



2024 | NARRATIVE MEDICINE BOOKLET



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Wisconsin
Chapter



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

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ESSAYS



1. First day as attending physician – How a missed teaching opportunity ended up creating a learning opportunity.

Kartikey Acharya, MD, MPH

John: "Kartik, how was your first day on consult service as the attending?"

Me: "It was OK. I felt like I did not teach much to the students and interns on the team."

John: "What were you planning to teach them?"

Me: "Oh, you know, there were these two cases of gram-negative infections where the resistance profile was quite typical and classic textbook. A case of CTX-M/ ESBL resistance in an E. coli isolate and a case of Amp-C expression on Enterobacter cloacae isolate. I wanted our students and interns to compare the sensitivities and look at Cefepime to help them differentiate between ESBL and Amp-C patterns. They had both these patients today. I missed talking about this concept and missed a potential teaching opportunity. Little disappointed in myself for this."

John: "Are you kidding me, Kartik? Didn't your team have 8 new consults? It seemed like a very busy day and you clearly looked overwhelmed. I am certain they were overwhelmed too. Do you think anything would have stuck with them if you would have tried teaching gram negative resistance to students and interns on a day like this?"

Me: "Well, they are on Infectious Diseases (ID) rotation, John. It will always be busy and if they don't learn this on ID, when will they learn this."

John: "I do understand that and know where you are coming from. Still, it is much more important to teach them how to triage patient care decisions and deliver safe patient care on your first day picking up a busy team from another colleague. No matter what they do in life, ID or not, they are always going to have to know how to triage questions and patient care decisions, prioritize things and keep patient care safe on a busy day in practice. You could just try role modeling that for them."

"And you are on for two weeks, right? You can teach them about gram negative resistance some other day while you are still on consult service. Maybe couple of days from now when you feel like you have a handle on your patients."

Throughout my career in Medicine so far, I have been very fortunate to have some incredible colleagues and mentors. I have received some great advice on being a better clinician, better educator and a better leader. This dialogue though has stuck with me, almost verbatim, for several years now. There are several lessons I learned from this single conversation. First, the importance of recognizing how extraneous and intrinsic cognitive load interact and affect learning.¹ With the busy consult pager going off every few minutes, with a new attending on their first day of inpatient work in attending physician career who is recognizing the struggle to balance education and patient care mission, with palpable stress (managing time and complex patient care decisions) during the table rounds, there were very few scenarios where teaching a complex topic like gram negative resistance would have gone well.

Second, while during residency and fellowship, my most rewarding moments were in teaching and simplifying complex topics to rotating learners at beginner level, I soon realized that there must be a time and space to teach some topics. While teaching on the fly is important, you cannot ignore the fact that learners are not going to be engaged in learning if all the work post rounds is still to be done and we are in early afternoon hours already. We often talk about recognition of cognitive load for learners to learn new content. There has to be recognition of cognitive load for educators to be effective at their teaching too. You are not going to be effective while you yourself are stressed and stretched thin as an educator. If your tank is empty, how can you take care of your learners and address their learning gaps?

Finally, the most important thing was to recognize the importance of timely and direct feedback. My mentor, John, and I had a very close relationship. He knew and embodied concepts of radical candor even before the book got published.² He cared personally and challenged directly. There were times when I did not like hearing what he told me. But I knew John cared and that advice and that feedback was correct and needed. Now, this is one of the most common pieces of advice I give to graduating fellows.

On your first day picking up a new inpatient team, be realistic about expectations from yourself during teaching rounds. You will do much better service to everyone on your team if you spend more time knowing your patients, your learners, and their goals and priorities. Teaching complex topics that interest you can wait, even if you think they are important for your learners. You don't have to take break from rounds and teach a topic for learners to learn something from you. The way you get to know and manage complex patients with high acuity on your first day on hospital service and the way you keep patient care safe on that day will teach them far more than you can fathom. No matter what they do in life, ID or not, our students and residents will need to know how to triage and make important patient care decisions on a busy day in practice; sometimes, and often, on patients they may not have known for a long time. It is important to teach how to do that. First days are hard. They never get easy. Hope you reflect on this advice as much as I do. I needed that learning on my first day as attending. It is the best advice I have ever gotten.

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2. Resurfaced Motivation: Enduring the MD to PhD Transition in MD-PhD Training

Nicholas L. Arp

It's 8 o'clock on a Tuesday night. I close the glass panel in front of me and press the ultraviolet button to project a radiant cascade of purple, microbe-killing light across the surfaces in the tissue culture hood. I shoot my gloves into the nearby trash, nearly missing, and leave the room as the door squeaks close behind me.

I glance down at my phone screen to see a seemingly endless list of notifications yearning for my attention from a group chat with my medical school classmates. I began to read.

I sink into my chair at my desk outside of the laboratory and continue to read the thread of messages about their days and nights on the wards, clinics, or operating rooms, the light from the screen illuminating my face. The thread ends abruptly.

I lock my phone and set it on my desk beside a random assortment of manuscripts and printed protocols. Leaning back into my chair, I look over to the florescent lights beaming down onto the benchtops, creating glares on the fume hoods. The stacks of pipette tips in boxes build a physical barrier to the far side of the lab. The silence is pervasive, save for the intermittent clanging of a broom by a custodian down the hallway.

For the past three years, I embraced the title of *medical student*. After coursework and clinicals, I now gain the title of *graduate student*. From feeling deeply connected to patients and their care to now peering at static cells in a microscope hidden in the nook of a sterile laboratory, I experienced the whiplash of new beginnings, yet again.

The initial few months of this transition were difficult as I wanted to return to the familiar setting of patient care and continue to train alongside my medical school classmates. Intermittent moments of doubt would surge into my mind. I recall my love for basic science research prior to matriculating; however, I'd ask myself: *was a career in research really for me?*

Later that week, I arrived at lab to isolate immune cells from patient-derived peripheral blood samples. After I set up my workspace, I am handed a sample that was collected from a subject with cancer. I sat silently, staring at the blood sample as I waited for an incubation step to complete. A memory flooded my thoughts.

I walked into the clinic room as an elderly patient looked up from a half-completed crossword puzzle. It was a follow-up appointment during their treatment course for a hematologic malignancy. After discussing any concerns, the patient inquired about my career goals. I explained how I wanted to pursue a career in *both* medicine and biomedical research. They reach out to my hand and looked into my eyes, and they said, *"Thank you. I am so proud of you, and you give me hope that others will not have to go through illnesses like mine."* This profound exchange of words will be forever engraved into my memory.

During the previous three years – with many additional years ahead – I trained to understand the patient behind these samples – the symptoms, the relevant history, the risk factors. Now, this was my chance to dive deep into the basic science and ask questions that may uncover new findings.

In tandem with the lack of consistent connection with patients, feelings of doubt, uncertainty, and emptiness due to the lack of traditional milestones, such as match day or graduation, are pervasive. Despite this deviation, resurfaced motivation from my past and future patients to train to be a physician-scientist will support me through this medical-to-graduate student transition.

3. The Measure of a Moment: Unveiling Generations of Care

Medhavani Chandra, MD

As the sun dipped below the horizon, casting a golden hue over the quiet hospital ward, I sat beside the bed of a 67-year-old patient whose life I had unexpectedly intertwined with mine in a profound medical journey. Her case, complex and quietly extraordinary, brought me face to face with the rare and enigmatic nature of tuberous sclerosis complex (TSC), a condition I had almost exclusively encountered in pediatric settings. It's a tale that highlighted the immeasurable worth of my dual training in internal medicine and pediatrics, proving that the most significant discoveries sometimes lie in connecting disparate dots across the vast canvas of human health.

Mrs. Thompson was admitted to the MICU following a hemorrhage into her left renal angiomyolipoma—a condition she'd lived with for years without significant issues. Except for her father's history of a seizure disorder, she had no history of cognitive disturbances or seizures in her younger years. The initial stabilization involved embolization, and once stable, she was transferred to my care on the medical floor.

Her complex history of bilateral renal angiomyolipomas, a rarity in itself, prompted me to delve deeper. My pediatrics background echoed loudly as I reviewed her files. I requested a second read of her lung CT, which revealed a new finding of pulmonary lymphangioleiomyomatosis (LAM). This was even more unsettling. It was an unusual presentation for someone her age, sparking a train of thought that perhaps I was looking at something systemic, something congenital, yet presenting uniquely in her twilight years.

Determined, I looked up literature, and based on the 2012 International Tuberous Sclerosis Complex Consensus Conference criteria, she met two significant criteria for diagnosing tuberous sclerosis complex. The patient's story unfolded further as her husband shared more about her recent neuropsychiatric changes—hallucinations and bouts of aggression, painting a picture of the broader impacts of TSC, including the tuberous sclerosis-associated neuropsychiatric disorders (TAND).

An MRI of her brain thankfully showed no typical neurologic manifestations of TSC, but the diagnosis was precise. Based on the available literature, TAND, renal angiomyolipomas, and pulmonary lymphangioleiomyomatosis are the manifestations of TSC in adulthood. This stable yet delicately poised condition allowed for her eventual discharge with a comprehensive follow-up plan involving a TSC specialist. The recommendations were poignant reminders of the lurking challenges: monitor for seizures, manage TAND and LAMs, and adjust to a new reality.

Reflecting on this unique case in the quiet of my office, I felt a deep sense of gratitude and fulfillment. Training in Wisconsin, with its myriad opportunities and supportive environment for medical professionals, had equipped me with the unique skills and perspectives necessary to unravel this medical mystery. The satisfaction of applying pediatric insights to adult medicine, diagnosing a condition typically identified in infancy during a woman's later years, was a profound affirmation of my career choice.

In medicine, we often measure our worth by the outcomes we can change and the lives we touch. For my patient and her family, my background in med-peds provided the lens through which a life-altering diagnosis was made, affecting not just her but potentially her extended family. As I documented the case, I realized that each patient offers us a unique story, a puzzle that challenges our knowledge and refines our empathy. Indeed, a physician's worth is not just in the treatments provided but in the connections made, the understanding deepened, and the lives understood.

In the narrative of our careers, these moments truly measure our worth, reminding us why we donned the white coat in the first place.

4. Failure*

Michael J. Dolan, MD, FACP

I entered the exam room and they smiled effusively. They were so happy to be there, to be able to unburden themselves and talk about the past year. Two brothers, bachelors, who had spent their life together in work and now in retirement. Approaching 80, health issues interfering with their once active lives, they still managed to approach their current circumstances with an incredible positivity that I wished I could bottle and sell on television. Mostly, they were there for me to discuss how I had failed them during a year that was going to change their entire existence.

It started innocently enough one year earlier when he came in for his annual wellness exam. Sam remained active, riding his recumbent bike around town and really didn't have much else to report. Anticipating a relatively normal exam, I looked forward to catching up on my afternoon schedule. As my stethoscope touched the front of his chest, I immediately recognized the irregular staccato of atrial fibrillation. "It can't be", was the first thing that crossed my mind, as my hopes for a short visit were dashed. "Sam, can you lay back?", I asked. He complied and I took another listen to his now worrisome chest. Nope, still irregular. A few minutes later I was staring at his ECG, which confirmed the diagnosis. I repeated my questions from earlier. "Any chest pain, shortness of breath, lower extremity edema, palpitations?" Nope, nope, nope, and nope. Over the next 20 minutes, we discussed how his heart had this problem. As I had done with others a hundred times before, I tried to reassure him that this was common and had many avenues of treatment, depending on his symptoms. I explained how the biggest risk was going to be stroke and that we could decrease that risk with blood thinners. Lab and echocardiogram were ordered, prescriptions sent, and I moved on to the next patient.

