

MEDICAL LITERARY MESSENGER

An Artistic Voice for the Healing Arts



Photo by Bryan Jarrett (see page 34)

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MEDICAL LITERARY MESSENGER

An Artistic Voice for the Healing Arts

We are proud to launch the Medical Literary Messenger with this inaugural issue. Although we are new and modest, we hope to explore the diverse meaning of illness through the creative lens of a medical perspective. Our contributors include students, physicians and patients both from and beyond Virginia Commonwealth University. The following pages of essays, short stories, and images have inspired us to pause and reflect on our varied roles as members of a medical community. We are honored for your readership of the Medical Literary Messenger and hope that you are moved by its content.

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Editor in Chief

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Before the Laying On

we are rostered into numbered, curtained cubicles
of faded green, pervasive in this place.
Apportioned to our spaces, those on the menu
and their audience, crowded between gurneys
covered in washed out green and white.
Bustling shoulders nudge the curtains,
urgent readying, with bundles of pale green.
Tubes and masks dangle, instruments to probe
about bare necks. A kit is brought,
toasted, whey-green blankets, exchange your clothes
for wispy gown, green leaf over nakedness.
An Asian woman across the way surrounded
by her chanting family, she supine, quiet Buddha
on the green, engulfing bed.
Voices everywhere but no faces,
each celled unit awaiting its call behind the cloth.
Into each tent the assigned professionals
collect, probing before entering with scrubbed fingers,
introducing themselves as if the green curtains
were wallpaper and the gurneys paisley love-seats.
Setting about the preliminaries, explaining
the features of near death, the procedures taken,
what to expect as the momentum of hands begins.
Nervous laughter at an awkwardness, glib immodesty,
the pale green bonnet all must wear like a shower cap,
the dangling strings over surprised skin.
And then the entry, the epidural twinge
and cold sweat at not moving, the green pallor passing.
Onto the gurney after a jab for veins, closed cold and
wincing, taped with a tap and intravenous well,
wheeling away through spreading doors
into a cold room whose lights
are great glass flowers with steel stamen.
Onto a table tumble, center-shuffled, you are
introduced to the green-garbed, as if at a party.
Some pretty faces busy before they mask,
centering you as a target, more green cloth
piles upon you. The busy voice that says it's time,
the mask that wavers before your eyes,
as if to give its silent kiss, secretly...

By Robert Eastwood*

** Author's note, page 20*

When the Medical Student Teaches

By M. Hoya

Most of you are probably reading the title of this and thinking that I'm going to write about those medical students who think they are 'know it all.' These are the students that answer questions with small 'zebras' they learned for the USMLE Step 1, that, frankly, you have yet to see in your 20 years of clinical practice. And while I certainly have a few thoughts about this type of medical student, that isn't my intention here.

Undoubtedly, I have left most of you very confused — what is she talking about? My attending teaches me, I teach the medical students, and medical students just listen, take notes, absorb, and do 'scut work' in between. I used to believe that medical students really could not contribute to my clinical education, but I have recently discovered that the medical students can actually teach me valuable lessons both on and off the wards. I am hoping to take a few minutes to highlight the usefulness of medical students to my own education in residency (and not just their usefulness as 'scut monkeys').

So what is it that the medical students have taught me? Well, the third year medical students — these are the students who are finally responsible for one or two patients, responsible for knowing the facts, and presenting them

to the team. These are the students that taught me enthusiasm. There is nothing like watching a third-year medical student observing his or her first bedside procedure. Sure, we do hundreds of arterial sticks during residency — but have you ever seen how excited a medical student is to do an ABG? They remind me of how I used to feel about medicine — before all the long hours and all the stressors of noncompliant patients. It was a

“I have recently discovered that the medical students can actually teach me valuable lessons both on and off the wards.”

simpler time back then — I, too, was once enthusiastic about my job, and excited that I had chosen medicine as my career. But these are all sentiments we too often forget as the years pass on. We need to always remember the reason we went into medicine in the first place, and the third-year medical students are here to remind us why.

Lesson one: Remember that you love medicine and that you find medicine interesting and exciting. This will help get you through the rough days.

And then the fourth-year medical students — the ones who are living freely on 'electives' before medical school ends and real life begins. While we might consider them 'lazy' on those spring rotations, what they have actually taught me is that 'real life' is as important as the job. The reason new interns are often so refreshed is because they have spent months on vacation, and they start their intern year off with a fresh focus and without any baggage or

residual exhaustion. We need to learn to take breaks once in a while. If there's one thing doctors have a hard time doing, it's remembering to leave their work at the hospital — that pending lab result, that patient death — they all haunt us when we get home, to the extent that they start to weigh us down. We need to just let it all go, to have no worries or cares — it's okay to be 'not busy' sometimes. Only then can we approach our jobs with the same serenity and determination every day, as we did on July 1st of our very own intern years.

Lesson two: Don't just go on vacation — turn your mind off. It's the most important element of maintaining your medical career.

Although I have limited contact with first-year medical students in residency, it's interesting to note that they, too, can teach me something valuable. What these students taught me is how to make medicine accessible to everyone. By accessible I am referring to the medical jargon — talking to my attending about a patient's abdominal pain is uniquely different than explaining the work up for abdominal pain to a first-year medical student. When I say LFTs and RUQ ultrasound, the medical student stares blankly at me, much like my patients usually do. These first-year medical students remind me that sometimes we know too much as physicians, and sometimes it might be better to forget the jargon we spent years memorizing. Granted, it is nice to know that pancreaticoduodenectomy

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Lesion

She arrives and he greets her
in a lead shirt.

They enter a room with black
walls and no windows.

She shivers on the table
with instructions not to breathe.

He captures the following images:

*a gray seed patch,
pea gravel in a fountain,
the face of a split pear.*

When the test is over
he hands her the pictures.

— By Stacy R. Nigliazzo

Stacy R. Nigliazzo is an emergency room nurse. Her poems have appeared in numerous journals including JAMA, Third Space, and the Bellevue Literary Review. She is a graduate of Texas A&M University and a recipient of the Elsevier Award for Nursing Excellence. Her debut poetry collection "Scissored Moon" is now available at the Press 53 bookstore (Press53.com).

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actually has meaning for us, but I'm fairly certain that both a first-year medical student and your patient will be clueless about what that actually means. (They will be even more clueless if you use the vernacular 'Whipple procedure'). In a world where medical jargon dominates our everyday conversations, maybe we should reconsider our audience and learn to adapt to various types of listeners.

Lesson three: Your patients don't understand most of what you say, but are afraid to ask questions — speak in basic terms and always describe things in the simplest way possible.

And what about the M2s? To be perfectly honest, they have so much studying to do for their USMLE Step 1, that they could care less about teaching me anything.

All in all, I think we should take a minute to thank medical students for reminding us of the things that we so easily forget when the job gets busy and people's lives are in our hands. We get caught up in our own medical world, and we sometimes forget why we did it, how to stay happy while doing it, and how to remove ourselves from the medical world when necessary. The medical students, not yet jaded and not yet only conversing in medical jargon, can help us remember these simple things.

So, to all the medical students out there — please know that I am as invested in your education as I hope you are in mine. However, I offer my sincerest apologies as I will continue to 'scut you out.' ✧

The Way Back To Childhood



Photo by Christopher Woods

Christopher Woods is a writer, teacher, and photographer who lives in Texas. More samples of his work can be viewed at his online gallery, <http://christopherwoods.zenfolio.com>.

“...my step-father, Gus, glances at his hands — middle-aged hands, nicked and scarred and band-aided hands, meaty Polish hands, the hands of a laborer, a builder, a craftsman, the storytelling hands of an artist — before he says to the night, I can fix anything.”

The Uselessness of Our Hands

By Sean Prentiss

During this late hour, when we're both too scared to sleep, my step-father, Gus, glances at his hands — middle-aged hands, nicked and scarred and band-aided hands, meaty Polish hands, the hands of a laborer, a builder, a craftsman, the storytelling hands of an artist — before he says to the night, I can fix anything. Plumbing. Electrical. I even built your mother this house. That's what I do. I build things. Repair things. I fix things, Sean.

I look at this house he built for the woman I call Mama. It is antique beams and a river-rock chimney and bay windows overlooking the Delaware River and hand built chairs and deer antler chandeliers and hanging flower baskets and restored tables and rock patios with railings of juniper. All built by Gus's hands.

He looks out the black window and gazes to the spot where the night river runs silent. Toward where the world is empty. Then he looks back to his hands, which rest on his lap, his legs crossed. He says, But I cannot fix your mother.

In two days my mother goes into the hospital for a mastectomy and breast reconstruction. The doctors will cut out her lymph nodes. They'll examine what was formerly her flesh, fat, and immune system to see if and how far the cancer has tendrilled through her body. We fear it has metastasized into her lymph nodes, her thyroid, other unspoken places.

Gus continues to stare at his hands. I can fix anything.

I think of my own hands, how I write and teach others to write. They are wide hands with stocky fingers. During the summer months, they grow calloused and scabbed from chainsaw work. But most of the year, they are the soft, pale hands of a professor.

Gus wearily stands, wraps his arms around me, says goodnight, before he falls beside my mother into bed. It's 11 p.m. Well past our bedtimes. But it is in these quiet hours of night that we let our minds turn to their darkest closets.

Once Gus leaves me to the night, I pull out paper and pen and write fourteen letters to my mother. One for each day to get her through the worst weeks. As I look at these letters, I wish that these hands (or Gus's) could somehow heal my mother, that we could carry her burden, that these hands could offer peace from all her fears.

But what use are these hands? What use is a letter to a mother or a poem to her god? What words can I offer in exchange for her health? How much more useless can these hands become? Still, with tears forming, I glance to the next blank page, that expanse of white in this dark night. And I write. ✧

Sean Prentiss is the co-editor of The Far Edges of the Fourth Genre. (<http://msupress.org/books/book/?id=50-1D0-343C#.UnZsZ>)

Never Forget You Work in Oncology

Nurses begin each day at the table
in the lounge, coffee brewing
and the vanilla creamer passing

cup to cup, catching up on the latest
of our traumas — death swirled in
with words of our families

activity. The cork board holds
the thank you cards from the dying
now dead, their tacked obituary.

