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SPRING
2019



DRINKING FROM THE FIREHOSE

Janus

Drinking from the Firehose

Dear reader,

Janus is a student-run narrative medicine journal at the University of Tennessee Health Science Center College of Medicine. Our name was inspired by the Roman god of transitions, who has two faces, allowing him to look simultaneously at the past and the future. Our journal encourages student reflection on our journeys in medicine through writing and artwork to better understand our patients and ourselves. Through reflection, we are positioned to better serve and more compassionately care for our patients in the future.

In this edition of *Janus*, we explore the oft-repeated adage that medical school is like “drinking from a firehose.” It’s an intimidating image that conjures up a sense of both worthy challenge and obvious futility. In our best moments, we conquer the stream. In others, we may feel as though we’re drowning. In others still, we may have no sense of our progress at all. Whatever the case may be, we know only that we must keep “drinking.” It is this unrelenting task around which our lives have taken shape, forcing us to either cope or collapse.

The earnest and powerful writings, artwork, and photography in this year’s edition reflect the full spectrum of students from beleaguered and beaten to conditioned and hearty. We are immensely grateful to our authors for sharing their stories, so that we may be united in our common struggle.

Additionally, we are grateful to the community of peers, faculty, staff, and administration at the College of Medicine who have vigorously supported our vision of creating and sustaining a vibrant narrative medicine culture on campus. We are truly honored to share this Spring 2019 edition of *Janus* with you.

Sincerely,



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Max Rippe

When people say the white coat is “heavy,” you might think that you understand what it means, that you know what to expect, and that you’ll be able to handle it as you have most things up until this point—with relative ease.

You know the coursework will be difficult and the load demanding. You might expect to be emotionally challenged by the experiences that will mold you into a doctor. There is something else less frequently considered: that putting on the white coat might mean taking off others, and wearing them less. This became my primary fear during my first weeks of medical school.

When I began, I had not been a student in a classroom in over two years. I had spent most of that time working and traveling in other countries. I never had a long-term plan during this time; I’d volunteer for a few weeks or months in a place, usually staying longer than I had originally intended, and then city-hop for a few weeks before settling in another place.

The coats I’d worn then—the big green one that kept me warm while hitchhiking during the Serbian winter, the hand-me-down I sported when playing basketball in a refugee camp, or the neon Adidas knock-off I wore while teaching Vietnamese students—didn’t seem to have a place in medical school.

These coats had turned me into an inquisitive risk-taker and an un-showered traveler; a friendly stranger and devoted journaler; a foreign volunteer, a trier of all foods, a listener and teller of stories. They had been a large part of my identity during the past two years, and now I was exchanging them for one crisp, solid white coat that made me match my 170 classmates.

Don’t get me wrong—this is the coat I had longed for, and there is truly nothing like the first time you put it on. But the hasty transition to this seemingly all-consuming world of science was not without difficulty for me. I had begun medical school fewer than two weeks after arriving back in the U.S. I was still processing my experiences and adjusting to being back in the country when it was time to dive into my new life as a medical student. My days suddenly revolved around anatomy lab and metabolic pathways, leaving little room for much else. The person who had donned all those different coats just a few weeks ago seemed long gone.

Then came my first days of shadowing. For the first time, I was wearing my white coat in the hospital under the title of *student doctor*. My perspective began to change. At some point during those days, I realized that my white coat wasn’t acting alone. It may have been the one patients saw, but the coats I had thought to be pushed toward the back of my closet were still with me. The lessons I learned in them—the importance of staying open-minded and curious, listening to every person’s story with respect and compassion, and being present in each moment—influenced how I thought and helped me connect with patients and peers. The person I had been in those coats wasn’t gone after all. Maybe, I thought, it’s possible to wear more than one coat at a time.

As days go by and I gain more experience in my new role as a medical student, I continue to find that the coats I wore for the past two years complement this white one I wear now. And if there is anything that the Serbian winter taught me, it’s that it’s usually best to layer.

The first question my father asked me after my White Coat Ceremony was, “How did it feel, taking the Physician’s Oath?” I told him, honestly, that it was terrifying. As physicians (or physicians in training), we ask our patients to give up their privacy, their money, and their comfort so that we may, in return, help them. Patients rightly expect doctors to save their lives, but there was nothing in the oath I swore that day that stated this. I swore to respect human life. I swore to look after the health of my patients. However, I also swore to respect my patients *after their deaths*. There is a gulf between our patients’ expectations and our own that sets everyone up for eventual disappointment.

As a medical student, I have faced this disappointment consistently since beginning my journey in medicine. I came to medical school wanting to save lives, but instead found slides and slides on causes and symptoms of diseases with no cures. My grandfather died of Alzheimer’s while I studied it for a histology test, and the only aid I could offer my family and myself was the advice not to spend money on a genetic test for the disease. That day, I felt like a failure regardless of my academic performance.

Our medical education does not conceal the eventuality of death. On our first day of class, we are introduced to our first patients: our cadavers. Our adjustment from terrified yet respectful to accepting is rapid as we poke, prod, complain about, and rename these people for a class designed to teach us the standard state of the body. Death is normal. Get comfortable with it.

This is not the wrong thing to teach; death is normal. Immortality is not within the purview of humanity. However, “everybody dies” does not comfort a dying patient. It doesn’t even comfort a patient with toe fungus. Still, we can normally suspend disbelief with our patients and prolong their lives for long enough that we might as well have saved them.

