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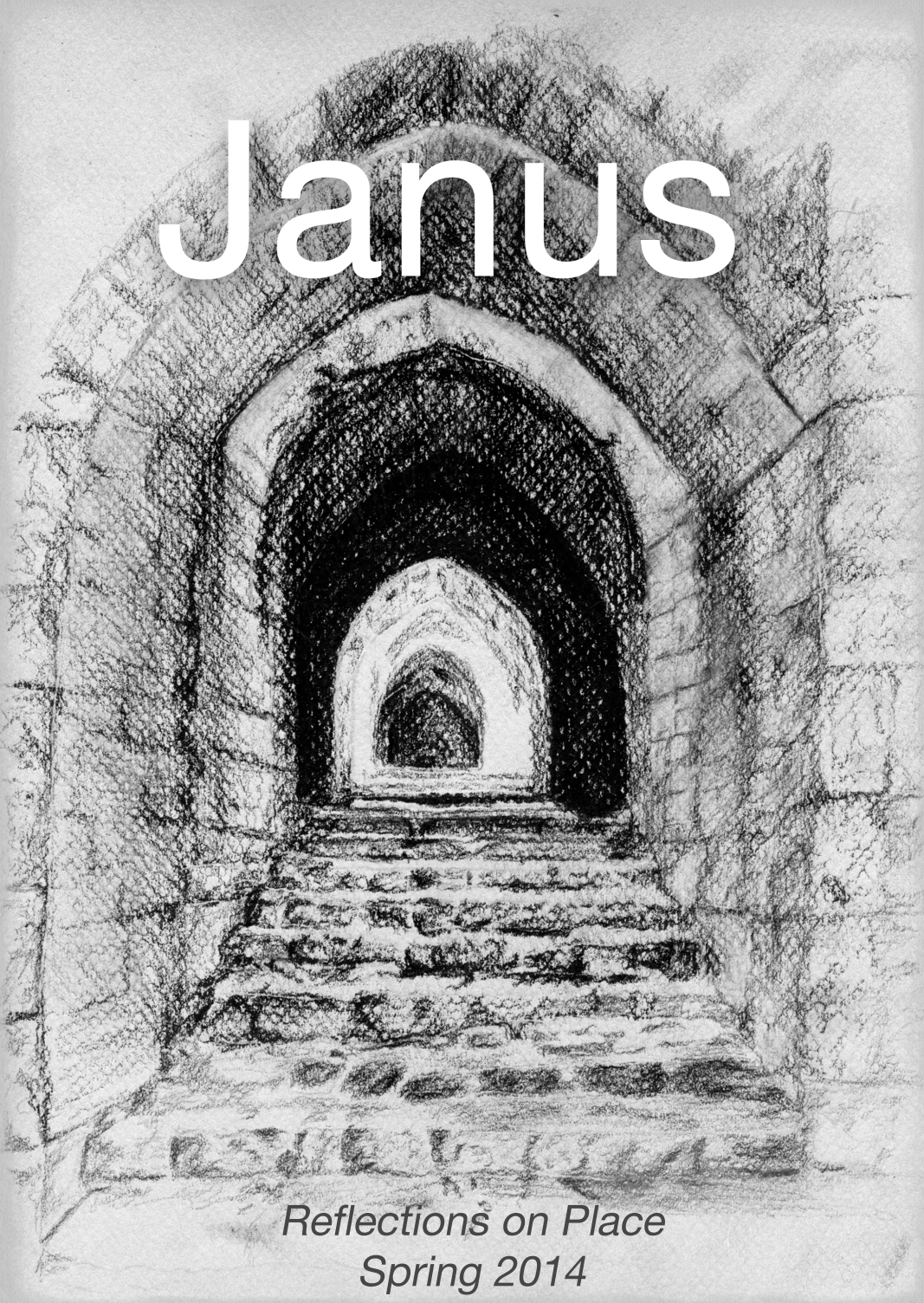

Reflections on Place
Spring 2014

Janus

A Journal of Narrative Medicine
by the Students and Faculty of the
University of Tennessee College of Medicine

Volume II: Reflections on Place

Spring 2014

An Introduction to Edition II: Place

Robert Franklin

The idea of place pervades our lives and our thoughts. Many of us have a distinctly geographical understanding of place- America, the South, Tennessee, the mountains, the delta, the city, the country. We ascribe significance and identity when we describe the places we know and relate to in such ways; we are implicit in the assertion that these places might suggest something about us. Yet this is only one way of thinking about place. Place may also be thought of on a psychological plane. We all inherently recognize this abstraction of the notion of place as a legitimate frontier when we use such colloquialisms as “I am in a bad place” or “everything is in place”. Furthermore, place may be approximated to spaces and their accompanying mental states—the comfort of the hearth and home, the professionalism of the work place, the leisure of the coast, the annoyance of the traffic jam. At a physiological level, there is much cutting edge research on the ways in which the hippocampus and so called grid cells function to allow for an understanding of place. Finally, and perhaps most importantly, place may represent community, or as Wendell Berry states, “the tragic imagination that, through communal form or ceremony, permits great loss to be recognized, suffered, and borne, and that makes possible some sort of consolation and renewal”* This ideal place of a community is a place where hardship and struggle can be metabolized and processed.

Each of these definitions of place, which are by no means exhaustive, must integrally inform the practice of medicine-- the unique epidemiological trials of Memphis and the surrounding region, the challenging mental demands of being a patient or a medical student, the identity politics associated with being “a doctor” or “a mother” or “a diabetic”, and the potential to create a community that promotes healing and care to all of the various ailments that may exist in a given place.