We write their names in chalk
on the board with the date and time.
Some nurse's handwriting curls like

a kindergarten teacher's, others rigid
with frustration dented deep
in the texture of the language

they choose. Passed on, expired,
went to heaven, died, or simply
a blank space like a weathered tombstone.

Rest here.

Some say our patients go in threes but I've seen
longer lists, five and six at a time

within weeks. Then we erase them, chalk
and choked remembering — forgetting,
the back and forth of our lives pressed to theirs.

— By Lorraine Waltz*

** Author's note, page 28*

Going Down

“If you want to know what’s wrong with your patient, ask him. He may not know the right words, the clinical terms, but he’ll tell you in his own words.” — Dr. Ted Paxson

“I don’t know what it is, I can’t put my finger on it, but I feel like I’m descending into my illness.” — Joe, a patient

By Thom Schwarz, RN, CHPN

Everyone is asleep. The rhythms of the world have halted. Perspective and color have been swallowed by the night. Like the bottom of the ocean, the dark has drowned the day, extinguished the sun. Aren’t those the truths of the night?

I lie abed but not asleep. Twenty percent of my brain hides, awake, behind closed eye lids. The pager jolts me, its awful beep like a sonar cry. The answering service gives me the raw facts: name, telephone number, and a condensation of the caller’s words, like an S.O.S. I pull on clothes. They are not yet cooled from the evening visits. My car’s engine is ticking as it, too, cools, releasing its heat from those fifty earlier miles. Now the middle of the night, the hours of lead, sucks the warmth from my sleeves and pants, grips my ankles coldly as my feet touch the floor. I step outside like a reluctant lifeguard.

A police car idles in a shadowy recess of a closed service station, sleepy eyes deciding whether to shadow me or leave me be. Perhaps they spotted the stethoscope dangling from my mirror. Maybe they recognize my car, a fellow denizen of night. I look harmless, not speeding; no need to rush, terminal illness is not an emergency.

I bring a flashlight on my house calls to illuminate street signs on unfamiliar back-roads. Often the trees and bushes have overgrown them. They sway and weave in the night wind. I troll with my thin beam to luminesce the letters. It’s easy to spot the patient’s house; it’s the one with all the lights on, the family’s cars huddled in the driveway, all empty, waiting. Sometimes the funeral van arrives before me, its engine running while they make “the pickup.” All this hushed activity in the middle of the night wakes the neighbors. Although their windows are darkened, I know they are watching behind drawn blinds, curious and sad. They know. They’ve watched the patient come and go, to the doctor’s office, the laboratory, the hospital, week after week. Once the patient was their old friend and neighbor, now he’s ancient, unfamiliar. He’s lost weight, they whisper, just skin and bones, hairless, hunched, yellow eyes staring from deep sockets, withering into some strange species. Yesterday he could still stagger from the car to the front door. That’s past, no more trips after tonight. He’s as far down as one can sink. From here the trip is up, towards the light.

Inside the house there might be silence or gospel singing, quiet crying or wailing. Someone brought a dozen donuts and a large cup of black for himself.

Food and drink are universals; silence and song are variables. But the atmosphere is always the same. The patient and family have collapsed in on themselves. There’s no time or energy left for others. The bottom is here, unseen but undeniable. The air is close and foul. No one opens a window. The crushing stillness is a sea that won’t be denied.

Sometimes the patient’s head lolls to one side at a painful angle. His leg snakes through the bedrails, caught while trying to escape death’s net. Most of the time the patient lays supine, mouth agape, hands cold and stiff as icicles across his chest. People wander in and out of the patient’s bedroom. They look mutely at the patient and then return to the kitchen. They look for some movement, something to spark their hope. But really, they know better. That’s why they called up to me.

I apologetically explain that I must do what I must do. Regardless of its futility I kneel and introduce myself to the patient: can he hear me? I listen with my cold stethoscope to his chest for a final heartbeat or unexpected breath like a last tiny wave. Nothing. Down here, his disease has crushed his life. Color and warmth are gone, his body a series of ridges, hard as coral. There is nothing so still and empty as a dead man’s chest.

My work is perfunctory as a priest’s but I choose my words carefully. What is said now will be remembered long after the funeral has been forgotten. A gaffe will roll on forever. An outsider, I don’t stay long. I come down into the depths

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Past Curfew, At a Time Past (1964)

A student nurse and her boyfriend, serious as monks,
sit in his car in front of the nurses' residence. The doors of the building are locked.
They stare blankly into the night.
Gut-wrenching to be outside past curfew.
She is choking from the whalebone corset of rules.
Rigid rules.
Student nurses, the ones that graduate, do not break rules.

Inside the dorm, waiting up, her best friend eyes the situation.
It demands action. On the run, the friend maps out a plan.
She doesn't stop to weigh things out like a farmer selling peaches at a fruit stand.
She shakes a sleeping classmate awake. The classmate, alert now, agrees to man a side door.

Driven by concern, the rescuer darts out, bangs on the car window.
A guardian angel in pajamas.
Desperate eyes widen in amazement. No need for words.
Propelled by trust, the student dashes after her friend through the open door.
Up the stairs, down the hall, the three race to their beds.
Under the covers, mission accomplished, they beam like victorious Navy Seals.

Barbara Carrington has put down her scientific pen after a long, diversified career in nursing for a creative writing pen. She likes the idea of becoming a late bloomer in the literary world. She lives in Houston, TX, where she is enjoying the transition.