What happens on the day when we can’t, though? Because there will be a day in every single one of our careers when we have to look at a patient and recognize that they will die on our watch. Death will win, we will lose, and that patient will lose everything. But we may still attempt to prolong their lives. We may strive to get them to their next birthday or their daughter’s graduation or the next football Saturday. We may aim for one more ride on their horse, one more steak dinner, one more laugh. We can grant them every second possible to live and then let them die with comfort and dignity. And, at the end, the one thing we can always do is make sure that they don’t have to face it alone.

We will still be letting our patients down, but it just might be enough to earn their forgiveness. That’s close enough to success for me.

A knot I could feel from the energy within,
I must find the residents' lounge to know where to begin,
Which floor, which room, which direction to explore,
Which patient to see, which note to write, how dare I ask for more.

A smile I must fake; it's confidence I lack,
I open the door to a patient: status post-asthma attack,
"Hello" I say and ask how the patient feels,
Gathering info to present, nervous about the ordeal,
Stuttering a little and pausing a lot,
The team looks at me skeptically; they don't trust what I've got.

Next comes the rapid fire, which comes as a surprise,
I don't have good answers, despite many tries,
I hold my breath for the next round of questions,
The resident says, "ease up; relax, it's about the progression."

I am new on the job, I tell myself, with a whole lot to learn,
I am a student; it's experience and learning I should yearn,
Time to crack open a book and study my cases well,
Clinical exams take much time and effort to excel,
It's ok to be wrong; that's how I learn of my weakness,
The poise and presentations of the residents show me I need this.

The curve on which I'm learning is uncomfortably steep,
Late-night studying and early-morning rounds, I am losing much sleep,
I am learning how to be a doctor, it's all a part of the process,
I strive to learn from failures but it's hard, I must confess,
The clinical world is an arena with many to impress,
But "keep going" I remind myself; it's all a work in progress.

I thought the coat would *make* me.

I thought the pristine white fabric would cleanse my self-doubt, hoped it would replace the layers of insecurity that I'd been wearing underneath it all.

That comfortable garment of perfectionism—the one with *aren't you glad we haven't gotten something really wrong yet* stitched across it—is most noticeable as I hold out my arms to don the longed-for coat.

In the seconds it takes to grasp the fabric, I imagine the purpose and confidence I'll feel wearing it. As I pull the white coat over my arms, though, I'm met with something unexpected.

Resistance.

There isn't enough room.

It's like slipping on a parka over a turtleneck.

I should've known it wouldn't fit.

Thoughts of doubt are instantaneous: *does it look more natural on other people? Shouldn't it fit? Why doesn't it fit?*

It doesn't take long to start sweating. Day after day, I wonder if people can see the bulky sleeves labeled *imposter* creeping out from the bottom of my coat arm. I wonder if people can see *fluke* poking out over the collar. The seams of the white fabric barely fit over the layers of inadequacy.

The coat didn't change a thing.

I feel the same, just *heavier*.

Day after day, I try to wear it, but I can hardly move against the restrictive layers. I try to wear it all until I cannot take it.

It's only as I catch my reflection—seeing that same bulky sweater of perfectionism underneath—that I realize it: the coat cannot cover what it was never made to conceal.

I can't wear them all. It will never fit if I do.

One by one, they'll have to go. Those worn, comfortable layers of self-doubt and striving that rest so easily on my shoulders after all this time.

I can't wear them all.

I thought the coat would make me.

Instead it made me choose.

Comfort or calling. Will I leave behind the familiar in return for something new? Will I trade what I thought fit for something functional? Will I shed my self-centered fears for the betterment of others?

What will I wear today?

“It’s like drinking from a firehose.” Every medical student has used this old analogy to describe their lives to friends, family, and those who dare to consider this training themselves. Why would they not? It creates the picture of a tired student gulping down knowledge, struggling to keep a grip while their abdomen threatens to burst from fullness. It’s the picture observers expect from us and one that we secretly love to display. It screams, “Look how hard I work. All I do is study. You can’t imagine how busy I am.” In a world that equates self-worth with productivity, medical students bask in approval until our heads mirror our swollen stomachs. I wonder, though, if we ever really examine this. Why do we accept a system that forces us to suck in information, only to vomit it back out? Are a few points on a test worth the sleepless nights, the numbness, the preempting of our lives? The truth is we spend more time learning the different mutations causing leukemia than how to tell a family their child has this devastating illness. The constant flow of the hydrant fills us so we learn the signs of diabetes without really learning how to encourage patients to make changes. Sure, we are lauded by our friends and families for hanging on, but if they knew the concoction we were taking in, they would realize it’s simply poison masquerading as fine drink. It begs the question, are facts worth more than people? Of course not. Therefore, I believe it’s time to flip this script. It’s time to hang up the hose so we can release the pressure. It’s time to undo the damage done for the sake of ego. After all, our patients don’t care about the size of our head; they care about our hearts, which this hose can’t nourish.

General appearance: patient resting comfortably in bed.

Mrs. M smiles when she sees me. We exchange good mornings and she jokes about the tasteless “rubber” eggs molded to her plate. I shine my penlight into her deep yellow eyes. *Pupils equal, round, and reactive to light. Scleral icterus.*

“Do you know your name?” I hesitate to ask, “Do you know where you are?” I dislike quizzing her each morning, as these ritualized questions derail our natural conversation. I was taught, however, that assessing cognitive status is part of a thorough exam, so I proceed: “What is today’s date?” She does not know the date or even the year. *Alert and oriented x 2.*

“It’s 2018,” I tell her gently, and she nods with defeat. Mrs. M is a proud woman, and when she is lucid, she describes herself as the matriarch of her family.

