Brain Candy: Wayne State University School of Medicine Journal of Arts and Culture, Special Edition: The Renaissance

Wayne State University School of Medicine Gold Humanism Honor Society

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Nour Nasiri
Jessica Zhang
Christopher Stone
Mugdha Joshi
Ragda Izar

Gold Humanism Honor Society
Thank you for picking up this year’s edition of Brain Candy: The Renaissance, a special edition to celebrate Wayne State University’s existence for 150 years. We are very proud of this year’s edition. We have incorporated paintings, written pieces, and poetry from all the different medical classes.

The first edition of Brain Candy was published online in 2009, produced by a generous grant by the Gold Humanism Honor Society (GHHS). The edition featured poetry, nonfiction, short fiction, and different types of artwork. With generous funding support from an alumnus, Dr. Thomas Janisse, Class of 1975, the journal was started in print in 2016.

We hope you enjoy this edition! If you are interested in the production of this journal or would like to contribute to future editions, please do not hesitate to get in touch: mravisha@med.wayne.edu.

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Chi-Town (above), Sunset in Venice (below) *Ragda Izar, c/o 2022*
Well-differentiated Squamous Cell Carcinoma with Keratin Pearls *Dr. Barbara Bosch*

Papillary Thyroid Carcinoma by Fine Needle Aspiration *Dr. Barbara Bosch*

Renal Cell Carcinoma, Clear Cell Type with Marked Vascularity *Dr. Barbara Bosch*
The White Coat: A Metaphor for the Art of Practicing Medicine

On this historic 150th anniversary of our school of medicine, it is an honor to share some thoughts on the art of medicine with you. Located in the heart of Detroit all these years, we have been privileged to be embedded in a city of world class art, music, architecture, and innovation. The arts and culture of this city have always played an integral role in my path to becoming a physician. As a pre-med student at Wayne State University, I often studied at the beautiful Detroit Public Library and spent free hours roaming the Detroit Institute of Arts. During medical school, the Detroit Symphony Orchestra (DSO) literally “played a part” in my medical education. Often after having survived yet another round of exams, a whole group of us could be found in the upper, upper balcony enjoying a cheap evening out with DSO tickets donated by an anonymous benefactor. The beautiful sounds from the stage were therapeutic and let us forget all about Biochemistry and Neuroanatomy, at last for a few hours. You can imagine how exciting it was to experience my very first White Coat Ceremony at Orchestra Hall as an alumnus.

The White Coat Ceremony was just starting to take root when I began my journey into medicine. As I learned more about the ceremony, I got curious about the color of the doctor coat itself. Even though I’ve worn the coat over twenty-five years now, I never actually stopped to ask, “Why White?” Historically, physicians, like the clergy, wore black symbolizing the serious and formal nature of medical encounters. In fact, until the late 19th century, a doctor’s visit was often a last resort and frequently signaled that death was imminent as few treatments were really effective. Out of reverence for the dead, black coats were also worn when dissecting cadavers. Paintings depicting medicine in the 1800’s show physicians in training in surgical theaters dressed completely in black. So why the drastic change to bright white?

In the last 100 years, medicine evolved from mostly home remedies into a true science. The understanding of bacterial contamination birthed the idea of antisepsis. As healthcare moved out of patients’ homes and into hospitals, white quickly became the preferred color distinguishing physicians as medical scientists. Soiling could be easily noticed on white coats and they could be washed at high, germ-killing temperatures without fading.

“The arts and culture of this city have always played an integral role in my path to becoming a physician.”
Over time, the doctor-patient relationship was increasingly viewed as a beneficial encounter. Especially after the development of antibiotics, the physician in white became a symbol of hope. For the first time, common infections like pneumonia or even an abscessed tooth no longer meant probable death. Physician respect and trust grew as patients came to depend on the verity of medical research and its’ clinical applications. The word white in Latin is candidus from which comes candidate, originating from Romans pursuing public office wearing white togas. Candor, or truth stem from candidus. In fact, statues signifying justice will often show persons dressed in white. This then, is what you represent in white: Truth, Purity, Justice, and Hope. For the next four years, you will sign all your e-mails with the notation: MD Candidate. White is now even part of your very signature.

The medical student coat is symbolically short and the final ten inches of material will certainly be pricey -- untold hours of study and instruction, sleepless nights caring for patients and roughly $150 thousand dollars! As you evolve from candidate to physician, the white coat you will slip on will quickly become the staple item in your wardrobe. So, before you are cloaked, let’s take a closer look at its design.

Over the left chest sits a pocket, strategically over your heart. When you reach for something in it, I hope you will remember this: our human connection is at the heart of every doctor-patient relationship. My first patient quickly challenged the idea that becoming a good doctor had mostly to do with information mastery and test-taking success. Having dissected and identified every square inch of my Gross Anatomy cadaver, I began to wonder: Who was this man? Did he suffer? And, where was he…the person…the patient? Medical science is certainly meaningless if disconnected from the living human spirit residing inside the amazing human body. Keep this in the pocket over your heart.

Next, it’s time to button-up – three buttons to secure and align the two sides of your coat. These are the fasteners that will bring your scientific knowledge in alignment with compassionate patient care, or what our patients call bedside manner. Let the top button, closest to your ears, represent hearing. How often have you heard people complaining that the doctor did not seem to be listening? If you can train yourself to really listen, your patients will almost tell you their diagnosis. So let us remember to literally “button up” and listen.

The second and center button represents the value of humor. While the practice of medicine is a serious matter, there are moments that can lighten the burden of both doctor and patient. In fact, laughter itself is good medicine, an ancient prescription found in the scriptures. Do not take yourself too seriously, even when wearing that bright white coat, and be able to laugh at yourself. Your patients will appreciate a doctor who is down to earth and real.

Symbolically at the very bottom, the third button of humility brings it all together for a good fit. This quality does not come easily to our profession even though lessons in humility abound throughout our training and practice. We can experience the test score that just fell short, a mis-diagnosis, or the patient that will not recover in spite of our best efforts. Humility is also realizing that you have been selected to embark on this career by a faculty who believes in your potential, a patient who puts his or her trust in you just at the sight of your white coat, and that you are an instrument of true healing which comes from above.

“Paradoxically, the practice of medicine can have a dehumanizing effect. The rigors and length of training, and the pressures of practice threaten to diminish the ideals you hold high as you launch your professional lives.”
Fully aligned, your two hands should now easily slide into your two side pockets – one hand in the scientific realm, the other in the humanistic. In these pockets you will store your instruments of examination and your iPad. Even so your hands will always be your primary instruments. Like nothing else, the human touch defines the doctor-patient relationship. Even in our high-tech medical world, our patients still expect it. Touch is innately humanizing and our patients, in most cases, will not feel that they have been “seen” by a doctor, until they have been touched by the doctor.

Just like the white coat will need occasional laundering to stay crisp and bright, so you will need to find a way to keep your dedication and idealism. Paradoxically, the practice of medicine can have a dehumanizing effect. The rigors and length of training, and the pressures of practice threaten to diminish the ideals you hold high as you launch your professional lives. It will take a deliberate effort on your part to maintain and grow your vision of the physician you want to become. You will need strong mentors in the field, your classmates, and your family and friends to encourage you to keep going, especially when it seems difficult to persevere.

