FLORIDA STATE UNIVERSITY
COLLEGE OF MEDICINE

HEAL

Humanism Evolving through Arts and Literature

PROSE

POETRY

ARTWORK

RIDE AT DAWN
Michael Hayward

HEAL
Humanism Evolving through Arts and Literature

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HEAL is a place for medical students to share their growth and development, for faculty and staff to impart their knowledge gained from experience, and for members of the community to express how health and healing have impacted their lives.

We hope this work increases your appreciation for the art of medicine.

FOR ALL OF US JUST STARTING OUT

Haydar S. Ali, MD
Florida State University College of Medicine
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First, carry your mistakes on your sleeve.
Introduce them to every patient you meet
as though they were old friends.
Give them time to reacquaint
and only then follow your course of action.

In an emergency, trust yourself, or
earn the trust of those around you:
you will often need both.

The patient is a descendant of
all patients before him,
respect him as such.

To the internist: your medicines are your scalpels,
fine-tune them accordingly.
To the surgeon: your scalpels are your heartstrings,
never cut what you can't see.

The patient is a poem, but don't over-analyze.
Read with the innocence of a child,
stopping at every line,
loving every rhyme.

If you find your eyes closed during the day,
don't let your mind wander to obscure facts.
Think instead of the first person you ever loved,
the sheen red-white of her lips,
like the inside of a strawberry.

For every laugh, laugh ten more.
For every tear, shed three.
And always, always, cry as though
no one is watching.

There is no art to medicine,
just singing in the rain.

No science to practice,
but a pendulum in the dark.

And last but not least: do no harm.

THE FISHING FLEET
Michael Hayward

Michael Hayward is a wildlife and portrait photographer from St. Augustine. His daughter, Anna Hayward, is in the class of 2022 at Florida State University College of Medicine.

SEEKING BALANCE IN HOSPITAL ANALYTICS

A. J. Rhodes, Class of 2020

The hospital is confusing enough for a medical student, let alone for patients. You are woken up at all hours of the night for vital sign measurements, blood draws, medication administration, and other tests. If you are an elderly patient you often become confused; the days blend together, you lose track of time, your memory worsens. Without warning you are whisked away for imaging or surgery. Physical therapy barges into your room and forces you to exercise. You are told conflicting information. You struggle to have your voice heard by your nurse or physician as they rush in and out of your room, seemingly more eager to chart about you on the computer than speak with you face-to-face.

Such is life as an inpatient in the hospital. Why must it be this way? Of course medication administration is important and vital signs must be taken. But must we wake up the 90-year-old lady who went in for surgery last night at 10 PM and subsequently became confused and disoriented when she awoke in her room after the procedure at 3 AM? She needs her medicine, and she needs to be monitored, but she desperately needs rest to recover.

Structuring the hospital to be fully patient-centered is not easy. "Patient experience" representatives come in and interview patients, but how is the data they collect presented to the decision-makers at the hospital? How often has a systems manager or high level administrator followed a patient from presentation in the ED, to admission onto a hospital floor, and through the length of their stay to their discharge? If a CEO or board member could find the time to do such a thing, they may begin to more fully understand the array of almost imperceptible moments that contribute to the sum of a patient's experience in the hospital. These seemingly insignificant moments may go unnoticed as they occur, but when taken together they manifest in a concrete and discernable way to a patient. Their weight is easily felt, but they are difficult to articulate. How does a hospital collect data to measure such a phenomenon? It's not straightforward.

We live in a data-driven world—and data analysis can be and has been beneficial. However, let us not neglect to balance our cold analytics with something more human. Hospital process algorithms must consider something beyond procedural efficiency. If we pause long enough to listen to the people we provide care for, we may discover that missing component. And we may see better outcomes. And we may find our hospital systems to be better for it.

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LUCK

Jacqueline DePorre, Class of 2020

Four-leaf clovers are lucky, so they say.
Finding one should bring good fortune, come what may,
But if one should spend hours on end
In search of something small,
Then when they find it in the end
Is it really luck at all?

1/10,000 sounds like a challenge,
But if you look long enough, I'm sure you could manage.
And if you find that clover, would it be an advantage?
Or were you bound to find one, like Irishmen?
And if you look at 10,000 more—should it happen again?

If a surgeon—instead of searching—studies his days away,
Is it just luck then
When he diagnoses a disease he read about that day?