— By Barbara A. Carrington, RN, BSN

Approaching Shadows

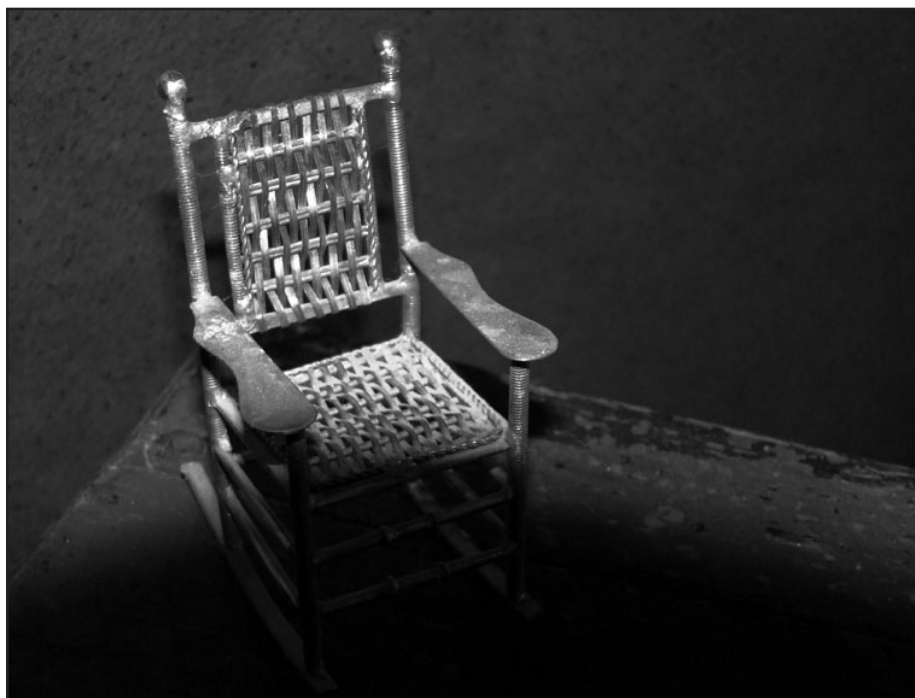


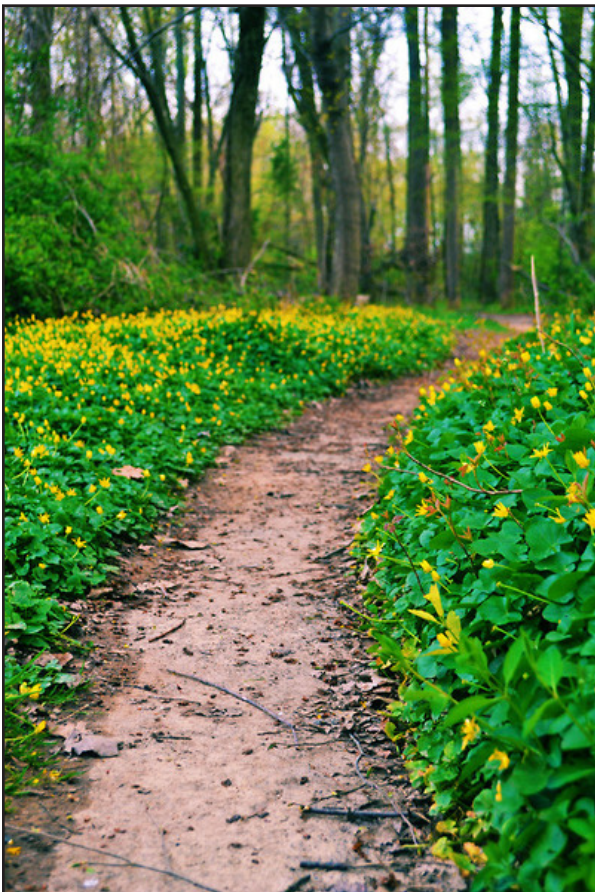
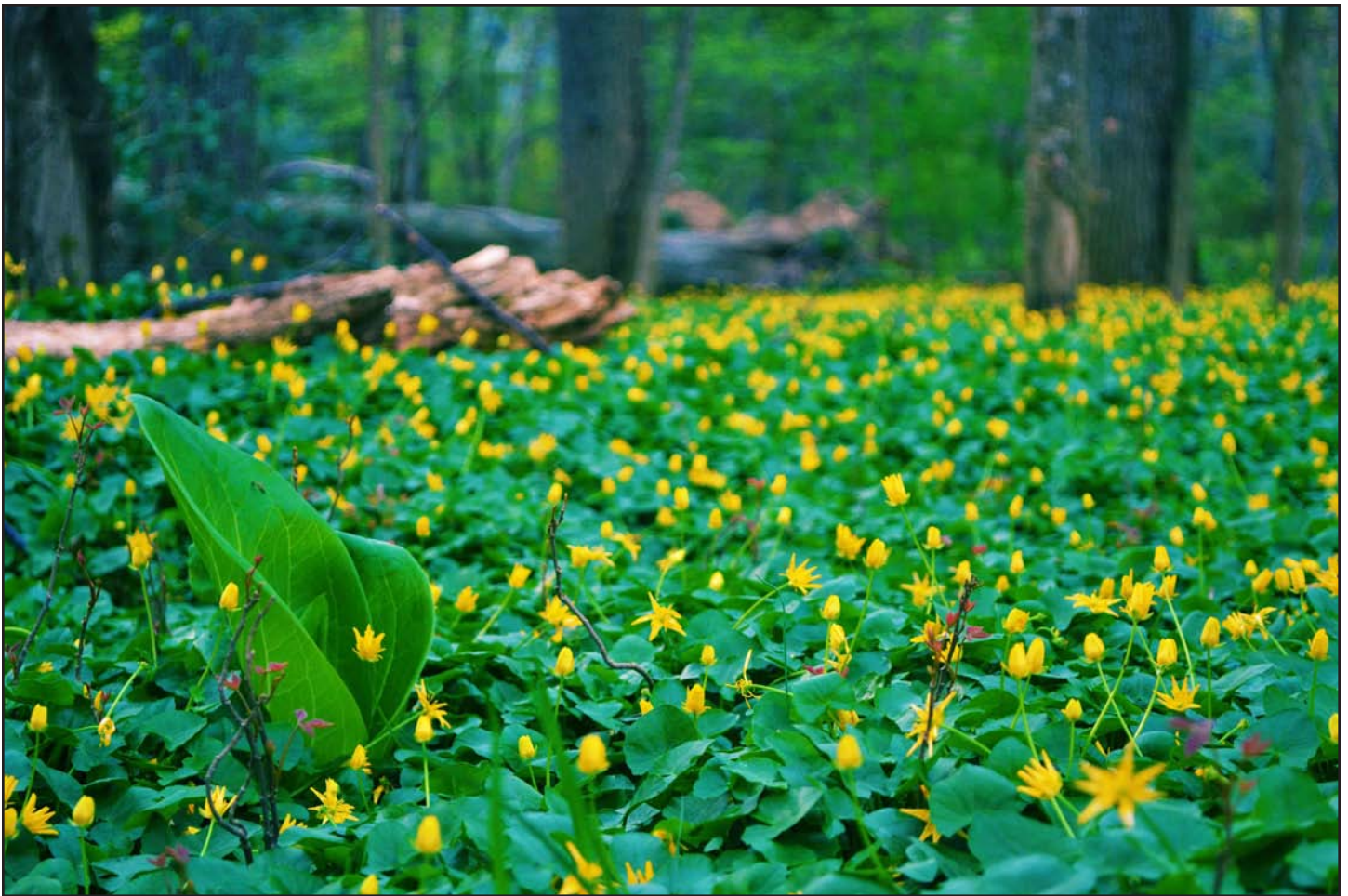
Photo by Christopher Woods

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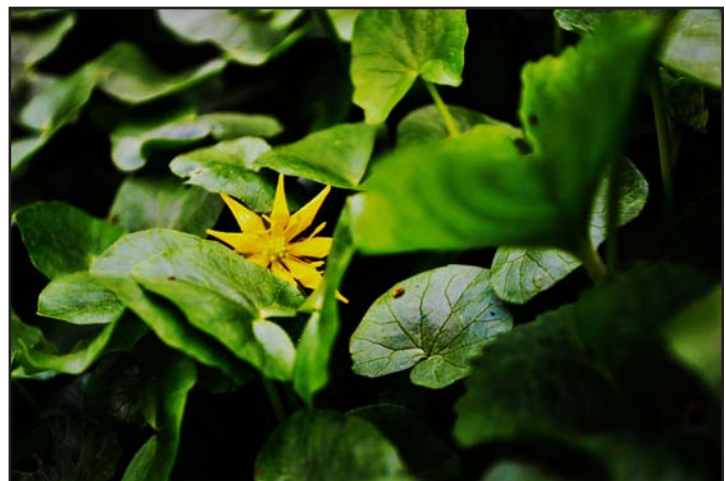
of this family's grief with only my empathy and my flashlight. I leave quickly, stating "I am not family, I don't belong here. This is precious time." They smile wanly and ask if I'd like a cup of coffee. "Drive safely," I hear someone say as I close the door behind me.

Outside the sky begins to lighten as the sun rises over the surface of a cold, new day. I catch my breath and turn homeward. ✧

Thom has been an RN for 36 years, the past seven years working in hospice and palliative care. He has been writing since he was eleven years old. He's beginning to understand the process of writing, the journey of living and dying, and he hopes he has another 65 years to get them both right.



Virginia Nature



Photos by Hannah Kim

Hannah Kim is a third-year medical student who was born and raised in Virginia. She graduated with a biomedical engineering degree from the University of Virginia and is currently studying at VCU's INOVA Fairfax campus where she was born. She hopes to enter a medical specialty in which she will best be able to serve others, and sees herself practicing medicine in under-served countries around the world.

“AHA!” Kevin yelled, his voice filled with the excitement of youth, hale and happy and whole! Moving on his bed as much as his active IV stints allowed, Kevin pressed the game. ‘The Queen of the Stick Monsters is afraid of Captain Kevin and his secret weapon, the Spray Ray of Death.’ Another shower of breakfast flakes flew out at his nurse.”

Is Six Always Six

By Ken Staley

Margaret Johnson loved Kevin, her 10-year-old son, with a fierceness only mothers understand. Moments of a healthy Kevin filled with the joy of life raced through her mind. Kevin, peddling his sporty bike downhill top speed, slammed on the brakes and skid 180 degrees stop in front of her.

“Look, Mom! A NASCAR burn-out! Cool!” And back up the hill he raced to do it again. Other images followed and questions that only curious 10-year-old boys ask.

“What decides what color a caterpillar is?” he asked one day showing her a captured specimen in a jar, the bug crawling down a stick.

Now, as he lay suffering in a hospital bed, Margaret wondered if today was Kevin’s last day or the day for a miracle. Christmas was supposed to be the season of miracles. Would a special star appear and let her know? Lately, death rattled his every breath and pain consumed his entire world. More and

more she found herself praying at his bedside, holding his cold hand, pleading with God to spare her son just one more day.

Still Kevin wasted away. He would not eat — could not eat with all the chemicals they put in him. She carried a treat — his favorite cookies — to induce him to eat something. She knew the plate would end up at the nurses’ station, untouched by Kevin. Margaret didn’t mind. They deserved cookies and more for their care of her son.

Margaret leaned her head against the wall outside his room and covered her face with a gloved hand. Once she thought she could not cry another tear, yet daily a new batch arrived. Yesterday, his doctors moved Kevin into a private room.

“Kevin is an extraordinary research patient,” they explained as they wheeled his bed across the hall into a private suite. “Patients like Kevin who undergo such special, experimental research require isolation so that the results might not be contaminated by others in the ward. We have high hopes with this

new regimen.”

Hospital administrators believed and these were smart men who knew things she could only guess at. They believed because they were men of medicine and knew how to read charts and blood and things. She believed because they believed and she was his mother.

Still, clouds of doubt whispered to her at night. As they moved Kevin into his private room, where death waited in each corner, she overheard the floor nurses and they called Kevin a ‘short list’ patient.

“He won’t see Christmas, I’m guessing,” Nurse Vicky said.

Three days, then, she thought. A miracle in three days.

Crude Christmas decorations festooned the halls and doors. Each child-drawn tree or candy cane only reminded Margaret that her two other, younger, healthy children, BD and Sheila, needed her to be a mother at home. She spent so much time at the hospital they had to be jealous. She

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knew that, understood that, but Kevin needed her so desperately. In spite of state financial assistance, Kevin's hospitalization ate up every spare dollar. Any Christmas presents for her children this year, like last, and the year before that, would come from charity's generosity.

Hearing Kevin squeal goaded her to move from the wall. She could face one more day if he could. Silently, she begged for just a bit more strength. She fished a well-used tissue from her purse and blotted anything that might be a tear from her face. She painted on a smile, determined to set a happy mood. She shrugged away the blues, squared her shoulders, took a deep breath, and pushed the door open — and froze.

Kevin knelt in the middle of his bed, as far as the tether by two IV drip lines in his arms allowed. Shirtless and emaciated, Margaret could count his ribs. A hospital pillow case-cum-cape emblazoned with a crude, hand drawn — CK — in marker pen knotted around his neck. He wore a 'helmet,' consisting of two empty hospital glove boxes stuck together with yards of white surgical tape. An oval opening that once dispensed sterile gloves now served as a frame for his face. Other marker pen designs covered the sides of each box. Two vascular clamps stood straight up from the top, like television antenna of old. An oxygen mask, taken from a rack behind his bed, covered his mouth and nose. Two empty IV bags, one on each side, their IV lines tied under his chin, were taped to the contraption as well. Surgical tape also held two half pint strawberry milk containers to his sash

and on the very top of his helmet, a red Christmas ribbon.

"Captain Kevin has driven his arch enemy, the wicked Orgainia, Queen of the Stick Monsters, to the floor! The President of Earth called Captain Kevin to protect all the people of Earth!" Kevin called out in a voice as low as he could make his ten year old squeal go, muffled only slightly by the oxygen mask.

Margaret, mouth agape, watched as Kevin dipped his spoon into a large box of a popular sugar cereal and, turning the spoon into a catapult, sprayed flakes across the length of his bed, showering his sheets. Nurse Judy, the lead floor nurse and target of his assault, sat on the floor with her back against the wall, pretending to cower in fear while laughing and weeping. Tears of joy ran freely as she squealed in pretended terror for Kevin.