Finally, compassionate care can really be distilled into the simple Golden Rule modeled by the Great Physician himself: Treat others as you would like to be treated. At the end of each day, you want to be able to hang up your white coat knowing that you did your best for the patients you vow to serve. The coat will be there waiting for you in the morning, just where you left it, as each day unfolds in your journey of becoming a physician.
Finding Their Footing

“I was a dancer, but then I quit.”

The words are spoken quietly by a 12-year-old boy from the Togolese Republic in Africa who moved to Michigan three months earlier. He loves to dance. He danced a lot at home. And now here, in Detroit, in a well-lit, window-lined room on the third floor of a medical office building on a hot summer day in August 2017, he dances again. He stomps his feet, spins on one foot, then leans his body back at a 90 degree angle, knees bent, one hand on the ground, the other reaching into the air, above his head. In one swift movement, his right leg circles counterclockwise toward the other. He springs upright, never missing a beat as he grooves with abandon to Taylor Swift’s self-empowerment anthem “Shake It Off,” playing from an iPhone nearby.

“I like it here,” he said.

The boy, Onction, was one of a dozen children between the ages of 7 and 12 who spent time with peers once a week dancing as part of a wellness project for refugees. “Here” is the Wayne State University School of Medicine’s Tolan Park Medical Office Building, where in the summer of 2017 WSU researchers teamed with the Michigan-based refugee resettlement nonprofit Samaritas to pilot three creativity-based behavioral interventions for refugees now living in metropolitan Detroit after fleeing a number of countries, including Syria, Iraq and Onction’s Togo.

The 10-week program helps newly-arrived mothers and children connect with other refugees in their new home and work out their emotions regarding their journey and related trauma through weekly 90-minute classes. The classes launched in June 2017, included dance classes for children ages 7 to 12, art therapy for adolescents 13 to 17 and yoga for women 18 and older.

The project was supported by Samaritas’ School Impact program and Trauma Support team. Samaritas is the largest refugee resettlement organization in Michigan and the fourth-largest in the country.

“This is the only time (some participants) get out of the house,” said Janet Donahue, who runs the Survivors of Torture program at Samaritas. “It is meeting a need and providing emotional support and tools to deal with the effects of trauma.”

Organizers aim to provide the women and children relaxation and social support while also reducing symptoms of anxiety, depression and post-traumatic stress disorder, said Lana Grasser, a WSU School of Medicine Translational Neuroscience Program graduate student who taught the dance portion of the program.

Grasser is focused on non-pharmacological approaches to stress in refugees, and is a member of the research team led by Assistant Professor of Psychiatry and Behavioral Neurosciences Arash Javanbakht, M.D., the principal investigator of “Risk and Resilience in Syrian Refugees,” a
A related study launched in late 2016 that measures the impact of violence on Syrian refugee children and families.

Results of the ongoing study to determine the mental health impact and biological correlation of civil war trauma on Syrian refugees now living in the United States showed that 30 percent of adult refugees experience post-traumatic stress disorder and 50 percent experience depression. In addition, 60 percent of Syrian children show signs of anxiety because of the trauma – very likely impacted by their mother’s PTSD, Dr. Javanbakht said.

One goal of the study is to provide culturally-tailored intervention and treatment for the affected refugees, hence the wellness project.

“I am absolutely thrilled for our team to be starting this program serving our refugee community. As the state with the second-highest acceptance of Syrian refugees, and ranking in the top 10 overall in the United States for accepting refugees worldwide, these programs are certainly necessary for this community,” Grasser said. “We have also applied for an institutional review board to add a research component to this study, and as we apply for multiple grants we hope to be able to fund this work to expand these programs and continue to offer them in 12-week cycles to more individuals.”

WSU art therapist Holly Feen-Calligan and Blue Moon Wild Yoga Studio owner and instructor Nicole Teufel taught the art and yoga classes, respectively.

“The feedback from the women has been really wonderful,” Teufel said. “They are cutting loose in a way they’ve never done before.”

About 12 women on average attend each yoga session, many hesitant about participating. Yoga isn’t something most of the women had experienced.

“There has been a very slow process of softening in the group,” Teufel said. “A practice like this takes a lot more time to lower their anxiety level. It allows them to soften that boundary a little longer. There are moments of safety.”

In yoga class, Nawal, a mother of three adult children, feels as if she’s connected to another world when she closes her eyes.

“I have time for myself,” she said.

She moved to the United States from Iraq on Aug. 10, 2016. A year later, she still has trouble sleeping at night. “Life is nice and quiet (now). Our life in the other country is war. Our life in Iraq is not peaceful,” she said.

The regulars include an older woman who spent the first few yoga classes simply sitting in a chair to the side, quietly observing.

“She was so resistant in the beginning,” Teufel said. Later, “she hugged one of us and said how much she was enjoying it.”
Reflections
What is your belief of the role of compassion in medicine?

“The hospital can be a daunting place. It is an unfamiliar area where someone voluntarily exchanges their right to autonomy for medical care. They are stripped of their own clothes and forced to wear gowns. They may be deprived of food and water. Visiting hours can be restrictive. Privacy is almost non-existent as healthcare providers can enter their room at a moment’s notice. **Compassion is restoring as much patient autonomy as we can. It is ensuring that our patients who come to us in their most vulnerable time feel safe, welcomed, and confident with us.** It is tailoring our care towards the individual as a whole rather than the disease they are suffering from. Compassion serves as the nucleus of the doctor-patient relationship and will always play a pivotal role in the practice of patient-centered medical care.” – Gong He

“Compassion is the fuel that drives medical professionals to be avidly invested in the future of their patients and motivated to deliver consciously-aware medical care. I believe in innatism, and that we come into this world with nurturing, positive beliefs that make us sympathetic to human suffering. **This innateness to help is compassion, and it is essential to the practice of medicine.** This compassion ties into the proper handling of patients and makes them the primary focus of care as opposed to their diagnoses.” – Adnan Khan

“Compassion allows me to address multiple dimensions of well-being in the practice of medicine. Medicine as a profession is not confined to physical diagnosis and treatment. Medicine, regardless of specialty, encompasses the emotional and socio-cultural aspects of injury and disease. Compassion in the practice of medicine means putting myself in my patients’ shoes, demonstrating empathy, and helping them recover from what sometimes can be a terrifying and isolating healing process. **Compassion is what bridges spirituality, morality and the art of living with the rigors of science and the evidence-based practice of medicine.”** – Mathura Ravishankar

“As students we spend a majority of time focused on clinical knowledge as key to success in medicine. It's the focus of M1 and M2 year, as well as our M3 shelf exams. Yet, from my observations in clinic and the hospital, compassion is key to excellence as a physician. Every attending I rotate with has superb medical knowledge and diagnostic training. **It's the physicians who show compassion to patients that I aspire to emulate.** I've seen both extremes: physicians who spent 60 seconds listening to patients and physicians who spend 10 minutes listening to patients. Both attendings had the same management plan, but patients of the compassionate physician left engaged in their care. Patients of the speedy physician felt ignored and isolated in their treatment.” – Eric Walton

“Physicians hold such a precious role in their community in the way that they are heavily trusted and relied on by their parents and peers. It is assumed that by spending so many years of rigorous training and dedicating our lives to improving the health of our patients we must be exemplary citizens who put the..."
needs of others before our own. And with such great expectations come great responsibility. To be a successful healthcare provider, a physician must treat each patient with respect, compassion, and empathy in every counter. **A doctor’s visit is a unique situation in which people will present themselves in a vulnerable state that few others in their lives will get to see. Thus, it is important to cherish the privilege to see this side of humanity, and respect the dignity of each patient we meet.** This means not scoffing at a patient’s ignorance or disregarding their emotional reactions of fear or anger to a new health obstacle. Rather, it is our duty to try to understand the patient’s perspective as receiving life changing medical information from their side of the exam table. It is only through compassionate care that we can form relationships of mutual trust and deeply impact the lives of our patients. I challenge myself everyday to be an empathetic physician-in-training, and look up to my mentors who have successfully fostered such relationships with their patients. When I graduate, I look forward to impacting my patients’ health both inside and outside the clinic by being attentive to treating their mind, body, and soul through the practice of humanistic medicine.”

