



2023

# NARRATIVE MEDICINE BOOKLET



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Wisconsin  
Chapter

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## *Sponsored by the ACP-WI Women's Committee*

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.

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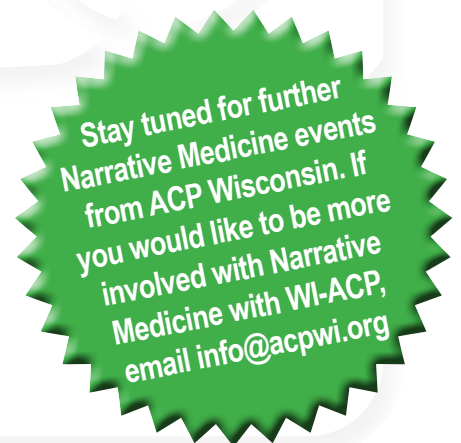
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# ESSAYS



# 1. The Mysterious Promises Doctors Can't Keep and the Unexplainable Moments That Leave Us All Wondering

*Christopher Barusya, MD, FACP*

Picture this: It's the thirteenth of October 2017, a busy day at the hospital. I, your humble Hospitalist, was on an admitting shift from 10:00 a.m. to 10:00 p.m. My mission? To get patients into the hospital so they could recover and return to their everyday lives. Sounds simple. Well, let me entertain you with a tale that perfectly captures our profession's complex and enigmatic nature.

It all started with an 86-year-old lady, not too sick but suffering from a bout of unfortunate diarrhea caused by some less-than-pleasant food. Her electrolyte levels were out of whack: low potassium, low magnesium, and high sodium. I thought she could be observed in the hospital instead of being fully admitted – a nuanced decision doctors sometimes have to make.

As I was speaking to her, trying to gather her medical history at 8:50 p.m., she suddenly passed out right in front of me. Panic ensued! I quickly checked for a pulse, but there was none. It was a Code Blue situation; as luck would have it, I was the first to perform CPR. We discovered she was experiencing ventricular tachycardia, and we shocked her three times to restore her heart rate and bring her back to life. It was a truly remarkable moment.

During a Code Blue, time seems to stand still. The only thing that matters is the patient in front of you, fighting for their life. When I finally looked up, I realized that around 45 minutes had passed. But here's the kicker: I had received four pages on my trusty doctor's pager, though only two people were trying to reach me. Three pages were from the same person, growing increasingly agitated with each message. It was like a trilogy of impatience, escalating from informative to questioning to near panic. My attention was torn between the urgency of the pages and the grateful son of my 86-year-old patient, who needed a moment to express his gratitude.

How could I ignore a man who had just witnessed a routine history-taking turn into a life-or-death situation? I gave him a brief two minutes; my brain half-focused, as I knew another sick patient might be waiting. He expressed his heartfelt thanks, but I promised to return later to update him. However, there it was, that urgent pager message demanding my immediate attention. Duty called.

I rushed down two flights of stairs to attend to a seemingly frail patient, not seriously ill but in need of care. She had been informed in the Emergency Room that she would see a doctor once she reached her room, but she had been waiting for an hour without any luck. Remarkably, she remained polite and understanding, given that her patience was already wearing thin.

Her frustration, however, stemmed from a different source – her diet. She couldn't believe that she couldn't even order a meal. The kitchen had closed at 9 PM, and she was told she could order once she arrived upstairs. She had kept track of the time and knew she had entered her room at 8:26 PM. From 8:30 PM to 10 PM, when I saw her, she had been fruitlessly attempting to order a meal – a meal that required my approval before the kitchen could fulfill her request. She had spent the entire day in the ER without even a sip of water. I sympathized with her situation; she deserved a proper dinner. But alas, time was against us, and I couldn't get it done in time. She would have to wait until the following morning.

At 10 PM, I finally managed to see her, but it was too late for her to enjoy a meal. Oh, and she was not pleased with my bedside manner either. Understandably, she had no idea where I had been or why I was late. All she knew was that I seemed indifferent to her needs, even a seemingly simple task like ordering food. She didn't even care that I was way past my intended work time and that it did not count as extra work hours.

To add insult to injury, she also took issue with her nurse, Molly. To her, Molly had not relayed her message to me with the utmost urgency, exacerbating her frustration. She had a point. When the workload piles up, you inevitably find yourself coming home late. Returning missed phone calls promptly becomes a luxury you can't afford. And let's not forget that it comes at a cost – the cost of patient satisfaction and trust. Sometimes, our patients require more from us than we can humanly give. And often, they're right in their complaints – if only you look at it through their eyes. I should have ordered that darn food!

So let this story from my journal remind us that doctors, despite their best intentions, can't always keep every promise. Sometimes, we find ourselves caught in the whirlwind of life-or-death situations, juggling multiple responsibilities, unable to attend to every detail. It's a delicate dance we perform, trying to balance the needs of each patient with the constraints of time and resources.

But despite the occasional unfulfilled promise, the mysteries left unsolved, and the meals left unordered, doctors remain dedicated to their noble calling. We strive to save lives, bring comfort, and offer solace to those in need. So, the next time you find yourself facing an unexpected twist in your healthcare journey, remember that we're only human, doing our best to navigate the complex and unpredictable nature of medicine.

## 2. Photographs\*

*Michael J. Dolan, MD, FACP*

Our team walked into his room just as we had the previous four days of his hospitalization. We filed in and took our respective places around his bed; attending physician near his head on the left, senior resident to his right, and the medical student stood at the foot of his bed taking it all in. The resident started by asking him how he was doing. Middle-aged and recovering from a moderate bout with diverticulitis, he was making nice progress towards a hopeful discharge in the next day or two. I watched in silence, observing the interaction between the two men, taking mental notes of what was going well and what could be done better.

As the the team started their examination, my eyes scanned his room. It was a cold, blustery winter day, with the gray light of winter streaming into his room. His message board had all of the pertinent information – date, medical team, nurse, times for physical therapy sessions that day, and contact information for his family. On the counter next to the message board were several photographs in frames. Smiling children of various ages looked back at us, and him.

The resident and student finished their exam, discussed the plan, and started their exit towards the door. I stopped and watched as his gaze moved to the pictures on the counter. I stepped closer and asked “who are the cute kids in the pictures?” His eyes shifted to mine and he answered, “those are my grandchildren. The only one not there is my grandson Kevin, who was named after my son that died 10 years ago.” Everything went quiet, as if all of the noise had been sucked out of his room. His last words seemed to reverberate in our heads as we tried to recall his family and social history, not remembering anything about a son that had passed away. I looked at the resident and he too looked puzzled, racking his brain for any piece of information about this man’s son. Nothing.

After what felt like 5 minutes, I was able to ask, “what happened to your son?” Part of me was worried that the resident and student would be irritated by my additional questions, which seemed to

have little to do with his current illness. But they stood motionless in the doorway, listening intently for his response. “He drowned in the river while fishing alone. He didn’t return and they found his boat drifting. Two days later they found his body not far from where his boat was. He had drowned and we never really found out what happened.” The pain in his voice was palpable to all of us. But nothing had prepared us for what he said next. “You know, for the first years after he died, I wasn’t sure if I wanted to live or die. Then my first grandchild was born and I realized that I had a lot to live for. Now I have six grandchildren and they are my world. But, when I wake up each morning, the first thing I think about is my son and that I won’t be able to look at his face because he drowned.” Tears streamed down his face and he turned away towards the grayness outside.

All of us were overcome with a deep ache, sensing the loss he felt in that moment. His pain washed over us and slowly dissipated as we stood in silence. We each offered him our condolences, squeezed his hand or shoulder, and turned towards the door. I stopped, paused and said, “he knows how much you love and miss him and I think he watches over you every day. Hopefully you know that.” He smiled at us and turned back to his photographs.

When we reached the hallway, outside of his room, I looked at the team. Each of them were feeling the impact of what we had just experienced. The resident had just become a father for the first time and could honestly understand the pain of losing a child and the long-lasting impact it could have. “I want you to remember this moment, because today we did more to understand this patient and what really matters to him than we will in any other visit we make today. Human beings are complicated things – filled with hopes and dreams, loss and pain. They have people that they live for, that make them get out of bed each day. Most of the time we go through our days oblivious to the things that matter most to those around us. Only through connection and listening can we truly understand.”

### 3. The Pendulum Swings

**Sharath Kommu**

The field of medicine is a captivating journey of discovery and adaptation, where our understanding of health and disease constantly evolves. Over the past decade, I have witnessed some intriguing pendulum swings in medical practice. These shifts in perspectives and treatment approaches have challenged long-standing beliefs, highlighting the dynamic nature of healthcare. In this reflection, I will delve into some notable examples of these pendulum swings and their impact on patient care, emphasizing the importance of embracing change in pursuing optimal healthcare outcomes.

#### Breakfast, the most important meal of the day?

As a healthcare professional, I recall promoting breakfast as the cornerstone of a healthy lifestyle. However, recent research has shed light on the benefits of intermittent fasting and its impact on weight loss. This revelation has given rise to a new understanding that skipping breakfast can be a viable strategy for achieving weight loss goals. While the previous belief was that breakfast kickstarts metabolism and prevents overeating later in the day, studies now indicate that fasting in the morning can promote fat burning and improve insulin sensitivity. As physicians, we have embraced this shift in perspective and reflect that in the discussions about lifestyle modifications with our patients.

#### The Sugar Saga: Unveiling the Real Culprit

Dietary fat was vilified for decades as the primary culprit behind weight gain and cardiovascular diseases. However, the pendulum swung as evidence began mounting against excessive sugar consumption. Evidence indicates that added sugars, particularly in highly processed foods, contribute significantly to obesity, diabetes, and other metabolic disorders. Consequently, dietary guidelines now emphasize the reduction of sugar intake rather than demonizing all fats. Now armed with the knowledge, the physicians have restructured the guidance they give patients about fatty and sugary foods. Encouraging patients to reduce

sugar intake has become a priority, focusing on promoting whole, unprocessed foods and highlighting the dangers of hidden sugars in their diets.

#### Aspirin: Reevaluating cardioprotection

I vividly recall the days when aspirin was considered a panacea for cardiovascular health, prescribed to most elderly individuals as a preventive measure. However, as research unfolded, it became evident that the risks of aspirin, such as bleeding complications, may outweigh the benefits in those without known cardiovascular disease. This shift in perspective has transformed the approach to prescribing aspirin, ensuring its consideration only for those with established cardiovascular disease or individuals at high risk, fostering a more personalized and evidence-based approach to care.

#### Atrial Fibrillation: The Dance of Rhythm Control

In the realm of managing atrial fibrillation, there was a time when rate control was considered as effective as rhythm control. However, evolving research has demonstrated the superior outcomes associated with rhythm control strategies. With this pendulum swing, rhythm control strategies are now considered a better option to mitigate long-term complications.

The practice of medicine undergoes constant evolution as new evidence and insights emerge. The examples discussed here highlight the phenomenon of pendulum swings in medical practice, where prevailing beliefs and treatment approaches change based on updated scientific knowledge. The shifts in stance in the examples discussed here reflect the importance of evidence-based medicine and the need to evaluate and update ourselves continuously. By embracing these pendulum swings, we as healthcare professionals strive to navigate the dynamic realm of medicine and contribute to the ongoing evolution of healthcare for the betterment of those under our care.



## 4. I Want to Wear a Bikini and Run a 5K\*

**Michael Lenz, MD**

"I walked into the exam room of my last patient of the day. I sat down and greeted "Shelly," a new patient in her early 30s. Before entering, I looked through her chart and noted that she had been to multiple doctors. She was accompanied by her highly exuberant, talkative, and curious preschool daughter, who stood in contrast to her worn-down appearing mother apologizing for her daughter's behavior.

"Why are you here?"

"A coworker friend told me to see you, that you might be able to help me." She shared her struggles with exhausting fatigue and chronic diffuse body pain. She saw several doctors over the last ten years but without significant help. We reviewed the EMR together and confirmed all the tests she had done previously, which all came back normal. They had tried a couple of different SSRIs and even some opioids to help assuage them. Still, they didn't seem to alleviate her elusive and invisible illness.

She looked at me with the expectant eyes of one anticipating a doctor to think, "what do you expect me to do about it?"

I went through the Wide Spread Pain Index and Symptom Severity Score, which showed that not only did she have fibromyalgia with her score in the very severe range. I went through the Revised Fibromyalgia Impact Score with her, which gave her a 92 on a scale of 0-100—one of the worst scores of any of the patients I had ever seen. I realized the amount of effort she needed to get through a day was immense.

I asked her to share her story from childhood until now. "I remember having stomach pain since I was a kid. My stomach always bothered me. I also got a lot of headaches. I did ok in school, getting mostly Cs. I had a more challenging time reading than most kids and got distracted easily. I never liked doing homework. I enjoyed keeping busy and playing some sports. I had a hard time sleeping and had growing pains throughout my childhood. My legs ached at night and were restless. In adolescence, my periods were excruciating, sometimes preventing me from attending school."

"After high school I was in a couple tough relationships, but the one I am in now with my boyfriend is pretty good, he cares about me."

I was getting a better picture of her invisible illness by listening to her story. I sensed she was getting validated by a doctor listening to her narrative and asking questions I knew she had never been asked. I followed up on her story, further asking about restless legs and periodic limb movement symptoms, which she endorsed and confirmed these diagnoses. I then went through

"the Adult ADHD World Health Organization ADHD version 1.1 questionnaire, which also supported the diagnosis of ADHD in addition to her clinical history. I asked about her diet. "I am the only one of my siblings or parents with no history of addiction. Well, except for food." She shared that her diet mostly lacked vegetables, fruits, whole grains, legumes, and whole grains. It was full of processed and ultra-processed carbohydrates and animal proteins.

She met the criteria for functional dyspepsia, irritable bowel syndrome, and migraines.

But still, she had the look of an old neighbor I encountered over Christmas break during college that I have never forgotten. Mrs. C knocked on my door with fear in her eyes. She was worried something was wrong with her furnace and asked if someone could help. I was the oldest at home then, and despite having no knowledge of heating a house, I followed her over. Her behavior is one that I had never encountered before. I didn't know what to think of it until a couple of years later when she was killed by her alcoholic husband, who was supposedly showing her the difference between two different guns when one accidentally went off and killed her. He received a manslaughter conviction.

