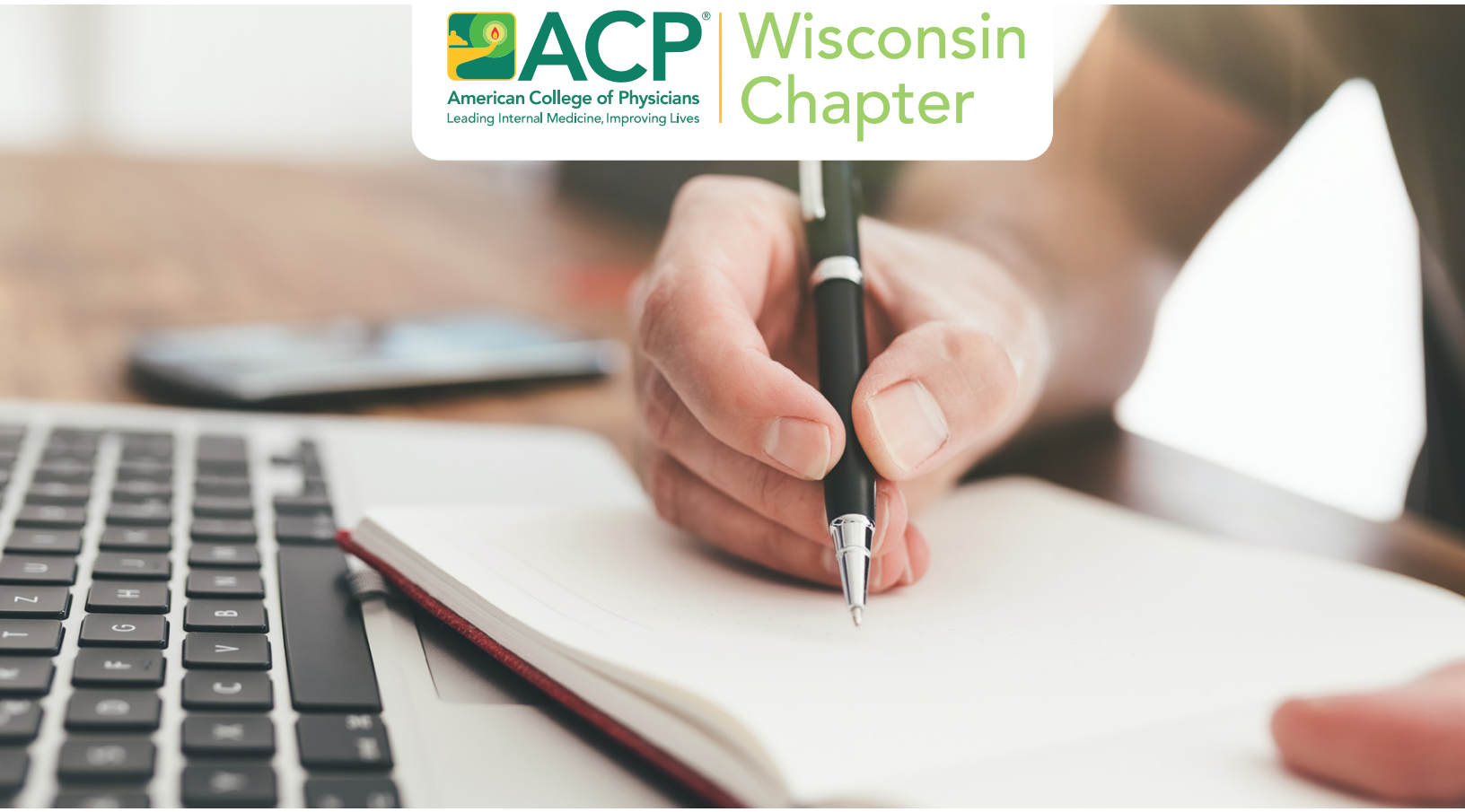
2026 NARRATIVE MEDICINE BOOKLET

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



ACP-WI Narrative Medicine Program Committee

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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Stay tuned for further Narrative Medicine events from ACP Wisconsin. If you would like to be more involved with Narrative Medicine with ACP-WI, email info@acpwi.org

TABLE OF CONTENTS

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

ESSAYS

** 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.*

TABLE OF CONTENTS

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

POETRY

** 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 has been acquired.*

ESSAYS

1. Who is your doctor?

Kartikey Acharya, MBBS, FACP

My mentor used to ask this question while interviewing patients to get a sense of who they saw as their doctor and why. For some of our extremely complex patients, often there are half a dozen teams following the case, but everyone works in their silos, and no one talks to one another. When someone tries to have a conversation, an occasional snarky "*Did you read my note?*" comment from other team members is often an icing on the cake. More importantly, to the patient, it seems like no one is in charge. This happens to patients while they are admitted to the hospital and when they navigate outpatient care with several specialists. There are of course, exceptions to this, oncologists and transplant physicians often end up quarterbacking care of patients with active malignancy and organ transplantation to ensure various teams with their varying level of engagement in their patient's care are on the same page. Counting medical students, residents, fellows and attending physicians from various teams, sometimes, patients would have close to twenty physicians following the case. Despite that, it would not be uncommon for patients to not be able to name or describe the doctor in charge of their care.

One can imagine that an admitting Medicine team would not feel comfortable outlining plans of care for a patient with new diagnosis of vasculitis or a new diagnosis of endocarditis. A Rheumatologist is going to be driving management of the vasculitis, just as an Infectious Diseases physician is going to be key in management of a patient with Staph aureus endocarditis who also has hematogenous seeding complication of vertebral osteomyelitis.

As an Infectious Diseases physician who rounds in the hospital and sees patients in the clinic, this is not an uncommon scenario. For that patient with endocarditis, like many of my Infectious Diseases colleagues, I am happy to repeatedly explain and answer patient questions like "*How will we treat this? How long will we need antibiotics? What are the side effects of the antibiotics? How do we assess improvement? How do we watch for and manage complications*?" Even with answers that may be frank with the short three-word responses "*I don't know*", I am happy to be "the doctor", the physician "in charge" as the admitting diagnosis is a complex infection. However, I feel awkward answering questions about their blood glucose changes and management, their diet, their pain control and related management as well as nausea management and timing of various procedures as well as discharge – questions that sometimes are more important for the patient than the Infectious Diseases moment of joy "*Hey! Your blood cultures are clearing*". Not uncommonly, managing certain symptoms like pain (related to vertebral osteomyelitis) and managing expectations of patients as you manage their pain are harder than managing the underlying infection itself. Should I be "in charge" then? Am I prepared to be "in charge"? How should I respond if my name comes up as an answer to the question of "*Who is your doctor*?" Pride? Superiority? Insecurity? Anxiety?

Sometimes, I wonder if the aspect of ownership is the underlying issue. While the definition of ownership is rather broad, the patient is usually able to sense through the action and the attitude of their physicians and the teams whether they are engaged or not.[1] I wonder what seems to hold us back from owning patient care. Do we think we are not capable of caring for the patient? Is it burnout? Is it an inability to see ourselves as one of the important members of patients' team?

I also wonder why we don't talk with each other to problem solve cases together. Do we stay in our silos as we don't have time and energy to talk to one another? Do we do this to "stay in our lane"? Does it help us stay efficient? Does it not prevent us from finding joy in working with each other to take care of patients? We clearly cannot do everything for everyone at a specific time, but is it not important to reflect on our engagement and involvement to ensure it was helpful for our patients and our colleagues?