"AHA!" Kevin yelled, his voice filled with the excitement of youth, hale and happy and whole! Moving on his bed as much as his active IV stints allowed, Kevin pressed the game. "The Queen of the Stick Monsters is afraid of Captain Kevin and his secret weapon, the Spray Ray of Death." Another shower of breakfast flakes flew out at his nurse.

Nurse Judy rose and tried to approach Kevin. She had other duties and changing his IV bag should have been a simple task.

"The sneaky Queen of the Stick Monsters believes she has won! The Spray Ray of Death does not stop her! Captain Kevin has one more secret that the evil Orgainia does not know about! He will use a older, more deadly weapon!"

With that, Kevin whipped out a handi-grabber, a three foot length of metal with a grabbing claw at the end. Holding it like a sword, making the jaws snap rapidly open and closed, he poked it at Judy.

"Take that, Evil Stick Queen! And that! And that! The Queen is afraid as Captain Kevin wields his trusted friend, Vise Pinch of Doom!"

Finally he felt the presence of his mother in the room and turned to her.

"Oh hi Mom," Kevin said and gave a hearty wave with his improvised weapon. "Er...Good morning, Princess of the World! You have arrived just in time to see the final battle! Captain Kevin is yours to command!"

The Miracle! Margaret threw herself at him, grabbed, and buried her head against his small, frail chest.

"Jeeze, Mom, it's just cereal. Really. It's ok."

She hugged him fiercely, her tears streaming down his chest. She felt his young hand pet her hair with tentative strokes.

"Really, Mom, it's all ok now."

She wept.

Impeccable white lab coats covered three and four hundred dollar 'work' suits, turning the hospital conference room into something more closely resembling a newly coifed field of snow. Icy, emotional tensions filling the room did little to discourage the image. Around the dark walnut table, men and women of similar ages played the game of studiously ignoring each other as much as possible while making the smallest of small talk. Department

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heads rarely attended the mortality committee meetings and each felt their time far too important to sit too long at this time wasting exercise.

“Before anyone leaves this room, I will have answers to the events leading up to Kevin Johnson’s death,” Dr. Gregory Jacobs told the collected group. “Dammit, this is one of the top pediatric oncology research institutions in the world. These things are not tolerated here and simply do not happen without a reason! I’ll know that reason before you leave here!”

Behind him, the image of Captain Kevin filled the wall...his ‘box’ helmet secure, his Vise Pinch of Doom at the ready, giving the camera a smile that would haunt many of them for decades.

“Run it again,” Dr. Jacobs demanded. Lights dimmed around the room and a greenish tinge covered the screen as security tapes replayed the exploits of Captain Kevin from a broader view that included the entire room.

“Stop!” Doctor R. Wellworth Raymond called out as a man entered and walked the length of the room, keeping to the center so as not to disturb a sleeping child. A timer in the lower right showed the man entering at 3:37 am. In spite of the man’s efforts, Kevin stirred. He brought a stool close to Kevin’s bed. “There! Who is he? What’s he doing? Is he the janitor?”

Tim slipped quietly onto the ward and made his circle. He eased the door to Kevin’s room open and slipped in. Watching him as he slept these early mornings rather than catching his near

comatose stare during the day helped him accept the fact that Kevin was already dead. He just didn’t know it yet. As he prepared to leave he found Kevin Johnson’s brown eyes blinking at him.

“Hey pal! What are you doing awake?” Tim whispered as he corralled a stool and wheeled it over to Kevin’s bed, sitting close.

“Can’t sleep,” Kevin said through chattering teeth. “I’m cold.”

“What happened to your quilt?” The hospital auxiliary made great quilts. Most of the other children wrapped themselves tightly in that warmth. Just a thin white sheet covered Kevin. To Tim, it looked like a shroud.

“Nurse Judy said Dr. Death Ray told her to take it away because he didn’t want to screw his research results,” Kevin said.

“Skew,” Tim corrected with a large grin. “Skew Dr. Raymond’s results. Amounts to the same thing, doesn’t it? Want to use my magic space blanket?”

Kevin nodded.

“Will it work?” Kevin asked as Tim settled his neural net around him.

“Guaranteed to make you warm or you get 1000% of your money back,” Tim said as he slipped a lap top from his pack and made the necessary connections.

“You already owe me all the money in the world for your last bet,” Kevin said.

“Did you touch my patient?” Dr. Raymond demanded as soon as Tim entered the conference room.

Tim crossed to the end of the table and scanned the various department heads. He recognized most of them by name and reputation, if not by face. He slipped his pack from his shoulder and placed it on the table in front of him.

“Did you touch my patient!?” Dr. Raymond demanded again.

“God I hope so,” Tim looked at him. “Did you? Ever?”

“What the hell is this?” One of the white mounds demanded as Tim spread his net on the table.

“For lack of a simpler term, I call it an exo-neural net,” Tim said. “I got the idea a few years back from a neighbor as I watched him decorate the bushes in front of his house for Christmas with a net of lights. I’ve been tweaking this net ever since. Rather than bulbs, this has neural stimulators on a macro level.”

“And you put this — this thing — on my patient?”

Tim paused and stared him to silence. He was in no mood.

“When I first saw Kevin was awake, I had two goals,” he said. “When he told me he was cold, I added a third.”

“This warmed him? How?” Pearl McArtd, chief of nursing asked.

“This stimulates certain sectors of the brain with little or no obvious visible stimuli,” Tim explained. “That doesn’t mean much because we can teach a monkey to stimulate neurons. What the monkey and computer cannot do is regulate the degree of that stimulation and fit it to the individual

**“Did you touch my patient!?”
Dr. Raymond demanded again.”**

Continued, next page

patient.”

“This isn’t medical information. What does all that techno-babble mean?” Dr. Raymond sneered.

“Gross pain receptors in the brain — hunger and sated; wet and dry; hot and cold; these are abundant and easily accessed. You can stimulate the brain to feel any of those in spite of reality. What you cannot do is manipulate the intensity. There is a very fine line, when artificially stimulating these areas between “gee this feels warm and cozy like a hot bath” and “I’m being boiled alive here.” It takes constant observation — human observation and monitoring.”

“How does it work?” she asked.

“Just slip your hands under the edge,” Tim invited. “I promise it will not hurt. In fact, I suspect you won’t even know it’s working. At least, you’re not supposed to know it’s working.”

“So,” Tim settled on the stool, adjusted the net’s settings, and turned the screen into a pad. “You ready for a butt kicking?”

Kevin’s favorite game, Castles and Tanks, popped up on the pad.

“Think you can beat me this time?” Kevin nodded.

“You’re already history, kid. I got a new strategy.”

“Hope it’s better than your last new strategy,” Kevin said as he scrambled the game display until a random map appeared on the screen. “You want to be Patton this time? Or are you sticking with the German loser?”

“Neither, comrade,” Tim said. “You may call me Semyon Moiseevich Kri-

voshein.”

“Who was that?”

“Vat? You haft never heeard of the great Semyon? Perhaps the greatest Soviet tank commander in World War II? You westerners must be taught everything.”

“Rusky eh?” Kevin said. “Won’t work?”

“And vhy von’t it verk, youngest of all western tank commanders? He vas great Soviet hero.”

“If he was Russian he lost too many tanks trying to beat up on one. You don’t have that many to lose in this game.”

“Two falls out of three then, western imperialist?”

“You already owe me all the money in the world from our last games,” Kevin smiled as Tim made his first move. “What do I get when I beat you, again?”

“You kept my patient awake playing games?” Dr. Raymond’s practiced cold voice designed to strike fear in those who heard him. He’d found his scalp. Stereotypical perhaps, but usually effective, blame it on the nurses. “Did it not occur to you that a good night’s sleep might be more beneficial to his health than a simple video game?”

“First, he was already awake because you insisted he be cold at night by removing his quilt,” Tim could match him snit for snit. “Next, don’t think I took mercy on a sick kid and let him win. We played 47 games before he died. I won six and none of the last 17. Finally, this is not a mindless video game but a complex mathematical challenge.”

“How do you know so much about

the game, Mr...ah...Tim,” asked Everett Bear, Chief of Pathology.

“It’s all these young people do these days, Everett,” Dr. Ray said with a dismissive wave.

“I wrote it,” Tim shrugged. “We didn’t play one game that night, but two. As for the time, it didn’t take all that long. We only played for...”

“Toast!” Kevin crowed as Tim’s last castle lay in ruins, surrounded by Kevin’s tanks.

“How long?” Tim asked as he shook his head and shut down the game.

“Six minutes and thirty-seven seconds. A minute better than the first game,” Kevin said with a smile. He looked at his own pad where he kept his won/loss records. The well used pad had been Tim’s before he purchased it’s upgrade. He was glad it was still of use to someone. “That’s almost a record for you.”

“Yeah? What’s the record?”

“For winning — meaning you stay alive — seven minutes ten seconds. For you dying — twenty-six seconds.”

“I think you cheat,” Tim said as he unplugged his laptop and wrapped up the leads. “You warm enough now?”

“Yeah. This is really great. You don’t hardly feel a thing. You get to keep your 1000% return,” Kevin said, pulling his thin sheet over him as he turned off his pad and slipped it under his pillow. “Besides, I don’t have to cheat to beat you. I’m just smarter is all.”

“I never doubted it. I gotta go, buddy,” Tim said as he gathered his net. “I’ll get fired if I spend all night playing

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games with you. I've got serious work to do."

"You gotta clean piss pots you mean, eh?"

"Hey! Watch your mouth! Bed pans are NOT piss pots. I'll have you know you're talking about valuable hospital equipment," Tim said as he finished packing his gear. "I might not be back for a day or two, okay? Besides, I've got to figure out where I went wrong when I lost that last game."

"Okay." Kevin said but Tim heard disappointment in his voice. He turned to leave — he had to — there was only so much time after all. "Tim, can you do me a favor?"

"Sure buddy," Tim paused by the door. "I can try."

"When you come back can you steal one of those bowls of sugar flakes from the cafeteria?" Kevin asked.

"Christmas decorations?" Tim's heart raced as he stepped closer to the bed. Excitement threatened to overwhelm him. It worked. He could trigger hunger with his net.

"Naw, I just used to like them a lot," Kevin said.

"Consider it done. How about tomorrow night?"

