



2022 | NARRATIVE MEDICINE BOOKLET



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Leading Internal Medicine, Improving Lives

Wisconsin
Chapter

Sponsored by the ACP-WI Women's Committee and the Council of Medical Student Members

New this year, ACP-WI's Narrative Medicine Competition, sponsored by the ACP-WI Women's Committee and the Council of Medical Student Members! The ACP Wisconsin Chapter recognizes the values of sharing struggles, triumphs, and everyday life as a way to foster a sense of meaning in medical practice. These written works remind us of the reasons we chose Internal Medicine, and why we continue practicing everyday. The pieces included in this booklet have been submitted by members across the state, at varying levels of practice, and reviewed by a panel of judges, with \$500 in prizes eligible to be awarded. Join us at the Saturday Awards Luncheon for the announcement of winners of the pre-meeting judging in the Student, Resident, and Attending Categories. The People's Choice Winner will be announced during this time as well. Attendees who would like to participate need to turn in their completed voting ballots, including their favorite submissions, by 11:00am on Saturday, September 10. We thank our authors for their courage in sharing these stories, and invite everyone to enjoy their writing. And lastly, thank you for the greatly appreciated efforts of ACP-WI Staff Veronica DeMore, Jenni Kilpatrick, and Dan Dudzinski in organizing submissions, coordinating judging, and creating the Narrative Medicine booklet.

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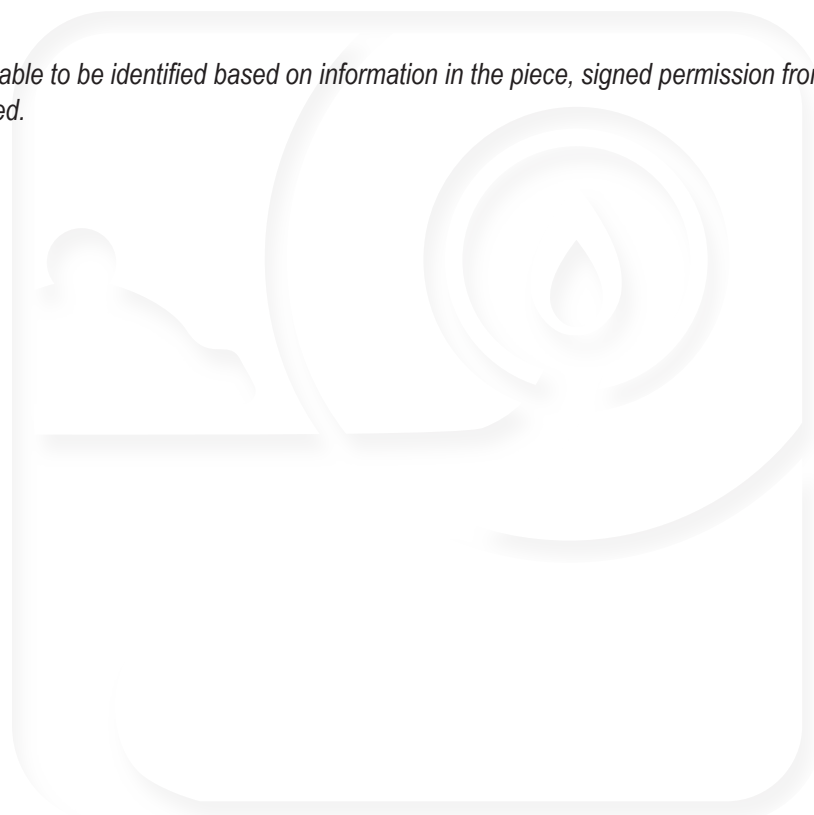
FEELING INSPIRED?

We encourage all ACP Wisconsin members to take advantage of Narrative Medicine opportunities and we are planning more activities on this topic in the future. We are always accepting submissions for our "In the Life of this Wisconsin Doctor" series. Additionally, we are planning a series of workshops on Narrative Medicine led by expert facilitators over the next year. For more details on submissions, latest news, or to be added to the Narrative Medicine mailing list, please reach out to info@acpwi.org.

TABLE OF CONTENTS

| | |
|------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| 1. Haikus To Say Goodbye <i>Matthew Aiken</i> 4 | 11. A Generation of Stories* <i>Katherine Recka, MD</i> 16 |
| 2. In the Life of this Wisconsin Doctor <i>Mahmoud Awad, MD</i> 5 | 12. COVID* <i>Melanie Ripley, MD, FACP</i> 17 |
| 3. The Structural Risks of Medical Training on Queer Mental Health <i>Tracy Bui</i> 6 | 13. Primary Care* <i>Melanie Ripley, MD, FACP</i> 18 |
| 4. Growing Like a Lupine <i>Mikaela DeCoster</i> 7 | 14. Desiderium* <i>Shawna Rivedal</i> 19 |
| 5. On Being a Resident: Finding Purpose During Difficult Times* <i>Matthew Eidenschink, MD</i> 8 | 15. Ask Her About Dogs* <i>Markayle Schears</i> 20 |
| 6. All's well that ends well <i>Rebecca Elon, MD, FACP</i> 9 | 16. One Step at a Time* <i>Jacqueline Tran</i> 22 |
| 7. Ditto <i>Abhishek Janardan</i> 11 | 17. The Moment After* <i>Margaret Walker, MD</i> 23 |
| 8. I Will Carry You With Me <i>Brooke Jennings, MD</i> 13 | 18. Laughing in the Face of Death* <i>Jennifer Woodard, MD</i> 24 |
| 9. Essay <i>Devesh Kumar</i> 14 | 19. Residency in the Time of COVID <i>Jennifer Woodard, MD</i> 25 |
| 10. An Experience Shared <i>Brett Linzer, MD, FAAP, FACP</i> 15 | 20. Don't Stop Feeling* <i>James Wu, MD</i> 26 |

* Any patient identities have been masked; if a patient is able to be identified based on information in the piece, signed permission from the patient or patient's representative is has been acquired.



1. Haikus To Say Goodbye

Matthew Aiken, Medical Student

*Poked, prodded, confused
Trapped by tubes, restraints. "Help me"
A heart in failure*

*Our hearts not failing
One more tube, one more pill: Hope
Hope is dangerous*

*A heart not beating
Is not a heart in failure
It finished its job*

*No longer restrained
Mental status: unaltered
A life discharged home*



2. In the Life of this Wisconsin Doctor

Mahmoud Awad, MD

I'm in Egypt and it's March the 18th, 2022. I'm sitting in the balcony listening to Björk singing about Venus as a boy. A stray black dog is barking its head off at nothing in particular, the weather is ideal, and I'm thinking of thinking about my father's cane.

When I look in the mirror, I wonder how much of my father I have physically and emotionally inherited. My father: sharp and clear-eyed, high-cheekboned, and slim-built. My father: faithful, strong, and patient. I like to think of my dad as my first patient; counter-transference aside, my patient of all patients.

It's a rainy Chicago day in October of 2011, and the doctors have just found my father's thyroid tumor. My world has been turned upside down. I can pinpoint the exact moment I felt all of my beliefs - about the world at large, my faith, my entire system of unrefined defense mechanisms, my narrow, uncomplicated teenage life - everything I thought I knew - EVERYTHING - being completely denatured and undone. And most of all, I remember, precisely, my pain and confusion. I remember worrying about brand new concepts like insurance, finances, and what it all meant for our family's future. I remember my mother's overnight flight from Egypt to Chicago. I remember her daily trips to the hospital, and daily Skype calls over spotty internet connection. And then there was my father's faith in the face of illness. Surgery, chemo, radiation - the weight loss, hair loss, muscle loss - his unwavering belief in fate and destiny despite it all. It was his inexhaustible faith that fueled his strength and patience, and it was his faith that fueled us all. And finally, that following summer, my father is back home, and we are whole again.

It's June of 2014 in Chicago. I had spent the past year rebuilding and refurbishing myself. Fresh off my first year of medical school in Egypt, I am now armed with the knowledge of words like prednisone, action potential, and interstitial fluid. My father and I are walking around our cozy suburb in the afternoon. He explains how the pleural effusions had been too much to handle in recent weeks and would now need to have an indwelling pleural catheter placed in both lungs to empty the fluid properly. That was something I hadn't learned in med school. My dad says we shouldn't tell the rest of the family, they were coming next week anyway, and I agree. The procedure goes well, and my family is again whole the following week.

As the summer merges into fall, I have to go back to start a new academic year. My father had been taking vemurafenib because it targeted the same mutation that caused his cancer. As a side effect, his skin was covered in acne. He uses a really sleek-looking black cane to walk, but he can walk, and he doesn't need oxygen. We are in the airport and I am embarrassingly inconsolable. I cried like a literal baby as we parted, cried a lot in the bathroom of the airplane, again in transit, more on the second flight, and finally dry up as I step under the shower in Egypt.

It's a cold but sunny Chicago morning in February of 2015. My father now has an oxygen mask on at all times and needs a wheelchair. He uses a scheduled nebulizer, and a PT-Assistant comes 3x a week to push up the fluid in his legs, but my brother and I do it every day regardless. My grades from the past semester had just been released, and I wait for the PT-A to leave to tell my family. I tell my dad I was now ranked at the top of my class, then I breakdown in tears in his arms.

It's late February. I have to go back for the next semester, and my flight is that night. I know what comes next, but I am too stubborn to accept it. I make an irrational pact with God (the B in DABDA), but I know I shouldn't. I have some idea about the psychology of grieving, but I can't help myself. I plead for God to keep him alive, to please let me see him one more time. I say something angry and have a moment I am not proud to recall. As I head out of the door of our apartment, I steel my emotions. I kiss my father on his forehead and his hands. That was something I had never done before, but something in me said I should.

On March 7th of 2015, I receive the inevitable call. My grief over the following weeks/months/years is not a blur. Over the coming years, much inner reshuffling results. It is necessary, and I am, contrary to my expectations, grateful to the circumstances. I am at times capable of fully sharing myself with the world, and at other times I am buried deep inside of me. Has my grief shrunk or have I grown around it? Different poets believe different things. And has any medical society published the guidelines for managing life?