– Madeline Ross

“I believe the role of compassion to be innate to medicine. In my experiences, it is compassion that drives us to provide the physical, mental, and emotional efforts needed to deliver the most comprehensive care. Without the empathic motivation to ease another human’s suffering, we are limited to seeing patients as a list of medical problems that need solutions. The emotional drive to help others is what has led me to seek to understand each person as an individual, to understand the whole life and existence and its role in the maintenance of the physical and mental health. Compassion allows us to establish rapport and gain the trust of our patients. The nature of empathy and caring for the patient is, in my experience, one of the most important diagnostic tools. **The trust we gain from an individual is the determining factor of whether we may acquire a unique understanding of a person’s life – his social, cultural, religious, and personal experiences and beliefs.** This acquisition itself is integral in the development of effective care plans for our patients. Most of all, compassion in in itself is the strongest emotional drive of an effective physician; that is, compassion is what motivates us to take the time and expand the energy to connect with and establish these components of history taking and doctor-patient relationship so that we may effectively ease the patient’s suffering.”

– R. Alexandra Bajaj

“After experiencing the inpatient side of medicine, not as a medical student but also as a patient, I can attest to the importance of compassion in medicine. From my own personal experience, I can say with confidence that the manner in which physicians interact with their patients has a direct impact on the patients’ overall attitude, as well as their compliance. During my own admission, I came in contact with a variety of physicians. As I reflect back on that time, there are two in particular who come to mind. The first physician approached my case in a very scientific manner. She would come in each morning, tell me what I had to do, perform a brief physical exam, and then leave. The other physician also approached my case in a scientific manner but instead of simply going through the motions of her routine, she sat down next to me at the bedside and had a conversation with me. It was because of her compassion that I fully invested in her recommendations. My willingness to follow the plan wasn’t because I thought she was
more knowledgeable, but rather it was her approach that made me believe that her recommendations were in my best interest. It is because of my own experience, as well as some patient interactions, that I believe compassion is at the core of effective medicine.” – Jennifer Jamerino

“In order to practice medicine, we must practice compassion. The field of medicine stems from compassion. I believe it is what drives our physicians to provide the best care regardless of external factors. We, as physicians, use compassion to connect with our patients, to understand their stories, and to better their health. As a third year medical student, I now understand just how necessary compassion is when practicing medicine. When we are compassionate towards our patients, I believe we make less medical errors. I believe we have better physician-patient relationships. And, I believe we have better patient outcomes. Excellence in medicine is not solely based on academics alone, but rather, it is the harmonious blend of academia, compassion, and empathy. In order for the field of medicine to thrive, we must promote and become role models for compassionate care.” – Mona Fayad

On the Shoulders of Giants
Connor Buechler, c/o 2021
There exists only one inevitability guaranteed for everyone; Death. Try as you might, you will never truly escape Death’s clutches. But how do you cope when, in a field like medicine, you see Death day in and day out? Do you crumble under the emotional pressure? Do you ignore the feelings and instead try to move on? Perhaps you face those daunting emotions and channel that energy into something productive.

Everyone copes with death in their own unique way and the writers in this section have turned to reflecting on the events of the deaths they witnessed as a way to process and learn from every experience. Perhaps the greatest lesson to glean from these pieces is the importance of taking the time, whether it be a few minutes or a few days, to come to terms with Death and how it impacts you. There exists no right or wrong way to grieve; what you do when Death strikes is under no one’s control. What you can control, however, is whether you grow from the experience or whether you wither away.

_Nour Nasiri, c/o 2020_
My patient died. It was week 1.

This patient was very sick, but we didn’t know the extent of it just yet. For now, he was a merely a person, not yet a cancer victim. He was the textbook mesothelioma case, but without the pathological confirmation, he was a wrongly accused prisoner awaiting his sentencing. He sat in his 9 by 9 foot rectangular space without complaining of the dim lighting, the constant bustle of his current environment, or the smell of bleach and alcohol wafting in from the hallway. He looked at our faces day after day as we explained how the pathology report would serve as both the judge and the jury determining his fate, and I always wondered if he saw right past the façade of professionalism that we use to mask our pity.

I held his hand as we collected what I didn’t know would be the last sample of oxygenated blood. I posed as the assistant in this procedure holding his arm in a prone position as my intern felt for a pulse to puncture. But I knew that in that moment, it was more important to fill his hand with mine. I was not convinced he knew who we were at that moment, but I didn’t think he would mind. If I were him, I would want someone to hold my hand too. His hand was cold. Freezing in fact. I wonder if it ever warmed up again? I bet it did. His wife and daughter would have seen to it. I had met them moments before. They greeted us with thankfulness and gratitude, a demeanor that exuded kindness without ignorance to the circumstance. I wonder if they’ll remember our faces? I hate that I will be associated with this day.

“He sat in his 9 by 9 foot rectangular space without complaining of the dim lighting, the constant bustle of his current environment, or the smell of bleach and alcohol wafting in from the hallway.”

In his last hours, I could feel the emptiness with which I looked at his face as I walked briskly past his doorway waiting for the final rise and fall of his chest. I kept my mind empty, my heart empty, and my emotions empty, as I found a place to stand out of sight from his wife and daughter. They were too kind to see broken. I wanted to stay empty for now.

“I kept my mind empty, my heart empty, and my emotions empty...”

After his final breath, I needed to fill my brain as any further emptiness would be futile. I sought out an explanation—a scientific cause of his demise, a mechanism for the breakdown of each organ system. This answer came in the form of his pathology report—a sentencing he didn’t live to hear. But that is probably for the better. He was delivered a life sentence anyways.

And then, my second patient died. It was still week 1.

Aimee Vos, c/o 2019

Last week there was an 85-year-old female patient on my team's service who was not doing well. She was suffering from a number of chronic conditions. Her body appeared cachectic, and it was clear to me that she carried a poor prognosis. It was evident to me that her condition was acutely worsening. I think any reasonable medical professional would agree that it was in her best interests to have the label of “DNR/DNI”—do not resuscitate, do not intubate. Given her poor prognosis and rapidly deteriorating medical condition, the goals of care should have been geared towards palliative efforts and hospice. The family, however, disagreed. They were adamant about keeping her full code. After several drawn-out discussions between our team and several family members, I quickly started losing track of the conversation.

“If it's her time to go, God will decide it, but until then, we must do everything it takes,” I remember the son whispering under his breath to me.

One morning, right before team rounds, she began to go into respiratory failure on the floor, right in front of my eyes. My team stood outside her door. Before we knew it, the medical
intensive care unit (MICU) team began intubating her.