These same emotions reminded me of Shelly.

"Shelly, many people with severe fibromyalgia have been through 'high stress' experiences. What have you been through?" She shared that she had been raped in high school and sexually abused in her first two relationships in adulthood but has not been with her current boyfriend. "I have never told that to a doctor before." I could see relief in her eyes that there was a doctor who cared and a glimmer of hope. But she now was intrigued. What more could there be to offer her than just compassion?

I discussed fibromyalgia, RLS, ADHD, migraines, IBS, and the complicated multidirectional impact of genetics, stress, sleep, diet, and exercise on these invisible but debilitating illnesses. I encouraged her to read more and listen to my podcast.

She had a glimmer of hope and curiosity. We started with changing her diet to whole foods plant-based and treated her RLS. I saw her in a couple of weeks, and she was sleeping so much better, and the stomach pain plaguing her since she was a child was gone. She also lost a few pounds, and her energy was improving. Her fibromyalgia impact score was cut in half in the first month. We then started treatment for her ADHD, adjusting the dose.

A couple of months after her first visit with me, she felt the best she had ever felt. Her impact score had dropped into the normal range. She also had been tracking her steps with an activity

"monitor, which had also gradually made strides increasing to about 10,000 steps a day on average, a massive increase from before.

Her whole demeanor was changing. The biggest smile replaced her timid, depleted former self. About nine months since I first met her and about 90 lb off her former 280 lb 5ft6 frame, she shared with me a goal she would never have considered previously, nor would I have ever suggested. "Dr. Lenz. I want to wear a bikini and run a 5K."

Patients like her are one of the least favorite patients for most doctors, but when you can help someone who has been struggling since childhood get better is one of the most rewarding."

## 5. A Narration

**Bharat Raman, MBBS, MPH**

“Be descriptive” they told us as we anxiously assembled outside the patients room. We were fourth year medical students beginning our clinical rotations. The previous three years in medical school had mostly been spent in learning the foundations of medical science - Anatomy, physiology, biochemistry, microbiology, pharmacology and forensic medicine. These disciplines teased us with what was to come - seeing real patients.

Use the patients’ own words to describe their symptoms, they said to us novices of clinical medicine. “Narrate” what you see they reiterated, and have your notes on each patient you see reflect the same. “You need to create an image of the patient”.

Sir Arthur Conan Doyle and his protagonist, Sherlock Holmes, were often quoted to reinforce the power of observation and deduction (Despite 40 plus years since independence some things from our colonial past seemed to linger on). At one point The Adventures of Sherlock Holmes seemed like required reading. We wrote detailed notes, describing the patients symptoms and our clinical findings. If a patient with similar clinical findings was admitted, you wrote the entire descriptive note again - there was no copy and paste!

We graduated, entered practice and the years rolled by. The length of the notes we wrote seemed to be inversely related to the years in practice. The practice of medicine was also changing. Independent physician practices became fewer as corporate medicine began to make inroads. Standardization became the new mantra and physicians took up the chant as loyal disciples. Everything seemed to have a template. Check off the appropriate boxes in your notes as RVUs depended on it. Office notes seemed to blend into each other as we adopted this new vision to improve patient care and bought into the utopian dream that

corporate medicine was going to deliver. Occasionally you could identify a patient from the note because someone inadvertently or subversively included a description that left no doubt which Mr. or Mrs. Smith was being referenced. We all know that time does not stand still and neither does health administration. The clamor that physicians were slow to adopt new technologies grew louder. We were the bottleneck, the speed bump that was slowing down the pace of healthcare improvement. Our writing was illegible, notes still varied, there was a lot of information in the SOAP note that was deemed non-essential to delivering care and getting reimbursed. The nudge to digitize became a shove. Physicians adapted to computerized records as they had adapted to changes over the years, complaining in private and to each other under a facade of keeping calm and carrying on. The computer would soon become the focus of the visit. We waited for the promised update of EHR software that would make things easier to deliver care (we’re still waiting!). None of us wanted to go back to the old days as we were aware of the benefits, the silver lining so to speak. So we soldiered on adjusting to each EHR update. Along with checkboxes, pre populated information, copying and pasting with minor variations or sometimes none at all seemed commonplace. Notes carried over from one encounter to the next blurring details. Several birthdays may have passed by but Mr. G remained a 50-year-old presenting for an evaluation of hypertension? We had the cure to stop aging! Stop copying and pasting notes and stop note bloat, and focus only on the assessment and plan was the solution proposed as reimbursement didn’t care much about the rest. No one, it seemed paid attention to the rest of the narrative note anyway. Now here I am, having attended a presentation on narrative medicine and the benefits one can derive from it.

A twist in the tale that even Sherlock may not have anticipated!

## 6. Frayed Bonds: A Journey of Compassion, Conflict and Resiliency\*

*Abhijai Singh, MD, FHM*

In healthcare, we touch the lives of so many patients and their families during their most vulnerable and difficult moments. Unfortunately, the experience of encountering hostility from grieving families is an unhappy reality for healthcare professionals. In this narrative, I recount a challenging encounter with a hostile family following a patient's demise, emphasizing the importance of empathy, compassion, and self-care in navigating such emotionally charged situations.

During a busy day, I received news of a patient's sudden demise. Feeling a pang of sorrow, I prepared myself to deliver the heart-wrenching news to the family gathered in the waiting area. As I approached them, I could sense the overwhelming grief and despair that engulfed the room, magnifying the intensity of the situation. Anna (name changed for the narrative) was a 98-year-old patient who had continued to decline with limited food intake, refusal of medications and midway during her hospital course had expressed intentions of not seeing her family anymore. Our palliative care team had constantly engaged with her and continued to provide emotional support to the patient through her difficult last few days.

I had inherited this patient as a hospitalist towards the tail end of her hospital course and had continued to respect her wishes to limit medical information to the family. She had categorically expressed intentions of letting go and had suggested that her family would have a hard time letting go due to their affection towards her. It was a unique situation since the patient wanted to stay in control of her healthcare decisions but at the same time understood the clouding of her loved ones' judgement due to their affection for her.

With a heavy heart, I broke the news to the family, offering condolences and expressing my deepest sympathies. In this tragic moment, grief enveloped them, and emotions ran high. Within 30 minutes of the news, there were about 13 family members in the hospital waiting room to discuss the care of the patient with the provider in charge. Instead of receiving their grief with acceptance, the family responded with hostility, directing their anger and frustration towards me. They began with blaming of the healthcare system and me in trying to prevent a 98-year-old from saying her last goodbyes. Aware of the pain they were experiencing, I remained calm, understanding that their anger stemmed from their profound loss.

Rather than reacting defensively to the hostility, I chose to respond with empathy and compassion. I acknowledged the family's pain, recognizing the devastating impact of their loved one's passing. Despite the verbal onslaught, I listened attentively to their grievances, letting them express their emotions freely. I understood that their hostility was an outward manifestation of their immense sorrow and sought to provide a safe space for them to process their grief. I could also sense an element of regret in the tone of her daughters for not being there during her demise.

While the family's hostility tested my emotional resilience, I remained focused on maintaining professionalism. I recognized that I was a

representative of the healthcare team, responsible for providing support and guidance during this challenging time. I refrained from taking their anger personally and instead concentrated on finding constructive ways to address their concerns while ensuring that their loved one's memory was honored.

To defuse the hostility and bridge the gap between the family's expectations and the reality of the situation, I offered to walk them through patient care day by day. Together, we reviewed the patient's medical records, treatment plans, and the events leading up to the demise. Armed with this information, I approached the family again, providing a detailed explanation of the medical circumstances surrounding their loved one's passing. I took this opportunity to remind them that our staff provided closely monitored care, along with a visit by the hospital pastor and arranging a hospital "pet visit" during her last few hours when she was unresponsive. I answered their questions honestly, addressing any misconceptions and offering clarity to the best of my ability. Finally, we all acknowledged that she loved them all and her isolationism was likely a defense mechanism to protect her loved ones from the angst of her suffering. Through the family's emotions I also had the opportunity to learn about Anna as a person, a strong-willed woman who would always want to be in control. I was able to remind the family that our way of respecting her memory should be aligned with her ability to make her decisions on her own terms and retain her choice until the end.

In the face of hostility, it was crucial to acknowledge and validate the family's emotions. I made sure to convey that their anger and frustration were valid responses to their profound loss. I reassured them that their feelings were heard and understood, emphasizing that our team was there to support them in their grieving process. By creating a safe space for emotional expression, we gradually paved the way for healing and acceptance.

Encountering a hostile family after a patient's demise was emotionally draining. In the aftermath of the encounter, I prioritized self-care and reflection. I sought solace in debriefing sessions with colleagues, sharing the challenges and emotions that emerged from the experience. Additionally, I engaged in activities that nurtured my well-being, such as meditation, and spending time with loved ones. Finally, a brief call to my own mom expressing my love to her provided me much needed comfort, a sense of belonging and unconditional support and love.

Navigating a hostile family following a patient's demise is an emotionally taxing experience. By responding with empathy, professionalism, and understanding, healthcare professionals can create a supportive environment where grieving families feel heard and validated. While challenging, these encounters serve as reminders of the importance of self-care and reflection, allowing us to grow and develop the emotional resilience necessary to navigate future encounters with grace and compassion.

## 7. Oli Otya

### Evanka Annyapu, BS

The words I learned to say after a week in Uganda. A greeting used in Luganda to wish someone hello. There hadn't been any other way I would've wanted to learn my first phrase in Luganda than a three-hour boat ride on the Nile River.

The Nile-freaking-River.

My first step to connecting with this country was learning how to say *hello* or *how are you* in Luganda amongst the hippos, crocodiles, and a magnificent view of the Murchison Falls. A local from the cruise had filled two hours of my time on the boat with conversations that delved into their perceptions of who we were as Americans on the trip. What began with inquiries of what our business was in Uganda as Kohler Fellows doing research at a small suburban clinic turned into conversations about my interest in religion, science, and politics.

*Oli otya* became a phrase that welcomed me, my passions, and experiences into various spaces, including the homes of animals we encountered on a safari. We plowed through knee-high grass to spot a lion, his girl, and five cubs when all I could hold were the words *oli otya* (o-o) and my phone steady. The beady white eyes of the lion were a resounding o-o, as if I've been 'most-welcomed' into their home and to stand with them, only meters away.

Through my binoculars, distance hadn't discounted my greeting to the elephants. The o-o was there as its ears flapped back, while it munched on its bushes. My eyes had been the closest thing to being present with the elephants, which had been a welcome that I didn't need to even whisper.

*Oli Otya* has given me the eyes to see things in Uganda, beyond the tourist. The phrase became a lens for me to catch the story of what I wanted to see and who I wanted to talk to. It was one step closer to learning what I came to learn—more about what I'm capable of. O-O teaches you how to be stripped of your necessities to restrengthen and rebuild your own capacity. Your greeting to the locals, animals and humans, welcomes you to recognize all the ways that you are more than what you think you are.



The shower is a camping cabin pitter-patter, the internet lags five hours from space and back, and crossing the street is a game of hop-scotch, yet you come back to what you've always known which is that you are so much more capable with even the least of resources. Even without all the things I've most relied on, I still find myself adjusting, navigating, and giving myself grace when I need to.

As soon as I landed in Entebbe en route to Kampala, I was eager to talk to anyone local or familiar with Uganda; I wanted to immerse myself in the local foods, music, and arts. My core memory with the city will stay with the song *Dior* by Ruger as my window was a crack open (not fully open to avoid anything being snatched right out of my lap) and the scenes of the city, suburban, and rural areas clipped by. This urgency to connect with the city had been a stark contrast to the pace that our clinic operates.

The Child and Family Foundation Clinic of Uganda in Kawempe, Kampala holds a special space in my heart and mind. Every morning, I'm greeted with a cheery, "You're most welcome." Something unique about this phrase is that it isn't a response to 'thank you,' rather it means an invitation to be welcomed. Lunch breaks were two hours, meetings started later than they were scheduled, and most of the time, our data collection days started after a couple hours than we intended. I warmed up quickly to the staff that taught me to be appreciative of their clinic spaces, tents we use for data collection, and the staff members we lean into for study participant mobilization days.

The more I came to learn the ways of our clinic staff, the more I realized the privileges I came with from living in America. The moments I needed to wait for our lights to flicker on in the office, or the toilet to refill before the next person used it, showed me the ways that I needed to be more mindful and patient with myself. While the eagerness fed an insane amount of curiosity, I quickly found myself frustrated when my encounters didn't fit the ordinary. Or at least what I had considered the ordinary before my time in Uganda.

I was at this clinic to collect data for my project on vaccine trends and parental behaviors for childhood routine and COVID-19 immunizations in Kawempe, Uganda. The project drew in at least 200 mothers with young children for our study, from 8am to 5pm for three days a week. Initially, these questions I was asking about vaccinations seemed like a given. You would have expected the government to send out vans to their villages to vaccinate the children for free. You would have imagined the mothers mostly being over the age of 30. You would have thought that the mothers would trust the COVID-19 vaccine as much as they trust the routine vaccines their children receive. I held back moments of awe when single mothers that were only 22 years old came in with three children or when mothers that exclaimed COVID-19 was created and spread by the government to develop vaccines.

I now say *Oli Otya* to the side of medicine I've been waiting to see. This was the side that embraced the human for beyond their few minutes in the clinic- it captured their villages, the network of individuals they knew, and how all these connections influenced their perceptions of the government and healthcare.

The words *Oli Otya* have welcomed me into a home larger than my own and more than my mind can even encapsulate. The sun's morning kisses to the windy breezes I've learned to swallow in our high-speed drives, I feel incredibly blessed by the homes I have entered.

## 8. In Moments of Vulnerability, We Respond\* *Amber Bo*



**JUDGED  
WINNER**

**ACP** Wisconsin  
American College of Physicians  
Leading Internal Medicine, Improving Lives  
Chapter  
**ESSAY: MEDICAL STUDENT**

It was my second week of internal medicine rotation, and my confidence was greatly bolstered by that elusive feeling of finally being useful that third-year medical students crave. All my patients the first week had smiled and called me by name when I pre-rounded on them at 7AM. I was quite cheery when I bounded into the Emergency Department to meet a new patient.