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Cover Art by Maryn Gardner, Class of 2015

Beyond My Skin
Libby Weaver

BRAIN

The morning breaks open my eyes
There is clarity deep as I drift out of sleep
Then the silence subsides to sparks that ignite
One by one they collide forming constellations
That transform to abrasions
Shaped like ideas at random
And hope and abandon
All tangled together
More hours to weather
Spinning and spinning
The worry is winning, then
Stop.
Erase.
This day, embrace.

HEART

Louder than the maddest drum
Steady as a setting sun
The center of the song that moves you
Crashing out like waves of thunder
And other hearts around you will hear
The rhythm that is absent of fear
And one by one
Armies will march
To the maddest drum.

LUNGS

Underwater, Safe and sound
Here I can't fall any further down
I hear no fear, serenity found
Floating, knowing I may never drown
Still I wonder when I will breathe again. And how.

GUTS

You, mountain
I, warrior
Sent to do battle with bears and with boulders
I dance to your wind as it carves out a symphony
And I lose myself somewhere between
The sky and the ground
In a place that feels like atmosphere bound
To the center of gravity, spinning in front of me
And I hold on to nothing as my heart shouts inside
And my lungs feel alive
Warrior, I.

The Sixth Floor
David Moquin

In loving memory of Lynn G. Moquin

I walked into Brigham and Women's Hospital in Boston, MA around 6:30 in the morning. In the past 72 hours I had watched in horror as my mother had a stroke, driven from Boston back to my home in New Hampshire 3 times, and severely questioned whether or not I could make it to medical school in the fall. The first floor was bustling with happy soon-to-be mothers in wheelchairs and new mothers leaving with their newborn children. I was not stopping at the first floor.

I read once that an oncologist delivers bad news more than 35 times per month. I wasn't home when my mom was diagnosed, or when they told her she stopped responding to chemotherapy, but I was there when her oncologist said that there was not much that we could do besides make her comfortable.

There was a small celebration going on in the early morning on the sixth floor. A patient was being discharged. Since all of the patients on the oncology floor were very ill, this was something to celebrate. I was filled with a little hope that maybe my mom could come home again and that things were going to be okay. I didn't realize that she had less than 24 hours to live.

Her condition rapidly deteriorated as we saw physician after physician come in and suggest an option for a treatment, but that it was their advice to just make her comfortable. Interventional radiologists, oncologists, neurological surgeons, cardiothoracic surgeons, pain management physicians. With all of these people it was hard for me to believe that there was nothing to do, but I respected my father's decision. In retrospect I appreciate all of the help that my mother had as she battled non-small cell metastatic lung cancer.

Twenty hours later the mood on the sixth floor had changed. My mom slipped away quietly surrounded by me, my sister, and my father. The nurse had a tear in her eye as the physician turned to us and said that she was sorry for our loss. Walking out of there everything was quiet. There wasn't a cake for us, or streamers, or even balloons.

The sixth floor over that 24 hour period represents the best and worst of medicine. There will be triumphs. There will be loss. Sometimes everything will go your way, and other times there won't be anything left to do except watch, wait, and attempt to take care of your patient the best that you possibly can.

An Unexpected Friend

Amy Smith

Sometime between walking into the first day of gross anatomy lab and walking out of it, I crossed an invisible line. I saw it coming, but all of a sudden I was staring at it, ready to put my foot across and join the people-who-dissect-other-people-for-science category. It was, I knew, a line that could not be un-crossed, so I took a deep breath of the preservative saturated air and stepped gingerly over it.

This step was, of course, followed by mass questioning by my friends who stood on the other side of the line. "Doesn't it seem wrong?" they asked. "Isn't it nasty?" they queried. At first I struggled with how to answer; I knew that it didn't seem wrong at all, but I couldn't quite place my finger on why. It came to me suddenly, however, as we worked through the muscles of the back. I realized that I had a very strong feeling toward our cadaver, and it was a strange one. It felt oddly like friendship.

I puzzled over that for a long while. How could I feel friendship toward a person that I had never met? How could I feel friendship toward a person whose body I was slowly taking to pieces? It didn't seem like the right emotion to have, but that was exactly what it was. Eventually, I came to know the reason. I felt friendly toward our cadaver because I was doing what she wanted. In life, long before I knew anything about her, she chose to donate her body. She looked at her own frame and decided that when she was done with it, I, the medical student that she would never meet, could have a look inside. She gave an enormous gift, knowing that, by the very nature of that gift, she would receive nothing in return.

So now I tell people that no, it doesn't seem wrong to dissect a person. Over here, on the other side of that line, I have found a place of bizarre friendship. By looking, by learning, and, occasionally, by gazing in awe, I am getting to know her, and I struggle to imagine anyone who could teach me as much as this one person already has.

Pahali
Sam Seyler

Below is an excerpt from a blog I and others kept while volunteering at a hospital in Kitale, Kenya, last summer. It started as a way to communicate with family and friends back home but soon became an avenue for catharsis. I think it speaks nicely to the theme of this edition of Janus. – Sam Seyler

"…So live, that when thy summons comes to join
The innumerable caravan which moves
To that mysterious realm where each shall take
His chamber in the silent halls of death,
Thou go not, like the quarry-slave at night,
Scourged by his dungeon; but, sustain'd and soothed
By an unfaltering trust, approach thy grave,
Like one who wraps the drapery of his couch
About him, and lies down to pleasant dreams."