Is it luck or was he prepared?
He read, he studied, he knew it to recall.
Smart? Yes. But lucky? Hmm…
Maybe he deserves the credit, not the leprechauns after all.

CHILDHOOD MEMORIES AT ST. GEORGE

Yolany Martínez Hyde, PhD
Department of Behavioral Sciences and Social Medicine

MELETE

William Butler, Class of 2021

Help me in this
Weary place to
Give you my soul;
To give you
my mind;
To give you
    my strength.

Allow me to be present in your presence,
When those around me are sick, or hurting, or in need of your light.

Thank you for this gift;
    to be a quiet place.
Help me to love and be with you all the days of my life.

Author's Note:
Tallahassee is a source of spiritual inspiration for me. Melete is the Greek word for meditation and means to ponder or contemplate. It is used several times in scripture. I wrote this poem after a prayer while studying in our neuroscience block.

ONE MONTH AFTER MICHAEL
Gabriela Cintron, Class of 2022

SOLACE

Michael Tandlich, Class of 2020

Mr. Jones was a very dissatisfied 55-year-old jaundiced hospital patient when I met him, but it was not the abdominal pain or skin discoloration that bothered him most. A team of doctors frequented his bedside with overlapping questions but little explanation. Mr. Jones felt frustrated and lost. "Don't these docs speak to one another?" he said. "The one you're working with asked me the same question I've been asked twice before!"

Part of his frustration stemmed from anxiety. My preceptor, an oncologist, was evaluating Mr. Jones for underlying malignancy. His CT scan showed multiple cystic hepatic lesions and biopsy results were still pending. Without answers to a grave question, Mr. Jones could not be discharged or have peace of mind.

Nonetheless, his frustration and confusion was something felt by many other hospitalized patients with whom I interacted. It was during my pre-rounding experience when I noticed this most. Many patients I interviewed were unaware of information in their charts such as significant changes in laboratory values and chest x-ray examination results, simply because nobody with access to the record had communicated these data. Gathering a history from these patients sometimes left them feeling more unaware and frustrated.

Furthermore, patients showed surprise over my encounters. "A doc hasn't spent more than 10 minutes with me since I've been here!" one said. Another patient showed much gratitude after I spent 30 minutes gathering a history, performing a physical exam, and simply talking to him and answering questions. He said, "Nobody has ever done this for me in here."

As a medical student, I was fortunate to have ample time and a small caseload. This enabled me to fully interact with patients who consistently appeared in need of more bedside rapport. It goes without saying that physicians often have a demanding caseload and merely not enough time to sit with each patient to discuss his or her plan of care and answer every question. But, during my internal medicine clerkship, there also seemed to be an inpatient hospital culture that lacked patient-centeredness. Doctors had fleeting encounters with their sick patients. Sometimes, they made no more physical contact than stethoscope to chest.

I empathize with those patients who may have benefited mentally from improved physician rapport. Taking an extra moment to address patients' fears could bring them comfort and eradicate some feelings of helplessness. I know I would have felt a similar dissatisfaction as did Mr. Jones if I was in his position. Between the beeping of hospital machines and devices, there can be solace in feeling cared for by the doctor, something that would bring me more peace of mind even in times of uncertainty.