Mr. C felt like an elephant was sitting on his chest and it was hard to breathe. It seemed like he was in heart failure exacerbation, possibly with a component of his unresolved COPD exacerbation from a few days ago. We got off...on a rocky foot. Within minutes of explaining that we were giving him diuretics to remove excess water from his lungs, he accused me of using him like a guinea pig. Flabbergasted, I repeated that the diuretics would not only make his breathing better, but that if he improved because of them, then it would be further evidence that he had a heart-failure exacerbation—

“Just listen to yourself.” He cut me off. “You just said you don’t know what’s wrong with me. You’re just giving medicine and using me as a guinea pig. All you guys do is draw labs all the time without giving me any answers.”

I was rendered speechless; I couldn’t understand how he came to that conclusion. I fell quiet. Listening had always been my strong suit after all. Mr. C didn’t need much prompting—he was a natural storyteller and immediately filled the empty air with his thoughts. He was very blunt about his distrust in doctors and hospitals, going into detail about his broken pain management contract, loss of the only doctor he trusted and his terrible experience with chemotherapy a decade ago.

He abruptly stopped talking and pinned me with a piercing gaze. Unsure of what he wanted; I blurted out the only thought in my mind. “What is the best thing we can do to help you?” It was a knee-jerk reaction, a reflection of my natural curiosity, but to my surprise, he didn’t miss a beat.

“Ha! A good physical to find out what’s wrong with me. No one’s given me a proper physical in years.”

Like a cartoon, my eyes widened in shock. A physical wouldn’t tell him why he couldn’t breathe or why he had such bad pain—but the gears in my head clicked at his surefire response. None of our advanced tests would reassure him about his health if he didn’t understand them or trust us, his medical team.

The air in the room shifted after I asked. He became a little softer, his speech a little slower. Feeling more like we were having a conversation again, I asked him a few more questions and he brought up how no one had checked his PSA, a marker for prostate cancer “in years” and that prostate cancer is more common in black men, and no one was going to find it until it’s too late. Well—that was an easy enough fix! I hopped on to the computer in the corner and swung it towards him so we could both see. “See? It was checked 2 years ago and was stone cold normal, so you do not have prostate cancer.”

And that, looking up a PSA on Epic, is how I won him over.

Turns out, Mr. C had a beautiful smile. He thanked me for explaining something that no one else had, and I finally started to relax—the guard he had thrown up the moment I entered the room was crumbling. “You’ll be on my side, right?” He insisted. “You’ll be on my side here at this hospital and tell me what’s going on.” My heart swelled. His bluntness was endearing. I reassured him that I would explain the reasoning behind all his lab draws if he wanted it. He explained why he was touchier these days. He’d recently suffered the death of his mom and son; two funerals, nearly back-to-back. Tears gathered in his eyes as he spoke. The transporter interrupted us to take him to his hospital room. Now alone in the ED, I felt a little stunned from all the emotions we’d gone through together.

Unfortunately, Mr. C’s clinical course grew complicated. After a few days, he was transferred to the inpatient cardiology service after a rapid response.

It was hard to characterize my interactions with Mr. C. He was unlike my previous patients who had actively liked me and whom I felt like my words made a difference to. But I think two things are absolute truths. You grow fond of those you take care of and seeing another’s vulnerability can override any preconceived opinions of them.

I don’t know my impact on him but through him I had a lot of my firsts. My first time being at my patient’s rapid response. My first time feeling confident enough to consult the inpatient cardiology service, giving report to the residents, fellows and attendings despite feeling like “I’m just a medical student.” Feeling what it feels like to have ownership of my patient and know their story because I’d taken care of them for days.

It was time to say our goodbyes. I held his hand. For the first time since the beginning of the rapid response, he smiled. “Mr. C. Take care of yourself. It was a pleasure to take care of you.” He continued to smile, but I could not understand his mumbles. Still, his feelings were transmitted wordlessly. I remembered he was a religious man. “God bless you.”

In a patient’s moment of vulnerability, we respond. It was reassuring to see that not only from myself, but also from my attending who squeezed his hand with comforting words, and the rapid response nurse who wiped away a cold tear trickling down his face. I was a little teary-eyed as I left the hospital. It was rather anticlimax, the moment he left our service. That was it, I thought.

The next day, when I was studying at a coffee shop, I got a page at 3:40pm. My 2nd page ever. I was shocked – I hadn’t called any consults for my patients that morning and wouldn’t my attending be the one paged instead of me?

The page read: “Just FYI, your patient Mr. C that transferred to cardiology looks amazing today! He’s doing great. Thought you’d want to know :) ~cardiology residents”

## 9. The Simple Things

### *Brennen Cooper*

It is astonishing to be quickly approaching the start of my fourth year of medical school. The whirlwind of the notorious third year came and went in incredible fashion. Before each rotation, I remember overwhelming feelings of equal parts excitement and trepidation. I would spend the weekend before the start of each rotation cramming educational content and then proceed to sprint through a two-month marathon. After finishing each shelf exam, I would collapse on my bed, take a breath, and pray that the last two months of work would earn me the most coveted letter in the alphabet. Additionally, I would cross my fingers that my summative evaluation would read something slightly more detailed than “student was professional.”

While this summary of how my year went may seem negative and pessimistic, please don't be concerned. Those who know me personally are well aware of the extreme drought of my sense of humor, and I truly enjoyed my clinical experiences. One observation that I found to be rather humorous over my third year was the significant difference between the evaluations I hoped to receive and the defining characteristics I would leave for the outstanding residents and faculty I worked with. While facetiously daydreaming about what my dean's letter might look like, I imagined powerful themes including “student was within the top 0.0001% of students I have worked with” or “student operated at the level of a senior fellow on the first day of the rotation.” However, my opinion of the most outstanding characteristics exemplified by my residents and faculty is exceedingly simple. “Resident included students in conversations and asked them

personal questions” and “Faculty introduced themselves to students” became my shining examples of what phenomenal teams were like.

I admit that on paper these statements seem rather banal, but they are extremely significant when put into practice. Both examples of taking interest in the students and actively introducing themselves instantly establish an inviting environment where medical students can truly thrive. From the student perspective, it didn't matter if their attendings could diagnose zebras from physical exam alone, perform zero-handed ties, or complete external cephalic versions using words of affirmation. What truly mattered was whether the teams treated the medical students like human beings. “Did they do the simple things?” is what I would ask myself before filling out my evaluations.

Now that I am in the highly prestigious role of fourth year medical student, many of my new third year mentees have been asking me about the keys to success during clerkships. They worry about finding the balance between appearing too eager and being easily forgotten. They fret about whether their question of “is there is anything else I can help with?” will make them look like all they want is to escape the workroom. My advice to all new third year medical students is to try your best to not overthink the social situations of clerkships. Avoid playing the game of medical school, be yourself, and never forget that you are there to learn how to take the best care of your patients. My one request to all students, residents, and faculty: don't forget the simple things.



## 10. From Aching Knees to Empowered Care: A Journey of Trust and Representation in Orthopedics

**Mark Ehioghae**

Every conversation with my mother over the past decade seemed to revolve around her aching knee, a constant source of distress after her long, exhausting workdays. The incapacitating pain severely limited her mobility, leaving her uncertain about finding lasting relief. Our go-to remedy involved applying hot water with a cloth, providing temporary respite. However, we were both cognizant of the fact that this was merely a band-aid solution, unable to address the underlying issue.

My journey in Kinesiology during my undergraduate degree opened my eyes to a new understanding of my mother's condition. I recognized that her knee problem couldn't be resolved through the simplistic application of heat. Though it offered temporary relief, the underlying problem persisted. Immersed in my studies, I delved into the realm of musculoskeletal diseases and rehabilitation techniques, gaining knowledge of aiding patients' in their healing processes. Armed with this newfound expertise, I eagerly returned home each day to guide my mother through targeted knee exercises and stretches, aiming to strengthen her surrounding muscles and improving her mobility. Grateful for my efforts, she often said, "Thank you, my son, I feel better." Yet, despite our daily dedication, her pain continued to fluctuate, indicating that we needed a deeper understanding and additional assistance. As a first-generation immigrant, I felt lost, uncertain about where to seek further guidance.

It was during medical school that I encountered the field of orthopedics, offering an opportunity to expand my knowledge and better support my family. In the summer following first year, I was privileged to work alongside two orthopedic surgeons who served a diverse patient population. This experience not only allowed me to serve my community but also enlightened me about the diverse barriers that hinder access to care. Witnessing the interactions between black surgeons and their patients, I realized the profound impact of seeing healthcare professionals who resembled their patients, fostering trust and establishing a sense of understanding.

However, unbeknownst to me, my mother had taken matters into her own hands and had already been seeking help from an orthopedic surgeon in our hometown. Her knee had deteriorated to the point where even basic tasks like walking and working had become impossible. The surgeon, recognizing the severity of her condition, recommended a total knee replacement as the most effective solution. However, my mother hesitated, harboring doubts about the procedure's efficacy and hoping for a better alternative. Her concerns echoed those of many black patients seeking orthopedic care, who, despite the proven safety and effectiveness of surgical interventions like knee replacements, undergo them far less frequently than their non-black counterparts.

This disparity could be attributed to various factors, including a deep-rooted mistrust in the medical system, a lack of cultural competency among healthcare providers, or simply skepticism about the procedure itself. I must admit that my mother's skepticism would have influenced my own perspective if it weren't for the eye-opening summer experience that deepened my understanding of orthopedic surgery. Armed with the limited knowledge I had acquired, I presented my mother with crucial data and information, directly addressing her concerns and instilling confidence in the potential benefits of the surgery. It became increasingly clear that what she needed was a healthcare professional she could wholeheartedly trust—a person within the system who comprehended her experiences and could guide her towards safe and effective care.

Examining the current state of orthopedic education, particularly in Wisconsin, reveals the glaring underrepresentation of black residents at institutions like the University of Wisconsin Madison and the Medical College of Wisconsin. Regrettably, this underrepresentation extends to the faculty level as well. Despite efforts to enhance equitable access for individuals from all backgrounds, it is crucial not to overlook the essential human element. The presence of diversity within the healthcare system can profoundly impact patients' utilization and trust in the available resources.

## 11. Scrubs Too Large\*

**Max Goodman**

The hospital room hummed with the steady rhythm of machines, filling the air with a sense of urgency and grim prescience. Amidst the beeping monitors and bustling medical professionals, I observed my patient, who I will call Carol, her face marked by fatigue and worry. Carol had the same cardiac condition as my grandfather, who unfortunately passed far away around my hometown during my clerkships here in Wisconsin. For the past couple of days being a member of her medical team as a medical student with scrubs too large and a notebook too worn, I took careful consideration and attention to her because of this tie, unbeknownst to her. However, little did I know that this encounter would soon plunge me into a heart-wrenching struggle between life and death, where the echoes of personal loss would intertwine with the fierce determination to save a life.

As she sat herself in a chair, Carol's vital signs suddenly plummeted. She became unresponsive, and upon her nurse checking her pulse and feeling nothing, panic rippled through the room as myself and others sprang into action. For me, time felt like it stopped, yet I was still moving. With adrenaline coursing through my veins, I found myself at the forefront of the resuscitation efforts, compressing Carol's chest with all the strength and fervor I could muster. I could not pause as much as my thoughts screamed that I was an imposter, a charlatan, a fake. The weight of the moment settled on my shaking shoulders, knowing that each compression held the power to sustain life.

In those frantic moments, my mind traveled back to the heartbreaking days calling my beloved grandfather as he waxed and waned on a hospital bed a thousand miles away from me. The sound of his voice, weakened by illness, haunted my thoughts. The regret of not being by his side in his final moments gnawed at my soul. It was as if fate had conspired to test the depth of my compassion, thrusting me into a race against time and all of medicine itself to rescue Carol, a patient who, like my grandfather, faced the perilous grip of death.

The concepts of death and medicine, explored by medical ethicists for thousands of years, offered me solace and guidance in this tumultuous moment. Elisabeth Kübler-Ross's words pounded in my mind, urging me to confront my own fears and embrace the vulnerability of those in my care. I understood that

my patient was not just a medical case but a person whose life was entwined with the lives of others—a family member, a friend, a loved one. The room seemed to fade away, leaving only the rate and rhythm of my actions with the sinus beeping of monitors. As I persisted with chest compressions, exhaustion threatened to arrest me. I was now fighting against myself but I refused to stop; I swore a moral responsibility to uphold the dignity and sanctity of life. My patient's life hung in the balance, and I could not falter. Sweat dripped from my brow, merging with the tears that welled in my eyes. The reverberations of my grandfather's parting became intertwined with Carol's struggle. I saw not just a patient lying before me, but the embodiment of every family member who had been separated from their loved ones during their final moments. With every compression, I poured my grief and determination into preserving a life. Eventually, someone else took my turn, and I was left to staggeringly watch together with everyone yet alone in my thoughts. Ultimately, despite our relentless efforts, Carol slipped away from our grasp, leaving a palpable sense of loss in the room. That loss still fills my heart today.

It took days to find solace in the realization that we had fought for her with every fiber of our being. I had honored the connection between life and death, bridging the gap that had haunted me since my grandfather's passing. In that sacred space, I have come to understand that my role as a medical student and future physician transcends the boundaries of medical degrees and titles. Medicine is a calling to embody compassion, whether from personal loss or the loss of all the patients before us, and to be a source of inspiration amidst the eventual cessation of living. As I reflect on the harrowing experience of losing my grandfather and the desperate attempt to save Carol, I am reminded of the timeless words of philosopher Albert Schweitzer: "The purpose of human life is to serve, and to show compassion and the will to help others." It is through this lens that I navigate the intricate web of medicine, intertwining the threads of knowledge, empathy, and unwavering dedication to each patient's well-being. For as long as I walk this path, I will carry with me the understanding that my patients are not merely strangers, but cherished members of an extended family, deserving of the deepest care and compassion until the last beat of their hearts. I honor Carol, my grandfather, and all my patients this way as medicine has done and will do forever.