"Thanatopsis" – William Cullen Bryant

I showed up to work last Friday--the final day of my surgical rotation and end of my second week in Kitale, Kenya--to a crowded ward. "Last night was very busy," Muff said. Muff, short for Muffadel, was an intern from Mombasa finishing up his training in Kitale. We had bonded after work the week before, and I was beholden to him for always including us in the rounds, patiently answering any questions we had. His busy evening had been preceded by a major automobile accident near the town.

Hordes of interns and doctors crowded around the sole light board in the surgical ward, looking at a cervical spine x-ray. C4 through C6 were all fractured badly.

"How's the patient doing this morning?" I asked.

"He passed." Muff's voice trailed off.

After a little bit of time, you learn to spot the patients that have died. Though just like the patients that are trying to get a little bit of sleep before being disturbed by morning rounds, a notable rise and fall of the chest is absent in the sheet that covers their head.

"In an equipped facility, you might go in and stabilize the fracture somehow. Here, this is not possible. It's really a shame."

"A shame that you don't have spinal surgery capabilities?" I asked. I thought that was asking a bit much of this hospital, of this town. A shortage of sutures--that's a shame--but a shortage

of neurosurgeons? That's a problem in some towns in America.

"No, a shame he had to die because an ambulance wasn't available," Muff responded.

Then came the kicker.

"They don't even have collars here, and they won't let us improvise." He was talking about cervical stabilizing collars. "Sand is all you need to create cervical traction bags. And how cheap is that? I can go out back and dig up some fucking sand." His tone grated my ears.

And so I took all this in. I can't say that it really struck me until 10 minutes later when the harsh clanging of the gurney that carried the dead was heard at the door of the ward. Two guys, very workmen like, both dressed in second-hand, mismatched clothing, came into the room, the plodding of their thick rubber boots quite audible. They tore back the curtain that divided the two beds, one for the dead man, the other for a patient that seemed nonplussed at the sight. One man hopped up onto the bed, his feet straddling the man's head, facing his feet. He tossed back the sheet that covered the man's body and began looking for a hand-hold. Sliding his hand through the man's collar and grabbing the bottom of his shirt sleeves, the orderly looked for confirmation from his assistant, received it, and then hoisted this man of the bed. His head lie to the right--probably as he was found at the scene of the accident--and his body was stiff from the rigor mortis, long set.

The chatter of the ongoing rounds behind me faded. I couldn't be bothered to listen to that now. It wasn't the first dead person I'd ever seen. It was, however, the first strapping, muscular body I had seen devoid of life. The man was easily 6'4". His arms resembled any athlete's I had seen. Perhaps he was a laborer, perhaps a mechanic. I imagined him ripping through firewood with ease, the sweat glistening down his back the only sign that he was taxed by the chore. Here was a man taken too early, an ox that had many more fields to plow, already retired to some fallow pasture.

In that moment, I'd had enough of this place.

Sitting outside, trying to warm myself in the morning sun, a hand grabbed my elbow. It was Muff. He could tell I was affected by what I had seen and offered some words of encouragement. It went a long way in getting me through that morning.

In what turned out to be an introspective day, my conclusion to surgery that Friday, I found myself thinking of a poem introduced to me many years ago: William Cullen Bryant's Thanatopsis, specifically the last stanza, resounded in my head. If only everyone were given that opportunity, to lie down to pleasant dreams.

Image Guided
Courtenay Glisson

Mandibular Angle

David McCormick

A little learning is a dangerous thing. Reach up and find the mandibular angle. Slightly inferior to this, find the carotid artery as it courses through the carotid triangle. Try to remember the name of the lymphatic chain that runs along with the carotid. Is it even named? If so, was it an anatomic name or an eponym, described by some almost immediately forgotten German, Italian, or French anatomist? Think back to your Netter's, quickly realize the irrelevance, and fall back on your burgeoning clinical skills. Is that just an odd lump? Does it mean anything? Are there really any lymph nodes there? OK, check the other side, it is definitely different. What to do? Ignore it for a few weeks and see what happens?

Uncertainty is a special form of torture when you're worried. At this point, I know just enough medicine to know that fixed, non-tender, slowly progressive unilateral lymphadenopathy in a male in his mid-twenties is a Bad Thing. The lectures mention reactive adenopathy; usually as something to "rule out" before moving on to the more interesting pathology. What about the more concerning possibilities? Hodgkin Lymphoma? Incidence of four per hundred thousand per year. Not common, but not uncommon either. Remember your lectures, think back to the vignettes – how many started in the abdomen? How many in the neck? Compare yourself to the vignettes and see if the way you describe your symptoms meets those. Or are you forcing things into a box simply to attach a label to your worry? On a more reasonable level, you know it's ridiculous. Hoofbeats mean horses, not zebras.

Thinking about these possibilities is like watching a wave function collapse. Standing on one side of the diagnostic divide, you can see both possibilities: the most likely, where everything is fine (except your pride), but it's impossible not to gaze over toward the less hospitable landscape. What if it is a "neoplastic process"? How would I tell my family and friends? Would I have to ask for a leave of absence? Will the school insurance cover any medical costs? Would I have to move back home? Would I have to repeat the six weeks of the rotation I had been struggling though? Mapping out the borders of this terra incognita adds an uncanny degree of reality to what one would otherwise dismiss out of hand.