To hell with schedules and time and sleep.

"Great," Kevin actually smiled. "and..."

"Something more?"

"Strawberry Moo Moo," Kevin gave him a sly smile, knowing he was asking Tim to break lots of rules.

"Strawberry, huh? I always took you for a chocolate milk man," Tim teased. "Well, ok. The cereal is a piece of cake

but I don't know what Dr. Ray will say when I sneak a pink cow onto the ward."

Kevin giggled. "He was here today."

"What? The Dr. Ray? In person? He actually came in here!? Did you genuflect?"

"What's that?"

"Never mind, but I'll bet you were laying down," Tim said. "He's got the bedside manner of a whale that's been dead on the beach for a month. What did he say?"

"He's as big as a beached whale, too," Kevin giggled. "He said he just had to verify the numbers and see if any changed."

"That's it?"

"I asked him a question. He called me a good boy and left. Fifty seconds. Almost a new record for him, too."

Tim reached out and took Kevin's hand.

"Get some sleep, buddy," he squeezed the hand gently, making sure Kevin was warm enough. "We'll party on cereal and Moo Moo tomorrow night. I promise."

He was almost at the door, feeling on top of the world.

"Tim?"

"Yeah?"

"Thanks. I mean, well, thanks for everything."

Tim nodded. It was all he could manage without crying. Kevin knew, and he knew that Tim knew. Nothing more need be said. He had to escape before Kevin saw him weeping.

Tim turned to leave a second time.

"I know the move that made you lose that last game," Kevin said, sounding sleepy as he snuggled his pillow.

"Yeah? What move was it?"

"It was when you pressed 'start.'"

"How is your hand?" Tim asked the nursing director.

"It's — warm," she snatched it from under the net and examined it. "Thank you."

"You brought that poison into a secure ward and fed it to my patient?" Dr. Raymond wanted blood.

"He was hungry — really hungry — for the first time in how many weeks?" Tim demanded. "How long has it been since any of you offered him solid food other than that pap they shovel out of the kitchen here? He wanted a small bowl of cereal. Hell, I bought him a whole box — the family super size. Did you weigh what remained to see how much he actually consumed?"

He waited for a response.

"I thought not. He wanted that and Moo Moo." With that he withdrew a pink, half pint plastic container from his pack and tossed it onto the middle of the table. "Sugar cereal and 2% milk, pasteurized beyond any redeemable nutritional value, with added artificial colors and flavors. A meal that is the life blood of many American kids," he paused, "or a dying child's request for a last meal. I tell you all right now. If I could have found a cow and somehow painted it pink, I'd have brought that in as well."

"This man is insane!" Dr. Raymond shouted. He pointed a finger at Tim. "You ruined my experiment. You deliberately undermined my research and completely invalidated any data. You took my focus case and..."

"He was a 10-year-old boy!" Tim

Continued, next page

thundered back, shouting the room to silence. “He didn’t ask to be sick! He didn’t ask to become the focus of your research, or mine, however valid that research might ultimately be. He didn’t want much. He was cold and I warmed him up. I did. He was hungry and I fed him. That ‘fun day’ at the end was my idea. I sent a strong tickle to his pleasure center. That was my payment for using this poor kid as an object of my experiments. And unlike you, I always ask the patient if I can use them for my research, regardless of age. Making Kevin hungry and happy were my objectives for the evening. By God, for all the information he gave me cereal and flavored milk was a damned small price to pay.

“Tell me, which of you paid him half as much? Can you honestly tell me you didn’t use him knowing you couldn’t save him? Didn’t you dangle veiled promises of hope and success in front of a vulnerable, uneducated single mother who could never comprehend your statistics? A desperate woman who refused to accept the inevitable right up to that very last second?

“And look at what that kid did,” Tim insisted as he pointed at the wall, filled with a smiling Captain Kevin saluting the camera with his Vise Pinch of Doom. “In one night he created a space suit! He created weapons systems from simple, every day objects. Above all, he created a world and lived in it. How many of you overstuffed suits can say you still have that much imagination left?”

“You said Kevin asked Dr. Raymond a question,” Dr. Ivar Ivanovich said into

*“Above all, he created a world and lived in it.
How many of you overstuffed suits can say you still
have that much imagination left?”*

the silence that followed. “What was it?”

“What did he ask you, Dr. Raymond?” Tim turned to the researcher with a smile.

“I don’t recall ...”

“Bullshit,” Tim said. “I bet you’ve been thinking about that question since you heard it.”

“What was the question?” Ivar asked again.

“Is six always six?” Tim replied.

“That’s it?” Dr. Peters said. He looked puzzled and a bit troubled. “That was the question? I’m not sure I understand.”

“Neither did I. So I asked him.”

“**W**hat do you mean?” Tim asked when he heard the question.

“Is six always six?” Kevin asked. “I mean, Dr. Ray wanted to know if his numbers changed. I want to know if a number can change. Not his numbers. I can see those change on his machines. But, well...”

“Take your time and figure out the question,” Tim actually sat on the edge of the bed, stunned and intrigued by the simple complexity of the idea — that it should come from a 10-year-old boy.

Kevin’s brow knotted as he took his own pad from under his pillow. When it came to life, he drew a thick, balloon shaped six with his finger. Colors flashed up and down the curves as the

number spun on a slow, invisible lazy susan. He showed it to Tim.

“Is six always six? I don’t mean six and a half, things like that. But — well — just six. Does it ever change or is it always six? I mean, we have five so it can’t be five. Same for seven. But is six always just six?”

“Buddy,” Tim whispered and realized for the very first time that he loved Kevin — and why. “I wish to hell I knew. You think about that when you sleep tonight. If you figure it out, you tell me and we’ll be the most famous math people on earth.”

“**T**hat was a child’s foolish question,” Dr. Ray said with a dismissive wave.

“No...”

“No it wasn’t...”

Several voices echoed around the table.

“You still don’t get it, Dr. Raymond. That question is probably the most deeply profound, simply expressed philosophical math question I’ve ever heard. And you’ll excuse me, but with my engineering background my math is likely far more extensive than yours and considerably more recent.”

With that he folded his net, stuffed it carefully in his back pack and spun away from the table.

“Where are you going Mr. Dilly?” Dr. Peters asked. Tim stopped at the

Continued, next page

door, one hand on the knob.

“Home, Greg, I’m going home,” he said. “I’ve had quite enough of this world and more than enough of your world. I think I’ll go home and create my own world — perhaps eat a bowl of the Spray Ray of Death and escape.”

“We’re not finished with you here,” Dr. Raymond’s comment was more threat than invitation to stay.

“When I look around this room I think of Kevin and I smile. You, who are so concerned with your numbers and research, couldn’t even attend the memorial service for one of its contributors. You’d better pray for a better place in the hereafter. Kevin Johnson met the Stygian Ferry two nights ago, tossed the ferryman overboard and rowed into Hades with his Vise Pinch of Doom in one hand and his Spray Ray of Death in the other. And, if we are really really lucky, when you lot of specialists arrive at the shore to cross over, he’ll toss your asses into the Styx!”

He paused when his voice finally broke. He took a deep breath and looked directly at Dr. Raymond. “You were done, Dr. Ray, before you even sat down. As my friend Kevin would say, if he were still here, your problem began when you pressed ‘start.’”

He nodded and left, closing the door softly behind him. ✧

Ken Staley lives and writes in the lower end of the Yakima Valley in Washington State. When not writing, he can be found working on stained glass pieces or sampling new vintages at local wineries.

Cheers

(Desvenlafaxine)

Every day, I shoot a square pink quasar into my brain;
a black hole vanishes, collapses on itself; a star is born.

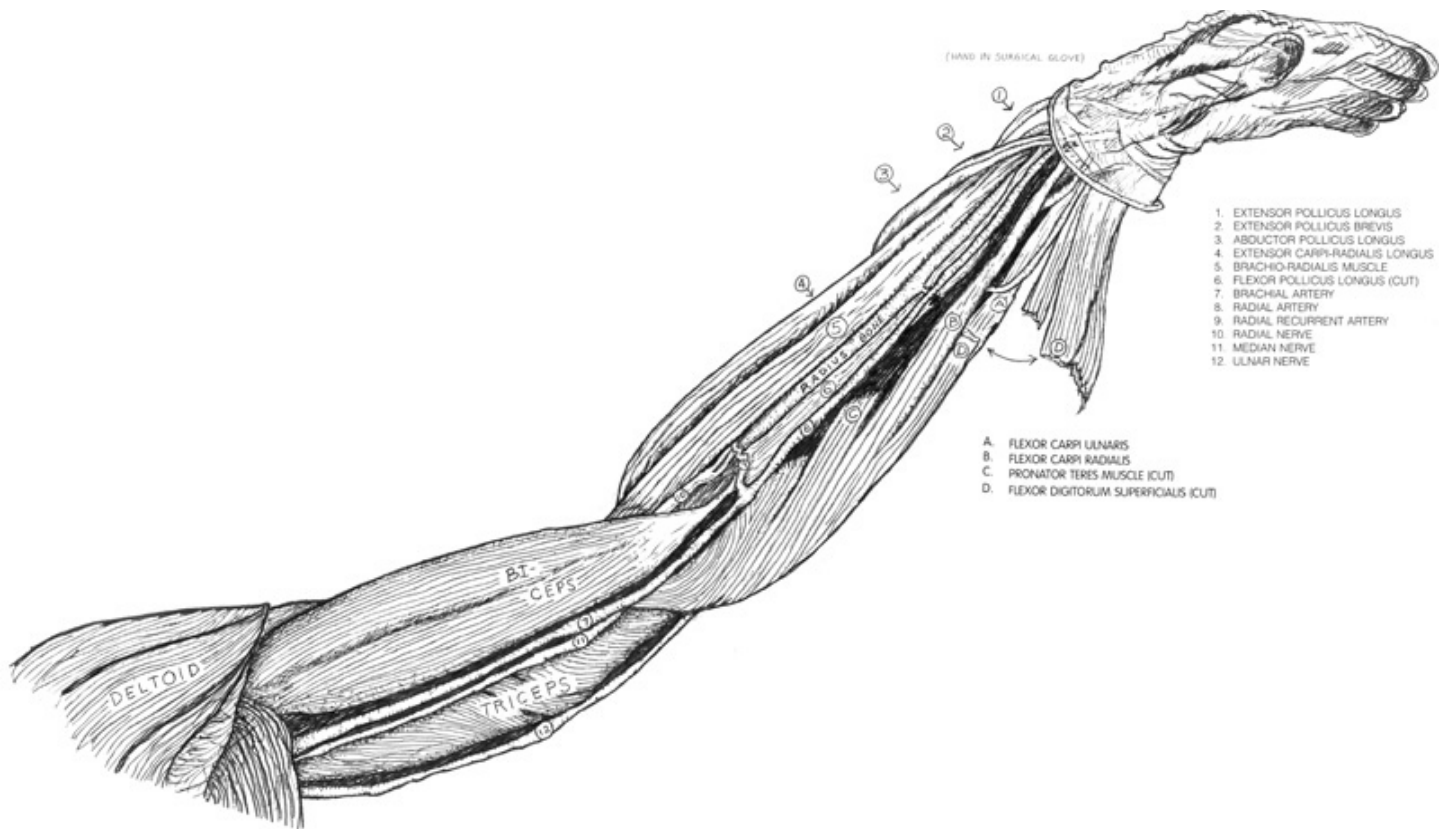
Heaven-headed, I am now charming, cheery; a patient
grownup. Run a movie in reverse of a mirror cracking up.

