do everything."
--Giovanni Battista Morgagni, 1761

**Immigration**

Jennifer Curtis, MD

I see the blood drip and pool on the cold tile floor
As they roll you off the body board
Cut your hundred dollar jeans off to see what they cost you
See pulses of warm life pulse from your buttock
And check for anymore
A quick finger up your ass, good tone gross blood

Fourteen hundred dollars of small bills and diamond teeth
is what you give your mama for coming to this country
seeking a better life
leaving her middle east war torn strife
begging with sacrificial eyes for your opportunity for peace

oh the country of the American dream with all opportunites before you
was the school too hard? Did they laugh at your accent?
Did you callous your hands and found your calloused heart preferable?
Or did the familiar chaos which crosses all languages and boarders find a familiar home in your war-torn heart

When the social worker comes in and asks who to call, it’s not your boys or your new toys who you long for- it’s your mother.
Mourning that her son got mixed up in the wrong crowd.
Anthracite (n.) (n thrə-s t)  
Brian McMichael, MD  
Resident Physician, Emergency Medicine  

A brawny, middle-aged man seated right by the door, impassively watching fútbol on the T.V. His left arm is wrapped in a chuck. The attending starts speaking in Spanish. I'm internally embarrassed because I'm surprised at her very good accent and fluency.

She is casually asking him how he's feeling. He's fine. How about the arm? It's fine. They regard each other for a long moment. Dispensing with niceties, it's time for a look. Once unwrapped, there's what looks like a great chunk of shiny coal as big as a burly fist sticky out of the flesh of this guy's upper left arm, just above his elbow.

[L. anthracites bloodstone, a semi-precious gem, from Gk. anthrakites (ἀνθράκιτης) "coal-like," from anthrax (ἀνθρῶπος) more at "live coal"]

Faceted like a despairing jewel set in a ragged, draining socket; it is frighteningly black. He's unphased by the meteorite embedded there - like there's nothing wrong. I like to think that I contained my shock, concentrating on their ping-pong-match conversation.
She is nonchalantly telling him that the thing on his arm is cancer. He just as nonchalantly says that it's not. She tells him that they will need to amputate his arm above the wound. He acts like he has never heard of such an outlandish notion before in his life. In any case, it really is no big deal. This guy is cool as a cucumber.

A hard, dense, lustrous, non-bituminous coal with little volatile material, high carbon content and low sulfur content

We don gloves and palpate the adjacent skin as well and the shiny-black sarcoma. The skin is hard and hot. He doesn't seem to feel any discomfort. She tells him she believes that this is very serious. He is unswayed, but respectful; he even seems a little concerned for our unnecessary worry. We say our good-byes.

She tells me that he is told that it is cancer multiple times a day and that he calmly, but consistently denies it. Supposedly, a doctor had told him once several years ago that it was not cancer. A routine biopsy is down at pathology. Maybe, he can see the "new" results and believe that ignites with difficulty, burns slowly with a short blue flame, without smoke and giving off intense heat.
Eiffel Tower – A Different Perspective

Golden Gate Bridge – A Painter’s Sky

Marriage: Anesth-Surg
Deepak Gupta, MD
Resident Physician, Anesthesiology

The day we married
It was a great dawn
For me
And for you!

I thought of
Helping you
Sailing along
Being a partner…for life…

I hoped of
Joining hands
Sharing joys
Overcoming suffering…together…

I expected
Welcome
Respect
Understanding…Admiration…

Did I achieve?
In ’Who is Alpha’?
In ’You are to Blame’?
Can I achieve?

What do you expect?
Will you tell me?
Can it be reasonable?
Do you trust…me…my judgment?

Have we realized…
Why we married
Why you interesting
To me!

Not for the joy of union
Not for the stability
Not for the fear of reprimand
Not for myself…or for yourself…

Joy pre-requisite to conceive
Stability to nurture the conceived
Security to ensure the well-being
Of our progeny!

What is in for me?
Watching their evolution
From total dependence
To self-sustenance

What is in for us?
Growing old with you
What will I do without you?
As we mean perennial togetherness…

So! May be we have
Difference of opinions
Still! Let us enjoy
Our custodial responsibility…and their care…in unison…

See! We are married
Life can be beautiful
For me
And for you!

Patient Care
Anonymous, WSU SOM Class of 2010

Patient Care, for all practical purposes is the engine behind the practice of medicine. What exactly defines the term, patient care, and who does it involve? I have stood outside the circle looking in at the care of the patient and now I am privileged to stand inside the circle of the health care system and actually deliver care to those in need. Standing outside, one does not really come to appreciate all the key players who are involved in caring for and/or managing the patient. I have learned that it is not only the Doctor and the patient, it is a team of professionals that come from all walks of life and hold all sorts of titles (just to mention a few: Attending Physician, Resident, Intern, Specialty Physicians, Physicians Assistant, Social Workers, General Nurse Manager, daytime/evening Nurses, Nurses assistants), and then there is me, the Medical Student. What exactly is my role in the grand scheme of patient care? What can I do to help? After all I cannot sign anything, I cannot order medications, nor can I advise the patient on anything that pertains to his or her current condition. I am assigned to an Intern who will guide me in applying the inordinate amount of medical information taught to me in the classroom setting to the care and management of a sick person.

After two months of patient care, I have only begun to scratch the surface of applying what I learned in the classroom to the diseases that plague our patients. I learned that the application of medicine does not only involve dissecting out details of a particular health ailment and treating it with medicine, but it involves getting to know and understanding the patient as an individual. Five weeks into my internal medicine rotation, I was assigned to a young man who recently had been diagnosed with cirrhosis of the liver, secondary to primary biliary cirrhosis, I knew just about everything there was to know about this disease, it is an autoimmune disease that destroys the intrahepatic bile ducts eventually leading to cirrhosis. Signs and symptoms include fatigue, jaundice, pruritus, and hepatosplenomegaly. Treatment is mainly supportive until the patient receives a liver transplant. After a
couple of days on the floor, the patient began to develop severe ascites and excruciating back pain, the ascites was developing as a result of his liver’s inability to make proteins that are critical for maintaining fluids in the vasculature. Ultrasound guided paracentesis was attempted to relieve the pressure, but was unsuccessful. We were able to relieve him of his pain with morphine and the process of organ transplant was underway. One of the many requirements for any transplant is that a patient have a strong social support network, unfortunately for this patient his social support was lacking because his family which consists of his wife and four children (ranging in age from 2-14), who all live in Yemen. In doing the history, the patient had communicated to me that he had been living in the United States for 15-years working and supporting his family overseas. He said he had never had any health problem; however, he had been under much stress because the U.S. embassy in Yemen had repeatedly denied visas for his wife and four children to come to the States. When I learned of the severity and the progressive nature of the patient’s condition, I looked into what the hospital could do in helping bring the patient’s family over from Yemen. I drafted a letter to the U.S. embassy in Yemen, stating the current condition of our patient and attached the pertinent medical documents supported by our attending Physician, and emailed all the documents to the U.S. embassy in Yemen. I received a response from the Embassy that same night, giving his wife and four children a visa appointment. The next day before rounds, I notified the patient, the expression on his face was priceless. That would be the last time I would see his icteric eyes open, within 24-hours our patient developed hepatorenal syndrome and was dead the following day. That would be my first experience with a patient dying under the care of my team. I was overwhelmed with such feelings of sadness for the loss of this man and for all those he left behind. Indeed, patient care has a plethora of facets, of which the medical student’s role however small it may come across, it can be quite significant in bringing a kind of comfort and reassurance to the patient that no medicine and/or test result could come close too.

A Patient’s Daily Pills

Photo by Mary Tanski, WSU SOM Class of 2009
My Land…My Country!
Deepak Gupta
Resident Physician, Anesthesiology

I had a dream
To fly
An eye on the sky
And soar high!

With perseverance
And years of toil
The day came
When I did fly!

I rose through clouds
I bisected clouds
I danced with clouds
Finally, I was calm!

