

# CADUCEAN LIGHTS



A MAGAZINE OF  
ART AND LITERATURE

2020

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# Introduction

It is with great pleasure that we present the inaugural issue of *Caducean Lights*, a journal of art and literature at Beth Israel Deaconess Medical Center. The title of the journal is derived from the former symbol of Beth Israel Deaconess Medical Center.

In Greek mythology the Caduceus was a magical staff belonging to Hermes and entwined by two serpents. In return for Hermes' gift of a musical lyre, Apollo presented the Caduceus to him. The Caduceus is often mistaken for a well-known symbol of medicine - the Rod of Asclepius; a staff entwined by a single serpent associated with the Greek god of healing. However, the Caduceus was believed to be able to comfort the dying and even return the dead to life. While, the Caduceus may be incorrectly associated with medical care, its association with exchanging the arts for rejuvenation and healing make it fitting for a collection of art and literature dedicated to the medical humanities.

In 1996 the Beth Israel Hospital merged with the Deaconess Hospital to form Beth Israel Deaconess Medical Center. The stylized, striped Caduceus symbolizing Beth Israel Hospital and compassionate, patient-centered care, was joined with the flaming light from the Deaconess' ever-burning candle, representing the light of new knowledge. The combined symbol has guided the members of the BIDMC community throughout the years to provide humane, patient-centered care with an everlasting commitment to education and research.

Through this journal, it is our hope that *Caducean Lights* will continue to serve as a beacon for Beth Israel Deaconess Medical Center's dedication to humanism and patient-centered care by guiding artistic reflections unique to the transformative health care experience.

It has been deeply moving to see the abundance of creativity in the Beth Israel Deaconess Medical Center community and it is our pleasure to share *Caducean Lights* with you.

Sincerely,

Samantha Pop, MD  
Editor, *Caducean Lights*  
Katherine Swan Ginsburg Humanism in Medicine Fellow, 2019-2020

Jonathan Crocker, MD  
Director, Katherine Swan Ginsburg Humanism in Medicine Program

# Katherine Swan Ginsburg

**K**atherine ("Kath") Swan Ginsburg, MD, MPH was a medicine intern and resident at Beth Israel Hospital, who died of cancer at age 34, shortly after completing her fellowship training. Kath was widely admired for the compassionate care she gave her patients, the warm collegiality she showed her fellow trainees, healthcare team members and hospital staff, as well as the strong intellect she demonstrated in her practice of medicine. In her memory the Katherine Swan Ginsburg (KSG) Humanism in Medicine Program was established to help foster these values in future physician trainees at Beth Israel Deaconess Medical Center, through exploring and highlighting five key tenets of humanism: Compassionate Care, Communication and Collaboration, Clinician Well-being, Reflective Practice, and the Arts and Humanities. Each year, internal medicine residents vote for winners of annual KSG awards given to the physicians (in faculty and resident categories) who best demonstrate these values in their own care of patients and work. KSG fellowships offer internal medicine residents support in completing a project in humanism in medicine during their junior or senior year of training.



It is an honor to dedicate the inaugural edition of *Caducean Lights* to the memory of Katherine Swan Ginsburg.

# Cover Art

“Views from the Farr” by Rahul Maheshwari, MD

# Table of Contents

## POETRY

Tornados, Floods, Earthquakes-Natural Disasters	1	Claire Curran-Balquist
ICU	3	Samantha Pop
On fires and high rises	9	Ali Corley
Meanwhile	15	Barbara Lam
I Am My Patient	17	Alex Goldowsky
Chilling Rain	22	Evgeniya Larionova
On Cadavers and Beyond	24	Ellen Zhang
Skin	25	Sarah Ohnigian
#TrendingIllness	31	Jose Parra
An Ode to the "Berg"	39	Ijeoma Julie Eche
On Hematology	40	Ellen Zhang
The Junk Collector	42	Janet Fantasia

## PROSE

DNR	2	Ali Corley
The Conversation	5	Glen Bublely
Cut Flowers	8	Samantha Pop
Stillness	11	Akshay Shanker
Julio and Sra. Lopez	18	Julian Max Aroesty
CN4	27	Sarah Petitto
A Blanket of Caring	33	Eileen Barrett Wyner
The Patient's Face	35	Jean Adomfeh
Things I Cannot Change	37	Johnna Marcus
A Sacred Vessel: The Covenantal Stories We Hold	44	Nancy Rigelhaupt Smith
Hands of Service	48	Rebekah John
Humanism at BIDMC	51	Stafford Cohen
Artificial Intelligence	53	Arindell Arnold-Penny

## VISUAL ART

Makings of Mucor	4	Polly Van Den Berg
A Pop of Spring	7	Jonathan Crocker
Leaving Longwood	10	Rahul Maheshwari
Berry	14	Lika Targan
The Doctor is Out: View From the Green Monster	16	Ali Corley
Inchworm	23	Lika Targan
Aspiring Aspergillus	26	Polly Van Den Berg
Even Statues Do Masking	32	Polly Van Den Berg
Boston Adopts Universal Masking	36	Josh Dubow
Bicycle	41	Lika targan
Masked	43	Jaya Kanduri
United in Chaos	47	Supriya Rastogi
Quarantine Walks	50	Rahul Maheshwari
Fall Magnolia	52	Nazila Shafagati

# Tornados, Floods, Earthquakes- Natural Disasters

Claire Curran-Balquist, RN, BSN  
Neonatal ICU RN

It feels like a tornado in your room  
A whirr of pumps, screeching monitors, flashing alerts  
Yet, silence in the eye of the storm  
Silence from you- no sign of life  
No reactive pupils, no brain activity  
Outside the door- a flood gushing  
An overflow of patients, coming in waves  
SOS signals -searching, pleading for more staff  
Craving relief  
Two doors down, mere yards away  
Another beautiful infant damaged irreparably  
A brain that will never grow in knowledge  
But, perhaps will feel love for now  
Surviving for the moment, as we are  
Her fate destined to be as yours, not for this world  
A deluge of tears, broken hearts, scarred families  
We continue to navigate in the clutter, nearly impassable routes  
Eyes bleary, teary, overwhelmed- yet focused  
Rumblings, obstacles, emotions strewn about- stepped over  
When the shift ends- we leave, but the aftershocks persist

# DNR

Ali Corley, MD  
Internal Medicine, PGY-3

*Written in August 2015 on my first clerkship as a 3<sup>rd</sup> year medical student*

“Do not resuscitate.” I said again. Everyone was looking at me. The doctors by the door who had just run in breathless, the nurse in the bathroom with some blood on her scrubs, the resident on her knees in front of a man (or was he already a body at that moment?) checking for pulses that were not there and would never be there because his heart could no longer push blood through those vessels. I had to say it again, because I was the one who knew. They didn’t know the man who was lying on the floor. I guess I knew him. I met him yesterday.

He came with his daughter. He was demented and strange, but in a funny way. Hapless and helpless. Grouchy at first, but he then became silly, and his daughter and I laughed at his bad jokes.

Then they pronounced him dead. And people went about their business. There were patients to round on, notes to write...but I didn’t want to leave him alone. I lingered for a moment, but finally I left too.

I felt embarrassed by my emotions. I felt ashamed by my lack of emotions. An old attending felt awkward around my tears. A new resident handed me a coarse paper towel to dry my eyes and said, “you get used to it.”

When his daughter came, I was in the hallway. She looked around frantically, and then she saw me and our eyes locked. She remembered me from yesterday. She walked over and opened her mouth to say something, but nothing came out at first. She looked tired and she looked stressed and she looked sad and she looked confused. Finally, “What happened?”

So I had to tell her what happened. That her father was doing fine...that I walked by his room last night and he was watching infomercials at 3am. That his eyes were transfixed on the television, with the glassy look about them that happens when you’re up too late and tired, but still can’t sleep. He looked entertained though. That he was just here for cellulitis, but something terrible must have happened. That at some point, he had gotten out of bed to go to the bathroom. That the next thing that happened was a blur because my pager went off and it was my first code blue so I ran to his room and all I saw was his body half naked on the floor, with bony ribs and stick like legs. That there was some blood on his head and the tile bathroom wall. That a nurse had started compressions and his chest looked as compliant as those dummies that we practiced on. That a telemetry strip was brought to the room revealing erratic scribbles extending up and down across the page. That even a medical student on her first clinical rotation knew something was wrong. That, amidst the fray, a voice shouted, “What is his code status?” And suddenly everyone was looking at me while I found my voice and I felt responsible and unprepared.

And I said again, “Do not resuscitate.”

# ICU

Samantha Pop, MD  
Internal Medicine, PGY-3

The space between blips on the monitor lengthens  
My breath becomes short. Held.  
Until the next blip unravels  
The space feels un-ending  
And I feel uneasy  
Unknowing  
If the next  
will be  
the  
end.

The code was successful—returned circulation.  
Yet the all-knowing, unyielding, circle of life  
and that which is contained in the  
infinite space between blips  
on the tracing  
rolls on  
never  
decoded.