Couple of years ago, I closed my practice at one of our clinics serving patients living with HIV where I used to do HIV care and primary care for my patients. For one of my patients, Mr. J, over the previous couple of years, I had slowly started involving one of my internist colleagues to help with his increasingly complex primary care needs. When I transitioned my practice entirely at our Infectious Diseases clinic at the main hospital, I had conversations with several of my patients about transition plans. After he decided he is interested in keeping his care with me, conversation with Mr J went something like this –

Me: It is a different clinic with different staff but as you know I will still be involved in your HIV care. You will continue to see

continued on next page

my internist colleague for your primary care, but I will be there if anything is needed from me.

Mr J: What do you mean that you will be there if something is needed from you, Dr Acharya? You are my doctor. You are not just my HIV doctor. You ARE my doctor.

I still remember this moment. I was quite embarrassed when I heard that from Mr J and I could not come up with a good response. Was I embarrassed because I felt recognized for being "the doctor"? Perhaps with some pride and some joy of feeling recognized for being "present" while taking ownership in his care in previous years. Was I embarrassed as I was trying to avoid being recognized as "the doctor"? Perhaps to avoid the burden of all the work the primary care physician, "the doctor", does – being responsible for minor ailments to major concerns and things that threaten to take away joys in medicine – paperwork, prior authorizations and everything else.

In my practice, these moments continue to be a struggle. A sense of discomfort comes when a patient looks up for help as no one else seems to be taking responsibility. The discomfort is there primarily as there is discrepancy between how I view my role in the lives of the patients and how they view my role. Am I just one of the consultants involved in their care or am I "the doctor"? Are patients open to my involvement as just another physician involved in their care if I am not the appropriate physician to be "the doctor" in charge? Do they feel abandoned, or do they accept and move on seeking guidance from another colleague?

"*Who is your doctor*?"

Responding to my mentor's question, if a patient was able to share name of another physician, I used to be in awe of that colleague. I used to dream of someone someday saying my name as response to that question. Years into practice, not knowing the exact reason behind it, I have a mix of pride and anxiety when my name comes up as the answer.

1. Cowley DS, Markman JD, Best JA, Greenberg EL, Grodesky MJ, Murray SB, Corning KA, Levy MR, Greenberg WE. Understanding ownership of patient care: A dual-site qualitative study of faculty and residents from medicine and psychiatry. Perspect Med Educ. 2017 Dec;6(6):405-412. doi: 10.1007/s40037-017-0389-2. PMID: 29209996; PMCID: PMC5732112.

2. Liminal Space

Natalie Anumolu, MD

"Lazy man! He wouldn't get up off the floor."

A woman tugs at my arm. Her husband—the patient—is laying on the exam bed. He can say little beyond his name. It's hour thirteen of my twenty-eight-hour shift. She's not so gently tugging at my arm which is keeping me awake.

"It's been four days since he's been on the floor, so I finally brought him here," she says. "I think he's just being lazy. Just before that he was fine- he just went to play cards with his friends."

"Ma'am," I say, "his labs suggest muscle damage. Did he fall? Why was he on the floor?"

She explains that he didn't fall. He regularly sleeps on the floor—he prefers it. Sometimes he lies there for two days at a time, and she brings his food and medications to him on the ground. "It's more comfortable for him," she says.

At first, we think this is rhabdomyolysis—a condition where skeletal muscle breaks down and releases its contents into the bloodstream. We start IV fluids, and his numbers improve. A few days into his hospital stay, he develops weakness in his leg. He whispers, "I'm trying," when he attempts to wiggle his toes, but nothing moves.

A code stroke is called. People rush into the room. We order MRIs of his brain and spine, worried about a stroke. Days pass—only a limited number of patients can get MRI scans each day. Neurology is puzzled; some days he can move his leg; other days he looks at me and whispers, "I'm trying. Help me." I watch his leg remain still. His wife continues to call him lazy.

Five days later, on a Tuesday at 9:30am, the MRI results come back. He has a hematoma—a collection of blood on his upper neck—that wasn't visible on his initial imaging. We place a cervical collar and urgently call neurosurgery. A few hours later, they call back with the words I dread: *He's not a surgical candidate.* There's nothing they can do. His paralysis has progressed—he can no longer move his arms or legs—and his frailty makes intervention not an option.

I go back into the room, and explain this to the wife; I say he must have injured his neck at some point while he was laying on the ground and has this hematoma- she asks me repeatedly "why didn't he tell me he fell? He never told me." At this point, I bring up the idea of the hospice, the idea of transitioning to comfort based care with medications to ease his suffering. He's still awake, whispering again and again, "help me", trapped in his own body.

I'm a new doctor- I've been a resident doctor for eighteen months, and I hope I will never be used to this feeling of helplessness—being this close to profound suffering with no words and no power to change the outcome. I've sat with this case for a long time, retracing my own clinical decision making, asking all the what if questions, and continue to be so unsettled. I want to blame this man's death on something or someone but ultimately I can't. I have a lot of assumptions that are frankly unfounded- the reality is that I don't know what happened between this couple, why there was a delay in taking him to the hospital, and why he was on the ground for days. I don't know why in modern day America we don't have enough MRI machines for our patients- and I don't know if the scan *was* able to happen on time- if knowing his diagnosis five days earlier would've made him a surgical candidate.

Some failures announce themselves clearly; others arrive slowly, hidden behind delays, assumptions, and the limits of what we are able to see in time. Residency is teaching me how much medicine happens in the liminal space- a space of not knowing the diagnosis fully, or getting it completely wrong, laying awake at night, wondering who to blame. I've learned to show up for my patients and their family, to stand at the bedside even when I don't have a treatment to offer; but I've been more recently realizing how crucial it is to also show up for my colleagues and myself, bearing witness to the questions that have no safe place to land.

No identifying information is provided

3. The Faces We Make at Bedside

Matthew Dandan, DO

HONORABLE MENTION

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

ESSAY: *RESIDENT*

I was startled back to reality as the cool breeze of a crisp April evening brushed against my face. As I walked across the parking lot, my body felt heavy, like I ran a 10k and did fifty push-ups afterward. Today marked the end of my second to last rotation of intern year, and I felt the wear in my body. There were heavy bags hanging under my eyes, less buccal fat on my cheeks, but a slight hint of cautious confidence in my eyes. Now, I was able to manage a workload that would've been impossible for me last year. My shift earlier was jam-packed; pre-rounding, calling consults, and a challenging goals of care discussion. Despite this, my mind was still restless. Through a haze, I drifted back to my first bedside encounter.

My first patient was a lovely lady with severe dementia who had broken her hip after a fall at home. Outside her emergency department room, I adjusted my stethoscope, rehearsed my introductions, and most importantly, remembered to enter with a smile. If Dale Carnegie got one thing right, it was the power of the pearly whites. Her daughter was seated at the bedside reading a book. After I finished, I thought it went quite well and I had portrayed some semblance of competence. Afterward, the daughter gave me a thumbs up and said, "I know you were nervous, but you did great!" I was left shocked. How was she able to recognize the fear underneath my guise? Her words cut right into how I was feeling as I walked out; a knife in a bowl full of spoons. Was it something I said? Something I did? But then it clicked. It was my face that betrayed my emotions. *The face I wore at bedside*.

Three weeks later, I was slowly gaining momentum, like fluids pushed through an IV. My studying was paying off, my presentations were improving, and I was slowly building relationships with patients and my team. I began to feel like I belonged. I felt like I was growing into that white coat I was wearing every day. My world was thrown off its axis when he came to the ED via ambulance. His skin was jaundiced, eyes yellow and crusted, and an abdomen protruding. But what hit me the hardest was his face. It was laced with worry, fear in his eyes, and creases in his forehead. CT scans ordered earlier came back positive for a large mass in his pancreas. I asked him if anyone had been by to tell him what the CT scans showed and he shook his head. This would be the first time I told someone they had cancer. It would be the first time I held a patient's hand, passed tissues amid sobs, and comforted him and his family.