The labs were remarkably normal, as was his echocardiogram. His hemoglobin was slightly decreased, but had been for many years, without any obvious cause found. His rate was now controlled, his blood thinned, and we discussed possibly seeing a cardiologist to talk about cardioversion. He seemed interested, and the referral was made. The cardiologist thought it was reasonable to consider a cardioversion and promised they would get him scheduled "in a month or so." Six weeks later he showed up on my schedule and when I saw him he was barely recognizable. Puffy, with swelling of his legs up to his groin, hands puffy and respiratory rate slightly faster than normal, he complained of an inability to ride his bike. He also found it hard to go up the stairs of their home, having to stop halfway up each time. Crackles could be heard at the base of his chest and his BNP was elevated. His CXR showed cardiomegaly and some bibasilar atelectasis, along with small pleural effusions. A quick call to the cardiologist to remind him of the planned but unscheduled cardioversion, with a recommendation to repeat the echocardiogram. Loop diuretics prompted many visits to the bathroom and the edema improved as did his breathing. Cardioversion followed and he reported some improvement.

The next autumn brought another visit, and things seemed to be OK. No, his breathing wasn't normal, but it was better than it was that spring day that seemed so long ago. We planned to see each other in 6 months, but he wasn't able to stay away that long. Two months later

he was in the emergency room struggling to breathe. His CXR now showed pulmonary edema and looked nothing like it had just a year earlier. More loop diuretics, more trips to the bathroom, and a follow up visit with me. Unable to see him in the 3 days requested by the emergency room, he was seen by my colleague. No, he wasn't better. And now his hemoglobin was 2 g lower. Crackles remained in his chest. Calls to Hematology and Pulmonary followed and both recommended consultation. A CT scan of his chest showed severe bilateral pulmonary fibrosis, and additional lab studies showed marked inflammation, with an ESR over 100. More testing revealed a high titer ANA, followed by specific antibody testing. A Rheumatology referral was made with a suspicion for systemic sclerosis.

And now, at this juncture, he was sitting in front of me. As I looked at him, I noticed the tightness of his facial skin, with furrowed wrinkles around his upper lip. The large telangiectasias on his chest were more noticeable, though I knew for a fact that they had been there for a few years. The crackles in his lungs were less "wet" sounding and certainly not symmetrical. His fingers were stiff and could not fully flex closed. What I had been able to pass off as minor findings or explainable by other causes, were now consistent with the silent disease that had been stalking him for probably several years. We talked some more about what the specialist might discuss with him, that there may be some medications to try, and a hope that he could find some improvement in the months to follow. They left that day, big smiles and showers of gratitude for seeing them and talking things through so they knew what to expect. As they walked out into the waiting room, I retreated to my office, sick to my stomach with the failure that I was.

Epilogue

My car followed the winding driveway to their house. I cautiously got out and went to the front door. Shadows could be seen moving beyond after I rang the doorbell. A look of surprise, followed by disbelief, greeted me. "I can't believe you are here, Sam will be so happy to see you." I saw the snake-like hose curved through the railing to the second floor as we made our way up the stairs. Sam was in his hospital bed, getting cleaned up by the nurse's aide. It had only been a month since we last saw each other, but he looked thinner and weaker. Oxygen flowed into his damaged lungs. I stood over his bed and his eyes locked on to mine. Tears welled up in his eyes as recognition set in. "I can't believe you came to visit. What did I ever do to deserve this." I told him that he was a wonderful human being that deserved everything good in this life but that he didn't deserve what was coming in the days and weeks ahead. We sat together, joined by his brother, for the afternoon, talking about everything and nothing. We talked about the hospice staff and the good work they were doing to keep him comfortable. He lamented the loss of his appetite and the inability to get down to the first floor of their house. The afternoon was drawing to a close and I could see he was getting tired. We said goodbye, hugged, and I told him I would try to see him again soon. As I guided my car down the treacherous drive, the sick feeling in my stomach returned and I hoped that it wasn't the last time we would get the chance to talk.

5. Futility and end of life... How humans value the life?

Ali Elkhedr

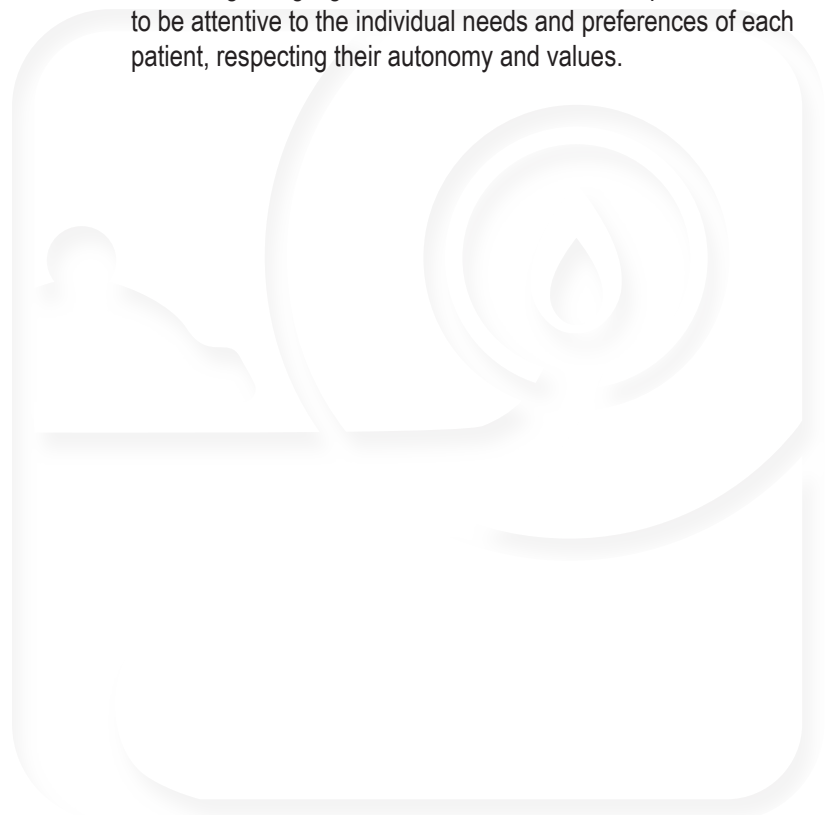
One of the most elusive concepts in medical practice that I have been trying to explore and understand since I started residency is the futility and end-of-life care. I came out of medical school with my mind programmed to think that physicians are required to keep trying until the monitor lines and curves are flat, and all those intensive care alarms are no longer beeping. However, that turned out to be not necessarily an accurate fact! Yes, at some points, it is totally fine to stop trying without feelings of dereliction. What makes it a challenging concept in the early years of practice is the beginner's enthusiasm, similar to what happens in all professions, not only in medicine. Beginners are always excited to apply everything they have learned back in schools and universities, something that usually declines with time until they come to retirement.

The first time I had to consider transitioning a young man to strict comfort-based care was a touching moment that raised several queries in my mind. Transitioning a patient to comfort-based care is a difficult decision that requires careful consideration and empathy. It involves shifting the focus from curative treatments to providing comfort and support to the patient in their final stages of life. In the case of this young man with a fragile heart, it became evident that medical interventions were no longer effective in improving his condition or prolonging his life. The realization of this reality was a profound moment that left me perplexed and deeply moved.

As a healthcare professional, I had been primarily focusing on the physical aspects of the patient's care, monitoring his vital signs, administering medications, and ensuring his comfort. However, during our conversation, the patient expressed his emotional and psychological distress, shedding light on the hidden aspects of his experience. He shared his struggles with the limitations imposed by his condition, his fear of the unknown, and the impact it had on his family. This revelation made me realize the importance of addressing not only the physical symptoms but also the psychological and emotional well-being of patients facing end-of-life care.

It raised questions about the value individuals place on their own lives and the quality of life they desire. It made me reflect on the balance between medical interventions and the preservation of dignity, autonomy, and emotional well-being. In this case, the patient's desire for comfort and the need to alleviate his suffering became paramount. It was a turning point in his care, where the focus shifted from aggressive treatments to providing him with the best possible quality of life in the time he had left. This involved managing his pain, ensuring his comfort, and addressing his emotional needs through open and compassionate communication.

This experience taught me the importance of holistic care, encompassing not only the physical aspects but also the psychological, emotional, and spiritual dimensions of a patient's well-being. It highlighted the need for healthcare professionals to be attentive to the individual needs and preferences of each patient, respecting their autonomy and values.



6. The Technology Fallacy

David Galbis-Reig, M.D., DFASAM

The greater the ignorance the greater the dogmatism

- William Osler: Aequanimitas 'Chauvanism in Medicine' 1914:301

Technological Dogmatism is born out of great ignorance for the consequences of such dogmatism. Healthcare technology is a double-edged sword; the fallacy that only the edge that benefits the patient-doctor relationship has been sharpened is foolhardy, a fact made quite evident by the recent string of cybersecurity attacks on healthcare entities in the United States and around the world. Without appropriate foresight, training, and preparation, healthcare's over-reliance on a digital technology infrastructure, including electronic medical records (EMR), can lead to significant disruptions in clinical care.

As a physician working through an ongoing cybersecurity incident at a large healthcare organization, I am learning first-hand the pitfalls of relying too heavily on digital technology to provide patient care. As a middle-aged physician who began practice in the days prior to widespread adoption of EMR's, I am fortunate to have had the experience of having to rely on the history and physical obtained directly from the patient or family members without being able to review a medical history in an EMR, and on having to write and/or dictate my documentation and orders; but many of my younger colleagues have never had such an experience. Staff and associates at the hospital also have little experience deciphering written orders and documentation, particularly when written in cursive. Staff and providers have also become reliant on digital communication (Epic Chat, etc.) to communicate with each other regarding patient care in place of picking up a phone and having a conversation with a colleague. Because clinic schedules are also stored digitally, disruptions in the digital health care environment may also lead to significant disruptions in ambulatory patient care. Some retail pharmacists have also assumed that a written prescription must be a forgery because they have not seen one in years (or if younger, never seen one at all!), and have refused to fill the prescription. As such, a sudden forced transition from the usual digital healthcare infrastructure to an "old-school" pen and paper infrastructure, has the potential to create significant disruptions in clinical care, inefficiencies, poor communication between healthcare personnel, and missed appointments all leading to a potential increase in medical errors or delayed patient care.

First, and foremost, the over-reliance on the EMR to gather a patient's medical history, review laboratory results and imaging studies, and obtain ancillary staff information cannot be overstated. In medical school, physicians are taught the art of obtaining an adequate medical history and review of systems; including the use of medical records to corroborate such histories. Since the onset, and widespread implementation, of electronic

medical records, healthcare providers have become increasingly, and dare I say oftentimes exclusively, reliant on electronic medical records to obtain such information; so much so, that many providers no longer even ask patients about their medical history or communicate in person with ancillary staff regarding the care of their patients. Patients have also become reliant on EMR's such that they do not now keep track of the medications they are taking and usually refer providers to their electronic medical record. Additionally, staff reliance on electronic medical records with their "type-block" results in staff and associates not being able to decipher handwritten notes or orders (especially cursive). The result of such over-reliance on the EMR system is that when such digital systems are disrupted for a prolonged period of time (days to months in some cases), healthcare teams that do not have the necessary efficiencies to obtain an adequate, or accurate, social and medical history from the patient in front of them in a timely manner, or who cannot communicate effectively with each other because staff members have trouble deciphering the handwritten word on paper and verbal communication is rare, will invariably fail to provide safe and effective patient care.

Clinicians have also become increasingly reliant on digital technology for interprofessional communications, to the detriment of the patients they see. Gone are the days, for example, when physicians would congregate in a physician's lounge and share cases or ask informal questions of colleagues regarding difficult or troubling cases. It is true that digital communication tools can permit more timely and efficient communications but oftentimes such communications do not provide the full breadth of the patient's medical and social history and are limited to very short, typed questions leading to significant presenter bias. In addition, many consult services in hospitals now rely on a digital consult order which results in the patient populating on a provider's digital census to be seen without there ever having been a formal conversation between the physician requesting the consult and the physician performing the consultation. The consultant's sole understanding of the reason for the consultation usually comes from a single word or phrase. When digital infrastructures are disrupted, the ability to access the consult list may be impeded and unless providers are willing (and able) to contact the consulting physicians by phone to request formal consultation, patients will go unseen leading to less-than-optimal care in some situations.