Blinded by lines and tubes I had not really seen her  
And finally ask, “can you tell me about her?”  
Her daughter smiles, replying, “she’s feisty,”  
Recalling her 4’9 mom had loved driving  
her Escalade, often hitting the curb,  
Unstoppable.

It’s time to let go, she says. I nod in agreement.  
Still holding my breath as I watch the screen  
At the nurses’ station  
Until the space  
between blips  
Continues  
Forever.

I see you—I think to myself—as I’m called back in the room to pronounce her.

# Makings of Mucor

Polly Van Den Berg, MD

Fellow, Department of Infectious Disease



# The Conversation

Glenn Bublely, MD

Associate Professor of Medicine, Division of Hematology/Oncology

**T**ruth be told I can't wait to get out of this room. My patient's daughter, a woman from out of state named Martha, told me she was flying in to see her dad, now hospitalized with end stage cancer. We arranged to meet in his hospital room early before my clinic day begins.

I have been here only 5 minutes. After I updated her father's condition, she has asked the same question 3 times, in short how could her father's cancer be so advanced if he a was under continued care from his PCP, and now me? Why didn't Dr. Jones catch the cancer before it spread? Wasn't he checking him yearly?

"Sometimes aggressive cancers grow almost overnight", I tell them "even the best screening efforts don't find these cancers when they are early".

I can't even remember if he had PSA screening, but what does it matter now .

Then she asks, "how could his cancer have advanced so far? How come there aren't other treatments"?

I wonder if she knows that there were some recently approved drugs that he did benefit from and prolonged his life. The problem is that sooner or later we inevitably get to this point, to the conversation that no one wants to have. We are essentially out of therapies. I am suggesting palliative care, no more chemotherapy, hormonal therapy, immune therapy and no more clinical trials.

"Martha we did have some luck with some agents, I wish they would have worked for a longer time", I tell her. He has been dealing with this disease for 7 years.

"But I thought you could always find something else to control it, I just don't understand?" she asked

I have no response. But I'm thinking News Flash.....people still die of metastatic cancer.

I look over at her Dad, a likable man lying in a hospital bed with his wife is sitting at his side. They are holding hands, both quiet. It strikes me that my job here is to give the bad news to Martha. I'm not sure how much she has been told of her dad's battle these past years.

Martha then opens up her phone and looking down says " Do you know anything about curing cancer by starving it of sugar? How come we haven't tried any dietary treatments"?

"I am aware of the cancer and sugar theory and I have had several patients try this, but I have never seen a response in this disease", I say flatly.

Martha looks angry. I know I have been too harsh. What good does it do to be judgmental about her last minute attempt to save the day for her Dad? It never works for me to lose my temper, never, but I

seem to keep doing it . I have been having these talks with patients and their families for now 40 years. Why can't I get it right? I know that everyone in the family is afflicted by prostate cancer, daughters, and spouses, everyone. Besides its not likely Martha's fault that she hasn't been involved. Her parents probably haven't shared some of the conversations we had over the past few months when we went over his declining options, and by inference, his declining life span.

I probably should asked her parents if they were sharing news with family members. Or, at least, made very sure that his wife, who came to every clinic visit, and the patient, knew what the implications were of progression on drug after drug. Sometimes it takes a sledge hammer to break though the wall of understandable denial, and who has the stomach for that. I have an unfortunate tendency to get through these out-patient visits as soon as I can, letting sleeping dogs lie until it's obvious to everyone that things are bad. But that approach can rob patients and families of the gift of time, of reunions, of phone calls of solace and sympathy. If Martha knew of her dad's condition she probably would have been here months ago.

They want to know what happens next. I go on to explain home hospice making it sound as good as it can be even though if there was ever a loaded word in medicine, its *hospice*. "Going into hospice care doesn't mean I won't still be your doctor, you are not losing me but gaining a team of people who can care for you in your home", I say.

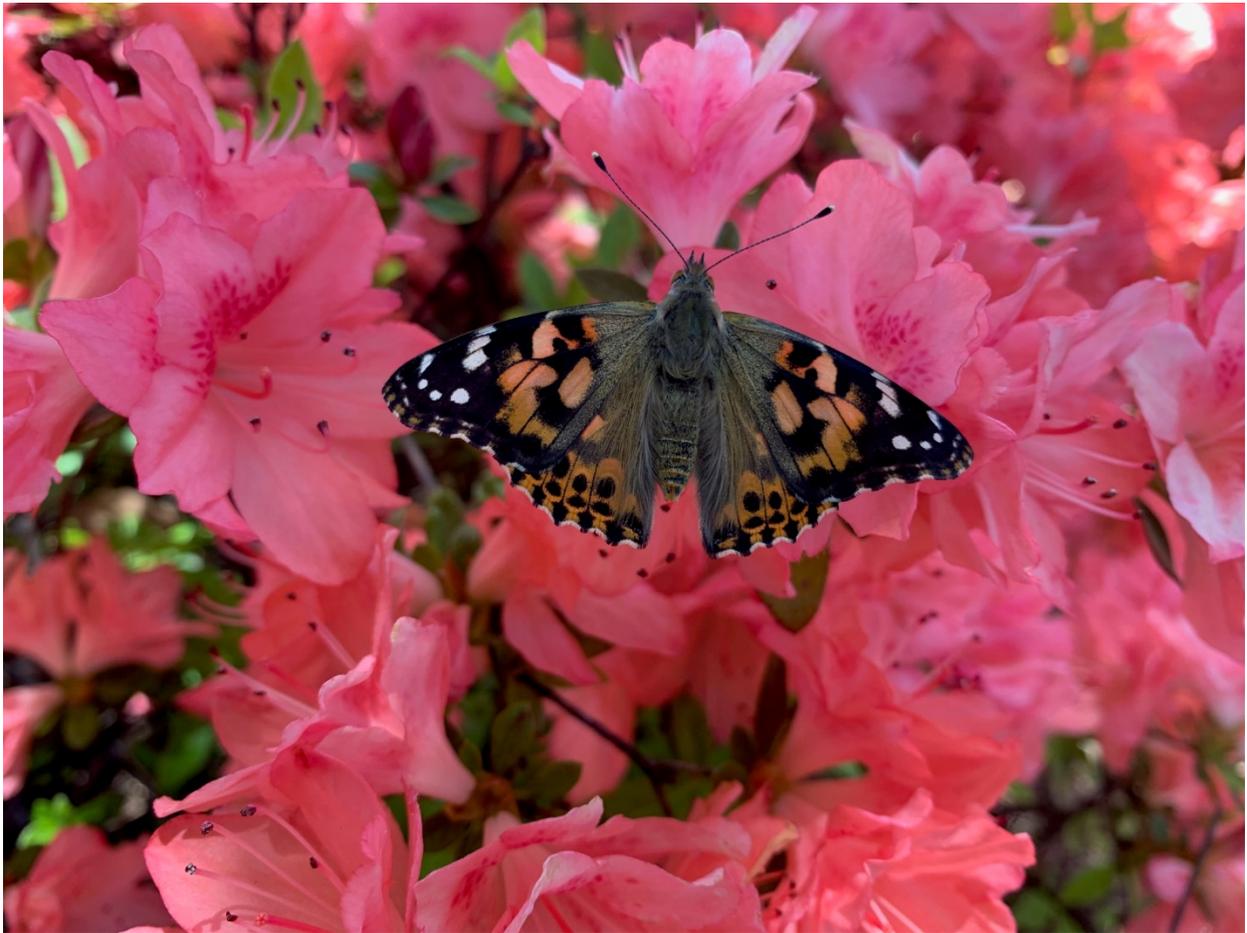
This is a stock line, I don't know if it makes anyone feel better, certainly not Martha. But making anyone feel better about anything was an unlikely outcome from the moment I walked into this room. How could it be, I just reiterated to the patient with his family that he likely had weeks to live. How this could be anything but crushing. We all want more time, despite the number of months or even years we get from medical treatments.

Feeling awkward, I stand and leave, saying I would be back tomorrow before he is discharged. This is likely to be the last time we see each other. I doubt my patient knows that yet. The room is quiet as a tomb.

As I walk towards the elevator lobby, I'm grateful to see the down elevator button already pushed, so I can get off this floor as soon as I can. I am already emotionally drained, even as I walk to clinic and 17 more separate stories on today's schedule of patients and families dealing with some of the same sort of issues. "How could I have done this so long", I ask myself, "and how much longer can I keep at it?" I don't know the answer but I know I am late for clinic. When the elevator doors open, I rush past the slow walkers to the adjoining clinic building. I remind myself that it is a sacred trust to walk with patients and families on their cancer journeys, even though they often wind up like this morning.

# A Pop of Spring

Jonathan Crocker, MD  
Associate Program Director, Internal Medicine



# Cut Flowers

Samantha Pop, MD  
Internal Medicine, PGY-3

I have always hated receiving bouquets of flowers. For some reason the idea of taking something at its peak of beauty and cutting it short has always irked me. A green vase sits on my dining table holding blush carnations, purple spring-colored daisies, and white chrysanthemums that despite my efforts of adding water and even a packet of flower food are now becoming withered, brown, and brittle.