It was boring
Above the clouds
So! I decided
To launch!

Hey! I was
In space
Out of gravity…Weightless…
Then I did see…

The unseen
The mesmerizing

The beauty of
The land!

I was still flying
In no-man’s space
Looking for
Gravity of no-man’s land!

I found it
I was delighted
I was pulled
To land unexplored!

I researched
I wandered
I hoped to
Meet aliens!

Inhabitation
Cohabitation
Invasion
Flashed across mind!

I did meet
Afraid
Cynical
Welcoming…Aliens…

Then I did feel…
For my dream
For my flight
For my land!

The call of gravity…
Existential gravity…
And then…
I did fly…again…

Beauty of my land
Still spell-binding
State of belonging
Felt like…Never before…

The vision broadened
The relationship redefined
And I prepared
For re-entry!

The embrace meant
Fires of friction
Shedding of debris
And the finale peace…Serene Sea!

As for my dream
I do fly again
Not from the land
But for my land…my country!

Artwork by Cerine Jeanty, WSU SOM Class of 2010
The tip of my right, ring finger
begins to ache
it swells into a tender knob
hot against my cheek

The surgeon says
it could be cancer
The game plan is:
I go under
they go in
a biopsy goes to pathology
Depending on the findings
I wake up
repaired
missing my finger up to the wrist
or missing my right arm to the shoulder
Ready!
Break!

Saying Goodbye
Patricia Dhar, MD
Department of Internal Medicine
Division of Rheumatology

As I sit by her bedside, remembering her vivacious spirit and smile
A great sadness engulfs my spirit
I cannot say what I really mean, too painful to voice
I can only smile through the mist in my eyes and tell her she looks great and is going to be fine
She looks in my eyes and I know she can feel what I am thinking but doesn’t want to say it out loud because she senses the pain in my heart. She knows and I know but neither of us wants to claim death and refuse to invite the darkness into the light.
I remember how she defied her disease, always dressed to the tee and wearing high heels as long as her body let her. Nails done, hair done, never giving in to comfort clothes. Not letting her disease dissolve her spirit. Her laughter always filled the room as we joked about the setbacks in her path. Regression was always followed resolve to overcome and find an alternate road.
She never missed an appointment, embraced compliance with twenty different medications and a maintenance regimen that would have made anyone quit, even teaching my medical students one year, her positive attitude radiating. The students watched in awe as she showed them all her pills and opened her life struggles to them, all with a smile. They learned more about becoming a doctor in that short encounter than all the lectures they had on her disease the week before.
At one point, it seemed that she would reach a turning point with a possible kidney transplant, but alas that was not in the cards and she took a slow and chronic downturn. Not giving in, she lived to stay around for her two children, valiantly fighting each fall down the abyss. Each time she climbed out, she was
weaker in body and her spirit began to fade. That’s when I knew the end was near. She was starting to give in, just didn’t have the strength anymore.

Now at her bedside, seeing her unable to walk or care for herself at the age of 40.
Unable to do her hair or dress up.
Unable to express her words, her mind failing her, she looked at me with sadness, just wanting to hold on until her first grandchild was born.
Never feeling sorry for herself, she counted her blessings and we joked about the negative patches.

I was with her the entire time since her diagnosis in the intensive care unit 14 years ago.
She was in a body she didn’t want and didn’t choose, and was powerless to do anything about it. The other doctors just saw a failing, sick person with terrible wounds and infections who couldn’t express herself or manage her personal hygiene. They didn’t know her and didn’t know who or what she was. I made sure they knew, but it probably didn’t matter to them. They just went about their business.

I sat by her bedside and we both knew the end was near. We talked about her children and her coming grandchild. I told her she needed to make it to his birth but we both knew that probably wasn’t how destiny would play out. I was just hoping she would make it through the holidays. She knew I had her back if anyone bothered her.

As I left the room with tears in my eyes, she shouted after me, “I love you Dr Dhar.”
I told her I loved her too without turning back but neither of us said goodbye.

### Fruits of Independence

**Deepak Gupta, MD**
**Resident Physician, Anesthesiology**

Independence to be conceived
Independence to be born
Independence to be welcome
Independence to be a celebration

Independence to grow
Independence to crawl
Independence to sit, stand and then walk
Independence to run

Independence to learn
Independence to trial
Independence to err
Independence to correct

Independence to rebel
Independence to demand
Independence to fulfill
Independence to retaliate

Independence to be amazed
Independence to quiz
Independence to seek
Independence to adore

Independence to love

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Prologue:

This courageous patient died last week after a long struggle. At least she made it through the holidays. Those of us who took care of her all these years are deeply saddened.
She will always be remembered in our hearts.
Independence to marry
Independence to procreate
Independence to leave

Independence to lay back
Independence to enjoy
Independence to reflect
Independence to joys and tears

Independence to be abandoned
Independence to not calling
Independence to be poor
Independence to suffer

Independence to professional help
Independence to 0015 smile
Independence to 2345 solitude
Independence to dying… alone…

Artwork by Cerine Jeanty, WSU SOM Class of 2010
Many people think that Emergency Physicians only treat emergencies such as gunshots, stabbings, heart attacks, and strokes. Well, that’s not always the case. For people who are hurting not from a gaping wound but rather mental anguish, who have no other place to turn; the Emergency Department is their haven. Everyday we meet people who are running on empty, who are just about to lose it and throw in the towel. It is our job to help them see another round.

A couple days ago a man in his 20’s presented to the ED, escorted by his mother. I glanced at his chart. The chief complaint read, “I’m vomiting.” No big deal, I thought, this could wait – since I am caring for 10 other patients who are much sicker than this young man with a few episodes of vomiting. About thirty minutes later, the nurse approaches me and asks if I spoke with the patient in room 13? “No, not yet,” I answer. “Could you please,” says the nurse. When a nurse tells me to go see a patient, I do it. It’s rare that this happens, but when it does, there is usually something wrong with the patient. So, I finish up a few things and walk over to bed 13.

As I approach the room, I see a young man with light brown hair down to his shoulders, sitting in bed, tears rolling down his cheeks, hyperventilating and vomiting clear to yellowish emesis. His mom is at his side, holding up his hair. He is rocking back and forth in the stretcher. I introduce myself to mom and she replies, “Hi, I’m Pauline, Steven’s mother, I’m a nurse.” OK, I say to myself what’s going on, this young guy, who looks miserable is here with his mom, a nurse. My first thought is that this guy has meningitis, an infection of the brain that causes young people to look very ill. I’m waiting for her to tell me about his high fevers and stiff neck, classic for meningitis. “Steven’s brother died a few months ago and he’s never been the same,” is the first thing she tells me. “His uncle died two days later,” she continues. “And his father, a police officer, died in 9/11, Steven was also in the building before it collapsed.” How do I handle this? I am at a loss for words. What can I do to help this family? Who am I? “I’m very sorry, it sounds like you have been through more than most people can handle,” I say. I don’t believe that society appreciates the effects of psychological stressors. I often see these stressors cause people to have physical symptoms; probably the cause of Steven’s vomiting. “We’ve been to 3 different hospitals over the last month, but Steven keeps throwing-up, can’t keep any food down. He’s been x-ray’d, CT scanned, even had an endoscopy, nobody can figure out a reason why he is vomiting,” says Pauline. I push on Steve’s belly, it’s soft, no areas of tenderness, then listen to his lungs and heart, look at his sclerae for icterus or yellowish discoloring seen in gallbladder disease. Everything appears normal. Steven says, “My hands are so numb, and my mouth is tingling.” I watch him breath, too fast, about 30 breaths a minute, double the normal respiratory rate. I tell the nurse to administer fluids and order a milligram of lorazepam, an anti-anxiety medication.