It's been seven years now. In a few hours, I will learn that I'll be doing my residency at Aurora Health Care. I will celebrate the start of a new journey and mourn the end of another. This is a life I am learning to unwind. I am in here, and I am thinking of my father's cane

3. The Structural Risks of Medical Training on Queer Mental Health

Tracy Bui, Medical Student

Medical Student Tracy Bui describes the added stress LGBTQ+ students face in creating and sustaining supportive communities because of the frequent moves necessary to complete years of medical education and training ...

The concept of mental health has never sat well with me. It may be in part due to cultural stigma. My parents are refugees and immigrants of the Vietnam War. In the contexts of political retribution (physical safety) and poverty (financial safety), the pursuit of “wellness” feels like a privilege. Perhaps the umbrage I take is with the institutionalized model of mental health – the model that encourages “personal resilience” instead of focusing on how social and structural determinants impact mental health. To me, mental health requires meeting Maslow’s hierarchy of needs: physiological safety, physical and financial safety, love and belonging. A major contributor to love and belonging for me and other queer identifying folks is the queer community.¹

Recently, I came across a Twitter post by a current resident ruminating on whether physicians would be more connected to their communities if they weren’t forced to move so often in the name of medical education. Relocating is not unusual—and it could be argued that it is, in fact, the norm—for a physician-in-training to move for university (four years), medical school (four years), residency (three to seven years), fellowship (one to three years), and to their first attending job outside of training; roughly five times, on average once every four years. For those not familiar with medical education, each stage of training is even more competitive than the last. We are taught to be grateful we even get an opportunity, a chance, a job. Only the most competitive applicants may have the possibility of choosing their preference of location.

My wife is in a Medical Scientist Training Program (MD/PhD) in Minnesota while I attend medical school in Wisconsin. She is actively encouraged to leave her home institution post-graduation for residency to maximize her opportunities. While we will try to train in the same locations, it is not unreasonable to expect us to spend the entirety of our training (up to seventeen years post-college for my wife’s extended program) away from each other. I can’t imagine building a family long-distance but personally know residents and fellows spending several years away from their spouses and children for the duration of their medical training.

Every time queer students are forced to uproot our lives to pursue the next level of training, we are forced to leave spaces we have found to be safe. We are forced to leave friends, family, and our established community. We are forced to re-out ourselves, re-identify allies, re-identify safe spaces, and remake our community. There is no guarantee that the new location or new institution will be physically, emotionally, or mentally safe.

Forty percent of LGBT youth and young adults report seriously considering suicide and 30% report at least one suicide attempt.² Medical students are three times more likely to die by suicide than their same-age peers.³ Twenty-one to forty-three percent of residents meet criteria for depression, with increasing prevalence as training progresses, and 21% of interns (first-year residents) report suicidal ideation.^{4,5} Roughly one physician dies by suicide every day, the highest suicide rate of any profession, and more than twice the rate of the general population. Intersectional data is sparse but a recent study showed that LGBT students experience more burnout, disengagement, exhaustion, self-rated health, anxiety, and depression compared to their heterosexual peers.^{6,7}

When it comes to intersectionality, we know that adversity is not additive but multiplicative.⁸ Medicine, and the path to becoming a physician, is difficult. The current structure of medical education and training can be harmful for every trainee, regardless of sexual identity. For queer-identifying folk, it is unnecessarily dangerous. For the safety of at-risk communities but specifically the queer community, we need to rethink not only medical education but the personal sacrifices that a career in medicine demands.

For further reading:

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4. Growing Like a Lupine

Mikaela DeCoster, Medical Student

A crisp breeze floats past. All around me tall, elegant flowers rise towards the sky. Tightly stacked petals like little pea pods climbing their stalks with colors of lavender, indigo, cobalt, and soft pink. The lupine flower is viewed as lovely and delightful by some and invasive and overwhelming by others; however, despite their debated value, lupines possess the remarkable ability to thrive in rocky, sandy, or infertile environments. While most flowers and vegetation require nitrogen and phosphorus in the soil to grow, lupines have developed the ability to provide those nutrients on their own. By mobilizing phosphorus within specialized cluster roots and hosting bacteria capable of pulling nitrogen out of the air and transforming or “fixing” it into a more usable form, lupines ensure their own growth. If the plant is disturbed, it releases its stored nutrients into the soil. This selfless act leaves its environment better than it found it, transforming harsh, hostile environments into lush, fertile plots of land.

I have felt like a lupine many times throughout my medical education. The process of learning and growing from medical student into future physician is intimidating and exhausting. I often feel as though I am struggling to grow in rocky, uncertain soil. I have often wondered, will I make it? Will I ever grow into something as beautiful as a lupine? This metamorphosis requires tremendous effort but also a certain vulnerability. It requires a willingness to be the beginner, to be unsure, to not have the answers but to be committed to finding them. It requires making countless mistakes and even appearing quite unintelligent at times. Many times as I start a new rotation, I, like the lupine, am faced with the question: Will I be viewed as a welcome addition or as an invasive annoyance?



Just as the beauty of the lupine goes far beyond its outward appearance, the practice of medicine goes far beyond knowledge in a book. Medicine is an art - an art of compassion, of resilience, of service and sacrifice, of growth and continuous improvement. It is the art of caring. But what happens when the demands grow so steep that what was once an art form becomes a mechanical assembly line, stuttering and lurching forward in a desperate attempt to merely continue? Perhaps this system, and this world, that seem so strained and exhausted following a global pandemic, has drained the nutrients once available in the soil around us.

However, a lupine planted in ideal soil likely won't grow. While each of us would likely choose ideal soil, perhaps what we really need to reach our full potential is the struggle provided by less-than-ideal soil. Starting medical school at the beginning of a pandemic could likely be described as just such a condition; however, despite these circumstances, I have seen the beauty and wonder of this profession whose sole purpose is to alleviate suffering. I still believe anything that is broken can be fixed, healed, and restored. Through the struggle, that belief and hope fuels my efforts to be resilient. And perhaps, that resilience and perspective have the ability to infuse hope and light into my surroundings, much like how the lupine fixes nitrogen.

We often assume that flourishing requires a perfect set of circumstances. But perhaps, flourishing is less about the environment in which we are placed and more about how we embrace the circumstances we find ourselves in. If lupines have taught me anything, it is that the process of flourishing is about resilience. It is about creativity, grit, and an abundance of patience. In the end, if I have applied that lesson successfully, not only will I flourish, but perhaps I will leave this profession that I love even better than I originally found it.

5. On Being a Resident: Finding Purpose During Difficult Times

Matthew Eidenschink, MD

Life changes in an instant when a six-week history of diarrhea leads to the discovery of a right lung mass and innumerable liver lesions on CT. Moments before we met, Mrs. L had been told by the Emergency Department physician that she had cancer. Fear and uncertainty set in as she was lying on a stretcher in a windowless, sterile examination room. Her plans for a quiet retirement were rewritten.

Two years earlier, my life had also changed in dramatic ways. Moving to a new city I was handed a pager, badge, and N-95 prior to being ushered onto the wards of the hospital as the pandemic quickly gained steam. Ascending from the rank of medical student to intern is not a glamorous transition. We were told “keep your mask on and stay six feet apart from each other.” In many of those initial days of my career in medicine I often felt disconnected from my peers. Social events were cancelled and replaced with increased patient caps. Days were spent waking before the sun, writing countless H&Ps, progress notes, and discharge summaries. While we were previously able to meet our patients face-to-face, our interactions occurred through a barrier of face shields, masks, gowns and PAPRs. The virus creating further separation between doctor and patient.

Now at the junction between the second and third year of Internal Medicine Residency, I approached her small examination room in the Emergency Department with a sense of calm that I seldom experienced as an intern. My role was clear: to get tissue, a diagnosis, and then consult Oncology to start treatment. Rounding, admissions and discharges had become my routine. After walking through the door, I introduced myself and found Mrs. L was surrounded by three of her children. I was promptly informed there were “more on the way.” It was quickly apparent that Mrs. L was the matriarch of a strong, large family. Word of her illness had already spread and mobilized children from distant states. While worry covered her children’s faces, Mrs. L was stoic, accepting her diagnosis.

Days passed accompanied by a multitude of tests and procedures. Each morning and afternoon, I would pull up my chair

to sit with Mrs. L and her family, sharing the latest results and next steps. They would share their concerns and I would answer questions and palliate symptoms. Stool studies, cultures, and colonoscopy did not reveal the cause of her diarrhea. Liver biopsy returned with high grade neuroendocrine carcinoma, suggesting carcinoid syndrome. With the diagnosis confirmed and Oncology involved, only one step remained before she could transition to treatment. An MRI brain was ordered to complete staging. In the absence of neurological symptoms, I shared that this was a routine scan. Later that day with my checklist completed, I looked over the chart of each of my patients one last time prior to going home for some much needed rest. Pulling up the recently completed MRI brain, I was shocked to find numerous metastases. Feeling a numbness wash over me, I made the journey to her room to share the news.

After telling Mrs. L and her family that she had brain metastases, tears fell from every eye in the room, mine included. In that moment, I felt shame having been taught (consciously or unconsciously) that doctors were supposed to be objective outside observers. I was surprised when I came back the next day and Mrs. L and her entire family insisted on giving me a hug. They appreciated having a physician who was sympathetic. One month later when I was off service I received a page from her primary care provider sharing the family’s request that I see Mrs. L one last time as she was discharging home with hospice. Despite seeing multiple doctors during her hospitalization and cancer treatment, our connection was remembered.

Over the course of residency, I have been reminded daily the value of an Internist is much more than generating progress notes and ICD-10 codes. Caring for Mrs. L emphasized the opportunity I have to partner with patients. By listening to her concerns and through translating our medical jargon into plain English, we were able to overcome the barriers between doctor and patient. In doing so, Mrs. L received personalized care and I was reminded of why this long journey through medical school and residency is worth it.

6. All's well that ends well

Rebecca Elon, MD, FACP

Now that Labor Day has come and gone and the kids are back in school, I wanted to write my version of “what I did on my summer vacation” to share some thoughts on my recent unnecessary roller coaster ride.

Back in December 2020, I underwent my usual routine annual bilateral screening mammogram. It was normal. In late May 2021, I returned to my primary care physician to discuss some changes I had noticed in my left breast and request further evaluation. She ordered a diagnostic left mammogram and an ultrasound. The appointment was scheduled for July.