This anxiety runs as a subtle undercurrent in interactions with patients. If mentioned in clinical diagnosis textbooks, how to manage it and talk to patients about it is usually found alongside such pabulums as "express empathy" and "communicate effectively." It's difficult not to feel a slight inward cringe thinking of the times I have told a patient "It could be this [insert suitably serious disease], but we don't think so. However, just to be safe we're going to do a test to make sure." How can we expect that our patients do not immediately imagine an alternate landscape for their life after bringing them to edge of the diagnostic divide and inviting them to peek over the ledge? How easy is it to forget to mention that the final test came back OK before discharge?

After a few weeks of waiting, I decided to collapse the wave function. It was, as expected, a low-grade reactive adenopathy. But the physician still attached a brief note to the lab work explaining that everything looked OK.

Kur-Ort

Renate Rosenthal, Ph.D. (Faculty)

German: Kur= cure; Ort= place, town

Germany and Austria, where I was raised, are dotted with picturesque small towns that are officially designated as wholesome. Kur-Orte; places where people "go for the cure." Not just for a few days, but for two or three, or even four weeks of prescribed medical attention, relaxation, and rejuvenation. With doctor's orders, a stay for preventive or curative purposes is not counted as vacation time, but as medical necessity.

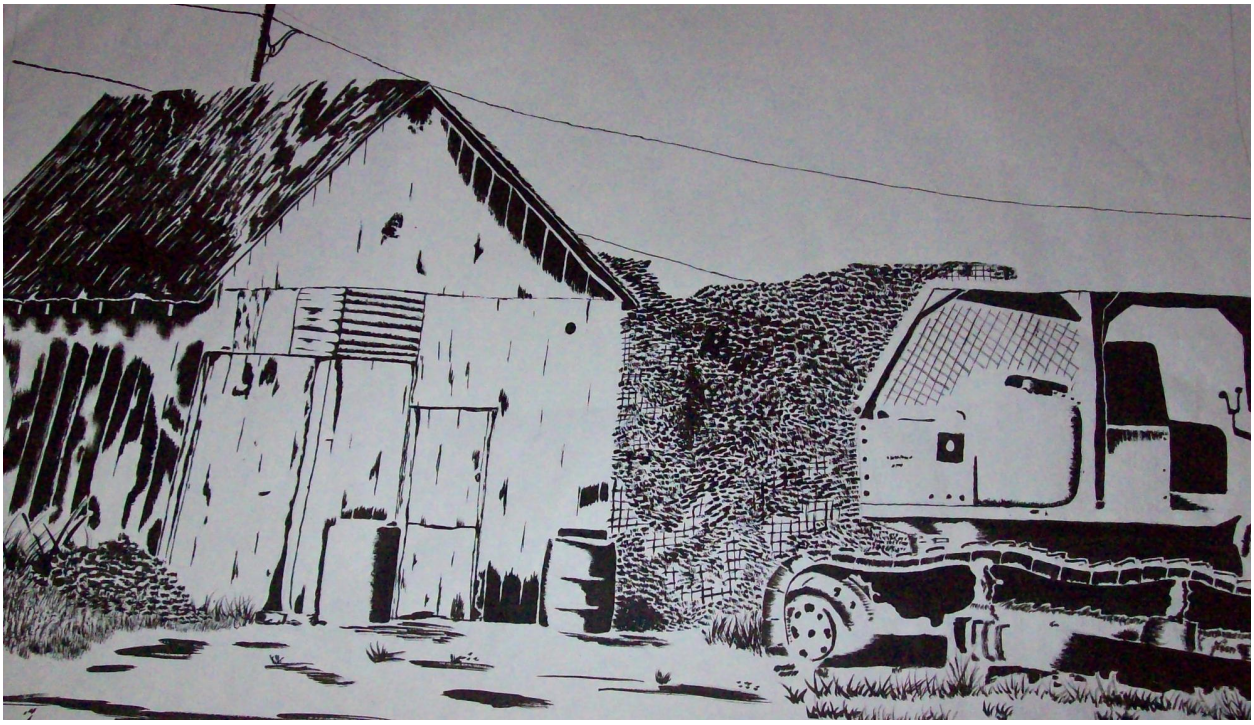
The Kur guests typically suffer from chronic conditions, such as rheumatism, orthopedic problems, and stress-related maladies. Or they are in need of extended rehabilitation from a major illness or operation. Treatment involves mandatory participation in activities, such as massage, supervised group exercise, physical therapy, or breathing treatments. Insurance benefits may take care of much of the cost. The government accredits these establishments as a "Healing Spa."

There are "Luftkurorte," or "air spas;" towns in mountains or forested regions where the air quality is officially designated as being healing for mind and body. Activities there involve mostly walking, and lounging in deck chairs while breathing good, aromatic air. There are towns with ancient mineral springs, specializing in mineral and thermal baths. The springs are fed into bathing facilities with state-of-the-art plumbing, resulting in a variety of abundant whirlpools and swimming basins. Some are restored to their art-deco splendor. There are towns near Bavarian peat bogs that specialize in moor baths and healing mud treatments; towns specifically dedicated to hot and cold water applications and other procedures, such as "Tautreten;" walking barefoot on a lawn covered in cold morning dew. These activities were developed in the 19th century by a pastor named Kneipp, and are respected to this day. The treatments are designed to strengthen the immune system and improve circulation. There are facilities by the North and Baltic Sea, offering the healing powers of brisk sea air, laden with salt and iodine. A total change of scene and climate for land-locked clients.

Patients cannot be expected to engage in wholesome and curative activities around the clock: There is time for reflection, for window-shopping, wine tasting, patronizing beer gardens, socializing with other guests. Many of the historic spa towns have a covered promenade with a bandstand where community bands entertain on Sunday afternoons.