Five-minutes after he receives the medication I walk back over to him, and already I can see a difference. The tears subside. “How is the tingling in your fingers,” I ask. “Much better,” says Steven. I see calmness in his body; his breathing slows down, the vomiting stops. “I think your symptoms are due to the enormous psychological burden you carry in your mind; its psychological symptoms manifesting as physical symptoms, that is why all of your x-rays and CT scans are normal.”
“There is nothing wrong with your organs,” I tell him. Steven sits in bed, staring straight ahead. “I can barely get the energy to go on living, everyday is a struggle,” he says. “I can’t imagine what you’ve been through, but I’m sure you are doing your best, I say. Steven replies, “I am trying, but failing.”

When things go bad in emergency medicine, it is usually not the patient who tells you. It is usually a vital sign, ECG, or lab result that is dangerously abnormal. Today, my patient is telling me that his health is critical. I call the psychiatrist and relay a brief history. “I'll be right over,” says the consult, “Sounds like this guy is sick.”

The most critical patients aren’t always those who are hypotensive. Sometimes, our most critical patients have a completely normal physical examination with normal vital signs. But if you look deeper, you’ll see their illness – a broken soul. It is our job to start the healing process in these patients. To find these patients the proper care. Steven presented to our Emergency Department broken. After two weeks in the in-patient psychiatry ward, he left with a sense of hope. Putting his shattered life back together, one piece at a time.

The Smoky Cloak
Nishant Targea, MD
Resident Physician, Internal Medicine

The vitreous walls & the glazed eyes
awake in th moist smoke and festive lights
the clamorous night & its burgeoning pride
the momentary silence & its pristine sight

My thoughts though intangible
fumble for a mile
impaling th peace that existed
but for a while
The arrogant web of dark looks on
the passion, this world, & the sleepy me, Yawn!!

My silent recluse & th arrogence of this night
The uncertainties for my company.. N th possibilities
away.. n yet just in sight..
My prehensile deeds and the belittling subtleties
befuddle me furthur.. conspired n hatched jus right.

It shall unfold before my eyes
where the road to my perdition really lies
if scepticism would give way
N th ball will rise, thru th east, th first morning ray
It will unearth N i shall be consumed..
In this smoke.. in this haze.. the stars marooned.
Hi everyone!
Saving the Skin!
Forgetting the Lungs!
Blaming the Mind!

Don’t you worry!
Saving the Gas!
Forgetting the Colon!
Blaming the Food!

You want some air!
Saving the Privacy!
Forgetting the Windows!
Blaming the Space!

Is it confusing!
Saving the Energy!
Forgetting the Healthcare!
Blaming the Population!

Do you get it?
Saving the Dying!
Forgetting the Alive!
Blaming the Choices!

Not satisfied yet!
Saving the Individual!
Forgetting the Family!
Blaming the Society!
Want More!

So you see!
Saving the Self!
Forgetting the Environment!
Blaming the Genes!

And what next!
Saving the Body!
Forgetting the Soul!
Blaming the Mind!

And not stopping!
Saving the Money!
Forgetting the Creations!
Blaming the Wars!

There is explanation! Uno!
Saving the Present!
Forgetting the Future!
Blaming the Past!

Though Ideal will be! Universal!
Managing the Present!
Nurturing the Future!
Lessons of Past!

Till that Time!
Save the Skin!
Kill the Lungs!
Blame the Mind!
Clockwise from top left: A Mother's Touch, Boy Behind the Mask, Healing From Within

Sequence by Elliott Attisha, DO
Carnival and Lent

We walked down a street in Miami Beach,
past a small group of silent men.
One, about my age, broke away from the group.
Weather-beaten face, thick grey moustache.
He asked almost inaudibly,
"Hello, Sir. Something for the hungry?"
I put my hand in my pocket to pull out a dollar
bill,
came up with two, and gave them both to him.
As we went on our way, a Rolls-Royce
turned the corner and went silently past.

Love you, Family! Love you, God!
Deepak Gupta
Resident Physician, Anesthesiology

I was born
No control
Over it
No choice!

The race
The face
The religion
The country!

I was weak
I was ashamed
Waiting to grow
My turn to run!

Run from shame
Run from name
Run from family
Run from God!

Family leaving extensions
Going on Single!
Poor dilution of
Personal ills!

Decided to search!
Looked for friends
Looked for soul mates
Looked for harbors!

Did I find trust?
Did I find endurance?
Did anyone stay?
Did anyone care?

Should I call back?
My family
Will they be around?
I believe so!

They never left
I drifted away
I lost faith
They never have!

Because of them
I can now fly!
No concerns for
Where to descend!

Loving family reborn!
Accepting extensions!
Believing God!
My only ‘Friend Indeed’!

Had ignored Him
Had fought Him
Forgotten Him

But! Never left Him!

Can I leave Him?
Whom will I weep for?
Whom will I laugh for?
Whom will I dance for?

He is the Father
He is the Mother
He is the Energy
He is the Conscience within!

I found solace in my name!
My race! My face!
My religion! My country!
I found solace in my birth!

What else to say
What else can I say!
Love you, Family!
Love you, God!
Oda al Durazno
Brian McMichael, MD
Resident Physician, Emergency Medicine

Tu nombre es tu color
pero durante el verano
el sol te tiñe
así que puedes tomar
la prerrogativa de la pelirroja
y adentro también
te conviertas más rojo
como se te entra más profundamente
intensificando al color de sangre

Mi amor suave y terciopelado
me envites con tu dulzura
y tu humedad
llenas mi mano
con tu densidad suave y redonda
tu rajadurita femenina
y tus curvas voluptuosas
me evocan el deseo
a te comer...ahondarte
a te comer hasta que
tu jugo corra
abajo por mi barbilla
no voy a querer parar
una vez que empiezo

Aun cuando muerdo mis dientes
en tu carne exquisita
haces solamente el sonido
de un corazón
entre dos latidos

sabores casi como nada –
delicado con una insinuación
de acidez

En el verano tarde
te conviertas la más indiscreta
las frutas estropeadas
cacen a la tierra
se afean - fangosos y pegajosos
como estiércol
atrayendo moscas
entonces te odio

Aun dentro el otoño es ineludible
de modo inesperado
tus rebanadas me vislumbras desde
mi tazón de leche
te acurrucas cruelmente
dentro de mi helado
usurpas los postres todos
te acuestas desvergonzadamente encima de
los pasteles, las tartas, las empanadas
abiertamente, descuidadamente

Ah, Fruta del Sur Profundo
estoy solo, en el invierno oscuro
me quebranto
atormentado por
su solo defecto sólido
que cuando finalmente
he llegado a tu centro
encontré tu cerebrito duro
en el lugar donde
tu corazón debía haber est
Your Lungs
For M.B., 1926-2008

Your lungs were more musical every day—inspiratory crackles, expiratory wheezes, a symphony that played your burden. You keep telling me every day that you’re feeling better, yet my stethoscope, listening through inexperienced ears, the gray, white shadows haunting your chest x-ray, say you’re getting sicker.

The nurse called me in the evening telling me your oxygenation: 72%. We gave you oxygen. I stayed with you for 45 minutes, my heart racing when I left you last night.

The next morning I came to see you but it wasn’t you. I knew. I went down to the lobby and cried.

I wasn’t there for your “code blue” I wasn’t the person to tell the news to your family. I wasn’t the doctor making decisions. I was

the last one

from our team to see you that night, the one who helped you put on a new hospital gown. We laughed together because I was having difficulty buttoning up your gown, your tangled IV lines in the way, my 7 years of college education not enough.

Stephanie Judd

“Heaven or Earth?” - Nirmal Gokarn, WSU SOM Class of 2012
Father-Daughter Conversation

We search for things to tell each other: Classes taught, jokes told to students, books read, dinners with friends. We don't tell each other how much we miss her, my wife, your mother. What good would it do? What harm would it do?

Howard Fischer MD

Who am I?
Deepak Gupta
Resident Physician, Anesthesiology

Who am I?
I don't know
I think I am
The big show!

The day
I was born
I had sheer
Desperation to survive

It was perennial fight
Survival of the best
Then, I learnt
To co-exist!

What brought
The change
My evolution
Into creator!

I was creating
Slowly
Steadily
Learning in process!