The diagnostic mammogram was normal. The radiologist came into the room to discuss the changes I had noticed, to determine if an ultrasound was truly indicated. After the ultrasound tech was done with her study, the radiologist came into the room say the ultrasound showed some dilated ducts. He did not think it was anything to worry about, it did not look like cancer, but that a biopsy should be done, just to be sure. I returned the following week for the biopsy.

The day after the biopsy, I got a call from a nurse who identified herself as the “cancer center nurse navigator.” I was shocked to hear her title. My immediate thoughts were “I guess I must have cancer if a cancer center nurse is calling me. Don't the doctors deliver bad news in person anymore or call patients to discuss the results of the tests they have ordered?” She said, “Your biopsy report shows you have breast cancer.” Wow. I was flooded with emotion, very recently having lost a dear friend from medical school who died at the age of 62 from metastatic breast cancer. “Really?!! OMG.” She continued, “Your biopsy revealed DCIS, ductal carcinoma in situ.” “Oh, what a relief!!” I replied, pulling up from the G-force descent of her prior telephone proclamation. If there is something bad like breast cancer, DCIS is the best bad thing to have. DCIS is stage zero. It is a malignant change in the ductal cells, but slow growing, non-infiltrating, and does not metastasize. If left untreated over time, however, it can be associated with infiltrating, life-threatening ductal carcinoma. The nurse navigator said, “I don't have your pathologic grade or receptor status yet. I will call you back when those results are ready, and I'll schedule an appointment for next week for you to meet with the surgeon and rest of the team.”

The following day, the nurse navigator called back. “Your biopsy showed grade 3 changes with nuclear necrosis. Your ER and PR status is negative.” This was not good news. Within the various categories of DCIS, grade three with negative receptor status is the worst possible scenario, indicating a poorly differentiated tumor. “Ok, so I have the worst of the best.” “The surgeon wants you to have an MRI as soon as possible in order to advise how to proceed surgically.”

I had never had an MRI before. I left all my jewelry at home as requested and put my glasses and hearing aids in a basket prior to entering the MRI suite. The tech inserted an IV line for injection of gadolinium contrast dye and said the procedure would take about 15 minutes. I was instructed to undress waist up, lie on my stomach, place my breasts into the buckets projecting down from the gurney, rest my head in a basket and extend my arms above my head and hold on to a bar. Devices closed in on my breasts, exerting some mild pressure. The tech placed headphones on my ears and asked me to select a category of music. The gurney moved me en masse into the donut hole of the machine.

There was a fan producing a gentle comforting breeze through the donut hole. There were low pitched, loud clanking sounds as the study began. Then came a series of intermittent, high pitched, rapid fire, literally deafening, pulsed sounds. Despite the headphones, this noise seemed to be over 100 db. Other than just being annoying, the noise was actually painful. I started reciting the Rosary. Suddenly, I became acutely intensely nauseated and wondered if the tech had just injected the gadolinium. Lying prone with my breasts in compression buckets and my head in a basket, I thought “Where can I throw up?” I did not want to move and disrupt the study, since I surely did not want to ever have to do this again. The head basket had some openings at the bottom. “I guess I will just have to throw up all over the machine.” Fortunately, the acute wave of nausea passed and settled into a less intense manageable nausea. The machine retained its pristine status.

After what seemed like much longer than 15 minutes, my left arm became painful and numb while raised over my head holding onto the bar. I called out to the tech asking how much longer the test would continue. I needed to move my arm. There was no response. When he finally appeared and announced the test was over, I vowed NEVER to subject myself to this sort of torture EVER again! I was still nauseated and woozy as I got up from the gurney. When I put my hearing aids back in, I realized the loud noise exposure had diminished my hearing thresholds, at least temporarily. When I removed my hearing aids that night, I found that my baseline tinnitus was much worse post MRI. I went online to see if studies had been done on the effect of MRI acoustical trauma in people with baseline sensory neural hearing loss and found none. My low-grade, persistent MRI-induced nausea did not resolve for a week.

Several days after the MRI, the nurse navigator called me back to say the right breast looked normal on the MRI, but there were extensive multi-focal, multi-centric areas of concern in the left breast covering a 7 cm area, including a “spiculated” lesion centrally. She said several additional biopsies were recommended and at least one area would likely need to be biopsied under MRI

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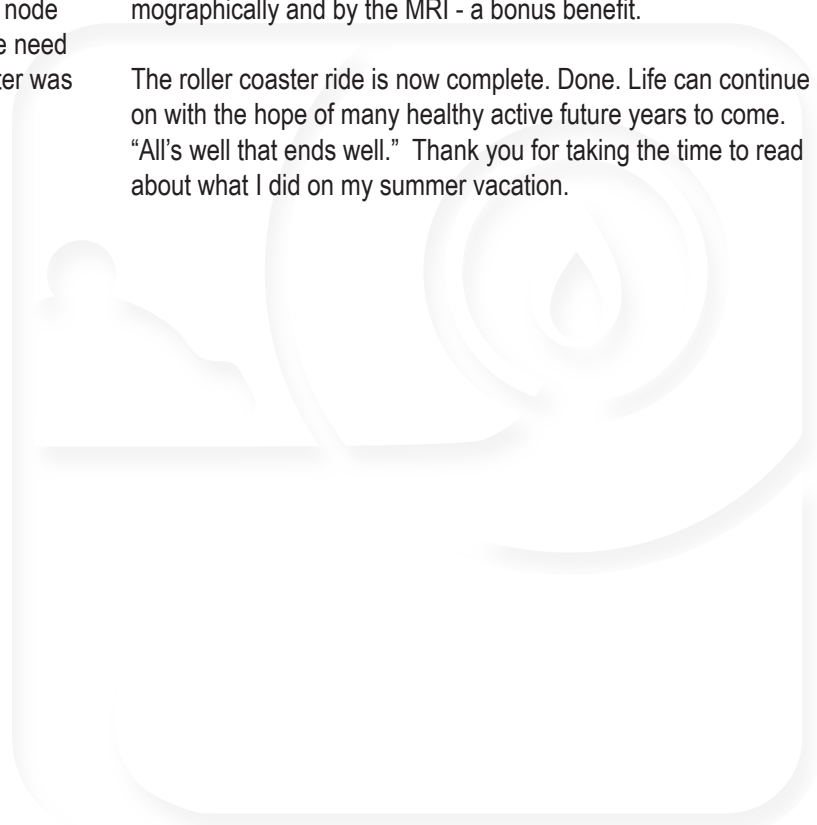
guidance rather than ultrasound. This was just the worst of bad news - badly bad. There was no way to dress it up. I explained to the nurse that with so many potential areas of concern in several different quadrants covering such a large area, including a suspicious "spiculated" (code word for likely infiltrating) lesion centrally, lumpectomy was out of the question. Therefore, further biopsies were not indicated. The MRI results meant I needed a mastectomy. I also discussed with her that since my DCIS and other findings had been "mammographically occult" (not visualized by mammography), routine MRI surveillance of the remaining right breast would most certainly be recommended post-operatively. With my strong family history of breast cancer, including bilateral breast cancer in my older sister by age 50 and my intensely negative MRI experience, it seemed that I should probably have bilateral mastectomies. "Ok, I will let the team know your preference," she replied. "Having a mastectomy is not my preference. It is what is medically necessary."

What started out as the best of bad news, DCIS, had become the specter of possible life-threatening infiltrating breast cancer, based on the MRI report. What started out as the need for a possible lumpectomy had morphed into a bilateral mastectomy. Although the MRI did not show any abnormal lymph nodes or involvement of the surrounding tissues, I was asked to meet with the radiation oncologist and the medical oncologist in addition to the surgeon. Due to the spiculated lesion and the extensive area of abnormality on the MRI, there was the possibility, or even probability, of invasive disease. A sentinel node biopsy would be required. If there were evidence of microscopic lymph node involvement or other tissue invasion, I might be facing the need for chemo +/- radiation post operatively. The roller coaster was definitely headed on a downward descent.

What if, what if, what if..... I really did not want to be immunocompromised, especially during this time of COVID. If I had to undergo chemo +/- radiation therapy, it was likely I would not be able to continue caring for my 97-year-old mom. She would probably have to move into assisted living again, which I had hoped to avoid. She is so fragile and vulnerable. I just want to protect her. What if I died before she did?? What if, what if, what if.....

My sisters were great. Bon mobilized to take care of my mom (and me as well) during my recovery. Surgery went well. Post-op recovery went well. Healing progressed well. And the greatest gift of all – my surgical path report. The nurse navigator called me the week after surgery to review the report. All margins adequate and clear. All lymph nodes negative. No evidence of infiltrating disease. Everything seen on the MRI was DCIS – multiple foci, high grade, multicentric, but no evidence of infiltrating disease. This was the best possible pathological outcome. It was truly a wonderful surprise. It felt like a miracle. I wanted to reach through the phone and give the nurse navigator a big "Covid-be-damned" hug. No need for chemo. No need for radiation. A surgical cure anticipated. Life-time risk of recurrence of breast cancer less than 3%. And another unanticipated pathological surprise – although most of the right breast tissue was normal, there was a small region of multifocal intermediate grade receptor positive DCIS found in the lower lateral corner. What was undertaken as a prophylactic mastectomy, due to strong family history and an unacceptably negative MRI experience, turned out to be a serendipitously therapeutic intervention for an early cancer that was occult, mammographically and by the MRI - a bonus benefit.

The roller coaster ride is now complete. Done. Life can continue on with the hope of many healthy active future years to come. "All's well that ends well." Thank you for taking the time to read about what I did on my summer vacation.



7. Ditto

Abhishek Janardan, Medical Student

Wake up. Shower. Allow coffee to course through my veins. Inhale the minutiae of medical science. Sleep. Repeat.
 The dreaded second year of medical school.

This sequence was how my second year of medical school was to materialize. Algorithmic and formulaic with hardly a crevice available for socialization or hobbies. A year where just walking outside carried the same magnitude as completing a marathon. Frankly, I was afraid my life during my second year was bound to be defined by a self-induced draconian regime. Any leisurely activity was to be keenly policed and even the slightest excess, condemned. Pure efficiency was to be my god, and an unflappable routine, my bible.