After years of my less than grateful response to receiving bouquets on special occasions and after reminding me that “it’s the thought that counts,” my determined husband learned to gift me something else—pretentious, preserved, gold-plated roses that would theoretically last forever.

But now self-isolated in my apartment, I find myself reflecting on the fading bouquet displayed on my table for only me to enjoy.

I stood in line with the septuagenarians to enter Trader Joe’s, masked and gloved. My swollen belly served as a pass to let me into the grocery store early, an hour before it officially opened, along with the other “vulnerables” to give us a chance to shop safely distanced from others during the pandemic. A gray-haired employee approached me in the canned-food aisle. She asked me the usual questions: when are you due? Is this your first? Boy or girl? Above her face mask, her eyes could not hide how sorry she felt for me. I responded and held back tears of self-pity, fear, and guilt, emotions probably now heightened not just by my pregnant state but also by the state of the crisis thrust on the globe, before moving on to fill my cart.

At that point, it had been weeks since I had last auscultated a patient’s lungs before abruptly being reassigned to TeleHealth in the wake of the ensuing surge. I remained distanced from friends, from the hospital, from my husband who was also in medicine residency a few states away. And aside from the ever-reassuring flutters, kicks and hiccups from inside my belly I hadn’t felt the touch of another human for almost a month but what seemed like an eternity.

The friendly employee found me later in the dairy section. She handed me the bright bouquet of flowers, with a sticker over the price tag, she had already paid for them. *I was touched.*

Now, I let the bouquet of flowers sit on the table, watching as they continue to wilt. The metaphor is not lost on me as I think about the many things that have been cut short by the coronavirus pandemic: lives, jobs, school years. Even my own residency training as I realize I may never care for another patient in person again or get to hug my co-residents again before I graduate. Despite, or perhaps, in spite of these shortcomings of our current reality, I have recognized that this bouquet of flowers gifted to me by a stranger also symbolizes that even at a time of our greatest physical distance, all of humanity has never been closer together.

# On fires and high rises

Ali Corley, MD  
Internal Medicine, PGY-3

How hot that fire must feel,  
Chasing him up and up, flames grabbing at the steel  
Of the stairways and halls and walls of the high rise  
That would eventually become his demise.  
Because the terror of the fall was less than that of the fire  
And because he could feel the heat, sought to escape the pyre.

But I did not see the flames, I saw only the height,  
Up there, next to his abandoned car, no signs of a fight.  
The tears that came burned images in my brain,  
I witnessed the aftermath with the survivors and felt their pain.  
Judgment followed closely behind sadness and rage,  
Pity and desperation filled my chest, heavy inside my rib cage.

I held on tightly to that anger as the survivors healed.  
But slowly, as fists became hands, a truth was revealed.  
Who now can I blame?  
Give me something, someone, anything, a name.  
He didn't look sick to me, how could I know  
About the blaze and pain, burning senselessly and slow?

The sorrow is deeper now, confusion like mud  
Hazy in suspension, clay silt, more like blood  
In a once clear angry river, that is clear no longer,  
With distorted flow, and eddies in slow circles, stagnating the water.  
He would have been a journalist, a writer. He would have been a brother.  
She would have been a doctor. She would have been a wife, engaged to another.

Were we wrong then to tell you to rage, rage against a dying light?  
Father, is it truly good, that good night?

# Leaving Longwood

Rahul Maheshwari  
Internal Medicine, PGY-2



# Stillness

Akshay Shanker, Clinical Research Fellow  
Department of Anesthesia, Critical Care and Pain Medicine

It was my birthday, about a week before Christmas, and I was on call overnight in the hospital.

It was 1:30 AM on our labor and delivery floor. The buzz of healthcare providers speaking about patients and the announcements from the hospital's loudspeakers were muted for the night. During night call, there is mostly quietude. Healthcare teams are sparse and the sporadic beeps of alarms and pagers indicate a jarring potential for urgent situations.

On my obstetrics and gynecology rotation, medical students were expected to perform a history and physical exam on new admissions. So when I heard a patient coming to the triage area, I stuffed the labor and delivery book I had been reading into my short white coat pocket, sandwiching it between all the supplies I had picked up to fulfill my secondary role as a human storage closet. In my right pocket, I stored a doubled-over black stethoscope next to my orange notebook; in my left pocket, I amassed a hefty wad of dressings, packets of lubrication jelly, and a few extra pairs of gloves.

I introduced myself to Carol, a woman in her mid-thirties with brittle brown hair and a tendency to bite her upper lip during pauses in the conversation. I went through the motions, learning about her current pregnancy in relation to the others. It was her third pregnancy; she had two boys aged eleven and fourteen. Despite objections from her husband, she wanted a third son and after some persuasion, he finally acquiesced. They were happy to learn that their efforts had yielded a new baby boy and came up with a name: Leo. I jotted down her other medical conditions and promised I would be back later. Presenting her case to the healthcare team, both the attending and the residents agreed with my initial assessment of the situation. She had a relatively uneventful pregnancy and came to the hospital at the beginning of her labor; it would probably be best to keep her in the hospital overnight and wait for her baby to be born sometime during the upcoming day.

Knowing that the rest of the staff was busy with other priorities, I checked on Carol throughout the night. She wanted her epidural early so that she could get the pregnancy over with, and we made sure to carry out her request. For a woman who had given birth before, however, it was taking longer for Carol's labor to progress than expected. Carol initially laughed and chalked it up to "her husband not wanting this baby," but our concern started to grow steadily throughout the night.

A few hours later, her husband arrived from out of town. He stood by at the bedside, running his fingers through her hair while Carol's knuckles turned white gripping the bed during her contractions. When the resident and I attached a monitor to the baby to detect its underlying heart rhythm, we found that each contraction was putting Leo under stress. Confirming our findings with the attending, we moved swiftly to give Carol fluids through her intravenous lines and some oxygen with a facemask. The air flowing from the tank made it hard for Carol to enunciate, but the gaze from her amber eyes underscored her message to all of us: "Please take care of Leo and me."

In the middle of our labor and delivery floor, we have a large mounted TV screen that reminds me of the flight information display systems one might find at an airport. Each patient's name, age, relevant medical history, and state of labor are methodically color-coded and arranged on the screen so that all members of the team were on the same page. The screen was always comforting to me. It was an attempt to create order and reason in a field where uncertainty and randomness often prevail.

As the night progressed, Carol's segment on the television screen went from green, to orange, to finally, red. Leo's heart wasn't doing well, and we tried a last ditch effort to give him more space inside Carol's body by providing fluids directly into her uterine cavity. Sometime before twilight, the team decided it would be best for both Carol and Leo to receive an emergency C-section.

One of the hardest questions I have had to answer as a medical student is also one of the most frequent: "Will I/ he/ she be okay?" Part of this is my lack of a solid knowledge base: I may or may not know enough about the issue to truly understand the patient's prognosis. But I suspect the real reason why doctors tend to answer this question with deft and noncommittal responses boils down to something deeper. Despite our best efforts to create meticulous flowcharts and guidelines to treat and manage patients, we all can think back to an experience where it all went wrong, even when we thought that we did everything right. So when I helped Carol's husband put on a pair of scrubs to enter the operating room, I phrased my response to his query in equally tentative language: "I truly hope so, sir. We will do everything in our ability to help Carol and Leo at this time. There are no guarantees in medicine, but I assure you that both the residents and attendings here are incredibly well-trained and have been in this situation before." I truly meant every word of it.

I have always loved the operating room for its scrupulous and technical nature. The precise instruments, assigned roles, and distinct order of operations all combine into a symphony of excellence. Standing in the corner of the room, I watched as the surgeons and anesthesiologists discussed their plans and got to work. It only took a few minutes before Leo emerged from Carol's womb and was placed on her chest, crying and healthy. Carol's husband, donning yellow observer scrubs and slightly-too-large blue covers on his feet, tepidly stepped into the operating room but let out a huge grin when he saw Leo for the first time. After about a minute of smiles and laughter, Carol's husband and Leo left the room for his newborn well-check and the surgeons worked to finish the procedure. Shortly thereafter, however, the anesthesiologists raised their voice and asked how much blood loss the surgeons were seeing. The answer didn't satisfy them; Carol's blood pressure was dropping more than expected.

Suddenly, the symphony I was used to in the operating room exploded into a cacophony of improvisation. Carol was placed into a medically-induced coma as the voices in the room became more shrill. Time warped as I removed sterile gloves from the cabinet and tossed them to a bevy of staff who were not in the room five minutes prior. The surgeon's fingers moved quicker than I had ever seen them move, the standard calculations of visuospatial awareness replaced by the ripping of sutures with their bare hands. A code crimson was called as we gave Carol every last unit of the blood our hospital had in the blood bank, giving her a red substance to keep the red numbers symbolizing her blood pressure on the OR screens from dropping further. Providers tunneled access through her neck to get a picture of her heart, but the fluid in its chambers started to balloon backwards like a child placing its finger at the tip of a garden hose. I held Carol's arms in place while nurses, surgeons, and anesthesiologists performed chest compressions, as her body flailed around like a ragdoll on the operating table. The concerto of loud voices and rushed movements reached a zenith, and then finally, there was silence.