Finally, in the ambulatory care arena, patient clinical schedules now live in a digital environment. When the entire digital infrastructure is taken down, access to the ambulatory schedules is no longer available (both from the physician's side and the patient's side – think My Chart) and appointments may be missed.

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Every missed appointment represents a missed opportunity to continue to develop the physician-patient relationship and improve the health of the patient.

With foresight, training, and preparation, however, much of the above disruption may be mitigated relatively rapidly with the reintroduction of old efficiencies. To begin with, it should be simple enough to create a regularly updated summary “hard copy” of the digital chart that is available off-line. Such a “hard copy” of the digital chart should include, at minimum, the patient’s demographic information and contact information, the patient’s primary care provider and specialty care providers, (including address and phone number), a past medical history, past surgical history, an active problem list, the name of the patient’s preferred pharmacy, current medications, allergies, and any upcoming appointments. Whether such a “hard copy” lives on a different server system as a separate electronic copy, on a patient-specific encrypted USB device that the patient carries with them, or as a paper chart with minimal entries housed securely in the medical records department of the hospital, should be determined proactively before such disruptions occur by the healthcare system. Additionally, providers should practice, and become efficient at, obtaining an adequate patient history without reliance on information in the electronic medical record, using the EMR only to corroborate the information received. Providing clinicians with an off-line method to access a summary of the patient’s medical history will go a long way in improving the healthcare information gathering challenges that digital infrastructure disruptions can cause and improve the confidence that clinicians have in their ability to obtain an adequate healthcare history (something that is especially important when the patient is not able to provide any history themselves).

As for the challenges posed by having to decipher the written word, it is important to recognize that cursive is no longer universally taught and should not be utilized for communication in the medical record. Clinicians must be mindful that they are writing their orders and notes for others to read and must do their best to print as legibly as they can. While printed handwriting does not guarantee that an order or note will be legible, it improves the probability that it will be able to be deciphered.

While it may be true that most clinicians are no longer likely to utilize a clinician lounge for various reasons, the availability of such lounges can provide clinicians with a way to meet, discuss cases, and learn about advances in other specialty fields directly from other colleagues. It is worth noting that such lounges do not have to be outlandish but rather provide a gathering space for clinicians away from patients and staff to be able to gather, regroup, and develop collegiality. It is also imperative that clinicians reacquaint themselves with the importance of verbal communication between providers regarding reasons for consultation. Provider to provider communication regarding questions and/or concerns is the cornerstone of medicine and fosters teamwork and collegiality.

In closing, it is imperative to understand that healthcare is a team undertaking with multiple different stakeholders at multiple different levels that requires integrated communication. When the team functions efficiently, even during very disruptive digital infrastructure events, new processes and efficiencies will develop rapidly within the healthcare team to ensure that patients are cared for. It is imperative to remember that technology is only a tool, no different than a calculator, and that over reliance on the tool to the exception of our own human ingenuity and skills can lead to unintended consequences.

7. No One Told Me I Was Dying*

Nick Gallo, MD

No one told John he was dying.

Before I met John, he had already survived lung cancer twice. He was first diagnosed after a lesion was identified on a screening CT scan. This was treated with partial resection of his right lung. Rehab was challenging, but he persevered, returning home to a full, independent life where he worked full time and enjoyed his wife and family.

Two years later surveillance imaging discovered a new spot on his left lung. A biopsy confirmed this was cancer, different from his first pathologically, a second primary lung cancer. Truly bad luck and the effect of smoking for fifty years. He pushed forward with both chemotherapy and radiation resulting in remission. After the second battle with cancer, life became more difficult for John.

Radiation helped kill the cancer but also damaged healthy lung tissue. During the course of his treatment, a pulmonary embolism, recurrent episodes of heart failure, infections, and escalating pulmonary arterial pressures continued to stress his poor lungs. They became reliant on continuous oxygen for support. He spent most of his waking hours in hospitals, rehab centers, and medical offices, leaving little time for home and family. Uncomfortable hospital beds, white coats, needle pokes, and oxygen tanks became very familiar to John. Life became more about what his lungs needed, and less about what John needed. He gradually declined and his independent life once filled with work, friends, and family became a distant memory.

I was a second-year internal medicine resident when I met John in the Emergency Department. He was being admitted for a recurrent episode of undifferentiated hypoxemia. I could tell that he and his wife were scared. When I looked into John's eyes, I could see they were hungry for air. His wife's eyes expressed concern fluctuating between John, his oxygen saturation, and me.

"Hey John, I'm Doctor G. I'm one of the residents and I'll be admitting you to the hospital. I heard you've been short of breath." He nodded in agreement. "Who's here with you today?"

"Hey doc." He replied followed by a three second pause to catch his breath. "This is my wife."

"It's nice to meet both of you. I'm sorry it's under these circumstances, but I promise we will take really good care of you while you're here." After asking John and his wife to tell me about his medical history and recent symptoms, I followed with, "John what are you most worried about?"

"I'm really worried I won't be able to find more air." Short pause. "I'm worried one day this is not going to get better." John seemed

to recognize there would be a time when medicine could not offer a solution to his problem. I wondered if anyone had discussed this with him. Without knowing it, he had opened a door to discuss end of life.

"You've been through a lot John. What have other doctors and specialist told you about your lung disease?"

"They told me I shouldn't have smoked for all those years. That I have bad lungs from all that smoking... and the two cancers."

I could tell our conversation was tiring him out. His abdomen moved paradoxically during inspiration and his neck muscles tugged with all their might to support a deconditioned diaphragm. He must have felt like a broken record repeating his story over and over again with each new medical encounter, but I had a few more important questions for John, so I pushed on. "It sounds like you've been told your lung disease is pretty severe. And I've read your medical history, so I know it's been a rough go over the past few years. Has anyone talked with you about how much time you might have left?"

I could sense the mood shift in the room. Fear and anxiety turned first to surprise, then contemplation. Pausing for air between sentences he replied, "I haven't thought about time. I know I will die from my lungs, but I've survived cancer twice. I figure I have a few more years in me."

I knew it was time for me to wrap things up when respiratory therapy arrived to set up BiPAP. I was hopeful it would relieve his work of breathing, but it would be nearly impossible to have a meaningful conversation with him through the beeping and roaring of the positive pressure machine once it was started. "I don't know how much time you have left John, but it may be shorter than you think. I'm worried your lungs are getting worse." A short pause, this time for me to catch my breath, "I'm worried you are dying."

It seemed like an hour passed before he replied. This time, the pause was not to catch his breath. He looked over at his wife. "No one told me I was dying. If I don't have much time left, I don't want to spend what's left in the hospital. I want to go home." There was no trace of denial or anger. In his heart of hearts, he knew what I said to be true.

"I hear you John." In silence his wife took his left hand. I offered mine, and he held it tight. Not a handshake but an embrace.

With permission from John, I invited the palliative medicine team to meet with him the day after his admission. They helped us to continue exploring John's goals and offer ideas to improve his

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symptoms. We shifted focus from treating lung disease, back taking care of John and his symptoms. At discharge he decided to go home with more support provided through hospice. John spent his remaining months at home with family. The clinic visits, lab draws, bouts of testing, and long commutes to and from the hospital were replaced by familiar visiting nurses, a skinnied down medication list focused on his comfort, and supportive home health services. Small doses of oral morphine relieved his air hunger and knowing it was available alleviated the associated

anxiety. He was treated for pneumonia and a COPD exacerbation at home with a short course of antibiotics and steroids when he developed symptoms, saving a trip to the emergency department and the inevitable admission that would have followed. John never returned to a hospital. He died at home four months after enrolling with hospice.

I told John that he was dying. I hated telling John that he was dying. But I'm glad I did.



8. Hospital Privileges

Julia Kyle, MD, FAAP



**JUDGED
WINNER**

I discharged the last patient.

It's been over a month, and I still can't say that sentence without tears welling up in my eyes and sorrow in my heart. In all my years of training and experience, nothing prepared me for the pain that came with that duty. It was a healthy newborn; a discharge that is usually routine and joyous. Instead, my obstetrical colleague and I put off our discharges as long as we could that morning, knowing this was it. We had the last inpatients in this hospital which had stood so strong, the tallest building in the city, an institution that had served the community for over 130 years.

We were the last inpatient unit to close, since finding somewhere to deliver over 800 babies a year safely is not an achievable task with just 2 months' warning. We embraced and cried in the room, not caring that this young family could see our obvious grief at the loss of a unit we had worked so hard over so many meetings and blueprints to redesign to better serve our patients. Could feel the connection we had with this sacred space, where so many similar families had joyfully grown. Could witness our shared memories of stressful situations inherent to childbirth; the hours we put into training and building our team to be ready for every emergency in both mom and baby. The practiced teamwork that led to the miracle of those first lusty cries. The fast dashes to emergent c-sections, and the rapid, well-rehearsed and orchestrated deliveries.

In 1889, when the Hospital Sisters of St. Francis extended their mission to Eau Claire and started their first humble hospital, did they dream their mission would grow to support a hospital that was the backbone of the community? A beacon standing proudly to welcome all those in need of care with state-of-the-art technology and science, with staff at every level, in every department, who never lost sight of the love and compassion at the heart of the Sisters' mission.

In his 40+ years as Chaplain, our resident saint, Father Edmund Klimek, set the tone of dignity and respect for all, at all stages of life, and especially for caring presence at the end of life. Thankfully, his ministry lived on after his passing through the staff who had the privilege to learn from him. After the initial shock of the announcement of the rapid and unexpected closing wore off, pictures of him popped up throughout the hospital. Every employee at every level, all of whom were losing their jobs and livelihood, first expressed concern for the patients and where they would receive care.

I had the privilege of practicing inpatient internal medicine and pediatrics at Sacred Heart for nearly 25 years. Hospital privileges don't always feel like a privilege. The hours are long and unpredictable. You never know what situations you'll be called into. You see humanity at its best, and sometimes at its worst. Through it all, you are a part of something so much bigger than yourself. You have the privilege of serving your community with the skills you have worked so hard and for so many years to obtain and fine tune.

As physicians, slowly and steadily we are acclimated to how little we control the care of our patients in our current health care system. Insurance coverage, or lack thereof, determines who our patients can see, what imaging they can have, what medications we can treat them with, what services they can access. Yet we are still responsible, and duty bound, to provide the best possible care for our patients.

We are suffering an epidemic of burnout. Loss of autonomy and all the factors outside of physician control are repeatedly found to be the main driver of physician moral injury. We spend countless hours and thousands of dollars keeping up our knowledge and skills, jumping through all the hoops to maintain our board certifications and credentials for the same insurance companies and institutions who restrict the care we deliver. We are the messengers, the ones who face to face in the exam room must explain to patients what ideal care would be, then what we can actually offer them. We jump through all the hoops for prior authorizations, drug discounts, difficult out of network specialty referrals. We add hours to our day to try to deliver the best care we can.

Even knowing this and having had to accept for years being a pawn in order to practice the profession I love, it is still so hard to comprehend how a hospital system can make a decision hundreds of miles away from the affected community to pull the tall and mighty tree out, roots and all, making it nearly impossible for us to care for patients. More than 1400 highly skilled workers suddenly unemployed. Suddenly trying to find somewhere for our babies to be born, our patients to be cared for in emergencies, acute mental health needs safely addressed, imaging, lab, pathology, chemotherapy, radiation therapy, detox, rehab, dialysis, birth to three services; the list goes on and on.

I am left with extreme sadness at being forced to use my hospital privileges in a way I never dreamed I would.

I discharged the last patient.

9. Still Teaching

Geoffrey C. Lamb, MD, FACP

HONORABLE MENTION

ACP Wisconsin
American College of Physicians Chapter
Leading Internal Medicine. Improving Lives.