I put my stethoscope to her chest, noting the clusters of dilated blood vessels that seem to crawl across her skin. I had never regarded spider angiomas as pretty until I met Mrs. M. The marks remind her of Meadow Rue, one of her favorite flowers from her garden back home. She shows me an image of airy clusters of pendulous lavender flowers that resemble her vascular lesions. I marvel at the photo and ask her to take a few deep breaths. *Multiple spider angiomas on trunk. Heart is regular rate and rhythm. Lungs clear to auscultation bilaterally.*

“Hold out your hands like you are stopping traffic,” I tell her. Her yellow hands flap. She is only 62, but her trembling hands age her. *Grade 2 asterixis.* I place my own pale hands carefully on her enormous belly. *Protuberant abdomen. Grade 3 ascites.*

“I am ready to go home,” she tells me.

“I know, and I want that for you too” I reply, unsure how and when that will be possible. Her morning labs were critical, and her muscles are atrophied from intermittent weeks of disuse in the captivity of a hospital bed. I will have to ask the resident.

As a 3rd year medical student, I have studied the pathophysiology of her failing liver: how her venous blood pools against the pressure of her distorted hepatic architecture, forcing fluid into her abdominal cavity; how her liver enzymes cannot conjugate or excrete bilirubin, and the yellow pigment deposits within the surface of her skin; how her hepatocytes no longer metabolize toxic waste products, and instead, ammonia saturates her neurons, robbing her of the capacity to think clearly. Yesterday, she told me she felt like she was going crazy and begged me to help her. I reassured her that the medication, lactulose, would trap the toxins in her gut and improve her waning cognition, only half believing this myself.

I examine the site where a therapeutic paracentesis had been performed in the emergency room three days prior. Blood seeps through the bandage. Her liver can no longer synthesize clotting factors, and platelets are simultaneously pulled into her congested spleen. In her fragile state she bleeds and bruises easily.

Mrs. M desperately needs a new liver, but I know the transplant team has already declared her an unfit candidate. I read their note earlier this morning. I also know that she has seven grandchildren whom she cares for deeply; one is graduating from the University of Tennessee this spring—the first college graduate in the family.

“Mrs. M, I am going to have your nurse replace this bandage, okay?” I pull her bed sheets up to her knees and press my thumbs to her swollen ankles. *3+ pitting edema. Pedal pulses 2+ and equal bilaterally.*

“I just want to go home,” she says tearfully. I desperately want that for her too. I hand her a tissue like they taught us to do in our standardized patient encounters. “Hang in there, Mrs. M,” I say as I squeeze her hand. “I’ll be back to check on you later.”

As I exit Mrs. M’s room, I see her son waiting in the hallway with inquisitive concern. Suddenly, I feel overwhelmed by his crucial questions: Why can she not get a new liver? What are our other options? When can she go home? Will she make it to her granddaughter’s graduation?

“I don’t know.” I respond sheepishly as I sanitize my hands and tuck them into the pockets of my short white coat. Unsure how to convey that I possess neither the authority nor the knowledge to answer him, I fumble, “I will ask my attending. I’m really sorry, but I’m just the medical student.” He sighs, and disappointment projects across his face. I, too, feel disillusioned about my role in Mrs. M’s care. While I have memorized the diagnosis, complications, management, and treatment of cirrhosis, I still possess limited clinical experience. There is a glaring disconnect between my scientific understanding of liver failure and the answers that Mrs. M and her family desperately seek. I may ace my shelf exam, but I feel grossly underprepared to navigate the nuance and uncertainty of caring for human beings. What will happen next? I do not know, and I am frustrated by my lack of insight. I do ask my attending, but he bounces the question to the transplant team.

I enter Mrs. M’s room for the last time later that afternoon. I find her sleeping peacefully and decide not to disturb her. I am relieved when her son is nowhere to be found. I dread having to tell him that I still know nothing about Mrs. M’s prognosis.

The next morning a resident pulls me aside: “Mrs. M died last night. I’m so sorry,” he says. I am struck with sadness, and in that moment, I finally understand what I could not extrapolate from a medical textbook: Mrs. M had been quickly deteriorating in front of my very eyes, and no one told her that she was never going home again. In her final days, I had failed her.

Days later, I am assigned to my second liver failure patient, also not a candidate for transplant. When I walk into his room to conduct a history and physical, I see a familiar yellow tint. Dilated blood vessels decorate the skin of his arms and face like a wispy floral motif. The side of his hospital gown is stained with bright red blood from an earlier paracentesis, and his distended abdomen bulges from under the gown. A strange feeling enters my own gut—what seasoned physicians call clinical judgment—and I begin to cry.

General appearance: patient is dying.

Ever since arriving at the UTHSC College of Medicine in the fall of 2017, I knew that in order to survive school and my new profession of medicine in the years to come, I would have to focus on my own health and well-being. This is much easier said than done—it is very difficult to juggle the intensity of coursework, the overwhelming volume of information to learn, and the constant fear and comparison that accompany Imposter Syndrome. Surviving medical school is often billed as “drinking from a firehose.” In many ways, it feels like an understatement, but too commonly we forget (or simply do not believe) that our peers and classmates are drinking from the same firehose we are.