“What is this patient’s code status? Is this patient DNR/DNI?” I remember one of the medical staff members calling out, as the patient was getting intubated. To be honest, it was still unclear to me.

Soon after intubation, it was evident that the patient would also require a central line. She had lost all of her pulses. After this, the events started becoming unclear to me. I remember several team members frantically trying to get in touch with a family member to reopen the discussion of this patient’s code status.

The senior resident on my team tried to call the primary decision-maker of the family for the second or third time that morning to give an update. When she finally got through, the family had begged to continue doing everything we possibly could.

At this point, several rounds of chest compressions were completed. As different members of the team started experiencing exhaustion, it was my time to step up. I had help with chest compressions despite believing we should have let this woman go peacefully. It felt like I was playing a role in torturing her. It was not my first time doing chest compressions. But it still felt like a struggle to keep myself from tearing up and getting nauseated as I felt this frail being's ribs crack beneath my hands. After my two minutes passed the MICU attending arrived. He was visibly upset, and said it was time to call it if she was still pulseless.

“I still feel violated, as if I were forced to do something I don’t believe in.”

I felt such a relief to hear him say that, but still felt disgusted with the events that had transpired. At the same time, I don't know what our team or the MICU team should have done differently. From what I understood, the family was well-informed about everything, and remained steadfast in their wishes. It is a difficult role we play, having to juggle the importance of patient autonomy, beneficence, and nonmalfeasance. I believe that we incorrectly escalated care in this patient, even if it was only for an hour or so. As the patient passed away, there was no adequate debriefing about the situation. All I heard was a classmate of mine point out, rather crassly to be honest, that at least this way everyone got more practice with chest compressions. As I reflect on this situation, I still feel violated, as if I were forced to do something I did not believe in.

Anonymous

I just found out that one of my patients, whom I had been caring for two weeks, died while I was not in the hospital. It had not been long since I learned this news, but as I was reflecting I wanted to record my impressions before they faded away.

When I first found out, I was shocked. The patient had been stable for days, and was just waiting for placement in a sub-acute rehabilitation facility. I actually found out about his death while I was checking some facts in his electronic medical record. I went back and read all the notes on the patient in the days preceding his death and there were no clues which could have led me to suspect it.

The next thing I experienced was guilt. This started when I read the discharge summary for the patient and was shocked at the physical exam (i.e. General: dead, etc.). Once the emotion started, it led my mind to other reasons for feeling guilty. Had I missed something in my physical exams? The patient had difficulty communicating because of his tracheostomy tube. If I had spent more time working to communicate with him, would I have found out something that would have made a difference?

“I want to get well…”

Although I'm sure my emotions haven't fully run their course, the one I am feeling right now is sadness. I keep remembering the morning a little more than a week before the patient's death when he wrote on a clipboard “I want to get well”; and showed it to me. I can't unpack all of what that memory makes me feel right now - I only know that it hurts.
My patient was a 28-year-old man with a history of intravenous drug use and high-risk sexual activity who presented with abdominal pain, hemoptysis, and a large purple mass on his anterior gums. He was newly diagnosed with HIV/AIDS during his hospital stay and was found to have disseminated Kaposi Sarcoma. He deteriorated rapidly in the hospital and died about a week after he arrived due to septic shock and respiratory distress.

One of the most difficult issues about this man’s case was his family situation. He didn't want his family to know about his HIV status, and he didn’t seem that interested in communicating with them at all. At one point while our team was in his room, his mom called him over and over via his cell phone, the hospital phone, and the nurse’s station, but he didn't answer any of her calls. Of course, it is his right to limit what information his family was given, but I wish we could have better helped him navigate that decision.

“…wishing that you had done something differently that had made him want to tell you.”

His death was a huge shock to his family; he had been walking and talking when he came to the hospital, and his disease progressed rapidly over the course of just a week. The blow was intensified by the limited explanation they had for his deterioration. After he died, his HIV status was legally required to appear on his death certificate, which is how his family learned about it. I can’t imagine a worse way to learn what was going on with your child—to just read it, with no elaboration, no discussion with your son for closure, no doctor there to explain what happened medically, and wishing that you had done something differently that had made him want to communicate with you. I hope his family is able to find a way to understand his situation and come to peace with it, eventually, on some level.

I learned from this experience the importance of helping patients communicate about their disease in addition to just treating it. Obviously it is crucial to respect patients’ wishes for privacy, but especially in such an acute, horrible situation, I believe that physicians, who have a much better idea of what is going on and what is likely to happen, have a responsibility to help patients communicate with their loved ones. It might be as simple as asking them what their thoughts are about talking with their families about their diagnosis, or even suggesting a few phrases they can use to explain the treatment plan. Just as physicians have the opportunity to treat patients’ physical illnesses, we also have the potential to mitigate emotional suffering, minimize confusion, and foster healing and hope for patients and their families.

MacKenzie Mayo, c/o 2019

I did not know how I was supposed to feel when the patient cared for by my team died in the medical intensive care unit (MICU). When I first heard the news I was deeply saddened. I was also in denial because I had just talked to him that morning. Normally when a patient leaves the hospital it is because he/she got better. When I found out he died, I knew that coming into work the next day would be difficult. This I mainly because I am left feeling confused at the way everything happened.

He was on my team for a week or so. He had a recent history of six stent placements. He began to have a slow gastrointestinal bleed, but we couldn’t get endoscopic imaging on him because he was still 2 months away from being off his dual anti-platelets. After he was stable he was sent back to the nursing home that was caring for him. A few days later he began experiencing chest pain. He was brought back to the hospital and was admitted to the MICU. We rounded on him once or twice. He was not stable during his last day, and the attending rounding on Saturday said that we should expect him to die at any time.

Saturday night at around 7PM I got a text from one of my interns telling me that he had died. At the time, I was confused. I mean, we all expected him to die, but I didn’t think it would happen so quickly. I wish I knew if he was alone. What was going through his mind? Was he in pain? His
family and the medical team had decided he would not be resuscitated. As he quickly worsened that night, there was no code called. I am glad I was not there. Reflecting on this situation now, I do not know if I am ready to watch someone die yet. I am left unsure if there is a special protocol when a patient dies. Does the team do a debrief? Do they, do we, reflect on the events? When do we talk about what could have been done differently? I suppose I will find out in the morning.

I wonder how the rest of the team is handling his death, including the other medical students on the team. There is a fourth year medical student that was directly involved in his care. I have not talked to him about it yet. I have been trying to process the events with another one of the students. It is also his first patient death. The two of us are almost relieved because we knew the patient was suffering. His past medical history was very complicated, and it ultimately culminated in multi-system organ failure. I guess I just hope his death was easy on him. I hope he was with someone. I hope it was comfortable.

Taylor Anderson, c/o 2019

LH was an 89-year-old woman with severe Alzheimer's Disease who presented to our floor with right orbital cellulitis. She also had a past medical history of Chronic Lymphocytic Leukemia (CLL) that was untreated. The family informed us that when she was first diagnosed with CLL 35 years ago, LH stated that she did not want to have chemotherapy. I began taking care of LH as we administered antibiotics and monitored her kidney function. She was alert and oriented only to person intermittently, but very pleasant while she was awake. I enjoyed visiting her every day. One morning, given the progress she had been making with her leg infection, during morning rounds I told the team that she could be discharged back to her senior living facility soon, where she lived with her husband, who also had a form of dementia.