## 12. The Antithesis of a Surgeon's Scalpel

*Hamsitha Karra*

A bullet is the antithesis to a surgeon's scalpel. It tears through skin and pulverizes bone and organ alike to cause as much harm as possible. A scalpel, on the other hand, uncovers the injury. It creates space to stop the bleeding and to allow the body to heal. The idea of these two seemingly random objects facing off against each other as if warriors in battle is precisely the image that came to my mind as I reflected on my experience surveying patients that had survived gun violence. The aim of our research was to better understand how to support these individuals upon discharge from the hospital. The survey was, of course, optional, so it surprised me every time when a patient agreed to participate. I could not say with certainty that I would have the grace and patience to do the same after my body battled a bullet.

The first question I asked was aimed at gauging their understanding of their injuries. I listened as they listed them off like one might read out a grocery list, detached and impersonal; 2 gunshot wounds, 4 fractured bones, 1 broken rib, etc. I never asked them about the circumstances surrounding how they were injured, but more often than not, they told me anyway. So, I sat in silence, unable to offer much comfort, as they described how they had been shot while on their way to a job interview or while sitting in their car stopped at a traffic light or while tailgating at a Bucks game. One elderly gentleman described the moment that he looked over to see that his wife of 55 years had died as he lay bleeding after being shot in his own home. My next questions were focused on understanding how much financial, emotional, and mental support these patients had during their recovery. The questions often brought forth a myriad of answers filled with worries and challenges. One patient expressed his fear of losing custody of his kids and being able to afford his weekly groceries because he would be fired from his job for missing so many days of work while hospitalized. Many expressed uncertainties about where they would go once they were discharged from the hospital. Some could no longer climb the stairs to their second or third floor apartments because of their injuries. Others described being unable to return to their home because that was the location of their shooting. Thankfully, there were also many others who had extensive support, both from their biological and chosen families. They had a place to call home, even if temporarily, and loved ones to care for them. Yet, many still worried about moving forward with their lives because despite the immense support they received from family and friends, they still had to navigate a system and society that treated them unjustly because they were poor or Black or one of the many other marginalized identities in the United States. At a time in their lives when they were most vulnerable, both physically and emotionally, they found a world that punished them for needing the time to recover from their injuries rather than one that allowed them the space to heal.

Listening to the stories of these survivors prompted me to reconsider the type of physician I wanted to be. You see, I have spent my entire adult life in pursuit of gaining the skills to help people lead happier, healthier lives. But in my very first interactions with patients as a medical student, I had to come to terms with the fact that regardless of the quality of care I provide, my patients can be harmed by their environment in a multitude of ways, including the constant threat of gun violence. And I could not help but feel powerless in the face of that reality. Because what logic or science or sense exists in the world to explain the epidemic of gun violence that runs rampant in our country? There is none. But letting that feeling of powerlessness paralyze me felt like a betrayal of the patients who so vulnerably shared the stories of their lives with me. It felt to me that by saying there was nothing I could do to help them beyond providing medical care, I was trying to absolve myself of the pain and anger that I felt seeing someone's life impacted in such an unjust manner. I think that sense of dissociating from the experiences of those we care for is not only a disservice to our patients but also to our profession and the tenets we took an oath to uphold. Rather, I hope to be the kind of physician that I believe every person deserves, and that often means being my patients' advocate in all the realms that impact their health and well-being, including politics. It means not considering my work to be done once my patients are discharged but rather when they believe they have the opportunity, a fighting chance, to heal from their injuries and pursue a healthy life. That means utilizing my role as a respected member of society to not only advocate against gun violence but for the policies and resources directed towards supporting gunshot wound survivors during their recovery. I recognize that this work is not easy, for carrying the stories and experiences of gun violence survivors is a heavy burden. As healthcare professionals, we are constantly forced to reckon with the unfairness of the system that we must navigate and work within as we advocate for our patients. But with tenacity tempered by humility and grace for ourselves, I believe that we can all strive to be the kind of physician that the health of our society requires. While tenacity is necessary considering the difficulty of this work, humility and grace for oneself are equally important so that we do not sacrifice our own well-being and experience burnout. Humility will help us understand that we, as physicians, cannot care for our whole patients on our own. We cannot be social workers, lawyers, and politicians all at the same time, so we must lean on, support, and work with our professional allies to do so. Grace for ourselves will allow us to live with the fact that while we cannot help every single patient in the way they deserve, we did all that we could within the realm of possibility. So, I implore every future physician, and current one for that matter, to join me as I strive to care for my patients with the same tenacity, strength, and grace that I witnessed in the survivors that I had the privilege of getting to know.

## 13. More Than “Just” a Medical Student

*Sophia Ly*

“You hide your stress so well,” she said. Just two days before this, I had broken down like a machine that had been running too fast for too long. Tears ran down my face like oil through the cracks of a machine fighting to finish its last job. I am only ten months into my medical education and one month into what everyone is calling, “the last free summer of my life.” I’ve been counting. My pre-med years were filled with advisors and medical school panelists sharing that when you are in medical school, your job is to just be a medical student. Sounds simple enough, right? What they did not share is that “just a medical student” includes being involved in multiple student organizations and hopefully earning leadership positions, volunteering, advocacy, and working if your financial aid cannot cover the costs of living. And “the last free summer of my life,” is doing research at what comes out to about a \$7.50 hourly wage, maintaining your student organization services, and increasing work hours since financial aid does not pertain to the summer months. They do not tell you this before you commit to the decade of training, so you hold your breath and your tongue to avoid being deemed ungrateful or incompetent.

I am not going to lie; this past school year has been one of the best and worst years of my life. Medical school has always been the goal and I achieved it – finally. This very fact alone justifies why my M1 year has proved to be one of the best years of my entire life. I want to justify the things that made this year one of the worst years as well, because if there is anything that I have learned in 26 years of life, it is that you can be and feel more than one thing at once. When I arrived in Milwaukee, I was ecstatic to start a new chapter but there was a sadness that moved here with me. Those blue feelings stemmed from leaving a city on the East coast that I had grown to love, that was mine alone from my family and friends that I had left behind in the Midwest. It was like I had been able to come out of this box labeled with expectations and achievements that I needed to match or live up to and returning to Wisconsin was going back into that very same box except it was the same size that I had left it, and I had grown during my one year away. I was also sad about leaving friends that genuinely loved me, and despite knowing that they were going to remain in my corner, despite their incredible support for this new chapter of my life, my feelings still persisted knowing they would not be just one short train ride away. I could no longer just call them after a long day to meet and commiserate about our lives over a few glasses of wine. Overall, there were a lot of “moving pains” from complicated emotions to issues with my half country move, such as living out of a hotel for the first week of school because my apartment had not yet been approved by the city inspector as habitable.

I soon discovered that I was the only Hmong student in my class at my campus and imposter syndrome set in. It has never gone away, and I have learned over the years that it never will. This time was different though. It seemed to perforate deeper into

my sense of self and confidence than ever before. Suddenly, on top of already thinking that I had something to prove just in case my medical school acceptance was a mistake, my mind began to accept the idea that I would need to work harder, do more, and achieve more in my four years compared to my white counterparts. However, it is not just an idea but reality. This is not to diminish the passion and hard work that my classmates have and do put into school and their futures as physicians. Since that moment of realization, I made a plan. I knew that I, of course, had to pass my classes, eventually conduct research, obtain multiple leadership roles, and engage in community service. My one caveat was that whatever I participated in had to align with my passions and values. Everything went according to plan. What I did not anticipate was how much I would have to work to make my plan worth it – the plan is useless if I could not financially afford to stay enrolled in school and to live in general. Contrary to what the government wants to believe, coming from a family with immigrant parents and six kids, the actual household contribution to my education is zero. I ran my life like a well-oiled machine. Everything was always full speed ahead with persistent and repetitive reminders that “this is all going to be worth it,” justified by, yes, the simple fact that I made it here at all – medical school.

While gaining acceptance and now completing my first year of medical school are tremendous achievements to celebrate – literal dreams come true. This sentiment was shaken as I sat on Zoom crying from the exhaustion, stress, anxiety, and depression had ebbed and flowed throughout my entire being for the past year. I recognized that it was and is time to challenge the notion that being in medical school justifies the pain and hurt that students sometimes experience, often in silence. We would not be here if we really did not want to be – we delayed other life experiences, took on thousands of dollars’ worth of financial responsibilities, and some have even left their families and homes. As medical students, we should be able to complain or be overwhelmed without being labeled ungrateful or incompetent. We should be able to feel, to be human, before being medical students. Too often we see stories of medical students and even residents on the news and Twitter who have left us too soon. All of the stories share common themes of how great of a student or physician the person was, how much they cared for others, and the plethora of extracurricular and community engagement activities they poured themselves into. But they were all more than that. They probably felt more than what anyone could see and needed to be more than their professional identities – more than just a medical student or a resident. We are all more than just one thing at any moment, and it is time we start acknowledging that and letting go of the need to hide our stresses well. We need to take care of both us and those around us as the whole humans that we really are, whether you are in the middle of one of the best or worst years of your life...or both.

## 14. The Dream Killer

*Meghan Schilthuis*



**JUDGED  
WINNER**

It's my first day in clinic as a third-year medical student on the surgical oncology service. After making multiple laps around the Froedtert Clinical Cancer Center through a maze of clinics with names like "Grace" and "Hope" trying to guess which one might be home to surgical oncology, I finally arrive at the correct work room and meet up with my attending. There are about ten patients to see this morning, most of whom carry a diagnosis of gastric or appendiceal cancer. Appendiceal cancer – who knew that the little worm at the end of the cecum once considered to be a vestigial organ could cause such havoc in people's lives?

Our first couple of appointments go rather smoothly. The relief in the room is palpable when my attending reports clear follow-up scans. Plans are made for continued surveillance, and patients and their loved ones are sent off with well wishes. On our way back to the work room my attending announces, "We have to go make a hard phone call to a patient I operated on yesterday." She tells me about a diagnostic laparoscopy she performed on a middle-aged woman with a gastric mass. When they entered the abdomen, they saw evidence of extensive disease and had sent peritoneal tissue biopsies and fluid for analysis. She had explained these worrisome findings to the patient after the procedure but had been met with exceptional optimism. The patient had been more concerned with returning home quickly to care for her young children.

Today the pathology results are back. My attending sinks into her chair and dials her desk phone with heavy fingers. The woman answers with a cheerful greeting. She is happy that she did not have to stay in the hospital overnight and says she is recovering well. My attending probes for her understanding of their discussion following the procedure. The patient acknowledges that things had not looked good, but she is hopeful that the pathology will reveal otherwise. "I'm sorry but I have some more bad news," my attending warns, "the pathology report confirms progressive cancer in your abdomen."

I brace myself for the blow, expecting a wail of sadness or silent dejection. Instead, the patient is unflinching and presses on without missing a beat. "Okay great, now that we know what it is we can make a plan to beat this. I might need some help taking care of my parents and my kids but I'm ready to do what it takes."

My attending is gentle but serious as she tries to convey the gravity of the situation. She acknowledges that the patient is an important caregiver for her family members but encourages her to prioritize her own needs. She recommends that the patient meet with the clinic's psychologist, the patient is unsure but eventually agrees. They set up a time for their next appointment and say their goodbyes.

My attending sighs as she sets the phone down. She wipes the tears from the corners of her eyes and looks at me. "You know, I thought I went through all these years of training to save lives, but sometimes I feel more like a dream killer. If I'm being honest, I think she has at most a year to live."

I absorb the conversation that has just taken place and wonder if I am capable of a job like hers one day. I consider my goals as a future physician: to heal, to alleviate, to comfort. To kill dreams?

I don't have much time to muse as we jump up to meet our next patient, a middle-aged man who is an immigrant from Eastern Europe. He too has a gastric mass concerning for malignancy and is scheduled for an upcoming gastrectomy. He asks blunt questions about the procedure and the recovery process and my attending paints a hopeful but honest picture. In his thickly-accented voice he tells her, "You are so strong – to look a man like me in the eyes and tell them the harsh truth." "Thank you, that means more than you know," my attending replies as she blinks quickly so as not to tear up.

The rest of the clinic is relatively uneventful. My attending and I go our separate ways for the afternoon: me to our service's inpatient floor, her to a meeting she is already late for. On my way I think about the words the man shared and the value of honest communication with patients. I also admire the emotional investment my attending demonstrated for her patients and resolve that I would like to be like her someday. I can't say that I aspire to kill dreams, but I do aspire to have the strength to deliver bad news honestly and compassionately and am grateful for the attendings who model this for me.

## 15. Tidal Desperation: Navigating the Waves of Our Healthcare System

**Mukul Sharda**

The sun was beginning to set over the picturesque coastline of the northern town of Arecibo, Puerto Rico, casting a warm golden hue upon the glistening waves. It was meant to be a serene evening, a chance to reconnect with nature's beauty. Unbeknownst to me, destiny had a different plan in store. As the gentle breeze caressed my face, I stood at the edge of the Atlantic Ocean, lost in the rhythm of the crashing waves. Without warning, a colossal wave emerged from the depths, propelled by the ocean's fury, engulfing me in a torrent of water and dragging me with an unyielding force. Panic enveloped my senses as I fought for survival, desperately seeking the surface. I could feel my head bumping against and my body being scraped by sharp edges of rocks. After what felt like an eternity, the relentless grip of the wave subsided, and I emerged, battered but alive trying to make sense of what had just happened. I could see blood dripping from my face like sweat and could taste it in the back of my mouth.

I was transported to a nearby hospital. As the adrenaline waned, however, a different kind of worry took hold—a fear of the looming medical expenses and the uncertainty of insurance coverage. After talking to the front desk, I found that my visit will not be covered by my US mainland insurance policy. With a heavy heart and a mind burdened by financial concerns, I contemplated the daunting decision ahead. Would the out-of-pocket emergency room visit drain my savings, potentially creating a burden that would extend beyond my physical wounds? And the answer was yes. Glancing upon the price tags attached to each medical service, my hope and optimism crumbled like my poorly constructed network of co-pays and deductibles.