I learnt to
Feel like God

Photo by Andrea Barbieri, WSU SOM Class of 2009
And how to
Have disciples…followers…

With creations piling on
I became worried
And I demanded
Protection!

With safer environment
Creations bloomed…more…
However, as a protector
Designs were shaping…creeping…

Designs to invade
Designs to destroy
Designs to acquire
Designs to rule
And creations meant for
Survival…construction…
Evolved from being served
To serve protector…destructor…

I fought all conflicts
I won many battles
I lost major wars
And I was tired…distraught…

Then, no battle to fight
No war to win
So! I turned into
Bidder…and Seller!

I didn’t differentiate
I didn’t appraise
I didn’t heed
I didn’t share

All my energies
All my focuses
Meant to keep
The membrane…differentially permeable…

Because I was smart
Enough to realize
Buyers should not become
Sellers…Never…

Actually, all this time
I have been missing
The point…
The Uno!

Am I the creator par excellence?
Am I the protector against disasters?
Am I the seller to share?
or Am I just a survivor…only?

Who am I?
I am the time-era!
I am the society!
I am…you!
The Burden of Stroke.
Ebere Azumah
WSU SOM Class of 2010

This patient is a 60-year-old black female with a history of Atrial Fibrillation, which was diagnosed after a CVA. Her CVA caused a left sided hemiparesis and dysphagia. This patient presented with altered mental status status post pneumonia, intubation etc. After talking to the patient's daughter, her guardian, I learned that although she had chronic hypertension for about 20 years she was not recently offered an EKG (prior to CVA). I believe an EKG would have shown atria electrical dysfunction and probably she would have been placed on an anticoagulation therapy and maybe she might not have suffered a stroke. As I rounded on my patient, she was totally dependent on others, and looked uncomfortable and miserable. She was always trying to communicate with me whenever she wasn't actively delirious but I couldn’t understand her, she has a tracheostomy tube. I realized the importance of following medical guidelines as a physician. Maybe, if her primary care physician periodically offered the patient an EKG, he might have diagnosed Atrial Fibrillation. If so, my patient Mrs. M. may we working rather than being dependent on others. Basically the cost of preventing a disease is cheaper than treating or managing a disease.

The answer lies in his history.
This patient is a 70 year old Caucasian male with history of dementia, schizophrenia and resides in a nursing home presents to the ED with mental status change post a fall. Patient was then sent to get a CT scan when he endured a new onset seizure. Fortunately a stat CBC reading was then performed which showed my patient, Mr. S. was hyponatremic. His hyponatremia was corrected and the patient's seemed better. However, doing examination, I noticed that the patient had some difficulty elevating his upper extremities above 30 degrees bilaterally. Initially I thought maybe it was part of the patient's age related osteoarthritis. But we decided to call the pt's caregiver. She informed us that Mr. S was very active prior to the fall and he was able to take out the household trash. A day later, I noticed that my patient had large ecchymosis on his upper extremities and this area had turned yellow. We were unsure what the etiology of these current symptoms were. Our differential diagnosis were medication induced myositis (he was on aricept and other antipsychotic drugs) or even polymyositis. We did order some labs and was about to perform a biopsy, when someone (intern) suggested that we perform a radiological exam of the upper extremities. Fortunately, the radiological exam showed that Mr. S had sustained bilateral humeral fracture! This explained why my patient had limited range of motion and ecchymosis bilaterally. From this incident, I learned that we should use the history of presentation wisely and critically. We should always start with the most common diagnoses before thinking of the "zebras". If we had thought of trauma causing his anemia, or elevated CPK we might have saved the healthcare system the money used in ordering other irrelevant labs or paying for consultation. Additionally, Mr. S. would have gone home sooner.

The Power of Patient education
This patient is a 65-year-old African American female that had a 40-pack year history of cigarette use, presents with chest pain. She was admitted for rule out Acute Coronary Syndrome. This patient also has a strong family history of cancer, mom died of a cancer and a sibling died of lung cancer yet this patient continued
to smoke. Initially while taking the history, I encouraged the patient to quit smoking and she was somewhat resilient. On hospital day two, patient was going to be discharged and as part of her smoking cessation program, my attending and intern encouraged me to counsel her again about smoking. This time, I found two articles that explained the medical burden associated with cigarette use. I went to my patient and explained the article to her and I encouraged her to ask questions. After few minutes of conversing, she told me she was going to quit smoking. She inquired on ways and tools to help her quit smoking. From this patient, I learned that patient education and understanding is key to patient compliance or lifestyle modification.

On receiving the news
Brian McMichael, MD
Resident Physician, Emergency Medicine

In that moment, when the horror of an accidental mutilation
Gets to you and you wish it not-to-be
And you wish desperately you weren’t here for this

You gave up everything to become a doctor
But when it comes to it
You are not fascinated

You do not want to participate much less witness this
You are transfixed with shame and doubt
doing nothing but standing there

After monstrous suturing
The replants remain dusky
You have no hope of their viability

You are angry at the pretense
and sickened at having lost your nerve
What in the world are you going to do now?

“One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.”
—Frances Weld Peabody
Prescriptions for the Week- Pharmacy in China

Auto-Immunity
Deepak Gupta
Resident Physician, Anesthesiology

I am the protector
I am the fighter
I am the savior
I am the immunity!

I am on guard
So you can be
Off-guard
And relax!

Nature gave me
So much fodder
To fight
And to kill!

I win some
Lose some fights
But I am
A survivor!

Century back
I was afraid
I was weaker
With few answers!

I depended on
Regular care
Personal hygiene  
Isolation and quarantine!

Thanks to penicillin  
I was re-born  
I was rejuvenated  
I was robust!

I was wrong!  
I was overtaken  
I was replaced  
I was out of service!

Did you forget?  
Pyramid of Ecology  
You are on  
The Top!

The view is better  
The outlook is phenomenal  
But you are alone and  
Chances to trip greatest!

Try to eradicate  
The weaker pathogens  
You are attacked  
By the stronger ones!

The weaker populations  
Dilutes the attention  
And delays the attack of

‘Egoist’ King Pathogen!  
Decomposers will be there  
Always!  
You may or may not  
Remain at the top!

Will you learn not to overdo?  
Will you learn not to kill all?  
Will you learn how to shield?  
Will you learn how to co-exist?

I doubt it!  
So whatever!  
I need my fodder too!  
Welcome to Auto-immunity!
The Positive Impacts of Communication
Jennifer Marie Finna, WSU SOM Class of 2009

One of my patients, an elderly lady named Ms. H, taught me an important lesson about the complexity of providing patient care while inside but especially after the patient leaves the hospital. Up to now I had thought that the hard work was the diagnosis and treatment of illness, but now I realize that an even harder part with elderly patients is setting up and making decisions about long-term care after their discharge.

Ms. H has stage four CHF (Congestive Heart Failure), and up to this hospital visit has been living with her daughter, who has been able to manage helping her with her activities of daily living. During this hospital stay her daughter told us that she no longer would be able to manage Ms. H after she is discharged. The daughter is too exhausted from all she has had to do already and with her mother’s deteriorating condition she does not want to be responsible for her care any longer. Ms. H’s response to this was “I am never going to a nursing home. I will go home and die if I have to in my home.” She was very persistent about not wanting to go to a nursing home. I don’t think she realized that if she were to go to her home and her daughter were to move out and leave her all alone, that she really wouldn’t be able to provide for herself, and in reality would die alone in her home. She was immobile, and that wasn’t going to change. Now the question came, since she is competent, do we abide by her wishes, and basically send her home to die?

This stressed me out as I had become personally and emotionally involved with Ms. H. To me, she was like my grandmother, and I wanted the best for her. Through striving to get the best care for her, I came to understand how critical the interplay is between what we as her healthcare team recommend versus the patient’s wishes versus the family’s wishes versus what social workers suggest versus what her health insurance would cover.