After I finished my presentation that morning, the attending was quiet as he read over her lab values. He then solemnly informed us that LH was in blast crisis and would not survive the week without treatment. It was incredibly surprising. I had seen her lab values, but I did not realize that her white blood cell count change constituted a blast crisis. We informed her family of this news and asked what they wanted to do. They told us that LH had made it very clear back when she was lucid that she never wanted chemotherapy. The family decided that hospice care would be the decision that she would have wanted for herself.

At that moment, it stood out to me the importance of making your wishes known to your loved ones while you have the chance. LH never filled out an advanced directive, but she explicitly told her family that she never wanted to undergo chemotherapy and prolong her suffering. That proved to be extremely important due to the fact that she began suffering from severe dementia and could not make that wish known towards the end of her life. I know individuals in my life who avoid any discussions of death, but I recognized in that moment that avoiding discussions on death with your loved ones could lead to enduring, unwanted pain.

“...she was alone when she died. This actually made me angry.”

LH died yesterday on the hospice floor of the hospital. It was mentioned in the note that she was alone when she died. This actually made me angry. Her family knew exactly what was going to happen and they knew that her death was imminent. And yet no one was with her when it happened. She probably wasn't aware that no one was there, but I can't imagine letting my loved one go through that alone. I'm sure there are things that I do not know about, but I know that I would never want to have that happen to my family or future patients.

I was lucky to be with LH during some of her last lucid moments. We talked about swimming and how her neighbors growing up had a pool that she would go swim in. It is incredibly meaningful being with someone as their time draws to a close.

Blake Arthurs, c/o 2019

May was not a month that I previously associated with anything. It’s between spring and summer,
and usually just passes by like any other. Not this May. This May has been an emotional rollercoaster.

I am writing this to help me process everything that has been going on during the month of May. Last December, on acute care surgery, I saw someone die in front of me for the very first time. He had a gunshot wound that pierced his inferior vena cava. I can still see his face when I close my eyes. After the incident, I went on with the rest of my day just feeling numb. I got home, studied, had dinner. As soon as my head hit the pillow, tears started flowing; some for the loss of life, and others just from fear of the unknown. That was December. I thought I would be better able to handle my emotions the next time around. A few weeks ago while I was on my weekend call, one of the patients on my floor coded. Before we put him under anesthesia for intubation, he kept on repeating, “I am dying, I am dying.” I can still hear those words. After a few rounds of chest compressions, he stabilized, and we transferred him to the intensive care unit (ICU) shortly afterwards. Things should be okay, I thought. The members of my team broke off to take care of other responsibilities. When we reconvened, I told my senior that was one of my first experiences with chest compressions. He responded by telling me that the patient died shortly after he was transferred to the ICU. I remember sitting there, taking in the news, wanting to cry, but suppressing that urge. At the end of the day, I got into my car and drove home. I could not stop crying. I did not want to follow my regular routines of studying or exercising. I just wanted to sit there and wait for the world to stop moving for a second. He was a person with friends and people who cared about him, and now he was forever gone.

“If I scream, I’m afraid I might fall apart.”

Earlier this week, one of my family members passed away. Then, my patient who I admitted and saw every day, passed the night we transferred her to ICU. The day after that, I learned my best friend's grandmother, who used to cook and play with us when we were kids, passed away. I did not cry, but simply suppressed those feelings. I wanted to hold myself together in front of my team, my patients, and my peers, and just get through this week while remaining professional and fulfilling my responsibilities. But now I’m sitting in front of this computer, trying to figure out how to process these feelings. It feels like I am on a rollercoaster, parked at the highest peak. When the rollercoaster pushes off the edge, I can either choose to scream and let my feelings out, or bite my lips and get used to this 'hollow' feeling. I can't decide which one is better. If I scream, I’m afraid I might fall apart.

Dr. Serena Liu, c/o 2018

On the way out of the OR, the attending and I spoke about the consult we were heading over to evaluate. She had been admitted to the hospital for vaginal bleeding. She was pregnant. In my mind, I tried running through all the morbid complications we try to rule out as soon as a patient of this kind comes in. The attending gave a very amused description of what people on this internal medicine floor were like when they called it in.

“Everyone freaks out when a pregnant patient has an issue. It’s no different than if she wasn’t pregnant. They just freak out and call us.” Satisfied with his interpretation of what was to come, I nodded my head and recited my stereotypical medical student response: “Oh, OK. That makes sense.” We were in the wee hours of Sunday morning and this was my last night shift on labor & delivery for the rotation. While I loved the service, I was tired and admittedly relieved to hear that I could essentially autopilot for this next patient.

We entered the hallway and heard exactly what the attending had predicted. The nurse assigned to the room had a panicked look on his face and ushered us into the room to evaluate the patient. The patient was moaning in pain when we walked in. In order to examine her, the attending hoisted one of her legs up, while I mimicked the same on the other side.
He seemed to know right away that something was wrong. “Unfortunately, it looks like you’re having this baby now. You’re in labor.”

She is 16 weeks along.

He examines her cervix with his hand, then calls out for assistance. Our patient is having contractions, wailing in pain and crying with each scream.

He holds her hand. I pat her shoulder. She passes the baby on the bed.

The attending and I both look at each other. Then down at the baby.

“…guarding God’s planned chaos in my hand…”

It is fully formed, with a head, body and limbs. It looks translucent, almost invisible amidst the towering, fully-formed adults before it. It’s curled up and extremely tiny. It came out suddenly and just lay there in a bloody mess, contrasting against the bright, white sheets of the hospital bed. Our patient is fairly large and takes up a sizable amount of the bed. The baby looks inconsequential in comparison. Invisible.

We help mom with the afterbirth. She doesn’t pass the placenta, so she is wheeled up to the labor & delivery floor. Baby is wrapped in a blanket and goes in a clear, plastic tub with a lid. I carry this tub with both hands wrapped around it, guarding God’s planned chaos in my hand, feeling an equal amount of chaos inside.

No words came afterwards.

Taz Ahmed, c/o 2019

“TB is a 43-year-old man with a past medical history of hypertension presenting with a chief complaint of abdominal pain.”

I started preparing my note before going in to see the patient. A “silly admit” was the label this one was given. He was thought to be one of those unnecessary admits from the emergency department.

I would have never imagined that in less than 24 hours, I would be hearing someone call a time of death for him.

As I reflect on my first encounter with him, I replay our conversation in my mind. I remember trying to get through the history of his illness with him. I recall certain questions that now stick out to me.

“Do you think you may have eaten something funny before you started having this pain?”

“Yeah actually right before I had eaten some fried chicken and mashed potatoes. Maybe this is just food poisoning.”

I carry on through the conversation, going through every question I’ve been taught to ask.

“Have you ever been to the hospital before?”

“No this is my first time staying at a hospital.”

Wow, he’s never been admitted to the hospital before. I think back to “silly admit”.

I finish asking my questions and start the physical exam. Eyes, mouth, and now onto the heart – my favorite part. I listen closely and hear what I believe to be a systolic murmur in the right second intercostal space. I finish the remainder of my exam, with unremarkable findings.

Silly admit, never been admitted, benign physical exam. The list keeps growing.

I call my senior to help me decipher TB’s cardiac exam. I wanted to take advantage of having a non-urgent patient so I can strengthen my physical exam skills. He follows me to the room and asks TB how he is doing. He listens to his heart and tells me to listen again. TB starts looking worried.