I was lucky during my first year that as an Aid for the Impaired Medical Student (AIMS) representative, I could speak with many of my peers whom I thought were far more talented and able than myself. I learned that they also struggled with their own fears, self-doubt, and anger over not performing to previous standards. One classmate guilted herself relentlessly over missing the “A” mark for the second test in a row; another struggled with personal demons. When the Wellness Committee began to take form, I was glad I could play a part in making sure students understood that they aren’t alone.

When a faculty mentor suggested that the Wellness Committee Newsletter have a greater focus on the humanities, I had the idea to adapt the extremely popular Humans of New York series (developed by Brandon Stanton) for UTHSC. The proposed idea went over extremely well in the Wellness Committee, and Mary Virginia Portera volunteered to join and provide professional photography.

Along the way, we’ve heard so many wonderful stories! It really struck me when I sat down to speak with many classmates whom I always thought had blown through their coursework with ease. One told me how it took him three tries to get into medical school; another talked about the fear of making such a massive financial and time investment while raising a family. Yet another shared her fears of living up to her family’s legacy. Every single person I’ve interviewed has told me they are not an exciting person and “can’t live up to the great stories being told.” Yet, they go on to give an amazing interview that ends up being cited the same way by the next interviewee: “Well, I can’t say anything half as exciting as they did.” We hope that as the series expands, people will continue to learn more about their classmates, the faculty and staff, and the students in other colleges across UTHSC. It’s really made my heart happy to see, hear, and share the inspiring and powerful stories from the Humans of UTHSC.

“Behavioral Intubation”

November 2018

Jackson Hearn

A man lies bound and covered in blood
from his scalp, running down his face (pepper-sprayed) to his handcuffed wrists
pressing cold and burying into his writhing belly as he is held down from legs to neck
and told to calm down.

He gargles blood, and suction is placed.

He breathes out fire and curses the hands holding him down.

He cries out for water poured into his eyes.

We comply and he is silent;

Propofol, milky and sweet, is given.

The kindness of the gesture stinging as it flows.

To My Patients:

Zoe Reasons

I wish I could talk to you...tell you about myself. About how we are not so
different, we are human after all.

I could tell you of my dreams...how they have always felt bigger than me.
They involved you, though we had yet to meet.

You could see my evolution. Where I began...compared to who I am now.
I was scared. Who was I to be so bold...arrogant? To desire the ability to heal?

How many times I failed. How failing myself meant failing you...creating fear
in its most ruthless form.

Maybe you could see that making it here today changed me. How I wish there
were no tears, and that my heart did not hurt sometimes. How this path hard-
ened me, broke me, then reformed me.

I hope I can tell you it was worth it. I would gladly sacrifice it all again to steal
your pain if I could know I would survive.

But when my heart's fire expires, and my eye's light dims, would you believe
me if I told you I tried? If you saw how I struggled, would you still call me
“Doctor”?

Dear Donor,

Is this an artery, a nerve, or a vein? I seemed to get this question wrong more often than I got it right. There was so much to learn that the simplest things sometimes escaped me, and the easier subjects were often still difficult. We learned so much outside the lab that we were constantly (and only sometimes successfully) searching you for clarity. Throughout my lessons with you, my first willing patient, a theme emerged: better to make mistakes now on you whom I cannot harm than to get it wrong later when lives are on the line.

Dear Donor,

In the sea of information, you taught me some of the most impactful lessons. From you, I learned that no two bodies are alike. You are barely over five feet with a petite frame. The donor right next to us could have easily been twice your weight. This contrast reminds me to individualize my future treatments. What works for one person may not work for another. You taught me that the way you treat your body has long-term consequences. You were eighty-nine when I met you, and I could tell from the beginning that you were a healthy person. Throughout the semester, we learned that you had pink lungs, red muscles, and extremely dense bones. You treated yourself well, and it shows. This is an important message for both my individual health and that of my future patients. Most impressively, you showed me through your scars that the human body can tolerate conditions that would have seemed unmanageable to me before I began training with you. These marks hint at stories we will never truly know, but when we peeled back your damaged skin, we found healthy tissue that bore no sign of the trauma above. You were my first patient as a future doctor, and I will carry the lessons you taught with me throughout my career.

Dear Donor,

I once read that the first step in changing the world is caring about issues that don't affect you personally. I can't imagine any better illustration of this than donating your body to medical education. There are so many people whom you have never met whose lives have changed because of you. A star's light shines long after it dies, and yours does as well.

Dear Donor,

Words seem insufficient for the gift you've provided my peers and myself. I deeply appreciate what you have given us: the opportunity to truly connect with the material we're learning. As information is thrown at us faster than I could have imagined, you've provided an opportunity to make sense of it all. Working alongside dedicated, excited classmates fosters a community of engaged learning that I have never experienced before. This experience is one I will cherish not only throughout medical school but throughout my life and career. I will be forever grateful to you.

Dear Donor,

Thank you for selflessly choosing to donate your body to science. Your donation is crucial in helping me and other medical students understand the human body in a way nothing else could. Whether I end up going into medicine or surgery, I know you have helped me become a doctor. Every patient I heal will not have been possible without your contribution.

Dear Donor,

I feel that I know your body more completely than I know my own, but despite the months, long hours, and late nights that I have spent with you, I really don't know you at all. You lived an entire life outside of my small world with your own strengths and opinions and emotions; things that I could never learn from my time spent with you. The only thing that I can know with certainty is how important you are to me. You, above anyone else, taught me more than I believed I could learn. You gave me the opportunity to discover skills and interests that I didn't know I had and knowingly gave yourself fully into the hands of people you would never know. I promise to return your selflessness and ensure that, long after our time together is over, the knowledge gained from you will be used for the benefit of others.

