OMENTUM

BAYLOR COLLEGE OF MEDICINE LITERARY AND ARTS REVIEW

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EDITOR'S NOTE

Art can serve as a reflecting pool to explore one's identities, morals, beliefs, and behaviors. By pausing to view health and disease through this lens, the true impact of our intimate human experiences reveals itself. We can carry on, as often we must, without engaging in this exploration of meaning. However, disconnecting from creative expression and contemplation leaves ourselves vulnerable to apathy and loneliness. During this past year of pandemic-related physical isolation, the practice of telling and receiving stories through art and literature has been integral to staying connected.

The word "omentum" originates with the ancient Egyptians, who searched for their "omens" within the omentum while embalming bodies. An omen, or a prognostic piece of meaning, is a central element to both the arts and the sciences. The physician Galen (128-199 AD) recounted "we ourselves removed almost the whole [omentum] from a gladiator wounded . . . The man was quickly restored to health, but he was so sensitive and easily harmed by external chilling, that he could not bear to have his abdomen uncovered, but always wrapped himself in wool." Perhaps a world without art is like a life without an omentum: survivable, but cold. Modern research beginning in the late 19th century explored the omentum's healing and protecting properties. The omentum supplies stem cells, induces angiogenesis, contains reservoirs of immune cells, modulates fluid exchange, and secretes collagen and fibrin - functioning as a dynamic, living bandage for the abdomen.

Similarly, our ultimate goal for *Omentum* is to bring meaning, warmth, and healing to you, our reader. We hope to provide a space for reflection, restoration, and reconnection. Here at *Omentum*, the medium is our message.

Thank you to all who made this publication possible, including our faculty advisory board, student affairs deans, and the office of professionalism. Most of all, we would like to thank those who submitted their artistry to our publication. This journal would not exist without your willingness to share a part of yourself with our community. We hope you enjoy the premiere volume of *Omentum*, Baylor College of Medicine's Literary and Arts Review.

-- Claire J. Wiggins

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GUIDELINES FOR SUBMISSIONS:

This annual publication features original poetry, prose, visual art, music, and multimedia from current members and alumni of the Texas Medical Center.

Submissions should connect to the healthcare experience in some way.

The confidentiality of information related to any patient or patient encounter is an ethical and legal obligation of all health care providers, and this publication seeks to uphold those same standards. Therefore, submissions that contain PHI or identify another individual will not be published unless signed permission is included. In addition to written details, this includes artwork and photography that could reasonably identify an individual.

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ABOUT THE COVER:

Artist: Rachel MacAskill

Medium: Acrylic on canvas

The poem inscribed on the Statue of Liberty, "The New Colossus," states, "Give me your tired, your poor, your huddled masses yearning to breathe free." Like Lady Liberty, healthcare workers have bravely adhered to this principle of taking in, helping, and protecting those in need, in particular those "yearning to breathe free" and to survive COVID-19.

COVID-19 has shown to have a more amplified negative impact on marginalized and more vulnerable portions of society. It is my hope that we will, as a nation, embody the spirit of this poem to help those most affected, the tired, and the poor, boldly don our masks and use hand sanitizer as Lady Liberty is here. We will make it through this together.

Rachel is a third-year medical student, who has enjoyed painting in her free time since she was 18. She spent her days in quarantine covered in paint, listening to podcasts, and being thankful for this outlet for creativity.

CONTENTS:

CONTEST WINNERS ~

POETRY ~

PROSE ~

VISUAL ART ~

MULTIMEDIA ~

all audio & video pieces are available at bcm.edu/omentum

Melancholy within a rain storm / Claire Luo

They say:
Spread open your arms,
wide your hands, and yet
lives drip through the lacunae
between our fingers,
fall through the millennia,
shatter onto concrete. Enough—
        Who is?
        Who is allowed to be?

Fold away those feelings
into the linen of your sleeve,
like rewinding a magician's act:
rabbit back into the bag, back
into the hat, back onto the head.
He pretends it was hollow all along.

But grief like puddles on pavement,
insinuates into already broken
crevices: water you step into
but never truly out of. It lacquers the sole
of your shoe, marks your path
with wetness; a constant reminder
tracing these city streets.

Questions, just drops
from the lungs, hang heavy
in humid air, sublimate into fog,
suffocating.

“Melancholy within a rain storm" contemplates the disparities within our perception of human life--how some lives are systemically devalued by our institutions, including healthcare systems. The poem asks how we can reconcile our heartache for these lives lost with our fundamental duty as medical professionals to deliver care.

Claire is a second-year medical student at Baylor College of Medicine with a BA in English from Rice University. When she’s not filling her head with facts about the kidney, she enjoys baking lemon bars and playing tennis.

Talismans / Chaya Nautiyal Murali

I lost my stethoscope in my penultimate year of residency. It happened without my even noticing. I know I had it on a Saturday morning, when I was post-call, but when I went back to work on Monday it was missing from my work bag, and missing when I searched my apartment that evening. I must have lost it somewhere, somehow, post-call. I'm actually pretty surprised this didn't happen earlier. The liminal space of Post-Call is veritably bursting with a propensity for careless mistakes. You see the evidence all the time: half-finished cups of cold cafeteria coffee litter desks in resident workrooms and the backs of wheeled computers. The post-call resident will make a ceremonial exit after saying goodbye to everyone on the team, only to sheepishly return a few minutes later to collect the coat or scarf or bag left behind. The antiquated shared team phone is carried off by an unwitting intern who has signed off for the day, only to beep madly when taken out of range of the hospital, prompting an exasperated U-turn that stretches an already interminable commute. All this is to say that it's easy to misplace things when you're post-call, so I wasn't surprised when it happened. What did surprise me was the intensity of my reaction.

One truth about me is that I hate losing things. It's a little embarrassing, really, how worked up I get when I lose physical objects. After all, my religion teaches me not to become attached to objects, that they carry no intrinsic value, that they're all part of the illusion of this physical world. Yet I can't seem to help myself. I get upset when I lose a water bottle, or a pen, or a sock, though I have enough insight to know that my emotions are out of proportion to the material significance of the loss. So I tried to apply some rational thinking when I lost my trusty stethoscope, and searched online for a replacement. Time to upgrade, I told myself. Finally buy a pediatric-sized one, or maybe one in a different color. But all I wanted was to find one exactly like the one that got away–a purple Littmann Classic II, outfitted with gray earbuds and gray trim on the bell. I knew that it wouldn't be hard to buy another stethoscope exactly like my old one, but, I kept telling myself, it wouldn't be the same. So I abandoned the effort, and opted instead to use a rinky-dink disposable stand-in that I pilfered from the clean utility room. It was a poor substitute, the sound quality dismal compared to the one I had lost, but I needed a placeholder before considering a more permanent solution.

Over the next several days, I told everyone who would listen about losing my stethoscope. I frequently proclaimed how sad I was to my teammates. I texted my partner and my best friend a minimum of two to four times a day about how much I missed it, capping off most of the digital messages with multiple sad-faces, tears welling in their eyes. I knew I was being a little melodramatic, but I really was that sad. Wearing a Fisher Price-esque black disposable replacement around my neck, I felt deflated by its lightweight frame. I missed the gravitas of my old stethoscope, the way it would slip down, chestpiece-side first, leaving the end with the earbuds to jut off my neck at a crazy angle. I cursed myself for not distinguishing my all-too-common stethoscope with my name, or a sticker, or a detachable toy the way other pediatricians do. I not-so-casually stared at every purple or purple-ish stethoscope I saw my colleagues walking around with, wondering if for some reason they had accidentally picked up mine.

Slowly, I began to dissect my emotions and try to figure out why I was feeling what I was feeling. My stethoscope was the one tool of my profession that I had continually used since the very beginning of my medical training. Unlike the short white coat of medical school, which was unceremoniously abandoned once I graduated to the long white coat of residency, my stethoscope had stuck with me for seven long years. It was a constant presence during my hardest cases, my moments of connection with families, the diamond-bright clarifying instances when I finally understood a medical concept through experiential learning. It was a witness to my growth as a physician. I still remember laying the end of it on my own chest and listening to my heartbeat for the first time, the way my heart began to race when my body recognized itself in a way it never had before. I remember all the times a patient borrowed my stethoscope because he or she wanted to listen too, and how I guided the chestpiece to the right spot on the patient's chest, and saw little eyes widen in surprise at the sound that sprang forth.

In the past, items I've lost have sometimes reappeared, accidentally tucked away somewhere and forgotten. A small part of me held out hope that the same thing would happen with my old stethoscope. In a vote of confidence of sorts, I didn't purchase a new one for months. Instead, I utilized my partner's old one, a sleek and functional number that was completely black, even the metal parts. Eventually, because I had no choice, I moved on. I upgraded to a double-headed stethoscope, adult-size for teenage patients, pediatric-size for infants. This one was purple too, though a warmer, pinker hue than the one that got away. It became part of my toolbox and with time, the sting of losing the old one faded away. Today it sits, coiled and pa-

-tient, at the bottom of my work bag. These days it doesn't get much action, with the pandemic converting much of my work to contactless consultation.

It's strange now to think back to that time right after the loss, how keenly I felt it, how fervently I hoped it would appear again. Surely part of this was driven by my own idiosyncrasies, but I believe that at some point, the tools of our work become talismans. We don the white coat, drape the scope around our necks, tuck the favorite pen in our breast pocket, feel for the familiar disc of a tape measure in the hip pocket. Outfitted in this way, we become the physicians we envision ourselves to be. So is it any wonder that a young physician feels lost when her beloved stethoscope disappears? I look forward to the time after the pandemic for many reasons, but one of them is that I will once again be able to employ all my talismans—the white coat that hangs at home lest it become a viral fomite, the stethoscope that rarely encounters patients in person these days, the tape measure that's been set aside in favor of its disposable cousins. May their power not be diminished by this forced repose.

This essay relates the story of losing my stethoscope in residency and mourning that loss, and muses on the meaning we place on the tools of our work as physicians.

Chaya Nautiyal Murali is a pediatric geneticist and Pushcart Prize-nominated personal essayist. Her writing, like her professional work, primarily focuses on identity, inheritance, and family, through the twin lenses of immigration and genetics. Chaya's work has been published in Aster(ix), Barely South Review, Entropy, and elsewhere.

Inside / Poornima Tamma

I'm inspired by human anatomy, form, and expression. I want my subject to come alive with the strategic placement of color, and minimal blending or layering. We recently covered the landmarks of the skull in anatomy lectures, and it was fascinating to explore the impact of skull structure on the expression of emotion. This painting focuses on the side profile of a human skull, jaws open in a sardonic grin. I wanted to suggest cranial features and convey a sense of structure and rigidity without indicating every detail. The lighting is dramatic, the colors are rich and vivid, and my brush strokes are strategic, bold, and thick. Photo reference credit to Anton and Arthur Nebessikiy.

Poornima is a second-year medical student at Baylor College of Medicine, and she wants to pursue a career in surgery. She started oil painting during the COVID-19 pandemic. In her free time, she loves playing Starcraft 2 with her friends and playing with her dog, Nick.

See / Mgbechi Ugonna Erondu

When the ocean first tip toes
onto the shore
by moonlight,
it is like
the twirl of a sundress,
a parachuted blanket,
a tongue licking a melted ice cream,
lips whistling a happy tune,
a hum.
When the sun crests
and smiles,
brightest,
the ocean reaches up
frothy.
A fantastic mane
Some call it a roar,
I call it
a shout.
I'm alive, she says,
with wings like a dolphin

I'm alive, she says,
like a casted net.
I'm alive.
I'm alive.
I'm alive.

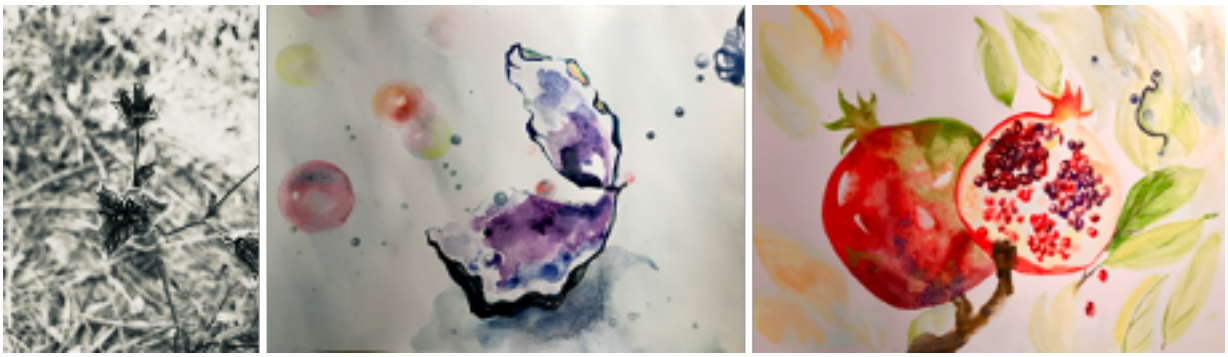
Mitochondria, or what am i doing inside this human body / Mgbechi Ugonna Erondu

Once upon a time I had a nucleus
A brain which folded and twisted and railroaded an alphabet
Which told me how big to grow and with what mouth I would eat
I could section inward and twin myself
I could come across molecules and engulf them
I could see another like myself and press into it
I could create
Two of me, me and not me
Where has my nucleus gone?

Mgbechi Ugonna Erondu, M.D., M.F.A. is a PGY-4 Anesthesiology resident at the Baylor College of Medicine and a graduate of the University of Iowa Carver College of Medicine and Iowa Writers' Workshop. She also holds a B.A. with Honors in Anthropology from Princeton University. During her time at Iowa she was a Humanities Distinction Track recipient and winner of several writing awards. Her primary interests include pediatric anesthesiology, narrative medicine, and palliative care.

Art Series / Chelsea Zhang

Meditation Series from left to right: Peaceful as Cherry Blossoms, Wholesome as Lychees, Mindful as Water Lilies



Cellular Biology Series from left to right: Flower or Pyramidal cells? Monocyte or Oyster? Strongyloides meets Eosinophil or Pomegranate seeds?

Anatomy Series from left to right: Terminal Duct Lobular Unit, No Broken Ribs, Thrombectomy

Hopeful Series from left to right: The Secret Homes for the Future (Seeds,), Tribute to a VA patient who Loves Motorcycles and Knows How to Live Life

Dr. Chelsea Zhang is a happy artist and resident who likes to share her artwork to brighten your day. She has a passion for pathology, making steamed buns in cool shapes, Zumba dancing, and laughing at silly things.

55-Word Story Series

There is a human in our tank.
Excited, apprehensive, the formaldehyde stings
my nose.
Unzip the bag – "It's grayer than I thought."
Male? Female?
Whirlwind of thoughts, broken by the TA's
voice – "Get started, just toss the skin into the
buckets."
One month later.
There is an assortment of muscles and nerves in our tank.

Melinda Wang is an MS1 at BCM. She graduated from Rice University in 2020 and is a huge foodie — whether that involves eating out with friends, baking, or consuming copious amounts of pasta, cake, and all things carbs.

COVID-19 surges; outpatient residents reassigned to hospital wards and ICUs;
I get the call; I get it, duty calls. Still, disappointed.
The workroom has a massive window.
Mortality, distress.
Still, we have a window.
I see the sun rise every morning. I see the rainstorms. I see humanity that isn't dying.
All from my window.

Peter Baek, MD is a PGY2 resident physician in BCM's family medicine program. He enjoys running, watching sports, and spending time with family and friends.

Tests of ability silently terrorizing the weeks to come.
Once capable, now questionable. Do I even want to be here?
Missed opportunities to progress. Will it cost me success?
Internal battles by the hour.
"You can do it, Felicia. You can be a doctor"
Will the numbers make or break me?
Only time will tell.

Felicia Rosiji is an MS1 at BCM. She graduated from The University of Texas at Austin in December 2019 and is interested in child and adolescent health. Felicia loves spending time with friends and eating lemon cake.

20-year-old mom, one-month old baby, born at 36 weeks, hasn't bathed once.
30-year-old doc, one month as an attending, hasn't heard of this once.
Ignorance and inexperience yield embarrassment and uncertainty.
Google teaches us both.
Baby can safely bathe, just not daily.
Premature babies lose heat from thin skin.
Chuckling, from nerves more than humor.