“Don’t worry,” my senior says. “There is nothing wrong with you.”

“I’m just trying to work on listening to heart sounds,” I say reassuringly.
How strange this brief conversation seems now in hindsight.

The next day, I round on my patients before meeting up with my team. I come into see TB. He says he is feeling better. His laboratory findings and imaging all seem to suggest that as well. My intern talks to him about possibly going home the same day. He is ecstatic. As we leave his room, I confirm the assessment and plan with my intern. She guides me with an additional differential diagnosis I can present during rounds in order to have a thorough and thoughtful presentation.

Silly admit, never been admitted, benign physical exam, unremarkable labs, possibly going home today. An easy one. And I get the opportunity to shine during rounds – what a nice bonus.

As we round, my senior is called away to a patient the nurse says is seizing. It’s TB. We take the information with a grain of salt.

Shortly thereafter, an alarm on the floor goes off indicating there is a code blue. My team and I leave a patient’s room and start running. I’m not really sure where we are going, but I follow. I realize we are running closer and closer to TB’s room at the end of the hallway.

I walk into TB’s room to an unforgettable scene. TB is sprawled sideways on the bed – his body completely exposed, arms and legs hanging off. My senior is standing over him violently doing chest compressions, standing in a pile of TB’s stool.

“He is swaying back and forth, dancing on that line between life and death. In this moment, I realize how fine that line is.”

By this time, the code has been announced throughout the hospital. The code team and physicians on call come rushing in. I suddenly find myself in a crowd of people standing outside of TB’s room. I watch as everyone fulfills their role in an unavoidably chaotic environment. But my mind keeps wandering – I am overwhelmed with confusion and pure shock. I can’t wrap my mind around why this is happening.

What did I miss? Why did nobody see this coming?

My trance is briefly interrupted by my attending. He asks me who this patient is, and what he originally presented with. I manage to spew out an overly detailed presentation on TB. But in that moment, I can’t help it. He had to hear everything so he could realize how unexpected this was.

I continue replaying everything in my head. TB was going from ventricular fibrillation to becoming pulseless. He is swaying back and forth, dancing on that line between life and death. In this moment, I realize how fine that line is.

In the midst of it all, my attending interrupts my trance again.

“Are you ok?”

“Yeah – I just don’t understand what caused this.” I reply with deliberate composure. Inside, I’m angry, confused; I am convinced there is something we missed. I’m wracking my brain for an answer because having no answer is not good enough.

Over half an hour passes before a time of death is called. I watch as physicians and nurses disperse back to their respective floors – almost as if nothing happened. I envied their ability to move on.

I felt stuck. The insatiable why inside me was tormenting. In the past, it was so often seen as a strength – such an inquisitive nature would make a great fit with internal medicine, I was told many times. This time, however, I felt trapped. I was bewildered, heartbroken.

We debrief, discuss, reflect. Later on, I watch my senior fervently look through TB’s chart, labs, imaging. Once, twice, three times. He’s looking for a reason.

I find comfort that I don’t stand alone in my refusal to accept no answer.

In the days and weeks that pass, I obsessively checked back on TB’s chart for the autopsy report. The why was still a burning question.
“Can we really do that much good?”

As I write this over a month later, I can say finding out the why didn’t necessarily give me the peace of mind I expected. The hardest thing to grapple with was accepting there wasn’t anything anyone could have done to prevent TB from dying. The idea of that still makes me uncomfortable. How useful are we as physicians if we can’t always stop the most feared complication of any disease process: death? Do we really have that much power? Can we really do that much good?

I realize now it’s about your perspective. As my attending wisely put it, when we are in a code situation, the patient is already gone – you are simply trying to bring them back. There is mercy in that perspective – you are trying to stop something that is frequently unstoppable, long before you even came in the picture. Therefore, you can’t feel responsible. You can’t carry that burden.

And there won’t always be a why. But if you can walk away remembering you did everything you could, I hope that gives you the peace of mind to move on. In the end, it’s what did for me.

_Sarah Zaza, c/o 2019_
Meditations

Granulomatous Inflammation Around Uric Acid Crystals Dr. Barbara Bosch

Cirrhosis of the Liver Dr. Barbara Bosch
For the End of The Sick

In the end we are bags of skin. And everything we have within eventually we’ll be without. The flesh and bones of fresh unknowns vanish all our meaningless woes. Indeed it is a sobering breakfast to crack a chest and sort intestines. We cut out a tongue that was once sharp and slice through a once loving heart. Of course we are looking for trouble, but we know that they’ve been through double. We know that this heart we’ve cut has probably been hurt enough. And through these miles of intestines butterflies have flown in sessions. These airbags that we’re disconnecting used to rise and fall with blessing. Now they’re just a floppy heft, but there’s always something left. Squeezing them expels the token of all the words better unspoken. Then we move on to saw the safe, that we once knew was our place. Somewhere we could always hide, when we’d think about our ride. Then we remove that prized possession, which holds within it every lesson. But how could all of everything be, in my two hands for me to see. Then I start to realize, the beauty right before my eyes. This design was just a vessel, intricate on every level, housing what was once a life that’s released by a holy knife. Then we do return to Him, without our blood, or bones, or skin. Only with what we have done, we pray for mercy from The One. So in the end just bags of skin, zip us up and take us in, because everything we’ve ever had will stay here in another bag.

My Peace in Your Pain

My troubled mind and floating head are briefly healed beside your bed. Looking up to me with trust, thinking that I know that much. For a moment my pain is gone, now clear I can hear your song. As I put the parts together, you feel that you might get better. I feel that I might be healed, but I walk out and start to reel. But in that moment there was peace, silence from a pain that ceased. You were hurt and I was helping, and by that act my grain was melting. Seems that pain can be quite helpful, if it’s another’s and just as dreadful. The pressure of my painful stride seems to begin with each “Goodbye”. Though when I knock and walk on through, my peace begins with “How Are You?”

Dr. Abraham Abdulhak, c/o 2018

Lower Peninsula
Alex Diaczok, c/o 2020
Shining On Another Path

Darkest before dawn they say. But what if dark is here to stay? It may seem dawn will never come, and only nothing’s to be won. In the blackness of this cold surrender, I feel an unworthy contender. Waiting for the light to reach, with impediment in my speech, I’m hoping there’s something to teach. For all I’ve learned is pain and sorrow, empty words and promise borrowed. And in this darkest of His lessons, we may profess some false confessions. We declare this is unjust and we begin to lose our trust. The dawn proceeds to slip away, and we die to die another day. This light seems it will never come and we fall spent under darkened sun. And when it seems we’ll never see again, we remember then to see within. For the light we need is all inside, and darkness only hurts our pride. This black is all just in the mind; our light comes straight from The Divine. All horizons it will break and all the darkness soon will quake. Our light, this light, comes from The One and it outshines the brightest sun. It’s born within us through his bliss and lights the deepest of abyss and reaches every single corner of a place that has no border. When we choose to use this light, that’s of His Power and His Might. The darkness slowly turns to dim, and dawn begins its fading in.