I am hoping for the day when we give more than lip service to the idea that mind, body, and spirit are intricately linked. When we are humble enough to admit that it takes time, permission, and a healing environment to de-compress. Humble enough to recognize that a change of scene, and an exemption from the workaday grind may be necessary to get started on the road to recovery. Our current American model of care does a great job with acute illness. But when it comes to prolonged suffering and stress-related maladies, it makes sense to follow the

example of our forebears and enlist the “healing power of place.” We have a lot to learn from the Old World. And so what, if the treatments capitalize on the placebo effect? First do no harm…



Farmhouse

Feenalie Patel

Where we reside is vital to our experiences and way of life. It is after understanding how our patients live in that place that we, as future health professionals, can more fully grasp their values, challenges, and definition of “good health.” It is after understanding how our patients live in that place that we are better able to provide care that is in harmony with their values and lifestyle.

Late Summer Memories of a Neurotic Child

Elizabeth Dohrmann

It will be just as buggy as ever, I know it
The summer house, it smells like its 150 years
Mold and daddy-long-legs
Dad scoops the spiders up and pretends to eat them
I don't think it's funny
Mice take over the kitchen at night
All our food must be locked away
My cousin made me finish that zucchini I didn't like
I'll never sit next to her again
I thought it was bug spray, not bug poison
I sprayed my body down with it, complained it didn't work
Dad scrubbed me in the tub
But the tub has bigger bugs in it
It's a dark and mothy bathroom
I won't be able to poop for a week
There are bats in the cabin out back
The local boy shows me where they hang
He climbs trees like a monkey
Maybe I'll marry him one day
But he does talk funny
The cliffs on the trail drop off to the valley below
I circle my sisters like a sheepdog, they might get too close
At night the ghosts make the floorboards creak
I want to sleep out in the hammock
But the wind makes noises
I can't sleep on this rock-hard bed
The portraits in the hall are spooky
The trap door upstairs leads to darkness
The ice-cold river has fish and snakes
I get in my innertube, but my bottom may be eaten
By those minnows swimming by
Mom and Dad take turns diving in, moving beyond our sight
My sisters and I cling tightly to the raft again this year
But not as tightly as last
One day, one summer soon, I'll swim beyond the bend too

Musings in the OR

Rakesh Patel

I'm standing next to the attending by the sink, scrubbing in. The timer above the tap is broken but it doesn't matter. As long as I take longer to scrub than the attending does, I'm golden. I enter the OR and soon I'm gowned and gloved, standing next to the operating table. I let out a deep breath ready for the long case ahead, and that's when the problems begin. Christ, why did I have to drink coffee right before putting this mask on? I've got dragon breath. No matter how cold the operating room is, the small area between my face and the mask is a tropical rainforest replete with humid air, exotic smells, and stupid expressions.

Half an hour into the case the attending makes eye contact with me while explaining something. "…which is why we're avoiding that structure and focusing on dissecting out these relationships here, see?" Open your eyes wide, work the eyebrows, and nod your head. That's how they know you're paying attention.

"Yes sir." Nope.

An hour of retracting goes by when the CRNA pops her head above the barrier to take a look at the operation. Well hello there. Without fail all the female CRNAs always make sure their eyes look pretty. And they don't wear the standard issue scrubs that make people look like lumpy masses of old tissue paper. They have the form fitting kind. I wonder if-

"Student! Suction here, the patient's bleeding." Pay attention idiot. It's been three hours since the surgery started and there's no end in sight. My legs ache and retracting organs awkwardly has twisted my back into a shape most mathematicians couldn't explain. To top it off, the attending is leaning over my outstretched arm for a better look so all I see is his back while my arm gets acquainted with his armpit. Lovely. The people not scrubbed in lounge around on swivel chairs and text on their phones. Callous asses, can't they sympathize with me? The anesthesiologist puts down his iPad and steps out of the OR to eat lunch. His vacant chair calls to me invitingly, singing its sweet siren's song, but someone else wanders over and plops down onto it. He starts to talk to the CRNA. My CRNA. Hypoglycemic and bored, I naturally label him the enemy.

"Student, go over to the other side of the table." Finally, something to do. I look up and assess the room, making note of the sterile areas and the narrow gaps between machines through which I have to navigate. Cords are strung about menacingly, expertly avoided by a seasoned nurse. I try to memorize the path she takes but it's a minefield. A graveyard of ships covered in sterile blue drapes. I look over at the CRNA expecting those hazel eyes to well up at the thought of my departure. She'll be Penelope and I Odysseus. I'll just have to ignore the name tag that reads: "Jenny." This isn't goodbye, I'll find my way back to you. I promise.

As I embark on my odyssey around the room, I can feel the malevolent eyes of the nurses on me, scrutinizing my every movement. I may be paranoid but I'm pretty sure they take bets on this sort of thing to pass the time. I can hear one now: "Ten bucks says the student slips on that cord." To which the other replies, "Five bucks says he hits his head on the surgical ceiling light."

They stand around pretending to ignore me, but I know better. They share conspiratorial glances and smirk maliciously behind their masks while I maneuver through the room, praying for me to trip over some machine and make the room explode. One by one I best their obstacles and make it to the other side of the patient. My voyage is completed and a surreptitious glance at Penelope is all I need to know she couldn't care less. Yeah, whatever, you ain't that impressive either. Back to reality though.