Dr. Arindam Sarkar

I tentatively approach the hospital bed. Metastases everywhere; lost his leg to complications.
How to offer comfort?
As we talk, he tears up.
Promises of restoring strength and mobility, of eventually fitting a prosthesis rise in my mind.
"I can't help others anymore" he laments. "My neighbor can't drive. Needs me."
Lessons in serving others.

Katelyn DeBord, PA-C is a physician assistant (BCM School of Health Professions '15) in UTHealth's PM&R department at TIRR. She enjoys baking on the weekends and crafting photobooks of trips taken with her husband.

"What should I do, doc?"
33-year-old male, decompensated cirrhosis, day before his birthday.
58-year-old female, repeated heart failure exacerbations, ejection fraction indeterminate.
89-year-old male, dialysis becoming less effective, completed a marathon last year.
Tinker with medications. Further restrict diet. Repair abnormal labs.
What should you do?
Connect with sincerity. Reflect with joy. Bequeath with pride.

Dr. Arindam Sarkar

The patient spoke only Spanish and the doctor spoke only English.
As a student, I silently stand in the back and watch the interpreter.
"How is the medication for your breast cancer going?" the doctor asks.
The interpreter speaks.
"I ran out in July."
"You were supposed to get it refilled."
"No one told me."

Joseph Anderson is an MS1 at BCM. He graduated from Trinity University in 2020 and hopes to pursue a career in Ophthalmology.

Dr. Arindam Sarkar, or Rindy as he's commonly known, is a former BCM student and resident. Now as BCM Family and Community Medicine faculty, he spends most of his time at Harris Health's Northwest Clinic and Ben Taub General Hospital helping trainees of all levels learn to provide effective and compassionate care. He especially enjoys hearing and sharing stories that increase our connectedness. Rindy often says, "Sharing feelings is the easiest way to build community."

As part of the elective course "Compassion and the Art of Medicine," Rindy recently challenged first-year medical students to explore a narrative tool called the "55-word story." This literary format has been around for 20 years and is especially useful in these times of limited time and attention. Distilling memorable experiences into a few phrases, lines of poetry or brief sentences is a challenging but valuable exercise in self-reflection.

Perfect Disorder / Sophia Huang

I intended to explore varying perceptions of the psychopathic brain and the normal brain by contrasting these differing images with one another. The overall artwork is composed of two larger acrylic paintings set next to one another, with two smaller water color paintings cut out and set adjacent to them. I chose this layout to convey the idea that, even in the psychopathic brain, there are aspects that the healthy, ordinary person can connect with, relate to, and understand on some level. On the flip side, I chose to associate the brain with flowers bursting out of one side with the darker, more sinister canvas to reflect the opposite approach to this idea - that there are aspects of a normal brain and experiences that the average individual and psychopaths both share. Thus, by designing the layout of these paintings in such a way, I hoped to invoke the impression that there is a bit of the psychopath in the normal, and there is a bit of the normal in the psychopath.

Sophia Huang is a second year medical student who finds that art has served as a meaningful outlet of exploring human nature in relation to society and medicine.

On Aging / Lan A. Li

Liao Jialun wanted to go home. Home was close, less than a mile from Moon River, the five-star resort that had been converted into a senior care home. But her daughter and son-in-law protested. Beijing winters were too cold. Summers were too hot. What if she caught pneumonia in the car? What if she had a heat stroke?

Then there were the stairs. The concrete tiles were slippery; the edges were sharp. What if someone tripped while lifting her in the wheelchair up the stairs? It was three flights up. A treacherous journey.

"I'm just too fat," she sighed, as if her weight made everything impossible.

Still, she wanted to go home. *Wo xiang huijia 我想回家*, was the refrain. *Huijia 回家* or "to return home" was a desire for the displaced. She wanted to look through my grandfather's paintings. She wanted to take stock of his work.

Sometimes, I brought his work to her. I would drag a heavy suitcase into her Moon River compound and one by one, present the bag's contents to her. She would unfurl a ten-foot long scroll, her eyes bright, following the fine strokes that outlined sparrows and magnolia trees. She had dedicated her life to safeguarding these paintings.

We often talked about death. "I'm not afraid to die," she said. People had to die at some point.

We made plans for her memorial. She made me promise not to cry. I didn't.

Before my grandmother's exile to Moon River, I filmed her at home. "I'm too ugly," she mumbled and asked to see the footage. It, too, brought her joy. "As long as it's useful for your research," she relented, her eyes twinkling.

The film was a truth and a lie. My grandmother was just that—direct, optimistic, pragmatic. But she did not always have the energy to look through grandfather's paintings. She did not always talk to me in this way. Reflections on her internal life, her emotions, were rare.

This is a partial perspective. It's not how I remember days in the Beijing apartment. It is an image that I created.

Transcription/Translation:

总而言之
To put it simply,
养生就得开心
cultivating life requires happiness
就得调心
requires adjusting your heart-mind
这句话真是
this saying, really
要做到不容易的。
isn't easily to accomplish.

真真的调心
Truly adjusting your heart-mind
不容易啊。
isn't easy.

我目前做的很有进步
Recently, I've made some improvements.
我不计较个人得失
I don't fuss over what I've gained or lost
不是怕人家给我提意见
I'm not afraid of what other people think
不过有时候心情还是不行。
But sometimes my attitude falters.

但是我现在有时候想不开
But when I can't think through a problem
不高兴一点
or I'm slightly unhappy
一想过、一下就完了。
I think about it, and in a second it's over.

不是像过去
Not like before
一器啊、器死了
I would get angry, extremely angry.
整天都想不开，没有。
Frustrated for the entire day, not anymore.

我目前这个状况
In my current condition
就必须要这么做。

I have to be this way.
要不然就一条路
or else the only path is
器死。
to die of anger.

想死很容易。
Dying is very easy.

觉得人生也有滋味。
But I feel like there is still meaning to life.
大家对我都挺好。
People are kind to me
有时候想到
And it's really interesting
挺有意思。
When you think about it.

Lan Li is a historian of medicine and filmmaker focusing on global East Asia. She is an assistant professor at Rice University's history department and medical humanities program. Her current book manuscript tracks a long history of meridian maps used in acupuncture and its relationship to the history of neurophysiology.

The video accompanying this piece, also by Dr. Lan Li, can be found at bcm.edu/omentum

As You Lay Dying / Julika Kaplan

I cradle you in my arms
Your lips are dusky and blue
Your pulse faint and slow
Your breaths shallow
As you lay dying

You are 14 days old
You just entered this world
I wish you had felt welcome
But now there is blood in your brain
There are fractures in your skull
You've had seizures for days
Just hours ago,
You had lines in your legs
Electrodes on your scalp
A tube in your throat
But now you are finally free
Free from pain and suffering
As you lay dying

Before you were here,
You were crying at home
You were probably hungry
Or tired
Or scared
But somebody ran out of patience
And in a moment of weakness,
An unforgivable moment,
The moment that ruined everything,
Somebody picked you up

And shook you
And maybe threw you against a wall
Now you are turning cold in my arms
As you lay dying

In that single moment,
All because you cried out for help
And somebody didn't want to listen
Your life was stolen from you
You will never smell a rose
You will never feel the sun
You will never touch the ocean
But you did feel love
Because I stroked your head
And rocked you gently
As you lay dying

I wrote this poem to help myself process the death of a patient from suspected non-accidental trauma (child abuse) in the Pediatric Intensive Care Unit.

Julika Kaplan is a third-year resident in the Internal Medicine-Pediatrics program at Baylor. She also attended medical school at Baylor and completed the Global Health, Medical Ethics, and Care of the Underserved tracks. Her professional interests include refugee and immigrant health, and she plans to pursue a global health fellowship after residency.

Heartbeats / Gulchin Ergun

A clipboard staked my claim on the counter nearest the nursing station. I poured myself a cup of coffee, whitened it with a packet of powder, and scanned the to-do list on the top page. Not so bad, I thought. My co-residents hadn't signed out too much. As the intern on call, the forecast for my night now depended on who got admitted to the hospital, but I expected it to be quiet. Around Lake Erie an advisory of sleet mixed with snow got the streets salted and kept most folks inside and out of the ER. I drew little boxes next to the things that had to get done, intending to fill them in as I went along.

I was immediately interrupted with "Doctor Hart, room 342. Doctor Hart, room 342." The even, detached tone of the voice belied the emergent nature of the announcement. For us it was a fire alarm, the signal for a scramble of residents, nurses, and respiratory therapists responsible for dealing with life-threatening emergencies.

I snatched my stethoscope, pushed back the chair, and thought of my lab partner from med school. She didn't keep her mantra a secret. "Never run to a code. Never. You might be the first person there."

I'd laughed when she said it, but mostly because it was true. As green doctors you didn't want to be first. Being first meant you had to figure out what was going on—was the man breathing, did he have a pulse, do you start CPR? And if he wasn't breathing, you had to be ready to squeeze the nostrils and kiss the lips to deliver a hopeful breath, despite the presence of blood or vomit.

I sprinted down the hallway and darted up the stairwell. I followed a group wearing white; somehow I got there before them.

The near bed was empty. On the far side a young nurse fluttered against the window.

"What happened?" I asked.

"I came to get his vital signs. When I got the cuff on his arm, he said he was lightheaded and sweaty. Then he fell back and didn't move. I pulled the cord and called the code."

I could still hear the operator overhead as someone pushed the "crash cart" into the room. Looking like a metal tool chest the size of a small refrigerator, it held the defibrillator, endotracheal tubes, and the drugs needed in a crisis.

I took a look around. People were arriving pell-mell: nurses, aides, even a medical student, but no doctor. I pulled at the stethoscope that necklaced my shoulders and went to the head of the bed. I

bent into the man's face and thought I detected a faint breath. I turned his neck to the side and placed my fingers over his carotids, hoping to feel for a pulse. I wasn't sure there was one.

In the hierarchy of running a code, one person is responsible for calling the shots. A team leader assesses the situation, makes the decisions about drugs and defibrillation, and assigns duties to the other people in the room. I never saw an intern run a code. They only started lines, checked blood gases, and squeezed breaths out of an Ambu bag once patients were intubated. Once in a while they climbed onto the bed to give chest compressions when nurses got tired.

"Has anyone checked for a blood pressure?" I asked.

A nurse they called Woody was tightening the cuff on the right arm and readying herself to listen for the sounds. She looked old-school in her starched whites and support hose. She had twenty years on me, but technically I ranked highest on the totem pole of medical education. I made a mental note of everyone capable of helping. There was Woody taking the blood pressure, another nurse pulling the crash cart to the foot of the bed, the sparrow of a nurse trying to stay out of the way, a medical student, and me. I asked the student to get the EKG machine and made the call to start CPR.

"Does he have a line?" I asked. Giving breaths and chest compression was one thing, but they weren't any good if he didn't have fluid in his veins. I asked the young nurse to begin CPR, and I set about putting a tourniquet on his left arm and starting an IV. About that time another intern sped breathlessly into the room. "What can I do?" he asked.

"Help get the EKG leads on and start a line," I said. "We still don't know what kind of rhythm he has."

Woody yelled, "I don't have a pulse or a pressure."

"Continue CPR and someone get a board under him," I said, and the nurse at the head of the bed squeezed a few breaths between the bluing lips and quickly moved to the chest to pump the sternum below her clasped hands. The EKG leads were placed, and the attempts of the heart to telegraph a rhythm were charted on a strip of pinkish paper that was starting to curl on the floor.

"Stop compressions. Woody," I ordered, "check for a pulse. Let's see what's on the rhythm strip."

I glanced on the monitor, then the strip. There were spikes indicating some type of electrical activity. Thirty beats a minute. Bradycardia.

"We have a rhythm. Do we have a pulse?"

"Not sure," Woody responded.

"I guess that means no. Continue CPR. Do we have a line yet?"

"I've got a sixteen gauge in his left arm," the other resident yelled, and I asked the nurse to hang a bag of normal saline. "Let it run in, wide open."

By now I had expected the room to be brimming with hospital personnel. *What the hell is going on here, where is everyone?* I thought. The other intern must have understood what I was

thinking as he gave a shrug, then wiped his forehead on his sleeve. His eyes darted from me to the nurse at the crash cart and back.

"Uh, by the way, where is the code team?" I asked. I may have passed the test and run a simulation on Resusci-Annie, but shocking a plastic dummy with a red wig and potentially electrocuting a person were two different things.

"Most nurses are ACLS certified," the instructor had said. "This is a team effort. You won't be alone."

Yeah, right, I thought and my mind ran through the scenario for pulseless bradycardia. *Think, think*, I said to myself. *What comes next?* I tried to visualize the algorithm on the page.

"Okay," I said. "This is the same as no pulse, no rhythm. EMD, electromechanical dissociation. Causes are hypovolemia, pulmonary embolism, cardiac tamponade. You're supposed to continue CPR, give fluids, and check a blood gas."

The other intern looked at me and mouthed, "Shock him?"

I looked at him, pausing, almost second-guessing my first inclination, then shook my head and said, "Get a blood gas. Send a CBC and lytes. We need to intubate him."

At that moment the nurse at the head of the bed said, "He's starting to move."
Woody called out, "We've got a pulse."

The rhythm strip showed that the heartbeat was dreadfully slow. It was half of what you'd expect in a sleeping man, but it wasn't a figment of our imagination. He had a blood pressure as well. Low, but it was there.

"Stop CPR," I said, "and give him one milligram of atropine," intending to block the nervous system responses that slowed his heart rate. The paper from the rhythm strip continued to document the response from the heart as it sped up to forty-six beats per minute.

"He's starting to stir," Woody said. "Sir, sir, can you open your eyes?" she asked as she shook his shoulder.

He gave a groan and rolled his uncomprehending eyes from side to side, trying to accommodate his confused vision to the commotion in the room, and he started to wave his arms.

"Don't MOVE," we said in unison while the other intern and the nurse pumping his chest jumped to restrain his arms, hoping to keep the precious IV and EKG leads in place.

The tickertape from the EKG continued to roll, and I looked at it a little more carefully, taking advantage of the lull and the relief that the man was alive and I wasn't going to have to tube him, shock him, or put needles in his heart.

"Hey," I motioned to the other intern. "Take a look at this. I think the p waves are marching out independently of the QRS complexes. This might be third-degree heart block. What do you think?"

I hoped for some kind of validation, at the least the support of someone else confirming my suspicions.

"I don't really know," he said. "I'm transitional. I'm going into radiology."

Great, I thought. It's bad enough he doesn't know, but he doesn't give a crap that he doesn't know.

"He needs to be in a unit," I heard myself announce to the room. "We need to transfer him."

He wasn't out of the woods yet. If he had heart block, it meant that the electricity to his Christmas lights were on, but the juice wasn't getting to the bulbs in his ventricle. A little shake, the bulbs might flicker, maybe go out.

"Has anyone seen the upper level or chief? They have to approve it." I was stating the obvious. Everyone knew he couldn't be transferred without their authority, but I couldn't wait to hand over the man to someone else.

Woody leaned into my ear. "We have a problem. The charge nurse said that the MICU is full, and there're two codes going on at the same time…that's why the upper level didn't come. The SICU's full too, and some kind of trauma's got the ORs busy. All available staff are booked. There just isn't anybody."

"You have got to be kidding me," I said, even angrily. "He can't stay on the floor. Am I supposed to babysit him?"

"They'll send somebody as soon as things clear up," she said and left the room.

In fifteen minutes I'd graduated from being an intern to a chief resident but without the benefit of thirty-six months of training. I parked myself in the blue guest chair that occupied every patient room and resigned myself to being behind in the charting, blood drawing, and x-ray checking I was supposed to do.

The other codes won't last forever, I thought. *Someone'll show up*, but my mind drifted to the morning. What if there was no rescue? How could I explain that the other patients weren't taken care of?
I'll just tell them what happened, I thought. *Surely they'll understand*.

I told Woody that I had to have a nurse with me. The comment was followed by a snort and, "Yeah, we'll see. We have work to do too. The floor's got twenty-two beds, and someone's got to give out meds. We don't have extra staff either."