None of the previously mentioned horrors ever materialized.

Because of teaching.

I am the son of a math teacher. A mess of homework papers, raggedy math textbooks, and a marked-up whiteboard characterizes the essence of my childhood. The most played soundtrack of my household were the formulas and theorems that amplified through our walls every weekday evening. I witnessed my father mentor and taught numerous students for countless evening hours during my childhood, all at the expense of family time. I could have never imagined that in 16 years I would follow in his footsteps.

Teaching was to me as a square peg is to a circular mold, does not quite fit. As a child, I was disturbed by the concept. It physically represented an action that perpetually separated me from my parents. Returning from school did not mean getting to relax, spend time with family, or talk to my parents. My dad began leaving me home by myself at the age of seven, the empty walls of our home represented a muted abyss, so he could go teach other children.

Fast forward 17 years, I am assigned to be a tutor for the Medical College of Wisconsin. I did not anticipate much. I expected to teach a few hours a week. Pocket income was the main pull factor alongside sporadic content review for USMLE Step 1.

Availability in the evenings represented a distant memory. My only company was me, myself, and my student through the virtual lens of zoom. The doors of MCW represented a prison gate I routinely left only at 11pm. Time for my personal interests steadily sagged further away. I became lost in a hallway of explanations and desperately missed my corridor of silence.

I ended up tutoring over 450 hours...

And I would never trade away a single moment.

I can't really elaborate on why or how I ended up teaching this much. I was fortunate to connect with a group of underclassmen medical students who tolerated my teaching style. They kept signing up and I was required to continue teaching. The two classes that I am delighted to have taught are "Molecules to Cells", also known as Biochemistry and Cell Biology, and "Principles of Drug Action". "Molecules to Cells" especially is considered a treacherous course. The information is excessively dense and brimming with basic science. In the words of Gen Z, "it's hella boring."

In my eyes, biochemistry is to medicine as arithmetic is to math. To understand the nuances that lead to algebra, geometry, and beyond, a strong comprehension of arithmetic is a must. Similarly, a strong appreciation of biochemistry is necessary to completely grasp the nuance driving the fields of physiology, pharmacology, and microbiology.

Let's take the Gs' subunit of a G-Protein Coupled Receptor (GPCR), a transmembrane receptor found spiraling within the plasma membrane, the outermost membrane of a cell. The outermost membrane of a cell plays a vital role in sending and receiving signals from other neighboring cells. Think of your house as a metaphor. For a neighbor to physically establish contact with you, they would have to ring your doorbell or knock on your door. Similarly, for a cell to communicate precious information with its surrounding cells, it would have to release a molecular signal that would most likely interact with a G-Protein Coupled Receptor. The GPCR then transmits the signal intracellularly via the Gs subunit, resulting in adenylate cyclase forming cAMP, which then activates a protein kinase A, the catalyst for a plethora of protein activations within the cell, that then leads to the necessary cellular response, whether that be growth, apoptosis, formation of a signal, etc. Likewise, when someone answers the door, the message is first conveyed from the guest to the person who answered the door, and then progresses on to other family members until it finally finds its way to the decision maker of the household and an appropriate action is taken. This simple pathway is exploited by numerous physiological systems, pharmacological intervention, and microbial invaders. A simple linearity intertwining multiple disciplines. A beautiful phenomenon if you ask me.

I learned that the value of teaching spans far deeper than just the transference of information from one mind to another. "We see the same thing". The pertinent lines of sight must align. Teaching requires the synthesis and incorporation of mass amounts of academic, social, and cultural information. Both the facts and the reasoning behind the said facts need to resonate between the teacher and the tutee. My student and I need to be processing information in the same coherent frame. If someone asks me a question concerning the function of sodium reabsorption within the kidney, not only do I, at a bare minimum, need to be familiar

continued on next page

with the kidney, I also need to effectively communicate the principle of charge maintenance, facilitated diffusion, water transport, etc. I also need to elaborate upon why it matters, whether it be from a scientific, clinical, social, and cultural perspective. Each nested reasoning layer serves as a steppingstone to another connection much like a Russian nesting doll “matryoshka”. The beauty of the pattern is lost even if a single nested layer is neglected. The real marker of teaching is being able to apply the underlying principle behind a given topic to an entirely unrelated scenario.

This is what I taught my students, who inadvertently transformed into my friends. The conversations spanned from spaced repetition, problem solving, Persians in LA, New Mexican cuisine, anime, memes, the Children’s Cafeteria buffalo chicken wrap, and far more. I learned an eternity more from any of the students I tutored than I could have ever taught. Relationships are the core of any endeavor, and nothing illuminates a room more than the power of the connections that permeate the air within it.

I finally caught a glimpse to why my father spent so much time teaching other children. It was the opportunity to mold relationships with his students and their families. To shape a child’s mind and incite a passion for a discipline of knowledge is truly a beautiful feeling. To be able to mince a core subject, rearrange the information into bite sized pieces, and reassemble it in its

totality, and patiently wait for the impending “aha” moment is a rare sensation. I am only able to infer this because these are the characteristics that motivated me to teach as much as I did. To be able to appreciate the significance between the intersection of basic science, clinical science, and the human emotions associated with it is what makes the advent of medical education special.

Medicine represents one of the most meaningful fields of practice in humanity. The unparalleled opportunity to impact the very core of a person’s livelihood, their health and wellbeing, is a privilege that very few are fortunate to receive. But it does force all its constituents to offer a sacrifice. Everyone donates their time. Patients grapple with their wellbeing. Physicians struggle with burnout. Trainees struggle with imposter syndrome and crippling debt. For me, the sacrifice of personal time became a blessing in disguise; through tutoring, I am grateful to have found both a passion for education and a mode to untangle one of the most conflicting memories of my childhood.

To answer the most frequently asked question of my childhood,

Do you think you are going to be a teacher like your dad?

Ditto



8. I Will Carry You With Me

Brooke Jennings, MD

I cared for you, and I will carry you with me.

I can remember the very first patient I truly thought of as mine. Mr. B was a thin gentleman in his 80s, who was soft spoken and kind, and each visit he happily shared thoughts and wisdom that he gained through his years of experience. He was often accompanied by his daughter who always embraced me with a warm hug, as if we were old friends. One visit I remember fondly. I walked in to see Mr. B dressed from head to toe in green and gold attire. "It's been a while", he said. It had been almost 6 months since I saw him for his last visit. At the end of the visit, he smiled and told me that I better be cheering for the Packers this weekend. I laughed to myself, but each time after when Mr. B was on my schedule, I made sure to check the latest score of the Packers game. Mr. B died two years ago.

Mrs. S came to clinic for follow up after I took care of her in the hospital. She was extremely sick – being supported by vasopressors and a ventilator for many days before her recovery. These patients were quite different. She laughed loudly, joked often with sarcastic humor, and shared stories of growing up in a tiny town where she knew all of her neighbors. She slipped a small round object out of her pocket and held it out to me, "a buckeye", she said. "My family has always carried one in our pockets for good luck and good health; I brought one for you." She pulled a darker, shiny one the size of a grape out of her pocket. "This one is mine," she says, "I twirl it in my fingers for good luck." I took the dark brown nut with a small tan patch from her, taken back by the small, generous gift.

Now, years later when I think of Mr. B or Mrs. S – and many others, my heart is warmed. On occasion, I have opened a new tab on my computer and checked the recent Packers game score. I'd picture Mr. B grinning after a win. I am quite sure if I saw his daughter now, we would embrace like no time has passed. "His memory lives on for me, too", I'd say.

I keep the buckeye from Mrs. S on my desk, it is within my reach almost every day. Sometimes, I pick it up and sift it back and forth, often hoping for some of this luck to go to my patients and their families. It is smooth and cold, and I can picture Mrs. S in her yard collecting a buckeye for her doctor.

It is a privilege to know another human being, to be let in by families, to build relationships, to be given the opportunity to care and to grieve.

Would I have ever known the story of the buckeye or the recent score of the Packers game without crossing paths with Mr. B and Mrs. S? We are fortunate to learn from them, grow, understand different perspectives in life, to help another human being. We often find ourselves hearing stories and sharing in some of the most intimate moments of a person's life.

"It's been a while".

And it has. But I am your doctor, I cared for you, and I will carry you with me - long after your journey here has ended.



9. Essay

Devesh Kumar, Medical Student

Having always had a passion for science, the path I chose to pursue was medicine. Coming from a lower middle-class family, I witnessed my father work hard and long hours in order to make ends meet and fund my and my sister's education. Witnessing the resilience and dedication to proper education that my family embodied, I learned to *not give up no matter the situation, always strive for capability and excellence, and always help others succeed* as well. My practice of Nichiren Buddhism reiterated these determinations and motivated me to add strive for my happiness and happiness of others to the list.

As a medical student, I set out on my journey to become a humanistic physician. This meant obtaining the foundational education in my basic sciences courses but also gathering the research, clinical, and scholarly experiences requisite for my professional development. One day as I was in Clinical Apprenticeship (part of the curriculum) exploring the provisions of patient care, I came across a 3rd year medical student, and we engaged in a conversation on evidence-based practice. One of the internal medicine physicians, Dr. Pinky Jha, overheard our conversation and decided to support me by pairing me up with said student as a mentee on a case report on Legionella Induced Hepatitis, which was later presented at ACP Wisconsin 2021. This experience was fruitful as I gained wisdom from the student mentor about the process of writing scholarly literature and I learned the importance of scholarly activities. This is one of the foundational experiences of my medical school which I often find myself going back to in order to encourage others. My passion grew and I wanted to pay forward this immense sense of gratitude I felt towards Dr. Jha and the student. I aspired to be a mentor for a case so I may support a student and shared the wisdom I received, thus also furthering the focus on scholarly activities at the Medical College of Wisconsin.