I was forced to choose a different path. With the limited knowledge obtained from a semester and a half of medical school, I did a quick neuro exam on myself using the bathroom mirror. Ruling out a concussion with a low confidence interval,

I embarked on a journey to a CVS pharmacy, where an array of medical supplies awaited my arrival. Armed with bandages, antiseptics, and an unwavering determination, I began to treat my own wounds. With careful hands, I cleansed the lacerations, meticulously tended to each cut, and gently applied the healing remedies I had procured. Over the next couple of days, the pain got better, and the wounds started healing. I returned to the mainland and saw my primary care physician. While we joked about how my insurance, although supposed to cover me all over the United States, somehow figured a way to deny coverage on a US territory, our frustration with the healthcare system was not entirely shadowed by our humor.

The more I think about it, I realize how my story is a glaring satire that unveils the absurdity of a healthcare system governed by profit rather than compassion; a foundation built on profit margins instead of the fundamental human right to quality care. Working at different hospitals and free clinics over the past three years, I have met countless patients who have not been able to get appropriate care due to some hidden clauses in their insurance policies. And I'm not even talking about people who can't even afford health insurance because of the premiums being so high. These patients are either forced to live with their deteriorating health or take charge of their health with remedies from friends or the internet, which does not always end well.

This satirical tale serves as a rallying cry, an incisive commentary on the millions left adrift in the wake of a broken system. It urges us to confront the towering waves of change, to advocate for a healthcare system that values human well-being over financial gain. Remember that within the chaos lies the power to reshape the future. Let us unite, challenge the currents of indifference, and strive for a world where the waves of fortune favor us all, regardless of our insurance cards or the depths of our pockets.

## 16. Out of Options\*

**Nicholas B. VanDerwerker, B.S. and current MD/MPH Student**

We are taught, as medical students, to solve problems. A patient has a staph infection? We have antibiotics for that. Diabetes? Lifestyle changes and meds can help. But patients are not Lego sets – they do not come with instruction manuals for achieving an ideal result. While our pre-clinical classes give us good foundations on pathophysiology and the treatment of diseases, they do not teach us how to handle the uncertainty and emotions of managing incurable illnesses. So, what do you do when there is nothing to be done?

It was late summer, and I was assisting an internal medicine physician during my pre-clinical phase of medical school. I had completed more than a year of medical school at this point, and I was finally starting to feel confident in my clinical skills and knowledge. We progressed through a morning full of back-to-back visits – attending to common complaints from chest pain and cough to hearing loss and hemorrhoids. I was sitting at the computer when Epic signaled that the rooming of our next patient - a man who we will call “Mr. Jones” – was complete. I hung my stethoscope around my neck, straightened my tie, and my preceptor and I entered his exam room. Mr. Jones – tall with a bristly brown beard and wearing a Packers T-shirt (a quintessential Wisconsinite) – was seated with his elbows on his knees, appearing distraught. We introduced ourselves and sat down to begin the visit. Excited (and rather naïve) to solve his problems and send him home happy and healthy, I asked “So, what brings you in today?” Thus began my first experience of feeling totally, utterly, and incomprehensibly powerless.

“I just want to feel stronger,” he shared resignedly while looking at me. “Can you help me with that?” Mr. Jones had ALS, also known as Lou Gehrig’s Disease. ALS is a disorder that results in progressive destruction of the neurons that control voluntary muscles. Patients experience muscle weakness that worsens to the point that they cannot talk, eat, and worst of all, breathe. Fortunately, there are a couple of drugs that can mildly slow the progression of the disease. However, ALS is ultimately incurable and fatal, with an average life expectancy of less than five years.

I paused and replied, “Tell me more.” Over the next few minutes, Mr. Jones conveyed the difficulties he faced. He had trouble sleeping and walking. His eyes were bloodshot red and he always “felt like crap.” His anti-depressant medications were not working and the only thing that made him feel better were the corticosteroids that he was taking for an adverse drug reaction. ALS was a five-ton boulder that he bravely carried on his shoulders every waking moment.

I listened as my preceptor and Mr. Jones discussed referrals and adjusting medications, including taking him off the corticosteroids.

This made Mr. Jones even more dispirited. “So, you’re telling me there isn’t anything that you can do to make this go away, to make me feel normal again?” In that moment, a straitjacket of sorrow tightened around my chest. I wanted to cry. I wanted to walk over and bearhug this big burly man and tell him that everything would be OK. I felt terrified witnessing such pain knowing that there was nothing we could do to fix it.

As the discussion with my preceptor slowed, I asked Mr. Jones one more question, “Lots of patients in these kinds of situations find talk therapy to be helpful,” I said, “Would you be interested in this?” “No thank you,” he politely responded, “I have my family for that.” With that, my box of solutions - neatly organized in my head by countless hours of lectures and studying PowerPoint slides - ran empty. I felt powerless - like the feeling you get when you watch a car slide uncontrollably down an icy hill. All I could do was watch and hope for the best.

When we finished the visit and Mr. Jones stood up to leave, I squarely faced him and shook his hand. “It was great meeting you,” I said. “I’m really glad that you came in today.” He paused, looked at me, and thanked me before walking away. I admired Mr. Jones’ strength and resilience in the face of an unsolvable condition such as ALS. However, that morning, cleansed of my naiveté, I fully felt the intense, frustrating, and infuriating helplessness that results when the limits of medicine are reached.

Over the next few days, my mind kept returning to that visit with Mr. Jones. I ruminated on how we possibly could have better helped him. Thus, like most people with a burning question, I went to Google. A search led me to a publication by the Italian palliative care physician Antonella Goisis.<sup>1</sup> In her article, Dr. Goisis shares that the best way to attend to patients with incurable conditions relies on fulfilling two primary needs. The first is to ensure that these patients feel welcomed and accepted. The second is to listen – to deeply focus on both the spoken and unspoken things they share. This wisdom gave me a sense of closure for a couple of reasons. First, it equipped me with a clearer script for dealing with similar situations in the future (I am a big fan of protocols and stepwise instructions). Second, and most importantly, it gave me relief knowing that we did everything right for Mr. Jones. Although I likely will never see him again, I hope that he left our clinic that day feeling as though we listened to and truly cared about him. In the end, for patients living with unsolvable diseases such as ALS, that is the best result that you can hope for.

1. Goisis A. Active treatment of patients with “incurable disease”: what’s the point? *J Med Person*. 2012 Aug;10(2):63-67. doi: 10.1007/s12682-012-0113-2. Epub 2012 Mar 9. PMID: 23336062; PMCID: PMC3546070.

## 17. How Lucky I Am To Have Something That Makes Saying Goodbye So Hard

### *Vazirnia, Parsia*

“Education. Education. Education.” This word was engrained into my head as a child while growing up. My parents would always tell me that receiving a strong education was the best gift that any man or woman could receive. My parents themselves were immigrants who came to the United States in search of opportunities for higher education during a time of political unrest in their home country—a revolution and a war. My grandparents were both teachers and school principals. I used to come home from school only to find them with a copy of my school’s textbooks wide open waiting for me to do my homework in front of them. I never really understood at the time how lucky I had it to have a family that was so involved in my education.

They watched me begin medical school and my older brother enter the workforce as a practicing physician after enduring the hardships of medical school, residency, and fellowship. All our achievements belong to them too. The more I think about my parents, the more I think about how much they sacrificed and how much time they invested to get my older brother and I to where we are today. They worked long hours. They struggled. They are retiring late. All of this to be able to provide better opportunities for their children and for the sake of a strong education.

My parents hold a special place in my heart. As I advance through my medical training, I see profound sadness in patients who have

lost their family and loved ones. It makes me think of my own family and loved ones and how I would feel if I ever lost them. I am developing a strong fear of losing them the more I see death in patients and the more I advance in my medical training.

However, my viewpoint on death is not all too negative. A discussion with my Hispanic classmates really resonated with me. As I explained to them my feelings of losing my loved ones, they made me find the irony in the concept of death. If it wasn’t for death, we would not look back and look at the legacy of our loved ones. If it were not for the concept of death, we would not cherish our loved ones and hold them so deep inside our hearts. Although we will miss them, death allows us to cherish the little moments that we have and turn them into memorable moments. This is the premise for the “Dia de los Muertos” celebration.

While education was ingrained in my head while growing up, I have begun to think about medicine differently than higher education and life long-learning. I view medicine as a unique field that reminds us of our humanism. We are trusted to enter the lives of patients to be with them in some of the hardest moments of their lives when they have people so important in their lives that makes saying goodbye so hard. A quote by Winnie the Pooh best summarizes it all--“How lucky I am to have something that makes saying goodbye so hard.”



## 18. Confessions of a Difficult Patient

### *Margaret Zwick, BA*

Life as a young adult with type 1 osteogenesis imperfecta is relatively unremarkable. Sure, I might have to take a daily thiazide diuretic to manage my hypercalciuria and get DEXA scans every few years to ensure my skeleton isn't slowly crumbling. And I've certainly had more fractures and sprains than your average adult and, as a result, am staunchly opposed to skydiving. But I also run half marathons, had a fairly successful ballet career that carried me through college, and am starting my fourth year as a medical student at the University of Wisconsin. My diagnosis does not loom large in my daily life, and the minor inconveniences of medications and occasional imaging appointments seem like a small price to pay for overall good health.

But this wasn't always the case. During my childhood, some of those minor inconveniences felt like major injustices. I did spend a lot more time injured during childhood than my friends, with about eight major fractures between infancy and the end of high school. I was well acquainted with leg and foot casts and my local orthopedist for a few of those years. But it was more the little sacrifices of dignity on top of the injuries and hospitalizations that made my blood boil and the tears spill.

For example: I remember being forced to change into a silly little gown and walk down the hallway – sans bra! – to the DEXA scanner in the children's hospital. As a child, and especially a teenager, this felt like torture. No matter how confidently I assured the woman at the check-in desk that there was absolutely no metal in my clothes, she was unmoved by my plight, and I was banished to the changing room, gown in hand. And then, having arrived at the DEXA scanner, I was told I also had to remove my bobby pins from my carefully coifed hairstyle. Lying on the DEXA table, hair disheveled, pride injured, and fuming, I resolved to be thoroughly uncooperative.

My twin sister is lucky enough to share my diagnosis as well as that of nephrocalcinosis, and as a result we required yearly renal ultrasounds which, much like the gown experience, sparked enormous embarrassment. To be getting an ultrasound at all was mildly mortifying – aren't those for pregnant people? And to have towels tucked into your underwear and a great splat of gel squirted onto your exposed midriff – please, for the love of God, no! The icing on the cake was when the ultrasound technician failed to fully wipe off the gel after the exam was done. Bake for 30 minutes and enjoy a large helping of sticky, angry child.

Because of her nephrocalcinosis, my sister had a couple inpatient stays for pamidronate infusions during toddlerhood to help manage her hypercalciuria. Hospital admission for a young child is emotionally challenging in itself, especially an admission necessitating IV placement and lab draws. But the ultimate insult, and what sparked the outpouring of tears, was when she found her IV pole was too tall for her to fit inside the play structure in the children's wing of our local hospital. Instead, she was forced to wander the halls, weeping and gnashing her teeth, with a stuffed animal, my mother, and IV pole in tow.

The common thread among these memories is the outrage my sister and I felt when our choices and agency were taken away. I didn't want to be restricted in ways other kids weren't or asked to do things that weren't expected of other kids, and I deeply resented the adults that enforced these rules, knowing even so that they only wanted what was best for me and my health. I didn't want to limit my sodium intake or not jump on the trampoline. I didn't want to be told I was fragile and that I had to be more careful than others. And I didn't want to put on the stupid gown.

Now, in my fourth year of medical school, I look back on these moments and my child indignation with a mix of humor and sympathy for my younger self, who I sometimes see in the patients I work with daily. I know, from my own interactions with the medical system, that the patient experience can be simultaneously uplifting and belittling, rewarding and embarrassing, and inspire both gratitude and an uncooperative attitude. What we, as practitioners, may view as minor sacrifices for the sake of better health care or patient safety, like changing into a gown or using a bedpan, may be interpreted as much larger slights in the setting of a loss of agency and autonomy. Many of these things are not going to change – the need to not wear metal during a DEXA continues to be a reality, and ultrasounds simply cannot function without the use of gel. But if we providers can shift our perspectives and realize that grumpy moods and gruff personalities may be a result of grieving a loss of autonomy, we gain both a deeper understanding of and stronger empathy for those we care for.

## 19. The Pepsi\*

**Nick Gallo, MD**

Mr. G didn't look too good. BIPAP forced oxygen into his barrel shaped chest, where emphysematous lungs wheezed audibly with each breath. Accessory muscles tugged with all their might. A pacemaker rested in a skin pocket below his left clavicle. An irregularly irregular heart rhythm scribbled across the monitor. Tattooed in the center of his chest was a long sternotomy scar from his previous triple bypass. Thin skin spread tightly over brittle bones. The stigmata of lifelong tobacco use were evident even from outside of his room (my theory was confirmed after finding a crumpled pack of Marlboros in his breast pocket). His appearance resembled that of a skeleton, yet he was full of life.

The weakness and shortness of breath that landed him in the ICU was explained by multiple abnormalities including acute anemia from a diverticular bleed, pneumonia resulting in an acute COPD exacerbation, and atrial fibrillation with rapid ventricular response. After I communicated the severity of his illness and what we found during our workup, he had a few questions. He asked, "Doc give it to me straight, do you think I'm gonna to make it? I just want to see my daughters again they are my pride and joy. I've been pretty sick the past few years, and they take good care of me at home. They want me to stick around. They don't even let me drink Pepsi because it's bad for my diabetes. I just want to have one more Pepsi doc. Do you think I can have one if I get out of here?" I told him I was optimistic he would get through this, assured him our team would chat with his daughters regularly, and even promised him a Pepsi when he got out of the ICU. His only follow up question was, "Can I get that promise in writing?"

Through the peaks of his illness, he never lost his quick wit and quickly became a fan favorite patient on the floor. His raspy voice roared over the noise from his BIPAP and the other machines in the ICU. Nothing short of intubation and sedation was going to stop the endless flow of jokes and stories. He shared tall tales from growing up as a "tough guy" on the south side of Chicago, serving in the military, traveling the world, and living what he called a "fast and loose lifestyle." When I rounded with his nurses, it became common practice to talk about his care plan then exchange Mr. G stories.