ESSAY: ATTENDING

It is a sunny afternoon in late April. I am heading back to the hospital from the Medical School and I find myself reflecting on the lecture I just left and the case that inspired it. It was a case based presentation on acid-base that I have been giving for over 20 years to the graduating seniors as part of a course preparing them for internship. The first case in that lecture sets the stage for the rest of the discussion on the importance of understanding acid-base and how to approach a patient with the disorder. And it is that case that dominates my reflections as I am walking.

My memory rewinds nearly 40 years to when I was a junior resident. I was 'moonlighting' in a local emergency room. It was not a very busy place and often an easy way to earn some extra pocket money. It was midway through the evening when I received a call from one of the general internists on staff. "I have a patient with severe COPD upstairs who is complaining of increasing shortness of breath. I've ordered a blood gas. Can you take a look at it when it comes back? I'll have the nurse call you with the results." I reflected on what I might expect to see – worsening hypoxia with relative hyperventilation, or worse a rising CO₂ suggestive of respiratory failure. The call with the blood gas came back a few minutes later: pH 7.27, PCO₂ 28, PO₂ 52, HCO₃ 14 O₂ sat 92%. A metabolic acidosis was not exactly what I was expecting. I dashed upstairs to the patient's bedside. I found an elderly man in distress, crying out because his legs were hurting. As I pulled back the bedsheets I could see that he was mottled and had purplish discoloration from the waist down. The legs were cool and pulses not palpable. I called his primary doctor who came in immediately and we were able to image him emergently. It was a dissecting aortic aneurysm. The patient elected not to have surgery. We did our best to keep him comfortable through the night and he passed away early in the morning.

In the discussion with the medical students I refer to him as 'AA'. I walk them through the case as I experienced it. What do you expect to see on the ABG's? These are the numbers that came back. What is the acid base disorder? What is your differential diagnosis? What is your next act? The students are usually quick to answer the first 3 questions correctly. On the fourth they most often request more lab work, typically electrolytes for an anion gap. However there is usually at least one student who comes up with the answer I am looking for – this was not what was expected. Go see the patient.

In this way AA has helped to teach nearly 5000 students. On that fateful night so many years ago, neither one of us had any sense of the contribution he would make on a generation of medical students. One of the great beauties of Medicine is that every patient and every encounter can be a learning experience that is in some way passed down and enriches the next generation. I do not know AA's real name or much else about him but I am forever in his debt. I hope that someday, somehow he can appreciate the impact he has had on so many.



10. Integration of the Head and Heart in a Medical Career

Brett Linzer, MD, FACP, FAAP

Thirty years ago I entered Loyola Medical School and my initiation into the culture of medicine began. As best as I could at the time, I prepared myself for the challenges ahead. I aimed to cultivate a strong will, powerful intellect and what I hoped would be enough emotional maturity to succeed. I did not have any family connection to medicine but I knew our society had certain expectations of me in my role as a medical professional. What I did not know is that during my training I would have to develop a persona to hide my inner sense of insecurity and sensitivity.

This persona was like a mask that enabled me to project a sense of confidence, knowledge, and strength to the people around me. It also allowed me to elevate myself and hide the deep sense of inner shame I carried within me. In this culture of medicine, which emphasizes head-based energies and focuses on competition, rationality, and science, my intellect would become master and my heart-based energies of empathy, compassion, connection, and acceptance had to be adapted and concealed. To conform to the norms of medical training, I felt compelled to suppress my heart-based energies and focus my attention on the development of my mind.

This learning was driven home forcefully one day on my third year rotation on General Surgery. I was taking care of a man in his fifties with pancreatic cancer who needed extensive abdominal surgery. I was the first to see him every morning and sometimes our conversation turned to his family. He had a wife and two teenage daughters and was concerned about the effect of his illness on them. One morning, on rounds with the surgical team, I expressed genuine sadness and grief that I was holding for this patient and his family. The senior resident stopped rounds and humiliated me in front of everyone, stating clearly, "We are technicians. We do not allow feelings and emotions to compromise our solid judgment. Your feelings do not belong here. What will make you a good physician is your strong intellect, confidence, power, sacrifice, and hard work."

I struggled with what that resident said and did to me. I questioned the validity of his words. That experience left an emotional scar of shame and isolation that I still tend to 27 years later. I desperately wanted to be a physician and conform to the customs and values of the successful physicians I aspired to be like. It was difficult for me to abandon my heart-based energies of emotions and feelings and so I developed adaptive patterns of behavior to succeed. I tightened the mask and put on another layer of armor around my heart and I settled uncomfortably into my persona of competence and self-assurance.

Reflecting on my life, from an early age of four or five years old, I had been practicing similar adaptive behaviors. In my childhood environment of fear and uncertainty, strong emotions were not

allowed and vulnerability was shunned. In the chaotic environment of not belonging, I developed a strong, independent spirit and took responsibility for myself and others around me. External achievement and competition was rewarded and encouraged. These behavior patterns enabled me to conform to my family system and proved useful in conforming to the rigors of the medical system.

Unfortunately, three of my friends seemingly couldn't navigate the complexities of the medical culture and chose to end their lives. One of them was my chief resident. His death was especially difficult for me because I saw him as a mentor and a type of physician that I aspired to be. He had a strong mind and elevated status. I imagined that he had all the answers, but he still took his own life. Now where would I look for answers, for a role model to follow?

In time it became difficult for me to differentiate what was me and what was my persona. A deep inner tension began to develop and I realized I was putting my relationships and possibly even more at risk. These adaptive patterns were interfering with my personal and professional relationships and made it difficult to fully connect with my wife, three kids, patients, coworkers, and even myself. People I was in relationship with did not want me to show up with a mask and a persona that protected me from intimacy, connection, acceptance and love.

In 2013, I reached an especially challenging point. I was so focused on my mind and solving problems that I almost had to break my heart in order to know I had one. I remember an especially chilling moment one night when I was sitting alone in my three season room catching up on Epic documentation. For months, I suffered in my attempt to solve my relational problems with my mind-my thoughts, my reason. That night, my attention turned to my three friends who took their lives.ing to solve deep relational problems with their minds, just as I was doing? I could not come up with an answer, and that scared me.

With the help of my wife, I reached out for help and I started working with a physician coach. He helped me to understand my adaptive patterns of behavior and normalized them in the context of the culture of medicine. I was not alone and I did not have an irreparable flaw. He helped me reconnect with my natural feelings of compassion and empathy, especially toward myself. This relationship sparked a decade long journey of self-discovery, revealing the many layers of my personality, and deepening my awareness of the fundamental components of building and maintaining meaningful relationships.

I now know the truth that being a good doctor means to be skilled intellectually and also skilled relationally and emotionally. I hope that my son and his colleagues, who are starting their first year at the Medical College of Wisconsin, can help to reshape the culture of medicine by learning early in their careers how to integrate their head with their heart.

11. Stopping

Amalia Lyons, MD, FACP

During my residency, I often remember the sense of running. Quickly moving between patient rooms on the wards, my long strides quickening to find the nurse that just came out of a room, and putting in my 10,000 steps just to place orders. (As an aside, orders were on paper back in my day and one had to go from ward to ward writing orders.) My mind was also always running: formulating plans and to do list for my patients, trying to retrieve information in the recesses of my brain to answer the pinging question from my attending, and telling my bladder to hold on for a bit longer, apologizing for drinking yet another cup of coffee.

The MICU. For some, the mere phrase may induce anxiety, fear, stress. For me, it was my ultimate race. While my future self chose primary care as a field, during residency, I loved the ICU for its fast pace. The vents, pressors, IV poles, feed tubes.....so medically fascinating. I was addicted to the speed of it all. Of all places, it was the MICU where I learned to stop running.

As a PGY 3, I had done ICU rotations before. I knew the race and it was comfortable. One day, I was covering my colleagues' patients while they were enjoying a day off. One of their patients was sick—sick by ICU standards. On life support, 3 pressors, two IV poles full of bags pumping the patient with fluid, antibiotics, and electrolytes, the patient had been in ICU for a few weeks and was not showing any improvement. On that day, the blood pressure kept dropping. There was no pupil reaction on my exam. The morning rounds went as I anticipated; we were going to meet with the family and discuss withdrawing life support. The meeting went well, also relatively quick as the family had been expecting this outcome. After the family said their goodbyes, two sisters asked if they could stay while the nurse and I withdrew life support.

This was not the first time I had withdrawn life support nor had the family present. Before I gave the first order, the sisters asked if they could pray. I didn't see any harm so said yes. What they did next changed my perspective. Each sister placed a hand on my shoulder and started praying. I initially was startled, not sure what to think. The nurse looked at me and I at her. Some part of my mind said the first order. Then we waited.

The sisters' hands weighed down on me, holding me in place. It was in that place, I stopped running. There were no more thoughts of my to do list, my next admission, my bladder. There were no thoughts of the medicine or machines or even which order came next. It was within this intimate scene, when I first saw the person, the person I had only thought of as a patient until this point, that I stopped. While my memory is forever engrained with this picture, it is hard to bring the words adequately describing the scene. My eyes only saw the person on the hospital bed, who looked so peaceful and yet fake with all the machines attached to them and no visible life. The nurse was close by. I only heard the sisters praying, quietly and with their proximity, clearly. The beeps of the ICU were lost in their loud whisper. I only felt the sisters' hands on my shoulders, the pressure reinforcing my stillness and connecting me to them and the person in the hospital bed. I remember feeling guilt, doubt, and failure as I felt like I was killing this person in front of their loving family and also belonging, acceptance, and reassurance as it was the sisters' voices, presence, and touch that told me it was okay, all was as it should be.

When the telemetry flat lined, I went to the person in the hospital bed, held their hand while I did the death exam. This person, whose name I do not recall and no fake name would do justice, I knew so little about taught me everything. After the sisters hugged and thanked me, I promptly found a remote hallway and cried.

I often think about this person and their family. While I fall victim to re-entering the race, more frequently than I like, I am reminded by this intimate scene to stop and see the person in front of me.

12. Chess in Medicine

Giridhar Murali

The perspective of a medical student into the implications that chess has had in my patient interactions:

The tapping jazz of clocks accompanies silence. My opponent sits across from me, with only the chess board between us. Eight years ago, marked a memorable accomplishment. Ever since I was four, I had been learning the art of playing chess. But what was special about this match wasn't my ability to see hours of dedication culminate into a win. What made it special was my opponent, "Henry." This was the first time I faced a new challenge, for "Henry" was blind.

Before our game, he assembled an exquisite chess set with braille pieces. In the beginning, I felt uncertain about this game. After all, how could someone play without sight? But throughout the match, what amazed me was how Henry did not let this disability deter him. He would play the moves on his board, voice record movements, and I would play both our moves on a separate board. Playing with "Henry" presented me with a challenge, not in the physical sense, but through my mental beliefs. He showed me the importance of the innate value in accepting diversity.

This was my first experience at truly seeing the art of chess. Finally, as "Henry's" king toppled, I began to really question the

purpose of chess. "Henry" did not play to win; he played to enjoy the game. "Henry's" life paralleled to a game of chess: his loss in sight meant he had to deal with challenges similar to how each game contributed to over 10^{120} unique situations. This experience made me put "Henry's" interest in the game above my interest in simply winning. It motivated me to become an advocate for equal representation by my efforts to organize small chess tournaments for children regardless of ability. Chess is more than a game. Like medicine, it heals, wielding patience, understanding, and commitment.

As a second-year medical student, these are skills that I use every single day in the wards and in the classroom. Just like no two chess games are the same, so is every patient encounter I have had as well. Rather than just solving patient cases, medicine for me has been about developing rapport with my patients and building lasting relationships, both on and off the board. My career in medicine may just be beginning, but just like any good chess game, a crucial opening is essential to a successful middle and end game. Just as two pawns may sometimes swap positions (known as en passant), I know "Henry" and I certainly will end up crossing paths again one day, whether that may be at another tournament or in the clinic. A game of chess or life for that matter truly does come full circle.



13. Silver

Alex Nelson

Prosopagnosia (from Greek *prósōpon*, meaning “face”, and *agnōsía*, meaning “non-knowledge”), also known as face blindness.