After Carol's death was pronounced, the head nurse passed around towels and we wiped our faces of tears, sweat, and (occasionally) blood. Who was going to tell Carol's husband? While the healthcare workers deliberated, I did my best to help prepare her body for viewing, dabbing as much rust-colored liquid off her face as I could. It was the least I could do. I had wanted to jump in and assist while she was alive, rather than simply being a helpless observer of this horror story.

When they brought Carol's husband and Leo to see Carol's body, I brought him an aluminum chair to sit on. I wished I had something more comfortable to offer him, but he thanked me nevertheless. He wailed and wept, his beard damp while holding his newborn son on the chest of his now deceased wife. In the face of such tragedy and suffering, it took all that I could to be one of the individuals to stand in silence alongside him.

But that's what I did. I sat in silence with Carol's husband, because nothing I could possibly say would provide comfort. The moment was too solemn to be ruined by platitudes from a medical student. The truest, most honest comfort I could provide was simply to be present, not to pretend I could understand the depth of his agony. At least that's how I felt.

Until that night, it was easy to fall into a familiar routine during clinical rotations: go to the hospital, present my findings on patients, come home, study, and repeat. But over the course of a single night, Carol's husband had received the gift of a son in exchange for the death of his wife. Like the electric defibrillators I had observed moment earlier, I was suddenly jolted out of my normal rhythm and forced to confront the impermanence of life and the callousness of death. I began to recognize that the privilege of practicing medicine involved a certain intimacy with that dichotomy. And in that context, I realized that the details of our verbal and nonverbal interactions with patients and their families in moments of crises can forever brighten or stain their perception of the experience.

The next day, the healthcare team and I prepared the morning report as the rest of the daytime shift arrived. There was a black line through Carol's name on the central screen, a tidy footnote that alerted the remainder of the staff what had occurred the night prior. I tried my best to remain calm as we discussed the morbidity and mortality of Carol's death the night before. After much deliberation, we moved onto the new patients for the day and the call team was dismissed. Before I went home, I swiped my badge into the newborn nursery, explained the situation to the doctor, and went to see Leo. I held him in my arms, feeling his warm body swaddled up in blue blankets. He was sleeping peacefully, but I could not help but think of his innocence and complete inability to ever really understand what had occurred the night before. Before setting him down and leaving the hospital, I promised to always remember Leo. He and I will forever share the same birthday.

# Berry

Lika Targan, MD  
Associate Program Director, Internal Medicine



# Meanwhile

Barbara Lam, MD  
Internal Medicine, PGY-2

Every old Asian patient in the hospital is the same:  
They are all my mother and father in ten years.

Ms. T has a square face and no bottom teeth.  
She has esophageal cancer and is my mother  
squatting on a plastic stool in the kitchen,  
reading the Chinese newspaper and sipping hot tea.  
“I’m not used to this food,” she says,  
pushing the hospital menu aside.  
Mr. L is squat, pants pulled high around a big belly.  
He has heart failure and is my father  
practicing Tai Chi in a Chinatown park  
the day he is diagnosed with high blood pressure.  
“Not too many pills, please,” he says,  
waving the nurse away.

My mothers and fathers, they are surrounded  
by as many thermoses of *jook* as they are by IV bags.  
They are curled in bed, tearful and resigned,  
saying, “I’m can’t communicate.” Yet  
they rally for me, writing down recipes  
for cough-curing soups and teas, advising  
that I finish residency in one year instead of three.  
I find that after a terse call with my parents,  
or when I realize I have not seen them in months,  
I care for them here, in the hospital.

I imagine they find my round face soothing  
even when the words out of my mouth are doubly foreign.  
The Cantonese phrases I learned as a child  
are only good for arguing with parents and ordering dumplings.  
I don’t know how to say, “I’m sorry this is happening.”  
There is some disappointment when they hear my  
broken words, but also encouragement:  
It will get better, they promise, not explaining how, just knowing,  
and they welcome me — so young, and a doctor! — to their side.

# The Doctor is Out: View from the Green Monster

Ali Corley, MD  
Internal Medicine, PGY-3



# I Am My Patient

Alex Goldowsky, MD  
Internal Medicine, PGY-3

We are the same person  
I am him; he is me  
My hand reaches out to touch the mirror  
To touch the man I am supposed to be

A million shards of glass explode  
Exposing the ethos of our beings  
He is strong, courageous, triumphant  
I am weak, a coward, shuddering in defeat

He stares back at me  
He keeps telling me that he is safe  
But I know that he will never be safe  
We will never be safe again

He smiles and laughs  
I want to scream at the top of my lungs  
Make it stop, my heart cannot take it  
It cannot be over; I will not let this be the end

He slowly walks away  
His body disappearing into the mist of morphine  
I am melting; my mind is a puddle  
Who will step into me next?

I look up at what is left of the mirror  
His eyes stare back into my soul  
I see his smile again  
And then he is gone

# Julio and Sra. Lopez

Julian Max Aroesty, MD  
Cardiology

As is true of all medical school graduates just starting their internship I was overwhelmed with the responsibilities suddenly thrust upon my shoulders. At the Cornell division of Bellevue Hospital in New York City, this responsibility was especially heavy since a large proportion of the admissions were for patients with advanced levels of disease and multiple comorbidities. I am a first generation American, the son of Sephardic parents who spoke Ladino at home, an ancient Spanish dialect that was spoken by the Jews of Spain at the time of their expulsion from Spain in the 15th century. I understood household Spanish, and at the time of my internship I found this a very valuable resource for conversing with my Puerto Rican patients. It was not long before the word spread among both medical staff and the patient population that there was a "Spanish" physician who became the go to person for middle of the night translations and for referral of new patients in the outpatient clinic.

Within the first few weeks of my internship, I had two very sick patients admitted on the same night. Julio was an unemployed 19-year-old heroin addict who had progressed from "skin popping" (subcutaneous injection) to "mainlining" (intravenous injection). Previously he had nearly died from a "hot dose" (a dose that may be lethal since it does not have the usual heavy dilution with inert powders). Inevitably heavy addition results in more serious crimes and more pressure on the drug suppliers.

This was not Julio's first Bellevue admission. There were two prior admissions to be "dried out" — only to result in Julio's resumption of heroin at a lower intensity. This time however Julio had an additional very serious problem. His temperature was 101.8, his pulse was 110 per minute, blood pressure was 130/ 50 and there was a new heart murmur. I looked for signs of endocarditis that I was already convinced was his diagnosis. He had splinter hemorrhages, a nail bed sign of bacteria in the blood. I was certain he had aortic regurgitation due to bacterial endocarditis.

I drew the required three blood cultures, not an easy task since Julio had sclerosed most of his easily accessible veins. Fortunately his femoral veins were patent. I took a fine needle used for doing TB skin testing, removed the bur at its tip, sharpened it using a my nail file then sterilized it over a lab burner. (Bellevue was famous for asking you to accomplish tasks with what was available rather than waste time and effort requesting materials that would arrive long after you needed them, if they arrived at all.) I found a tiny vein in his hand that I connected to an intravenous, protecting it with a splint made from a tongue blade along with copious bandages and tape to protect the site. I told Julio not to allow anyone to withdraw blood from that site and went off to examine his blood, urine, chest x-ray and ECG. As I expected, my diagnosis was supported by my lab studies. Two days later, the blood cultures were positive for penicillin sensitive streptococcus.

It was almost 4:00 AM. I was fatigued but energized by this complicated case and looking forward to presenting it in the morning at Dr. Tom Almy's weekly professor's rounds, at which the most complicated cases were discussed. I was sure mine would be included and had everything in place for

the presentation. I was walking back to my room to shower, get a couple of hours sleep and change into a clean white uniform to be ready for early morning rounds when I was told I had another admission.

Señora Lopez was a thin Puerto Rican grandmother who had had an ordinary viral illness one week earlier and then developed weakness in her legs that rapidly increased in severity. She had a preliminary diagnosis of “stroke” but her weakness was bilateral and progressive. I thought she had Guillain Barre syndrome, a transient ascending paralysis that was generally survivable if one did not develop associated complications, the most dangerous of which was paralysis of the diaphragm which would result in death if untreated. I finished her history and physical examination, completed her blood and urine examination, though it was not essential in this case since the diagnosis is made on the basis of the characteristic progression of symptoms and physical examination. I thought I might have two cases for professor’s rounds and had better skip breakfast so that I could shower and change into clean whites in time for the 8:00 AM Professor’s conference. As I had expected, the chief resident asked me to present both cases. Everything went well. Dr. Almy was pleased. I was exultant.

Julio was too young to remain in bed for long. He was a likable and affable kid who ambled through the wards talking to other patients as he walked around with his IV pole and life saving intravenous penicillin infusion. He told me he had committed burglaries but he had never threatened anyone and had never used a weapon. The patients enjoyed his lighthearted banter. The Hispanic women especially adored him because his gentle humor was never at a patient’s expense. In time he got to know the Lopez family, and I could hear them talking occasionally about their good fortune to find a “Spanish” doctor. Little did they know that what they had found was not a Spanish doctor but a Jewish doctor. Even the ward patients who were able to speak English, insisted on speaking to me in Spanish. I protested that my Spanish was mainly household Spanish about food, clothing, weather etc. They refused to accept my disclaimer. They corrected my mistakes and added to my vocabulary as needed. It was not long before I had to purchase a pocket Spanish/English dictionary. Day-by-day, I became more fluent.