At the onset of my second year, I was able to work with another second-year student on a case which was also accepted at ACP Wisconsin 2021. As a medical student, we are often considered "bottom of the barrel," "lowest on the totem pole," or simply a liability within the comprehensive medical hierarchy. This experience made me feel useful and the impact was far reaching. My drive to help others in this manner only grew stronger so I started taking on more and more students so the Medical College of Wisconsin will be considered a school who churns out patient-oriented evidence-based humanistic physicians. Students and faculty started reaching out to me to mentor more students and effectively train them to take on other students which starts this scholastic ripple effect. I'm happy to report that through this initiative, I was able to mentor 15 students, out of which 4 of them have become mentors themselves and have mentored 3-5 students each. After receiving many reports from mentees, it warms my heart to share that although this initiative was important for the professional CV development for these students, it was also crucial for patient care as it has allowed them to view patients' situations critically and work collaboratively with the residents to come up with a patient-centered management plan. I urge other institutions to implement this mentor-mentee model as well.

This is largely due to the efforts by the American College of Physicians. It is the state and national conferences that encourage students to break out of their comfort zone, at which point the focus on scholarly activities translates to better patient care and patient outcomes.



10. An Experience Shared

Brett Linzer, MD, FAAP, FACP

Early one morning in 1996, after a sleepless night on call, I stood with my team in the VA hospital, outside room 102. I was a 28-year-old intern on the general medicine service. We were making rounds on twelve patients that my intern partner, myself, and our supervising resident had admitted overnight. We would walk room to room and the intern would present the information regarding the patient by gathering data and putting it on a small white note card. I presented the case of a 62-year-old veteran who was admitted with chest pain. His pain had resolved and the EKG and lab work were both reassuring. Our attending and team were satisfied with my presentation and we entered the room to find a pleasant man sitting up in bed eating breakfast. He was enjoying scrambled eggs and mashed potatoes that were on his wheeled table overlying his bed. After a few moments of small talk, the attending was confident the patient was in our good hands, and we left the room.

As we walked down the hall to our next patient, I realized that I made a big mistake. I had used the wrong note card and I had presented the information for a similar patient in error. It was the wrong patient! I had never done that before and was not sure what to do. A feeling of nausea came over me and I felt faint. I took a few minutes to gather my thoughts and find some courage. I shamefully declared my mistake to the attending and the team. My attending was kind, though a little confused. "Okay, we will sort it out after rounds" he said. We continued walking down the hall to the next patient's room. Our discussion outside of room 110 was interrupted by a loud overhead page "CODE BLUE room 102" followed by a number of residents on the code team pushing past us to attend to the emergency. I felt a wave of disbelief. We followed the code team down the hall to my patient in room 102. There I saw my patient laying lifeless on his bed, while the resident forcefully pushed rhythmically upon his chest in the process of CPR. The code team leader yelled out "Whose patient is this? What is the story?"

At that moment, I wanted to be invisible. I was already mortified and the situation was getting worse. I had a brief moment of hope, assuming that my supervising resident would step in and take some responsibility. However, in his own state of fear and confusion, he left the room and did not return for 3 days. Again, louder, "Who is responsible for this patient and what is the story?" I raised my hand meekly and told the appropriate story.

Twenty minutes later the code was ended and the patient declared dead. My attending and I were the last people to leave the room. He was supportive, but when he looked at me it was almost as if his face was a mirror for me to see my own shame and worthlessness that I felt inside. I did not make a mistake. I was a mistake.

That afternoon, after 32 hours of continuous work, I had to go to the morgue to sign the death certificate indicating the cause of death. It was a long, lonely, walk through a poorly lit basement hall to get to the morgue office. After my arrival, I stood for a few minutes in my state of exhaustion and confusion, staring at the small rectangular box on the white piece of paper with the small words in the left hand corner-"Cause of death".

At the end of my shift, I left the hospital through a rear door. I sat down on the steps in isolation, trying to gather my thoughts over the previous 36 hours. I cried a little, but was too overwhelmed to fully process what had just happened. I told myself, "Look, you are exhausted, you have to return in the morning and you have a lot of work to do. You will deal with this later."

In the subsequent 2 weeks following the death of my patient, there was a peer review and an autopsy performed. The final report determined there was a clot rupture and a large myocardial infarction. Multiple people reassured my team and myself that we did all the right things and there was nothing else we could have done. Part of me was comforted by these facts. There was also a part of me that felt deep shame and worthlessness. That event was confirmation for me: I was not good enough to be a physician and I did not belong there.

This shame followed me through 22 years as a primary care physician and preceptor of medical students. It contributed to a sense of disconnection with patients, colleagues, and even myself. I worked with a physician coach who helped me to understand that shame is ubiquitous in medicine. It is part of the culture in training.

This comforted me to know that I was not alone and I was not broken. Even though it is a common experience, shame often lives in the silence of our own story. It is an uncomfortable emotion that is not welcome in our perfectionistic and competitive culture of medicine. Role models and mentors who have worked with their shame can be helpful to others, making it more comfortable for them to share their shame experiences. Unfortunately, these types of mentors can be hard to find.

It is important to understand that shame is difficult to process on one's own. Shame can be a powerful negative emotion leading to withdrawal, isolation, addiction, and even suicide. It requires someone, or a group of trusted individuals, who can hold space for the vulnerability and honesty that is required to heal and integrate the shame experience. Self-compassion and empathy from others are key components of the process of healthy integration.

Being honest with myself and facing my experiences with shame was not easy for me. At times, it was both physically and emotionally uncomfortable. What I discovered through this work is when I share the difficulties I encountered in training with learners, it enables them to discuss their own fears and challenges. The result is often a deeper connection and healing for both of us.

11. A Generation of Stories

Katherine Recka, MD, Associate Professor of Medicine

Early in my career, as a student, the stories were new to me. As an M3, I tried to reorient a delirious Veteran by asking about his service history, and he Sergeant barked in a moment of clarity: !! KILLED! NAZIS! Back then we had more WWII Vets, and it was impossible to miss the humbling contrast between his late teens and mine. Their defining moments became cocktail party anecdotes without the urgency of a generation leaving us.

In the few years it took me to become faculty, those WWII stories became increasingly scarce and exponentially more precious.

On our consult service, “I just think that it’s my time,” he shared. His adult children sat in the late fall afternoon sunlight, perplexed, disappointed. We had all heard the day before that a new type of cancer drug might be possible, a miracle drug that might help even if a person was too sick for regular chemo. Didn’t he want more time? “Well,” hesitantly, “I heard a voice that I’ve heard before. I think I have a guardian angel, and I think it’s my time.”

He had heard it once before. Northern France, a season like this one, but cold, grey, rainy. He and a partner, a bridge out, a jeep accident, freezing water, his partner now dead, German voices getting closer. Another voice was clear and close. It was English, American English, and it told him to play dead. Now the Germans were silent. Were they gone? This third GI, the one who told him to be still wasn’t answering. Was he dead too? Too dangerous to move, he followed the voice’s orders and lay corpse-like half in and half out of that frigid stream.

Finally, he heard the rumble of another jeep, a new set of voices, this time surely American. Later, body patched up, youth left somewhere out in a muddy French field, he tried to find out about that GI, the one who had warned him. Nobody knew anything. No one had seen him.

Now 60 years later, that voice came back to offer more advice. The children, now grown, tearful, confused. Why hadn’t they ever heard this? They had been sheltered, told about the girls, the rations, the cold, but never the jeep, the stream, the voice. Veterans protect people.

In our old hospice unit on 8AS, another Veteran lay quietly in his bed. Walls grey, close. His face grey, peaceful. Next to his bed, a glamour shot of a young man, devastatingly handsome. His airman’s white scarf almost blowing in the wind. He’d been given

a choice, go to the camps in California or go to war, and he’d had no hesitation. His wife, now the bearer of his history was bolstered by a cracked photo album, yellowed pictures and scraps of documents concrete reminders of sacrifice by patriots whose loyalty to their country wasn’t returned.

She hadn’t had the choice to serve her way to freedom, but Japanese Americans who had family in other states had been allowed to leave California, and she fled to Milwaukee. They had met on Bradford Beach. “The Hawaiian boys used to have luaus there. It was a place we could feel safe.” A lightening flash of emotion across her face, her heart still blasted apart by our country’s shameful labeling of her citizens and put back together by meeting her true love at a luau.

Just this week, back on our hospice unit, a different unit now, buffed up with laminate instead of linoleum, signs labeling the way to “Heroes Corner” in case you forget who you’re seeing. Always up for telling his stories about D-Day, he rested. We had laughed along with him, the irony of ending up in history books just so he could get out of “the stocks,” the English girlfriend he had snuck out to see, not back in time for bed check. He shook his head, “Court martial or Normandy. Well, you know which one I took!”

I took my chance, “You know, The Medical College asked me to write something about Vets. What should I write?” Suddenly bashful, unsure, “I don’t know what to say. I’m 99 years old, and as much as I love talking to you girls, I’ll forget what I said the minute you walk out the door.” He switched topics quickly, gracefully. Today was Friday, which meant Bingo. How many canteen bucks he would win was a safer subject.

We hear that trauma lives in bodies, lives in generations, but stories live on too. They live on in us when those minds and bodies and generations of ordinary extraordinary men and women leave us. They live in you, live to be held and beheld and tended. I know the burdens of the VA, the policies, the procedures, the endless and ever changing acronyms. I also know that you can step away from your SOP, and your PIV and CPRS, pull up a chair and sit in the ice storms of the Choisin Reservoir, the desert heat of 29 Palms or a warm Milwaukee beach across the decades, across the artificial barriers of age and politics and let those stories reach you and teach you. These will never be our stories, but we have the great honor to guard those stories as carefully as we treat the bodies holding them.

12. COVID

Melanie Ripley, MD, FACP

One of my primary care friends feels this intense guilt about “not being on the front lines” as if, in healthcare, there is a threshold, or a baseline that you have to meet in order to warrant sympathy. Like the general pain and human suffering we deal with on a regular basis doesn’t warrant sympathy, you only deserve sympathy if you are making decisions about the allocation of scarce resources for sick and dying patients. We know though, that someone else’s suffering doesn’t diminish our own.