A disheveled Post-it note titled “W” clung to the scaly lever with a piece of duct tape. Juxtaposed was a metal coin, lashed to the bar with chicken wire, reading “22”. W-22, W-22, W-22, I reiterated as I cross-referenced the cork board with which a half-dozen pieces of paper were stabbed. Lifelessly dangling from the bottom, “93 YO, FEMALE, COPD EXACERBATION, SMOKING HX, HOMEMAKER”.

An air of propriety – stainless steel tanks, bright lights of an operating theater, chipper anatomists – wafts away the stench of rotting human dignity – my pervasive, yet misguided, experience of invalidity when cutting up a dead person as a 22-year-old. The silent dichotomy of medical training is deafening – one day, you are struggling with the Basic Life Support (BLS) mannequins, alarms blaring as you struggle to hit the automated depth presets on your compressions. *One, two, three, four. Ah, ha, ha, ha, stayin’ alive, stayin’ alive.* It could not seem more artificial. The next day, the polarity reversed. The mannequins you pretend are real; the cadavers you pretend are fake, or, at least, you try.

Your mind’s eye, a looking-glass self, implodes as soon as the tank opens and the human form, draped in what presents as a cheesecloth, rises from a post-mortem amnion, one half at a time. Each rusty lever, chained in place, yanks this woman from her rest. Sensitization. *Snap.* You experience everything, everywhere, all at once.

‘Cutting’ is wrong. That first, unforgettable incision – running from the jugular notch to the xyphoid process – I watched as the skin and underlying fat unzipped from the cold, barrel chest of this 93-year-old woman. Who was I to view this forbidden sinew? Who was I to violate society’s most fundamental taboos? Who was this woman before she met my blade? How did she talk? What did she enjoy? Who did she love? Who loved her? Who am I? An integral member of her story, now.

The scalpel was sharp, really sharp. The hunters in the room reconcile the emotional sequelae with levity, drawing macabre parallels to their first field dressing and conflate the ‘silver’ of a white-tailed deer with the deep, investing fascia of the hairless biped laying before them. Coaching the blade through viscera, I was careful not to damage the sheen of the endogenous wrapping paper lurking below. Trepidation bled into tenacity as incisions became tears and as my emotional presence wavered between sensitization and habituation. The sight of webbed sinew, tugged at by my tankmate, the future of vascular surgery – and the sounds of shearing connective tissue weaved within Taco Tuesday plans – dulled to ambience as my monologue instructed, “Remove the subcutaneous fat, and preserve the investing fascia. If you see pink muscle, you’ve gone too far. Preserve the fascia. Preserve the fascia.” Rhythm, time immaterial, three hours elope: slice, rip, scrape – slice, rip, scrape, examine – slice, rip, scrape.

I sat on the 80 – the free, intra-campus bus line – rotting in my seat as the diesel creature lurched from stop to stop, inching its way from the laboratory dungeon to the medical school Parthenon. My internal monologue resumes as I disassociate, staring blankly at the handgrip rocking back and forth with each turn. *I should really review lymphatic drainage before Thursday’s exam. Did I identify the saphenous? What about the inguinal nodes? What were the important thoracic dermatomes? I’m tired and, oddly, hungry.*

I strip and sit on the corner of my bed. Taking off my tan, round-framed glasses, like any other day, I began to clean the lenses. Pinching the glass, I rotated my fingers, adding solution periodically and, took inventory of the day. Gazing into the frames – to think of what lay dormant within those thin panes of glass – a small, yellow glob of subcutaneous fat caught my eye as it desperately clung to the edge.

Physicians constellate a memory of their patients, which they carry into every clinical encounter, shaping a lens that informs decisions and humanizes the practice. She was my first. I am forever grateful for you, W-22.

14. I WANT TO BE LIKE YOU

Samyam Bickram Pathak, MBBS

PEOPLE'S CHOICE WINNER

ACP Wisconsin Chapter
American College of Physicians
Leading Internal Medicine, Improving Lives

ESSAY: MEDICAL STUDENT

“What do you want to be when you grow up?” It is a common question we ask every child we meet. Varieties of answers are given, and we enjoy hearing them. However, one child’s answer during my elective in pediatrics at a hospital in Wisconsin made me think deeply. I was on shift since seven in the morning, busy learning the case notes of patients and preparing my case presentation, when a phone call from the emergency room came. They reported an 8-year-old girl with Acute Lymphoblastic Leukemia (ALL) who had come in with sudden shortness of breath, fever, and wheezing. She had to be admitted after emergency management.

I rushed to see the patient for a thorough history and examination. I have seen many patients during my career, but only a few have touched my life deeply. This 8-year-old girl with ALL is one of them. When I met her in the emergency room, she was on 7 liters of oxygen with a face mask, and her chest X-ray showed bilateral middle lobe consolidation suggestive of pneumonia. Her mother was crying, but I had to take her history. I felt guilty when I learned she had been undergoing treatment for leukemia for the past three years, and the doctors had already mentioned that she had only one year to live. This broke me inside, but I couldn’t show my emotions in front of my patient.

Nevertheless, she was admitted, and I gathered the courage to take care of her even when I was not on shift. I did not sleep that night, as I felt so attached after learning her history. As days passed, she started recovering from her illness. She was no longer on oxygen therapy, and her pneumonia resolved with antibiotics and intravenous fluids. On her fifth day of admission, I began interacting with her more.

During rounds, I felt proud of myself for taking good care of this child.

The day came when she was about to be discharged. Taking some time, I asked her, “What do you want to be when you grow up?” Her answer profoundly impacted me: “I want to be like you—a perfect doctor who creates hope in other people’s lives.” I just smiled and couldn’t even say thank you. Later, when I came to the room, I asked myself, “Am I a perfect doctor?” I couldn’t believe that unknowingly, I had been an inspiration to someone’s life, both as a doctor and as a human.

For the first time, I realized the importance of being a doctor. I still remember my medical school days, studying hard day and night to get good grades and pass exams. I didn’t realize then that those days were not only for exam preparation but also for preparing to inspire patients when given the responsibility to save their lives. I realized the beauty of the medical profession and how respectful it is. I am really thankful to my parents, who helped me pursue a path in the medical field. I believe that doctors are not only caregivers but also influencers who can bring positive changes to someone’s life.

Receiving that answer from the 8-year-old girl changed me. It made me want to work harder, respect my profession more, and fully dedicate myself to my patients’ treatment. I wish I could bring a permanent cure to her Acute Lymphoblastic Leukemia so she could lead a fulfilling life and become a doctor someday. But I feel pity that I haven’t found that magic yet.

Lastly, I feel blessed to be part of the medical profession, and I will always embrace it to bring meaningful changes to someone’s life. I believe that one day I will succeed in finding a permanent cure for Acute Lymphoblastic Leukemia by becoming a capable oncologist. Before closing my story, I would also encourage medical aspirants to pursue a career in the medical field if they truly desire it, as this noble profession will help them realize their importance and its beauty someday in the future.”

15. Return to clinic

Bharat Raman, MD

"It was not how he intended to spend his "golden years".

He had been looking forward to spending time at his lake cabin. Fishing from his boat in the lake, gently rocked by the waves and lulled by the muted sounds of nature around him. Sunlight filtering through the foliage, with the blue sky beyond.

Yes, this was rhythm and blues, he thought, of those serene days. Instead, he now faced an uncertain future having been diagnosed with metastatic cancer. He would now spend his time in the sterile settings of the nearby medical center under the harsh glare of fluorescent lights, with the occasional hum of machines and hushed voices of hospital staff. He would receive radiation followed by chemotherapy. He was made aware at the outset that his cancer was not curable. Progression would eventually occur. The relentless march of the tumor could, however, be slowed. How long? It was hard to say. His team of doctors had reviewed the literature and statistics with him.

Based on available data, there was significant variability in recurrence rates and survival, but eventually, all individuals did succumb to the cancer. Decisions were shared, between his treatment team and him. He was hopeful the treatment would give him more time to sort out some of his affairs. Say some last goodbyes. He was familiar with hope. It has helped him at various times throughout his life. It had served him well as he served his country. He had been drafted into the military at the height of the Vietnam War. One of the thousands of young men and women at the cusp of adulthood, thrust into world events many found hard to understand. Through his tours of duty in Vietnam, hope was sometimes all he had to help him get through from one day

to the next. During those tortured times he came to realize that hope was the difference between life and death. Hopelessness was akin to a death sentence. He had made it through that war and its aftermath and attributed this in no small measure to not losing hope. While the future was unknown and unexpected, and amid all the death and destruction, he had hoped for some future good. The good had eventually happened to him. For one he had survived the war unlike many of his comrades, whose hopes were shut in flag-draped coffins like Pandora's box. He had gone back to college on the GI bill, graduated with honors, married, raised a family with his wife, had a successful career, and eventually retired. He thought it was interesting how you can compress the years when your future is uncertain. His life following retirement was tranquil. He traveled with his wife, spent time in his wood shop, and started and shelved projects as only a retiree with no agenda might do. His life then was good and hopeful. He had not lost hope when his wife took ill. Her declining health over several years and eventual passing from complications of dementia had made him more resilient to adversity. He had created routines that helped him cope as he saw his wife's life fade away just as her memory had. Slow, relentless and merciless until the very end. Faced with his illness he realized he would need different routines built around his treatment and medical appointments. While navigating the unknown following the diagnosis of cancer, he realized from past experiences that having some predictability in life helped. He was at some level still a military man and knew the benefit of routines. He felt his clinic appointments were helpful in this regard. It gave him hope every time he scheduled a return to clinic appointment. The return visits an unofficial timeline of his remaining life until he was a no-show."

16. Beneath the Surface

Mukul Sharda

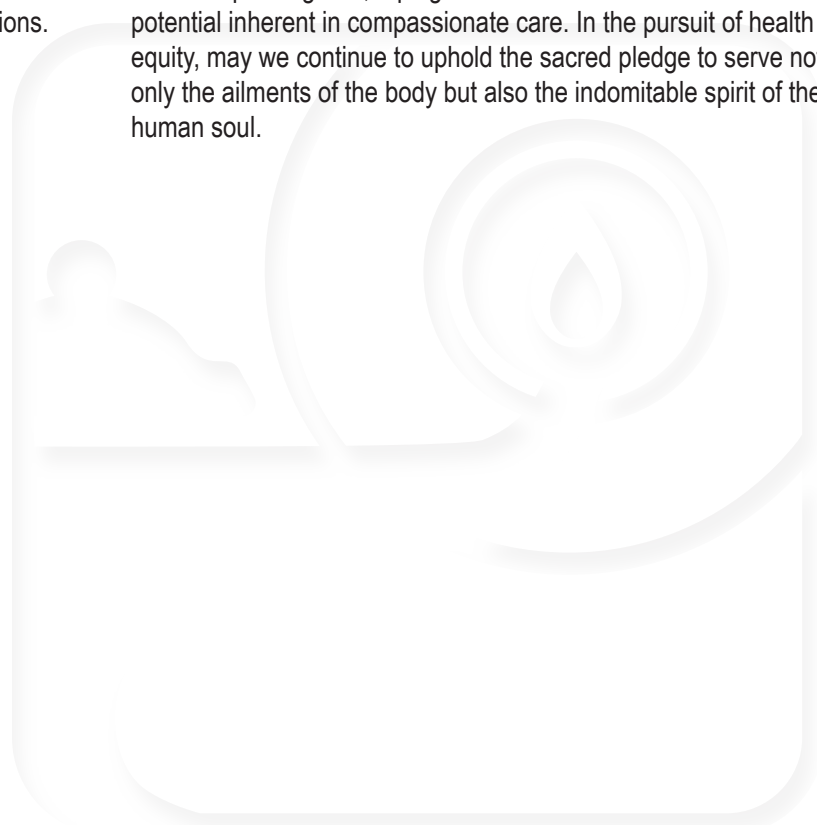
"Workers' compensation? I don't even get paid the minimum wage. And I can't do anything about it because I'm undocumented." These words, spoken by "Jose," a hardworking construction worker, epitomized the struggles faced by many in our community. Before starting medical school, I volunteered as an interpreter and scribe at a student-run free clinic. Jose arrived at our clinic, his face contorted in pain, with a long splinter embedded in his arm. The severity of his condition was clear, and swift medical intervention was necessary.