From this patient, I learned that fluid communication between ALL parties is necessary to solve such a complex issue. At first I was making phone calls separately to her family, then to social work, and then to her insurance company, and then back again separately to each party, and the story kept changing and the options kept getting more and more confusing. After two days of this I had gotten nowhere, so finally I decided to arrange a meeting in Ms. H’s room with Ms. H, her daughter, the social workers, our team of physicians, and myself, with her insurance information in hand, to figure this out. The meeting was effective, and a compromise was settled between all the parties and Ms. H. We would send her home with homecare helper aides and a nurse that would come out a couple of times a week, and her daughter would assist her on the days that homecare didn’t come out. This would be a trial period for a few weeks, with the understanding that if this wasn’t successful, or wasn’t enough assistance, that an assisted living environment would be the next step.

The lesson I learned is that the best way to handle different parties that influence a patient’s care is to bring them together in the same setting, where everyone can talk to each other face to face, and then come to a mature compromise with the patient’s best interest in mind. Also, we must not forget that independence is a fundamental human right that often is shattered by aging and disability. We must not forget how traumatic it can be to our patients to lose it. I know that I will be more adequately prepared to handle my next complex case having had this experience.
DISSECTING ANEURYSM
Noreen Rossi, MD

Virgin youth, innocence
Surrendered in war.
Emotions quake. Memories
heave. Distorted dreams
Disrupt tranquility.

Crack! Instant ecstasy.
Exhilaration. Pressure
Mounts to Vesuvian
Proportions. Molten iron
Seeks the tectonic fault.

Fragile crevice in a muscular
Wall gives way, rent
In unremitting agony.
Liquid diamonds seep
To the glazed surface.

The core of life erupts
In a gush of bloody magma.
Congealed power oozes, then
A deafeningly mute scream
Tears the unearthly silence.

“Physicians think they do a lot for a patient when they give his
disease a name.”
--Immanuel Kant

Beasts of Burden
Brian McMichael, MD
Resident Physician, Emergency Medicine

Sitting waiting for my take-out pizza
a woman my mother's age
comes in and places her order
her accent beckons
with the promise of a story
I chatted her up

She was from the mining districts in the south of Wales
we remarked on recent mining disasters in West Virginia
I shared that my great-grandfather was killed in a mining
accident in Indiana
At the turn of the last century

She then told me about the husband of a friend
who had grown weary of the hardness of the pits
and had gained a transfer to the relative safety of the top
within months he was pining for the grime and darkness

He found his way back down again
by becoming a pony driver
and spent 20 years
hauling carts of coal

According to tradition
once down in the pits
blinded by the stygian darkness and the coal dust
the ponies never left the pits alive

I told her how it reminded me of the K-9s
I handled in the Marine Corps
once the dogs are trained to attack
by the United States Government they are doomed to live out their days enclosed in kennels coming out only for training or to work

When one of our dogs became too old, too arthritic or blind to actually fulfill their purpose we would fudge and cover-up to steal them another few, hard months in our limited care before their bureaucratic euthanasia was eventually carried out according to regulations

My pizzas ready
I said good-bye to her as I got into my car I wondered once we fully enter onto our paths as doctors whether we are no different from the Pit Ponies and Military Working Dogs aren't we also doomed never to see the light of day? or to know the comforts of home again?

“O let me ever behold in the afflicted and the suffering only the human being.”
--Moses Maimonides, Prayer for Physician

Artwork by Mary Jacob, WSU SOM Class of 2010
ABANDONED
Jennifer Curtis, MD

There’s something about abandoned houses, cities, stores that stirs a sense of horror in us. As we walk through the dusty rooms, seeing the dress hanging in the corner of the still small room with moth nibbles at the sleeves, still some of the tenderly woven embroidery remains. We imagine the care put into sewing the seams, creating from imagination, magazines, and hopes a dress to adorn her beloved daughter, to highlight her small waistline and gracious thighs, oh I can almost see her slipping this new dress on and looking in the mirror with hopes of what and who this dress may attract into her North Dakota country girl life before the water ran out and the town went bust… and 100 years later I stand looking in the same dirty mirror, seeing a young girl’s hopes and fear that they will be left, rejected, and eaten away year by moth eaten year. This dress confirms that my hopes may not be watered and grow, no a drought may come and I too could fall prey to its horror. To be loved and left when the love runs dry. To be lovingly fashioned and left in sudden desperation.

There is something beautiful within us all, something that longs to be nurtured and maintained, drawn out and treasured and held close to someone else’s heart.

Maybe that explains my fascination with antiques and abandoned cities. I know the pain of being left, of showing my most beautiful parts and then being left alone. I feel the same ache that these burned out Detroit houses feel, lovingly designed and carelessly torched, with no thought given to the loving embroidered detail in the mantle woodwork or the custom designed crystal doorknobs. Just a quick decision, a quick match and the whole beautiful thing goes up in flames and it burns to the core. Horror oh horror the heart is scarred and broken.

Oh Detroit, North Dakota, antique barn I feel your pain. I long to restore your soft and tender embroidery and repaint your vibrant colors just as I long for someone also to find my soft curves and tender corners and forgive someone else’s past abuse.

Jawad Khan, WSU SOM Class of 2011

Abstract:
Allocation of medical resources, whether micro- or macroallocation, is an aspect of medicine surrounded by a great deal of controversy. In fact, it not only pertains to medicine, but also to ethics and economics. The question is not only limited to who should receive the life saving medical treatment, but also who is deserving of such treatments. Utilizing past and future contributions to society as criteria for medical treatment is unethical, based on the idea that we are in essence judging an individual on subjective factors that are functions of race, gender, and social class.

Keywords:
End-of-life issues, health care delivery, rationing / resource allocation, ethics committees, health economics, medicine

Manuscript:
Allocation of medical resources, whether micro- or macroallocation, is an aspect of medicine surrounded by a great deal of controversy. In fact, it not only pertains to medicine, but also to ethics and economics. The issue in question is not only limited to who should receive life-saving medical treatment, but also who is deserving of such treatments. The word “deserve” directly implies that one individual is more worthy of medical treatment than another. This worthiness is usually based on something the individual has done or has accomplished. The problem arises from the fact that deeming one individual more deserving than another is a completely subjective judgement, and varies from person to person. One can label a certain individual as more deserving than another, and someone else might completely disagree. Therefore, in regards to life saving medical treatment, it is unethical to utilize past or potential future contributions as criteria in deciding who should get
life saving medical treatment when resources will only allow a limited number of individuals to receive such treatments.

The focus should remain on who better qualifies for medical treatment based on medical facts. Although Rescher incorrectly argues that the potential of the person in making future contributions and the person’s record of services or contributions (Rescher 1969) should be factors in deciding the allocation of “exotic medical lifesaving therapy”, he does establish several criteria that are important and relevant. Following his same line of thought, there should be criteria of inclusion and criteria of comparison (Rescher 1969), followed by a random, indiscriminate selection.

For criteria of inclusion, we can begin with the constituency factor; that is, is the individual a member of the community that this institution serves? This can include any type of geographic boundaries, such as, are they residents of the state or even citizens of the United States? Clearly, any type of discrimination based on race, religion, sex, etc. is unacceptable and unethical. This should not be a very stringent or significant criterion when dealing with life or death situations. Imminent situations call for emergency response, and any type of geographical limitation should not be taken into account. A second type of criterion should be the progression of science. Individuals can be included in the first group depending on any potential benefit the hospital or researchers might be able to obtain from this patient. The last constituency principle is the prospect of success. The hospital and the physicians should aim to include individuals who will benefit from the therapy. When considering these criteria, one needs to think of these in the context of inclusion, and not look at these as a basis for rejecting individuals. These criteria, and potential patients, should be evaluated solely by a medical committee.

The next set of criteria should be used to compare individuals and determine who are more qualified for receiving the services. These should be evaluated by a committee consisting of primarily physicians and bioethicists. The exclusion of individuals should be based on three factors: relative likelihood of success, life-expectancy, and number of dependants (Rescher 1969). The relative likelihood of success will help determine which patients will benefit most from the therapy provided. Obviously, individuals in whom the therapy will prove ineffective are not legitimate candidates for this scarce resource.