Dear Donor,

Although your body still sits in the cadaver room, we hope your soul has found peace and happiness. We have learned more from you than we ever thought we could know.

Thank you,
Table 20

Whimsy fell on my head today.

It had been tacked up on a 2'x4' poster above my bed. Big Letters to remind me every day of Big Plans to live a Life of Whimsy: a life of Joy, Spontaneity, and Fun. Letters which I've often had to dust off during my first two years of medical school. They had been replaced by long days of studying, striving, and stressing. I woke up to those Big Plans falling off the wall and into my life. Inconvenient for me but maybe right where they should be.

When I'm dissatisfied with an aspect of life, my tendency is to buffer it with Big Plans. Instead of carefully planning small, everyday steps toward where I would like to be, I am more inclined to make a big, quick change in the direction that I want to head. People applaud you, and you feel like you've done something worth celebrating. Like a New Year's resolution, Big Plans start out exciting and bold, but often are unsustainable in the long run. The difficulty awaits the next morning or the next week when you wake up, and the glitter has faded, and you're tired and running late to work and could really use another cup of coffee. The compulsion of Big Plans is their demise. They're difficult to sustain, and failing one part makes the whole seem too daunting, leading to abandonment of the Big Plans altogether.

When I was overwhelmed by the tedium of rotations and wanted a change, I thought that putting *Whimsy* on a wall would make the word suddenly define my life. I wanted a quick fix, but didn't want to put in the hard work of bringing whimsy into my day-to-day life. But *Whimsy* isn't meant to be up on a wall. Living a life of whimsy is a decision you make and stick with, even amid the monotony of normalcy. It will probably be thwarted every now and then by obligations and commitments and "*How in the world will I ever match into a residency?*" Most days, I remind myself five times before noon that I want my life to be defined by more than just medical school.

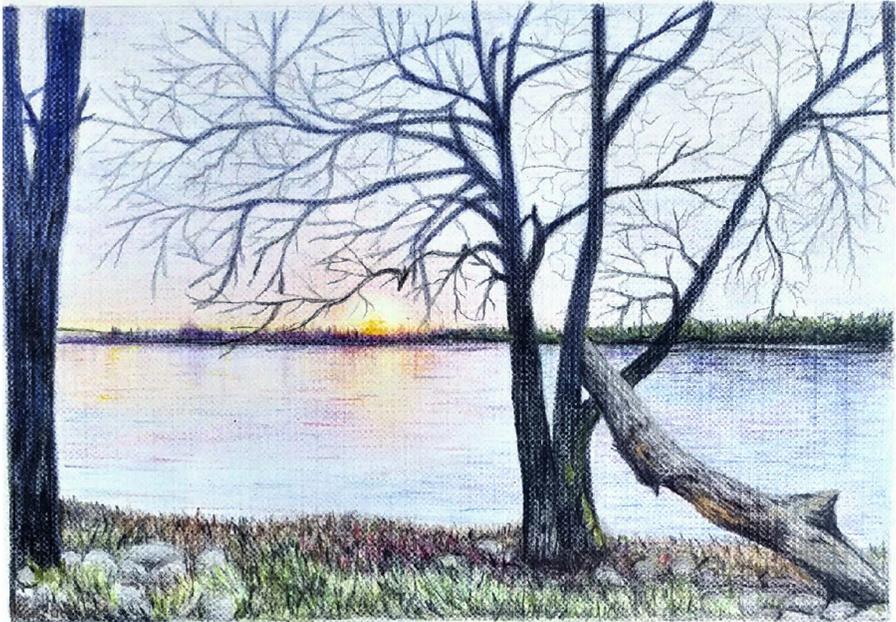
One day I hope to become a Woman of Whimsy. A strong physician, a kind soul, and a woman of my word who is always ready for an adventure. The day that *Whimsy* fell on my head, my day didn't look too different from the day before. I woke up, went to the hospital, and rounded on my patients. But that day was also a little more fun. I was looking for opportunities to laugh and to make the kids whom I was caring for smile. Trying to improve from the day before, I worked a little harder on my patient notes. The day may have not looked much different, but it was defined by small attainable steps towards the physician that I would like to become. I'm not there yet, but today I'm a little closer than I was yesterday.

Whimsy will probably fall on my head again.

I hope it does.

Hours before the sun rises, I see myself in the cold cadaver lab trying to orient myself to the intricacies of the human body. Suddenly, I hear my alarm going off, and I awake to the reality of climbing another mountain that is a new organ system. It is still well before the crack of dawn as I trek up the cold, steep slope with the end of assigned Robbins reading nowhere in sight. As I stand at the top of Mt. Haleakala, under the Milky Way, my primary motor center telling my whole body to shiver for warmth, I sometimes wonder why I left the comfort of the warm, tranquil beaches of Hawaii. But as the sun began to peak through the skyline, all my discomfort disappeared as my perseverance was rewarded by the vibrant, dynamic colors of a sunrise. From the self-discipline of finishing a demanding curriculum to the development of empathy and patience, the challenges of school brought out the best in me and made me a better person. I am thrilled with how these long hours of grit and grind have shaped me, and I can't wait to climb more mountains. I wouldn't trade this journey for any other path. Thank you, UTHSC College of Medicine, for changing my life.