One morning I received a call from our house supervisor who asked if Mr. G would be appropriate for transfer to a non-medical floor. I selfishly wanted him to stay on my service but reluctantly agreed to the transfer. With my promise in mind, I set out to find a Pepsi. After losing \$1.80 to two different vending machines, I finally secured a sweet can of soda from the VA Canteen. When I met with Mr. G later that day, I told him I had both good and bad news to share. The bad news was that he was too healthy to be on my service. The good news was that he could finally have the Pepsi he had been craving. "Doctor's orders," I told him. For the first time during his admission, he was speechless. With watery eyes he took one of my hands in both of his and held me tight. He expressed his gratitude and left me with these parting words, "Have a fun life kiddo, don't forget to cause some trouble."

I won't ever look at a can of Pepsi the same way again.





## 20. The Door\*

### Brooke Jennings, MD

I opened the door to the work room and went to my computer. I sipped my black coffee as I reviewed my list of patients. Two new patients overnight. I jotted down the morning labs and vitals.

I rubbed my tired eyes and hurried to the next patient's room on my list, Mr. G. He has end stage heart failure with worsening cardiac cirrhosis and several additional comorbidities. He has already received the optimal treatment regimen from his cardiology team. Unfortunately, this is his third admission in the matter of two months. Mr. G had not been able to get out of bed since he was admitted to my care over a week ago.

I ran through my thoughts for the day before knocking on the door. No big changes for the day, I will check on his pain and shortness of breath. See how the fluid did over the weekend. Goals of care discussions have been ongoing.

I open the door.

He was sitting in bed, he smiled as I walked in.

We chatted; he told me about his grandkids as he smoothed his silver hair down for the day.

I examined him, his belly tense with fluid. He winced as I gently palpated his abdomen.

I listened as he finished his story about little Lucy, his youngest grandchild who loved visiting her grandparents and seeing their kitty. I paused for a moment, and then sat in the chair that was pulled up next to his bedside. *"I am very worried how fast the fluid came back on your belly"*.

He reached for my hand and said, *"Well you'll take care of me, right doc?"*

My heart twinged. There were no more curative treatment options. His medical plan had not changed in days. He smiled and shared beautiful stories with me, yet I had nothing more I could do for

him. After weeks of enduring a repeating cycle, he decided to transition to hospice. He told me he wanted to be at home and spend as much time as he could with his wife of over 50 years and his beloved grandchildren. That I could help him with, I would get him home as soon as possible.

I checked Mr. G's chart to see how he was doing a few weeks later. The EMR notified me that the patient's chart I was entering was now deceased. He died earlier that same week. Tears unexpectedly welled in my eyes as I wondered if he got to see Lucy run her tiny fingers across his cat's black and white fur one more time. I thought he would have more time.

*\*beep, beep, beep.\** My pager rang. My patient in room 5000, Mrs. S, is having chest pain. I wiped the tears from the corners of my eyes and headed down the hall. I ran through Mrs. S's hospital course thus far in my head and my differential for her new onset chest pain. I open the door. Mrs. S looks uncomfortable, I take the stethoscope draped around my neck and began to go through my questions while examining her. Her son sat tentatively in the chair next to her bed. He didn't have to say it, but the look in his eyes said, *"You're going to take care of her, right doc?"* I wouldn't think of Mr. G again until I laid down for bed that night.

As physicians, we carry the weight of caring for another human being. Death becomes engrained in our daily work. We watch families suffer devastating losses. We grieve the loss of patients we come to know. The next minute we may be walking into the room of a patient who deserves us to be fully present the moment we open the door. I am learning to tuck my grief away and show up for the next patient. As I learn how to navigate this life in medicine, I try to remember to pause as I walk in the door to our workroom. This may be a very typical day at work for me, but the importance of our work as physicians is not ordinary at all.

## 21. A Lesson from Intern Year with a Side of Oats\*

**Abishta Prabhu, MD**

I had never spent as much time reading through the in-room dining menu in a hospital as I did the last month of my intern year. The menu was vaster than I imagined with a variety of customizable options and daily chef's specials that added an element of surprise to the dining experience. As someone who particularly cherished breakfast foods, I found myself drawn to the morning selections found in these menus. This was one of the many things that I had in common with Alice. I first met Alice when she was admitted overnight to our inpatient medicine team. She came in with a chief complaint of fatigue and stayed because her extended work up had revealed metastatic colon cancer that required possible surgical intervention. When I initially told Alice about her diagnosis of cancer, she did not seem surprised. She wanted all the information without any sugarcoating and told me to be as honest as possible with her. I obliged in her request and told her that her cancer was not curable, but her symptoms could be managed best possible while consulting teams explored life prolonging ideas.

As her primary inpatient provider, I wrote out updates from multiple consulting medical services on her hospital issued notebook every day. I gave her the daily changes from surgery regarding the mass obstructing part of her descending colon, from radiation evaluating her for palliative treatments for spinal metastasis, and from oncology who were patiently awaiting her markers and pathology from the recent biopsy. One day as I was going through updates in her plan, Alice stopped me and handed me her dining room menu. "Omelet or oatmeal?" I stared at her quizzically and then confidently went with oatmeal, although that was objectively the more boring of the two options. She committed to my decision and called in her breakfast. The next morning when I went to see her, she wasted no time in explaining to me that my decision was stale, and she was going with the omelet the next morning. We laughed, talked about her lab work, then continued the pattern almost daily.

I think we both liked breakfast because we thought it was the "safest" meal of the day. The options were predictable and usually when ordering something it was exactly as expected. In an environment as labile as the hospital this was comforting. It was nice to know with how drastically Alice's body and symptoms were changing, there was something constant and in our control. A few days later, Alice had further imaging and scopes for her intestines showing small bowel tethering, proving that she could no longer tolerate only oral intake as a clear source of sustenance for her body. She was set up with total parenteral nutrition (TPN), to bypass her gastrointestinal tract and it seemed as though her treatment options were dwindling.

Everything prior to medical school teaches us that doctors are the ultimate puzzle solvers. Like Sherlock Homes, we navigate through a myriad of diagnostic studies and clinically correlate patient presentations to their symptoms. Through this first year of residency, I put my detective

skills into action, read about my patient's conditions daily, and came up with evidence-based plans. Then at one point through seeing patients, like Alice, I realized my sleuthing powers were not as strong as I thought. Sometimes my patients asked difficult questions that I didn't have the responses to. They were questions regarding life after they leave the hospital, questions about why their medicine for guideline directed therapy was too expensive to afford, they asked why they felt sick and were in the hospital if all the diagnostic studies had no clear answers. In Alice's case, she asked about the prognosis of her metastatic cancer that was getting worse day by day. The most hurtful part was that she knew a portion of the answer herself but looked to me for comfort.

Being a resident physician has taught me so much about the doctor that I want to be as well as the individual that I am. I chose this profession to help others and give them answers but my first big lesson through residency is that medicine is partly about learning to be comfortable with the unknown. Knowing how to be there for patients during their time of need but also being honest with them when you don't have all the answers. Most importantly, knowing that even without solutions to all their problems, as a physician you have the power to empathize and listen to patients. That is something that even the greatest detective might not be able to understand.

I continued seeing Alice through her hospitalization even when she was in the process of being transferred to the oncology service. We talked about her family, her life, her adjustment to TPN, and the big impact this new diagnosis had on everything. Sometimes when the conversations got too emotional, we would distract ourselves with random topics like the new book at her bedside or the usual: the menu. Even after her transition to TPN, Alice made me pick out a breakfast or snack option every morning. I didn't know if she actually ordered half the things we talked about, and her weakness had gotten to a point where she could only tolerate a couple of bites of formed food prior to transitioning to hospice care. Regardless, she made me entertain the conversation daily. Looking through something as trivial as a food menu felt so sacred. It felt as if continuing our daily ritual would shield us from having to talk about the "hard stuff" for just a few more minutes. We continued joking about odd food combinations and our favorite flavors of Jell-O. Sometimes to keep her on her toes, I would continue to suggest the oatmeal but add maybe with some berries or maple syrup. I knew she wasn't a fan of my breakfast opinions, but based on how happy she was discussing it, I didn't mind volunteering my plain choice in entrees. This is something that stays with me. Even now when reflecting over all the difficult discussions I must have with patients in the hospital, I think about finding their version of "oatmeal." In the unpredictable world of healthcare, everyone needs something that is safe, comfortable and a little bland to keep grounded and remember the simple joys in life.

## 22. Wally\*

**Geoffrey C. Lamb, MD FACP**

It was mid-December of my internship year and I was nearing the end of my rotation on the wards at the VA. I was finally starting to feel somewhat competent but far from truly confident. My resident that month was “Wild Bill”, so nicknamed because of his flowing mane of long black hair and a certain intensity around patient crises. That morning he came up to me in the resident room. “Wally’s numbers are not looking very good. I think you should have a talk with him and try to convince him he should not go back on the ventilator. If he goes back on he will probably never come off.”

Wally had just been transferred from the intensive care unit where he had been on a ventilator for the last three days. He had severe COPD and had been hospitalized requiring a ventilator multiple times in the last few months. During this hospitalization he had been on the ventilator twice already. Now his CO<sub>2</sub> was starting to climb and it was clear that he was once again going into respiratory failure.

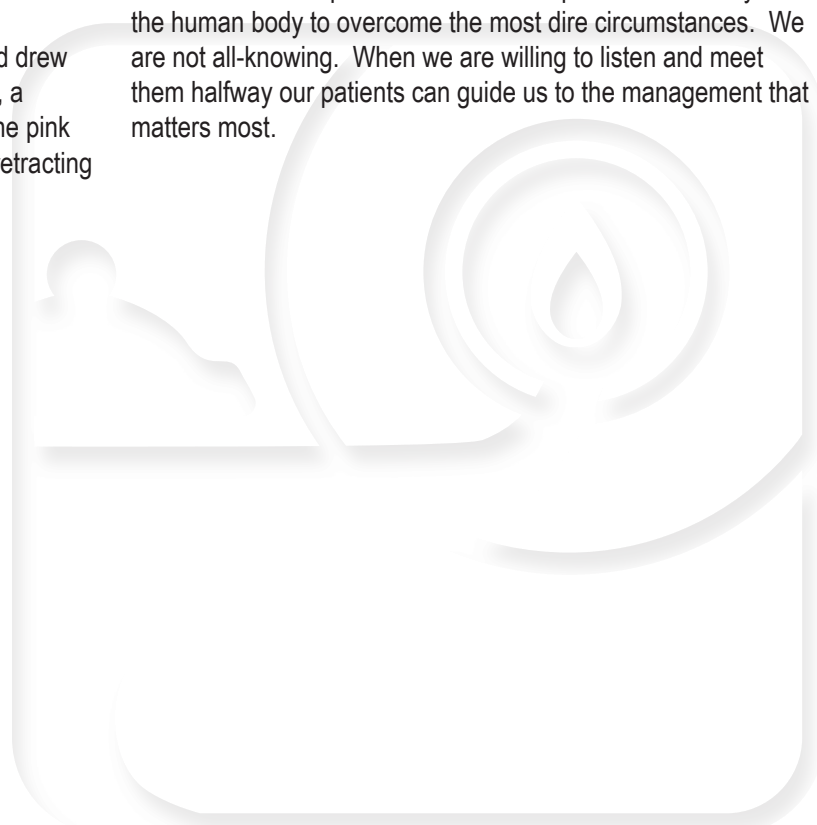
This was not a conversation I had ever had with a patient before. I was nervous and not sure how to go about this or how he would respond. I rehearsed to myself the points I was going to make: his lungs were no longer able to keep up on their own; if he went back on the ventilator he would likely not be able to come off and he would spend the rest of his days on the machine; if he chose to let nature take its course we could keep him comfortable and he could pass away peacefully.

I vividly remember the scene as I went to the bedside and drew up a chair to sit beside him. He was sitting up in the bed, a wizened gnome-like man. He was the classic image of the pink puffer – very thin with a huge chest, intercostal muscles retracting

between his prominent ribs, the sternocleidomastoids in his neck tightening as they tried to help the chest move air. I laid out the situation for him using my carefully rehearsed words. He looked at me knowingly. He could speak but the words came out in short bursts. “I hear you Doc. I understand what you’re trying to tell me. But the thing is my wife doesn’t turn 62 until March. If I die before her birthday she only gets partial instead of my full government benefits. Can you keep me alive until then?” This was not what I was expecting, but it was clear he was sincere and this was important.

Wild Bill was not enthusiastic, but we agreed and we re-intubated Wally that morning. I moved on to another rotation a couple days later and over time Wally faded from my mind. Fast forward 2 years later. Now I am the all-knowing senior resident and I am back at the VA on the general medicine service. It was a typically busy call night and I pull back the curtain to meet the next patient I am admitting. There before me with a big grin on that wizened gnome-like head was a familiar face. “Hi Doc – Remember me? I’m not dead yet.” He had recovered and been discharged home after that fateful conversation two years previously and had done remarkably well. This was his first time back in the hospital. This stay was relatively uneventful and he was able to return home in a matter of a few days.

Wally’s story has stuck with me ever since. We often underestimate the power of the human spirit and the ability of the human body to overcome the most dire circumstances. We are not all-knowing. When we are willing to listen and meet them halfway our patients can guide us to the management that matters most.



# POETRY



## 23. Who Am I ?

*Aileen Alquinto Anonuevo, MD*

It's 5 am, with a view of gold peeking into the gray.  
The sun invites me to get up and watch its full array  
My energy, my desire is parallel to its command  
Mind and body rested... "Stand up Doctor, a list awaits thy hand".

Take those steps, be ready, organize that intellect.  
Venture a pause, no matter how daunting, a quick reminder "all they long is thy respect".  
Now tease out the matter, break down in layman's term.  
For to be effective, they should hear, understand... and then confirm.

The light will shine, sustain that effort, be luculent, be brave,  
be direct, be tender;  
Everyone we touch, in their own battle, they are the contender.  
New ones come in, as the revolving door of medicine swings around...  
And for the luckiest ones, in varying duration, their enigma will resolve and they're back homebound.