After completing the patient intake, I joined a medical student and a seasoned physician preceptor to examine Jose's arm. The diagnosis was grim: surgery was imperative to alleviate his suffering and prevent further complications. However, the mention of surgery triggered a wave of distress in Jose. His furrowed brows and tense demeanor betrayed his anguish as he expressed his inability to afford such a procedure. With empathy and determination, the medical student explained the possibility of workers' compensation covering his medical expenses. Jose nodded in agreement. After the encounter, I returned to the room with the discharge papers and instructions for workers' compensation. Avoiding eye contact, Jose remained visibly unsettled as I spoke. Sensing his lingering unease, I asked if something was wrong. Initially hesitant, he gradually began to open up as I reiterated our unwavering support and commitment to his holistic care. In a voice tinged with trepidation, he disclosed his undocumented status and the exploitative conditions of his employment, devoid of even the most basic labor protections.

In that pivotal moment, the enormity of Jose's vulnerability struck a chord within me. Yet, it also highlighted the resilience and dignity inherent in his spirit – a resilience mirrored in the fabric of our community. With a sense of duty and solidarity, I shared Jose's story with my colleagues, galvanizing a collective response rooted in advocacy and compassion. Fortunately, our preceptor's seasoned expertise and our clinic's comprehensive resources enabled us to navigate this complex situation. We swiftly mobilized a multifaceted plan, encompassing both medical intervention and legal advocacy. Referrals to specialized surgical care and legal aid services were seamlessly arranged, offering Jose a glimmer of hope amidst his darkest hours.

Reflecting on this transformative encounter, I am reminded of the profound privilege and responsibility inherent in our roles as healthcare providers. Beyond the realm of medical expertise lies a deeper imperative – to cultivate spaces of trust, dignity, and inclusivity, where patients like Jose feel seen, heard, and empowered. In the tapestry of healthcare, every individual narrative weaves a unique thread, each imbued with its own complexities and challenges. Yet, through these interconnected stories, we glean the true essence of healing – a process that transcends mere physical restoration to encompass the restoration of dignity, agency, and hope.

As I departed from the clinic that day, the memory of Jose's resilient spirit lingered, a poignant reminder of the transformative potential inherent in compassionate care. In the pursuit of health equity, may we continue to uphold the sacred pledge to serve not only the ailments of the body but also the indomitable spirit of the human soul.



17. Why Do Physicians Write?

Julia Usatinsky MD, FACP

I saw how men died. I saw how they bore pain. I saw what hope looked like, fear and relief...

Somerset Maugham

I write.

I write fiction in my mother tongue. But occasionally, I venture into the realm of my language-in-law, English, the one I acquired and fell in love with as an adult, along with my newly acquired and equally beloved home country.

In the hierarchy of my life priorities, writing begrudgingly shares space with my profession: that of an internal medicine physician. The former brings joy, fulfillment, occasional heartache, and a small but loyal band of readers. The latter brings occasional joy and fulfillment, plenty of heartache, and a number of clients bigger than I can handle. And, unlike writing, it puts food on the table.

I've always been an avid reader. As a child, I swallowed books whole. As a medical student – long before I seriously tried my own hand in writing – I came to realize how many of my favorite writers were physicians. Doctors Chekhov, Bulgakov, and Aksenov - my famous compatriots - were literary giants, as were Arthur Conan Doyle and Somerset Maugham. Celebrated medieval writers, Rabelais and Maimonides, were physicians. Later I discovered such amazing authors as Michael Crichton, Abraham Verghese, and Khaled Hosseini - all doctors.

Some of them continued to practice medicine throughout their lives. Chekhov's fans were known for posing as patients in an attempt to get his autograph on a prescription pad. I can just imagine modern-day Chekhov denying an antibiotic to a disappointed patient with a URI, thus denying them a coveted signature. Others left medicine to pursue literary careers, as did Maugham, whose first book became a bestseller while he was still a medical student. Some stayed passionate about the medical profession - Conan Doyle called it a "privilege", while others – like Hosseini – admitted that medicine was just an accidental detour. With time, I discovered that many of my colleagues beyond the famous few write for pleasure - the ACP Narrative competition is a testament to that fact. And I started to wonder: Why do physicians write? Why do we want to express ourselves in prose or poetry?

As doctors, we meet people from all walks of life. We are touched by new human fates daily. I sometimes believe that I have enough material for a novel after just one day at the clinic. In one clinic room, I encounter a young woman with paraplegia, who was able to escape war-torn Kyiv, and who tells me how during the bombing she would turn the lights off and stay in her apartment, unable to quickly descend the steep staircase to a bomb shelter. In another, I talk to a widower who no longer takes his daily

medications because his late wife of fifty some years used to set his pills in neat rows in front of him every morning. Yet in the next room I am greeted by a cheerful grandma who decided to pursue hospice care for her terminal illness instead of going through painful and time-consuming treatment, so that she can spend whatever remaining time she's got with her family.

But the urge to write doesn't only come from an opportunity – and a privilege – to peek into people's lives.

Maybe we write because...we have always written, and even outside of work we remain incapable of releasing a pen from the spastic grip of our tired fingers. The notion of physicians constantly scribbling their wordy notes may be a thing of the past, along with the outdated joke about our unintelligible handwriting, but we are still adept at chronicling our patients' lives in terse, technical prose.

From the very beginning, medical education enriches a person not just with a sum of facts and practical skills but with a unique perspective on the human condition. You routinely observe the randomness and fragility of human life. You study the innumerable ways nature is capable of inflicting pain and suffering on a human being. You learn that people make irrational decisions all the time – and, if you have a dose of humility, you soon realize that despite being armed with all the scientific evidence in the world, you, too, often have not a clue what the rational decision might be.

So, you turn to writing to make sense of what you see. Nothing helps organize your emotions and sharpen your thoughts better than putting them into written words. And with no shortage of emotions and thoughts, writing is certainly a sound way to put them into perspective.

Allow me to suggest that physicians make good writers (or simply writers) in part because there is an important quality common to both medicine and writing: the ability to empathize unconditionally. When a writer creates a character, she must get underneath her fictional person's skin - she must try to understand the character's incentives and motives, the logic of their behavior. And in doing so, a writer can't help but empathize even with the most unpleasant of their creations. Similarly, to be successful as a physician, empathy is paramount even when you don't accept your patients' behavior or don't approve of their choices.

A quick final note: it'll be some time before artificial intelligence is taught the ability to empathize and replaces us in the uniquely human endeavor of healing. And when it does...well, some of us will spend our newfound free time writing. Although writing itself may be replaced by AI even sooner. Oh well.

18. A Father's Legacy

Katrina Victoria, MD

Our family moved to Eau Claire, Wisconsin, from NYC, early March 2020, when the first case of COVID-19 was reported in New York. I started a job to focus solely on infectious disease, as I was working in primary care prior to this. I have a few months to prepare for when Wisconsin was hard hit the fall of that year. It was a challenging time, full of fear, uncertainty, mistrust, sorrow, helplessness, even hopelessness. It was soul-crunching seeing people die one after the other, after taking care of them for weeks on end, until they succumb to their illness. But as with everything in life, things slowly improved, and there were more and more people surviving. I was finally hopeful for the future, as I waved goodbye from my office window with a view to the hospital entrance, to a COVID-19 patient of mine, who have stayed in the hospital for more than 3 months, and was finally going home after his long battle with the illness. He was going home ambulatory, albeit hooked to supplemental oxygen. It was then, in early April 2021, when my family back in the Philippines contracted the virus, and the entire household was infected. They were still waiting for the vaccine distribution at that point. Everyone improved, but my dad did not. His condition worsened, and was admitted to the hospital where he worked as a general surgeon. He was listed as the first few to receive the initial vaccine approved, but unknown to us, he declined as he was waiting for the "better" brand. I helped managed his condition, thru video chats with the doctors and staff. My sister who is a pediatrician, was the one who updated me on everything, on every single bloodwork and imaging study, on every change in his condition. He went through the same course that my patients here in the US did - requiring high flow oxygen then intubation after a couple of weeks, undergoing dialysis when kidney failure sets in, receiving Remdesivir and Tocilizumab, as well as antibiotics and antifungals. He received the same standard of care. He was well taken care of, as the medical and nursing staff knew him well.

It was later revealed that my dad took Ivermectin, which he bought secretly from a pulmonologist friend, and took it early when he got infected with the virus. He was not improving despite best effort, and it was believed that the side effects of the drug might be one of the driving factors that led to his further deterioration, eventually conquering his life. I witnessed how the

doctors did CPR on him in real time, but unable to bring him back. It was not a sight any family member would want to see done on their loved one. It was a big loss to the local medical community. He was well-liked and respected. He passed on Mother's Day.

I felt like I failed him. An infectious disease doctor who was unable to save her father from this infection. Even now, I do not voluntarily share the reason for my dad's passing. It is excruciating what has happened.

As per city protocol, they can only give patients who died of COVID-19 a week for the wake, before the burial. I was scheduled to fly to the Philippines for the funeral, but got a call from the airline as I was on my way to the airport. The city where we lived, has prohibited any incoming international flights the last minute, due to the increasing number of cases and lack of available rooms in quarantine hotels. I was devastated. The last time I saw my dad alive was when he visited me in NYC in June 2019. I didn't know then that it was the last time I will ever hug him. I did not even have a chance to say goodbye.

This month marks the third year of his passing. It is still painful grappling with his demise. He has made a huge impact on me, not just as a daughter but as a physician as well. I was rereading my personal statement recently, that I sent to ERAS 15 years ago, as I was applying for Internal Medicine residency. I wrote how I knew I wanted to be a doctor when I was five years old, while waiting outside my dad's clinic in Tripoli, Libya, where he used to work in primary care decades ago. I witnessed the transformation in the patients' faces and demeanor after seeing my dad. Hope was written in their faces. I was both fascinated and intrigued with whatever transpired within. I dedicated my life to science and medicine from that day forward.

My dad has always imparted in me a positive outlook in life. That no matter the trial or tribulation, life is beautiful, and it is our duty to live lives the best we can, in service of others. I have learned from him, how to have a heart of a healer. And to never take anything for granted. This is the legacy I carry with me, until we meet again.

19. Taking the Leap

Jennifer A. Woodard, MD

I've always been more of a leaper than a stepper. I am eager to get my hands dirty and my feet wet, and I believe I will figure it out along the way. I want to get started rather than sit and discuss different options, and I want to try new things, even if I am bad at them (I usually am). Obviously, not many people are like me: most want to know the facts before they jump in, feet first, to a new situation. Sometimes the risk of taking a running jump is that you end up in water over your head and are unable to keep treading. Caregiving is a bit of a mix of leaping and stepping - but in both cases, you never really know what is up next.

I tried to tell someone they were not safe to drive today. He failed two driver's road tests and objectively, every measure we had that correlated with increased risk of an accident.

"It's the only thing left that he likes to do," said his wife. She could hardly fathom taking away his joy. In these situations, what can you do? We are constantly walking the tightrope between independence and safety, hoping we have just enough tension to prevent a fall, knowing that we have little control over the ongoing sway.