"Help the resident close this area." Finally given something to do, the sleepiness and daydreams evaporate into the sterile air. The next hour passes without a single thought of the CRNA entering my head. All that matters is the work. This part I like. I look up afterwards and realize the top of my facemask is digging into my eyes. If I make one wrong move it's going to slip up and touch sclera. I'll open my mouth really wide and work my jaw like I'm trying to unstick a piece of laffy taffy from my teeth, that usually moves the mask away from my eyes. Thank god nobody else can see how ridiculous I look behind my mask.

Hour number five. I just touched something that wasn't sterile. Shit, I hope nobody saw. Attending and resident? Check. They're busy with something else. Scrub nurse? Oh no. She's looking at me with an eyebrow raised. I look back, frozen in place, preparing for her wrath to descend. I can sense the other nurses' gleeful anticipation at my imminent dressing-down. She lowers her eyebrow and turns back to the case. Thank the lord she's forgiven me.

Hour number six. This is a very complicated case that necessitates the concerted efforts of multiple surgeons and doctors monitoring different aspects of the case. I should be paying close attention and being proactive by asking relevant quest-will I break the sterile field if I fart right now?

Thin Fascia

Robert Franklin

In Thomas Mann's The Magic Mountain, a young and healthy Hans Castorp, the protagonist of the novel, travels to the Berghof sanitorium in the Swiss Alps to visit his cousin who is suffering from tuberculosis. It is the first decade of the 20th century, and upon arriving, he is enjoined by Dr. Berhens, the medical director to prescribe to the "rest cure" his consumptive cousin adheres to, a cure consisting of highly scheduled periods of rest, clean air, good nutrition, and rigorous sanitation. The physician tells Hans, "you would be a better patient than [your cousin], I'd lay odds on that. I can tell right off whether someone will make a competent patient or not, because that takes talent, everything takes talent…there's no wiser course than to live for a while as if it were a slight tuberculosis pulmonum, and build up your protein a little" (Mann, 54). It is in this statement that is at once medical, social, and moral, that Mann begins to paint a picture of a health institution that became popular in the early 20th century as a means of dealing with the morbidity and mortality associated with Tuberculosis. It is an institution that came about before the advent of powerful antibiotics such as streptomycin, rifampin, isoniazid, pyridoxine, and ethambutol, but late enough in history that a firm belief in germ theory was present in the collective consciousness of medical thought. In this adolescent state of medical development, coupled with the cultural and moral forces that were particular to Europe at that time, Mann finds a medium to articulate, narrate, and magnify the components that went into a very distinct species of healthcare institution. Through Mann's penetrating gaze, coupled with modern perspective, we are able to view the sanitorium as an institution taut with contradiction- it is outmoded yet remarkably current in its approach, at times morally questionable and yet often unquestionably moral, and while it is often designed to most naturally meet the needs of the elite it equally often serves as a symbol for everyman's right to health. Perhaps most embodied in the idea of enforced rest, I believe these contradictions shed light on the fascinating ways in which we attempt to understand illness, and the unavoidable ways in which we bias the approach with our often subconscious thoughts and desires.

Mann at once communicates how the sanitorium was, on one level, an institution informed by medical advances: the germ theory of disease was formally borne into existence with Robert Koch's postulates, which he then used to discover the mycobacterium responsible for tuberculosis. Concordant with the ideas of germ theory came chemical advances in aseptic and antiseptic approaches through scientists and surgeons such as Joseph Lister, who used the idea of "minute organisms" as a basis for antiseptic agents in preventing "suppuration" with surgery. (Lister) Of course these comprised only a small portion of the enormous advances in biomedical sciences in fin de siècle Europe, but their impact cannot be underestimated. To begin with the premise that microorganisms were the causative agent for a disease process reframed the discussion of how to prevent the illness and treat its cause. With more precise diagnostic capabilities came more precise treatment modalities. Some of these modalities worked at prevention on the molecular level, like the "methyl aldehyde- even the toughest bacteria can't take that" (Mann, 13). Other treatments focused more on gross pathology- Mann

discusses the group of individuals at the sanitorium who have fraternally dubbed themselves the “Half-Lung Club”, a reference to the now questionable practice of therapeutic pneumothorax which “allows [caseated lobes of] the lung to rest” (Mann, 58).

Yet the sanitorium was also an institution informed by social and political tendencies. On one level, the tuberculosis sanitorium represented broad and philosophical movements in art and architecture- the prominent French architect Le Corbusier stating that “on the day when contemporary society, at present so sick, has become properly aware that only architecture… can provide the exact prescription for its ills, then the time will have come for the great machine to be put in motion” (Topp, 414). This great machine seems to be an idea that health and well-being must be viewed in the context of the external forces that affect our lives, and that architecture could be the field that directed and coordinated those contextual forces for the betterment of mankind. This mentality appears to be present in the conception of the sanitorium: cantilevers were built into many patient’s rooms that would lift off the roof to promote fresh air while still being able to rest in bed. Rooms had “sharp luster…both cheerful and restful, with white, practical furniture; heavy washable wallpaper, likewise white; a floor covered with spotless linoleum” (Mann, 12). The architecture spoke of the antiseptic qualities espoused by the medical practitioners. An equally important social component seems to be the close and often ambiguous relationship the tuberculosis sanitorium had to the less medically heralded and more socially differentiated health resorts popular at the time. These resorts served as a natural snapshot of social gradients as they were often prohibitive to anyone except the extremely wealthy. In this way the tuberculosis sanitorium became a symbol of the wealthy individuals access to a more extensive form of healthcare, not to mention a sort of gathering place of the politically notable invalids in Europe. Similar social forces were shaping the ideas of sanitoriums in America. Social forces regarding sanitoriums were at work as well in corporate and union life in America. As Helen Bynum mentions in her book Spitting Blood: The History of Tuberculosis, “the International Printing Pressman and Assistants’ Union added a tuberculosis sanitorium to their technical trade school, retirement home, and headquarters site in the mountains of north-eastern Tennessee” (Bynum, 130). Access to union-owned sanatoriums were being pitched as labor benefits much as PPO and HMO plans offer access to hospitals today. In sum, the sanitorium of the first half of the 20th century played an important social role in the healthcare landscape of the western world.