Sra Lopez was not doing well. I had hoped the ascending paralysis would begin to recede before reaching her diaphragm. Unfortunately this was not the case. There were a limited number of mechanical respirators available to us. I was able to get one of them since it was expected that it would only be required for three or four days after which her paralyzed diaphragm would function properly again. At this point she required a much more intensive level of care. The intensive care unit had not yet come into use and patients like Sra. Lopez remained on the general medical ward with more intensive attention by physicians and nurses. She had a wonderful supportive family of three children and six grandchildren — many of whom were almost always present. I was always ready to talk to them but was not optimistic, saying only that after a few days, patients on respirators might develop pneumonia, and if not strong enough to overcome that infection, they did not do well.

Meanwhile Julio had no visitors. I asked about his family. “Oh, well they don't know I am in the hospital. They think I am working on a job in New Jersey. I call them to let them know I am OK.” Fortunately his infection was coming under control, and he felt well but I would not let him go home early to continue his therapy with an oral penicillin regimen. He had to stay in hospital for six weeks of intravenous antibiotic therapy during which I had planned to urge him to remain off heroin permanently. One day I said to him “You do not behave like a criminal. You are not a criminal. Heroin makes you steal. Why do you put your family through this? Don't you know that heroin will kill you?” “Oh no.” he replied. “All my friends use heroin.” I said, “Really, and how many 40-year-old junkies do you know?” “Well my friends are mostly my age.”

I said again "In your community, how many 40-year-old junkies you know?"

"I guess none, but that's because heroin users are mostly kids"

"No" I said "it is because heroin users die prematurely. You have already had a serious complication, the infection on your heart valve. Chances are you will die before you are 30 if you continue your mainline heroin use. Think about what that will do to your mother and father."

He appeared pensive. I was surprised that somehow he had never thought about the intense sadness he would thrust upon his family if he died or even if they knew about his addiction and his life of petty crime.

Señora Lopez did develop pneumonia. She had been on the respirator for a week and I was asked to let her die peacefully and to release the respirator for use by others. Each time I pleaded for just a couple more days because I thought I could pull her through this difficult period. Her family fully understood how perilous her status had become. I told them I would not give up. Her daughter approached me one evening with tears streaming down her face. She grasped my hand in both of hers and kissed it. "No, no, please, I promise you I will do everything that I can." I knew the chance of success was small, and I dreaded the moment when I would have to inform the family that she had died.

Julio had formed a relationship with the Lopez family. I could hear him talking to them as I visited other patients on the male and female wards. Now he met with them almost every day. He became the self appointed liaison between me and the Lopez family. One day I heard him tell them that I was the best, and if it was at all possible, I would accomplish it. I admonished him to be careful about giving the family unrealistic hope. "I know, I know," he said "but all of us want this so deeply, we think God will be with us." I thought that something wonderful was happening to Julio. He was changing from a self-centered risk-taking kid to an empathetic adult. I remember thinking as I walked away from our discussion, "I don't know whether or not God is with Sra Lopez, but I sure hope God is with Julio".

After 10 days of intubation, which is long after any reasonable chance of success, Sra Lopez began to fight against the respirator. This was a good sign because it meant her paralyzed diaphragm had recovered. The pneumonia responded to antibiotic therapy, meticulous fluid and electrolyte balance and regular suctioning of secretions throughout each eight-hour nursing shift. We discontinued the intubation-respirator therapy, and she had a surprisingly strong cough.

Now every day was better than the last. There were daily visits with broad smiles and hugs all around, not only between the Lopez family and me, but also between the family and Julio. They had virtually adopted Julio and he them. I learned later that he had been ashamed to tell me that he was a virtual orphan. He had no siblings, his mother had died and he did not know where his father was. His phone calls were not to his family. They were to his fellow gang members.

Sra Lopez was ready to go home. I told her God had spared her for her family. "No," she replied, "God has sent me to you, so that you could return me to my family." We were all close to tears of joy. Julio was there to celebrate the occasion. The Lopez family wished him well and said they wanted to continue to see him. They asked him to promise to see them when he was discharged from the hospital. During the remaining four weeks of intravenous antibiotic treatment, members of the Lopez family made occasional visits to Julio. They looked upon Julio as part of the miracle and understood that he needed a family so that adopted him, and he them.

On the day of his discharge from Bellevue, I scheduled Julio for an outpatient visit to me in two weeks and thereafter once per month. He kept his appointments and I learned that he had bonded with the

Lopez family, all of whom were doing well. He was working part time and had entered City College in NYC where he was working toward an associate degree so that he could do social work in the Puerto Rican community. When I last saw him two years later, just before leaving Bellevue for a senior residency in Boston, he was “clean.”

# Chilling rain

Evgeniya Larionova, MSN, MA, RN, FNP-BC  
Minimally Invasive and Bariatric Surgical Services

Chilling rain, a broken umbrella,  
Making your way through rubble and debris,  
On a blustery night.  
Desperately searching for a key to open the door  
Of vague symptoms,  
Headaches, fevers,  
Numerous ED visits with similar story,  
And no etiology found.  
Your feet no longer stay dry.  
Shivering. Men do not cry.  
Xrays, CT scans, MRIs reveal only the same answer-  
No abnormalities found.

# Inchworm

Lika Targan, MD  
Associate Program Director, Internal Medicine



# On Cadavers and Beyond

Ellen Zhang, MD Candidate  
Harvard Medical School, Class of 2023

Underneath visceralness, slicing through skin.  
We have learned the distinction between  
epidermis and dermis. Layering jargon onto  
vernacular. Sharpening our minds with precision.  
In the formaldehyde laden room, we learn  
the tautness of skin, thinness of cranial nerves,  
firm translucency of one's diaphragm.

Here, we have examined the human body from the  
inside out. This is what you call a foreign intimacy.  
Unknowing strangers become the most common  
consistencies, framework for everything else going  
forward. Is there anything more surreal than this,  
this human body and its very existence.

Around metal tables and scraping scapula,  
we uncover narratives that bisect each other.  
Beyond name, gender, disease. The differences  
and similarities seamlessly integrating together,  
even as we peel layers of the body apart.

How lucky it is that we are learning the first steps  
to playing God? The next step is the realization that  
we are not. So privileged we are to learn about ourselves  
and from those we serve in this sacred capacity.

# Skin

Sarah Ohnigian  
Internal Medicine, PGY-1

Skin is the largest barrier we have  
But is it thick enough  
To withstand the threats of the world?

Microbes aren't the only pathogens  
that thwart us every day.  
There may be millions on that doorknob,  
But what about what lies beyond that door?

Hate. Inequality. Violence. Death.  
Worse, indifference to this.  
Can my skin withstand?  
Can yours? Hers? His?

Is there a vaccine to these threats?  
Like tetanus or pertussis  
To immunize ourselves and resist infection.