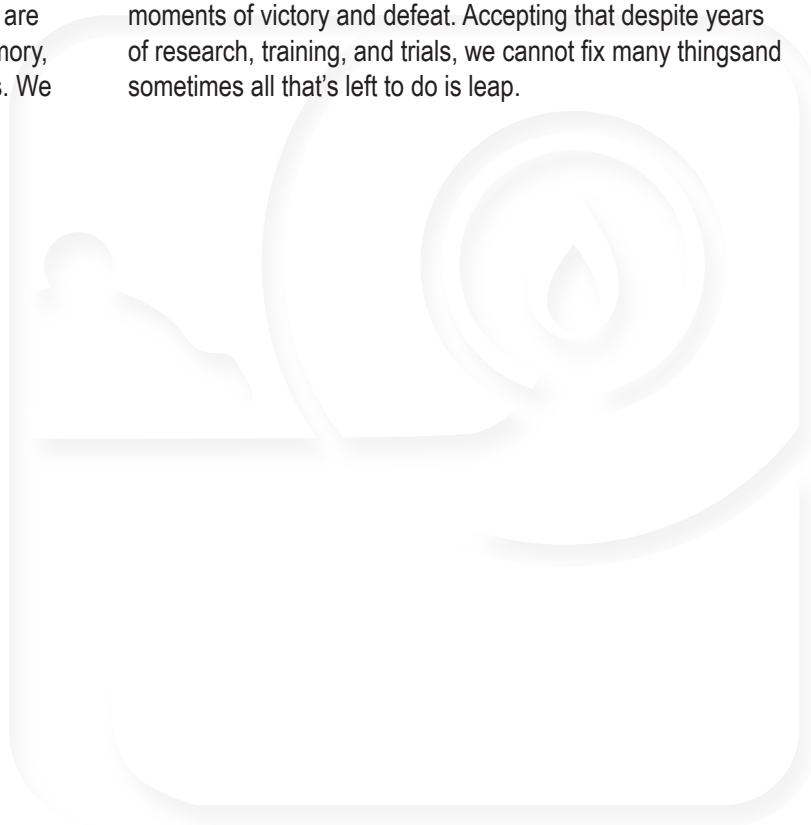
Dementia is a cruel disease: there is a predictable progression and decline, but it feels so simplistic to nod along and reassure caregivers that yes, the confusion in the afternoon is normal. Yes, the burned food and hidden car keys are normal. In reality, there is nothing normal about seeing someone's personhood slowly whittled down by amyloid plaque. Forgetfulness is common with age - but the implications of its progression are far more sinister. At first, there is impaired short term memory, difficulty managing the cadre of medications and finances. We

start trying to intervene, to slow the decline of this inevitably progressive disease. Diets are changed, medications are added and subtracted. Millions of crossword puzzles and sudoku games are played, reminder notes placed around the house - all while knowing that if you don't die from something else first, your brain will continue to fall into ruin. After you fail to recognize family and friends, you lose the ability to feed yourself, the ability to put food in your mouth and chew. At the very end, you lose the ability to smile.

In the early stages, I am there for the patients. They realize they are losing skills, forgetting appointments. The exquisite pain of seeing yourself decline until you can no longer recognize the person you used to be. After that, I am there for the caregivers. Those who are left in the scorched battlefield of their marriage. They have made the impossible decision to move their spouse into a facility so that they can sleep at night knowing that their loved one is finally safe behind locked doors.

Even through these impossible moments, there is still triumph. The husband who can still write "I love my wife" on a piece of paper. The songs they both remember and sing together. Sometimes that one additional point on a cognitive test feels like such a hard won victory. The months of changing their habits and titrating medications has made the single point on an arbitrary test possible. Many great leaps with just a small step in return.

As physicians, it is our duty and honor to bear witness to these moments of victory and defeat. Accepting that despite years of research, training, and trials, we cannot fix many things and sometimes all that's left to do is leap.



POETRY



20. The Breath That Lives On

Taylor Blair

HONORABLE MENTION

 **ACP** Wisconsin
American College of Physicians Chapter
Leading Internal Medicine. Improving Lives.

POETRY: ATTENDING

Take a breath. Close your eyes. This is it.
Your first memory. Your first love. Your last hug.
It comes on so suddenly and then within a breath it is gone.
But is it truly gone? That breath lives on.
In the ones that you loved. The ones that you helped. The
ones that you inspired. In the work that you did. In the home
that you built. In the pictures you graced.
In the places you explored. In the food that you cooked
(sometimes burned). In the kisses you shared. In the music
that you sang.
It's still there.
Take a breath. Close your eyes. This is it.
Our first steps. Our first scalpel. Our first patient.
We push through the doors into our future as physicians. And
you are one of the first to welcome us.
The breath that lives on.
In my hands that hold your heart. In my mind that stirs
advancement and knowledge. In my soul that knows I am
exactly where I am supposed to be.
In the halls with us as we treat the next ones more prepared
and more compassionate. Your breath. Your gift. Lives on.
So take a breath. Close your eyes. You can rest while we get
to work.

21. Through Seasons of Healing: A Med-Peds Physician's Reflections

Medhavani Chandra, MD

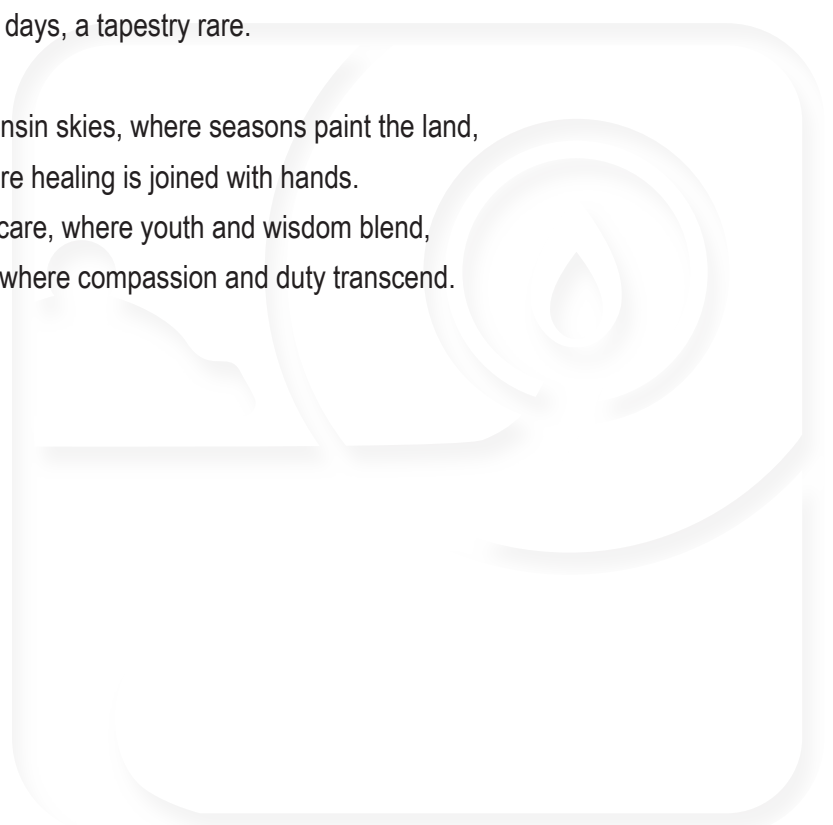
In Wisconsin's early morn, my day begins amidst whispers of snow,
Each flake a silent note in the symphony of care we bestow.
Through hospital doors, where echoes of footsteps mingle with hope's call,
I navigate corridors lined with drawings, the scent of antiseptic mingling with all.

From newborns cradled in warmth, their cries piercing the quiet air,
To elders sharing tales in raspy tones, from wheelchairs worn with care.
Each room a chapter, each face a story beneath the fluorescent glow,
I listen, learn, and gently guide through life's ebb and flow.

The young ones show resilience, their laughter bubbling like a stream,
As I mend their wounds, their trust in me is a recurring dream.
Then, to the quiet corners where the aged rest, their lives softly unfurl,
I offer solace, a hand to hold, as stories and farewells swirl.

In this dance of hellos and goodbyes, of first breaths and last,
I scribe the human condition—each pulse, each silent gasp.
It's not just the science but the stories that we share,
That stitched the fabric of my days, a tapestry rare.

So beneath these vast Wisconsin skies, where seasons paint the land,
I treasure every moment where healing is joined with hands.
For in this lifelong journey of care, where youth and wisdom blend,
Lies the heart of my calling—where compassion and duty transcend.



22. Echoes of the Untimed Heart

Felipe Echeverria

Two months have passed since I penned my last hope to you,
Silence was your reply, yet in dreams, you still wander through.
I wonder, in your quiet moments, do I cross your mind?
Could we have soared together if fate had been kind?

Left waiting by the bridge, amidst the embers you left behind,
Your absence a shadow, your memory etched in the rewind.
A perfect fit, your embrace, now oceans apart,
Useless against the vastness that separates our hearts.

We were merely a wish, fleeting along time's vast line,
With borrowed kisses that faded, unable to define.
Understanding doesn't ease the ache that remains,
You were the right soul, wrong time, amidst our refrains.

The clock's hands move, perhaps suggesting it's best,
To accept this distance, to put my heart to rest.
Yet, as the miles stretch out, a relentless span,
I find it tough to sleep, far from where we began.

Deep down, rage simmers — I can't seem to let go,
Three years on, and acceptance is slow.
Why, if desire is power, did we falter, unable to stay?
Did time weave a barrier we couldn't sway?

From a hug that once promised more than a fleeting touch,
To the bitter realization that love wasn't enough.
Yet hope whispers, maybe in another life, another time,
We'll reconnect, where love is free, in perfect rhyme.

But here, in this life, we faced a truth too harsh to mend,
That sometimes the right person arrives at the wrong end.
Late to return, far too much space to cross,
We stand as a testament to love's greatest loss.

We chase echoes in the night, each a pang of what was,
Defying the cruel fate that wrote our laws.
Our love, a chapter concluded before the plot was due,
A tale of two hearts, genuine, yet askew.

In a quiet twilight where silent hearts bleed,
The echoes of our love meet unmet needs.
In another universe, we dance under shared stars,
Where late is timely, and close isn't far.

23. The Girl in the Asylum

Michael Esson

Curses swirl and hurl all around her,
Vile breath and venomous tongue whirls around her, as if the sun
around the world,
Hate lingers in eyes that pierce, vanishing shadows of whispers unfurl,
All the while, the girl in the asylum stands strong, hands on hips,
On her pierced lips, a defiant grin, time in her grip.

A thousand tear drops fall from her gaze,
Swift like gossip, her smile beams a thousand sun rays,
Bare feet embrace the cold caress of the earth beneath,
She studies the encircling walls: a glass front, a T.V forever replaying
an endless sitcom, and me — standing on the east,
Bathe in her glow, I'm entranced in fascination,
Her gaze intense, delves into my thoughts, sparking revelations.

Innocence blooms in her embrace, a hint of black from her sweater on
my palms,
Thin, dark curls soothe my shoulders calm,
Her smile reveals teeth with a touch of yellow, like a golden pearls'
reflection,
And in a whisper, she says "I like you, because you don't dress fancy",
a heavenly connection.

24. 'Dr'inking Wisconsinly

William Graft, MD

Friday, February 23
Epic Haiku notification, critical result
Mr. J's carbohydrate deficient transferrin is positive
His mystery encephalopathy is no longer a mystery
He was hitting the bottle after all
My first bonafide case of delirium tremens
How exciting
For me
Obviously not for the patient
Poor guy
I should probably draft a page to the ICU

Why did I buy his 'one month sober' claim?
I wonder if he owns a 'Drink Wisconsinly' T-shirt
"Spare him your judgement, please, you're a physician after all"
My inner monologue urges me to be kind
"You're here to stamp out illness, not perpetuate stigma
Alcohol withdrawal is a disease
Same as toxic-metabolic encephalopathy"
Fine
I will medicalize, not moralize

Minutes after the Haiku app notification
A text in the intern group chat
"Guys we need drinks this week lol"
"Brewery at 7?"
"SO DOWN"
"Count me in"
"Bro, I need to get drunk"

Hard to argue there
It's been a rough week in the life of these Wisconsin baby doctors
In the Brew City, nonetheless
And in my experience
Even the first sip of local ale drowns the emotional exhaustion
Perhaps too well
To bear witness to suffering
Or to beer?
The classic post-sign-out question

Second thoughts arise
Time to Google
Medicine is an open-book test, after all
15.3% of physicians suffer from alcohol use disorder

Says a study from 2014
Not a stat cited on rounds
Or journal club
A fleeting thought
"Did COVID bump that number up to 19%?"