There are many faces we encounter at bedside as physicians. Some stay with you long after they've left the white, sterile halls of the ward. Others, although the faces may blur with time, the impressions left change you, whether you notice it or not. Over my medical training, my face has changed in the mirror but also in what it has learned to carry. I've been able to feel the ebbs and flows of what builds between doctor and patient. I've seen on their faces hope, struggle, exhaustion, but also grace at their most vulnerable. As I rest my hand on the steering wheel, I picture the face I wear as a senior. More bags under my eyes, slightly more wrinkles on my forehead, but sharper, confident eyes. Will it be one that I'm proud of? How about when I'm done with training? And I wonder what the face across from me when I'm in that hospital bed will look like?

4. What the Teapot Carried

Sonam Dolma, MD

Resilience—a word woven so tightly into medical training that it is often stretched thin, like elastic, until its meaning risks snapping under repetition. It is praised as one of the most essential attributes a physician in training can possess, offered as both expectation and consolation in the face of long hours, uncertainty, and sacrifice. At times, I have wondered whether resilience, stretched so often across the demands of training, risks losing the very tension that gives it force. Is it much ado about nothing, or is it, as Shakespeare suggests, all's well that ends well?

When I search for an answer, I find myself looking not just to medicine, but also to my family. My father was eleven years old when he lived in a nomadic tent high in the mountains of Tibet with his parents and eleven siblings. Even at that age, he understood the weight his parents carried to provide every morsel of food. In those days, children could earn only a few cents by collecting discarded plastic cans. So each morning, my father rose early and walked out into the cold to gather what he could. With the small money he saved, he bought his father his first pair of new shoes.

My grandfather still keeps those shoes in Tibet, where they remain, decades later, as a quiet shrine to the devotion of a young boy who understood hardship before he understood childhood.

Soon after, my father became one of countless Tibetans forced to flee. He tells me of crossing the snow-covered Himalayas on foot, escaping persecution alongside other refugees. Among them was a mother carrying a newborn. He remembers the collective fear that the infant's cry might reveal their position, and the eerie silence that followed. The child never cried. As though even that newborn understood what survival demanded.

For months, they walked through the mountains, often surviving on little more than ice.

When they finally reached the Nepalese border, another obstacle awaited them. Border guards searched each refugee, confiscating whatever money they could find—hidden in waistbands, beneath shoe soles, tucked into pockets and hats. My father had only a small metal teapot his own father had given him for the journey. Thinking quickly, he rolled his money tightly and concealed it inside the narrow spout. The guards opened the lid, searched the hollow interior, and found nothing.

That teapot carried more than money. It carried possibility.

Eventually, my father arrived in India, where the Tibetan refugee community was offered sanctuary. In December 1997, I was born in one of those refugee settlements in Bir. Amid the constraints of displacement, when educational opportunity was uncertain and daughters were seldom prioritized for schooling, my father resolved that both his daughters would be educated. It was an act of deliberate hope, born not of rebellion, but of the courage to imagine a future beyond present circumstance.

Because of that hope, I am here.

When I think of resilience now, I no longer think of it solely as a principle discussed throughout medical training. I think of worn shoes preserved across decades. I think of a silent newborn crossing the Himalayas. I think of a metal teapot with possibility hidden in its spout.

I think of inheritance.

In medicine, resilience is often discussed as though it is something we must build from scratch, a skill to be acquired through endurance. But some forms of resilience are inherited long before we enter our first lecture hall or don our white coats. They are carried forward through sacrifice, memory, and the quiet insistence that suffering can be transformed into purpose.

There are moments in medicine when reflection arrives unbidden—after difficult conversations, in the stillness between responsibilities, in the quiet fluorescent hum of long days and nights. In those moments, I often think of my father crossing the Himalayas as a child, carrying possibility inside a metal teapot. That history reframes the challenges of medicine, grounding the perspective with which I care for others.

If resilience is the capacity to return to shape after strain, then perhaps I have always been learning from those who bent without breaking. My life, my education, and my path into medicine are all products of that elasticity.

When your very existence is born of resilience, it becomes difficult not to carry that same tensile strength into the care of others.

Perhaps that is what medicine asks of us—not simply to weather adversity, but to carry forward the strength it reveals.

And perhaps, in the end, all is well not because hardship disappears, but because meaning endures through what we face.

5. The Arms That Hold Us

Vineesha Kollipara, DO, MPH

A hug. The dictionary defines it as "a close embrace with the arms especially as a sign of affection."

Hugs are symbols typically of love and comfort. However, in the hospital, hugs can mean hello, goodbye, and everything else in between.

During a rotation in the ICU, we spend countless hours not only caring for critically ill patients but also supporting their family members. As an intern, I cared for a young patient for a significant portion of my rotation. Unfortunately, she developed a significant complication: an ischemic bowel, which was deemed a catastrophic event by the surgical team. Upon hearing this, the mother, who was the primary 24/7 caregiver, broke down and turned to me as one of the providers informing her of the turn in her daughter's course. Sitting next to her, with her breaking down in tears while trying to process the dramatic change in her daughter's condition within the span of 12 hours and holding her as she processed her emotions was a moment in my training that I will never forget. For several minutes, I simply stayed with her, saying little as she cried in my arms, mourning the loss of her baby. Soon, her phone started ringing with multiple family members asking about what had happened. She wordlessly handed the phone over to me with every call to update the family member on the situation, while she remained seated beside me, overwhelmed with grief. In medicine, it can be easy to focus on diagnoses and treatment plans as a method of compartmentalizing the gravity of the situations we see and endure. But this experience reminded me of the hardest part of being a physician: simply being present and offering comfort and steadiness during someone's most vulnerable moment, which is a humbling experience.

Another significant moment during my training occurred more recently during an especially chaotic week on the wards. I had just set my bag down and was placing my lunch in the fridge in the team room when all of a sudden, a rapid response was called overhead. With the quick realization that it was called on my patient, our team rushed over to the room. In the room, the patient was found slumped in bed without a pulse, and a code blue was immediately called, with multiple team members quickly jumping into their roles. As I was not the code leader and there were many people already in the room, I stepped outside to reach out to the patient's emergency contact to relay the events of the case. In the hallway, as I was making my way to the closest phone, I noticed a woman hovering in the area, appearing tearful and terrified. I recognized her as the patient's fiancée and approached her quickly. In talking to her, she stated that she had been in the building when the rapid response was called and had recognized the room number, ran to the patient's room, and had been hearing all the comments and the course of events as they were happening. As I updated her on the events of the code blue, I could see her face changing, her eyes filling with more and more tears. I immediately reached out to her to offer her support, and she immediately embraced me and collapsed into my arms sobbing. Just the day before, the three of us had been sitting together discussing the plan of treatment and answering questions about barriers to discharge. Now the situation had completely changed, with me standing in the hallway discussing a potentially very different prognosis. The feeling of being unable to offer much else besides a hug and the updates that I could on the situation left me feeling helpless, but in that moment the hug that I was able to offer meant more than I ever imagined it could.