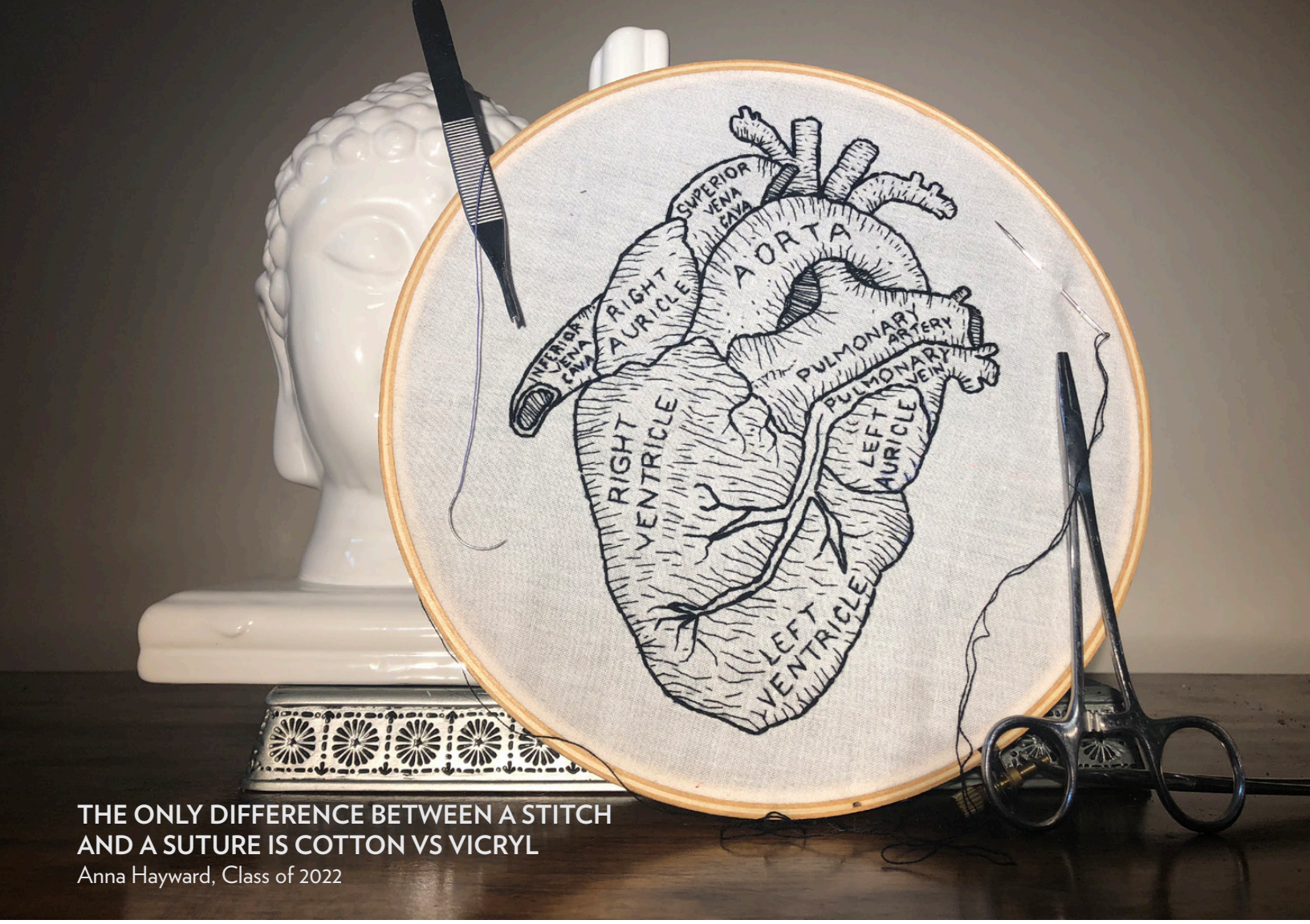
Mr. Jones felt frustrated and lost. "Don't these docs speak to one another?" he said. "The one you're working with asked me the same question I've been asked twice before!"

Photo courtesy of Patrick Blocher

DIVINE DECKS, TAMPA

Zakriya Rabani

Zakriya Rabani is a Florida artist who received his MFA in Sculpture from the University of South Florida.



THE ONLY DIFFERENCE BETWEEN A STITCH AND A SUTURE IS COTTON VS VICRYL
Anna Hayward, Class of 2022

HONORING THE SACRED GARMENT

Eric Laywell, PhD
Department of Biomedical Sciences

"The body is a sacred garment. It's your first and last garment; it is what you enter life in and what you depart life with, and it should be treated with honor."

These words, by American dancer and choreographer, Martha Graham, have always resonated with me. And you may remember seeing them before, as I always include them on the final slide of the First Patient presentation immediately before the incoming medical students go down to the anatomy lab to meet their cadavers. They express a near-universal understanding that the human body, while a material thing, is different from all other material things. Different in degree, it is true; but also different in kind. There is, literally, nothing else like it.

Some among us would say that this is because we each reflect the divine spark of our creator. That is, in the words of Benedict the XVIth, "Each of us is the result of a thought of God. Each of us is willed. Each of us is loved. Each of us is necessary."

Others would say that what sets us apart—what makes us unique from all other animals—is our natural capacity for rational thought. These two ideas are surely not mutually exclusive, and they both help to explain our deep and mysterious reverence for the human body, even when that body has ceased to function as a self-integrating organism: that is, when it dies.

The passage of Time barely reduces this innate need to respect and honor human remains, as can be seen by the great pains that we take not to disturb the ancient burial sites of people who lived hundreds or even thousands of years before us. It is not until the recognizable human substance becomes indistinguishable from Earth that we finally say they are gone.