Lets call him James, one of many patients I cared for during the COVID-19 pandemic. He was a sturdy Wisconsin man, lived alone in a cabin, his life made meaningful by fishing, hunting, drinking high life with his friends while ice fishing. He contracted COVID, suffered ARDS, was intubated, prone and had a prolonged ICU stay. As a hospitalist, I received him as a handoff from one of the intensivists. James is a great guy and I met him when he first came out, looking still very sturdy. He was still needing heated high flow oxygen, but his nurse in the ICU had educated him, encouraged him to use his incentive spirometer every hour and he adhered to that treatment. He and I had a number of conversations about his post- ICU course: he could not wrap his head around why he still needed so much oxygen (he remained on heated high flow for weeks), why he was so weak, why he needed so much help getting to the bathroom. Because he had had severe COVID and because our community spread was so high, he could not receive visitors. I remember the day I came in and he had received a package from a friend with some puzzles and he could not even bring himself to do the puzzles: he was too fatigued. I went off of service, he was still needing oxygen, his fate had been solidified to transition to a SNF, neither of which he was excited about. I came back on service a month later and he was still there. He had lost probably 20 lbs and he declared “I am de-

pressed”. He was a different man. How could this have happened in one hospitalization?

This story made me really think: is this really what this patient would have wanted. His heart seemed so broken after this hospital stay. He was a shell of his former self when he finally left the hospital months after his initial hospitalization. One of our intensivists had told me mid pandemic: when you are discussing critical illness with a patient with COVID and multiple risk factors for severe illness: make sure you ask them: do you want to spend weeks and weeks in the hospital and probably go to a SNF after?

I reflected on this with one of my intensivist friends, and we commiserate over how poorly we sometimes communicate serious illness and its aftermath. You know, sometimes patients are very clear: they know exactly what they want, sometimes this makes sense to us. This is a best case scenario and also feels so rare. Maybe we aren’t good at discussing serious illness, maybe we lose the forest for the trees, or maybe we just don’t know. We can’t always predict who will do well and who won’t.

One thing I know for sure, I definitely think about the suffering that we sometimes put patients through and there is no doubt in my mind that we could do a better job communicating serious illness and preparing patients for the sometimes long and arduous journey ahead of them. I hope that all of us people who practice primary care in some capacity have the space, time and where-withal to have some of these conversations beforehand, time to put it in writing, time to allow patients to think and process.

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13. Primary Care

Melanie Ripley, MD, FACP

I practice part time in the clinic and part time in the hospital in a small urban area and I often share, with really anyone who will listen, how impossible the job of primary care feels in the time allotted and with the “tools” we are given. A recent simulation study noted that if the average primary care physician were to do all the things needed to take care of a panel of 2500 patients, it would take a laughable 26.7 hours a day.¹ This is purely numbers, the bare bones or the nuts and bolts of the job. This does not take into account any of the other number of things which could affect your work flow (rooming, staff, late arrivals, complex patients, etc.). I guess I say this as a way to make myself feel better for not being more “efficient”, but also as a call out to anyone in administration who is taking part in evaluating what we consider full time. Even if we wanted to work like our predecessors did, we couldn’t even finish the job in a day.

Additionally, on any given day, I will walk through a new cancer diagnosis, a divorce, the news of a new grandchild or a new child. As a woman practicing primary care, I can be expected to answer more messages and have an even heavier emotional ask placed on me by patients and colleagues.² I often say that not a day goes by when a patient doesn’t tear up, maybe two or three.

Now, I remind myself on a regular basis how special my job is. Patients let me into their lives at the drop of a hat and they trust that I will hold sacred that relationship. And I hope that all of us do this. It is incredibly special to journey through life with our patients and that is quite literally what we do. We sometimes celebrate with patients, sometimes mourn with patients, and ideally always cherish the relationships that we share with patients. It can be an incredibly formative relationship, or it could be a very functional relationship. Some patients, probably the majority, yearn for the provider who will see him or her or them through thick and thin. Sometimes when I think about what we are expected to navigate in a day it makes me take a pause. We need to change and shift and navigate such a wide variety of scenarios: is the patient

grieving or traumatized? Does the patient want more or maybe less? What is the patient bringing to the table that day and what am I bringing to the table? Will I ask the right questions, will I be able to help?

There is something very special that happens when a patient feels heard and seen. Sometimes it happens in a single visit, sometimes, the layers of the patient are peeled back over the course of many visits. There is a magic that happens when patients trust their provider, and this takes time. Time that many of us don’t have and if we do, it is out of our own emotional piggy bank or our own time bank. This is the essence of primary care. A place for patients to come, be seen and heard and healed. This healing, this takes time and is facilitated by continuity and relationships.

The more I learn about patients and the more I do primary care, the more I realize that within me is an oral history of my patients. I think that what we have, what we create is incredibly unique and special. Irreplaceable really. I certainly hope that healthcare systems, administrators and insurance companies will start to see the light, will appreciate the importance of continuity, the hidden costs of these relationships and will start to place value on the relationship. The way it is now, the patients and us providers are looking for a way to hold on to the bond that we have, that improves health outcomes³ and patient satisfaction.⁴ I hope that there are many among us that continue to fight for true primary care for our patients.

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14. Desiderium

Shawna Rivedal, Medical Student

On Thursday afternoon, we admit a man who I have already seen and discharged during my week on service. He is short of breath, propped onto three pillows, nasal cannula dislodged from the left nostril. He says he takes his water pill; his legs say otherwise. I ask him about his diet (still canned soup and bananas), and he tells me about his wife. For forty-five minutes, he tells me that ever since his wife died of COVID, he wishes he was dead.

He tells me about their travels. About how his wife loved to drive at night but hated pumping gas and sometimes she would nudge him awake in the passenger's seat with a sheepish grin and an apology, the tank at nearly zero, fifteen miles from the nearest filling station. About the way she loved to sing while baking scones but always seemed to burn them and now he can't eat them any other way. About their kids and their house and their bright red Corvette. About how all his friends were their friends and now he's the odd man out. A fifth wheel. He tells me his wife was vaccinated and they got groceries delivered, but she still had to go to her chemo treatments. He tells me how careful they were. Mostly he repeats how life has no meaning without his best friend of sixty-four years. He tells me that he isn't actively suicidal and that his religious beliefs forbid him. But he stares out the window at the parking garage and repeats he wouldn't mind if he didn't wake up tomorrow.

The next morning, I introduce myself again and ask him how he slept. Pretty good, he says. Only two pillows. He denies any chest pain or palpitations, wheezing or fever and chills. When I ask him how I can help him today, he tells me about his wife. For forty-five minutes, he tells me about how he wishes he was dead.

His dementia is characteristically cruel. He does not remember me or the resident or even his daughter, who visits every other day. He cannot tell us where he lives or why he's here. He thinks

it's 1982. He needs a surgery for his heart, but it would require intensive medical follow-up and his dementia precludes this, and so he sits by the window and becomes short of breath just existing.

We go on like this for days, performing different dances to the same song. We want him to eat more, to walk with physical therapy, to talk to psychology—and he agrees to do them tomorrow, except tomorrow never comes. We are stuck in the same day

The patient is crying. He throws his hands up in the air in anger, accusing us of holding him indefinitely in his room. Am I a prisoner? He asks, his stooped frame shaking. Am I—his words catch in his throat, hang unanswered. In that moment he seems acutely aware that he is old and he is frail and if he left his fluid-filled lungs would not make it far. His body is failing him but not fast enough. I don't know how best to help. I listen to him and hope that by sharing stories of the person he loved most helps his grief.

We tell him we are worried about him. We are worried that he wanders. We are worried that he falls. We are worried that last week he was found at night walking in the woods with a letter from his wife, searching for someone whose story is over.

The next day is a holiday. I'm on call. The residents claim the day should be quiet. But instead of new patients, we get paged about a disturbance on the floor. The patient is wearing a tie and refusing to get back into his wheelchair.

We're going to church, he says. Donna and I always go to church on Christmas. The hospital church is being renovated, so we take him outside. We take him to a courtyard ensconced with greenery that has yet to bloom. There are no birds in the trees. He puts his hand in the half-frozen water fountain and tells us he can't wait to go home, to Donna.

15. Ask Her About Dogs

Markayle Schears, Medical Student

Patient

I've been in and out of hospitals my whole life. Since the day I was born, I've been fighting for some stability. There are months that I spent more time in hospital rooms with doctors and nurses than at home with my family and friends. When I see stethoscopes or medical gloves, I cringe almost involuntarily, because they bring up memories of painful procedures done to me over the years.

At home, I don't find my condition to be much of a problem. I feel "normal", I can do school from home and go at my pace. Most importantly, I can play with my dogs! I like to draw and dance. Here, I am a teenager, a sister, a daughter, just one of us.

It's outside of this bubble that I've had the greatest struggle - especially in the medical world. Therapy and doctors' visits serve as regular reminders of how far my skills and functions are falling behind. I also started to realize all my friends were adults from therapy and that my days became the sessions. So, I decided to take regular dance classes with other kids instead. The classes have been working for me and I've even met some friends my own age!

Mom

We thought she had passed away when her heart stopped not long after she was born. After 3 weeks in the NICU, the doctors told me, "We don't know why, but she is fine now." We were happy to take our baby home. We noticed she struggled to hold her head up and wasn't meeting growth milestones. When she was 6 months old, we found out she had cerebral palsy. I didn't grieve, because I knew that we were going to focus on doing everything we could to give her a good life, however long that was going to be.

We have focused on this. Our social life revolves around other families with disabled children and community action efforts. Only recently did my husband and I, finally take our first couples vacation weekend, an hour away to celebrate our 25th wedding anniversary.

Strangely though, when you break it down, insurance considerations consume the majority of our energies in advocating for our daughter's care. Providers say, "Don't worry you have Medicaid." Well, for equipment needs, Medicaid only seems to cover the expensive things, not the more cost-effective items. Can you imagine waiting 18 months for a wheelchair? In terms of appointments, most places don't accept Medicaid or only cover half-time sessions, and that's only after you get off the 6-month waitlists.

The kicker is that when we finally do get to these visits...they can often end in tears. Many appointments aren't set up with the

idea of celebrating my daughter's strengths. They look to quantifying weaknesses, or loss in her functioning. Commonly, a list of challenging questions on a clipboard might be rattled off before a basic rapport is established. Worse yet they may entirely ignore her and ask me for the information instead. I even pushed to get a note at the top of her chart saying: "Ask Her About Dogs", and I'm amazed at how few providers do it. When they do ask, it's like night and day. They can connect with my daughter and get what they need accomplished. Ultimately, this is a major goal for us - that my daughter feels comfortable around medical professionals.