![Photo](https://via.placeholder.com/150)

*Photo by Andrea Barbieri, WSU SOM Class of 2009*

Also, life-expectancy is of importance. Patients should be evaluated not only on how effective the treatment will be, but also how long they will be able to live with the benefits of the therapy. Finally, the number of the individual’s dependents should be evaluated to determine the number of other lives possibly affected. Of course, the extent of the effects on the dependent’s lives should be evaluated to determine if the effects are significant or not. This would entail financial, social, and emotional factors that would
perhaps be altered. Some might argue that the number of dependents is an unethical criterion of selection. This could be due to the fact that child-bearing can be a function of social class, culture, or personal preference. These should not be underlying factors that give one an advantage or disadvantage over another. While this is true, family size can be and is, in some cases related to many factors; this does not change the present situation. The fact remains that more will be affected by rejecting patients with more dependants. After all, the inclusion and selection criteria have been applied, if demand still exceeds supply, random selection should be applied to determine who ultimately receives treatment. As simplistic as this may sound, it is the only nondiscriminatory method of selecting the recipients of the services or goods. Allowing factors that measure social worth based on past services rendered or potential future contributions is unethical due to its explicit judgment of a person’s merit based on many uncontrollable factors.

The strongest objection to the argument above could be that future contributions is a viable selection criterion because it is in society’s best interest to choose those individuals who have the potential to make these contributions (Rescher 1969). Also, following the same line of thought, past services rendered is important because it is the best indicator of the individual’s future contributions; that is to say that past services rendered will highly correlate with future contributions. Therefore, with all medical factors comparable, a pharmaceutical scientist will be given treatment over a carpenter. The scientist will be much more important due to future contributions to medicine and health.

Although strong, the above stated argument depends on assigning value to an individual’s worth based on arbitrary and subjective factors that can be judged differently by different committee members. How can one judge who will contribute more to society between a painter and a carpenter, or a scientist and physician? Rescher only answers this by stating that we must face this problem. He provides no solution, because in reality there is no solution. How can there be an ethical solution to this unethical question? Past or future contributions rely heavily on a person’s opportunity to make contributions. Opportunity levels differ vastly on a person’s income, level of education, social class, religion, ethnicity, etc. In effect, we would be discriminating against those individuals who were at a social disadvantage for any particular reason and were not given even an opportunity to make a contribution to society. The only solution here is not to judge who is more deserving of medical services based on past or future contributions, but the best solution is to solve the disparities between various groups and populations so that we can offer individuals equitable opportunities to make contributions. This would also affect the number of individuals in need of these medical services or goods. For example, the poor receive inadequate healthcare, and individuals can become poor based on discrimination of gender, race, or sexuality. Answering opportunity disparities will also answer health disparities. This will lead to increase in overall health among Americans. Individuals with equal opportunity and quality healthcare can be prevented from ever needing exotic medical lifesaving therapy.

Criteria of inclusion should be founded on constituency, progress of science, and success and the criteria of selection should be based on likelihood of success, life expectancy, and number of dependents. After this, if an excess of individuals still exists, the only ethical solution would be a random selection process to maintain the ethical standards of the entire process. This process would serve best because it maximizes medical factors, and minimizes social factors. Utilizing past and future contributions to society as criteria for medical treatment is unethical based on the idea that we are in essence judging an individual on subjective factors that are functions of race, gender, and social class.

A Role for Compassion
Mary Tanski
WSU SOM Class of 2009

While on my Internal Medicine rotation, I had the opportunity to participate in many health care plans for patient care. Most of the time, the focus was on doing everything possible to treat the patient’s symptoms, ensuring the patient was stable with appropriate follow up, and discharging them home to heal.

In the course of the two months that I rotated, I came across an interesting patient with completely different treatment goals. This patient (whom I will call Mrs. Scott) was a 70 year old female with multiple medical problems and a recent diagnosis of metastatic cancer of the pancreatic ampulla. She was taken to the ER by her daughter, and admitted with pain, dehydration, and general malaise. During her stay, we were able to get her pain under control and to rehydrate her with IV fluids. She was evaluated by surgery, who decided her disease was too advanced and that she was too weak to be a surgical or chemotherapy candidate. She had some bleeding from her rectum and hemoglobin of 5.5, but she was Jehovah’s Witness and would not accept blood products in any circumstance. We had multiple long, difficult conversations with her sons and daughters about the future treatment of their mother. It was finally decided with the patient and her entire family that the most appropriate course of action was comfort care with a hospice service. So, many phone calls were made and plans were set in place. Because of insurance issues, the patient was to be seen by hospice in her home the following day and was sent home via ambulance. My team had helped the family reach a difficult decision, and we were glad we could be there to answer questions and show support.

However, the next week, we were called by the attending for the admission of a new patient...again it was Mrs. Scott. Apparently, when the patient returned home she was in better spirits and was feeling less ill, and the family decided not to go through with hospice. The patient did well at home for about a week, when she again began having intractable pain, nausea, and vomiting and she returned to the hospital. I had seen the patient previously and was greeted by the patient and her family. I helped get my new team up to speed on Mrs. Scott and her medical condition. We again began the long difficult discussions about what would be best for Mrs. Scott and her family considering her diagnosis. This time, the patient and her family seemed more accepting of Hospice Services. The Hospice Team decided to see Mrs. Scott in the hospital, and I was able to be present for the meeting. During the consult, I was amazed with the compassion shown by the nurses towards Mrs. Scott and her family. The team was patient and kind and explained each and every detail, answering questions and extending options. Our team helped to set Mrs. Scott up for discharge to the comfort of her own home, where she would be visited by the Hospice Team daily. The family was comfortable with the care their mother was receiving and they were so relieved to know that her pain would be controlled so she could have a painless passing.

This was my first experience with palliative care in action. I learned that while prolonging life may not always be in the best interest of our patient, there is always a role for compassion.

Photo by Andrea Barbieri, WSU SOM Class of 2009
ON BECOMING A DOCTOR
Noreen Rossi, MD

My gestation was long and arduous
Surrounded with fluids foul foreign,
Not nutritive. All senses benumbed
Defense against perfumed corpses
Anointed, serene, innocently clinging
To their souls. Sleep unsettled

By a knife. Limitless formulae
Leave me starved, feeble to face
The vastness. The moment of quickening
Terrifies. Development arrested.
Knowledge incomplete, deformed. Fear
Threatens abortion. Yet,

I survive. Muscles tight in anxious
Anticipation, clumsy touch encounters
The gentle pulse of waning life.
Modesty exposed to ignorance,
Ever hopeful of reprieve. Delivery
Breech, blue. A whimper then

A shriek. Examination complete.
My nakedness swaddled in jargon.
Clothed for the ritual, crisp white
Starched, I enter the sanctuary.
Agony not solace await. Baptism
Not of water but blood.