By the work of Fire, the people before us this evening—your "first patients"—have been reduced to ash. Soon, these ashes will be scattered, and they will become Earth once more.

It was their hope that they could teach you valuable lessons, and that you would carry those lessons with you as you practice medicine. Some of you will share the story of those lessons this evening. And some of you will carry those lessons silently in your hearts. But there is no doubt that those lessons will shape and guide you as you make a difference in the lives of your future patients.

I know this is true, because even I am surprised by the things that I learn from these body donors. Even I am sometimes taken aback by the things that I see, and the feelings that are evoked when studying their bodies.

As most of you know, the prosection demonstrations this year were substantially different from prior years. I had the opportunity to work through some of the new approaches over the spring, since we had an extra cadaver. I wasn't sure that all of the new demonstrations that I had in mind were feasible, and I wanted to work out any bugs before asking your teaching assistants to spend their time on it. It had been quite a long time since I last had the chance to do my very own dissections; I'm usually too busy fixing all the things that you do in the lab.

In any case, I was working on a shoulder dissection of an elderly man whose occupation had been some type of manual laborer. His muscles were large and looked powerful, especially given his advanced age.

As I approached the shoulder joint and began trying to open the joint capsule, it just didn't want to cooperate. There seemed to be lots of adhesions and scar tissue, and it was very slow going. Eventually, I managed to open things up, and was rewarded with a view of the most arthritic joint I have ever seen.

The humeral head was misshapen and very deeply pitted, and it seemed far too small given the man's overall size.

And then I had a brief but significant moment of clarity. Maybe it was because I was alone with only my thoughts in the prosection room, but the anatomy and pathophysiology of that shoulder came together in a way that was very real. And I felt a profound, visceral sympathy for this man and the pain that he must have experienced every time he moved his arm. I was, in short, changed. I can tell you: at my age, that is not something that happens very often.

This past summer you and I had an amazing and rare opportunity to study the human body in a deep and meaningful way. For most of you, this opportunity will not come again. Tonight I join you in honoring and thanking those who lent us their sacred garment so that we might learn and be changed.

"The body is a sacred garment. It's your first and last garment; it is what you enter life in and what you depart life with, and it should be treated with honor."

THE CENTURION
Matthew Hager, Class of 2020

WHEN THE SCREEN FALLS AWAY

Michael Rizzo, Class of 2019

"Don't ever lose your compassion." "Don't let medicine jade you." "Make sure you don't build up a callous to patient suffering." These are pieces of advice I have heard over and over again throughout medical school, and each time I have smiled, said "Don't worry, I won't," and filed away yet another reminder to maintain my humanism through the gauntlet of medical training. But really, if there's one thing that I have never had to worry about it, it has been losing my compassion or empathy. I make an effort to be kinder to patients than the other medical students and doctors I see. I make mental notes so that I can maintain good eye contact instead of furiously scribbling, or worse, typing. I put my hands on the bed rail, I smile, I laugh, I pat the patient's hand. These are things, honestly, that come very naturally to me. I am a very average medical student on standardized exams; my strength is this.

It came as quite a surprise, then, when near the end of my very first rotation, I found myself confronting this issue in earnest. It was my second week of inpatient internal medicine after a long, difficult month of outpatient, sifting through long medication lists and extensive past medical history in a little clinic. I found the hospital environment exciting, with all the people milling about, doctors and nurses and techs bustling around at all hours of the day and night. It felt like the popular medical shows, with all the lights and sights and the steady, soothing beeping and booping of fancy medical equipment. And I, walking around in my neatly pressed white coat, was thoroughly enjoying every minute of it. I would have friendly, pleasant interactions with patients, get a good history and physical and present to my attending, and feel proud and privileged to be there. I had an encounter with a patient freshly diagnosed with lung cancer, and it was actually quite a nice visit. I examined him, we chatted about this and that, joked about the food they were bringing him, all very light-hearted, and then I went on my way. He was whisked away to another floor and I didn't see him again.

> And sometimes, what's needed is simply your time, your presence, and a hug.