Brother

People ask, "How is your sister doing?" and look at me with pity eyes. I tell them, "Oh she is going to camp next week or she's got a new dog" Because her life is more than the times she spends cooped up in hospitals like some sick person.

Don't get me wrong when my sister is sick or can't breathe, the whole house is upended. Each emergency is a little different, but there's always panic in the unknown and wrestling with the possibility that this could be the one that pushes her and us all over the edge.

Still, just doing everyday life things outside the house is one challenge after another. Want to take a trip to the mall? Well, you'll find the disability doors don't work (and haven't in years). Also, no handicapped bathroom stalls. And, ah yes, you'll come across parents hushing their kids' innocent questions about how small my sister is - *Quick! Look away, children!* Finally, what's an outing without adults not keeping their own off-handed, pity comments to themselves. But hey - at least we got out.

I've spent a lot of time with my sister, and try my best to be a good brother. I really love to be around her and help out as much as possible, but now that she is a teen, I get that she needs more privacy and greater independence. Which only makes sense - it's the golden rule - treat others as you would like them to treat you.

Medical Student

I had the opportunity to engage with this family over the course of several months. Their stories and perspectives continue to stay fresh in my mind. Each meeting with the family brought up different emotions from anger over the systemic and social injustices they have faced, to guilt in recognizing my part in the perpetuation or passive acceptance of ableist norms and obstructionist systems. I also continue to feel a strong sense of gratitude. Despite all that this family has weathered and continues to endure, they are still reaching out to connect and share their knowledge with trainees in the hope that it could make a difference to patients and their families in the future.

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We hope this reflection can serve to spark greater awareness in rising physicians of the challenges and strengths that families with children with disabilities have especially in medical environments. Getting to know this family in depth was a gift and an important reminder of the critical social dimensions that can be overlooked in a fast-paced, medical context. While it is not possible to know all the ins and outs of individual patients' support networks, life experiences, and value systems – small, but mighty details matter. So, I definitely asked her about dogs.



16. One Step at a Time

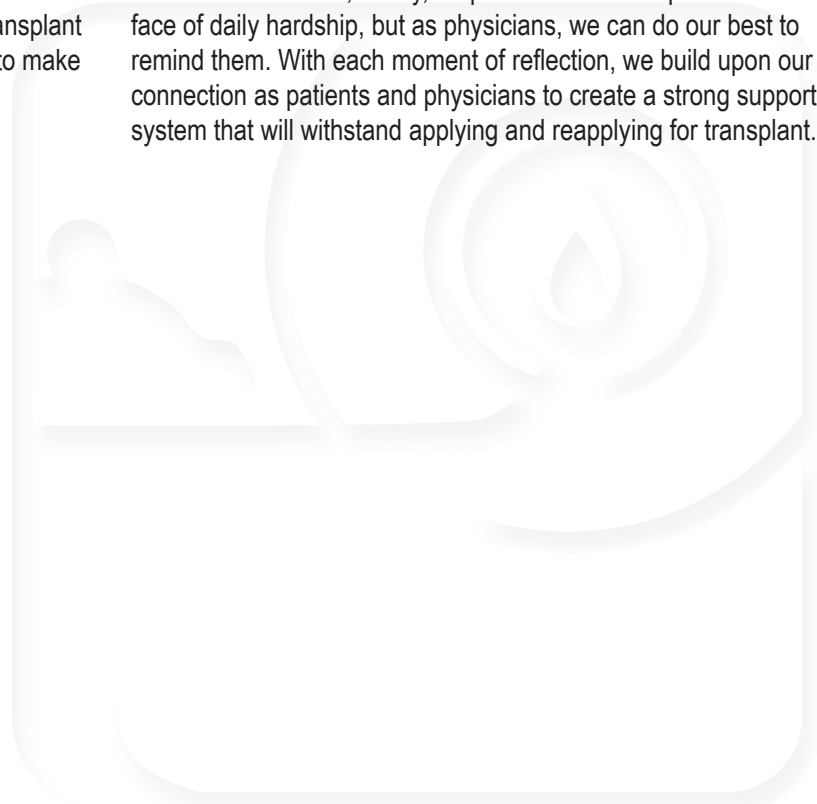
Jacqueline Tran, Medical Student

We all remember the times we embarrassed ourselves six, twelve, or even fifteen years ago but we fail to remember the victories that most likely surround those times as well. I personally (and vividly) remember the time I ran across the gymnasium in seventh grade and fell flat on my bottom in front of all my friends and classmates. What I sometimes forget to recall is that I had just placed 3rd in the regional History Day competition that same year. A trivial example but exemplifies a particular human habit of remembering the negative more than the positive. It affects how we approach and think about things happening around us and in the world. This lesson has shown to me that I need to reframe my negative focus – make note of it, address it, change it. A moment of reflection allows us, as medical students, patients or simply as humans, to think about how far we have come. Yes, failure or hardship has once again confronted us, but what will we do with it?

My very first patient on my very first rotation needed a lung transplant. My team was hopeful and fulfilling the transplant workup, checking off our list. Two weeks down the line, our patient starts to decline, requiring more oxygen at rest, refusing physical therapy (PT), and feeling more anxious about his prognosis. The patient was encouraged to stay active and continue PT but consistently felt too anxious to exacerbate himself. The news of his decline did not help his case with the transplant center and ultimately, he was denied. Before the patient was even informed, a new note in his chart from his physical therapist shared with us that the patient was pushing himself during yesterday's session and walked for a total of three minutes! The devastating truth is that the transplant center can't see how hard our patient is pushing himself to make it on that list and had already finalized their decision.

We had many conversations with our patient to explain the scarcity of lung transplants, the risks and benefits, and his high-risk status making his candidacy for transplant a lot more complex. Once we broke the news of his rejection, he asked the team, "Was it because I didn't do more PT last week?" In this difficult situation, the patient's introspection about his missed PT appointments made me wonder, how can I help him reframe this "failure?" Our team discussed other options that remain and what our next steps would be. We can reach out to other centers and start the transplant process over again or we can spend some time rehabilitating and appeal this denial with our original transplant center of choice. The big reminder here was that amidst the delivery of this bad news, the patient had just previously walked more than he had in two weeks. Reframing this negative situation, we reminded our patient of his great improvement just yesterday; we encouraged him to maintain his activity level and continue with PT because it would show to the transplant centers that he would be fit for surgery. With every right, our patient was disappointed and saddened by this news but agreed to continue working with PT and regaining his strength one step at a time. We addressed this difficult news and decided to change it.

It was very important to me and the team to continue to encourage our patient and support him through this transplant process. What he works against daily, just to simply breathe, is a powerful testament to his willpower and perseverance. One missed PT session does not negate the progress of living with a chronic disease. It is difficult, surely, for patients to remain positive in the face of daily hardship, but as physicians, we can do our best to remind them. With each moment of reflection, we build upon our connection as patients and physicians to create a strong support system that will withstand applying and reapplying for transplant.



17. The Moment After

Margaret Walker, MD

On my days off, I read novels. I get drawn in by the first sentence. I hold on during the exposition and develop a deeper understanding of the oft-flawed characters. Then the climax crashes down making the central conflict apparent, and finally, the end appears. The moment after a book ends, a wave of emotion hits. Some stories leave me satisfied, others angry and frustrated, and some just leave me waiting for the next volume. Stories are as diverse as the individuals sharing them, and their endings are no different.

On my work days, I listen to my patients' stories. These stories start in the middle, and are considerably more messy than those composed by authors. They are laced with pain and paired with a request for help. Occasionally, I witness the end of these stories. As with the end of a book, there is a moment of pure emotion after the end of each life story.

I remember the moment after my first code experience resulting in a death. I was a fourth year medical student rotating in the surgical ICU. I had just arrived to begin the day's pre-charting, and our team was quickly notified of an evolving medical situation. The patient had undergone a major abdominal surgery the day before, and for unclear reasons, she lost her pulse. We raced downstairs to begin compressions. Blood crept up my arms from the open surgical wound as I performed my first compressions on a human. The room was filled with people, equipment, movement, and voices. I remember the patient's son arriving, walking into the room, and observing the massive resuscitation effort. After several minutes, he asked the team to stop their efforts. Family had arrived to witness the violence just before death. The moment after was painful. I was a student, standing outside the door, and not responsible for medical decisions, but I witnessed the events leading to the end. I was grateful that our fellow took the time for a team debrief. She helped us to process the patient's and our own trauma of the code.

I remember the moment after my first patient death as a doctor. It was intern year and my first week of my first month of inpatient medicine at the Veteran's Administration (VA) Hospital. Our census was inching up, and I was struggling to mark each checkbox on my list. I didn't have time to listen to my patients' stories; I simply had to complete tasks. One of our patients was declining, and we could not identify an underlying driver. I arrived one morning to the cross-cover intern asking me to come to the ICU. My patient had died minutes before I arrived. I doubt that I could have changed the outcome, yet the weight of responsibility hung heavy on my shoulders. For the first time since starting residency, I began to understand what it was to carry patient outcomes with me. This moment was confusing. Once again, a debrief session was held. Our attending, only three months out of residency himself, taking the reins to review the case. He addressed our emotions and concerns while providing encouragement. After all, we still had our whole day ahead of us.

I remember the moment after I first witnessed a death. To this day, it was my worst night of residency. To set the stage, it was at the peak of the COVID-19 pandemic prior to the vaccine. Our VA hospital was bursting at the seams with chronically ill individuals fighting a losing battle against the virus. I was on night cross-cover, caring for six teams' patients, and I had already responded to countless pages and nurse inquiries. In addition, I had notified three separate families of the death of their loved ones. In each of these cases, the patient's death was expected. Yet the toll of restricted patient visitation was acutely felt as each family had to hear from me, a covering physician, that their loved one had passed. Finally, I had been responding to multiple telemetry calls for a patient who had multiple irregular heart rhythms. His heart rhythm kept reverting back to a normal sinus rhythm. I replaced his electrolytes and checked regular electrocardiograms. I had just made it back to the call room at 4 AM to eat my dinner when my pager buzzed with a rapid response. I bounded back up the stairs to my patient. He was in the dreaded Torsades de Pointes rhythm. The energy in the room was electric. Detritus littered the floor: spare needle caps, bloody gauze, wrappers for this and that. The patient was agonal breathing. His DNR/DNI bracelet was identified just as his pulse was lost. I watched the last deep breath go in and out. While the in-house attending arrived at the rapid, it was too late for further intervention. I felt alone. The sting of tears behind my eyes arrived as if on cue, but I had a job. For the fourth time that night, I called the family to notify them of their loved one's death. This moment was heartbreaking. As I finished out the remainder of my shift, I questioned my actions. I struggled with this ending. I am grateful for the chief resident who took the time to process the case with me. Once again, the outcome was likely unavoidable, but I will carry this moment with me.