Be confident, be systematic  
Investigate, mitigate and be less pragmatic  
Can it be hematologic, cardiac or even hepatic?  
Focused and cordial, for a dozen hours, do cast that serious labor.  
And at the end of the day, maybe one soul shall stop by, to express and remember.

(I am a Hospitalist.)



## 24. Medicine Man

Michael J. Dolan, MD, FACP

The scientist's rigor  
deducing right from wrong  
open and shut, black and white  
only the facts belong

But the blinders he wore  
kept him in the dark  
so much was unseen  
right from the start

The Medicine Man  
wisdom keeper of long ago  
talked of connection  
to all things we know

Surely his words  
were not the truth today  
science would not  
allow such disarray

The skeptic shook his head  
he could not believe  
his life was one path  
rooted in what he could see

Can the blind see?  
or the deaf hear?  
the paralyzed walk?  
His resolve had no fear

Medicine Man pushed on  
surely the blind can see  
and so can you  
but blind you will have to be

And blinded he was  
left alone to wander  
across the room he searched  
but could not find her

Relying on the senses  
he had remaining  
lost in the expanse  
the effort was draining

Open your mind  
Medicine Man said  
make a connection  
see with your heart instead

The flesh on her arm  
was warm to the touch  
he closed his eyes  
"this won't do much"

Blinded he became  
and cleared his mind  
he thought of her arm  
leaving his senses behind

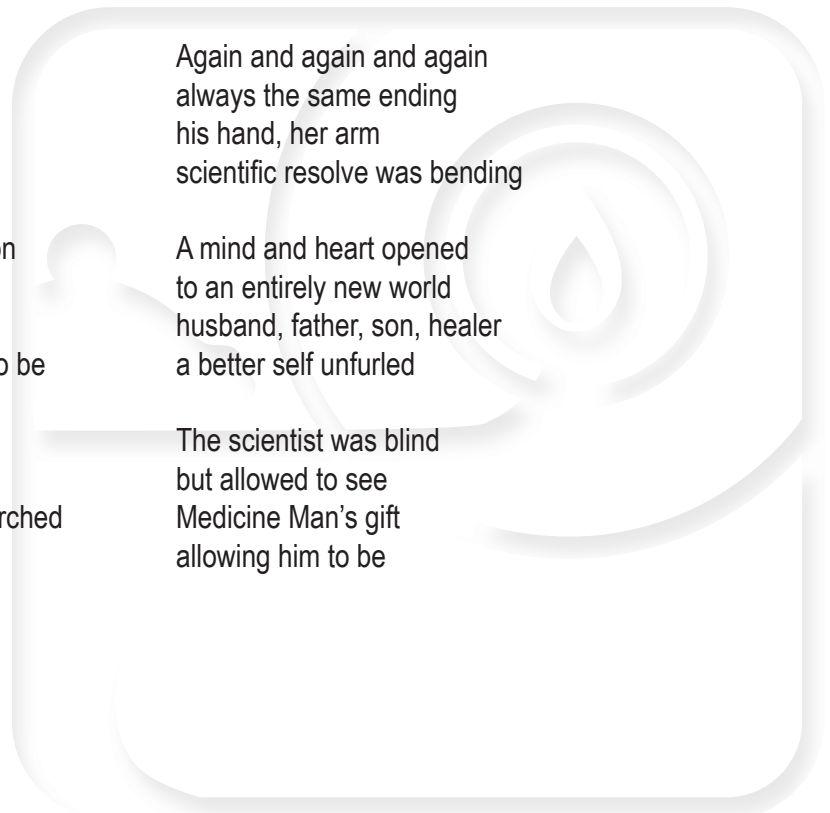
His feet began to move  
her presence was near  
reaching out his hand  
resolve starting to fear

Skin touching skin  
blinders came off  
his hand, her arm  
the mind tried to scoff

Again and again and again  
always the same ending  
his hand, her arm  
scientific resolve was bending

A mind and heart opened  
to an entirely new world  
husband, father, son, healer  
a better self unfurled

The scientist was blind  
but allowed to see  
Medicine Man's gift  
allowing him to be



## 25. In Our Defense

**Bharat Raman, MBBS, MPH**

Endocrinologists do not begrudge sugar or sweets,  
We are prone ourselves to have the occasional treat,  
We do however tell our patients,  
As part of their rations,  
To moderate their intake of sweetmeats.

### *Author's Note:*

*Submitting a limerick and not sure if it qualifies for your poetry section. A little background regarding the submission.*

*It is not unusual to hear comments from colleagues particularly around the holidays on how anti-sweets/sugar endocrinologists are.*

*An e-mail from a colleague sums up the general sentiment I am trying to convey. The message from my colleague was in response to positive feedback from a patient.*

*My colleague congratulated me and referencing the message stated, "I'd say "sweet", but that wouldn't be good for Endo". It's all in good humor of course.*

*I thought a little clarification may help clear the air. Not being a poet, a limerick is what I could muster.*

## 26. Harmony's Tapestry: Embracing Diversity, Inclusion, and Equity

*Abhijai Singh*

In a world of vibrant colors, we unite,  
Diversity, Equity, and Inclusion shine bright.  
Bound by a vision, we walk hand in hand,  
Creating a tapestry that's truly grand.

Diversity, the mosaic of who we are,  
Embracing uniqueness, like a shining star.  
Different backgrounds, cultures, and races,  
Enriching our lives, leaving beautiful traces.

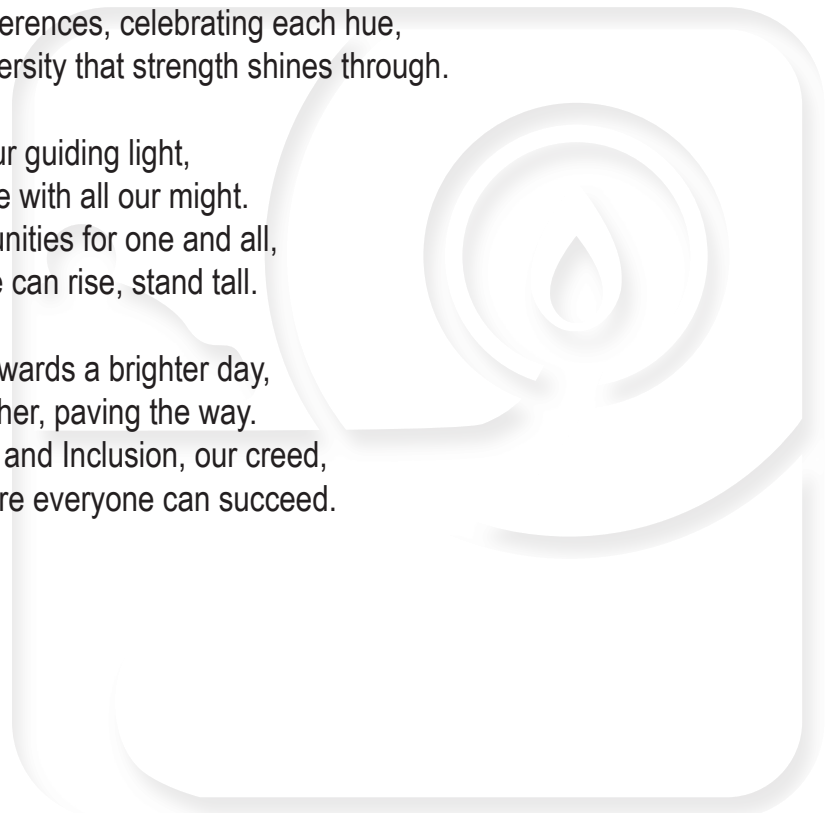
Equity, the bridge to a fairer ground,  
Breaking down barriers that once were found.  
Leveling the playing field, creating balance,  
Where everyone's voice has a chance.

Inclusion, the embrace of open hearts,  
Welcoming all, regardless of their parts.  
Creating spaces where everyone belongs,  
Where love and acceptance are our songs.

Together, we build a world of unity,  
Breaking down walls, fostering community.  
Honoring our differences, celebrating each hue,  
For it's in our diversity that strength shines through.

With equity as our guiding light,  
We fight injustice with all our might.  
Ensuring opportunities for one and all,  
So that everyone can rise, stand tall.

In this journey towards a brighter day,  
Let's stand together, paving the way.  
Diversity, Equity, and Inclusion, our creed,  
For a world where everyone can succeed.





## 27. Seeds of a Dream; Blurred Lines; It Was Short, but Intense

Michael Esson

### Seeds of a Dream

I know a tree:  
Once discarded on the lonely mountains of despair, it was only but a seed—  
Battered and bruised by the heat of injustice, rooted in pain,  
But with a promise of hope, it sprouted for all to see.  
Nurtured by the abundant downpour of love, it rose from its mother's fertile womb—it's bark, strong as a fortress of ebony—  
Towering like Kilimanjaro, it looked eye to eye with the heavens; branches spreading from sea to sea.  
Under the tender kisses of sunshine, its vibrant flowers bloomed for many moons.

Oh, I know this tree,  
Beneath the shade of its lush canopy, I'm forever free!

### Blurred Lines

As you read each vowel and consonant in this line,  
Feel the emotions woven by the line of migrants and refugees before  
me,  
And those who stand in line, ready to succeed me.  
Line by line, ensure that our perspectives intertwine,  
If you lose your way, find your place in line, for this perspective is  
genuine,  
And it aligns with my people's experiences, unmistakably defined.  
Definitions so pervasive, blurring the lines between truth and lies.

Whether my story aligns with your expectations,  
Hold back the urge to reshape and realign,  
Embrace the diversity within these lines, a space for definitions,  
With that in mind, the journey begins with the first line.

Bags packed, road paved, but no directions ahead—faith.  
When you uproot your family and sow them in foreign soil—migration.  
When your culture, dreams, hopes, and tongue seem too unfamiliar—  
alien.

Arrival marked by camps, detentions, and asylum—refugee.  
When you are deemed unwanted—illegal.  
The immigration crisis—scare tactics.

“Go back where you came from,”—the echoes of ignorance.  
When you change your name for their sake—acculturation.  
Melting in the pot—assimilation.  
A minivan and a white picket fence—the American Dream.

Through a journey of misery and sleep deprivation,  
Blurred lines will unfold, revealing wonder and beauty.

### It was short, but Intense

Breathe in!  
For at last, your journey begins.  
From the distant west to the limitless east—  
Witness the grandeur, as far as the eyes can see.  
All of it, your father's land,  
It's bounties, from the fruits of your mother's womb.

Breathe out!  
For with me, you are free.  
With each exhale, your burdens relieved with ease,  
The warmth of your breath,  
The depth of your stares; the comforts of your embrace,  
Oh, how my heart longs and aches!

Breathe in!  
For today, the stars have aligned,  
I had an intuition, that you would be mine,  
It came like a vision, with no reason or rhyme,  
Your beauty undressed my heart, forever etched in time.

Breathe out!  
Let the flames of love ignite!  
You held my hand through the flood, you never let it down,  
Another step into your waters, you never let me drown.  
As time ticks and tocks,  
I'm left with these rhymes, and if it could talk,  
It would say, “It was short, but Intense!”

**28. Her Version**  
**Rachel Heschke**

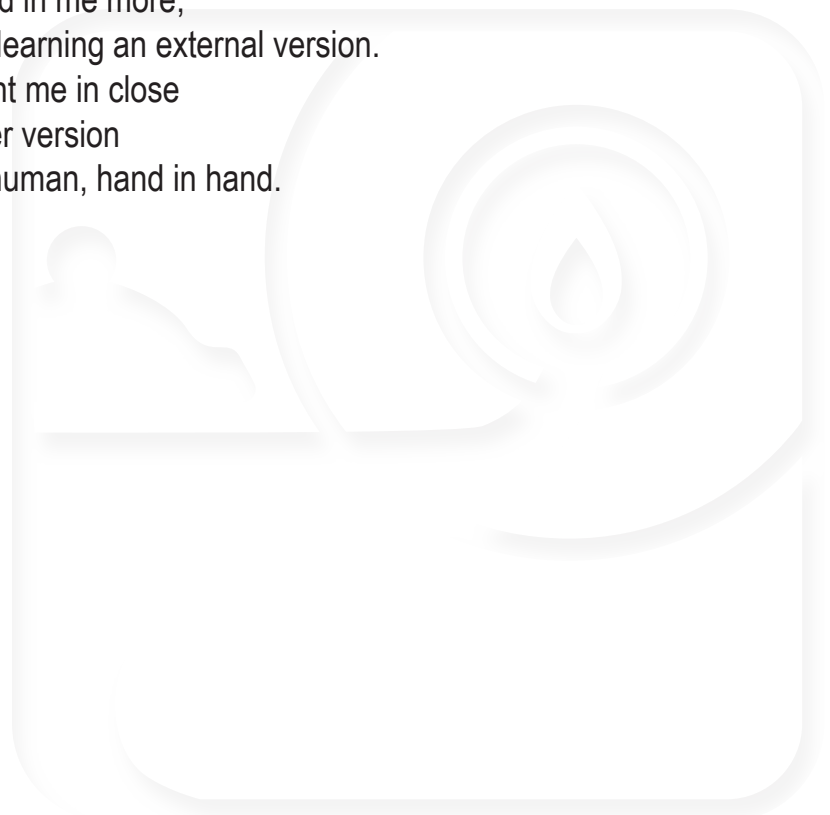
The resident and attending  
placed their hands  
on her swollen abdomen.  
A new life within  
but upside down.

Their hands like magic  
gently twisting, pulling, pushing.  
I stood next to her.

Her hand  
grabbed mine,  
squeezing tight.  
Discomfort  
spread across her face.

I gave a few squeezes back to say  
“I am here.”  
You are not alone.

She instilled in me more,  
more than learning an external version.  
She brought me in close  
to share her version  
human to human, hand in hand.



## 29. Dissection Amy Holzer



**JUDGED  
WINNER**

And there I was in this moment, standing still in a sea of noise  
Murmurs and action swirled around  
Not as chaos  
But as excited pieces of conversation, palpable energy  
Shared eagerness of people at the precipice of an opportunity  
they know to be rare and precious.

And in the middle of all that busy air  
I stood at the head of a large, silver tank.  
Starkly juxtaposed to its sharp corners and heavy doors  
Was the shining, delicately contoured brain resting in my hands.