*original artwork in colored pencils

Slide after slide of lectures, hours of podcasts, videos, and countless more of studying. Medical school is the challenge I choose to wake up to everyday. True, it is difficult and exhausting; often I fall, and it feels like I might finally fail. But in these times, I lean on people filled with love and encouragement. They are the ones who keep me from completely stumbling to the ground. Like the log, I am tired and exhausted. But, there remain those who support me with love, so I may continue this journey and realize its beauty. If anything, “drinking from the firehose” has made me appreciate all these wonderful people in my life, as I continue with support to lean on.

Breathe. I turned off my car and braced myself as I watched the tractor-trailer speeding towards me in my rearview mirror. Powerless, all I could do was wait for the inevitable collision. I braced myself as the semi crushed my car like a soda can into the cars in front of me, likely filled with people who were also going home to their families for Thanksgiving. If my second year of medical school had not proven hard enough already, dealing with the aftermath of a traffic accident that could have killed me took me to depths I could not have imagined. My physical and mental health suffered—my body in constant pain and my self-confidence shot after barely passing the school year. All of this resulted in my inability to focus on studying for Step 1, a career-defining stepping stone that required more attention than I could afford. The vicious thoughts flooded my mind: *Do I even belong in medical school? I don't deserve to have any patients. I'm a failure.* A drastic change needed to be made, so I asked for help in a way that conflicted with my prior ideas of success—I asked to repeat second year.

This proved to be the most difficult decision of my life, and I immediately felt simultaneous relief and doubt—relief that I had more time to prove myself, doubt of whether it was worth putting my life on hold for an extra year. *Did I make the right choice?* I called a friend to confide my struggle for the past six months, failing to hold back my tears. He told me he was proud of me for making such a mature decision and that my future patients would appreciate it without even knowing about it. Medical school is a long and difficult process. It can feel as if you are in limbo, technically an adult but not quite there. It can also be a rewarding process when you make a difference in a patient's life. He told me something I use as a reminder, more than a year later, to carry myself through the most difficult days of third year—embrace the process.

She was one of my first patients as a third-year medical student. Upon opening her chart, just about all of her lab values were red, denoting they were out-of-range. Pressured by the nagging fear of an attending thinking I was lazy or did not care about my patients, I wrote everything down and tried to come up with an explanation for all these numbers. I began with her admission note from the night before. She had been transferred from an outlying hospital for a higher level of care after being stabilized from a life-threatening episode of septic shock. She had an extensive past medical history, including years of substance abuse, a dental infection causing her to lose all her teeth, chronic obstructive pulmonary disease from an extensive smoking history, and two tricuspid valve replacements secondary to endocarditis. Whenever a student comes across tricuspid valve endocarditis, the first thing that comes to mind is intravenous drug abuse. She was barely in her thirties.

After reviewing my patient's information, I began to search for the medical ICU, a place I had never been before, stopping every so often to ask for directions. Upon finding the room, I saw a pale, cachectic woman groaning in her bed. If I had not already known her age, I would have assumed she was at least 60 years old. As I began my interview, I realized that she had no idea where she was or what day it was and would respond to little less than her name. She was still very sick. On examination, I could hear the fluid in her lungs and see the petechial rash of someone who had begun to enter DIC, signaling the end is very near. Of note there were track marks over both arms and even between her toes. She also had a murmur that would begin a complex debate on what should and could be done next.

Initial management of my patient required broad spectrum, "big-gun" antibiotics. Blood cultures from the outside hospital were positive for MRSA. Her murmur and follow-up echocardiography soon proved the source of this infection was again tricuspid valve endocarditis. This would now be her third tricuspid valve infection, which was almost certainly caused by continued intravenous drug use.

Now, the question was what to do for this woman. Her surgeon was frustrated; he did not see yet another procedure as an option. The two prior were extremely expensive and difficult and were the result of what appeared to be a self-destructive lifestyle. The treatment of tricuspid valve endocarditis consists of weeks of intravenous antibiotics, which meant she would need semi-permanent intravenous access if she was ever going to go home; this could be all too tempting for a current intravenous drug user to take advantage of. Documentation of her husband pushing drugs into her lines at a previous hospitalization further concerned and disheartened her previous providers. She had proven she could not be trusted and had no intention of changing her lifestyle. There were very different ideas of what the plan for this woman should be and, ultimately, the hospital ethics committee was consulted.

About a week and a half after I met her, she had a significant turn around and was suddenly able to answer questions. She had faced an extremely difficult first week fighting off the bacteria that had multiplied in her blood stream and seeded throughout her body, including her lungs and spine. There was also some suspicion that she was going through some kind of acute withdrawal during this time, adding to her distress. Now able to talk and interact in

a meaningful way, she cried and apologized constantly. She thanked everyone for saving her life and voiced a true desire to change. She was very convincing, and you could not help but want to do everything you could for her. She was so young, but her appearance was a constant reminder of the abuse she had let her body endure.

The ethics committee agreed an operation was not possible. A consulting surgeon described how operating on the infected, previously manipulated tissue would be like “stitching wet tissue paper together.” The only option would be to manage her medically, which meant some plan for long-term intravenous antibiotics requiring long-term intravenous access. Even if the infection could be eliminated, she already had significant damage to what was left of her replaced valve and would suffer from cardiac complications that would bring her life to a premature end. The following week consisted of a series of meetings with the patient, her family, and social workers to discuss end-of-life goals and the critical nature of her situation.