I flipped through the chart, reviewing the admitting note. In a very vertical and angular blue print, it said that the patient was a 57-year-old black man who had never been in the hospital. He had passed out while shoveling snow in his driveway but didn't remember anything else. His neighbor called 911 when she saw him collapse. He woke up quickly once he got into the ambulance, even arguing that he didn't need to go to the hospital because he felt okay, but the paramedics convinced him otherwise. The ER found nothing wrong except a few bruises on his shoulder but admitted him for observation. He'd done a tour in the Korean War, so he was brought to the Veterans' Administration hospital.

Their physical exam was pretty much normal except for obesity. His blood count, electrolytes, chest x-ray, and EKG were all normal. The ER had ordered a drug screen, probably overkill since it didn't show any trace of marijuana or narcotics, and from what I read, he was pretty much a straight-shooter, married with a couple of kids, and worked in a machine shop. The presumed diagnosis was syncope, doctor-talk for fainting, perhaps brought on by the combination of overheating with exercise, unrecognized heart disease, or some rhythm abnormality. The plan was to watch him, make sure he didn't have a heart attack, and get a cardiology consult. Pretty routine, I thought, and began to document the events that had just transpired.

As I wrote the last line of my note, the spikes on the rhythm strip that coiled in my lap went slower and slower. He hadn't really said anything that made much sense since all the commotion, but now he piped up, "Doc, I don't feel so good." After a feeble attempt to sit up, he fell back, out cold. The only way that I could get help was to reach for the cord above the bed to call for a code, again.

It turned out he was arousable. A tough rub of the knuckles to the sternum triggered a moan, "Hey, that hurts," as he struggled to push my hand off his beefy chest. When Woody and another nurse came back into the room and checked his blood pressure, it was really low.

It was clear that he was unstable and had symptomatic heart block. The electrical impulses between the top and bottom of his heart were not in sync, and the ventricles responsible for the pumping action of the heart were not able to deliver enough of a blood volume to maintain his pressure. I ordered more atropine, thinking that it had worn off, but I knew now that this was only a temporary fix. He needed a pacemaker, a drumbeat of electricity necessary to stimulate the ventricles into systole without relying on the natural conduction system of the heart. And he needed a cardiologist. I didn't even have an intensive care unit. The medical student had disappeared too, along with the radiology-bound intern. *Probably hiding in the call room,* I thought and paged the cardiology fellow.

"Listen, it'll take me forty minutes to get there," he said. "I think you should put in a transvenous pacer."

"I've never put in a pacer," I croaked. "I've never even seen one done before. That's why I called you."

"Well, the guy's unstable," emphasizing the uncertain and urgent nature of the problem I

already knew existed. “Have you ever put in a central line?” he asked.

“Yes,” I said, trying not to sound overconfident.

“If you’ve put in a central line, then you can put in a pacer. Same concept. Just get it started. Tell your upper level when he shows up and I’ll call my attending,” he said and hung up the phone.

“Woody, I need a pacer kit,” I ordered and did my best to explain that I would be the one using it, but that the fellow would be joining us.

I knew she was hiding her surprise, even concern, when she replied, “Well, that’s a first,” but added, “I’m sure he’ll get here soon. The roads aren’t that bad.”

I was grateful that the man was asleep or unconscious and didn’t have to hear me tell Woody I’d never put one in before and that I wanted to read the instructions before we started. I took some deep breaths. Woody must have noticed because she put a gentle hand on my arm. “You can do it. I wouldn’t let that other guy try, but you can do it.”

We unlocked the brakes and pushed the bed away from the wall so that I could get to the head of the bed. I had them position the EKG machine with the rhythm strip on my right so I could turn my face to see it. Woody was responsible for charting, checking the blood pressure and pulse, and delivering any medications. I looked up at the clock, “Start time, 10:35 p.m.”

I took the pillow under his head and threw it onto the chair. I positioned his head so that he was looking to his left. I took the penlight out of my pocket and shined it at a thirty-degree angle to see the pulsations of the vessels underneath. Noting the carotid artery, the external jugular vein, and then the position of the internal jugular vein, I identified the sternal notch, clavicle, the two heads of the sternocleidomastoid muscle, and my imaginary line to his right nipple. This was my angle of entry.

This is just the same as putting in a central line, I told myself. *Put the needle in, withdraw blood. Make sure you don’t hit the carotid, then slide in the wire. Pull out the needle, advance the dilator over the wire. The only thing different is attaching a sheath. Then pass the pacing catheter into the right heart. Bingo. That’s all. Turn it on.* I tried not to dwell on all the bad things that could happen, like puncturing the carotid or collapsing a lung.

I took my cue from Woody. If Woody knew how nervous I was, she didn’t let on. She precisely assembled the kit on a table next to the bed and turned on every light in the room with the efficiency and authority of experience. She put on a sterile gown and pointed to mine as if we’d done this together a thousand times before. I pushed my arms through the plasticized blue paper, secured the belt, and slipped on the smooth, faintly powdered, sterile gloves.

“I gave you size six-and-a-half,” she said. “Your hands aren’t that big,” and handed me the plastic packet with the povidone-iodine cleaning swabs.

I took the first swab from her and started to clean the right side of the neck in a circular motion, starting in the center and moving outward. After cleaning it two more times, I asked for the drape. I positioned it so that the center cutout was positioned directly over the brownish-yellow area I'd just cleaned. I patted it into place, noting that the excess iodine had run down the side of his neck in brown rivulets, staining the bed sheet, even dripping onto the tile floor.

I looked into the kit and reached for the ampule containing the lidocaine, broke the glass top into a short stack of gauze, and withdrew five ccs into a syringe. Then I injected the anesthetic. Not so bad, I thought.

"How's he doing, Woody? Pulse and blood pressure okay?" I asked.
"Still good."

"Keep checking. Let me know how he's doing."

I asked for the syringe. I slid the needle in slowly, aiming in the direction of his sternum and nipple, aspirating the whole time. At a depth of about an inch and a half, I got blood and stopped. The blood was dark red, not pulsatile, so I was sure it wasn't the carotid artery. I pinched the needle with my right index finger and thumb and removed the syringe. "Hand me the guide wire," and used my left hand to thread the needle with the wire. Then I withdrew the needle and advanced the introducer into the vein and removed the wire. Hallelujah. Step one done, I said to myself.

Now that I had access to the blood vessel that led to the heart, the next step was to attach the sheath to the introducer and thread the catheter with the pacer wires directly into the right heart. This was the hard part. How was I supposed to know when it was there? It's not like I could feel my way around or see where the wires were since there was no fluoroscopy.

"Woody, put those instructions on his chest so I can see them. And hold the rhythm strip a little higher next to me so that I can see what's going on."

All I could think was, This is stupid, really stupid. I can't guide myself through this guy's heart based on some cartoon diagrams I've got propped up on his chest. What was I thinking? I don't know what I'm doing. What happened to "see one, do one, teach one"?

Woody looked up at my face, saying, "I can't hear you," as if the involuntary movements of my lips were actually instructions for her. I switched to giving the directions out loud, letting my secure, confident self give instructions to the shaky, sweaty one.

"Okay, the wave form changes based upon the location in the heart. If it's in the atrium, it looks like a big p wave, and the QRS spike is small and narrow. When you pass the mitral valve into the right ventricle, it starts to get taller and broader," I announced. I get it, I thought.

But what if I passed the catheter too far into the pulmonary vein and into the lung? I could perforate the vessel. If that happened, instant death, so I decided to keep the negative thoughts to myself. Woody didn't need to hear that if the catheter tickled the heart, I could precipitate ventric-

ular tachycardia, the anarchy of electricity where the heart would not be able to rest long enough to fill with blood, let alone pump it to any tissues. Even his slow rhythm was better than no rhythm. At least it generated a heartbeat and blood pressure. Of course she probably knew this but kept quiet, doing her best to keep from reminding me what we both already knew.

"Hey, Woody, I hate to ask you this, but could you wipe my forehead? It's really hot under this gown."

Once we cleared the hurdle of the atrium to arrive in the ventricle, it was time to hook up the pacing catheter to the pulse generator and apply energy to stimulate a rhythm. Now I had to pick a rate and an amount of energy. Since this was a single chamber ventricular pacemaker, I didn't have to worry about choosing the setting for the atria. I picked eighty beats per minute. It was a normal rate yet faster than his native rhythm. The instructions said to start at an energy output of fifteen milliamperes and sensitivity between two to five millivolts.

I looked at the doorway. Still no one.

"Well, it's now or never," I said. "Turn it on, Woody." We glued our eyes to the EKG strip.

Nothing.

Nothing happened. We watched it a full minute. His heart rate was still thirty-two. No pacer spikes.

Shit, I thought. "Let me see that box." Panic. "Bring it a little closer to my face," as I examined the unit. "Turn it off again. Recheck the connections for the wires on top. Does it have a fresh battery?"

She jiggled the connections at the port for the pacing wires. "They may have been loose. And yes, I put in a fresh battery."

"Okay, let's try again." I took a breath. "Turn it on," with a wordless *Please. God, please. God, let this work.*

The rhythm strip now showed widened QRS complexes with a pacer spike preceding each one. The rate was eighty beats per minute. Christmas lights were on.

"Check a pulse, please," I said, placing my own fingers over his carotid, and I knew the pulse was a strong eighty beats per minute before she said it out loud.

She flashed the first smile of the evening with "One-oh-eight over sixty," and I sutured the catheter into place. I then listened to his heart and lungs, pleased to note that I hadn't dropped a lung. He was beginning to move around and ask what happened.

It wasn't long after that the cardiology fellow rushed in. Puffed up with a ski jacket dusted with snow, he yanked a soggy Browns cap off his head. "Okay, let's get started," he barked and

motioned to Woody. "We need a pacing kit right now," somehow missing that we'd already gotten the job done. The senior resident followed. "Sorry, it was really busy," and then the chief resident showed up. He wrapped up his assessment with a succinct, "Strong work."

All the people I'd wished for had appeared. The patient was bundled up and transferred to the unit.

I took a look around; it looked like a bomb had gone off. There was debris everywhere. Bloodstained gowns and drapes overflowed from trash cans, and empty angiocath containers, inside-out latex gloves, and EKG curls sprinkled the floor. Oxygen tubing going nowhere dangled from outlets on the wall, and flat surface areas were crammed with the remains of plastic bags of saline and face masks. The open pacer kit, pirated of its contents, stood on the tray with a red sharps containers next to it. Iodine and blood stained the floor near a huge cardboard box with a red biohazard garbage bag replacing the patient and his bed. The wreckage a still life of medical exertion.

I thought of how detectives might interpret the rubbish that filled the room if they hadn't the luxury to interview the people who were there. They might surmise that something serious, even grave, had occurred, but they could never know that the little piece of paper with slow spikes was the decision that I made to give atropine. They would not discern that the recognition of heart block meant dominating my fear to put in a pacemaker. They could never know that the spikes of a paced rhythm was a lifeline to me as much as the patient, and that the garbage bobbing in the sea of this room was the nexus of decisions that helped make a doctor out of me.

I stepped out into the hallway and found a bathroom where I could wash my face, and I looked at my reflection. Bedraggled, with blood flecks on my scrubs and pupils the size of pennies, I looked like I had been in a fight, but you wouldn't have known that I was the victor. I'd had a good outcome, but I was too tired to even congratulate myself. I was spent. There was no place to sit, so I sat on the toilet. I put my face in my hands and closed my eyes. I let the muscles in my face go. I let my neck and shoulders relax. I thanked God that the man didn't die and that I'd maintained my wits to do what I had to do. I washed my face and went back down the stairs, back to my floor's nursing station.

The coffee was cold. The brown liquid stained the rim of the Styrofoam cup, and the clipboard stood exactly where I'd left it. None of my little squares were filled in, and I'd missed the antibiotic level due at 9 p.m. Two hours and a lifetime had passed since that deadline.

I gathered up the things necessary to draw the blood—alcohol wipes, a red top tube, tourniquet, and butterfly needle—as the medical student on our team came up, pockets bulging with a reflex hammer, tuning fork, ophthalmoscope, ruler, and the *Washington Manual of Medical Therapeutics*, all the stuff he thought he needed to get through the day.

"Hey, I heard there was a code," he said. "What'd I miss?"

"Come on," I said. "Let's walk and talk. Are you good at drawing blood?" I asked. "We

have a lady with a staph infection and we need levels. I could use the help."

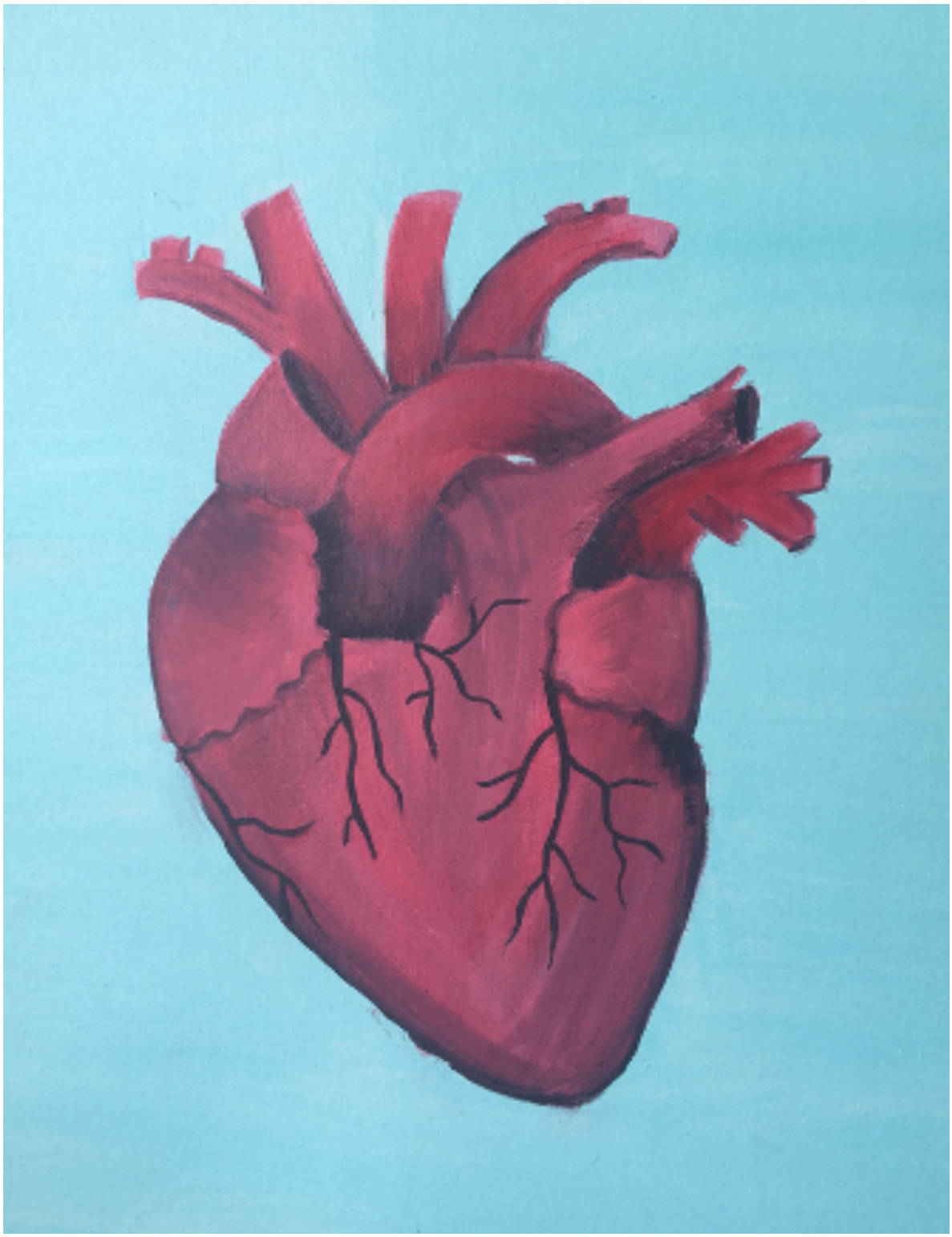
He took strides to match my own as we walked down the hallway. "It's my first clerkship," he said. "I've only tried on my lab partner."

We stopped outside the room. I knocked on the door and turned to the student. "Here's the stuff you need," and handed him the paraphernalia I'd just collected. "You need to try," I said. "But I'll stick around until you get it right."