There's something special about the brain, almost sacred.  
I have had chills when lifting a heart  
Took pause when adjusting a hand  
But time stopped for several seconds when holding that brain.

As children, we sing songs about having love in our hearts  
As dreamers, we feel things in our bones  
As lovers, we search for emotions in each other's eyes  
But when it comes down to it, everything that makes us \*us\* in the  
way that our families, our friends, our neighbors, and strangers  
know us to be  
Is held in that brain  
Every good idea  
Every bad idea  
Every memory cherished dearly  
Every mistake we never forgot  
Held in that brain.

This brain in particular  
Crafted masterful sermons for Sundays  
Listened generously to souls in need of guidance  
And perhaps learned more names and faces than I will ever meet.

I do not know any of this for certain.  
All I know are his age and his occupation  
How many years he lived and a clue to what he may have done  
with them.  
Sometimes it seems strange that with so many ways to identify a  
person, we lean heavily on job titles to think we understand who  
they are.  
Surely, we must be more than our work  
But I am quickly learning that if my occupation was scrawled on a  
slip of paper next to my name, people would know a lot about me  
too.  
I like to think that is something we would have shared, he and I  
Defining ourselves by our careers, calling them our vocations.

Still, I wish I could have heard his stories  
So far that is my favorite part of medicine:  
Hearing the stories.  
It must be exhilarating to excise a tumor or transplant an organ  
But it's the rare privilege of being trusted to know intimate details  
about people's struggles, triumphs, worries, joys, relationships,  
and goals that makes me more excited for this job every day.

Seeing his injury brings heaviness, knowing he felt that kind of  
pain.  
But when I hold his brain, I feel hopeful.  
Hopeful that maybe the pain was outweighed by beautiful  
memories he called to mind instead  
Final thoughts of people he loved  
Perhaps excitement for a chapter that may come next.

I once met a woman who suggested praying with your palms up  
Letting peace settle into your cupped hands  
So when I stood there with my palms up  
Holding this precious, beautiful brain,  
It felt a lot like praying.

### 30. The Doctor Said / I Said

*Margaret Summerside*

I delivered his sentence – or was it my own?  
more emotion than fact  
The truth, no doubt  
but fruitless, no less

I think I apologized  
as if my grief held some weight  
More for the benefit my own  
placating my guilt with his fate

And a thank you I received  
gratitude to the reaper  
How to take such a response?  
How to respond such a take?

We stand and shake hands  
as men are taught to do  
We meet eyes and say nothing  
as men are taught to do

I leave in silence  
with no more to offer  
I am the envoy of death  
to an audience of appreciation



## 31. Grief

*Jacqueline Tran, BS*

I'm strong and rooted, surrounded by sand.  
Yet, I'm afraid of the ocean.  
The sand that surrounds me, it protects me and  
Engulfs me in warmth as if I was especially chosen.

The days are long, and we gently battle each wave.  
Splash, the sand moistens with the wave's salty kiss.  
Tempted, I urge you to stay. Keep me warm and engulf me in love.  
Splash, the sand slips and this wave weakens your embrace.

It gets heavy but I can take it, can you?  
Up and back, up and back. We battle each wave.  
Hold on as tight as you can.

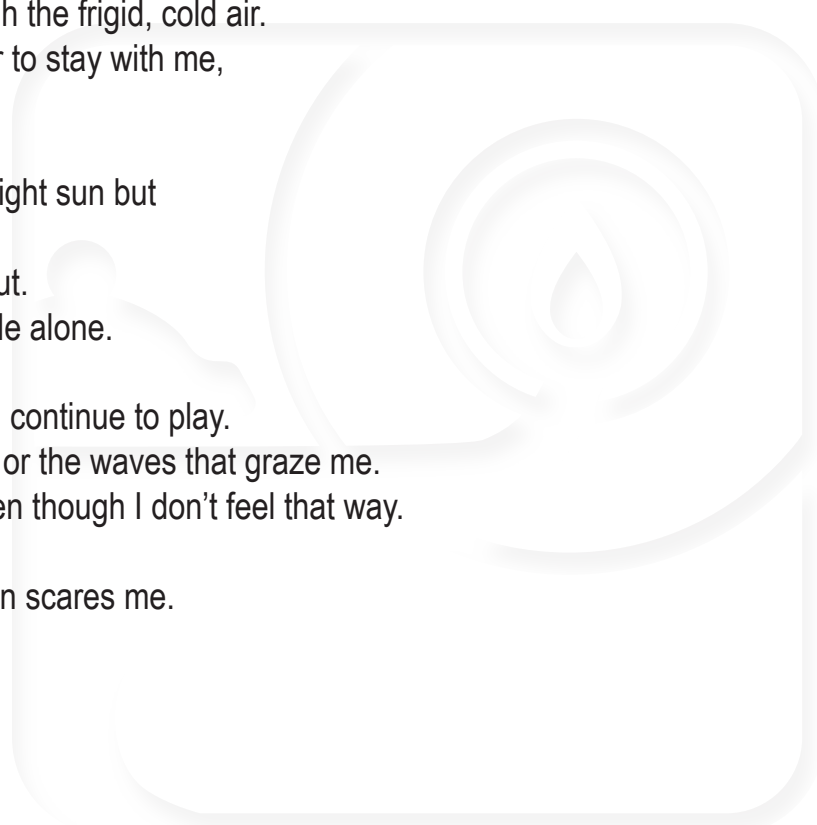
As the night falls, each wave  
Climbs higher and higher.  
Out into the darkness like a breath from your lips  
Crash, you get pulled further and further.

Crash, you follow the ocean as it tempts you to leave me.  
It calls your name through the frigid, cold air.  
It gets harder and harder to stay with me,  
By morning, I'm bare.

I'm surrounded by the bright sun but  
I feel alone.  
My rocky walls, bluntly cut.  
For today's waves, I battle alone.

People fill the beach and continue to play.  
They pay no mind to me or the waves that graze me.  
I must look the same even though I don't feel that way.

And that is why the ocean scares me.



## 32. Shakin' Off the Blues

Noah Trapp

Forth from the machine, like a sapphire dream  
Come some scrubs, a faded blue hue  
With a click and a whir, a hiss and a purr  
I'm equipped to make my debut

But these pants are too short, my irate retort  
Alas, I'll return and peruse  
With each button's press, elevations in stress  
Gambling for lengths I might use

At long last a pair, so beloved and rare  
Those hewn with appropriate bounds  
I leave a new man, with such fine care plans  
Dressed to impress on these rounds

I greet the doc, see two patients in shock  
And display my collection of facts  
You missed a murmur, please palpate things firmer  
He tells me before heading back

Impending doom, in the residents' room  
I contemplate what had gone wrong  
I steeled myself, to crush this next Shelf  
And palpate my patients more strong

Back in the machine, goes my sapphire dream  
Now at the end of their trip  
I find with a start, desecration of art  
In the bum, a nice big ol' rip

Tomorrow'll be better, so I pull off my sweater  
And drag myself out of my blues  
I'm not too glum, 'bout the rip in the bum  
'Cuz a good day's when scrubs reach your shoes

### 33. Rubber Band

*Austin Tubbs*

Oh look at that rubber band  
Limpely lying, happy  
But it must be used  
Because it can, so it will  
Look how much it can stretch!  
Pulled and pulled and pulled  
Taught fibers visible like capillaries  
Used and worn and satisfied  
“More,” it is told  
“No,” it pleads  
But it can, so it will  
Stretched and tugged and yanked  
Till it snaps like a bone  
But that was its job  
“Satisfied,” thinks the user  
Broken, is the band



## 34. The Cold

*Brooke Jennings, MD*

I held your hand,  
Aged by time with deep lines to show.  
I sat at your bedside,  
Our living room now resembled the inside of a hospital room.  
I took the pink sponge  
And wet the inside of your dry mouth.  
I talked to you,  
My voice cut through the heavy silence that filled our home.

I stood dressed in black.  
My hand clutching my crumpled eulogy.  
I did not notice my knuckles turning white.  
My fingers felt cold and numb.  
I watched myself from afar, walking through the day.  
I did not have your hand there to warm me.

The funeral was over.  
The visitors went home.  
I was a shell.  
I curled up in bed.  
I grabbed one, two, three blankets.

I still felt cold.  
I wrapped my arms tightly around myself and closed my eyes.  
I only shivered more.  
I wondered if I would ever feel warm again.

The spring turned to summer to fall to winter.  
Eventually years passed.  
I can now look back on the absence of your warmth,  
and not be flooded with the shivering cold.  
My season of grief now warm,  
the memories of you envelope me like a soft blanket.

My patient's daughter stood tentatively at the bedside.  
His extremities were cool,  
the sounds of shallow breath filled the room.  
"I wish we could give you more time together" I said.  
She took his weathered, calloused hand in hers.  
Tears welled at the brim of her eyes.  
I could tell the cold was creeping in.  
I wanted to reassure her.  
I wanted to tell her she will feel warm again.  
But for now, I will not intrude.  
The icy season of grief is upon us.



### 35. America, America – Why are your nursing homes filled with tears? (Homage to Ginsberg)

**Rebecca D. Elon, MD, MPH, CMD**

America, America, what rough beast is this,  
Who consumes the weak and dying,  
and removes them from our sight and care?  
Who reduces my strong proud mother to tears saying,  
“I would rather drink hemlock,  
than spend another night in this god forsaken place.”

America, America, our ranks are depleted,  
We feel under siege and are demoralized.  
We have called in Filipinas to do the work that you eschew.  
We need your understanding. We need your help.  
We need for you to roll up your sleeves and work alongside us.  
America, there is much to do, we cannot succeed without you.

Our campaign, our purpose is simply this:  
To care for the mothers and fathers of our nation  
during their period of long decline.  
Our terminal decline reveals  
the great success and the miserable failure  
of American medicine and American society.

America, America, when will you be worthy of your nursing  
assistants.  
We’ve given you all. We’ve done mandatory overtime.  
We’ve neglected our own families for this great task.  
We are chronically exhausted and understaffed.  
Now we are fired,  
and now we are nothing.

America, America, why do you think 3 hours of care a day is ever  
enough,  
Or 4 or even 5? Are you so morally demented you’ve forgotten the  
4th commandment? (Or was it the 5th?)  
Why have you codified neglect? This is situation impossible,  
So why now do you think that punishment will lead to loving care?  
America, stop punishing me, I know what I’m doing.

Our work is sacred, though mundane.  
The structure of the work, however, borders on profane.  
This is your creation, America.  
Like a vengeful god  
you stand in judgement and condemn  
the imperfect beast that you yourself have wrought.

America, America, I am addressing you.  
Your arrogance astounds me  
only more than your hypocrisy.  
But then it occurs to me,  
I am America.  
I’m talking to myself again.

Precisely in the name of America, America.  
I humbly beseech you with tears in my eyes.  
Return to your heritage,  
Make it your legacy.  
Remember, who at your best you know yourself to be.  
Recall us from this folly.



# *Narrative Medicine Session at ACP-WI Annual Scientific Meeting —The Parallel Chart—*

*Sponsored by the ACP-WI Women's Committee*

**September 9, 2023 • 2:30 - 4:00pm**

UW's Center for Healthy Minds has identified four pillars of well-being: awareness, insight, purpose and connection. A writing process can foster all of them: encouraging you to observe your work and world more closely; examine and consider the nuances of your feeling about your subject; and to use writing, directly or indirectly, to articulate what is important to you and why. Finally, sharing your work with others in a writing group or workshop allows you to connect with others, whether their perspectives are similar or differ. In this 90-minute workshop, we will discuss ways writing can provide a place for reflection and self-care while also honing a useful skill. We'll also write and discuss an in-class prompt. For any questions, contact [info@acpwi.org](mailto:info@acpwi.org).

**1.5 AMA PRA  
Category I Credit(s)<sup>TM</sup>**

### *Registration Fees*

- *\$25 for Attendings and Retired Physicians*
- *\$10 for Medical Students and Residents*

## **PRESENTER**

# *Michelle Wildgen*

*Michelle Wildgen has facilitated a writing group with the UW Palliative Care Fellows since 2017. She has more than two decades of editorial experience with an award-winning literary journal and has taught at UW-Madison and the Madison Writers' Studio, which she cofounded. Her work has appeared in places like the New York Times Book Review and Modern Love column, Oprah Magazine, and RealSimple.com. Her fourth novel, WINE PEOPLE, will be published in August.*



**Register for this workshop through the 2023 Annual Scientific Meeting form.**



Wisconsin  
Chapter

# NARRATIVE MEDICINE

# How to Write an Op-Ed

LIMITED TO 60 ATTENDEES - SIGN UP EARLY!

*Sponsored by the ACP-WI Women's Committee and the  
Health and Public Policy Committee*

## Monday November 6, 2023

7:00-8:30 pm Central (8:00-9:30 pm Eastern)

This event has been  
designated for a  
maximum of 1.5 AMA PRA  
Category 1 Credit(s)<sup>TM</sup>.

**Session Focus:** The ACP Wisconsin Chapter's next session in our Narrative Medicine Workshop series will be focused on how to write an Op-Ed. We hope those with interests in Narrative Medicine or Health Policy will join us for this engaging and informative session. During the Zoom session, participants will come to understand the world of op-ed publishing, understand the audience for these pieces, and review the structure of an op-ed. There will be an opportunity for free writing and discussion of writing in breakout groups to help you get started on an Op-Ed you may eventually submit for publication!

Please come prepared to write about a policy or practice issue you are passionate about. You do not need to do any pre-writing or be an expert! Just come with an idea for something from the experience of your patients or your own life that you have an opinion about. All opinions are valid! Writers of any skill level are encouraged to participate.

### PRESENTER



*Dr Elizabeth Cerceo, Associate Professor of Medicine,  
Cooper Medical School of Rowan University*

*She is the Health and Public Policy Chair of the New Jersey Chapter of ACP. She has taught Medical Humanities to Medical Students for many years, and she has numerous publications on Health Public policy in both Medical and non-medical journals, news outlets, and websites.*

## REGISTER TODAY!

Click the link below 

<https://uso6web.zoom.us/meeting/register/tZwkcOCorDIiHtDQRAdKfMP5ZBShB675oDaq>