While tuberculosis sanitoriums provide a fascinating look into medical and political forces at play in the first half of the 20th century, they provide an equally fascinating, if not more subtle, depiction of the effects of those forces on ideas of morality. Dr. Berhens’ casual remark regarding Hans being a “better patient than [his cousin]” (Mann, 54) speaks of a distinctly ethical component to notions of illness, health, and medical authority. Some of this liberty with prescribing medico-ethical advice surely arises out of the less than scientific injunction to “build up your protein a little”- which at its best may be interpreted as “clinical judgment”, and at its worst a purely personal and social judgement made by the surgeon. Interestingly, it is a species of advice that is not absent in the modern healthcare setting. It seems that in the necessary ignorance that accompanies medical knowledge, we are often forced to retreat to more general, less medically specific opinions in our assessment of a patient’s illness. It is here that it becomes much easier to ascribe non-compliance, unknown genetics, or psychogenic

causes to the failure of a patient's improvement. While each of these entities may indeed be valid, it cannot be denied that they are also able to quickly assume a moral tone. The "non-compliant patient" so frustrating to the physician surely often suggests a moral assessment as much as a biomedical one. It seems that in this light, medical virtue becomes virtue itself, and perhaps even more dangerously, the opposite may occur as well. Bynum makes this same assessment as she notes that "adherence to the 'gospel of the germs' was essential [in sanitoriums], for dirt and morality were closely intertwined. Not following the doctors' orders was a form of moral deviance, which was to be countered by those in authority for the greater good of society" (136). As Hans' cousin notes, "strict cleanliness is essential" (Mann, 13).

As Thomas Mann artfully depicts in *The Magic Mountain*, the tuberculosis sanitorium embodied a multitude of acquired facts, medical ideas, socio-political forces, and moral judgments. It was an institution that functioned integrally within the anatomy of early 20th century healthcare and culture at large. As a product of medical, architectural, social, and moral endeavors it may be seen as a direct expression of humanity at a specific time period. Over time, as antibiotic regimens became increasingly more effective and patients required shorter periods of hospitalization, the sanitorium became increasingly obsolete. Yet it leaves valuable lessons to us today: the sanitorium's focus on treating a specific disease like tuberculosis surely serves as a model of multidisciplinary commitment to curing an ailment. It also leaves warnings of how thin the fascia is that separates medical advice from moral advice. The patient and physician are often unable to discern somatic etiologies from those moral in nature, and this ambiguity leaves room for potentially dangerous medical decision making. This is especially true in the context of the language of sanitation, which has historically ranged in its application from the science of surgery to the propaganda of xenophobic dictators. The sanitorium, like the slow-growing Mycobacterium tuberculosis that it was designed to fight, represents a distinct species in the evolution of medical care and its attempts to treat those with illness. In understanding it, we potentially uncover some of the rudimentary assumptions and ideas that we may hold today about modern healthcare, enhancing our belief in those ideas that are beneficial, and checking us in those that may lead to dangerous practices.

Perspective from a White Coat's Pocket

Christy Beyke

I started out empty
New, clean, fresh
and whiter than the brightest cloud.
The first item to come to me was oddly shaped,
a "bell" that didn't ring had been attached to y-shaped rubber
It was an odd thing, a strange thing,
yet somehow exciting.
Then other things came
Pens--both black and blue--hand sanitizer, granola bars
A strange cylinder with a light on one side,
Then more:
Stickers for children, note cards,
A bright spiral note pad, sutra scissors, and a pack of size seven gloves
A small green book, fourth edition,
Papers and papers and still more papers,
hair ties, bobby-pins, paperclips and trinkets.
More and more was shoved down into the white coat pocket,
and as time passed, I got heavier and heavier
My fabric stretched, but I stood sturdy.
Then, in the end, when the coat was set aside,
I did not mourn.
I had done my job, seen this journey to its end,
I protected the notes, kept the keys from escaping,
and didn't let that mischievous phone wander out of sight
I have coffee stains, ink splats,
and that one spot that you don't want to know about,
I've been carried across the state of Tennessee,
I've been left on hooks, hangers
couches, chairs,
and some other places that no coat had any right to be.
I've been lost, found,
dug through, emptied, and refilled
I've grown heavy with burdens and the weights of responsibility
But I held fast.
I did my job,
and now my favorite Doctor is doing hers.

In situ

Grace Cho

This time last year, I was in a dark place. My classmates were wonderful and instructors expressed their support, but I felt like I didn't belong. Regardless of how hard I tried, I made zero progress. I bleakly marvelled at the precipitous drop in my self-confidence since the first day of class. I felt like I had made a huge mistake coming to medical school and that all my years of preparation had been in vain. Finally, things came to a head when I could no longer find meaning in my pursuit of service to others.

Every effort led to the same miserable result, so what was the point?

I felt so alone, despite being surrounded by 170 people day in and day out. I thought I was the lone imposter in a sea of highly capable and successful individuals who seemed to absorb information like a sponge. No one else seemed to be drowning like I was, though we were drinking from the same proverbial fire hydrant. My normal standards of earning an A seemed too lofty to attain. Hell, I was struggling just to pass.