A doctor reflects on a milestone experience during internship, when a new doctor is suddenly the person in charge as a man's heart almost stops.

Gulchin Ergun is a proud Turkish-American, Ohio native, and graduate of Case Western Reserve University School of Medicine. She has been in Texas for the past twenty years working in the Texas Medical Center as a gastroenterologist with a specialty in motility. She writes about growing up with evil eyes and Girl Scouts and her experiences in medicine. She is a Pushcart prize nominee and her work has appeared in Missouri Review, Bayou Magazine, Potomac Review, Sou'wester, and others.

The Heart of Medicine / Rachel MacAskill



I painted this acrylic on canvas after dissecting the human heart from our cadaver in anatomy lab during my first year of medical school. This experience was so special and moving, something that no one else outside of the medical field will ever do in their life. We are blessed to have this intimate connection with the human body, and I am thankful to the donors for contributing to our medical education in this special way.

Rachel is a third-year medical student, who has enjoyed painting in her free time since she was 18. She spent her days in quarantine covered in paint, listening to podcasts, and being thankful for this outlet for creativity.

Stitches / Ginger Hooper

I'm a quilted kind of character

stitched together somewhat haphazardly

from varied scraps of cloth.

I offer up different squares

depending on the situation

Sometimes my favorite squares

hide from me.

I pull at my stitches,

wanting to become something

whole, coherent.

But it would appear my surgeon

had a deft, unartistic hand.

He just won't seem to let me

fray at my edges.

Doctors are required to wear a lot of different hats and put on a lot of different faces, and that can be tiring. We're not allowed to unravel and I wanted to capture that through this poem.

Ginger is an MS1 at Baylor. She's originally from Austin but has been in Houston for a few years now. She enjoys creative writing as a hobby and outlet.

I Find No Peace / Charis Tang

In October of 2015 (my freshman year in high school), I noticed a small subcutaneous lump near my right chest wall. Afraid of all the harmful possibilities this could hold, I immediately went to see my pediatrician. When he told me it was simply a bone malformation, I was immensely relieved. With this assurance, I was able to thrive the rest of my freshman year up until the first semester of my junior year despite the constant realization of the lump's continuous growth in size and firmness tugging at the back of my mind. I was worried, but I consciously buried this from my friends and family out of fear, again, of all the harmful possibilities it could hold, but also fear that of harmful possibilities interfering with my smooth-sailing academic and piano careers. But eventually, out of mortal necessity, I shared this with my parents in the second semester of my junior year. Yet again, my pediatrician reassured us with 99.9% confidence it was absolutely benign, but suggested I get it removed anyway. We visited with several surgeons on his recommendation, all of who also assured us of its benign nature. I got an ultrasound, and my mass displayed extremely unusual features, prompting immediate removal.

On April 11, I underwent the first surgery of my life, a right breast excisional biopsy. I had my postoperative follow-up a week later, on April 17, where my life was turned upside down - I was diagnosed with dermatofibrosarcoma protuberans (DFSP), a rare form of sarcoma skin cancer. The surgeon was equally as shocked as we (my parents and I) were. She claimed to never have encountered DFSP in all her years of practice, nor ever diagnosed cancer in anybody as young as myself. Due to the high recurrence rates of DFSP, I needed Mohs micrographic surgery as soon as possible, but I delayed the operation to June so I could finish my academic and piano responsibilities for the school year.

Though June 15 was blurry in many ways, there are few things I remember from that day, and those few things I remember are etched in my brain with the same vividity as the day it happened. The hair-raising sounds of a scalpel scraping skin, attempting to remove the impurities afflicting my body. The scent of burning flesh each time they electrocauterized my incision. The vulnerable feeling while shivering in the waiting room between each of the three rounds of Mohs, only a paper-thin hospital gown separating me from the frigid air, my wound hastily veiled by a sad piece of blood-soaked gauze. The sight of the picture they took before stitching me back up, a sanguine gaping hole in place of what was once a part of my chest.

This disease not only left physical scars, but it also took away a sense of security, damaging my emotional well-being. It left me the most helpless I'd ever been, forcing me to rely on people in ways I never thought I would need to. For example, my mom helped me shower for over a month after my Mohs surgery because I was in so much pain and would faint in the shower. Cancer also introduced me to a whole new world of loneliness. It was difficult for my friends and family to empathize with me because they had never experienced cancer themselves; some of my friends even shunned me after discovering the news because they didn't know how to act or what to say around me anymore. Nonetheless, I found the strength to embark on the path to emotional recovery through music. Practicing ushered a sense of normalcy back into my life, and I projected my emotions into perfecting a piece that has come to mean so much to me: Liszt's Sonetto del Petrarca 104,

one of his Tre Sonetti del Petrarca. He found inspiration for them in Petrarch's Sonnets while traveling in Italy with his then-lover, Countess Marie. Liszt includes the original sonnet preceding each piece; 104 is "Pace non Trovo", which translates to "I Find No Peace":

Warfare I cannot wage, yet know not peace;
I fear, I hope, I burn, I freeze again;
Mount to the skies, then bow to earth my face;
Grasp the whole world, yet nothing can obtain

His prisoner Love nor frees, nor will detain;
In toils he holds me not, nor will release;
He slays me not, nor yet will he unchain;
Nor joy allows, nor lets my sorrow cease.

Sightless I see my fair; though mute, I mourn;
I scorn existence, and yet court its stay;
Detest myself, and for another burn;

By grief I'm nurtured; and, though tearful, gay;
Death I despise, and life alike I hate;
Such, lady, dost thou make my wayward state!

The poet is pondering the tumultuous state of mind he is in why he relishes in the bittersweet pain of his unrequited love. Liszt mirrors the rapidly changing emotions of this poem in his piece, from sweet tenderness to anguished torment, through contrasting sections of flowing harmonic passages (labeled cantabile con passione, singingly with passion) and explosive climaxes filled with intense agitation (labeled agitato assai, very agitated). Although this poem is about romantic love, the emotions are not dissimilar to what I felt throughout my illness and recovery. Cancer demanded of me emotions I was arguably too young to feel. I, too, was confused, and the range of emotions I felt during the experience was a roller-coaster, to say the least. Some days, the burden of this disease lay so heavy on my heart that it was hard to function. Some days, I was okay. But despite the countless ups and downs that come with dealing with something like this, I have found complete healing through music. Liszt ends the piece calmly, with a prayer-like final cadence. For me, this signifies my victory in the battle with lasting physical and mental scars of cancer: I have found peace.

I decided to write about one of my personal stories, but one that I am willing to share. Not many people are diagnosed with a rare cancer at a young age, so I wanted to share the story of my journey from diagnosis to full healing, in hopes of helping those who might have gone through or are going through similar situations feel less alone. I also included my performance of a piano piece that helped me a lot in recovering from the emotional scars of cancer - this was actually one of the pieces I played in my audition at the Shepherd School of Music at Rice, so it means a lot to me.

Charis Tang is currently a junior at Rice University, studying Health Sciences and minoring in Medical Humanities. She began as a Piano Performance major, but discovered that her passion lay in the multifaceted aspects of health and healthcare equity. Although she is taking a break from playing the piano right now, she hopes to pursue both her passions in health and music, as she believes that music heals the body, mind, and soul, as demonstrated through her own experience.

Migratory / Colleen Driscoll

As the light fades the sun

Burns my hair to red

Like glass that was spun

As a veil for my head.

A shroud not white

But dark as the weeks

When the day's mostly night

And the blood moon peaks.

Birds bees and I know

Weeds and flowers go to ground

Then after winter grow.

Just as they who circle round

Will leave through the air

Time is all we can compare.

After a long shift at the hospital, I like to take the time I spend walking home to mull over things I've seen and done during my training. I struggle a lot with concerns of the impermanence, and even futility of my work. This poem is a reflection of that.

Colleen Driscoll is a Student Editor for Omentum, and a third year medical student at Baylor College of Medicine. She graduated with Honors in 2017 from Texas Tech University, where she studied Biochemistry and Political Science. She enjoys writing poetry and short stories, and is particularly interested in the roles played by art, literature, and science in social and political movements.

Challenges Amidst a Pandemic / Pranali Kamat

This painting highlights the challenges citizens face during the COVID19 pandemic. It is split up into 5 sections, each representing a specific hardship. This painting is intended to be viewed in a clockwise manner chronologically. The hand sanitizer and disinfectant wipes characterize the initial stages of the pandemic and the challenge individuals have making sure they do not spread the virus to other individuals, protecting themselves, and having access to these products. The iPhone symbolizes the increased use of virtual meetings and communication, leaving individuals isolated. This translates into mental health issues as people are not able to receive the social interactions they are used to. As the pandemic progresses, many people lose their jobs and struggle to make ends meet, depicted by the empty wallet. The fight to find a vaccine is highlighted in the last section. Finally, the center is symbolic for frontline health care providers. A physician, wearing a mask, looking out into the distance represents the tenacity to continue the fight, put their own lives at risk to take care of others, and yearn for a brighter future.

Pranali Kamat is a 3rd year medical student at McGovern Medical School. She went to undergrad at UT Dallas where she majored in Neuroscience and minored in Performing Arts. Aside from her passion for medicine, she enjoys painting, learning different art forms, knitting, acting, improvisation, playing piano, and spending time with family and friends.

Support / Alexis McAlister

I'm known in my family as the levelheaded one. My dad's been affectionately coined the family hypochondriac, and my mom has a flair for the dramatic, so, at a young age, I learned to be the rational, logical one for my family when medical matters were concerned.

My strategy had been working for over two decades. That is, until I felt something wrong. One night after showering, I palpated a mass on my breast. Instantly, I froze. It felt like ice had filled my veins, waves of chills hitting my entire body.

The next morning, I sat alone in the waiting room of the physician who I found the night before and had immediately booked the first available appointment. I stuck out sorely among the other patients, most appearing to be in their forties or older. Frantic Googling told me that I most likely didn't have breast cancer, although the gnawing in my stomach left me unconvinced. I felt increasingly vulnerable as I noticed most women were accompanied by spouses or adult children, while I hadn't yet told my parents so as to not worry them.

My thoughts were disrupted by a nurse calling my name and leading me to a hallway of changing rooms. She handed me a rough white robe and instructed me to undress from the waist up. Afterward, I wandered in a daze to a second waiting room occupied by women in identical white robes. There was an attempt to make the room resemble a spa – a few lamps were scattered around the dimly lit room, lavender incense filled the air, and lukewarm lemon tea sat in the corner. Despite the clinic's best efforts to create a calming environment, my feeling of defenselessness grew as I became increasingly aware of the fact that only a thin robe protected me from others now. When the nurse called me into the examination room, I looked at my feet to see a pile of pink nail polish flakes that I had chipped off as a result of my growing anxiety.

The room smelled aggressively sterile and the fluorescent lights shone too bright. My doctor walked in and introduced herself with a perkiness that I couldn't reciprocate. She then kindly asked me to allow her to examine me. It was during this moment that my feelings of vulnerability culminated to nearly unbearable levels. Suddenly I felt like a little girl again, yearning for my mom to be waiting in the lobby. The doctor explained that she'd need to run some tests that day. She quickly finished her diagnostics and left the room. I was left isolated and lonely.

The results came back two days later as benign. I called my parents and explained to them what had happened with an air of nonchalance in my voice. I told them I hadn't worried for a second, that everything was fine, and they shouldn't worry either. In becoming the backbone of my family's support structure, I realized I had lost my ability to confide in them.

This piece is about my experience as a young adult with my first real medical scare. It explores the unexpected loneliness that comes from handling medical issues and the hesitation to worry your loved ones.

Alexis McAlister is a senior at Rice University studying neuroscience and cognitive science. After graduation, she hopes to go to medical school.

The Neck Of The Giraffe / May Ameri

Tick. Tick. Tick. Tick. The faint, rhythmic sound of the gold clock near the top of the stairs sounds harsh and abrasive in the heavy silence that surrounds me. The house is empty. I should get ready, but I cannot move. Mom and dad have already left. I should get ready. Traffic is going to be bad. Traffic is always bad. I cannot move. The appointment is at 9:30. It's only 9:15. I should really get up. I don't want to be late to class.

"Any updates?" I type out a text. I don't send it. It's not 9:30 yet. Leukoplakia. Proliferative verrucous leukoplakia. One of the worst types of malignant mouth cancer one can have. The words I spent hours googling last night rattle in my skull. My classes only aided in pushing my hysteria farther off the cliff, tipping the scale of my sanity. My eyes burn. I'm probably tired.

Tick. Tick. Tick. Tick. I check my phone again. 9:18.

I walk into the study. It is spotless as usual. The sun seeps through the windows and cast a glare on the frames on the wall. Three gold frames lined up perfectly. One of her medical board certifications inside each.

I walk into her room. The bed is made, like always. I stand in the same spot I did last night: Hand grasping the door handle, careful not to let out a squeak. I listened for her breathing but this time, I could not hear it. My throat closed up. My temples were throbbing. For the first time in a long time, I felt so unabashedly young.

I wanted to run over and shake her awake. Lay on her pillow, have it soak up the wet tears. Have her soak up my fears. Have her tell me that she'll take care of it. She always takes care of it. This time, she's scared.

My dad used to joke: she has a pain tolerance I've never seen before; explains why she can be brutally practical. It's not funny anymore; the irony tastes metallic in my mouth. I should have gone with them.

It had spread to the other side of her mouth within a week. The white patches looked like an obvious sign of something sinister. It's 9:20.

Last week, I complained. The world owed me. I had an acne flare up. I missed a quiz. Traffic was bad. I had a "bad" week.

Last week, I snapped at her. She doesn't understand. It's hard being a student. She's been a doctor too long. She's too perfect. Not all of us can be perfect.

I forgot she came from war. Forgot the time she heard a bomb go off in the street and covered me with her own body. Made it out before Iraq was swallowed whole. Still though, she didn't understand. The world owed me. I had a bad week.

9:40. I pace. I'm already late. I should've just gone with them. "Any updates?" This time I press send. "Doc is late," He responds. This time, he was scared too.

I can picture him there: putting his head in her lap. Her being the strong, practical rock she always was. My dad and I have always been emotional--rash even--compared to her. When I was a little girl, she would tell me an Arabic proverb: "May your neck be as long as a giraffe's so that the words will take time to come out".

"What is going to happen?" he asks without expecting an answer. There would be options, she said: a couple of laser treatments, skin grafts, tooth removal.

NO. This shouldn't happen like this. Doctors don't get sick like this.

I pace. Each step matches up with a TICK. My room is a mess. I snapped at her because she doesn't like the mess. She doesn't understand. The nuisances of last week seem inconsequentially far away. I wish I didn't snap.

10:05 TICK. TICK. TI—the phone rings. My knees nearly buckle and I have to hold onto the kitchen aisle. "Hello," I mouth the words but nothing comes out, my throat is closed. He would not call if it wasn't serious.

"It's only inflammation, it's benign." My knees fully buckle, I'm on the floor. I cannot see through my tears. I am thankful. I am thankful.

I am thankful.

A piece written about the intersection of introspection, vulnerability, invincibility, and thankfulness for health. "The Neck of the Giraffe" describes what occurs when healthcare workers' roles are suddenly reversed and they are thrust into the sick role--forced to face the heart-wrenching experience their patients face everyday.

May Ameri is an MS1 at UT McGovern Medical School. May became interested in the intersection of medicine and humanities while taking a Medicine and Society Minor at her Undergraduate University; today she is pursuing several humanities electives under her Medical Humanities Concentration. May believes introspection in medicine is necessary for continued fulfillment and avoidance of burnout in medicine.

Empowered Women Empower Women / Elizabeth Kravitz

As an aspiring Ob/Gyn, I am in constant awe of the strength and resiliency of women. These pieces were inspired by this admiration.

Elizabeth is a fourth-year medical student at Baylor College of Medicine. This fall she applied to residency in obstetrics and gynecology. She is passionate about the intersectionality of women's health with other social justice issues, which are an inspiration for her career pursuits and her needlework.