Hugs in medicine do not only occur with patients, but even between colleagues and friends. As residents, we work so closely with our co-residents and we see each other during difficult days as well as joyful days. Hugging a friend who just matched into their dream fellowship to congratulate them and convey how proud I am of their incredible talents or hugging a friend who has had multiple difficult goals of care conversations with families of patients they are taking care of and just feels defeated feels like helping to share the burden that very few others can relate to. Taking a moment to step aside and sit in the feeling of the hug and the emotions that we are able to convey with just a mere embrace, while holding strong to our closest friends is a gratifying feeling.

A hug. In my few years of medical training, I have learned that sometimes the simplest gestures- those that offer no explanations, solutions, or promises, can carry the greatest meaning. A hug can offer comfort in moments of agony, fear, and grief. A hug speaks when all other words fail. This form of human connection can leave a greater impact than I ever realized.

6. The First Thing I Noticed Was His Glutes

Haemi Lee, MD

JUDGED WINNER

I noticed his glutes before I noticed anything else. He was mid-glute bridge on the exam table. A ninety-five year old, hips in the air, completely unbothered. He caught me staring, winked, and said, "Gotta keep the glutes strong, doc. Also, did Dr. W warn you about me?"

I had looked at his age in the chart before coming in. The image I had constructed dissolved immediately. He had neither a walker nor hearing aids, and he certainly did not seem interested in apologizing for taking up space.

Somewhere between residency, my own glutes had quietly retired from active duty. Standing there, I was fairly certain his glutes were better than mine. I thought about saying so. It was a compliment, after all. Then I remembered the feedback I'd received earlier in the year. You can be blunt sometimes. Perhaps surprising a ninety-five-year-old veteran with an unsolicited compliment about his gluteal strength was not the ideal way to begin a clinic visit.

He was there for a cough that had lingered after a mild cold three weeks earlier. He pointed to his right side. His ribs ached from coughing. No shortness of breath. Still walking an hour every day. I checked his throat, pressed along his sinuses, and listened to his lungs. Post-infectious cough. Sinusitis. Allergic rhinitis. I had my differential. I had my plan.

What I didn't have was weather talk.

In the clinic where I rotated in northeastern Wisconsin, I noticed that appointments rarely began with the chief complaint. There was Packers talk first. Weather talk. Gardening, grandchildren, the farmer's market. I sat with my mental clock running. When were we going to discuss the blood pressure? The colonoscopy they've been avoiding? The cigarettes?

I told myself I understood the value of rapport. What I didn't understand yet was that I was watching something I hadn't learned to see.

I was in third grade when I made my best friend cry. She asked if I wanted to go to the bathroom together. "No," I replied. Simple. Accurate. Efficient. She burst into tears. I remember feeling confused. The answer seemed straightforward. I didn't need to use the restroom. Therefore, I would not be going to the restroom. I genuinely had not understood what she was asking. My mother told me from the time I was seven that I needed to learn to speak more gently. I thought clarity was kindness. Be clear, be correct, be efficient. If something mattered, say it plainly. This felt, to me, like respect.

You can be blunt sometimes.

Looking back, that may have been my first lesson: communication and information are not quite the same thing.

He came back the following week for a cyst on his knee. This time, he was doing triceps dips, wearing a cap that said VETERAN. He saw my name badge and told me he'd known quite a few Lees in his life.

I asked which war. He named the one my grandfather had fought in. He remembered the names of port cities with surprising accuracy. I told him my grandfather had been there too. That of all the young men from his village who went, only my grandfather came back.

Then he went quiet and said "I hope I never see anything like that again."

The more patients I saw, the more I noticed that the important things were almost never said first. Sometimes they were not said at all. They surfaced in a long pause, a joke that landed slightly wrong, or ten minutes spent discussing tomatoes before mentioning the drinking. Packers talk that was really about a spouse. Fishing stories that were really about loneliness.

At first, I assumed this was a regional thing, a Midwestern grammar I simply hadn't learned yet. But the longer I sat in those exam rooms, the more I suspected it was something older than geography. People often needed to establish something before they could say what they actually meant. Not dishonesty. Just a different grammar of trust.

Before residency, I thought I was a good communicator. I still think I was. The problem was that I understood communication mostly as the art of expressing myself clearly. What I had not yet learned was that medicine often depends on a different skill entirely. It requires recognizing what another person is trying to say without ever quite saying it.

I am learning something more difficult. I am learning a new language.

Not English, not Korean. Not simply how to read a body. I am learning to read what goes unsaid. A joke that arrives too quickly. A hesitation in the middle of a sentence. The vigorous glutes of a ninety-five-year-old man who has survived a war he will not describe, and the silence that crossed his face when I asked him about it. These are also clinical data. I just didn't know, until recently, how to collect them.

7. Trenches

Jennifer Mackinnon, MD, FACP

When I was on the D1 tennis team at my University, I went to quit one sunny afternoon because I could not play the sport every day and maintain my studies. I walked up to the chain link fence of the court where my coach was drilling someone with balls from the net. After I told him how I could not handle it, he stopped and walked over to me and said, "I understand you have too much on your plate as a music major with required orchestra work and ensembles and solo pieces along with being a biology major and trying to complete pre-med classes. You told me all of that and I listened. I will say, though, if I was ever in a war, I would want you in the trenches with me."

Now, I find myself in the trenches again for the past 20 years working full-time as a primary care position. I always fought for my patients and their health from access to care to marginalized populations facing higher mortality and morbidity rates, across-the-board and almost all chronic diseases and cancers. Now on November 6, 2024, I realize that the trenches have deepened. The for profit health care system and infrastructure is completely broken. The government healthcare system and structure is completely broken. I am trying to care for patients in the trenches with no armor and no weapons.

Yesterday I had worked and had to see 20 patients the day after the election. My first patient when I asked how she was doing she just burst into tears. She's a teacher and our city of Milwaukee and has students struggling at every level. They cry to her with major worries and go without. They have parents who are not present and addicted to drugs. They have teachers who are so tired. They just put their hands in the air and let the class be unruly. Support or armor, knowing with the head for the department of education and public schools across this country.

My next patient was a woman who raised six kids and had two abortions safely in the 1970s. She talked of one of her daughters who has lupus, on multiple medications, and accidentally got pregnant with her husband and had to travel to Illinois to get the care she needs. She cried for that daughter, all of her granddaughters and great granddaughters.

My next patient was a woman, despite being on multiple medications for ADD and anxiety, felt no one was helping her with menopause even though she had seen an integrative medicine clinic where she spent $10,000 on blood work with results that she wanted me to analyze and print out off of her MyChart account. I did and tried to go through them with her and emphasize which were actionable.

The next patient was an angry 74-year-old man on Medicare who complained nonstop about the system and how he was on hold for 30 minutes to try to book a test for his leg pain that he didn't understand and kept saying why has no one explained my pain to me when there were countless MyChart messages, phone calls, explaining why he has the issue he has. I even said I was sorry to him all my gumption and then went through each diagnosis, test result and explained all of it in great detail. When I left the room, I thought to myself if you think the systems broken now, just wait.

My next patient whom I've never met before she was 78 year-old woman who had had five primary care doctors in the past 10 years and felt isolated and alone. She explained all of her history to me and great detail. I listened and then she burst into tears and cried for how sad she was that the election went the way it did and that racism was alive and well in the United States. She recalled George Floyd's murder and then she explained what happened to her own grandson in the face of police brutality. When he died, she said her soul died. She had a glimmer of hope in this election and then it was extinguished once again and she wanted to die.