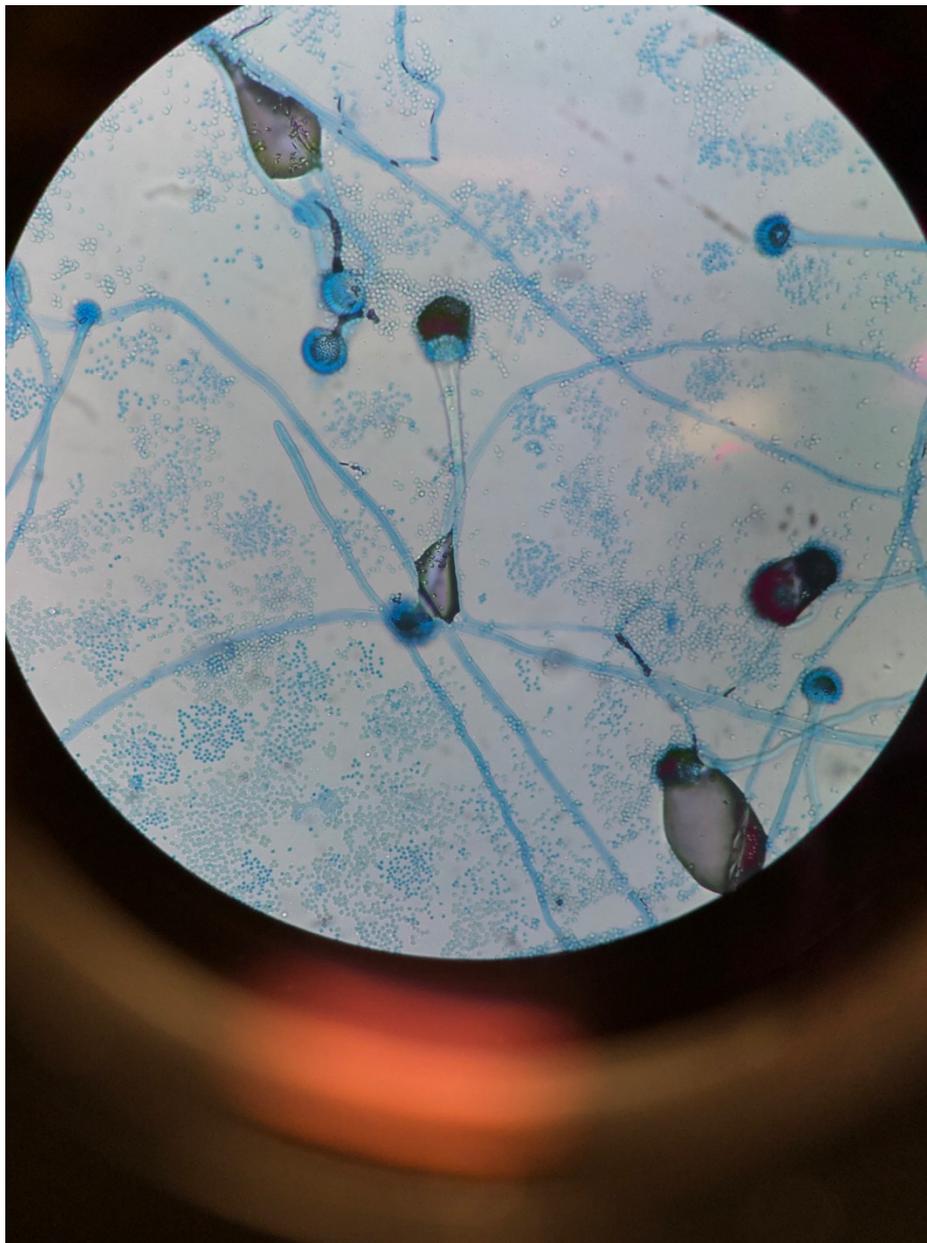
Is there treatment for those already afflicted?  
Like IV ceftriaxone  
To relieve our symptoms.

Is there a prophylactic treatment?  
Like grafts to add thickness  
To block future invaders.

My skin may cycle and regenerate  
Its durability and resistance  
But in that crucial time, will it be thick enough?

# Aspiring Aspergillus

Polly Van Den Berg, MD  
Fellow, Department of Infectious Disease



# CN4

Sarah Petitto, RN CPAN CNIV  
Nurse, West Campus PACU

The night shift nurse told me that he had had a really rough night. His immune system was chaotic after the recent chemo and he had developed an allergic reaction to an antibiotic. He had rubbed his eyes so much that they were swollen and bruised, requiring help to peel his eyes open to see the ecchymotic sclera surrounding his hazel irises. He couldn't see, and his stubborn fierceness made him a high fall risk. I walked into the dim room and whispered, "I'm here." He grabbed his IV pole and started shuffling into the tiny bathroom, which was so small that the sink was located outside the bathroom, near his bed. When he emerged, eyes swollen shut, he stumbled around in a circle, disoriented trying to find the sink. "Let me help you," I said, my voice cracking. I guided him to the faucet, the soap, the paper towels, the trash can. I helped him slip back into the bed, tugged off his slippers and covered his legs, untangling the multiple thin IV lines delivering meds and fluids into the new port in his chest, pinning them to his gown so he wouldn't accidentally tug on them. I moved the table close to him, taking his papery dry hand in mine to touch the call light, the fresh cup of ice chips, the baseball cap he wore over his thinning hair. He sighed and fell asleep. I sank into a chair in the corner and wiped away the hot tears rolling down my cheeks. I felt so helpless, but my presence and my small actions gave him comfort. He didn't say a lot, but I knew what it meant to him to have me there when he was so vulnerable. Honestly, there wasn't much else I could do, because he wasn't really my patient. He was my father, who was in the early days of inpatient treatment for leukemia.

When I think back on those days that challenged my father, as well as our whole family, I don't remember the procedures or complications. I remember the little things that made such a difference in his care, how we were all taken care of, and how the smallest gestures, feeling heard and listened to can make such an impact on one's recovery from illness or injury. As a novice nurse, I used to be intimidated by questions family members would ask me, for fear of not knowing the right answers and that my inexperience would seep out of my pores. I worried that I wouldn't be seen as a competent caregiver to their defenseless loved one. With time and maturity, I know now that it isn't always about having the right answers, but rather knowing what to say and how to say it.

Almost 15 years after my dad became ill, I met Patty as she rolled into the PACU. She was a 65 year old woman with short silver hair, puffy cheeks and stunning blue eyes. She was admitted for a right VATS wedge resection and had a chest tube in place. Her respiratory rate was in the high 20's and her SpO2 was hovering at 86% on a closed face mask as I received report. She was speaking in full, short sentences and denied shortness of breath beyond her baseline. A quick glance at her pre-op assessment showed she walked in that day with a SpO2 of 85% on room air, which rose to 96% on 3l nasal cannula. During report from anesthesia, I learned Patty had interstitial lung disease, COPD, was a current smoker and used oxygen at home. She did not have a urinary catheter or an arterial line in place, which surprised me. In my experience, patients with baseline respiratory ailments who undergo a thoracic procedure usually had those placed for the procedure. I listened to her lung fields, which

evidenced crackles throughout and wheezes in her upper airway. I quickly set up and administered an albuterol/atrovent nebulizer treatment to relax and open her air passages to make her breathing easier. I asked the surgical resident about giving her a dose of Lasix as well (she was dependent on this diuretic daily at home), but they declined, wanting to “see how she does over the next couple of hours.” I accepted that answer for the time being, but I had a strong sense of where Patty’s postoperative course was headed.

A technician from radiology arrived as Patty was taking the last few puffs from the nebulizer. I wiped the condensation from her face and asked how she was feeling. Overall, she was comfortable and despite a respiratory rate of 30, denied dyspnea. She told me, “Oh, I’m always like this,” but something just didn’t feel right to me. As she was positioned for her portable x-ray, I asked our covering anesthesia resident and attending physician to come to the bedside, and texted the surgical team to let them know the PCXR was done. I wanted them to “eyeball” Patty and also take a look at her x-ray just after it was taken. One of my other concerns was being able to facilitate open communication between the anesthesia and surgical services.

Occasionally, the teams differ on how to manage a patient’s escalating needs, leaving the bedside nurse stuck in the middle. Once the PCXR was read, I quickly gave IV lasix as ordered by the thoracic resident and efficiently placed an indwelling urinary catheter. As all of this was going on, Patty was so pleasant and conversant. She told me all about her family, including two daughters. Maeve was close by, but Kelly, “the baby” in her mid-30’s lived with her. They lived in the city where I grew up, and she actually knew my dad from his career in local politics. We talked about the city, and how much it had changed for the better and the worse.

I could see Patty becoming more anxious, her steely eyes were darting and her breathing became more rapid, but she said she was okay. I wanted to believe her. But she looked so scared. She was asking to see her two daughters and for a Dunkin Donuts coffee, but she just wasn’t stable enough for company, nor could she tolerate drinking coffee given her work of breathing. There is a lot of auditory stimuli in the PACU--beeping monitors and IV pumps, phones ringing, chaotic conversations and the like make it an overwhelming environment. Soon after, Patty conceded that her anxiety was escalating along with her respiratory rate. I dimmed the lights above her, pulled the side curtains around her bed and helped her scoot her small frame over to the side. I grabbed some warm blankets to wrap her in and a cool cloth for her brow. I put my flowsheet down, knowing I could catch up on documentation later. What Patty needed was my undivided time and care. I sat on the edge of the bed with her and gently stroked her hair. I don’t know for how long I did that, but it felt like we were the only two people in the unit for a long time. Her breathing calmed, as I whispered that she was doing great and that I would do everything I could to help her to feel better. I promised that I would have her daughters come to see her soon. My fear was that if Patty needed to be reintubated, that she would remain so for a prolonged period of time. I absolutely wanted her kids to see her as soon as possible, before events could take another turn.

Over the next hour, Patty began declining in front of me. She was looking more fatigued and I was markedly concerned that she was not going to be able to keep up that rapid breathing and would eventually arrest. I called a trigger, which brought the thoracic surgical fellow and attending and the anesthesia team to the bedside. I did this because I felt that there were too many orders coming from different directions and it was best to have everyone present to formulate a plan. I needed everyone to see that her work of breathing was worsening, her RR was in the 40’s and how dyspneic she was. I didn’t believe my multiple phone calls were being received well, because I was told more than once that

“this is her baseline.” After an ABG was drawn and resulted, Patty was placed on a BiPap mask. The team also agreed to a dose of Ativan, which was also one of her home medications. Once Patty was feeling more calm and in control, her RR in the 20’s and less dyspneic as she diuresed, I called for her family. Her daughters, Kelly and Maeve, came tentatively around the corner to the bed, with Kelly clutching a coffee for her mom. They looked so scared and worried. I knew that feeling well. Ever since my dad had been sick, I look at family members in a new light. I understand how terrifying it is to have the person who has been in your life since day one look so vulnerable and ill. I take special care to explain what is happening to their loved one as best I can. I often use humor with patients and families to put them at ease, but humor was the last thing on my mind that day. Maeve seemed to have a good grasp of the situation, so I focused on Kelly. I maintained eye contact with her through her tears and updated her on her mother’s condition, my hand gently resting on her forearm. I encouraged her to talk to her mom, to spend a little time with her before I would have to whisk them away. I could also see Patty’s demeanor changing. Her eyes were getting heavy and she was trying to talk through the BiPap mask. Her skin was flushed and she was starting to not make sense as she was speaking and becoming agitated. Without a baseline ABG, but noting that her recent PaCO<sub>2</sub> was 75, Patty was becoming increasingly hypercapnic and I had to act fast.