Enough on epidemiology
Inner monologue is back
Urging me to self-reflect
"Do I use ethanol to drown the crushing stress of my job?
Same as this patient?
Same as 1/6 of my colleagues?"

Burnout runs rampant
Especially when the snow is gray
And the Wisconsin sun sets at 5:33
Also
I was yelled at by a patient today
"You're just an intern?"
I ordered the wrong formulation of metoprolol, again
There's a red box around Ms. T's POC glucose
Still struggling with sliding scale
Seven months in

Remember the group chat?
It's hard to dwell on your inadequacies and mistakes
If you down a few with friends
Like they are planning on tonight

Just a couple drinks
Not problematic at all
Right?
Snap out of it
Remember the statistics
Double IPA is not first-line for imposter syndrome
What would I tell a patient?

But then again
I can't turn down every social event
There aren't that many
And booze is the law of this land
Is it even possible to decline the GABA modulator?

"Hey guys, it's been a while!"
"Hey Will, glad you made it"
"What would you like to drink?"
"I'll have a club soda"

25. Internship

Bridgette Klein, DO

It was like swimming,
She decided.
Down there in the quiet;
All sounds and feelings muffled.
Focused –
Oh, so focused –
On holding your breath.

And kick, kick, kicking your legs
In near desperation,
Trying to make it to the other end
Before the air runs out
Because you never
Quite mastered
Rhythmic breathing
And so must haul yourself to the surface
To take a quick,
Gasping,
Sputtering gulp
Of oxygen
Which (almost) takes more energy
Than it's worth.

And you know it's beautiful –
Oh, so beautiful! –
Because (in those brief,
Shining moments
When you stop fighting for your life)
Everything that seems to matter
Is trapped above the surface.
That silence,
That stillness
Is overwhelming,
All-encompassing.

That's when skin and water could not be
separated
Even by a scalpel,
She thinks.

And your lungs ache for air
But you make them wait
Because the second
You break the barrier
Between wind and water
It all comes rushing back,
Wave
After relentless wave.

And she remembers
That allegorical cave
And knows what it must be like:
To be surrounded by rock,
Your back heated by flames
And your ears filled with nothing
(But echoes)
Down there in the quiet;
All sounds and feelings muffled.

And she knows how they must have
revolted,
Rearing up like horses
As they were dragged toward
The ever-mercurial heat
Of the sun.

26. Just a rash?

Michael Lenz, MD

You never know what to expect
when a new patient with a rash presents
often simple but sometimes complex
but today, I met someone of interest
The rash diffuse and itchy
review of systems suggests a mystery
Send her away without success?
She deserves an answer; it's obvious
Ask more questions to discover
the answer and to uncover
She had the same rash 10 years before
an important clue, and there is more
it occurred after an event of utmost distress
after a life connected to her was ended
while caring for her spirited child was attempted
now, a few days before this rash
her simmering pot of tea reached a roar
Her body could not take it anymore
But there is more
She hurts all over with pain and poor sleep
exams and assignments with due dates to keep
This wasn't new; has been since she was a
child
no answers or balm had she received
Her child was showing the same signs
no sleep, no answers, despite many visits
has been crying, poor eating, poor growing,
much perseverance
Mom wiggled in bed since she was a child
so does her daughter, unreconciled

Today, we discover a clue that leads to more
questions and answers
During the night, her child has the most painful
dances
legs moving throughout but never addressed
by her doctors not knowing what was there to
detect
the signs and symptoms that were so direct
RLS, PLMD, and more in due course,
diagnosed
dominoes were falling, and puzzle pieces were
placed
an intricate pattern revealed much more than
the skin eruption
Her and her child's bodies screaming for
resolution
today and the subsequent weeks
a chance to flatten those debilitating mountain
peaks
I love seeing those missed by the rest
hopeless and helpless, just trying my best.
Taking the time to address
not just the symptom but all the rest
It was not a cream that was needed by her
but long alluded connections to tie together
This narrative needs to be told
so relief is given to the child, not waiting til old
The cycle now has the chance to avoid being
repeated.
A rash defeated, much more in the end.
Maladies of undetermined cause
leave the invisible victims without recourse
now, there is hope for those with much more
than a rash.



My first ever patient
overnight. Intern year.
He's confused,
I'm told. Demented.

Not long demented,
at least not in a way
his attendant daughters
have noticed.

He fell hard
about a month back —
SLAM.
Concrete curbing.
No one's fault.

At 80 something,
hit the back
of his head,
blood newly
making a home
in his brain:
buying furniture,
selecting curtains,
painting cranial walls
with fresh coats
of subdural blood.

He looks at me,
eyes of a toddler
learning to navigate
unfamiliar boundaries
in real time.

"It's time,"
he tells me.
"It is time."

...to settle down, I think
is what he means.
To settle down
as he has
so many times before
I was ever here.

Late beloved wife.
Six children;
seven jobs;
eight decades
of life and
still counting,
in theory.

I know
this settling down
will be his last.
I know this.

He will leave here
and find himself
under the care of
strangers within
a carpeted building
for those whose
days, whose 7
years, whose
months are
countable
on one hand.

"I'm ready,"
he lies to me
for the first time
tonight.
"I am ready."

28. ECHOES OF A BROKEN TRUST

(Dedicated to my Late. Grandmother who died of sudden heart attack in 2022)

Samyam Bickram Pathak

PEOPLE'S CHOICE WINNER

ACP Wisconsin
American College of Physicians Chapter
Leading Internal Medicine, Improving Lives

POETRY: MEDICAL STUDENT

Being so close to our hearts, You're still miles and miles away

From hearing the echoes of our hearts.

Thinking of you as the only one to trust and rely on, We poured out all our treasures for your sake.

The beat of your heart and soul was our only concern,

But you have turned the pages of our beautifully composed tales.

Truly, you have deserted us in ways we could never have imagined, Making us feel worthless—not even valuing us for who we are.

Our eyes have gone blind, our lips dry, unable to utter a word; Our minds are blank; our faces pale at the thought of you.

Tears don't even roll down, lost in their search for a path to flow. Your words had the power to bring our lives from bliss to torment, The paradise of your world has left us blind, deaf, and mute.

Your influence is so strong that Flowers lose their beauty,

The sun forgets to rise and shine, The air seems still and solitary.

The moon hangs its head low,

The rainbow fails to unite and glorify. Leaves no longer dance,

Stars have ceased to twinkle,

And the earth rests without rotation.

I feared it was a nightmare,

But gradually, I realized it was a cruel reality, not a dream. The pain of betrayal eases over time, but not your offense. Your actions are like a poison that doesn't kill at once,

But creeps through life more fatally than any disease. Now and then, our hopes are shattered,

And the future seems crushed.

Yet, I have a few words to share—my swan song: You still occupy a space in our hearts,

And that's why we fail every time we try to forget you. We're going to drown in the sea or die in the desert, And yet our eyes continue to search for you, only you. Alas, it will never happen—never again

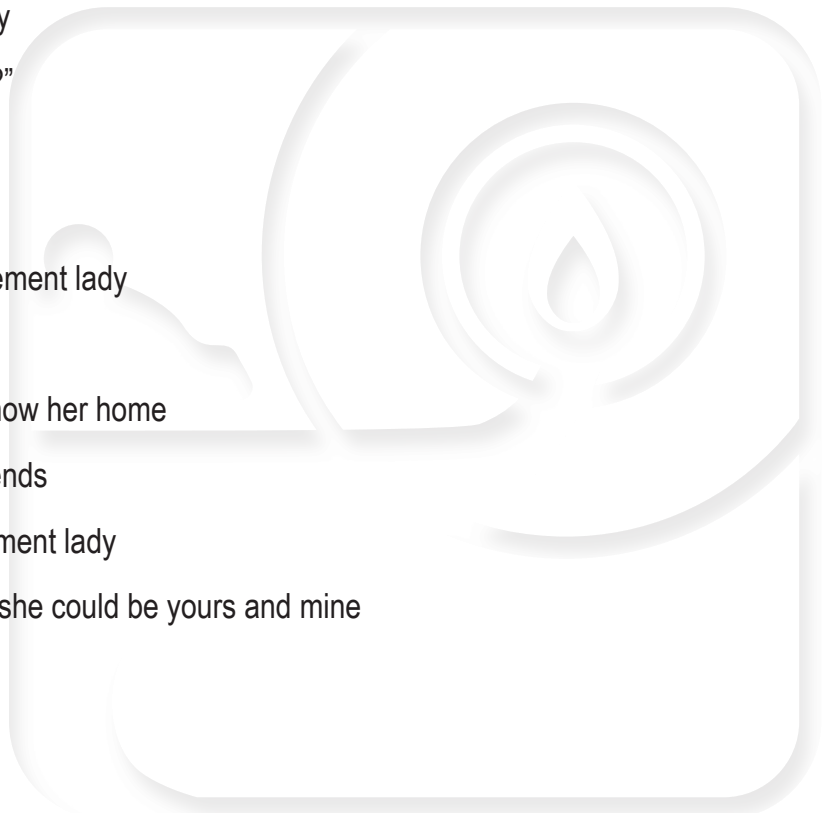
29. The Placement Lady

Alisha Sharma, MD

I see her laying on the bed day and night
Head always turned to the door
Eyes trying to find the shore
Waiting for someone
Someone to free her from that room
But days go by and no one has come by

Today I got her in my list, and she is my “placement lady”
I introduced myself
She said another one has come by
Weeks go and new providers show
The walls are cold
Slowly growing hidden mold
Is this a prison she asks
Absolutely no I reply
But “why can’t I go?”
“Why can’t I go?”

Oh, she is my placement lady
She is here to stay
For the hospital is now her home
We are now her friends
If you have a placement lady
Please be kind, for she could be yours and mine



30. Laughing through the medical mishaps

Abhijai Singh

In the world of healing, where wisdom should rule,
There's a side of medicine that's sometimes a fool.
With doctors and nurses, and all in between,
The funniest mishaps are often unseen.

There was Dr. Smiles, with a charming grace,
Who once stitched a bandage right to a patient's face.
With a gasp and a giggle, he said, "Oh my word!
Looks like you've got the best mask in the world!"

Nurse Betty Bloop, always swift on her feet,
Once served up bedpans with lunch for a treat.
The patients all laughed, and so did the staff,
"Now that's a meal plan that's sure to make you laugh!"

Dr. Fumble, in surgery, had quite a knack,
For dropping his instruments and losing track.
One time, a scalpel took flight through the air,
And landed right in a nurse's big hair!

"Oh dear!" cried the doctor, with eyes open wide,
"Your new hair accessory is quite the ride!"
The nurse simply chuckled and shook her head,
"Next time, try aiming a bit lower instead!"

In radiology's room, with machines all aglow,
Tech Timmy Tweaks had a mishap to show.
He scanned the wrong patient, a mix-up so grand,
They found a knee in the chest, quite unplanned.

"Oops!" said Timmy, with a sheepish grin,
"I guess I've discovered where knees might have been!"
The patient just chuckled and shook her head,
"No wonder my backache hasn't been fed!"

Dr. Mix-Up, renowned for his quirky ways,
Once prescribed pet meds for a patient's malaise.
"Take two of these treats and call me next morn,"
Said the doc, unaware of the laughter he'd born.

The patient replied, "Do I sit up and beg?"
"Or chase my own tail, or lift up my leg?"
Dr. Mix-Up turned red, then laughed with the crew,
"These are for Fido, not meant just for you!"

In pediatrics, with kids all around,
Dr. Silly Socks made laughter abound.
He wore socks on his hands and gloves on his feet,
Confusing the tots he would often greet.

"Why are your gloves on your toes?" asked a child,
"Because my socks on my hands are what's styled!"
He juggled and danced, making giggles erupt,
In the land of medicine, cheer never corrupts.

So here's to the mishaps, the blunders so bright,
In the halls of healing, they bring such delight.
For even in medicine, where seriousness reigns,
A sprinkle of laughter eases the pains.





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