Prostituted Prayers
Jennifer Curtis, MD

She leaned forward, breathing fast from pain and I listened carefully
to her consolidated lungs, consoling her with the news that she is on
a lot of antibiotics that should help clear the lung and pelvic problem.
I ask her what the news was and how she was feeling today, and she said
that her sister came to visit her as a single tear made a chocolate path
down her deep black face. Her eyes search mine- the only thing
visible over my hospital mask in her isolation room, her monitor
keeps beeping and I push the temporary silence button as I think of
what to say to the recently incarcerated professional prostitute laying
characteristically naked, yet newly vulnerable on the hospital bed.
“Did you tell her about what is going on with you?”
“Yeah, I told her…” she hesitated. I put an encouraging hand on her
back.
“About your HIV?”
“Yeah I told her that too.”
“And what did she say?”
“She said she loved me” I heard, barely audible, as she began to sob.
I patted her back, and wanted to transfer compassion like electricity
from my long white fingers to her dark, clammy shoulder blade. She
is scared, but not used to revealing how she feels, she quickly dries
up her tears and harshly asks me to get her a spit bucket and tissue.
Relieved to have a task that I am confidently capable of
accomplishing, I vigorously retrieve her requests, knowing that she
needs more than a spit bucket and tissue to heal the scared and
suffering soul revealed by her tears. She needs more than the
antibiotics, and I know she needs more than me too, needs the love
of her maker, father, and forgiveness incarnate to cleanse her from
the shameful cause of the virus destroying her body. So I ask her
what her faith background is and if she’d be ok if I prayed with her.
She said that’d be ok, so I pulled up a chair, held her hand and
prayed, “Dear father, I come before you with Ms. R***, and she’s got
a lot going on right now. Lord, you are her father, you know her and you love her. You created her in her mother’s womb, you have never left her and you are with her now, looking down with compassion on all that is going on right now. Lord, you created her body and you have the power to strengthen it, and we pray for strengthening right now, along with your presence with the surgeons later today. And lord I thank you for the encouragement of her sister. I pray that that would continue. And most of all, I pray that Ms. R*** would cast her cares and worries on you, knowing that you are the only one who is trustworthy, the only one who really can do anything about what’s going on right now. Please give her peace. In Jesus’ name, amen.”

We sat for a while, listening to the beep of her monitor. Both of our faces were wet with tears. She looked out the window longingly and said wistfully that she’d like to feel the sunshine- she’d been locked up since winter. I told the weather was finally clearing up, it was a harsh winter- she didn’t miss much during her incarceration, and I patted her hand one more time and told her I’d check in on her later. As I left the room, I felt a pressure weighing on my chest, felt like I need to learn how to practice the prayers I pray for others and learn how to cast my cares on broader shoulders.

SATURDAYS
Miriam Levine, WSU SOM Class of 2011

Amira Barak stops calling her mother.

She used to call every Saturday, in the morning because of the time difference. There was an element of guilt in the fact that these conversations had become an appointment. Lately, though, they approached pure drudgery; and Amira found other tasks to address first: make breakfast, read the paper, do the dishes. Sometimes she even resorted to taking care of the mail – after all, the bills must be paid. But the dishes were already in the dishwasher and the rest of the jachnun was already covered and back in the fridge, along with the tehina and the tomatoes.

Sighing, Amira stood up from the kitchen table and picked up the telephone. She dialed slowly and mechanically. Maybe Imma would be out.

She wasn’t. “Hi, Imma, ma nishma?”

“B’seder, how are you? Just a minute.” Amira heard her mother shouting to her father. “Dov, turn the radio down! How am I supposed to hear Amira? It’s enough already, this sitting of yours all day on the sofa and listening to the radio.” Her father shouted back a reply and then her mother picked up the phone again. “Nu, what’s doing?”

“Nothing much. We just ate breakfast.”

“What’d you have?”

“Jachnun – they sell it at the Arabic market. Oh, and some leftover ful.”

“That frozen junk you call jachnun? Come home and we’ll have real jachnun at the Yemenite restaurant.”

“Actually, it wasn’t bad.”

“Ha! Right. When are you coming home?”

Amira paced the kitchen; she could never stand still while talking on the phone. She circled the kitchen table, then the island. “We were thinking Rosh Hashanah. Ari and I put in for two weeks of vacation, so we could stay until after Yom Kippur.” She passed the stove on the way toward the dining room.

“Yofi. Maybe by then you’ll have some good news to tell me.”

“Imma, stop already!” Amira stopped mid-stride by the sink and stomped her foot, hoping Imma wouldn’t hear. “We had Eitan and that was
enough.” What she wanted to say was, Shut up already! You’re driving me insane and this isn’t your business. Amira still couldn’t stop looking through the photo album, and she was supposed to move on? She held her breath to stop herself from saying something she’d regret.

The long pauses infuriated Shula. As usual, Amira was being as obstinate as possible. The conversation was short and not particularly sweet. Shula desperately wanted Ari and Amira to move back. It was one thing when the plan was temporary — “two years, three at the most” — but then Eitan started nursery school, and they were going to move back when Eitan entered kindergarten. At that point it was too difficult to leave because “Eitan was doing so well in school, had his friends, was used to the educational system.” But there could be no excuses now. Professor Ron had been calling Amira to recruit her back to the Technion. He’d even offered to try to pull strings on Ari’s behalf. But the more Shula pointed out the advantages — tenure track, for goodness’ sake — the more short-tempered Amira got until she invented pitiful excuses for hanging up.

Truthfully, Amira was dying to be back in Israel. She was almost as homesick as Ari. It was the nudging she couldn’t stand: emails several times a day despite the slowness of her mother’s dial-up connection, and for no other reason than to announce that Shula found the perfect apartment for them, or there was a discounted one-way flight, or she’d gotten in touch with the infertility specialist. Sometimes she even tried to enlist Ari’s support, reminding him how much he missed home and begging him to at least try to talk to that crazy wife of his.

Shula stressed only one thing more than she stressed moving home: Amira must and should get pregnant again. It was the only way to stop grieving for Eitan. Amira just didn’t realize how healing it would be to hold a new baby in her arms and to devote her energy to the child. It wouldn’t be a replacement — God forbid they should replace Eitan. Of course they’d always think of him. But Amira needed children. (Okay, so Shula wanted grandchildren. That’s a crime?)

“You haven’t lost a baby. You don’t know what it’s like.” This was Amira’s retort before slamming the phone down to cut off her mother’s response. Pacing the kitchen was no longer enough, so Amira grabbed the Windex from under the sink and wiped the kitchen counter in vigorous circles, jerks of her shoulder. If she focused on cleaning she could block out the constant arguments with her mother. From the counters Amira moved to the stove. It was stainless steel and gas — Amira absolutely refused to cook on an electric range — and Amira scraped and scrubbed until she could see her reflection. She ought to start coloring her hair. See what Imma did to her?

Looking at herself in the countertop, Amira decided to stop calling her mother.

The first Saturday on which Amira doesn’t call she stays home all day, expecting “international call” to show up on the caller ID any minute. Ari points out the foolishness of refusing to call yet carrying the phone hooked to her pocket and checking the time every five minutes, but he immediately regrets it. Amira’s glare kills any hope of a serious discussion about moving back. She storms into the library, closes the door, and settles into the rocking chair to read old issues of Nature. The wooden rocking chair once belonged to Ari’s grandmother, and it’s become Amira’s favorite seat.

Ari himself sets up his easel in the basement. He turns on the bright light he uses for painting and pulls over a storage bin for a seat. He should’ve known not to mention his mother-in-law. He fell in love with Amira for her intensity, but he’s learned that the enthusiasm for her work that so magnetized him when they first met translates into equally passionate anger. He’ll never forget the time she threw a physics textbook at him. At least she has no aim. Ari smiles. He’s sometimes tempted to paint his wife in acrylics even though he usually works in watercolor. He feels like doing a landscape today, though.

Ari thinks back to their first anniversary, when they went to that restaurant in the Golan. It was small — the size of a house — with only a few tables, big hunks of deep-brown wood. There were pyramids of preserved olives on shelves, and strings of garlic hung from the ceiling. There might have been some vintage French or Italian ads on the walls, but Ari can’t remember any in particular. What he will never forget, though, is that one entire wall was glass, and he and Amira could see out over what felt like the entire country. It was at that restaurant too that he and Amira first discussed starting a family. Ari opens his paintbox and dips a brush into the light green. The food was overpriced and really only average, but the view compensated. If they celebrate their next anniversary at home he’d like to go to the same restaurant — and this time, with film as opposed to an empty
camera. Amira had wanted to go back, too. If only she still did. But she’s Amira, and she’ll only be more resistant the more Shula nudges her.

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When Amira doesn’t call Shula is worried, of course. What if something happened? Sure, Briarcliff is quiet; but you never know. She reads about what happens in the States. Dov is right: How can Ari and Amira stand it – not a day passes without some tragedy making the front page of the *New York Times*? Shula talks to Dov, who for once is just as worried, and considers calling them. She dials and lets the phone ring once before hanging up instead. Worrying is stupid. If Amira doesn’t want to talk, fine. Shula can be just as stubborn.