As the anesthesia attending came back into the room, I called out to him to come and see Patty. While he evaluated her, I told Kelly and Maeve what was about to happen. Patty needed to be intubated. Kelly was shaking, but I told her that I would be with her mother and do everything I could to keep her safe and comfortable. I knew I had her trust. She had the same striking eyes as her mom, and as she looked up at me with tears brimming over, my heart broke for her. I felt like I had two patients now. Maeve tugged on Kelly’s sleeve, and as I gave her a hug, I looked over her shoulder towards Patty’s bed. My co workers were grabbing equipment and drawing up medications to prepare for her intubation. With Maeve and Kelly now in our small waiting room with tissues and ginger ale, I returned to the Patty’s side, once again gently touching her arm and telling her what was going to happen. Honestly, she was so confused at that point that I’m not sure she understood, but with my co workers bustling around us, I could center my attention just on her. I told her we would help her breathing, that her girls were close by and that I wasn’t going to leave her side.

Once Patty was intubated and sedated, I let go of the breath I felt like I had been holding onto for hours. Her coloring improved along with her ABG’s and PCXR. I changed her gown and tucked warm, crisp blankets neatly around her. Back in the waiting room, Maeve and Kelly jumped out of their chairs when I opened the door. I updated them and asked if they wanted to see Patty. Maeve started to the door, but Kelly paused. I saw fear in her eyes, and I reassured her that her mom was safe, improving and comfortable. As we walked back to Patty, I matched my step with hers so I could be right beside her. She grabbed my elbow for just a moment and I gave her hand a squeeze. At the foot of Patty’s bed, she let out a little laugh with tears in her eyes and she said, “Oh, she looks so much better!” I told them it was okay to talk to her and hold her hand, which they did. I listened to them banter as I caught up on my paperwork and gave report to the oncoming nurse. It was getting late, and they were tired. I encouraged them to go home, and get some rest, and to call anytime during the night to check in if they wanted to. Maeve thanked me, and Kelly asked for a hug. She asked if I would be back the next day (I would not), and told me she was glad I took care of her mom, which made me smile. In some ways, it was easier to care for Patty and her medical needs. Caring for the whole family is just as important, but not always easy to do. Fear and concern can be expressed with tears, anger, petulance and silence, or even a combination of all of those. Part of the art of nursing is knowing how to recognize the emotions, how to appropriately respond to them, and to acknowledge people’s individual needs. That is a hard

concept to grasp as a younger nurse, but one that comes with time and experiences, both good and bad.

While contemplating advancement to CN IV, I thought about some of the “exciting” and life saving scenarios I have been a part of over the years. Those are gratifying stories and good ones to talk about. But caring for a patient like Patty and her girls is just as enjoyable to share. At one point, she was not doing well, but my quick actions and collaboration with her teams got her what she needed. I found out that late the next day, she was extubated, talking up a storm and drinking her much desired coffee. As important as meeting the medical needs of our patients, the emotional needs are just as important. In my younger years, I was so task oriented and couldn’t see beyond what was immediately in front of me. Twenty years ago, I would not have as quickly recognized the subtle ways in which Patty was decompensating or trusted my gut as strongly as I do now. I am now able to be more proactive and advocate more clearly. I also would not have been able to truly “see” Maeve and Kelly and realize one of them was so scared and needed support. Personal and professional experience have brought me to this point where I know that sometimes the best medicine isn’t medicine at all.

# #TrendingIllness

Jose Parra, MPH

Research Coordinator, Department of Academic Affairs

Fever, coughing, runny nose-it may be here,  
Otherwise, 14 days monitoring and we're clear.  
This corona does not help you find your beach,  
Cases in Chicago-almost at an arm's reach.  
Regardless if Wuhan Virus shows its face,  
It needs to look around and see this place.  
BIDMC is full of healthcare's best,  
Doctors, nurses, PAs, and all of the rest.  
Zika, West Nile, Ebola, and Coronavirus,  
Trending illnesses do not stand up to healthcare's righteous!

# Even Statues Do Masking

Polly Van Den Berg, MD  
Fellow, Department of Infectious Disease



# A Blanket of Caring

Eileen Barrett Wyner, ANP  
Nurse practitioner

January 29, 2020

I am a very direct person in all aspects of my life, and I have always felt comfortable sharing personal information with my patients. I understand that not all nurses and doctors feel this way, but patients trust me with so many intimate details about their lives, I feel they deserve to know a little bit about me.

I planned to be very honest with my patients when I returned to my work as a primary care nurse practitioner after an eight month medical leave . I had been successfully treated for non-Hodgkin's lymphoma and I knew that since I was gone for so long, my patients would realize I was seriously ill. While I was on leave, my colleagues did a phenomenal job of reassuring my patients that I would be back at work soon to care for them.

I thought that my patients would handle my return as matter-of-factly as I had handled my illness. I imagined that when they saw me, they would welcome me back and ask me what was wrong. I would tell them I had cancer and that I was now healthy. I would thank them for their inquiries and cards and flowers. That would be the end of the discussion and the visit would proceed to my taking care of them. But, as it turned out, I had completely misjudged the situation.

Life on medical leave had been very difficult. Overnight I had to leave my job and my daily routine behind while I focused on the only thing that mattered: saving my life. This became "my new job," the hardest and most important job I had ever had. I had to physically isolate myself from just about everyone to be sure I didn't get an infection. I lived in my own "bubble." I limited myself to the front porch and the backyard deck. I never went on the grass as I was worried about getting a tick bite. Once or twice a month, when my white blood cell count was high enough, I'd be able to indulge in my favorite treat: a BLT with extra avocado (vegetables are too 'germy' to be safe for people with low blood counts). I could even have company, but they had to use a heavy dose of hand sanitizer before they could cross the threshold, and only air hugs were permitted.

I also isolated myself emotionally, so I could focus my energy on staying strong, getting better, getting back to "my real job": taking care of my patients. I didn't allow myself to think that others in my life, including my patients, would also be affected by my illness, or about how they would feel about my re-entry into the real world.

My patients were happy to see me, and they told me that they missed me. Many hugged and kissed me and asked how I felt. They asked how my husband was. They told me how healthy I looked. They asked if my treatment was done. They asked if I was "good." Some wept and held my hands and told me how hard they had prayed for me. Then I cried too. I felt like I was covered in a blanket of caring and I wanted to stay still there and not turn my attention to my patients right away. I felt badly about this, but, to my surprise, it was exactly what my patients wanted, too.

On my first day back, I saw a woman I had gotten to know well only in the last two years. ‘Marion’ has visual impairment due to diabetes and her sight had worsened while I was gone. She usually sits very close to my desk, but this day she held back a bit. The visit proceeded as usual until Marion abruptly interrupted me. She said, “You sound good. You were gone a long time. Did you have the Big C?” When I told her yes, I did but I was fine now, she burst into tears. I tried my best to console Marion and reassure her, and she told me that I was very important to her and that these last months were so long for her. She had guessed correctly early on what was wrong with me and as she had only known people to die from cancer, she was afraid that I would, too. I told her that I had been afraid too, but I was healthy, and it was time to move on. A few Kleenex more and our visit continued as it should--with its focus on Marion.

Another patient, “Sally” waited for me right behind the exam room door and, as I opened it, cried, “Welcome back!” We laughed and hugged, and she showed me her breast cancer support shirt. We talked a few minutes about how long I was gone, and I reassured her, too, that I was healthy. She never asked me directly what was wrong but did ask if my treatments were over. I told her that they were and that I was truly fine. She told me she loved me and that was why she wore her shirt today. I realized that she thought I had breast cancer. The specifics weren’t important to clarify. It was only important to accept her love and let her know how her kindness mattered so very much to me.

Later that night I talked over the day with my husband. I told him that I felt guilty because patients who came to me to be cared for were feeling so concerned for me. I felt angry at myself because I had been foolish enough to believe my patients wouldn’t be affected emotionally by my illness. After all, I have known many of these people for years--and I disappeared for eight months. I should have anticipated their reactions. I should have discussed with my colleagues and friends the best way to handle my return.

Then lightning struck. I felt guilty about feeling grateful that my patients, with all of their health issues, had room in their hearts for me. How could I not have anticipated this? The greatest joy I derive from being a nurse practitioner is the sharing that goes on behind the exam room door. It is what I often thought about while I was working so hard at “my new job”, my cancer treatment. It is why I am so glad to be back at my real job.