My next patient was a scientist from Egypt, who's been in the US on a visa doing a post doc after a 10 year PhD and he was 39 years old and worried that he would have to go back after all of the years spent trying to publish papers and advance the field of imaging technology here in the United States for our universities. He didn't cry, but he clenched his jaw tight. He explained a chronic daily headache that's overcome him and it happens every morning when he wakes up. He wanted me to try to solve it all before the end of the year so I ordered many tests that I will follow up on with him and hope that Muslim and anti-immigration would not go into effect.

My next patient was a woman who smelled of marijuana right when I walked in the room and she had had two children, but couldn't lose the postpartum weight. Her fiancé immediately asked me as I was logging into my computer, what is your definition of a narcissist? I found it odd but I answered. I explained it is someone that doesn't say they're sorry and they think they're always right. They can't realize the other side or have empathy. The fiancé said kind of like the person who was just elected. We all laughed and in my heart, I wondered if they had voted. They had so many questions about how to eat healthy and what to do to get themselves healthy for their two young children at home. When I talk to eating vegetables and fruits, they just looked at me and said they didn't have enough food stamps for their family and with that covered those types of foods I was talking about. I said I didn't know but offered social work to call them and that they could try to use the money they have for recreational things such as marijuana hopefully purchase these things for the health of their family. They walked out after a nice physical exam, but it was unsettling. I also knew that any GLP medication is cost prohibitive and the disparities between the haves and have nots is growing.

So I just walked through the trenches with you and gave these examples of patients and what we face each day with the empathy we have as human beings because that's what we all are after all is said and done - beings who are human.

8. Before Cancer Diagnosis: Integrating Internists into the Early Continuum of Cancer Care

Anannya Patwari, MD

My interest in oncology began early in medical school. As the first person in my family to attend medical school, I often accompanied my family members to physician visits including consultations with oncologists. I became the spokesperson for my family helping interpret medical information, coordinate appointments, and navigate complex healthcare decisions. Through these experiences, I witnessed firsthand the physical suffering, emotional uncertainty, and financial burden that accompany a cancer diagnosis, which instilled in me a lasting commitment to caring for patients with cancer.

Cancer clinics are often designed around treatment after diagnosis, yet many patients struggle long before they reach that point, particularly in rural communities where access to specialty evaluation is limited and delays are common. As an internist integrated with in the hematology/oncology clinic at Emplify by Gundersen Health system, I felt humbled by the opportunity to care for patients standing at the threshold of a possible cancer diagnosis. My role is centered on helping build a cancer diagnostic clinic designed to expedite evaluations for patients with suspected malignancy, many of whom were ultimately diagnosed with advanced or metastatic disease. Most travel from rural communities, sometimes driving several hours to reach our clinic. By the time they sat across from me, they were often carrying far more than physical symptoms. They carried exhaustion, fear, unanswered questions, and the quiet realization that life might never look the same again.

I vividly remember an encounter with a patient who came to see me in the clinic with severe pain radiating down the legs. Imaging revealed metastatic lesions, but the primary diagnosis remained unclear. The patient and his family sat quietly in the exam room, carrying the visible weight of uncertainty. During those early visits, I not only focused on expediting diagnostic workup but also on symptom management, optimizing pain control, initiating corticosteroids, and arranging early palliative care involvement. He was ultimately diagnosed with metastatic prostate cancer and promptly started on hormonal therapy through close collaboration with the oncology team. Several weeks later, I learnt that his pain had improved significantly, and his disease was responding to treatment. What stayed with me was not simply the clinical improvement, but the realization that meaningful oncology care often begins before definitive treatment ever starts. In those early moments before pathology reports and treatment plans patients are often searching for someone willing to guide them through uncertainty with urgency, honesty, and compassion.

Another experience that left a lasting impression on me involved a patient who presented with progressive back pain and was ultimately diagnosed with metastatic renal cell cancer with impending spinal cord compression. Prompt recognition of this oncologic emergency, initiation of corticosteroids, and expedited coordination with radiation oncology helped prevent further neurologic decline. I learned from my prior experience as a Hematology/Oncology Hospitalist that delays in cancer recognition and treatment can profoundly impact patient outcomes, shaping my commitment to timely diagnosis, coordinated care, and early intervention. In this case without an integrated clinic model, delays in early recognition of oncologic emergency could have led to disease progression and eventual emergency department presentation and hospitalization for diagnostic workup and management.

As an internist integrated within the Hematology/Oncology clinic, I serve as a bridge between worlds that too often function separately. I coordinate diagnostic evaluations, recognize urgent oncologic complications, manage uncontrolled symptoms, collaborate closely with hematology, oncology, palliative care, subspecialty teams, and help patients navigate the uncertain space before a diagnosis is fully established. I came to understand that oncology care often begins long before pathology confirms malignancy. For many patients, it begins with someone recognizing the seriousness of their symptoms, prompt evaluation, easing suffering while answers are still unfolding, and ensuring they do not become lost within the complexity of the healthcare system. Having once helped my own family navigate that uncertainty, I was able to empathize deeply with many of my patients.

I firmly believe there is immense value in incorporating internists within Hematology-Oncology clinics, particularly in rural and underserved settings. More than a clinical role, I view this as a different philosophy of cancer care—one that recognizes patients do not experience illness in isolated phases. Instead, diagnostic uncertainty, symptom burden, emotional distress, logistical barriers, and treatment often coexist rather than unfold in a linear sequence. Integrating internists within oncology clinics helps preserve continuity through these vulnerable transitions, reinforcing that meaningful oncology care often begins long before cancer-directed treatment is initiated—with someone willing to recognize patient distress early, guide them through uncertainty, and remain present even before a diagnosis is confirmed.

9. She is Here

Soni Rikin

I enter the room, same as the one next to it, and the one next to that. Immediately, a smattering of Marlboro menthols shock my senses. I recall who it is I am here to see:

> A female* in her early 60s with a PMHx of COPD, CKD on dialysis, CHF, edema, hypertension, T2DM controlled with metformin here for follow-up after a recent 2-week hospital stay due to pneumonia.

My preceptor had caught me up to speed on her case, emphasizing the fragility of the case as the rigidity of our patient was strewn across our display. She gave me the rundown, the recurrent prolonged hospitalizations, the attempts at medication adherence through patient-centered approaches, the declining renal function, the dysfunctional medical system that has still kept her alive. I tried to take it all in, trying to recall my motivational interviewing techniques, the NURSE mnemonic, and what I could do to get through to the patient I was about to see in T minus 5 minutes. I clicked on the discharge summary, filled with inundating dot phrases, overflowing off the screen with guidelines, toll-free numbers, and after-visit summaries I was sure our patient had not bothered with. It told me *all* the information as everyone before me had gathered it. Her story, pixels on a screen. I smashed Ctrl+Alt+Delete and walked to the room.

Inside the room, I sat with her. "Patient appeared jaundiced, disheveled, and sick but A&Ox3" I thought to myself, as she hacked a cough. She told me what had all happened, how it had gotten out of hand – the pneumonia. I listened. Or I tried to listen. I could not get out of my head the thoughts on what I could do for a patient like this. A patient that is unwilling to listen, to take their meds, to stop smoking, to do what is minimally asked by their doctor (who is obviously not me) to save their life. Maybe, she is depressed. PHQ=0, never mind!

I focused. She told me about the issues with transportation. How the quality of her life was dependent if she could get there. I bit my tongue. I attempted to understand. On some ethereal level, I understood. She was hooked on a machine that kept her alive but also got her hooked, causing withdrawals and intoxication doctors recommended. Or, I thought I understood. I marched on, I listened to the heart sounds, the lungs, noting the cacophony of an orchestra within my patient's thorax. I closed my eyes, tried to decipher the S2 from the S3, the rales from the wheezes, as the woman in her early 60s persisted. Her presence emitted something I could not figure out. I asked how we could help her.