Instead she spends several minutes reorganizing the spice cabinet. It’s not really necessary to do this every two weeks, but she loves the way the cabinet smells, and although lately she’s been going to bed on the early side, Shula is not yet tired. She opens the cupboard and inhales deeply. Cinnamon is strongest, but she smells other aromas too as she shifts the jars around: baharat for meatballs, brown and unassuming in its squat little baby-food jar, paprika, which adds little flavor but gives a lovely red color; a tall and thin bottle of zatar, green and slightly mysterious. And of course, garlic. One can never use too much garlic. It combines with cumin, coriander, and turmeric to smell like an ancient bazaar must have smelled. Shula does not usually daydream, but she closes her eyes and imagines colorful stalls run by men wearing long robes and kaffiyes, each hawking their wares at the top of their voices, and camels tied next to tents in the distance. Shula will organize the spices in alphabetical order this time, right to left. She sniffs each jar before moving it. When she gets to the vanilla, she lingers. It reminds her of Tante Hannah and rugelach and the time before the war.

Shula was a little girl when they stood on the deck of the boat bound for Palestine waving white handkerchiefs to say goodbye to all the relatives. She doesn’t remember crying over Shmulik the horse, who would stay with Uncle Avram – though Mama used to say that Shula threw her arms around the animal and refused to leave without it. Supposedly Shula also spent most of the boat ride miserable from seasickness. All Shula remembers is that Tante Hannah gave her a tin of rugelach to eat on the voyage. Shula didn’t have to share the pastries with anyone and they were filled with strawberry jam, her favorite. Shula has tried many times to imitate her aunt’s rugelach, but no recipe comes close. (Although Ari’s were more than just delicious – his rugelach recipe was reason enough for Shula to approve of her daughter’s marriage.) Years ago she was so set on perfecting the rugelach that she experimented with a different recipe every day for a month, and Amira came home from school to a plate of still-warm rugelach and a glass of tea. Amira would tell her all about school, and who was going out with whom, and what was the latest news. It was their moment together before Dov came home from the office and it was time to make dinner.
This is what Shula thinks about the next Saturday night when she finds herself with an intense craving while walking down the baked-goods aisle at the market. She hasn’t spoken to Amira all week. Maybe if she doesn’t call her, Amira will realize that this isn’t the way to treat her mother. So although Shula has continued to clip every potential apartment ad in Haaretz and save them in a file on her desk, she doesn’t call her daughter.

This same Saturday Amira again carries the phone with her all morning as she straightens, goes through her papers, and cooks for the week. By afternoon, though, the phone is back in its cradle. It’s too late to call Israel, and Imma would have phoned now. The Baraks are down the street for Hanan and Michal’s housewarming party, holding hands and pretending they haven’t spent the last half hour “discussing” whether or not they too should move. At least if they don’t, they now have friends from home in the neighborhood. Mindful of last week, and tired of arguing with his fireball of a wife – she’s been even more hot-tempered than usual lately – Ari stifles a laugh when upon coming home Amira goes to the message machine before even taking off her shoes or going to the bathroom.

The third Saturday Amira sighs. She’ll have to call home. She’s been wondering for a while, but now she’s sure. Her first bout of morning sickness only confirms her suspicions. She thinks of Eitan and finds herself sitting on his bed hugging his old teddy bear, Dubi.

After pulling herself together and finishing as much of a piece of toast as her mutinous stomach will accept, Amira finds an old notebook and sits back down at the table to write letters to Eitan. She uses her simplest Hebrew so he can read and understand it himself. Eitan Hayakar, she writes, don’t blame me. I didn’t mean to and I didn’t want to. I didn’t forget you. Please, motek, understand. Or: Maami, help me. I don’t know what to do.

She writes to Baby, too. Little one, katanchik, why? Why must you complicate things like this? Why do you force your way into my life? I was fine. I made my peace. Now what? Amira slips the letters under the journals stacked on her nightstand where Ari won’t see them. The letters don’t show underneath the small mountain, and her journals don’t have nearly enough organic chemistry to interest Ari.

After straightening the spines of the journals Amira decides she has to write another letter. Ari will be back from the cleaner’s any minute, but this need only be a short note. I’m sorry, Baby, she writes. I didn’t mean it. She slips this letter underneath the journals with the other letters.

Maybe she’s writing the letters in part to stall. Calling Imma means Amira will have to endure ten solid minutes of “I was worried sick” and “How dare you don’t call your mother” before she can get out the news. Then Imma will shriek and laugh in delight and Amira will have to bear another ten minutes of “I told you so.” Amira feels more like crying.

Before Amira can even dial Ari walks in. Might as well tell him now, Amira decides. He’s so attached to Eitan that it’ll be hard on him no matter what. She goes downstairs and meets him in the kitchen. “Ari, I have news.”

He’s been expecting this. He hasn’t said anything – didn’t want to, in case he was mistaken or something went wrong. But she has to know that it’s okay. He crosses the room and envelops her in his arms. “We’ll get through this together.” They walk together into the library and he stays by her side while she calls her mother.

Shula is vindicated when the phone rings after dinner. “Allo,” she answers.

“Hi, Imma. It’s me.”

“What’s wrong?” Shula swallows the last dregs of her coffee and reaches to her right to turn off the radio on the end-table.

“Why should something be wrong?” I can’t call you without something being wrong?” Amira sits in the wooden rocking chair. Ari leans against the bookshelf beside to her.

“Amirush, I can hear you rocking through the phone. You only rock when you’re upset. What is it?”

Amira takes a deep breath. “I’m pregnant.” Neither she nor her mother expects that it will be Shula who starts crying.

After telling her father and hanging up, Amira goes back into the kitchen, seeking comfort in a cup of tea. She looks out the window and sees a little girl. She’s about as old as Eitan would be, wearing pigtails and a purple sweatshirt over jeans. Amira stands up to see better and realizes the little girl is lying on the grass beside shiny red bicycle caught in the shrubbery. At first it seems the girl is crying. Amira sets her cup down and goes to the door. “You okay?” she calls to the little Goldilocks.
“I’m fine.” She laughs as she gets up and brushes grass off her sleeves. “I fell on your grass so I didn’t even get hurt, and I made it all the way around the block by myself.”

“No thank you.” She rights the bike and climbs aboard. Amira watches her teeter and wobble until the little girl is out of sight.

That night instead of the newspaper she reads over the list of girls’ names tucked in her nightstand drawer for the past eight years. Ari busies himself in the kitchen, filling the house with sweet smells. He’s making baklava.

He realizes she knows about the painting, the one he’s kept covered with an old sheet in case she ever came downstairs. “You’ve known all along, haven’t you?”

“Of course.” Amira puts her arm around him. “I want to see it when you finish.”

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**Dayenu**
Brian McMichael, MD  
Resident Physician, Emergency Medicine

suspended drumhead taut  
between weather systems  
the mid-December sky is  
immobilized stock-still and transparent

I glance at a blur in my peripheral vision,  
something does not compute with that hawk  
gliding low over nearby treetops

too close for its speed  
too fast for its distance  
it is just plain too big  
it is no hawk

but the first golden eagle  
I have ever seen free, on-the-wing  
colossal

it is altogether at ease  
gaining altitude quickly  
shaving off thin layers of sky  
as it plies gravity and lift  
at nuanced angles of attack

with a precise tip  
it slides sideways  
at effortless velocity  
early out of sight  
in a few heart beats  
soaring upwards on a thermal  
earning its name
as sunlight suddenly perfuses its plumage

my eyes follow
as it wheels across the sky
to join the unnoticed
second, third and fourth eagle

at once there are
two pairs of golden eagles
gyring in my view
steering a smooth, luxurious
course south

* Dayenu, Hebrew for it would have been enough; title of a traditional children's Passover song that recounts the multiplicity of signs and miracles in the Exodus story.