How did I go from making A's to simply wanting to pass?

How? Because I was depressed. Really, really depressed. In an environment like medical school, where academic demands often overshadow personal needs, depression can go undetected for a while. It is insidious and quietly siphons motivation and self-esteem. It's difficult to stay motivated without some sort of positive feedback, you know?

Initially, I was hesitant to accept that depression was actually what I was experiencing. I believed myself to be strong enough not to succumb to the negative thinking and hopelessness. Yet I felt increasingly inadequate and out of my element. Lethargy and apathy soon followed. I can't pinpoint exactly when I stopped taking care of myself or caring about anything at all, but even with a clouded mind I knew that waking up wanting to never wake up again meant that I was reaching a critical point. If Dean Shreve hadn't intervened when he did, I'm honestly not sure where I'd be right now and that is a sobering thought.

I had not been kind to myself in the intervening months, so recovering from months of self-loathing and frequent pity parties was a slow and arduous process. It is exhausting and truly debilitating to be in a state of depression for an extended period of time. Depression is as real a disease as any other. At times, I felt like I was relearning how to do things that were once intrinsic. I had to rediscover how to enjoy being.

Though I passed that semester, there was still a lot of work to be done intrapersonally. Where I am today is immeasurably better than where I was last year, but I'm still learning to forgive myself for making mistakes and accepting that they will happen. The difference is now I am able to move on. No longer am I in that dark place and at last, I belong.

Now I am in situ.

Journey to Kolkata: learning to heal both body and spirit
Blake Briggs

Walking onto the streets of Kolkata for the first time, the first thing I noticed was the smell. The thick smog of pollution filled the air, along with the blended aroma of garbage, human feces, and urine that piled alongside the drainage beds of the sidewalks. Amidst these smells, my eyes raced from the sights of those who were victims of the greatest health inequity in the world. I helplessly walked past the homeless man who had blistering sores, the motherless child begging for a hand to hold, or the teenage pregnant mother crying for food. After walking through this overpowering mix of smells and sights to the Mother Teresa Clinic each morning, I began my work of hospice care to tuberculosis victims who were found on the streets by the Missionaries of Charity. It was on these dirty, unsanitary streets that I witnessed poverty at a level so prevalent and debilitating.

The re-occurring vision of those who lived in extreme poverty is emotionally jarring and revolting; this image will never leave my mind. In detail, I still remember a moment which changed my life forever. The middle-aged man, diagnosed with TB, was brought to the clinic and was to die very soon. He had no family, no house, and no money. He was ignored by Indian society and viewed as an “untouchable”. He had lived on the streets his entire life. As I hurriedly carried the frail, 100-lb man into the clinic ward, the abhorrent odor and sight penetrated my senses. For the next four hours, I provided him with constant care. His condition was hopeless. He exhibited all the symptoms of late stage tuberculosis, and I strived to alleviate his pain as the disease took over every aspect of his body. I assisted him to the bathroom, I spoon fed him water and milk, for it was difficult for him to open his mouth and swallow. I wished I could lie and tell him everything would be okay, and that he would persevere through this suffering, but I did not speak his language. All I could do was to periodically apply cool, moist towels on his forehead, and position him to allow him to cough up blood into a bedpan. At 11:46, I saw his eyes close and he breathed in his last. My first patient, the first human being suffering from disease under my care, died. I never uttered a word to him, and did not even know his name.

Thus, when reflecting on that particular “place” which most strongly influences my call to medicine, it must be the streets of the Kolkata. It was within these streets, working at the Mother Teresa Clinic for the terminally ill, where I affirmed my calling to medicine I hold onto this encounter, for it has given me a sense of benevolence. Despite the lack of medicine, administering a sip of water to a dying individual may sound like an effortless gesture, but the power of human touch and a sense of human compassion, does more to bring peace to the soul than any physical need. In the simplest of ways, India taught me the most basic of physician skills: empathy, even in the most helpless of medical situations. As Mother Teresa eloquently stated, “The greatest disease today is not TB or leprosy; it is being unwanted, unloved, and uncared for. We can cure physical diseases with medicine, but the only cure for loneliness, despair, and hopelessness is love. There are many in the world who are dying for a piece of bread but there are many more dying for a little love.

Two Years

Laura Sherwood

Here I am.
Adorned by a string of pearls of late nights and early mornings
Trapped in the cacophony of perpetual last-minute notifications
Drowning in the sheer vastness of this information onslaught
Scrambling to master
or just understand
the integration of concept and application
This battle within
weapons of mnemonics
repetition
fatigue
raw determination – or desperation
And always,
the ever-present
never-ending sensation
There is never enough time.
The effort involved there –
when the white coat feels so heavy
keep going
keep working
keep fighting
– earn what was given in promise
building the strength to wear it
It's a needy lover
a demanding taskmaster
a rigorous transformation
an incredibly isolating vow
I will never be here again.
Here I am.
Living in a world defined by intellectual stimulation
Where understanding is the doorway to saving lives
Fed by those brilliant moments when it falls together
when it makes sense
when the diagnosis is made
and every organ
every drug
every concept
when played together
paints the most beautiful and ancient harmony
Surrounded by those who share the pursuit

who joke about DLCO
sympathetic postsynaptic acetylcholine release
apple-green birefringence
and check for a palmaris longus

It's a unique camaraderie
a fascinating livelihood
an academic playground
an incredibly humbling calling
I will never be here again.
In this wonderful
terrible
necessary place.