There was obvious frustration from many of the more seasoned medical providers with this patient. I am sure they had encountered similar cases before of non-compliant and even self-destructive patients who had repeatedly abused an already overburdened medical system. Witnessing this compassion fatigue was frightening so early in my own career, but I really could not blame them. I am not sure exactly where I stand on this particular case because I have never battled with addiction, nor did I grow up in this patient’s world with her struggles. During an ethics discussion of this case in a class midway through the rotation, a professor brought up an interesting point. She asked if anyone had ever taught the patient to use clean needles and how to obtain such supplies. I was not sure, but I assumed the answer was probably no. I could imagine that if she had been shown, she would likely still have the first, if not her original, heart valve. It would take a lot of needles to get anywhere close to the half-million dollars she had amassed in medical bills. She claimed her original insult was a car accident years ago that began a downward spiral requiring more pain medication for chronic back pain. While her story may not explain her methamphetamine use, it could be argued her opioid addiction began with an over-prescription.

The final plan was to send the patient home with her mother, who would provide supervision of the patient. She was also referred to a methadone clinic. She would return to a resident clinic weekly to receive her antibiotics and undergo a urine drug screen. If she failed for any reason at all, then her care would be terminated. She did not have insurance, and the hospital was going to cover the cost. She was excited to be given another opportunity and wanted nothing more than to spend whatever time she had left with her family. We hugged on her last day, and I did all I could not to cry. She thanked me and our whole team for figuring out a way to give her yet another chance at life. I still had mixed feelings about the situation in general but was happy a reasonable plan had been worked out. I still cannot help but wonder what will happen if she relapses. If the antibiotics are stopped, she will present again in septic shock. She will have to be stabilized because the law compels as much. That hospital admission will again be very expensive, and some new medical team will have to decide what to do next.

“In room three, we have Mr. Hastings, a 60-year-old Caucasian male here to establish care. He hasn’t been to the doctor in years and says he’s been drinking a lot of water and waking up several times each night to urinate. He doesn’t take any medications and says he’s never been told he has any chronic conditions, but his *polydipsia* and *polyuria* likely point to diabetes,” I tell Dr. Warner, my attending physician for my family medicine rotation.

Adjusting his anchor-themed bow tie and pushing up his round tortoiseshell glasses, Dr. Warner replies, “Great! Let’s see Mr. Hastings together.”

Mr. Hastings is a burly man. He wears a tattered t-shirt with a few dime-sized holes. His baggy jeans are blotched with brown stains, and his black tennis shoes are weathered and worn. According to the EMR, he had seen a partner of Dr. Warner’s a few years back but had failed to return for a follow-up visit. After introducing himself, Dr. Warner begins to ask Mr. Hastings questions about his medical history and life. He starts with his current symptoms. “How long has this been going on?”

“Well, doc,” answers Mr. Hastings with a worried look, “it’s been like this for years, but in the past few months, I think it’s gotten worse and worse, and I can’t sleep.” When asked about diabetes, Mr. Hastings answers, “nobody ever told me I had diabetes, so I never took any medicine for it.”

Mr. Hastings’ medical records from two years ago show that his hemoglobin A1c level, a marker for diabetes control, had been over 8; he had had uncontrolled diabetes for at least the past two years. Dr. Warner patiently asks Mr. Hastings what he knew about diabetes, which turns out to be little, before explaining diabetes and the importance of controlling it.

Then, placing his left hand on Mr. Hastings’ right shoulder, as if for reassurance, Dr. Warner uses his right hand to navigate Mr. Hastings’ chest with a stethoscope. He hears the same benign two-out-of-six systolic heart murmur and decreased breath sounds that I had heard. As Dr. Warner searches for the distal pulses, an indicator of blood flow to the legs, Mr. Hastings apologetically brings up another concern: his toenails.

Under Mr. Hastings’ shoes and mismatched socks, discolored and gnarly toenails had grown and curled back toward his skin. Dr. Warner motions for me to come closer. Embarrassed, Mr. Hastings tries to cover one foot with the other, so Dr. Warner reassures him that he could help. Usually, procedures at the clinic were performed on Thursday afternoons. But Dr. Warner doesn’t want Mr. Hastings to go another day with the pain caused by these toenails.

With a heavy-duty toenail clipper, Dr. Warner clips Mr. Hastings’ toenails. Mr. Hastings cries out in pain, and Dr. Warner apologizes, “I’m sorry it hurts.” After bandaging the minor bleeds, Dr. Warner gingerly helps Mr. Hastings put his socks and shoes back on. “Now, your toenails will feel better in a few days, and let’s also make sure we start taking care of the diabetes and follow up in two weeks.”

As I observed Dr. Warner's history-taking and physical exam, I begin to understand how much it differed from mine. I had memorized a set of questions and flew through them with Mr. Hastings. Instead of maintaining eye contact as Dr. Warner had done, I stared at the computer screen as I typed. While I got minor medical details like how he had an appendectomy in the 1990s and had started smoking at age 17, I missed Mr. Hastings' greater life story – of how he had moved to Memphis two years ago and still misses the sunshine and his favorite food carts in California; or how he had worked in construction and knew a lot about fixing old Victorian houses. Similarly, my physical exam of Mr. Hastings was standardized and rushed. I never made space for him to voice other concerns, and thus, I had no idea his toenails caused him pain every day.