Dr. Abraham Abdulhak, c/o 2018

Med School in a Nutshell

As medical school comes to an end, I think about how far we have come and all that we went through:

Year I was all about learning to play the game:
How to memorize, learn, how to spot friend from foe

How to look death in the eye through our cadavers
As we learned about what keeps us alive

Year II was all about the specter of Step I
We could not do a single thing without thinking of it

Any moment of vain was left with me feeling
I could have squeezed in a few more questions

Year III was like playing a game with no rules
Each month was a new team, new attending, new way of doing things

Often times, we were left to our own devices
To figure out what worked for us
As we all struggled to get the best evaluations
And to just make it through the year

Year IV was finally facing our future
Making big decisions like what to be, where to live

It’s about more than the MD, it’s about learning who we wanted to be
And then we waited with bated breath for Match Day
To face a future, we now had no power to change

Congrats to us all for making it this far,
I know the next part of our journey, will be no less difficult

But I hope we persevere, just as we did through here

Anonymous
Always Free

Where he steps, moss grows and flowers bloom. The forest loses dry, shady gloom. All fauna flock, even flora turn his way: sunning themselves in light, whether night or day. Deer stretch out their necks for his loving hand. Wolves lay belly up for this master man. Even butterflies abandon their nectar to flutter in his breath.

During all this commotion, he laughs a hearty laugh. Their fare of devotion sounds better than brass. Triumph bursts from his eyes. They lick gentleness from his fingers. With each mile he walks, his fragrance lingers. He journeys with purpose, without wandering but always wondering. His eyes searching with hope and without haste.

Joy resounds off the trees ricocheting his renown for miles. The very air hums, like a bell rung, and the sky seems to wear a smile. The wind dances in excitement, with deep breaths from a lover’s arrival. The rivers rush with new vigor from the earth’s heart’s revival.

Then everything is silent. He stands before the foot of the mountain. He scans from peak to valley with fervor and without fear. He commands its doors to open. He descends into the deep. No friends dare follow him there.

Virgin walls, never cursed by light, are scorched by his radiant fury. Away vile goblins violently scurry. Farther and further he goes, exposing the world’s atrocities.

Sickly cries and cackles fill these catacombs with evil’s cacophony.

The swarm sounds the alarm and hideous hosts gather to unleash a hell n’er seen by any man nor beast. He grabs his hilt and the sword rings when unsheathed. Then he proclaims these words, “You may feast”.

In a breath, they are upon him like a murderous wave, but they crash and spray off leaving him unscathed. Yet, rebuked flies return to a good entrée, and bodies sealed the tunnels as a stone seals a grave. Although his victory is sure, it is not matched by his mail. His flesh is torn by tooth and pierced by dirty nail. But, after many mortal wounds, the warrior’s stance never fails, and the hive flees to crevices carved deep in the caves.

He steps through the silence as the walls shrink and cold thickens. He squeezes through wormholes that excrement slickens. He swims through a sump: at first frigid and then steamed, then he splits through the surface in a cell with no key.

That is where he found her: in a trap of her own making. She had journeyed to this hellish snare, seeing an abscess: not her heart. Believing she must live here, with penance tearing her apart. He kneels to meet her: one hand on her hair, comforting her with his gentle stare.
He whispers boldly, “Semper liber. The free can now depart.”

Ben Drumright, c/o 2020

Through the Cloud Ceiling

When the sky was cloudy, I would take flight. Escaping the shade (dysthymic night) through misty nothing. Arriving at my blank, bright world.

The open expanse confronted me as violently unnatural.

My eyes ached, as if crossed too long at the utter flat white.

Yet, the floor’s gentle evolution soon restored essential, organic asymmetry. A gift of mountains unmeasurable to imperceptible.

New white wisps formed and fused, adorning the grounds with fluffy tree caricatures and stones of strange contour. It seemed a ruse plagiarized from heavy snowfalls.

Walking through the nebulous wonderland, the world began to concentrate. Floating, lonely puffs matured into leaves. Car sized cotton-balls mineralized into boulders. Next, pigments blushed through, bringing vitality.

My favorite was watching fields of grass drink in deepening emerald.

The green was so lush and fresh it glistened, making me thirsty too.

All that existed below was forgotten.

With induction complete, smells and touches flooded in.

Wind kissed me and carried earthy whispers. The gentle sighs of flowing water and swaying leaves became new elements of silence. A world sensuous to the point of ecstasy. A continuous dance around pleasure: flowing between ignited longing and fulfillment.

Ben Drumright, c/o 2020
El Marrikh
Ragda Izar, c/o 2022

Golden Harvest
Matthew Tukel, c/o 2021
Space

“Make space,” I said
As I curled up in the crook of your arm
“I only need this little space,” I said
And you let me in

…
When I fell asleep in the crook
I kicked my legs out
And snuggled in
To get comfy
And make more space
You moved over a smidge

See, I always thought
I only needed
A little space

But now I see.

My cubby
Turned into a room
Which turned into the whole house

When I study
My pens lay across the desk

My purse is stretched out
Because I stuff it full of lipstick and tissue

My car doesn’t have room for passengers
Sometimes
Because all the stuff in the trunk
Bled out into the other seats

The problem was
I thought I could stretch
That you’d eventually learn
To love me in your space
Even though
You weren’t my purse
Or car or cubby

More people have come by
Some thought they wanted me
To unfold into them
But they don’t
And some put up signs
Saying “keep out”
Because it’s their space

I’ve stopped at all kinds of places
Looking to share

It’s really what I had always looked for
But you weren’t looking to make room
And I didn’t know I had to ask
Today I’m with someone
He has a chair in his room for clothes
Sometimes they drop on the floor
I help fold them up
if he wants me to

However much of the bed
I want to sleep on
He gives to me
We fit in each other’s open spots
And it’s our space

Anonymous

Kuru

Alas more than I could have bargained for
A flavor so sweet I missed your confirmation
Lending to me not only satisfaction, but a weeping willow to stand beneath
What is it you ask from my normalcy?
I have given unto you the most ultimate sacrifice
To let go of my true self so you can convert me, devour me
Mix my emotions until they emulsify the textures of a broken soul
For the blood of my kin runs deep to pass a barrier of pleated sheets
Eradicated you are not because in the flesh your secrets keep
My brain is your feast.

JT Knight, c/o 2021

‘Tick Tock’

Tick Tock
Goes the Heart of the patient
Quick Quick
Goes the Pen of the doctor
Cut Cut
Goes the Knife of the surgeon
Think Think
Goes the Mind of prevention

Mermaid Cove
Mugdha Joshi, c/o 2022
Out Out
Goes the Opportunity here to
Think Think
Of ways to Save the man so
Cut Cut
Off the diseased chains that Bind
Quick Quick
Offering new ways to Heal the
Tick Tock
Before the clock Strikes no more

Chris Hopper, c/o 2019

**A Thousand Worlds Apart**

A thousand worlds apart,
Always with me in my heart,
Your loving grace and touch,
Saves me from this demonic labyrinth,
Hark my heart,
Know it’s true,
This ineffable feeling radiates,
How wonderful life can be.
Dulcet words, gentle guide, I may stumble
But I cannot fall with your love.
Sleepy Sundays,
I thank the heavens,
For dropping me a piece,
For every anguish, is suddenly bearable.
My love,
My dear,
I will love you, Forever.