Side effects include: sexless love, sepia dreams, poetry;
if you hear angels, see medical attention immediately.

— By Nick D’Annunzio Jones

Nick D’Annunzio Jones, a nom de plume for a former reporter at The New York Times, is a poet and conceptual writer in Seattle. He also lived in the Fan District of Richmond, VA, many years ago.

Arm Dissection, MCV Gross Lab



Drawing by David J. Bromley

The experience of teaching Gross Lab for artists was a career highlight for me; it was rewarding to see the interaction of Medical Students and my Honors Students: both groups are among the best in the University. The relationship between art and science was keen until modern times, and the opportunity to bring together students of drawing and anatomy, a single study in Renaissance times, was a genuine pleasure. Presented here is an ink drawing I completed in the studio based on sketches I made in the lab. Outstanding examples of student work from this course are available online at www.people.vcu.edu/~djbrumle

In the Cancer Ward

It's the farthest wing
where there are many quiet wars.
Nurses clear the fields of heroes.

His wife's hand covers his, another
juncture over tubes on the bed.
Smells of roses & urine intrude
upon a potpourri of disinfectants.
As dawn arrives through cypress
on the hill, she opens the blind.
An aura, a soft golden dust,
settles on her face,
her bowed shoulders.

Somewhere a buzzer,
unremitting, frantic.
A muddle of voices in the corridor.
Morning rounds & susurrus replies.

Under the coverlet his knees climb
some far hill. He stumbles
on a drape of tubes. A moan escapes
his latest skirmish.
She touches the dropper to his lips.
"No more of that. I'll go to sleep,"
he wants to say, but has lost
the protocol of words.
Over flat, jade oceans, he fears
he's lost his way.

.
And then she caps the amber bottle.
He sees it as a jewel caught by the sun.
It makes her simple act
a folio of beauty, a compass,
a beneficence for which he wants to bless her
in this twilight of gestures.
His eyes, she must believe,
still pull him toward her,
his Ithaca for which he rudders.

— By Robert Eastwood

Robert Eastwood's work has appeared in many journals, online and in print. Recent appearances are: The Dirty Napkin, The Wild Goose Poetry Review, Poetry Quarterly, Full Of Crow, The Legendary, fiction 365, and Loch Raven Review. His poetry has won the Berkeley Poets' Dinner Grand Prize and the Ina Coolbrith Circle Grand Prize. His chapbooks, The Welkin Gate, Over Plainsong, Night of the Moth are by Small PoetryPress. He has twice been nominated for the Pushcart Prize.



Photo by Jaclyn Arquette

Jaclyn Arquette is currently a third-year medical student at VCU School of Medicine. This photo was taken in the rural village of La Hicaca, Honduras, where she took part in the Honduras Outreach Medical Brigada Relief Effort (HOMBRE) following her M1 year.

Reflections on an International Medical Brigade

By Marilena Lekoudis

May 26, 2013 was approaching faster than I anticipated. That was the day I was set to travel to Honduras for an international elective through the Global Health and Health Disparities Program at VCU. We were traveling for one week

as a medical brigade to open a clinic in the rural region of Yoro. There we would offer preventive services, basic medical care and education, and conduct global health research. The group would include attending physicians, residents, fellows, pharmacy and medical students and nurses. Months of preparations finally

culminated in five full days of clinic in the resource-limited, rural and mountainous region of Yoro. It was an exciting and rewarding experience and I felt very lucky to have been involved with a group dedicated to improving the overall health

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of a community with little access to health care.

I have traveled to poverty-stricken regions before, but this was the first time I felt immersed in the culture and participated in a service project. We slept, ate, and worked at the local school. This was humbling and proved important for understanding their way of life. Although I had expected this prior to arriving, it was eye-opening to see how little basic care was available in these Honduran villages. At times I felt our efforts were minuscule compared to what we can offer at VCU, but at the end of the day, I realized how small amounts of medical attention and medications can go a long way. In addition to our daily clinics, the water filter program was particularly memorable. Our small team managed to sanitize and seamlessly assemble over 100 water filters for distribution to families whose sole source of water was the local river. Creating a device that would prevent significant morbidity from waterborne illness was a powerful moment that I won't forget.

One of my goals prior to the trip was to gain exposure to tropical and rural diseases uncommon in the U.S. I witnessed complaints not typical to my middle-aged male veteran population at the VA primary care clinic, such as fungal skin conditions common to humid areas, severe dehydration, and parasitic infections. It was also refreshing to focus on the physical exam and clinical skills for the assessment and treatment of patients. One elderly female who presented with shortness of breath exemplifies

this point. In the absence of x-rays and spirometry, I was forced to rely exclusively on my clinical skills for both the diagnosis and treatment of her shortness of breath. The way we managed her asthma exacerbation without ancillary tests gave me more confidence in the physical exam, and is something that I can carry over to my daily practice. Moreover, upon returning to practice in the U.S., I have become more keen to the resource-rich environment that I have trained in thus far. While there had been a few moments where I took a step back prior to ordering a lab test or imaging study, I also reflected on how fortunate we

are to have them readily available. This international experience gave me a renewed respect and appreciation for the relevance of clinical skills, and for the easily accessible ancillary services and diagnostic testing at VCU.

This brigade certainly increased my awareness of the global health disparities across countries and how stark contrasts in care exist among impoverished communities, even in comparison to some of our patients at VCU. This invaluable experience was not only personally enriching, but also is something that will shape and continue to influence my future medical practice. ✧

Wellness Check



Photo by Eveline Chu

Eveline Chu is currently a third-year medical student at VCU School of Medicine. This photograph, and the one on page 25, were taken on an international medical outreach trip. The photographer notes: I was a part of the HOMBRE medical outreach group in Dominican Republic summer of 2012, where we held clinic at an elementary school for an underserved community. I really enjoyed this experience because I was able to combine my two passions — providing medical care for those in need, and traveling and learning about a culture different from mine. I wish to incorporate global and international medicine into my future medical career.



Photo by Kelly H. Chen

A hungry dog stares at a young student's meal after clinic. Taken in Pinares, Honduras on the HOMBRE Medical Mission Trip, June 2012.

Haga Así: Do as I Do

By James P. Mendoza

I was sweaty, uncomfortable, and hadn't showered in a week. Lying there on my sleeping pad on the floor of a worn-down school, I looked up into the mosquito net and asked myself, "Why did I choose this again?"

In September 2012, I had to choose a medical brigade site in Central America. I knew that a mission trip abroad had the potential to expose my naïve self to the struggles of global medicine, but I wasn't sure how much of my first-world luxury I was willing to sacrifice to experience them

first-hand. I eventually chose a medical relief site with no electricity and no running water that was largely isolated in a mountainous region. I chose a medical brigade in Northern Honduras, and it was the most meaningful decision I've made in my short time as a medical student.

We were a group of students, interpreters, nurses, and physicians, and the initial days were a test of endurance. We slept on concrete floors and awoke at 5 a.m. to the sound of roosters and donkeys. We braved the outhouses and navigated pitch-black

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"Prior to our brigade, instructors taught us to say 'Haga Así' if our Spanish fails while performing a physical examination.

Translated to English, this means 'Do as I do.' I wasn't aware that after my time in Honduras, it would be me that was imitating them."

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nights with flashlights. These memories are still very fresh and I feel that the rugged environment resulted in a unique bond between the 23 members of the medical relief trip.

Yet, what seemed like adversity to us was simply normal to the locals. And despite the living conditions, health problems, and poverty, life was gratifying and fulfilling for many. For instance, young boys of the village would play soccer with goals that had no nets. Many of the boys were barefoot, even in a field covered with animal droppings. Still, from the players yelling “¡aquí aquí! (here here!),” calling for the ball, to the younger ones on the sideline acting as their commentators, the group’s camaraderie helped them share an enjoyable and meaningful experience even in impoverished conditions. It was heartening to be reminded that togetherness, which I saw in people from a culture vastly different from ours, is still universal.

Indeed, values like this kept surfacing. While treating patients, I became aware that some families walked nearly three hours from their village to come see us in clinic. They first walked in dirty clothes because they would get sweaty. Then, as they got near the clinic, they would bathe in the river and change into their nicest church clothes before the visit with the medical team. I remember one woman, smiling through her fatigue. The only thing more beautiful than her sundress was the amount of respect she had for our group.

For Honduran children, collecting bracelets on the wrist is fashionable.

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“Sonríe”



Photo by Kelly H. Chen

The young lady on the right requested that I take a picture of her, her mom, and her sister. When I asked them to “sonríe” (smile), I got the best response ever: a continuous fit of giggles and laughter. Taken at one of the schools we hiked up to in mountainous Pinares, Honduras, where we conducted dental/vision/health screenings as part of the HOMBRE Medical Mission Trip in June 2012.