One day we went up to the ICU, and I got to see very sick patients that had things I had read about, and I even got to do a paracentesis. The doctors and nurses would stand around chatting, joking and laughing about some patient or other who had been ill in some humorous way. On one such occasion there was a gaggle of doctors and nurses giggling about some guy who had recently arrived in a coma due to a "seizure" when everyone knew it was an opioid overdose since his disheveled girlfriend had told the ED nurse he had been in a methadone clinic. I didn't think this was funny, but I smirked a bit as I saw his bed rolling past further down the hall—you know, just to fit in. Someone said, "Look, the family is here," and I turned just in time to see a man I knew well (I'll call him Mr. L), sobbing as his wife crumpled in his arms. I froze, horrified, and the TV show turned starkly into reality.

I had no idea what to do. Instinctively, I hurried after my attending, who had walked away towards the next patient's room. Numbly, I fumbled through my presentation, and went through the motions of being friendly to this new patient, but something had changed. The weight of someone else's grief, someone I knew, was unbelievably heavy on my shoulders. I wanted to somehow comfort, to make them feel better and have a happy, hopeful conversation about his likely recovery. At the same time, I wanted to teleport anywhere else. I was terrified that they would see me, that I would have to talk to them. I didn't know what to say in this situation where there was really no hope to give.

This patient was a 20-something year old man who had apparently seized and gone into cardiac arrest for many minutes before EMS was able to restart his heart. He was in a coma, with fixed, blown pupils, acute renal failure, severe metabolic acidosis, and hyperkalemia. When I entered his room, he was on a ventilator and they were scrambling to get him on dialysis. From what little I knew about critical care, I understood that this was essentially a hopeless situation. I told my attending that I knew this patient, and that I wanted to hang around his room to…well, really, just to be there. I had no role in his care other than just to stand there and look at his face, and pray. I stood there and I stared at him and I prayed for probably an hour before my attending told me to go get lunch. Lunch. It seemed an odd thing to think about at the time, but, obediently, I headed for the elevators, in a daze. I rounded the corner, and walked straight into Mr. L.

For a second he froze, his red, puffy eyes wide in surprise. And then he hugged me. This was a gruff, strong, capable man whom I had gone to for advice on manly things like buying trucks and fishing.

We were friends, but he was not the type of man to be vulnerable, or touchy-feely, or overly warm. But he embraced me as if I was his only friend. Here he was, in this strange, unfamiliar environment with his son dying nearby, and he had found a familiar face. I stood there and I held him up as he leaned on me and cried, and I was silent. Eventually, he gathered himself up, looked me straight in the eye, and asked me if his son was going to be ok. I didn't look away, I didn't cry, and I didn't stumble over my words, but deep down I knew that any hope I offered him would essentially be false. I knew that I had little to offer as a medical student in terms of prognosticating, and I knew that I really wasn't supposed to make an attempt, so I didn't. But it wasn't in me either to leave him there crushed, with nothing. I told him that the doctor would be by soon with an update and to answer questions, but that, for now, vital signs were good, the potassium had been brought down to normal, and that he hadn't developed any cardiac arrhythmias, but that the neurologist would be by in a little while to assess neurological status, and that was going to determine much of the prognosis. I told him nothing that he didn't already know, and I didn't really offer any hope, but I also didn't snuff it out. He seemed comforted just by the fact that I had a small (really meaningless) status report, and that I was there talking to him. I don't know if I should have handled that conversation differently, but I was scared and put on the spot, and just said what my gut told me to say.

I hugged him again, hugged his wife, and told them that I'd be coming by to check up on them in the coming days. I wasn't there later that day when their son was pronounced brain dead, and I wasn't there the next morning when he died. But I will never forget that day, and I will never forget what I learned from it. This is not a game. It is not a TV show, and it is not light-hearted. I don't walk around solemnly, mourning each sick patient I see, and I have not changed my friendly, happy approach with patients. I still enjoy being in the hospital, and I do not scorn medical professionals that cope with death and dying with humor and making light of the situation. But I do understand now, and really feel, that every patient is the most important thing in the world to someone, and that patients and families are sincerely afraid, often searching a physician's every word for hope. I learned that, for me, truly feeling the weight of patients' and families' concern is what allows me to connect with them, and provide a feeling of comfort and being cared for, even when there is very little hope. And sometimes, what's needed is simply your time, your presence, and a hug.

This essay originally appeared in Intima: A Journal of Narrative Medicine*, and received an honorable mention in the 2018 Compassion in Healthcare Essay Contest sponsored by* Intima.

PEACEFULNESS
Suzanne Harrison, MD
Department of Family Medicine and Rural Health

HOPE
Michael Hayward