Humans First / Ritodhi Chatterjee

My phone buzzed, and I pulled it out just as my former intern's name flashed across the screen. I had been anticipating the news, but my heart still dropped like a rock as I read the text: "Mr. H died." Closing my eyes, I tried to envision our final meeting last week, when I had informed the family that my rotation was over. Looking at him then, stoic as always despite unrelenting pain, I did not see a 38-year-old patient with aplastic anemia and secondary necrotizing enterocolitis who was a poor surgical candidate; I saw a man struggling to be strong for his wife in the face of near-certain death, and a father worried about his children's future. Over the preceding month, I had poked and prodded Mr. H daily looking for acute exam changes, explained every detail of the plan to his wife at bedside, and spent hours figuring out how to request disability payments from his employer and emergency visas for his parents. Though strangers on paper, we had developed an intimate connection born of vulnerability and trust. As we shook hands that day, the gratitude was mutual. The encounter inspired me and helped shape my emerging professional identity, and I likewise hope that my compassionate presence provided some measure of comfort amid the stress and uncertainty of his final weeks.

I have often reflected on why this early clinical experience left such a profound impression. I realized it was the first time the following maxim had resonated with such intense clarity: those entrusted to our care are humans before they are patients. While this notion was implicit in my initial motivations for pursuing medicine, which brimmed with well-intentioned idealism about "helping people," I did not yet have the experience to understand what it truly meant or, more important, how to translate it into practice. Furthermore, the academic rigor of medical school, with its focus on pathogenesis and diagnosis, can favor intellectualization of patients as clinical cases or learning opportunities. The line between person and condition can blur. But meaningful relationships with Mr. H and others helped re-center patients' humanity in my clinical approach. In the spirit of holistic care, we must recognize that these are multifaceted men and women whose health is the summation of complex internal and external factors—individuals with diabetes, rather than "diabetics." As is true for anyone experiencing difficult times, being made to feel safe, significant, and affirmed can be as therapeutic as alleviation of physical symptoms. My focus pivoted from trying to "fix" people to listening with intention, soliciting concerns and perceived obstacles to recovery, and encouraging input in care decisions. In embracing this philosophy, I felt what can only be described as purpose, that elusive spark that produces fierce patient advocates and imbues our day-to-day work with meaning.

This commitment to empathy and humility in clinical practice is not immutable; it must be consciously nurtured and renewed. As our medical careers progress, administrative burden will grow, schedules will tighten, and disillusionment with a flawed and inequitable system will deepen. We cannot allow our humanism to wane. In a similar vein, the COVID-19 pandemic has complicated the patient-physician relationship by imposing barriers both physical and metaphorical. Not only are we hidden behind layers of emotionless PPE, but there is also a pervasive shroud of fear and caution that makes us wary of closeness or physical touch. Yet in this era of

restrictions, and social isolation, patient and provider alike crave human connection more than ever before. Thus, we must be especially thoughtful and deliberate in our interactions. Spending a few extra minutes sitting at bedside or taking special care to commiserate over a personal story uplifts both parties in a time when such kinship is sorely needed. While decisiveness and clinical acumen may be the keys to managing disease during a pandemic or not, it is often empathy and patience that promote true healing in our patients and in us. After all, we will always be humans before we are physicians.

This piece is a reflection on how my appreciation for the humanistic side of medicine has developed through my training thus far, and how empathy and patience are more important now than ever as we face the ongoing COVID-19 pandemic.

Ritodhi Chatterjee is a fourth-year medical student at Baylor College of Medicine who is pursuing residency training in Internal Medicine.

When Paths Cross... / Armando Martinez

Together, separately,
we spent a whole year not knowing where
we would end up.

Amidst a sea of choices and decisions,
we met where paths cross,
and we didn't even know it.
Didn't wanna blow it, so I left it at an interjection
Hindsight 20-20

Chaos, change, and travel continued,
but somehow and for some unknown reason…
one impossibility became two.

Where the river runs, we came to a junction.
A small town became a small world, and soon,
we realized we were on similar paths, that sadly
still digressed.
Nomads through thick and thin.

Now, a path is the only thing in the way
of journeying together.
I just need the courage to walk it.
Together, separately.

What if you found "the one" at a medical school interview? What if you fell in love with them, two days later, at another one? What are the chances? "When Paths Cross" explores when lightning strikes twice for two soon-to-be medical students oscillating between the amphipathic forces of love and distance.

Armando Martinez is a first-year medical student at Baylor College of Medicine in Houston, TX, and his partner is a first-year medical student at Paul L. Foster School of Medicine in El Paso, TX. Thanks to fate, pure luck, or divine intervention, their unique journeys in medicine have now been intertwined in a wonderful way. In one another, they find the support to make the most of the ups and downs of a trying medical school curriculum.

195,259 / Lucy Hart

This watercolor piece harkens back to the times of the Great Plague yet feels eerily familiar during these unprecedented times. The title refers to the number of COVID-related deaths in the United States at the time of submission.

Lucy Hart is a fourth-year medical student at Baylor College of Medicine. Lucy just started watercolor painting as a COVID hobby. Her work has been described by friends, colleagues, and her dad as "surprisingly not bad."

Growing Pains / Kevin Jiang

"Each morning, I make my way to joy, joy that God has given me the breath of life for another day. The process is never instantaneous though. My alarm is usually blaring for five to ten minutes continuously before I can get up, but sometimes I'm able to jump out within a minute. I purposely place my alarm a physical distance away from me so that I'm forced to get out of bed to turn off the pesky annoyance. And when it's off, I make my bed and sit at the edge and I pray that I consciously choose joy over the circumstances of my day."

- February 19, 2020 journal entry, surgery rotation, pre-quarantine

At the start of 2020, my biggest concern was beginning clinical rotations. As a medical student, I could finally start contributing to patient care, which was both exciting and terrifying. Surgery was my first rotation, arguably the most time consuming and emotionally exhausting. But by taking this rotation first, I would have time in my schedule to attend my best friend's wedding in July. I was a groomsman and I wouldn't miss it for the world. By the middle of my second rotation, medical schools across the nation pulled their students out of clinic. Two weeks later, the county judge issued a "stay home – work safe" order on the city of Houston and we received an email that we would not return to the hospital for another 2 months. Never did I expect a global pandemic to put life on pause.

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You're standing in line at H-E-B. The intercom blasts overhead. "Shoppers, we kindly ask you to practice social distancing. Wear a mask and maintain at least six feet distance between each other. We know these are difficult times, but together, we can stop the spread of coronavirus." The line is already bleeding out of the grocery store. It turns the corner and continues as far as it can before looping back on itself. X's are marked 6 feet apart. Anytime shoppers leave through the exit, an equal number are permitted inside. It feels like a perfectly balanced scale where any disruption can tip it into chaos. Most people don various types of face coverings from home-made cloth to certified surgical masks. You press down on the seal of your mask and readjust your glasses, which have started to fog up. It's now your turn to enter the store. You squeeze some hand sanitizer before putting on gloves. Technically it shouldn't matter whether your hands are clean, but at this point, it's become a force of habit. For all intents and purposes, the gloves are not sterile. They can touch produce, packages of meat, and any other item in the store. But they cannot touch your face. If there's an itch, you don't dare touch your nose. Though, you make an exception for glasses only if you pinch the rim. You have a system. The left hand touches store items and pushes the cart. And the right hand can reach into the pocket and navigate the grocery list on your phone. It starts off well. You remember the first few items off of the list. Left hand grabs a container of celery and puts it in the cart. It proceeds to grab the pre-diced carrots and bell peppers. What's next on my list? Right hand reaches inside pocket and grabs the phone. The face ID doesn't recognize you with your mask so you have to type in the password each time. Oh that's right, avocados. Right hand puts away phone. Left hand fidgets open a plastic bag and instinctively the right hand goes

to grab an avocado. Shoot. I messed up. As long as you don't touch anything else, you're fine. You put the bag of avocados in the cart. Up next is the meat section. Both your right and left hand begin to push the cart. You don't even stop. You've already messed up. My system sucks. I'll just wipe my phone down when I get home. Whatever I do, I can't touch my face.

I forget what day is today. They've all blurred together in my mind. The weekends were once a much-anticipated reprieve from a busy week of clinic. Now they're no different than a weekday. What makes a weekend so special when the entire week is otherwise unremarkable? My alarm continues to go off. I stumble out of bed to turn it off. My routine had started out with great intentions, but like all habits, motivation started to dwindle after a few weeks. Though I had no clinical responsibilities in my quarantine, I wanted structure in my life. After all, I was still a medical student. I listed out tasks I needed to complete every day: Read my Bible. Work out. Zero out review Anki cards. Do 10 U-World questions. Complete any new Anki cards. By 6 pm, all work had to stop. My routine then devolved into completing the tasks whenever I could (even if it meant staying up late) and soon even attempting to do the work was the only qualification of a job well done. The desire to be productive butted heads with the need to rest. But rest imprisoned in one's home inevitably brought on a feeling of apathy and lethargy that could only be mitigated by productive work. This is the vicious cycle that confronts me each morning.

There's a picnic table across the street from an open field that hasn't been mowed in months. The area lies underneath wooden roofing with a lattice beam structure. It's the perfect place to hang my gymnastic rings. I've never seen anyone else use the area. I found this place after a month and a half of working out in my house when the only daylight I saw was taking out the trash and my 45-minute walks with my roommates. Now, I've carved out this little haven. It's my one time of the day I'm outside and even in the blistering Houston humidity, I'm still grateful for it. When I'm out here, I forget for an hour that a virus is ravaging our world both mentally and physically. I forget that the largest medical center in the world is barely keeping pace with the rising cases of COVID-19. I forget that our society's future looks different than what we ever predicted: a generation of students shifted to an online platform, businesses barely surviving with employees working from home, and families wondering whether surviving the pandemic is worth suffering through the recession. In that hour, I forget all of that. And I remember what it's like to soak in the warmth of the sun. I remember I have healthy lungs to breathe in the fresh outdoor air. I remember that even though it feels like life is on pause, nature's beautiful symphony still plays on. And the best part is I'm still alive to hear it all.

"Mom. Dad. Are you sure you don't want me to come see you? I'm going back to the hospital soon." You haven't seen your parents for months. The last time was on your birthday two weeks before quarantine. They live twenty minutes away from you, but you can't afford the risk of exposing them and neither can they. Out of an abundance of caution, your interactions have been limited to video chats and phone calls. Besides your two roommates, you haven't seen anyone else. It's been a while since you've shaken someone's hand or given them a hug. The wave to your neighbor or the simple nod as you walk past others at the park is more exciting than you care to admit. Sometimes you think you've forgotten what it's like to talk to another human being. Zoom has become the new hangout spot. The friends you're used to seeing in person every other day, you're grateful to see even once a week on a screen. And the friends you talk to a few times a year,

you've now been able to see once a month. But soon, the conversations start to lose steam. There's something about the physical presence of another human being that a digital medium cannot fully capture. You run out of creative ways to answer "How have you been?" because the truth is nothing has happened and nothing has been happening for a while. You start to crawl back into your hole. All the time in the world is somehow not enough time to call your mom or text your friend. But it's more than enough time to face your inner thoughts whether you want to or not. You used to always have one commitment after another, unable to spare time for anyone else. It turns out the issue was never other responsibilities. It was other priorities. But there's no point in dwelling in the past. Grace is a wonderful thing. Maybe this quarantine was a blessing in disguise, the rest you never knew you needed in order to make the change you subconsciously always wanted to make.

Lately, I've been craving pizza. For a few weeks, it was fried chicken and then it was burgers. But now it's pizza. I live with two of my best friends—one of them is the friend getting married. Work just ended and they make their way to the living room. "I could go for some pizza but we got pizza five days ago." A thirty minute discussion to diversify our dinner plans with healthier options or new experiences only serves to justify what we were all thinking the entire time. Pizza. We call in the pick-up order and jump into my car. My Spotify daily mix starts shuffling. I take the highway and we catch the sunset on our right. There's no rush-hour traffic. I roll down the windows a bit and pop open my sunroof. The wind starts rushing into my car. Folk-pop is playing in the background and we're singing along, at first seriously and then obnoxiously. Nothing seems to exist outside of this moment of pure joy. We arrive at the restaurant. The front door has a sign. All customers are required to wear a mask. We walk in. Masks accentuate everyone's eyes and it feels like they're staring at us. Some say eyes are the windows to the soul but sometimes they just look like mirrors that reflect our biggest insecurities. "Hi, pick-up for Kevin." I insert my credit card holding on to the tip of it to avoid touching the machine, and I quickly sign with my pinky. As soon as we get back to my car, I immediately put on some hand sanitizer. The music starts playing again. We get home and set up our pizzas on the coffee table. We inevitably decide to watch our go-to show, Psych. A few episodes later, a food coma starts to set in, and we sit comfortably in silence. Then one of us makes a comment. Someone else laughs. And the conversation is reignited staying strong until well past midnight. We haven't stayed up this late since college. After six years of friendship, we still manage to laugh at the same jokes as if we heard them for the very first time. Life feels great. What did I do to deserve friends like these?

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You're back in the hospital. It's been two-and-a-half months. They screen every person that enters the building now. In the past 14 days, have you travelled internationally or been in contact with anyone who's travelled internationally? No. Within the last 24 hours, have you experienced any coughing, shortness of breath, fever, chills, diarrhea, constipation, or muscle aches? No. Blue or white mask? The blue mask is fine. Medical students aren't allowed to see COVID-19 positive patients or PUI's (patients under investigation). That means any patient with fever, cough, or clinical history suspicious for COVID-19 is off limits. It feels like you've forgotten all of your clinical knowledge, but you're considered an essential worker. You look at the intern who's already admitted a patient and is doing the full work-up. She asks you to go in and take the history. This is a

heart failure exacerbation patient. Did you remember to ask about any recent infections? No, I forgot. That's fine. Remember that it's important to understand the underlying etiology of heart failure exacerbation to prevent future recurrence. Were you able to hear the crackles on auscultation? Not really. What's your assessment? They seem fine. What's the plan? I think they're stable enough to be discharged. You feel so lost keeping track of all these moving parts for this one patient. You can't even begin to imagine yourself three years in the future when you're an intern in charge of 5-6 patients at a time. On the last day before summer break, you get your feedback. It's surprisingly positive. Somehow in all the fumbling around and self-perceived failures, you've grown. The EMR is easier to navigate. A differential diagnosis seems less daunting. The clinical flow and reasoning make more sense. You don't get as nervous picking up a new patient, realizing your role as a learner does not take away from your role as a provider. You walk out of the hospital. It's a sunny day. Another year of medical school has officially passed.

The cardboard exterior makes the couch particularly hard to grip as we heave it from the garage to the second floor living room. My friend and his fiancée are setting up their new house in anticipation of the big day. He gives me a tour. The house's aesthetic seems fitting for a young married couple. Most of the rooms aren't furnished yet. There's a dining table here, a different couch in the study and a bed frame in the master's. I picture them starting their lives in this new home. I picture the memories they'll make along the way. I picture them figuring out how to grow together, learning each other's quirks and loving each other through it all. Their children will know that in the midst of a global pandemic, mommy and daddy got married and faced it together. We order burgers for dinner, the first of many meals in this house, which is a convenient distance from all the good restaurants. It looks like I'll be coming over more often.

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Assessment: 3rd-year med student with PMH of 2 months of clinical experience s/p quarantine presenting with mild anxiety in the setting of a global pandemic. Labs are unremarkable. Physical exam findings likely 2/2 growing pains.

Plan: Reassurance and supportive therapy.

"Growing Pains" depicts what it's like to live during a pandemic as a medical student. And just like anyone else, it can be stressful to deal with life all at once. This story aims to reflect on the joys of life in spite of a pandemic and ultimately produce hope that better days are yet to come.

Kevin Jiang is a third year medical student at Baylor College of Medicine currently interested in specializing in radiology. He graduated from Rice University in 2018 with a major in Mathematical Economic Analysis. Outside of writing short stories, his other passions include fitness, basketball, and anything involving good food!

Odin only gave an eye / Tyler Brehm

Medical aspirant, mundane man.

Ambition achieved as acceptance accomplished.

Reservoirs of knowledge ahead to discover.

Ability to ameliorate, proficiency to prescribe,

Mending hearts to fulfill mine.

Medical clay, separated citizen.

Remember the lab, people on trays.

Remember each cut, organs displayed.

Remember the knowledge, pray that it stays.