She asked about refills, she asked about the locations and pickup time for the refills, she asked if the refills would be enough till she comes in to *see us again*. I tilted my head. My face blank but my mind racing, trying to connect the dots across her EMR, putting together the story. Her story.

I stood up. I thanked her, and I walked out of the room rehearsing the one-liner:

> A female in her early 60s with a PMHx of COPD, CKD on dialysis, CHF, edema, hypertension, T2DM controlled with metformin here for follow-up after a recent 2-week hospital stay due to pneumonia, requesting med refills *till her next visit with us*.

** Identifying details have been changed to protect the patient's privacy. No name, dates, or location are included, and the patient cannot be identified from this account.*

10. Beyond the Charts

Tyler Vang

I first became interested in healthcare watching my sister become a CNA while also starting a family. Watching her balance caregiving, work, and family responsibilities showed me what dedication to others could look like. Through her example, I began to see healthcare not simply as a career, but as a way to care for people during vulnerable moments in their lives.

Inspired by my sister, I eventually became a CNA myself, where I had many experiences that made me realize I wanted to better understand the care patients were receiving. One such experience occurred at the nursing home where I was working. "Mary," a resident, was never late for fish fry and always reminded me to push her wheelchair a little faster to make sure we got there on time. Later that night, Mary had difficulty breathing. I was shocked to see her in that state and ran to notify the team. The nurse noticed the oxygen rate being administered to Mary was incorrect and quickly remedied it. Mary thanked us, and I was relieved, but also shaken by how little I understood in that moment. That night stayed with me because I realized how much more I wanted to understand about caring for patients in those moments.

I began my nursing career in med-surg, where my knowledge grew along with the compassion I felt for the patients I cared for. At this stage, I better understood my patients' conditions, but I also came to know many of my patients as people outside of the hospital. However, I was again met with a situation where I realized I wanted to better understand the decisions being made during situations like these. "John" was admitted with shortness of breath and received the appropriate treatment. Shortly after, John continued to deteriorate and required intubation. This was one of the first times I interacted with a physician in a stressful environment. The physician handled the situation in a way that left me somewhat in awe. The physician not only intervened decisively but also calmly and pointedly led the team. Perhaps what amazed me most was that after John was stabilized, the doctor sat down with the family and discussed what had happened and the plan moving forward. Watching her lead the room and then sit quietly with the family changed how I understood medicine. In the middle of crisis, she made the family feel informed and heard.

I have been fortunate to work in several areas of nursing, though my time in the emergency department most clearly showed me the importance of building rapport with patients quickly. The emergency department also taught me how quickly trust forms between strangers. Patients often met us on some of the worst days of their lives, and within moments they trusted us with their fear, pain, and vulnerability. While many encounters in the emergency department were brief, I began to notice how often the problems bringing patients into the hospital extended far beyond the immediate emergency. Many returned repeatedly with complications rooted in limited access to care, gaps in follow-up, or the absence of long-term support. Those experiences showed me how important continuity and relationships are in medicine. They made me realize that beyond treating acute illness, I wanted to know patients beyond what was written in the chart and care for them over time. I have come to believe that the best medicine is practiced by those who truly know the person and not just the patient.

My path toward becoming a physician has taken many turns, and now, as I enter my final year of medical school, I value every experience I have had along the way. Each role I stepped into showed me a different side of caring for patients and families and gave me a deeper appreciation for the people who make up the healthcare team. Over time, I found myself wanting to better understand the decisions being made during the most complex moments of care. The physicians I admired most were the ones who could steady a room while still making patients and families feel heard.

All identifying information has been changed to protect patient privacy. The names used are pseudonyms, and clinical details have been modified or generalized to prevent identification of individuals.

11. The Space Between Heartbeats

Niki Viradia

HONORABLE MENTION

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

ESSAY: *MEDICAL STUDENT*

The monitor always told the truth before anyone else did.

I learned that early in my training, the steady green tracing, the rhythmic blip of reassurance, the sudden stutter that could shift a room from routine to urgency in seconds. But what no one told me was how much could live in the silence between those beats.

It was 3:17 a.m. when I met Frank. He had just been admitted for what seemed, at first, like a straightforward exacerbation of heart failure. Fluid overload, shortness of breath, a body quietly drowning in itself. By the time I saw him, the night had settled into that peculiar stillness hospitals carry, fluorescent lights humming, footsteps softened, the world outside forgotten. He was awake. Most patients at that hour are not. They sleep, or try to, interrupted by vital checks and alarms. But he was sitting upright, eyes open, watching the monitor as if it were a conversation partner.

"You trust that thing?" he asked, nodding toward the screen.

I hesitated. "It tells us a lot."

He smiled faintly. "It tells you numbers. Not the story."

I pulled up a chair.

There is always a quiet calculus in medicine, how much time you can afford to spend, how much you should. Notes to write, pages to answer, patients to see. But something in his voice made the decision for me.

"What's the story?" I asked.

He did not answer right away. Instead, he lifted his hand slightly, as if weighing something invisible.

"I used to run," he said finally. "Five miles every morning. Same route. Same sunrise. I thought if I kept moving, I could outrun everything."

"Everything?"

"Loss. Regret. Time." He chuckled softly, though there was no humor in it. "Turns out, the body keeps score better than the mind does."

We sat in silence for a moment, the monitor filling the space between us. Beep. Beep. Beep.

"I wasn't always good," he continued. "Missed anniversaries. Missed birthdays. Told myself I would make it up later." His eyes shifted from the screen to me. "You ever tell yourself that?"

I thought about the messages I had not returned, the dinners I had skipped, the family gatherings I had attended in body but not in presence.

"Yes," I said.

He nodded, as if confirming something he already knew. "Later is a dangerous word."

His oxygen tubing shifted as he leaned back, wincing slightly. Instinctively, I reached to adjust his pillows, a small, practiced gesture.

"You're good at that," he said.

"At what?"

"Taking care of people." He paused. "Just do not forget to be one of them."

The comment lingered longer than I expected.

We talked for nearly an hour, about his life, his work, the daughter he had not spoken to in years. About the run he stopped taking when his knees began to ache, the symptoms he ignored until they became impossible to dismiss.

At some point, his voice softened, words slowing as fatigue overtook him. I checked his vitals, adjusted his medications, did all the things I was trained to do. But before I left, he said one more thing.

"Promise me something."

I turned back.

"When you hear that," he gestured toward the monitor, "do not just think about keeping it going. Think about what it is keeping time for."

I nodded, though I was not sure I fully understood. By morning, his condition had worsened. Rounds and sign out became a blur, labs trending in the wrong direction, consults placed, plans adjusted. The language of medicine took over, diuresis, ejection fraction, prognosis. Words that create distance where emotion threatens to interfere.

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By the next night, the monitor told a different story. Irregular. Then erratic. Then silence. I stood at the foot of his bed as the team moved with practiced efficiency. There are protocols for these moments, clear steps, clear roles. We followed them all. But some things cannot be reversed. Time of death was called. The room emptied slowly, leaving behind a stillness heavier than the one that had existed the night before. The monitor, once alive with motion, now showed a flat line, uncomplicated, absolute. I found myself staring at it, remembering his words. Not the numbers. The story.

Later that week, I called his daughter. It was not required. Someone else could have done it. But his story felt unfinished, and in some small way, I had become part of it. She answered on the third ring. We spoke briefly, about his hospitalization, about what had happened. Her voice was steady, but there was a fragility beneath it, like something carefully held together.