I had assessed Mr. Hastings' chief complaints to be polydipsia and polyuria. But Mr. Hastings' real concerns were not understanding why he constantly felt thirsty and why he had to wake up several times a night to go to the bathroom. I had reduced his concerns to medical jargon and put my perceptions of his illness before his own experience. I had simplified the human being before me into an assemblage of symptoms, an intellectual challenge I wanted to solve. I thought I had succeeded. I had recognized Mr. Hastings' symptoms and understood how they pointed to diabetes; I had identified his heart and lung sounds on exam; and I had recommended a healthier diet, exercise, and the need for medication.

But I realized in clinical training that success is much more than just arriving at right medical answers. Anyone can recognize the symptoms of diabetes or a systolic heart murmur on exam, but whether the patient truly feels cared for elevates the calling from just a job. Dr. Warner showed me what compassionate care looks like. He gives his care without judgment, advocates for his patients by listening to and addressing their concerns, and cares for them as people, not just as patients.

I understand why Dr. Warner's patients keep coming back. They don't just receive care; they feel cared for. Some had seen him for nearly forty years. I encountered dozens of patients who told me how much they loved having Dr. Warner as their family doctor and how lucky I am to be one of his trainees. In the clinic's waiting room, Memphians of all backgrounds sat next to each other. I met patients with fibromyalgia, Alzheimer's disease, and HIV, but Dr. Warner knew them beyond their medical diagnoses. He knew them as stand-up comics, grandmothers, and volunteer firefighters. He knew their families and extended families. Through his round tortoiseshell glasses, he looked into every shade of eyes and treated his patients all the same.

One morning, two weeks later, as I arrived at clinic, I hear a familiar voice out front in the parking lot. "Good morning, young lady!" It's Mr. Hastings. After two years of not seeing a doctor, he's back, excited for his follow-up visit with Dr. Warner.

Trees

Nerve, artery, vein, and asterisk.
 Space, potentially
 Saturday morning encore
 Know it cold, a joyless pun
 Charts, cards, colors, sketches, schemes
 An encyclopedia, not a manual
 Therefore the middle and a light trophy
 For reverse-engineering the forest

Walking

You're not paying attention — rewind —
 You're not paying attention.
Take a walk. Catch up tomorrow. Just keep walking. Everything will be okay.
 Eat something. You've got to eat something.
Talk to someone.
 Take a nap. Sleep. Please, just sleep.
It might help.
 Pick it up. Put your fingers on the neck. Find a reason.
Guitar. Remember?
 Like it. Please. Like anything.
Take a walk.

Firehose

6:00 AM
 You're up anyway. You can make it up tonight.
Fifteen minutes.
 Wait, which one's McArdle?
Coffee.
 Oh, yeah. Remember to look at that chart again.

6:13 AM

Nice!
Click. Double-speed.
 I hate that intro.

10:00 AM

Four hours a day, really??
Spreadsheet.
 Yep. Maybe if I...
Spreadsheet.

10:17 AM

[!]
 What a waste of time.
UWorld. 40 questions. Timed. Tutoring mode – Off. Begin.

4:00 PM

0% of users chose this answer.
 Am I the dumbest person...
Performance.
 Doesn't seem fair to call that line a progress curve.
Pharmacology 90%
 Whoa, am I a genius?
Pathology...
 Nope. Definitely not.

4:15 PM

Okay, Pathoma.
Click. Double-speed.

6:00 PM

"Dinner's ready."

6:21 PM

"Thanks for dinner. It was delicious."

6:22 PM

MALE AND FEMALE GENITALIA AT WEEK TEN.
Tenitalia.
 PANCREAS—DERIVED FROM FOREGUT.
Get more panc for(e) your gut.
 Nice. Killin' it.

7:44 PM

"Hey honey, how are you?"

9:45 PM

"Ok, babe, I'm going to sleep."
 Goodnight. Sleep well.

10:20 PM

Toothbrush.
 This off day's really gonna stress me out.
Shower.
 How can you be off at a time like this?
Pillow.
 Wait, which one's McArdle?

Omelet

“Chefs, if you win this auction, one of you will have the right to deny another the use of the frontside of their pans.”

“Our esteemed food critic will have no knowledge of the obstacles placed in your path.”

[Yawn]

Her vitals are uhh stab—unremarkable. Site’s clean and dry with minimal tenderness. Neuro exam is nonfocal. No red flags for compression. CT is unchanged.

So, what do you want us to do?

We were just thinking about letting her follow-up Monday. You guys saw her just a few days ago in clinic. Is there any reason that’s not appropriate for this patient?

Let me get this straight. Is this a formal consult?

Well, my attending just wanted—

Because we don’t do this.

Well, since you operated on her last week, we didn’t want to send her without—

Either consult us or don’t.

You are consulted.

We’ll be there in four hours.

Well, she’s already been here six h—[Click]

Hi, ma’am. So, it looks like they do wanna come see you...but it’s...it’s gonna be a while.

Really, are you serious?

Yes, ma’am, I’m sorry.

Are they gonna do all that stuff again?

Yes, ma’am, in all likelihood.

You people...you don’t care...at all.

“Today’s challenge dish — an omelet.”

End

The war is over, but I still stash food under my bed

Some part of me has learned scarcity.

Guilt is a strange word for this feeling, of being furloughed

It’s more like the sting of some distant, familiar disappointment

“Do something,” it says. “I did,” I reply.

Workahol peering at you from the shelf

Quite a long time to learn that the hours weren’t the real vise.

Still, forgetting isn’t quite as painful as learning

and at least you’ve already learned how to survive.

The End