Remember yourself… fading away.

Medical dilettante, diligent doll.

Learning path, learning phys, learning pharm, forgetting who?

Patience required for knowledge accrued.

Questions from family, haven't a clue,

Mudpiles of flash cards, digfast through,

Alas, A, B, C or D won't do.

Medical mnemonist, alienated human.

Small step a great leap,

Reservoir tapped, hydrants don't seep.

No time for family (with heart attacks and cancer)

Questions about 82 year old male freelancer,

It's an MI? Please answer.

Medical seed, indistinct individual.

At the reservoir I learned, but now I'm at sea.

Patients aren't books, not easy to read,

But residents reach down, down through the debris

And slowly I grow, now able to see

New answers for my family's plea

It's TB I now know! Not A, B, C, or D.

I'll tell them someday, if time permits me…

Medical metamorphs, masquerading mannequins.

Awash with choices, flooded with possibilities.

As peacocks strut, parading their steps,

Ranking each place amidst the rat race.

Those close to the sun will scramble anon,

But should they catch fire, consider them hired.

Medical minions, perishing persons.

Proficiently prescribing to ameliorate sores,

But nostrums for them, their hears ignored.

Yet students somehow see them soar,

But weight w'll sink beneath Chiron's oar.

Arms were up, up! not down anymore.

"Theseus" sailed on, ipseity onshore.

Medical masters, complex characters.

Gone the summer student and sunshine pupil,

Here the diagnostic deities, actions beyond scruple.

But idols know, there are no gods, only We,

Who gave ourselves to and accepted the sea.

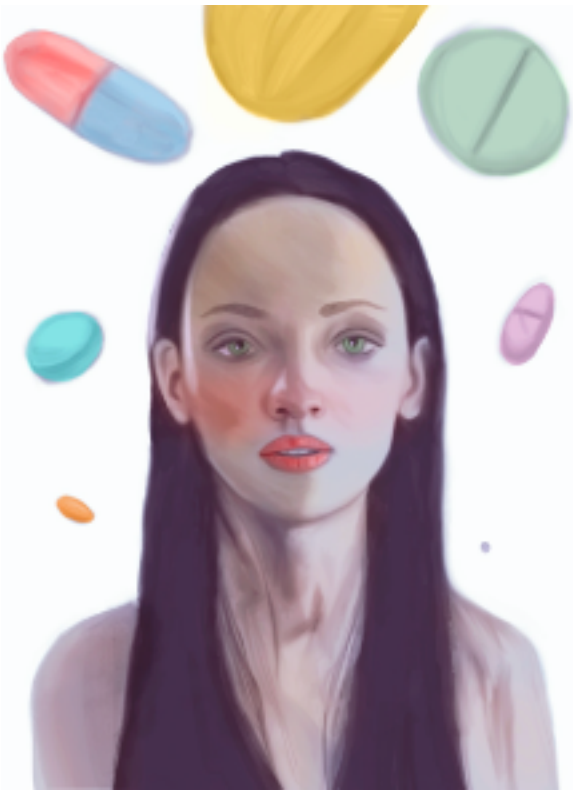
So I set out, depart from my Bree.

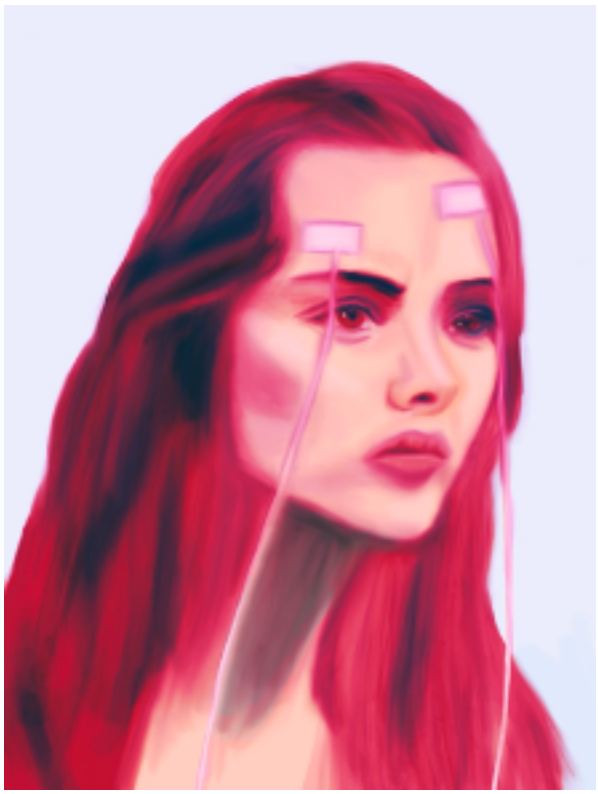
Hoping I'll stay, despite Charon's fee.

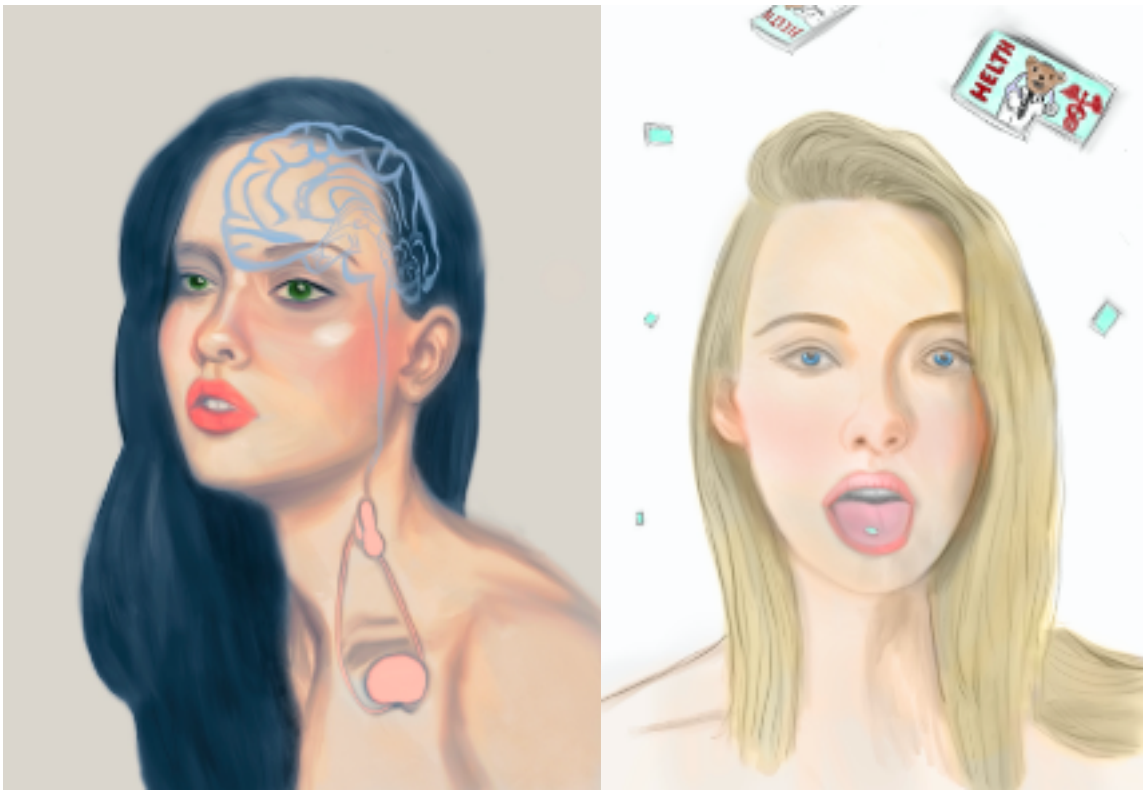
I wrote this piece in the middle of my third year of medical school. I was having a difficult time finding balance between myself as a medical student and myself as a person. I ended up writing this poem as a way to explore my emotions, and in particular my frustrations, with a journey that continually emphasizes the importance of our humanity but places us under stresses that strip away that humanity.

Dr. Tyler Brehm is an intern in Internal Medicine at Baylor College of Medicine. He is a lover of the outdoors, a die-hard Green Bay Packers fan, and an avid reader of the fantasy genre. Currently, he is enjoying finding a balance between his work as an intern and his responsibilities as a new father.

A Handful of Remedies for Depression / Grace Pham







"A Handful of Remedies for Depression" is a series of digital paintings I made when I started my psychiatry residency at BCM. I've long been interested in neurostimulation and other experimental modalities to treat depression. I also think that life as a young millennial woman is rife with conditions and circumstances that contribute to dysthymia and sadness.

Grace Pham is a first-year research track resident in Psychiatry at Baylor College of Medicine. While pursuing her DO and PhD degrees at the University of North Texas Health Science Center, she taught herself photography and digital painting. She also created fine art installations as a member of the co-operative art space 500X Gallery in Dallas, TX.

Our First Patients / Navya Kumar

i demand your body
and you
crack open your chest for me
peel away skin and
scrape away fascia for me
reflect layer and
layer of muscle for me

you take a saw to the rib cage for me
i hear the ache your body makes
a soft protest, and
you offer it up as a salve for me

even in death you expect nothing

you rip into your viscera for me
you cut your arch and
pull it out
you know i crave the taste

you tear yourself apart for me
and i devour

Progress is a ritual sacrifice.

indebted and voracious
i meet your gaze when i look for absolution

even in death you expect nothing

who allows the consumption of your body for my edification? who else?

mouth sticky with marrow in molar cavities and strands of sinew in incisors
i grin
and you grin
bloody and tacit
approval

Like so many others, I loved anatomy lab. I marveled constantly at the fact that we were able to learn this way. But one day, with my hands deep in someone's body cavity (someone's mother, daughter, sister, teacher, friend, lover; why is it that thinking of relationships shifts everything into jarring focus?), while laughing with my tankmates about something ridiculous that had happened in class that day—and then again, as the appointed "bone saw user" of my group, with aching shoulders and a sore neck after bisecting the skull and the hip—I wondered what I was doing. What of the violence that lurks in my own hands? Why was no one talking about this? This poem came from that deep frustration and a heavy responsibility.

Navya Kumar is a second-year medical student at Baylor College of Medicine. An Austin native, she has been writing and performing poetry for as long as she can remember. She has performed most recently for various events at Rice University, where she earned a B.A. in Sociology.

Inside / Grace Kao

When you open me up,

Do you see inside?

See another surgery, another hip?

Labral tear, you said, with

Hands folded, eyes searching for

My silent nod.

Pain swims circles through my veins.

Do you see inside?

Among the blood and the bones,

And the empty space,

Do you see the wound that

My dreams crash through?

Despair spreads thickly through my head.

Do you see inside?

Heads shake and fingers point.

Too much dance, they said, their

Voices thin, like thread through needle

Sewing me in.

Confinement hangs heavy between my lips.

Do you see inside?

Where worries hide in shallow gasps,

Declaring fear like a war cry and

Doubts like soldiers storming

Fresh fields of calm.

Anxiety skips lightly across my chest.

Do you see inside?

See my mind wondering

If I'll dance again,

Whispering, both my hip and life

Are in your hands?

Breaths arise from deep within.

I breathe the way that I've been taught.

Belly up and down and

Up and down; I exhale

And what you see is I'm

Letting it out.

This piece was penned while I worked with a young dancer with a history of labral tear, chronic pain, and anxiety about surgical repair. As a pediatric psychologist, I feel great privilege in being allowed to share life and experience with youth navigating loss, adjustment, and most certainly, pain. This patient's articulate expressions of her worries, anxieties, and concern of being "one of many" in the healthcare system, while feeling as if her very personal dreams and future hinged on this surgery, inspired this piece.

Grace S. Kao, PhD is an assistant professor at Baylor College of Medicine and pediatric psychologist and co-founder of the Interdisciplinary Pediatric Pain Medicine Clinic at Texas Children's Hospital. By day, she helps children and adolescents with chronic medical conditions find hope and healing. By night, she seeks her own well-being, in part, through penning stories and reflections inspired by these stories of rehabilitation and recovery.

The Penguin On Her Hoodie / Chelsea Zhang

"No quiero que ella sufra",

the young mother looked at her daughter

over the doxorubicin infusion of red poison

as I gently lifted the IV line

to hug the girl in tears

running down her face,

running down her hoodie,

where a plastered graphic penguin was smiling.

Singing.

Meant for a cozy family gathering over movies,

meant for laughing about over baking cookies,

not learning about parting,

or hearing sorry.

Dr. Chelsea Zhang is a happy artist and resident who likes to share her artwork to brighten your day. She has a passion for pathology, making steamed buns in cool shapes, Zumba dancing, and laughing at silly things.

I Have Walked The COVID Paths / Lee Lu

In March on my mom's 82nd birthday, I witnessed my first COVID-19 patient deteriorating. A fatigued lady who kept telling me "I am very tired. Help me. I could not walk to the bathroom this morning." On a 5 L of oxygen with an oxygen saturation of 91%, she could not even complete a short sentence and had to take frequent pauses in between. When I saw those desperate eyes pleading for help, I did not know what to say. There was nothing I could do except pray that she would not need to be intubated. So little was known about COVID-19 at that time. I wanted to stay to comfort her but had to limit my exposure because of my fear of contracting it and passing it onto other patients and my own family. In my career, I had seen many patients dying from cancer or any number of other causes. Most of them had their families by their bedside, or the families were at least able to spend time with the corpse in the patient's room. My patient was all isolated while she was deteriorating. Her daughter kept calling my team's phone frequently and had asked to see what else we could do. She was willing to donate her lungs to save her mom, though she knew that was impossible. Desperately, she said, "All I want is my mom back to me!" and informed me that her grandmother was intubated and two other family members were also sick with COVID-19. The isolation and desperation were overwhelming. Even with all my training and experiences in medicine over two decades, I felt helpless. As I drove home that night, the empty streets and shops seemed like a ghost town. I could not give my mom a birthday hug. I started to cry. I was worried about my patient.

One August morning, my husband, a physician, woke up with extreme fatigue. The next day, he developed a cough and subsequently was tested positive for COVID-19. The source came from his medical practice. He was previously healthy and physically fit, so he should do well and just needed supportive care with isolation, I thought. I was not worried because we just went hiking in the mountains trekking a 12-mile trail, and he did well. During the second night, he developed severe chest tightness and had difficulty breathing, but his oxygen saturation remained high - 98% on room air. When he woke up next morning, he felt better. As the days went by, he walked less and just wanted to lay in bed, but his oxygen saturation remained above 95%. He did not want to eat or drink much. In my mind, I kept telling myself to be patient because COVID-19 symptoms could last for a couple of weeks. I wanted time to go faster. Every minute seemed like hours. On day 7, while I was on a teleconference, I received a text from my husband with the message "please pick up dexamethasone and oxygen for me now." My heart was beating so fast that I thought it was going to jump out. I picked up the medication and oxygen and went to examine him. He did not look well. His oxygen saturation did dip below 94%, but then went back up to 95% - 96%. I wanted him to go to the hospital, but he was hesitant, stating that the treatment would not be any different from the current treatment he is receiving at home and he would be all isolated without visitors. His fevers and cough persisted. Panicking, I called my colleagues asking for advice. I became terrified. The image of my first COVID-19 patient's desperate daughter came to mind. I am in her shoes now, I realized. I could not sleep and kept going into the room to check on my husband. I asked him to sleep prone and gave him enoxaparin shots as prescribed. I heard fine crackles up to mid lung fields. My husband, with oxygen on, could not walk to bathroom without my assistance and could not even brush his teeth. My first COVID patient had told me that she could not walk to bathroom and did someone help her? I did not when I saw her. I felt guilty.

My husband and I had read about Remdesivir, but the data showed success rate was in the low 30%. The thought of losing my husband scared me. Thirty-six hours had passed while on dexamethasone, and my husband continued to worsen. I had no option except to take him to the hospital to receive Remdesivir. He could not walk so I used a desk chair with wheels to bring him from the bedroom to the car. At the same time, my older son who was tested negative for COVID-19 had to move into his college apartment. My younger son's birthday was coming up in one day. Bad timing. The adrenaline was rushing, and I was in survival mode with the top priority being my husband's health.