"He talked about you," I said before I could stop myself.

There was a pause.

"He did?"

"He wished he had said more. Sooner."

The silence that followed was different this time, not empty, but full.

"Thank you," she said quietly.

After we hung up, I sat for a long time, thinking about the spaces we leave between heartbeats, the words unsaid, the moments postponed, the lives we assume will wait for us. Medicine teaches you how to measure life in precise increments, beats per minute, millimeters of mercury, liters of fluid. But it takes patients to teach you what those measurements mean. Now, when I hear the steady rhythm of a monitor, I still think about physiology, about stability, about the next clinical step. But I also think about sunrise runs, missed birthdays, and dangerous words like "later." And I try, in the space between those beats, to remember what we are really keeping time for.

12. Embracing the Uncomfortable

Andrew Wu, MD

Just double checking, 40 meq of potassium will be ok?"

As healthcare providers, we are often entrusted by our patients to have all the answers. In a time where they are sick and vulnerable, patients depend on us to give them the best treatments possible. As a new intern perhaps overly aware of these expectations, I remember being more or less in a constant state of anxiety. Seemingly on a daily basis, I was being asked new questions or instructed to perform new tasks I had never done before. A few months into the year, as I finally felt things slowing down and I was starting to get a grasp on my new role as a provider, I entered some potassium for a hypokalemic patient. A nurse quickly messaged me back confirming the dose. Funnily enough in retrospect, in what was an innocent confirmation for her, sent me into a panicky re-analysis of my entire life for me: did I overestimate her AKI? Am I going to be responsible for a crazy arrhythmia? Am I missing something deeper and the entire world is about to be taken over by a species of aggressive but benevolent ducks?

"Can't we do anything else for his pain?"

As a third year resident, having benefitted from a few more years of experience, the neuroticism began to tone down and I began to develop more confidence in my decision making. Interestingly, I began to find myself more frustrated rather than anxious when second guessed now, wishing others would trust I know what I am doing. In treating a cancer patient with difficult to control pain and already on a substantial amount of pain and anxiety medications, his wife asked for another dose of pain medication. They were still choosing a life sustaining treatment plan and while visibly drowsy already, he would groan audibly with every movement. It was after hours — there was no palliative care team to bail me out. Prepared to again talk about the need to limit further sedating medications, as I watched the tears well in her eyes, I realized she did not necessarily doubt me; my frustration and stress was not with others questioning my judgment – it was with me subconsciously wondering if I was truly doing the right thing. As I held her hand, I silently called myself a big dummy and wished I was an attending already when things would finally at last be clear.

"Should I scan this guy?"

I was admitting a woman who had sustained a minor scratch on her great toe a few days ago but now presented with severe pain up to her thigh and confusion. Strangely, aside from the little scratch mark on her finger, she had no erythema on her leg. After fluid repletion and antibiotics, she remained tachycardic and I did note her oxygen requirement was at 4 L at this point. Because of a creatinine of 6 from a baseline of 1, she never received a CT scan in the ED. It was a few years after I graduated residency at this point and I felt the familiar cascade of anxiety, frustration, stress wind knots inside me again as I asked myself what the right thing to do was. Am I going to send this guy to dialysis? Am I going to miss some crazy vascular event? Yet, as I talked with the surgeons, I felt a little sense of calm inside me as well. I think I started to realize there will probably never be a point where everything is clear and everything is comfortable; there's just too many variables in how patients present, how their disease manifests and ultimately in life. But I also think this is part of what makes medicine so rewarding: the challenge of something new and unknown. And in the end, I think I actually really like that. Making a note to practice my deep breathing exercises more, I get up to go talk with the family about the plan.

POETRY

13. Thursday Night Learning Objectives

Naa Asheley Ashitey

HONORABLE MENTION

The sun now sets at 6:30,
Though I still hear Cicadas screech
through October sunsets.
They sing in sync with my mother's heartbeat
at her last appointment.

I promised my mother that I would not add
To her suffering each time I make her
Dial the phone to schedule another appointment,
promising I'll cover the co-pay
with the money she was
going to pay me back for covering her last one.

When I end up at that street next to Monroe,
the temperature drops to sixty-five
and the earth falls silent.
By 7:15, that silver fence fades into the dark.

I'm too strong to let my knees give out,
So, I hold back the wails of the child
locked inside the body of a girl[woman]
who still doesn't know when or how
to convince her dad to make a life insurance plan,
because she's too occupied
trying to learn the cranial nerve pathways,
and feeling guilty that
the hardest thing she had to today
was memorize cranial nerve pathways.

14. Learning with a Cost

Aylinh Eng

She gets to take her patient history.

She gets to conduct her focused physical exam.

She gets to present to her attending.

She gets to help write clinic notes.

She gets to answer questions.

She gets to make mistakes and learn from them.

She gets to move on and go about her day because she is a medical student.

Someone gets to oversee her.

Someone gets to give her feedback.

Someone gets to answer her questions.

Someone gets to give the patient a diagnosis.

Someone gets to take the fault and responsibility.

Someone gets to move on with weights on their shoulders because they have trainees and patients depending on them.

Someone gets to be woken up for their vital signs to be taken and blood drawn at 4am.

Someone gets to be asked the same questions multiple times by different people coming in and out of their room.

Someone gets to be a practice for learners because they are at a teaching hospital.

Someone gets to have a nasogastric tube inserted and have their throat be in pain every time they swallow.

Someone gets to receive the news about their cancer progression and poor prognosis.

Someone does not get to move on because this is their life now.

15. Foreign Lines

Nicolette Khalifian

My eyes were once soft ,warm,
innocent and unworldly,
painfully delighted by his tempered stare.
For it was a reminder that he chose me.

My hair was soft ,neatly brushed.
My cheeks still lifted beneath smooth ,unmarked brows.
My feet married the kitchen floor ,and my manicured hands
wiped
and wiped
until he smiled.

And then I did too.

I was his very own Cinderella–
quiet,
obedient,
grateful,
beautiful.

His hands were meticulously sculpted ,strong.
They find my neck with precise
force.
My eyes meet the mirror ,and I watch my pink lips turn blue,
and then pink,
and then blue again.

I stay quiet
so he releases me.

Decades pass.
I meet the mirror again.

Heavy eyes,
furrowed brows,
fallen cheeks,
and
folds
and lines
that are not mine.

I don't know her.

I look at the plastic surgeon with eyes that are soft,
warm,
innocent,
unworldly–
begging him to use his knife to take me home.

16. Heliotrope

Alexander Nelson

He is the flower, whose modest eye,
Breathes his softest, sweetest sigh.
Tender, he slithers from the throat of divinity,
And ignites the heavens in fervor — serenity, stripped from the skies.

Heliotrope; oh, heliotrope, you foolish one.
Heliotrope; oh, heliotrope, you long for the forsaken son.
Your eyes, veil your demise,
Under an ephemeral guise for the Eternal Sun.

An immortal curse, the first impression of life.
Desperate, you cling to lucidity in strife.
Delicate, naivety draws your bloody tear,
"*Heliotrope; oh, heliotrope*," you hear, beckons the scythe.

Your grip begins to slip on the memory of your youth;
Your eyes, veil your demise, with an unspoken truth.
In faithless idolatry for Helios, you gaze.
While psalms set souls ablaze, tragedy remains your Book of Ruth.

A kindred spirit on sickly sweet passion;
Grief, the fallout of love, is what you must ration.
Your limbic lust purges past from future's stage.
Heliotrope; oh, heliotrope — once a boy, now aged and ashen.