Welcome and Curiosity



Photo by Eveline Chu

Medical clinic held at an elementary school in Paraíso, Dominican Republic.

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The more bracelets one has, the better. As I was interviewing a young boy in the pediatric clinic, I noticed a bright orange rope around his wrist, tied as a bracelet. I realized it resembled the rope we used to hang tarp from the ceiling. One of our group members had tossed the leftover rope as trash, and it was now the child's newest wrist accessory. The village made use of nearly everything and wasted nothing. This belief resonated even with the children.

Prior to our brigade, instructors taught us to say “Haga Así” if our Spanish fails while performing a physical examination. Translated to English, this means “Do as I do.” I wasn't aware that after my time in Honduras, it would be me that was imitating them.

Because of this trip, I have learned some valuable lessons. I will resist complaining, knowing that my worries may be dwarfed by the problems of my patients. I will be respectful and professional, no matter how tired I may feel. Finally, I will make the most of what is in front

of me, just like the Honduran boy with the orange bracelet. These values will remain with me as I continue my medical career. The cultural, economic, and social diversity of patients I will encounter may seem daunting at first. Yet, the people of Northern Honduras will remind me of core values we all share: community, humility, and respect. Indeed, Haga Así. ✧

James is a second-year medical student at the Medical College of Virginia. Last summer, he and his classmates traveled to Northern Honduras as part of the Honduras Outreach Medical Brigade Relief Effort (HOMBRE).

field notes from the buried box of an almost-surgeon

i think i am in love
with little plastic needles, sterile
blues, the arrogance
of early a.m. overhead
lighting; size 6 latex
gloves that know
the thrill of a one-
handed knot
in 2-0 silk, over
and under
and over again;
back pockets
stuffed with blunt scissors &
stethoscope & note-
cards that read
like a map through
heartache:

*the femoral nerve
courses laterally
to its artery as it passes
the triangle of Scarpa.
blood enters the liver
at 1500cc a minute,
mostly through the portal
vein, whose pressure
should not rise more than
5 millimeters of mercury
above the pressure
of other veins. neurogenic
claudication causes
pain on spinal flexion,
comes from central
locomotor stenosis.*

other things too i
knew, that i would have
learned harder
had i thought they
could save you...

some nights
i miss those mornings,
sunless & taped
into narrow tubing
with adhesive
that still pulls,
even now.

— By Joanna S.Lee

Joanna Suzanne Lee has never been formally trained in any kind of writing. She can, however, dissect the brainstem of a neonatal mouse or diagnose your lower back pain. Her first full-length book of poetry, *the somersaults I did as I fell*, was released in January of 2009. Her work has recently appeared in *Contemporary American Voices*, *scissors and spackle*, and *Caduceus*, among others. She hosts monthly poetry events in and around Richmond, VA, her adopted home, where she is also on the Board of Directors for the James River Writers. She writes (semi) regularly at the-tenth-muse.com.

COAN Trip, Leon, Nicaragua



Photo by William Mark Bruch III

Mania

My face is afire
Lit from within
By a brilliant madness
I want to harness this
Kinetic energy
For something useful
Like burning down
Buildings
Or felling
Trees
I'm alone in my head
Ready to release and
Relinquish
This terrible secret
Upon an unsuspecting world

— By Debbie Collins

Being manic in the throes of a bipolar episode can be exhilarating, but this poem reflects the very human side of mania and destruction, whether internal or (figuratively) external.

Into the Blue

I dive in to the pool mid-day blue
post hospital stress across
my back and blades, rivers and tests —

The hum of the day is caught in my ear
then pushed away through the swish
of my hands, the forced hot blow of breath
through my nose and the decisive turn

at the end of the lane. There is a calculated
focus on the black line across
the bottom, a cramp and release with the
kicking. The water echoes to the roof, blank

with voices. The sun shines its intensity through
the large panes. A draft billows through
unnoticed until I crawl out of it and shiver.

— By Lorraine Waltz

Lorraine Waltz RN, BSN, OCN has practiced full-time as an oncology nurse and manager for more than twenty years. She is a graduate of Lycoming College and has written poetry about the medical experience since her career began. She lives in Richmond, VA, with her husband, two children, two dogs and cat.

Keeping Birth, Losing Fear

A 21st Century Birth Story

By Hannah McCormick

The first time meeting Hawa I buzzed her ringer in the apartment building in the lively immigrant neighborhood of northwest Montreal. In a nervous French that became more fluid as I spoke, I introduced myself and the shadowing doula. She greeted us with a kiss on either cheek. Hawa was 28, from Guinea, and having her first baby alone here, due on August 20th. She was already very pregnant, with a colourful African skirt wrapped around the dark skin of her belly.

I have been asked to explain the term “doula” countless times, and each time I fumble for the right words. I always manage to express a thorough, though convoluted answer. Here is the lengthy definition: a doula is a non-medical companion to women throughout pregnancy, labour, delivery, and the post-partum period. Doulas offer emotional and physical support throughout the process of birth. Doulas allow the woman to labour in her own way, minimizing fear and fostering a safe, quiet space in which the woman can experience the birth process.

Hawa did not know what a doula was — she had never heard the word growing up in Guinea or in France, where she had recently emigrated from. I explained the role simply, hoping that it would become clear as time progressed. I left her apartment after our initial meeting feeling energized by the presence of a beautiful pregnant woman

and the birth ahead, though I had the feeling she was bewildered by our sudden entrance into her birth experience. Two young, white, English-speaking women had suddenly entered her home, trying to express to her the importance of the birth experience, something she had assumed was part of the jurisdiction of doctors and hospitals. She did not want a cesarean section, but she had not thought about other medications, assuming that heavy pain medication like an epidural may be necessary, depending on the doctor’s advice.

In the next meeting we discussed a typical labour and delivery from start to finish. A doula’s role during labour is to facilitate pleasure. When certain pleasures are experienced, especially those connected with the love feeling, the brain releases the hormone oxytocin. Oxytocin stimulates uterine contractions which open the cervix and push the baby through the pelvis and the birth canal. Consistent pleasure throughout labour not only eases pain but helps the woman to labour quickly and safely. I explained to Hawa the process of birth so that she could know what to expect and feel in control of her situation. We explained the ways we would support her during labour at home and in the hospital. After leaving her, I was still unsure of her reception of us. The education I was imparting was helpful, but she was still wary of our role. More than anything, she had to trust me.

It wasn’t until I got up to leave after

our third and final meeting that I knew Hawa had let us in to her birth process wholeheartedly. I could sense she wanted us there as she remained sitting, searching for any last questions. I finally had a sense of what we were doing. Birth is not something to be frightened about. We eased that fear, just by being there.

Hawa called on a Sunday afternoon five days past her due date. She was having strong contractions she had timed at eight minutes apart. I got on my bike and raced up the hill to her house, my mind consumed with excitement and anticipation. I arrived and she was labouring alone on the couch. With red eyes she looked incredibly tired. Her limbs and upper body seemed to shrink behind the immense belly she held on her lap. I sat with her quietly, and comforted her when contractions came. Soon enough the contractions were only five minutes apart, and in both of our nervous excitement and anxious inexperience, we decided to rush to the hospital. She didn’t want to walk with the intense pressure on her cervix; the birth seemed imminent.

At the hospital, we were confronted with bright fluorescent lights, a room full of monitors, and busy nurses asking questions, taking temperatures and reading blood pressures. The resident asked if Hawa wanted an epidural before she checked the dilation of her cervix. Hawa wanted to wait. The

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resident dismissed her response. The resident's simple conclusion seemed to be that if a patient is in pain, then there is no reason to refuse medication. The doctor checked her and she was one centimeter dilated, meaning she was in very early labour. After all this anticipation and excitement, this was incredibly disappointing to Hawa, though first mothers often progress slowly.

She was almost sent home when the baby started having heart rate deceleration with each contraction. Though it never decelerated outside of the normal rate, staying mostly between 120 and 130 beats per minute, they immediately gave her an oxygen mask and IV fluids. This filled the room with a sense of emergency. Hawa laboured for hours in this way, forced to stay attached to monitors, forced to experience the stress and fear of concerned doctors and forced to hear the constant throbs of her baby's heart rate that resonated through the room in the silent pause between contractions. We would wait quietly, resting, listening to the monitor, and as the contraction came, I held her and massaged her back. I rocked and swayed with her for hours in almost silence. At 10 p.m., she asked for an epidural. She was frightened and exhausted and disappointed in her progress. She could not be encouraged to wait.

I had explained to Hawa that epidurals can slacken the pelvic floor muscles which help the baby maneuver through the mother's pelvic bones. She knew that the horizontal position of the mother, unavoidable by the complete numbing of her legs, stops the mother from helping the baby move

down through her own pelvic movement. In the midst of labour though, there is no room for dialogue. It is only sensation, and Hawa's pleasure could not be maintained in her environment. I affirmed her choice, and within minutes I was holding her hands as they inserted the catheter into her spine.

As soon as the epidural was administered, the doctor returned to give a vaginal exam. She had only progressed to one and a half centimeters. Exhausted mothers and stressed fetuses need intervention, and with that slow of a progression, the induction of her labour began. The doctor broke Hawa's water and manually stimulated the opening of her cervix. The doctor inserted a catheter that opens the cervix by inflating a small balloon that stretches the opening. Finally, as Hawa tried to rest, the nurses administered pitocin, a synthetic oxytocin, which stimulates intense uterine contractions that are almost impossible to labour through without pain medication. Hawa continued to feel incredibly intense contractions stimulated by the pitocin throughout her epidural. She could not rest with the immense pain and constant disturbance.

Around three in the morning she was checked again. She had just been turned to her other side, and there were more severe decelerations of the baby's heart rate. The doctor decided to call obstetrics. An older man entered the room, and without an introduction, or an acknowledgement of the woman in

labour, he checked her cervix, and almost scoffed at her progression to three centimeters.