My husband received his first dose of Remdesivir and did not feel better. My older son and I celebrated my younger son's birthday without my husband. It was a somber ambience. I tried to smile for the pictures, but my heart was heavy and sad. While eating, my college son noticed that he could not smell and taste his food. My heart sunk further down. Oh no, he has contracted COVID-19! I took him to be retested, and the result came back positive. He developed low grade fevers with a cough and mild shortness of breath. Meanwhile my husband was still in the hospital, facing an uncertain outcome. After the third dose of Remdesivir, my husband felt better. He still needed oxygen but was able to walk to the bathroom without assistance. He continued to improve and was discharged after the 5th dose. On the day of his discharge, I lost my sense of smell and taste. I tested positive for COVID-19.

My family and I are on the mend now. From this experience, I have gained a better understanding and empathy for COVID-19 patients and their families. I promised myself that I would stay to help the debilitated patients with feeding and going to the bathroom. Coincidentally, immediately after I recovered, I was given an opportunity to care for one of my clinic patients who tested positive for COVID-19 and assisted her family. I called them every day to provide guidance and alleviate their fears.

Being a physician during the pandemic is not easy, but COVID-19 has given me the opportunity to walk on the three paths of being a physician, a caretaker, and a patient. Through this, I have become more resilient and know that resiliency will help us defeat COVID-19.

The COVID pandemic has devastated many. I want to share my own experience with COVID to show that resiliency is a key element to defeat COVID.

Dr. Lu is a faculty who works with trainees in an outpatient and inpatient settings. She has taken care of COVID patients and had her own personal experiences with COVID. From her experiences, she is ready to serve those who need help.

The Toaster Oven is Crooked / Jessica C. Sheu

The toaster oven is crooked,

crooked…

crooked…

focus, focus, breathe

But it's dusty, the fridge, I feel warm

I need to wash my hands,

only water,

no soap,

I promise…

focus, breathe, breathe

But I know it's me, my thoughts, not real

Look at me,

What I'm touching—

the orange juice,

the cranberry juice,

the apple juice!

breathe, breathe, breathe

But it's there, I feel, I know

Ah! The toaster oven is crooked,

still crooked…

still crooked!

Exposure and Response Prevention (ERP) therapy is the most important type of Cognitive Behavioral Therapy (CBT) for patients suffering from obsessive compulsive disorder (OCD). This piece was inspired by a particular ERP session that I was able to shadow during my OCD elective. I hope to capture the delicate balance between courage and fear that patients experience during the course of this therapy.

Jessica C. Sheu is currently a medical student at Baylor College of Medicine. She is interested in pursuing psychiatry and is passionate about learning more about the interdisciplinary nature of the field.

The Anointment of Grief / Amanda Ruth

I am barely into my update when the father loses it.

He turns his back to me, his body now hiding the tiny warmer bed from my view. His shoulders shake as sobs rattle out of him.

The pause stretches. A small corner of my brain notes how still the mother is. Her head is cocked towards me, her whole body straining to catch my words like they were precious gems, sifted through the fraught air.

I decide to raise my voice. It feels inappropriate in this fragile moment, but with my mask and the father's crying, volume is my friend.

"As you can see, he's not taking any breaths aside from the ventilator. When I touch him, he doesn't move... he doesn't blink. His heart's still beating, but I don't think he's truly with us," I half shout.

The mother flinches, the brittle edges of my proclamation finding their mark. I see the moment she hears the unsaid between the lines. Her eyes widen, hurt, like I personally betrayed her. I resist the temptation to defend myself, let silence fill in. She too turns away from me, halfway towards her husband.

The father is still bent over the child. He is a beautiful baby. Everyone who has been in this room has remarked on his beauty, noted the piercing color of his eyes, all the more visible because those eyes could not close on their own anymore.

Big teardrops are landing on the baby's head. Although it has only been a few minutes, his father is crying so much that the baby's face is wet, his hair soaked, a baptism in tears. Vaguely I hear the mother ask me a question, but I am distracted. All my life, I never understood that biblical story where the prostitute wets Jesus' feet with her tears and wipes them with her hair. Here in my sunny ICU room, technology quietly humming, I finally get it; see the grief and shame that bring forth enough tears to bathe another human being.

It doesn't take much more for the parents to understand. They've been hearing it. Traumatic brain injury – your baby's brain was hurt. Severe hypoxic ischemic injury with hemorrhage and herniation – his brain won't recover. And finally, abusive head trauma – his father had shaken him, very hard.

I watch the father weep. A thought comes unbidden: We are more than the worst thing we've ever done. I do not say it. Absolution is not mine to give.

In this room, now, I am extraneous. This is the time I leave this family to their grief. As I prepare to leave, I catch the baby's eyes one more time. When I exit, I make sure the door closes quietly.

This piece was originally about the challenges of patient care during the COVID-era with visitor restrictions and the strain it placed on families and hospital caregivers. Along the way, it morphed into something that I've long struggled with; the way I see families in challenging cases, when my glimpses of them are framed by perhaps their worst moments.

Amanda Ruth loves children, critical care, and reading. To combine these interests, she is a practicing pediatric intensivist at Texas Children's Hospital and helps run the Medical Humanities program. In her spare time you can find her buried in either another space opera or a fairytale.

Art of Anatomy / Rishabh Lohray

The Italian Renaissance was a fascinating period where the connection between the arts, humanities, and medicine was stronger and more magnificent than any other era in the history of art. The connection is apparent in the insatiable need of artists to gain an intimate knowledge of human anatomy. Two artists-Michelangelo Buonarotti and Leonardo da Vinci- known and respected for their art were also brilliant anatomists. While artists studying anatomy mostly used that experience for bettering their art, there were those like Leonardo who cut into cadavers only to satisfy their curiosity of the arcane. This piece will examine some instances where Leonardo and Michelangelo express their interest in anatomy and how their approach is similar yet different from each other.

Leonardo da Vinci was an exceptionally curious man. From the flapping of a bird's wings to the color of woodpecker's tongue, everything interested him. His approach to anatomy is that of Aristotle's Empiricism, where knowledge of the world is gleaned through observation. His interest was purely for the sake of knowledge. We know this because rarely did his anatomical knowledge reflect in his art. While he was able to render physical forms beyond compare, there is nothing to suggest that he might have gained that skill by dissecting. There is no anatomical exactitude in his works to the degree seen in artworks by artists who dissected, such as Michelangelo. However, we do know he knew his anatomy very well because of his extensive and detailed diagrams based on his dissections.

Leonardo, in his quest to unravel the secrets of the human body, was the first to suggest that the heart had 4 chambers, and he also correlated ventricular contraction to the pumping of blood by gutting the hearts of pigs. He also created complex hemodynamics experiments wherein he highlighted the vortex-like flow of blood through the semi-lunar valves (Fig. 1). He theorized using wax casts of the aortic valve from bull hearts to understand the intricacies of blood flow through the valve. His theory posits that the blood pools in the sinuses of Valsalva and forms graceful vortices as shown here which is sufficient pressure to close the valve shut. He concluded that regurgitation of blood flow is hence not required for aortic valve closure, a fact which was only discovered 450 years later by modern cardiothoracic surgeons using dyes and serial cinematography.

He was one of the first anatomists to study the uterus and suggest that it has 1 chamber instead of 2 as was thought at the time. He was able to render drawings of the fetus from multiple perspectives and conclude that the umbilical vein provides nourishment to the fetus (Fig. 1). The level of detail is just awe-inspiring even though it is not completely accurate. He even drew placental villi in exquisite detail. He says: "In the case of this child the heart does not beat and it does not breathe because it lies continually in water (amniotic fluid). And if it were to breathe it would be drowned, and breathing is not necessary to it because it receives life and is nourished from the life and food of the mother." He was also the first to document arteriosclerosis.

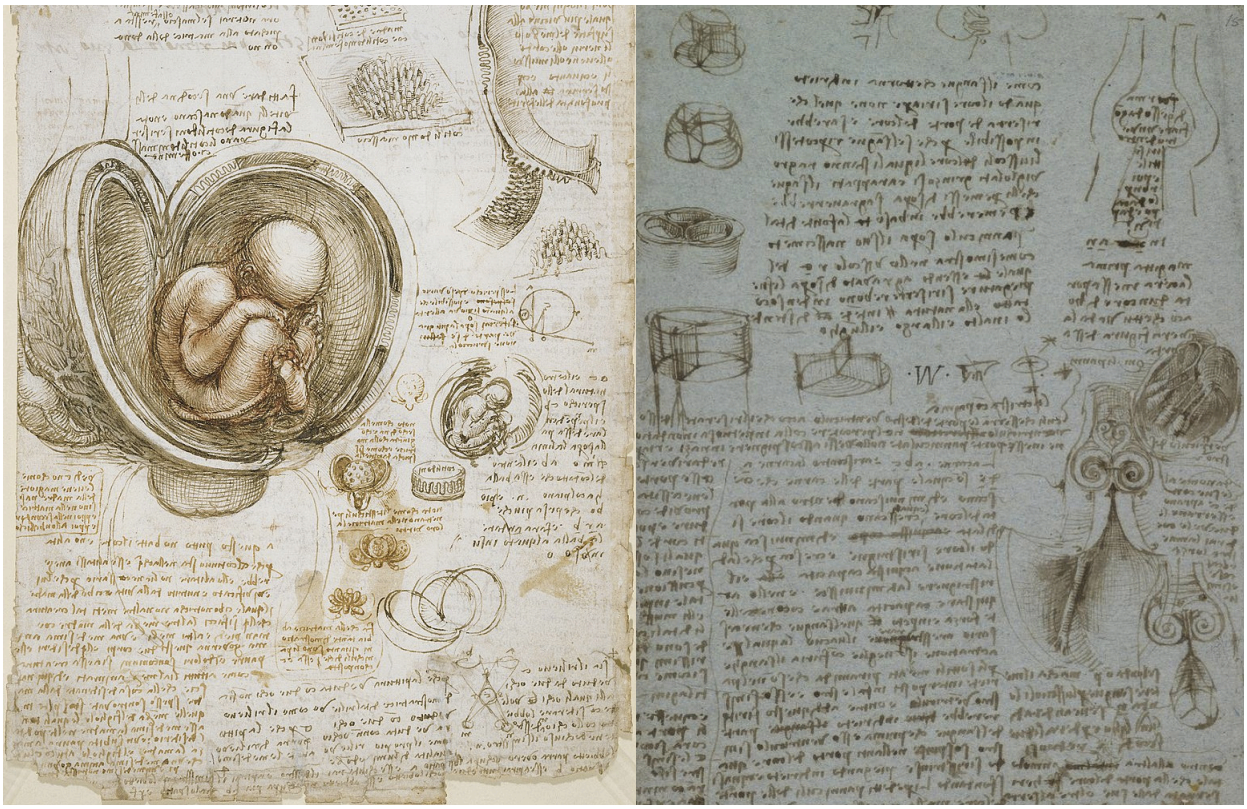


Fig 1. Leonardo's anatomical drawings: Fetus in a Uterus and Flow of Blood through Aortic Valve in vortices as seen on bottom right.

He does an excellent rendering of the mesenteric vessels including the SMA, IMA as well as the renal arteries and veins. He drew tortuous vessels. These are an obvious indication of arteriosclerosis. His explanation for this was that a lack of exercise caused this as the "blood was not warmed" which while not scientifically correct, does hint at the basic pathophysiology of the condition. These drawings compel us to accept that the genius of this man was indeed boundless, and his works remain an inspiration to both artists and physicians alike to this day.

Michelangelo had a different approach than Leonardo. His interest in anatomy, like most traditional artists, came from a desire to better his art. Such was his skill at anatomy, that Giorgio Vasari, an art historian, and artist, claimed that Michelangelo's knowledge of the human body was unparalleled in all of Italy. Hyperbole aside, Michelangelo dissected extensively but was motivated by a Neoplatonist desire to help his works achieve their maximum potential. He viewed every canvas and block of marble as an untapped reserve of potential waiting to be discovered by the artist. The purest expression of anatomical expertise is seen in Michelangelo's sculptures. He believed that the stone contained an IDEA and it was the sculptor's duty to unleash this idea in its truest form, out from the stone. The truest form, in Michelangelo's view, would be organically balanced, anatomically exact, and as naturalistic as possible.

Some of Michelangelo's best work is seen in the earlier part of his career. One of his greatest works, commissioned by the city of Florence for its Cathedral, was the larger-than-life marble sculpture David. According to legend, Michelangelo carved David out from a very thin and narrow block of marble that generations of expert Florentine sculptors like Donatello and Verrocchio were unable to turn into art. So exquisite was the sculpture, that instead of placing David high on top of the Cathedral as originally intended, the city placed it in their public square for all to gaze on its glory. David is intense and contemplative as he strategizes his attack on the giant Goliath. The tension in his face is paralleled by the tensions in his muscle and popping vasculature. Hence, Michelangelo's dissecting experience helped him create an anatomically exact David (Fig. 2). The muscles of the arms, the abdomen, and the legs are chiseled with unparalleled exactitude. If one looks closely, the superficial veins of the hand are very well done. One can also see the Basilic and Cephalic veins and the Cubital vein in the cubital fossa. Michelangelo was very proud of his knowledge of anatomy and was not shy to showcase it in his creation here.

Fig 2. David's arm, hand, superficial vessels and musculature, & Pieta, Michelangelo.

Another beautiful example from his early career is Pieta (Fig. 2), commissioned by a French Cardinal in Rome. Polished and elegant, the Pieta is considered one of the greatest works by the master. Once again, the musculature is very well delineated as seen in the exact rectus abdominus and biceps muscles. One must remember that Michelangelo is working with rock hard Carrara marble, but the boundaries between stone and flesh seem to be blurred beautifully here

and in David. The superficial veins in the hands and arm of Jesus are rendered with the same exactitude as in David. It's interesting to note that the naturalism in Jesus's anatomy is contrasted by the idealistic beauty of Mary, who would have been much older at the time of Christ's death. The real and ideal are in a dichotomous relationship here as Michelangelo tries to recreate the moments post-crucifixion.

Michelangelo continued to explore anatomy in his future works. His most vibrant and colorful work at the Sistine ceiling further exemplifies his interest in musculature. Twisting and turning forms accentuate the muscles of every figure in this world-famous series of frescoes inspired by Classical Greek sculptors who incidentally were also famous for dissecting human cadavers. The most astounding example of anatomy meeting art in this fresco cycle is seen in Michelangelo's rendering of The Creation of Adam (Fig. 3).

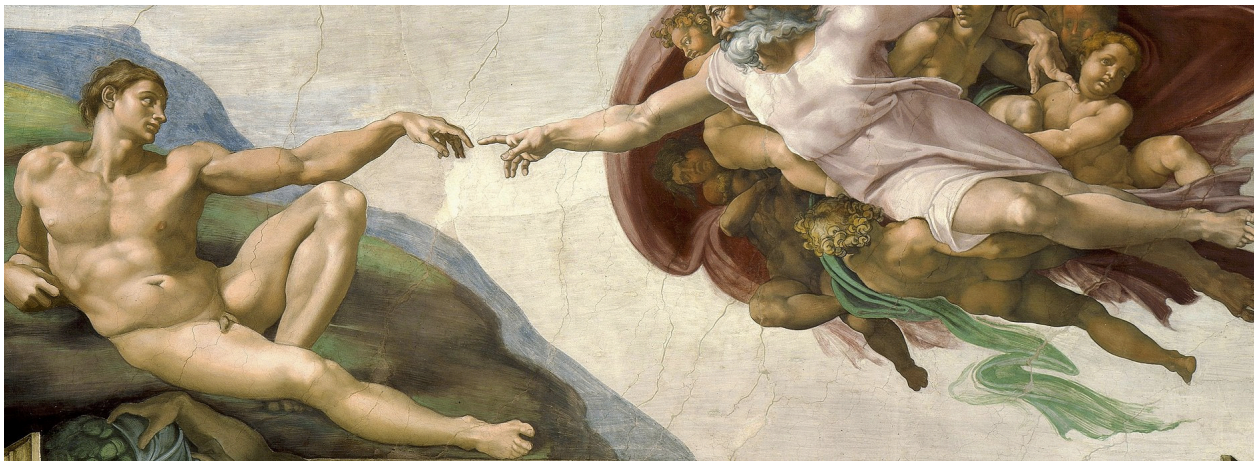


Fig 3. The Creation of Adam, Michelangelo.