A pious corpse, forever bathed in auspicious light;
Writhing, through agonal gasps of hellfire and spite.
The roaring opera of ruin within,
Raises a requiem for kin that you can no longer fight.

Under the crimson crucifix, you now worship within.
A Galean gospel; A Hippocratic hymn.
Those golden rays pierce the horizon of rebirth,
Yet cast your ivory chasuble in a violaceous hue, a shadow of sin.

Child of Clytie, what is it you seek?
Your Virgil is now Vicryl — your vow to keep.
Tepid across sterling alters, you repent.
Alas, you lament in vain — no valor to reap.

The faithful flower, embalmed by the once prosperous hour.
Your eyes, now crystallized, by an ichor of power.
For, a love so deep it buried itself alive.
Heliotrope; oh, heliotrope, you are free and so am I.

17. 317AM

Kaden Rawson, MD

"I'm sorry to inform you that your son is dying,
Despite the drips and the drugs—everything we're trying.
We've been giving extra care,
But there's a perf, or a tear. And I just—"

"Good morning, Doctor, but I'm not so sure that you know
My son gave his word, a promise, to attend a show.
His little girl loves to dance.
So I'm beggin' you now, please give Him a chance."

"It's the numbers, it's his labs. The blood and the gas...
Maybe, I think--I'm deeply sorry--his time has passed."

"Do you have a child, good Sir?"

"No?"

"Then you don't understand my sorrow.
The best you can do with such pain is attempt to borrow."

"I—"

"I request a favor, nothing major, just an ask if I could.
Please call back tomorrow, and tell me something good."

18. Quietus

Soni Rikin

He lies there
On hospital sheets
Sheets so soft, so white, so pure
It blinds, and shocks, and paralyzes death
He lies there
Crowding the empty room
With his single thought
Silencing the hums of the machines
Halting his wish
He lies there
Motionless
As the traces of the leads
Dance and plunge and scatter
Reducing the life of his years
To fragments on the screen
He lies there
Aimlessly
Pointing to the looming shadow
Confirming to me
With his might
His decision is made
He lies there
With morphine in his veins
Bellowing his soliloquy
He harbored for so long
Through an unblinking stare
He lies there
He lies there
He lies there no more…

19. Vital Signs

Niki Viradia

JUDGED WINNER

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

POETRY: *MEDICAL STUDENT*

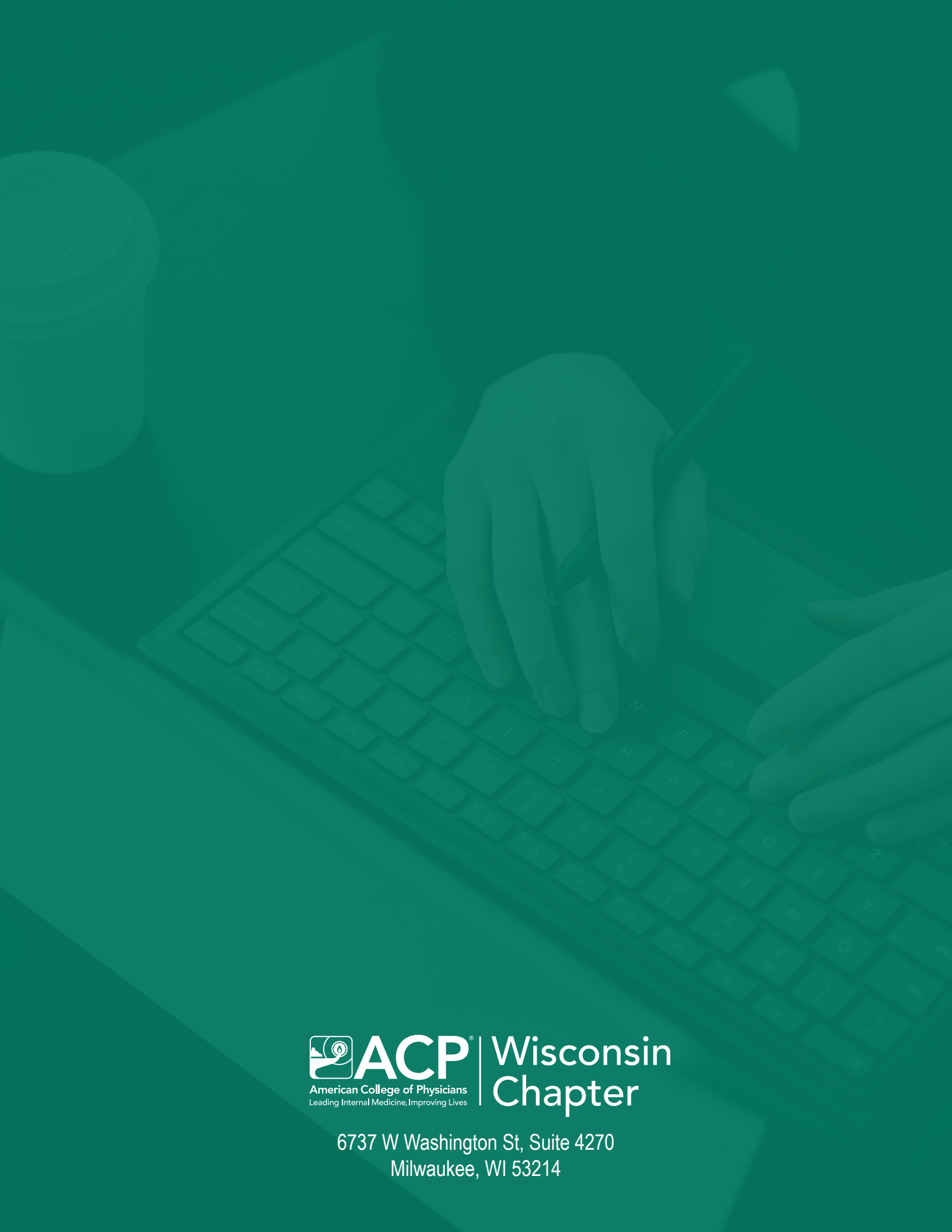
The monitor speaks
in a language we pretend to master,
green lines rising, falling,
a quiet metronome of borrowed time.
We learn early
to trust its rhythm,
to chase its deviations,
to fear its silence.
But no one teaches us
about the spaces in between.
The pause
after a question left unanswered.
The breath
before bad news becomes real.
The stillness
of a hand no longer squeezing back.
We chart numbers
as if they are truths —
heart rate 92,
oxygen 94%,
pain "manageable."
But where do we write
the weight of a daughter's voice
over a late-night phone call?
Or the way regret lingers
longer than any arrhythmia?
There is no box to check
for "I'm not ready."
No unit of measure
for "I wish I had more time."
So we listen instead,
not just to the beeping,
but to the stories
threaded through each fragile beat.
A man who once ran
toward sunrises
now watches a screen
count what remains.
A physician stands nearby,
stethoscope in hand,
learning too late
that saving a life
is not the same
as understanding it.
And when the line finally stills,
unwavering, absolute,
the room does not erupt.
It exhales.
Because even in silence,
something continues —
not in the body,
but in the echoes
of what was left unsaid.
The monitor goes dark.
The story does not.

I will soften myself, when the moment is hard
I will be curious, when I do not understand
I will be patient, when the way is long
I will seek the ground where you and I both stand
And then, we can begin

21. Only Human

Andrew Wu, MD

I sat there broken
My head low
And yet there you were
And you made me whole
Hand on my shoulder, reminded me that in the end
No matter how hard we try
Or study, or work, or pretend otherwise
We are still only human
And years later, I can't tell you how much that means to me still



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