I remember the moments after good deaths too. What makes a good death? This is the question that I continue to try to answer. Throughout my time as a resident, I have seen peaceful deaths. Those where in the moments after, gratitude is present. Those where families feel at ease knowing that their loved one isn't suffering. Whether it be in the ER, the ICU, on the floor, or in a patient's home, I continue to strive towards meaningful, satisfying ends. If we equate death with failure then we will always fail.

On my days off, I read. I read the novels piled up on every surface of my house. I read medical journals, MKSAP, and patient charts. I soak in the stories. While each story does eventually end, I wait for the moment after. The moment of closure. Yet, my story keeps going. I continue to see patients. I continue on with my day after each patient death. I keep turning the pages to see where my story takes me -- knowing that there will be an end and, eventually, a moment after.

18. Laughing in the Face of Death

Jennifer Woodard, MD

It may be morbid to have a favorite death, but the story of my patient Don has been my favorite to date.

“He wants to hear a song,” Don’s family said when I walked in the room. For a minute, I froze -- surely, they were not expecting me to sing? Fortunately, one of his daughters pulled up YouTube on her phone and “Another One Bites the Dust” began playing. His wife told me that they played the same song at their wedding 40 years ago.

Just yesterday, we had been trying to decide what the next treatment options were for this patient. He needed to get fluid off, but his kidneys were not responding to all of the diuretic medicines we were pushing. We tried dialysis, but his blood pressure dropped too low when they removed fluid with the machine. His heart had converted into a rhythm called atrial fibrillation, which it never had before. It could have been in response to the stress of dialysis or his worsening heart function, but we needed to act to protect him from this abnormal rhythm.

We were on a last-ditch effort to transfer Don to the intensive care unit where he could receive a gentler form of dialysis called CRRT (continuous renal replacement therapy). Before I left, I spoke with him and his family about the unfortunate path we were heading down. He had decided long ago that he did not want CPR, but the discussion around the many invasive medical procedures we offer is still nuanced. The last thing you want to happen overnight is being unable to contact family or speak with the patient about their wishes. At the same time, we still hope that the interventions we offer are enough to help the patient return to health. If we are successful in helping the patient recover, did we put the patient and family through unnecessary emotional distress of discussing all the worst-case-scenario options?

In this particular situation, we spent a longtime discussing intubation if Don’s breathing were to worsen. We had a few steps to go through before we reached that point, but I was worried he could easily head down the road of respiratory distress. They were not sure at that point, but Don had previously said he did not want intubation, and now that it was a potential reality, my patient and his family had changed their minds -- but were still not 100% sure. Over the course of the night, the worst-case scenario I had posited earlier happened -- the dialysis was not working fast enough to make up for how poorly his heart was functioning. The last

possible intervention we had to offer was not enough. His breathing was okay, but the overnight team ended up needing to start medications to help with his heart squeeze (inotropes) and with his blood pressure (vasopressors). His family was able to come to his bedside where I found them the following morning.

Our discussion that morning centered on where we go from here. Don’s heart was so weak that we were doing everything we could to sustain him, though it was only to buy some time. He and his family ultimately decided to change the plan of care to comfort later that morning, and the last few hours of his life he was kept comfortable and surrounded by the people who loved him most. As he so eloquently put it, “What more could I want? Maybe some coffee.”

While I am no stranger to end of life situations, particularly in the hospital, I am always struck by the patients who face death head on. We usually have discussions with family members because the patient cannot speak for themselves, but it is rare to have the patient involved. It is even rarer for the patient to face it with an unrelenting sense of humor.

During our morning discussion, I asked the patient if there was anything else I could do to help make him comfortable. He dryly replied, “Bourbon rocks.” While I could not deliver on the bourbon, I told him I could get him coffee from the nursing station, but I assured him it would not be good coffee. He took me up on my offer and continued to joke throughout the day that I had only half delivered on my promise. I also had the incredible privilege of sharing space with his family as they recalled their favorite moments together over the years and he corrected his wife’s details about where they were and how they met. He told his family that he would be gone by 10am, but he stayed with us well into the afternoon before I was called to pronounce him.

So, why is this my favorite patient death? While we cannot change the body’s ultimate fate, we have the privilege to guide our patients and families through this transition. In medicine, we tend to focus on ideal outcomes -- patients going home with their families and returning to what they love -- but often this is not a realistic expectation. While there is no way to capture the relationships we have built with our patients and their families for billing, I would argue that there is just as much, if not more value in being able to look death in the face and still laugh.

19. Residency in the Time of COVID

Jennifer Woodard, MD

“Do you think something bad is going to happen?”

I didn’t know it at the time, of course, but those would be the last words she would ever say.

“We’re just going to help you breathe for a while on the machine,” was my response - as much reassurance as I could reasonably give. How can you tell patients that the Bad Thing has already happened? They have gotten COVID and in another few short days or weeks, they will die from it.

As a new second year resident, the entirety of my postgraduate medical education has been in the COVID era. In my fourth year of medical school, as I eagerly awaited Match Day, I started signing up for volunteering to help with various projects around the hospital related to the COVID response. At that time, we were all fresh and nervous, but hopeful that we would be able to overcome this new virus that seemed to be sweeping the world. How naive were we to think that there would be enough people willing to listen to the science as it evolved and trust the very people treating this new disease? I was wary of everything I did - my husband and I dutifully wiped down all of our groceries with bleach and wipes, rationing the small stock of cleaning wipes I had. We changed our wedding plans entirely and got married in a small park with only a priest, one of our groomsmen, and his immediate family. Everyone else watched over Zoom. It felt noble, at the time. Everyone was masked, distanced, and outside. I have a Zoom recording of our first wedding, which in its own way was a reflection of the hope we had that we’d be able to celebrate in person soon.



I left Baltimore and moved to Milwaukee to start residency in an era of online meetings and social distancing. Every outing with my co-residents was needed, but even now, I try to balance the guilt of eating at a restaurant and the human need for connection with the risks of contracting COVID or passing something to my patients. I had multiple near-misses with exposures, and I changed plans to see my family numerous times because I was (and still am) terrified of infecting them with this virus that seems ever-present. Even now, I feel so lucky that I was able to be in that first wave of people who got vaccinated. I was hopeful that finally we could move forward, and I wouldn’t be having to tell families over the phone that the loved one they hadn’t seen in weeks would never be coming home.

Over the past few weeks, I have started to lose that hope. We are seeing more people than ever who come in without the vaccine, struggling for breath. They are younger than before, many of them victims of medical misinformation. They are the most vulnerable of our society - the poor, the uneducated, prone to the lies about COVID and vaccination that have spread throughout our country like a more pervasive virus. These are the very people I trained to help, but we are getting to them too late. The science and evidence I love about medicine has been thrown out the window because of memes and misinformation. Still, we push on - still not having good treatments for those who get sick, crossing our fingers that we have done enough of the right thing in time to save them. In medicine, we cannot save everyone; we know that. But the toll is too high right now, and something needs to drastically change if we are to ever move forward.

20. Don't Stop Feeling

James Wu, MD

I was on my first inpatient rotation as an intern. And I cried in the ICU bathroom.

Never having done an ICU rotation in medical school, I was taking of a critically ill patient for the first time. Cardiogenic and septic shock. Four pressors. Broad spectrum antibiotics. Intubation. Coma.

I immersed myself deep into the workup, trying to understand every aspect of the complicated care, trying to make sure that I hadn't missed the smallest detail that could potentially help my patient. I got to know all of the consultants very well, often relaying information among teams. Saying hello to my unconscious patient and saying hello to her husband and children became a part of my daily routine. I tried my best to make sure her family always knew what was going on. Those conversations were always honest but not always easy.

The days passed, interventions were implemented, but not much had improved. I could feel the overwhelming sense that others didn't feel like our patient would make it. Why did it feel like that I alone kept on holding onto hope? Maybe I was too naïve. Maybe I hadn't taken care of enough critically ill patients to recognize the signs that a patient was not going to make it. Or was I being resilient? But what does resiliency in medicine even look like? Maybe telling myself that there was hope was my way of coping and protecting myself in the midst of a pandemic and so much death in the ICU. Regardless of the reason, I held onto hope.

One day, a consult attending said she had been reading my notes and was really impressed with my care for the patient. For whatever reason, this comment, on that particular time and day, broke me. Without any warning, I could feel tears starting to well up in my eyes. I quickly and quietly went to the bathroom at the back

of the ICU. And the floodgates opened. Whatever invisible wall of protection that I had built up to protect me from all of the suffering in the ICU had been momentarily shattered. I just stood there in front of the mirror and sobbed uncontrollably for a couple of minutes. I felt an overwhelming sense of helplessness and sadness. I felt that despite trying so hard and caring so much that I couldn't save my patient. And that feeling sucked. In that moment, crying was therapeutic and cathartic.

I wasn't ashamed of crying. I knew it was a sign that I cared, a sign of empathy and compassion. For patients and families, empathy and compassion really make a difference. But the reality is that working in the ICU is hard, working in oncology is hard, working in a pandemic is hard, dealing with life and death daily is hard. We need healthy ways to process our emotions, to let our walls down, and for some people that takes the form of crying. And that's okay.

Later that year, I was on another inpatient service. One of my co-intern's patients had suddenly died from a massive intracranial hemorrhage. He was heartbroken. Our whole team was right by his side. I shared this story of crying in the ICU bathroom. Other residents shared their own stories of patient loss. We cried together. We healed together. Look out for your team because we are in this together. Don't be afraid of feeling and showing emotion. That's what makes us great physicians and patient advocates. To quote one of my mentors, "don't stop feeling."

Even as I am sitting in front of my computer now writing and thinking back on these memories, I have tears welling up in my eyes. And I think that's beautiful, the human side of medicine.