On close examination, many art historians and physicians have likened the borders of God's dramatically billowing cloak to major sulci (lateral sulcus seen) of the cerebrum, the angel's back in the foreground to the pons, the bulging piece of cloth to the frontal lobe, the green tortuous cloth to the basilar artery, the bifid angel foot to the pituitary gland, and the flexed angel leg to the optic chiasm. The scene captures that electricity-filled moment before God breathes life into Adam. Michelangelo chooses to inject drama into the scene by leaving some negative space between the hand of God and the hand of Adam, entrusting the viewer to close the circuit, so to speak. The main takeaway is not just that God's cloak represents brain anatomy, but that God here is endowing Man with his soul in the earliest moments of creation, hence underlying the perception of the brain as the seat of the soul.

Despite the benefits of exploring human anatomy, dissecting in Renaissance Italy came with its risks. Even physicians rarely had the privilege to dissect and had to do it in secret because of the popular perception of anatomy as a dark art with ties to necromancy. It puts into sharp perspective the privilege and honor modern physicians are accorded in being allowed to dissect on their human donor's bodies. Despite getting in trouble for their semi-legal activities, both Leonardo and Michelangelo continued to dissect throughout their careers and dazzle their patrons

with their curiosity and art. It's also interesting to note how all this beauty was acquired in not so beautiful circumstances. They were dissecting at night, in the heat, by candlelight on a decaying human cadaver. One can just imagine Michelangelo and Leonardo dissecting and sketching in the heat, surrounded by bacterial fumes, creating sublime beauty by probing the depths of the unknown, one's mind ignited by Neoplatonism and the other driven by Aristotelian Empiricism.

I have always been interested in exploring how art, medicine, and literature intersect. In this art historical analysis, I use some of Michelangelo and Leonardo da Vinci's greatest works to elucidate the symbiosis between High Renaissance art and philosophy and the science of anatomy. What interested me about these giants was their insatiable thirst for knowledge and desire to demystify the unknown. I hope that readers will come to a better appreciation of these connections that have existed for so long and will get inspired to forge new pathways between art, literature, and medicine in their field of work!

Rishabh Lohray is a Student Editor for Omentum, and a second-year medical student at Baylor College of Medicine. He graduated with Honors in 2019 from UT Dallas, where he studied Biology, Neuroscience, and Art History with a specialization in the Italian Renaissance. He is interested in the intersection of art and medicine and likes to campaign enthusiastically to integrate arts and humanities into premedical and medical curricula.

Lingual Metabolism / Claire Luo

Language is visceral:

these words are voracious,

eating into the spleen;

puncturing the vessels;

bolus in the stomach,

unwavered by bile salts and acid,

burning up the esophagus;

choking the trachea;

shuttering the epiglottis;

cutting past the teeth:

I'm sorry,

I wish I had better news.

"Lingual Metabolism" was written after a "SPIKES" session, after playing out scenarios in which we had to give bad news. Afterwards, it was clear that words contained this immense power with the potential to be a source of comfort for a grieving patient, but at the same time were so immensely difficult to deliver.

Claire is a second-year medical student at Baylor College of Medicine with a BA in English from Rice University. When she's not filling her head with facts about the kidney, she enjoys baking lemon bars and playing tennis.

Caution / Isabel Draper

Leaves fall and we meet in the park

Gravel crunches, six feet apart

I wonder what we would catch

If we both removed our masks

This poem captures the struggle of forging connections in our current global pandemic. The normal fear and uncertainty inherent in any relationship are only amplified by the existential dread of contracting a virus.

Isabel Draper is an MS1 at BCM. She recently graduated from UT Austin with a degree in English and Plan II. Her work seeks to question the artificial division between the arts and the sciences.

The Rock Collection / Donna Huang

When I was in third grade, I was obsessed with collecting rocks. I would spend my entire recess scouring the playground for specimens. Granite, mica, rare bits of quartz littered the red dirt, lying in wait of the patient prospector. I kept my eye out for vibrant colors or strange shapes. I even convinced my parents to buy a few overpriced geodes or tiger's eyes from museum gift shops. This must have struck my immigrant parents as strange, buying a resource that could be scavenged from the ground, but they indulged my childish fascination. My collection was displayed on top of my bookshelf. Each was unique. Each was treasured.

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"Oh my god," my senior resident shook her head in dismay as she surveyed our team's list of admitted patients, "we have such a huge rock collection." I was a second year medical student on my first clinical rotation.

"A what?"

"A rock is a patient who gets admitted to the hospital and then gets stuck here."

After graduating and assuming the humble mantle of the intern, I too would learn to grumble about my rock collection. They were low maintenance. Generally, the longer they lingered in the hospital, the less active medical management they required. Nevertheless, when you are hungry, sleep-deprived, and cannot remember the last time you peed, any additional work is unwelcome. My collection was displayed on my home screen of the electronic medical record. They were all the same. They were all a burden.

***

Sulfur

Almost every organ in his body (his heart, his kidneys, his lungs) was failing, but his liver brought him in. He was rail-thin but had a beach ball of fluid in his abdomen – ascites. His skin was yellow from the backed-up waste products that his liver could not filter. He lived in a homeless shelter where he caught scabies. He brought that with him too.

He was mean. I tried to remind myself that it must be hard to be polite when you are suffering. But someone can be sick and be an asshole at the same time. He would yell at the nurses if they did not arrange his bedside table just so. He would refuse medications that were holding his body's fragile ecosystem together because he "didn't feel like it." He usually regarded me with guarded reticence but at times was openly hostile, "None of you have any goddamn idea what you are doing!"

He was stuck on our service for weeks. He was too weak to fend for himself in the shelters. He had a history of drinking and substance abuse, which made many skilled nursing facilities wary of him. One day, a facility agreed to accept him on the condition that he could propel himself in a wheelchair. They did not have enough staff to care for a patient who was immobile.

I pushed the unwieldy hospital-issued wheelchair into his room. "We're going for a walk. If you can push yourself in this wheelchair, you get out of here." With much effort and my steadying hand, he transferred from his bed to the chair.

"Can you start off pushing me? Once we get down the hall, I'll start," he bargained. Not wanting to set off one of his recalcitrant moods, I started pushing. At the end of the hall, he convinced me to keep pushing until we got off the elevator on the first floor. He again balked because the bustle of people around him made him nervous. I pushed him to the cafeteria where he bought a burger, fries, and a candy bar. I pushed him to the gift shop where he bought some Kleenex. "This is way better than the sandpaper they have upstairs," he grinned.

"Where next?" I asked once we left the shop.

"There's supposed to be a smoking area somewhere around here isn't there?"

"Sir, I'm your doctor. You can't possibly expect me to push you outside for a smoke."

"Well, what if I push myself?"

"Only if it's just to get some fresh air."

"Deal. I haven't been outside in weeks." He inched his way down the hall to the designated smoking area, a hidden cramped patio behind hospital. I waited inside while he "got his fresh air." Later, in my progress note for the day, I wrote, "Patient was able to demonstrate independent wheelchair mobility. Ready for discharge to skilled nursing facility."

***

Limestone

He had a heart attack the day before Thanksgiving. He survived, but he would need a triple bypass. Because it was a holiday, his surgery could not be scheduled until the following Monday. He would be my patient in the cardiac ICU until then. He was a soft-spoken, bespectacled man with a full mustache. He had already had his share of medical mishaps. He had gotten an infected foot wound the year prior, a complication of long-standing diabetes, that had required a below-knee amputation. Almost every artery in his body was choked with calcified plaques, the result of years of high blood pressure and cholesterol. He had been shot when he was in Vietnam; there was still shrapnel in his body. "I've had some close calls," he reminisced, "but I'm pretty damn hard to break."

As an intern, you can be sure that you will spend most, if not all of the holidays, in the hospital. There is a skeleton staff. The lab and imaging services slow to a glacial pace – emergencies only. The staff tries to brighten the atmosphere by decorating the wards and bringing in food, but it never completely covers the lingering odor of suffering.

It was a slow day. I asked him about his family.

"One brother. Lives in Arkansas. Pretty much everyone else is dead."

"Sorry you have to spend the holiday here. Do you have a favorite Thanksgiving food?"

He thought about it a while…"Pecan pie." The next day, as I placed a pecan pie on his bedside table, I joked,

"Don't tell your nurses it's from me. I don't think pecan pie is part of the hospital diabetic diet."

"Our secret," he winked.

The day of surgery arrived. He lost nine liters of blood. He came back to the ICU intubated, on three pressors, clinging to his life. I spent the next three weeks monitoring his blood pressures like a hawk, making minute adjustments to his medications, monitoring his labs to make sure his new bypass grafts were not failing. As he had done so many times before, he cheated death. When he was finally stable enough to be extubated, he opened his eyes, saw me, and said, "Hey, thanks for the pie."

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Lepidolite

Cat-a-to-ni-a / kadə'tōnēə (noun, psychiatry): abnormality of movement and behavior arising from a disturbed mental state (typically schizophrenia). It may involve repetitive or purposeless overactivity, or catalepsy, resistance to passive movement, and negativism.

She was drowning in an ocean no one else could see. She did not rest to speak; she did not rest to eat; all day and all night, she thrashed her arms and legs in the air. She was a Vietnamese woman about my grandmother's age. She was a schizophrenic. She had been admitted recently at a hospital across the street for a urinary tract infection. The details of the admission were unclear, but by the time she was discharged, she was catatonic. The harried ER physician who handed off the admission to me,

"All of her tests are normal. She doesn't seem to have an infection anymore, or any new medical issues. Her family just dropped her off in the ER because they can't care for her at home. Psychiatry can't admit her because she isn't eating. Our case managers in the ER are swamped so we won't be able to find her a nursing home from here. Plus she has psychiatric disease so she'll need a locked unit; there might not be a bed available for months. So, she's coming to you."

Day after day, her relentless swim continued. We fed her and pumped her full of antipsychotic medications through a tube that snaked from her nose to her stomach. Nothing seemed to be able to break the vicious trance that gripped her. One day, I was able to get her outpatient psychiatrist on the line, "Her schizophrenia has always been very hard to control. I had to stop seeing her a few years ago because she lost her insurance. The only thing that has really helped her in the past is electroconvulsive therapy, but in Texas the patient has to have capacity to consent for that procedure…I am guessing she is in no state to do that now."

I envisioned her silently clawing and pedaling the air, "No…she's not."

Her daughter came to the hospital every day. She asked the same questions every day, "Why is she like this? Why isn't she getting better?" With each passing day, I dreaded my encounters with her daughter more and more. One day, I did not make it in to see the patient until late in the day, having battled a full day of caring for other patients. The daughter rose from the chair anxiously as I entered the room. I avoided eye contact with her, as I tried to go about my routine exam as quickly as possible. When I finally could no longer avoid her, I glanced up and mumbled, "No changes today," and tried to slide past her out the door. She blocked my way, shaking with rage. Weeks of frustration boiled up in her throat, and at last, she yelled, "WHY IS SHE STILL LIKE THIS? YOU'RE NOT DOING ANYTHING TO HELP HER!"

She was right. For weeks, I had been bashing my head against the walls of the limits of our abilities to treat her intractable catatonia and against the system that precluded her from getting the help she needed. There is no medical school lecture about how powerless you can be. The daughter's words broke the dam that held back this secret shame. I yelled back,

"THERE IS NOTHING I CAN DO TO HELP HER!"

A stunned silence followed. I pushed past her, sprinting out of the room. I slammed the door behind me. I ran back to the resident workroom, blinking back tears. A message from the case manager awaited me. A bed in a locked unit at a nursing home had become available. I happened to be sitting at a computer at the nurse's station when the ambulance came to take her away. I pretended to be engrossed in whatever was on my screen as they wheeled her by. Out of the corner of my eye, I could still see her legs, kicking, kicking.

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Iron

He came from Lagos straight to the ER in Houston. When he got off the plane, he could barely breathe. His only notes in our records were from the 1990s, "57 year old Nigerian man with acute myeloblastic leukemia in remission." Now, his blood was in revolt. The leukemia had reawakened. It had flooded his lungs. He was put on the ventilator. He had two cardiac arrests while in the ICU. His immune system was weak due to his leukemia, so he endured countless infections. By the time he became my patient, he had already been in the hospital for one hundred and eighteen days. He had not woken up. The machine still breathed for him. The only way I had to get to know him was through the thousands of progress notes that had been written:

"…vegetative state"

"…devastating anoxic brain injury…"

"…likely irreversible"

In the beginning, I diligently rounded on him every day. He was a mountain of a man and lay just as still. His heart was barely audible through the thick wall of his chest and over the whirring of the ventilator. Sometimes his eyelids would open, his eyes roving aimlessly around the room - the only clue that he ever moved. I would sometimes speak to him, "Hello?" pressing close to his ear, "How are you doing today?" I would hold my breath in the stony silence that followed. My daily report to my team members about him became increasingly brief, "Still here." We would all shrug and move on to the next room. On busy days, we would skip him.

It turned out he had a big family. One afternoon, I found myself gathered in a stuffy conference room with his wife, daughter, son, daughter-in-law, and niece. His brother was on speaker phone from Nigeria. My supervising physician, a case manager, a social worker, and a representative from the hospital ethics committee lined the other side of the table. Each member of the medical team took turns speaking.

"…vegetative state…"

"…devastating anoxic brain injury…"

"…likely irreversible…"

The case manager concluded, gingerly explaining that it was time for him to move on from the current level of care. The patient did not have insurance. A nursing facility was not an option unless the family wanted to pay out of pocket. The best hope was to find a charitable organization who could loan the family a refurbished ventilator. The family members' faces remained inscrutable. Finally, the son spoke,

"When he got here, he was conscious. He was talking to us. He was a professor in Nigeria. He had a whole life. Now he is like this. You did this to him. We are not taking him anywhere. You can't just throw him away. He is a person."

At the end of the month, my rotation ended and I handed over his care to another intern. Almost three months later, I received a text message: "He died today." I wished I had been able to see how he had lived.

***

The beaches of Iceland are covered in rocks. They crunch and crackle beneath my feet. At first glance, they are an undifferentiated mélange of grey and black worn smooth by waves lapping day in and day out. I kneel down to look closer. Here, a piece of tholeiite, its lacy red markings

form a map of the world. There, a piece of olivine basalt, its green patches resemble moss. Over here, a piece of rhyolite, so full of holes it looks like it could float. Over there, a piece of obsidian, one side perfectly round, what Yorick would have looked like if he were a stone. I pick them up. I carry them with me.

In this essay, the author contemplates finding compassion and empathy for those who disrupt or violate our expectations of the "good" patient.

Donna Huang is an alumna of Baylor College of Medicine Class of 2014. After completing PM&R residency at Spaulding Rehabilitation Hospital/Harvard Medical School and spinal cord injury fellowship at the VA West Roxbury/Spaulding Rehabilitation Hospital/Harvard Medical School, she returned to Baylor as a faculty member in the H. Ben Taub Department of PM&R in 2019. She enjoys writing creative non-fiction as a hobby; exploring the emotional landscape of practicing medicine is one of her favorite themes.

Hysteria / Claire Luo

Well, it feels like my organs are vibrating,
an incessant hum, cacophony within
my chest. A few inches under this flesh,
simmering like a foul stew: a kitchenette
on fire, wondering how to douse the flames,
reclaim the ashes, singed hair, sooty nose, cheeks
creased by lacrimal fluid, and burns and burns and all.

Sorry, it feels like my lungs
might yet rupture, a river
I could stand in. I wonder if you could see
the ripples beneath my skin, prove it's not
the hysterics seeding my blood. I wonder if
you could account for the metaphors
or the crazy woman before you.
Sorry to bother.
I wish—
I wish I could stitch
myself together: so
I might seam
the edges
shut.

"Hysteria" is a reflection on the continued stigma surrounding mental illness and how gendered historical origins of certain illnesses can perpetuate the silence around these issues. Using literary devices, the speaker begins to elucidate her experience of illness and creates the space for introspection.

Claire is a second-year medical student at Baylor College of Medicine with a BA in English from Rice University. When she's not filling her head with facts about the kidney, she enjoys baking lemon bars and playing tennis.

NOTES:


OMENTUM

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