The doctor told Hawa she would need a cesarean. Hawa, quiet and reserved even in the midst of contractions, responded with a deep and strong *Non*. She did not want surgery, she had expressed that in our first meeting. Now resistance was useless. The doctor told her that her cervix was inflamed, the baby was in a posterior position, meaning he was facing towards the mother's

“I knew that the powerful technologies of hospitals often end up working against a woman who could otherwise labour and deliver her own baby.”

pubic bone instead of the more desirable position of facing the spine. Labour would be very long and difficult and the baby was in distress.

I knew that the powerful technologies of hospitals often end up working against a woman who could otherwise labour and deliver her own baby. I did not expect we would get to that point with Hawa. I believe that women who work hard on their own, listening to their body's cues and the loving support of partners, friends, doulas, nurses, midwives, and doctors can have their babies naturally. Those babies enter the world alert, open eyed, and with an energetic body, unaffected by pain medication. These women feel empowered as mothers not only because they brought a baby to term but because they took control of their labour and delivery. Hawa had not been given this opportunity in this hospital system. I

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thought I could give it to her as a doula, as a companion in the overwhelming structure of a hospital. But I could not. I could only help at that point by being there. I kept my thoughts and tears to myself, and I told Hawa that it was fine, a cesarean was always a possibility, and that she would do beautifully.

I went with her into the operating room. We kept a quiet soft space behind the blue sheet raised to block the view of her sliced abdomen. I brushed her hair from her face and reassured her with a calm voice and a slow touch. Her baby was lifted out of Hawa's view, crying strongly. I raised myself above the blue sheet, and saw his beautiful curved spine and backside, a pale blue white still covered with Hawa's bright red blood. There is nothing burning with more newness than a just-born baby, no matter how he comes out. I kissed her and told her she did it, she brought a son into the world, she was a new mother.

Hawa and her son were separated for four hours while she went to recovery and he went to the nursery. The shadow doula and I both tried to keep the new mother and the new son well loved. Hawa was finally brought up to the maternity ward where her son waited quietly. She put him to her breast immediately, and he was suckling within seconds. After such a long separation and a traumatic birth, I could not believe the ease at which he fed. For Hawa, holding her baby against her full dark breast was the incredibly

sweet fruit of a fraught night of heavy labour. I kissed her goodbye when the room was quiet.

I left the hospital and relived Hawa's story with my doula mentor on her sunny back porch. I asked many questions. Did the vaginal exams cause the inflammation? Did we go to the hospital too quickly? Could we have known anything about the posterior position? I thought that with these questions answered I would go into my next birth experience better equipped, and that I could prevent the same sort of trauma that Hawa endured. But we were not told the baby was posterior. We could not have refused the eleven total vaginal exams and the manual cervical manipulation. We could not have made a better judgement about the fetus's stress levels than the doctor. We did what we could in the moment and we were present throughout the night.

In western culture today, pregnancy, labour and delivery are medical dilemmas. Labour and delivery are generally considered terrifying and dangerous processes that only a doctor's lengthy medical training will remedy. Pregnancy is seen as a problem of a too large growth in a too small body, causing all sorts of logistical, emotional and health issues that only medicine and hospitals can bring to an end.

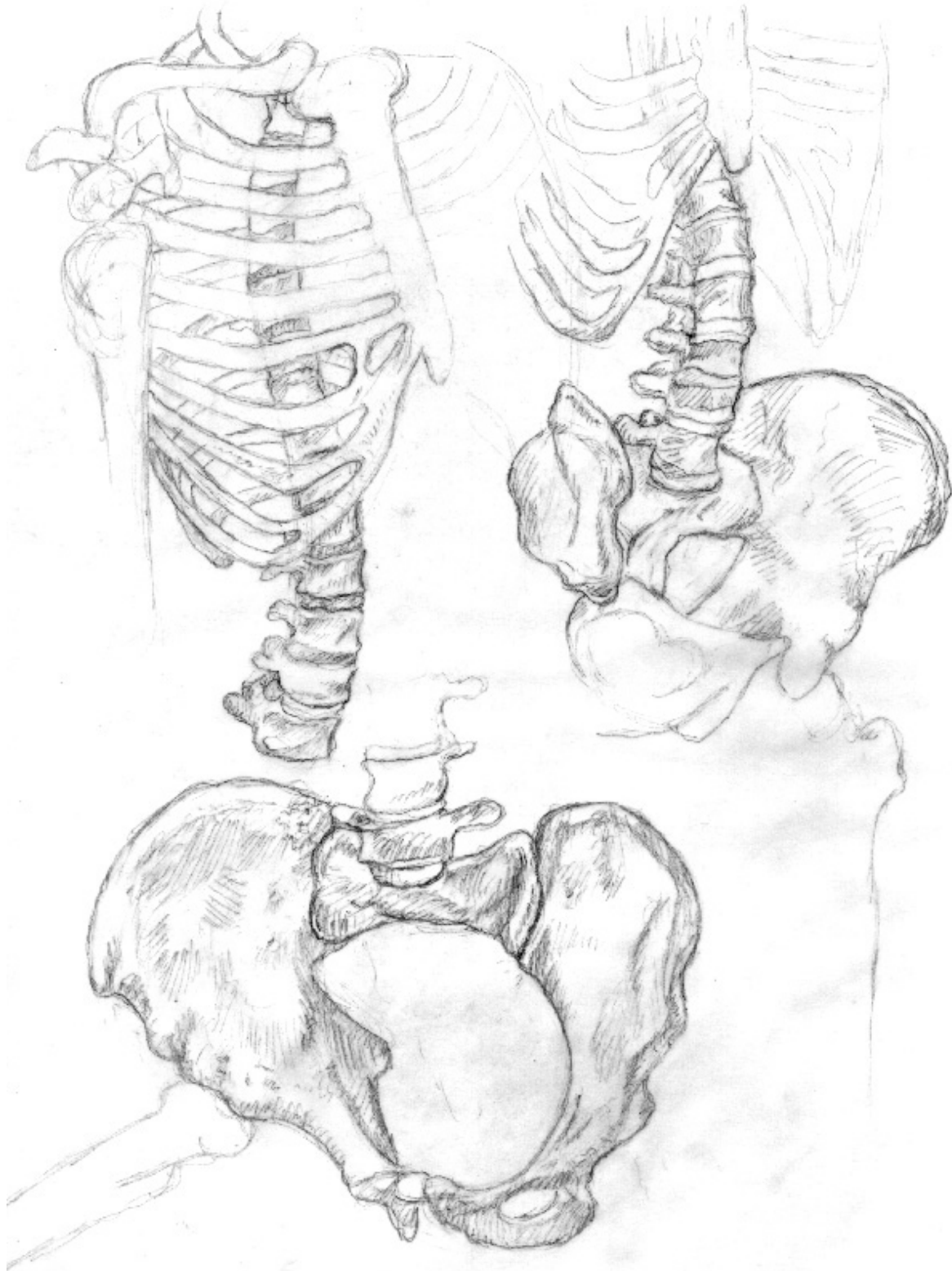
The medicalization and pervasive sense of fear and emergency within the hospitals give licensed medical professionals an undue power over the birth process. Trained companions to women, whether they be doulas, midwives,

or doctors, cannot save women from the frightening birth process through medical interventions. Mothers and fathers can only be saved from their fear through education. Parents should understand the birth process anatomically, emotionally, and practically, the way adolescents are taught about their changing bodies straightforwardly and honestly at the appropriate time.

When it came to labour and delivery though, my role as an educator and advocate changed. I was there to accompany her on her difficult journey through the medical system. I was there to keep her feeling safe and not alone. I was there to give her love and affirmation. I thought that by being with Hawa I could single handedly save pregnancy and birth from illness, and women from passivity, but I was wrong. Hospital births cannot be saved from illness. Women, especially minorities, will be forced into passivity as patients in the immense and buzzing medical institution. Birth must be taken out of the institution, and acknowledged as a natural and empowering process. Women must be educated so that they can strive to make their own decisions for the birth that they want. Women in need must be given more attention and care, because even when facing the most difficult situation, such as an emergency cesarean after a long painful labour, it helps to not have to face it alone. ✧

Hannah McCormick grew up in both Montreal and Richmond. She completed a humanities degree at Concordia University's Liberal Arts College in Montreal and was certified as a doula by Montreal Birth Companions, a non-profit organization working to serve women in need throughout pregnancy and labour. She now lives in Richmond, VA, and plans to become a certified nurse-midwife and to always continue to write.

Skeletal Studies



Drawing by David J. Bromley

David J. Bromley began taking his drawing classes to the MCV Gross Anatomy Lab in the 1990's. In the 2000's, the coursework was developed into an Honors module, "Anatomy for Artists." The rigor involved in the drawing of this type is of highest value to the art student and art professional: critical observational representation is part of a complete artistic practice, and gross observation is the anatomical component of this study. Here is an instructor example. Many thanks to Dr. Seibel (ret.) for the opportunity and his vision. Preparatory Medical Illustration is now part of the curriculum at VCU Communication Arts.

Water, Air, and Ice

“Water, air, and ice” he smiled,
“the only things I need to live.”
And food? I asked, is there no use?
Nor rest it seemed, for he rarely did.

He lived in just the way he said:

content to sleep without a bed,
content to wake before the sun,
and pay no mind as it set, for
“there is work to be done!”

Moved by ideas in his busy head
and a scalpel in his laurelled hands,
he existed simply — only fed
by the pleasure of mending the broken ones.

And I laughed, because I liked the last:

that among the water and the air,
he thought ice to be as necessary —
as if it were his little spoil
amidst a life of austerity.

— By Catherine Pearson

ABOUT THE COVER PHOTO

Waiting



Photo by Bryan Jarrett

As I was walking down the hall at the end of a shift at the Veterans Hospital, I looked and saw a patient holding his IV pole, staring out the window on a beautiful summer's day. Even before I found out he was waiting to get open heart surgery the next day, he reminded me of how, even while we are trying to help heal patients, ultimately they are in some way trapped in the hospital, waiting.

Bryan is a medical student going into Emergency Medicine who also loves the outdoors and photography. Although he usually shoots landscapes, this particular scene struck him on his way out of the VA Medical Center.