Ariana Ganji, c/o 2021
Bellows of the Biosphere

The canopies are cavernous
Mist covers the floor
Jaguars roam ravenous
Monkeys howl for war

A burning sea of sand
Devoid of hydrogen peroxide
Serpents buried beneath land
Scorpions raise stingers with pride

Around the Earth’s poles
A frozen hell to beware
Orcas hunt for souls
White fur cloaks the polar bear

A land straddled by tall grass
Where bramble trees teem
Nights with bright lion eyes pass
Hippos guard their stream

Within the murky depths
Brimming with the unknown
Sharks chase bubbles of breath
Till tentacles are thrown

Tower wooden columns
Covered in toxic shrooms
Echoing howls solemn
As a fox stalks and looms

Perilous snowy peaks pierce the sky
Terrain that’s rough and scorned
Air filled with a cougar’s fearsome cry
A goat stands mad and horned

Deep underneath the ground
Lies the scariest void of all
Bats locate prey with sound
Centipedes crawl along the wall
Scattered across this great big world
Are kingdoms of tech, sweets, and tomes
Made for us all to lay unfurled

Safe and sound from nature’s biomes

Alvin Varghese c/o 2020

99 Lives

Leaping through the air
Then grappling the cliffside
As the wolfman screams

Upon a tower
Lays the king of all demons
Time and time again

From the Lunar folk
Who fled from their own trash heap
Came machines of death

Mix and matching Jobs
Guiding the neediest town
While sailing the seas

The dark dragon roars
Issuing a bold challenge
But first comes fishing

A singing coven
Chants an avian folklore
Galactic war begins

Talking animals
A new civilization
From a genie’s wish
Befriending spirits
Who seek love, gold, and vengeance
In a sky city

Without memories
Marked with a cursed inscription
Digging up treasure
A doppelganger
Televised victims appear
In about two dozen years
Near a hundred Lives
Yet still not enough

Alvin Varghese, c/o 2020

On the Wards

Broken parking gate, broken elevator, slow computers, and lost access. Suffocating bureaucracy, administrative code grays, and endless paperwork. Caustic soap, week old tuna in the cafeteria, and the smell of Lysol in the warm stale air. Beeping. Endless beeping of pagers, monitors, phones.

A broken system fixing broken men.

A large American flag, warm smiles, and thankful patriots instilled in memory. It gives you more than you give to it.

Dr. Syed Mahmood, c/o 2018
Sunrise in Chicago

Dr. Syed Mahmood, c/o 2018

Lac Laffrey

Saara Mohammed, c/o 2020
Anatomy Impressions

On the first day of anatomy lab we had to a-b duct your arm
With alphabetical reflex I grabbed your hand
Indigation
I went home that night and chewed my fingernails raw
Not as a sign of indignation toward you
I consider it your impression on me

I stared direct into the muscles of your chest
But since anatomy requires the knowledge of space
I registered that my body was almost always near your hand
It was your right one
Was it dominant? I decided you were gentle

I was handed a scalpel and I cut through a blood vessel
My nerves almost as exposed as yours
It took practice to recognize the difference

There were stars planted into your skull
How fitting they refracted before the thick galaxy of matter
And that I couldn’t breathe
Metastatic and infectious knowledge rooted deep in my brain
As the cancer must have in yours

Black humor filled your lung the same way it spilled out of my mouth
I also had to learn to cope, breathe in a different way
Maybe not different, maybe just more appreciative
Learn the intimacy of your body more than anyone before

It felt intimate and I started to uncover some of my commitment issues

There’s a possibility this will make me a better person
I try to focus on you, your body is a lesson, but you are still a human
Inhumanity in the way I held a saw against your skull is not lost on me
There’s a probability that I exist under contradictions
After all, I am preparing to do no harm

The day you left me I felt relief, selfish
The day you left me I felt relief, quiet
The day you left me I felt relief, solace

I consider this your impression on me
Thank you for that.

Brianna Sohl, c/o 2021

Hear No Evil, See No Evil, Speak No Evil
Ashley Kramer, MD/PhD Candidate
Dichotomy (above), Quiet Streets (below)

Matthew Tukel, c/o 2021
On Haikus

A haiku is defined by three lines - the first consisting of 5 syllables, the second with 7 syllables, and the third with 5 syllables. Though short, it can capture an idea, a feeling, or an experience quite eloquently. That is exactly what we were hoping to accomplish with this year’s Haiku Contest. We invited members from the different classes at the medical school to submit as many haikus as they wanted, and what we found were expressions of varied emotions and ideas, beautifully crafted in the confines of a haiku.

Congratulations to our winners – First Place: “A Medic’s Reward” – Eric Klomparens, Second Place: “CPR” – Alexander Waselewski, Third Place” “:)” – Julie Fynke. We have also included for publication honorable mentions by Christopher Clement, Chris Yee, Uche Nwagu, Amanda Najor, and Elizabeth Moore.

Mathura Ravishankar, c/o 2019

On a Beach in Hawai‘i
Mugdha Joshi, c/o 2022
The Medic’s Reward
a brief moment’s peace
amongst tumult and tempest
patient’s smile of thanks

Eric Klomparens, c/o 2020

CPR
Get on the body.
Crunch, Crunch. Give epi. No change.
Go tell the family.

Alexander Waselewski, c/o 2019

Unshaken
The autumn winds blow
Through the branches of the tree
But the last leaf clings

Christopher Clement, c/o 2019

Secondhand Smoke
You violate me.
I try to fight it alone;
I am powerless.

Chris Yee, c/o 2019

:) W
Wet nose, lots of floof
Eternal love and tail wags
Golden Retriever

Julie Fynke, c/o 2022

Daylight Saving Time
Pointless, needless pain.
We should really ask ourselves:
Why do we do this?

Chris Yee, c/o 2019

The Land Before Time Zones
When can I see you again?
We’ll dance to different beats
Until I find you.

Chris Yee, c/o 2019

Chest Compressions
The eyes stared at me
Glossy; everything was gone
That is all I saw

Alexander Waselewski, c/o 2019

How Do You Want Your Eggs?
I have no answer.
So many choices to weigh!
I am paralyzed.

Chris Yee, c/o 2019

Advice
For when you can’t tell
The difference between two cells
Doctor Braun will help

Elizabeth Moore, c/o 2022

Advice II
“Be more efficient
And just study fewer hours”
“Get out” I replied

Elizabeth Moore, c/o 2022

Boulevard of Broken _____
Much bellyaching
Promises broken as roads
None will pay to fix.

Chris Yee, c/o 2019
UCF Knights Football
You can be perfect,
But some doors will still be closed.
The world is cruel.

Chris Yee, c/o 2019

Excuses
I could write poems.
I could try to save the world.
I just do my best.

Chris Yee, c/o 2019

A Sequel to Creed
Sons fight each other
To right wrongs fixed years ago.
We need new stories.

Chris Yee, c/o 2019

Deceit
She said what I wanted
It was all I had needed
She changed her mind

Amanda Najor, c/o 2022

For You and Me (Not "I")
We were taught what's right.
Now our mistakes wreak havoc
And break teachers' hearts.

Chris Yee, c/o 2019

Airplane Disembarking
Can't wait for signal!
We rise up in a frenzy
Only to stand still.

Chris Yee, c/o 2019

Like Gravity
Tender to the touch
But the heart is cold as ice
I will never learn

Uche Nwagu, c/o 2020

Unpleasant Surprise
Waking up, look out
White speckles fall to the ground
Why is winter here

Uche Nwagu, c/o 2020

Leeched
It never leaves this place
Still pinching me to wake up
What a mess it makes

Amanda Najor, c/o 2022