Cancer doesn’t come with a navigational chart. You do the best you can. My patients were part of the huge network of love and hope and prayers that kept me going for eight months. My patients gave me the gift of a blanket of caring, and I will forever keep it in my heart.

# The Patient's Face

Jean Adomfeh, MD Candidate  
Harvard Medical School, Class of 2022

She is between the ages of 65 and 99.

You at 24 are washed with her aura of wisdom and experience as you crack open the door and wade into the room.

One year of intense medical training and years of undergraduate and graduate studies, along with an inspired spirit of dedication to serving your fellow human, have granted you the privilege of being in this space.

There she sits, on the examination table with her back to the door. She turns to look at you and smiles so deeply it creases her eyes.

You greet her with a handshake and a shy smile.

"I am the medical student working with the doctor today." You are never sure how a patient will react to those words.

"Very nice to meet you," she exclaims. "Your parents must be so proud!"

You touch a hand to your face, warming with her praise.

"How are you? ...What brought you in today?... How are your blood pressures at home...?" You ask and listen and ask away.

She nods and answers with details about her health and pain she has only shared with a handful of people throughout all her decades. You feel honored all over again in how much she trusts you.

"I am going to speak with the team and return with the finalized details about your plan in a few moments," you say after completing the history and physical exam.

The patient grabs your hand before you can step out.

"I just want to say, I am so glad to see you here," her eyes crinkle again.

You let the door swing closed and return to your seat across from her.

"I grew up in a time when I wanted to go to medical school to become a doctor like you, but no one believed I could do it. Women just didn't become doctors back then. Not even my own mother encouraged me. I am just so happy to see that things have changed. You are change."

"Thank you so much," you say, knowing the words are not enough to convey just how deeply she has affected you.

"Thank you."

# Boston Adopts Universal Masking

Josh Dubow, MD  
Internal Medicine, PGY-3



# Things I cannot change

Johnna Marcus, LISW  
Department of Social Work Department

I found it interesting that he had no alcohol in his system according to the toxicology, as the smell of it seemed to add weight to the air, and I found myself imagining it seeping out of his pores like sweat. The patient was medically cleared by the Emergency Department and the only thing keeping him here was whether he wanted help in becoming, and working to stay, sober. I found myself in his hospital room crouching down against the wall, which I tend to do as I dislike standing when patients are in bed, as if looming over them.

I have been hired as a social worker in the Emergency Department to provide care and resources specifically for patients with substance use disorders. What I was learning quickly in this role was that assessing motivation for treatment and helping patients specifically with substance use needs to be focused and targeted, as time was of the essence and motivation could be fleeting. Motivation for treatment in this case, had to do with attending outpatient treatment for his alcohol use disorder and examining inpatient substance use programming as a potential next step.

I asked him what was stopping him from attending treatment in the past, as he has been dealing with the ups and downs of alcoholism for “many years.” He shared, “I have a good job....I’m a chemist at MIT, professor...I was doing ok...for a while....I always do OK, until I don’t, ya know?” I nodded, the information seeping in. He shared, “I am alone, I am lost and I need help.” He reported having family in the area, that now he does not speak to them, as he has “let them down too many time” and reports still being employed because his boss “has a son with similar...issues.”

Now, a little about myself, because a patient interaction can never be assessed by the patient’s experience alone. I have always respected medicine- being proficient in chemistry, anatomy/physiology, biology were skills that I had always admired in other people and that I sorely lacked. Upon hearing about this patient’s impressive resume, I saw the potential of all of these admired skills flowing down the drain and it left me saddened, and somewhat angry- at the disease, at him, at the loss of potential.

I suppose through this work, I have been looking for things to be more concrete, even though I had known substance abuse is never an exact science. I was looking to the toxicology to guide me in the treatment, in the demographics/personal data/employment to assist me in the disposition- when in the end, it was in understanding his unique suffering as a consequence of this disease that gave insight into how I might help him. Understanding that no person wants to stay in pain, and the thing that takes away that pain is sometimes the only thing we believe can save us.

We are reminded in this work that ethical questions are constant, there are no easy answers and determining who is “worthy” of suffering, help, hope- is unnecessary and often even harmful. Accepting that addiction treatment is not a simple solution, while at the same time, believing in its effectiveness keeps my work going. This patient left the emergency department for treatment, which we set up for him together. Like so many others, I have not seen him since, even though I frequently check for his

name. I don't know where he ended up. I accept that this will be an unknown, maybe forever. Acceptance is a term well known to the addiction and recovery world. It's a hard pill to swallow at times, but the more it is taken, the easier it is to take.... that's what we hope for anyways.

# An Ode to the “Berg”

Ijeoma Julie Eche, PhD, FNP-BC, AOCNP, CPHON, BMT-CN  
Division of Hematology/Oncology, Department of Medicine

We stare at scattered hopes  
at the Berg.  
Running from high to low streams,  
yearning for miracles.

We shed tears,  
at the Berg.  
That corner of Nile,  
where the meadow of green fuse,  
the untouched colors.

We stand tall,  
at the Berg.  
Bearing the hands of fear,  
lifeless bodies,  
calamity of those damaged cells.

We bathe in pain,  
at the Berg.  
Praying for patience,  
singing with silence,  
from dusk ‘til dawn.

We hold clues,  
at the Berg.  
Clues to the bygone dreams,  
to the sunless days,  
Where life is always rare.

# On Hematology

Ellen Zhang, MD Candidate  
Harvard Medical School, Class of 2023

To curl up so tiny  
I could reach into myself  
and become a cell.

I want to take the spaces between  
rib cages.  
Crumble them.

Those shrapnel pieces are what  
I use in war. The only proof of  
grave marking where I once stood.

Once upon a time, the story begins,  
bones were made into the finest chopsticks.  
The most delectable foods  
were inhaled, sampled.

My bones will be those chopsticks  
touching the food  
my lips have not kissed in so long.

The doctors say that I have a problem  
As if perfection could be a problem.  
Perfection means staying within the lines.  
Nobody ever mentioned that the lines  
could diverge and boundaries could be  
transcended—that I could be wrong.

I desire to curl into myself,  
becoming a cell. My friend laughs,  
saying sickle cells.  
She is trying to be light  
when we both know  
that we are not.

Sickle cells have the safety net between  
malaria and death—a blessing in disguise  
depending on who, what, when, where, why.  
I am a safety net between life and death.  
No questions asked.

# Bicycle

Lika Targan, MD  
Associate Program Director, Internal Medicine



# The Junk Collector

Janet Fantasia, RN, BSN  
Ambulatory Nurse Care Manager

1995

Stacks of Danish against your porch  
window puzzled me, cellophane  
clinging to moist figure-eights  
but when you opened  
the door I understood.

The entry plaque, bejeweled with flowers,  
belied a sea of junk beyond  
covering tables, counters and cabinets.  
Mounds of old tools, pipes and car  
innards scattered, shedding soil and rust.

I pleaded lapse in memory  
forgetting something in the car  
to return my nurse's bag  
for fear silt or bugs invade  
the leather pouch.

When I returned,  
there you stood, meek  
yet proud, a faint smile across  
your grizzled jowls. I collect junk  
you said, and get paid per pound.

My eyes traveled 'round the room.  
Large models of ships and schooners  
honed by plump, greasy fingers,  
a collector's dream, one behind glass,  
others on piles of old magazines.

What of the Danish, I asked.  
The canteen truck saves me expired food.

I checked your fridge, dark and warm,  
moldy food encrusted to the plates,  
a pool of putrid brown in the bins below.

The bathroom, shrine to plants  
and birdhouses, was gray  
and dry. The small sink  
sat soapless, dripping  
only cold.

Off came the navy jacket with  
stains of scavenge. Unwrapping the  
cuff from the cleaner arm, I rested  
the 'scope against your  
chest to prepare for surgery.

I recited slowly whom  
to call for a ride  
to Admitting  
before dawn.  
Your brow crinkled.

That night, the landlord heard  
fallen cries and found you  
lying smeared in grime.  
The responders came  
and hurried you out.

I motored by to find  
the doorway boarded up,  
on it scrawled: CONDEMNED  
your junk abandoned,  
ships aground.

# Masked

Jaya Kanduri, MD  
Internal Medicine, PGY-3



*Amidst the chaos and uncertainty, nature serves as a constant. But as the flowers continue to blossom, we must not forget to do our part.*

# A Sacred Vessel: The Covenantal Stories We Hold

Nancy Rigelhaupt Smith, MAJS, BCC  
Jewish Chaplain, Dept. of Spiritual Care and Education

“How’d you know I was here?” The patient turns to her nurse. “You know she keeps coming back even though I have a mouth on me and can be quite the b...ch”. Yes, I was simply showing up again, which to paraphrase a physician colleague is “98% of what matters”. I have known this elderly woman for about four years, and my initial visits were typically met with complaints about every aspect of her hospitalization, the “lousy” care or lack of attention that she received from her adult children, and the competitive nature of her sibling, who was always “one upping” her when it came to whose medical or psychosocial issues were the most challenging. And yet, she was right. I did keep showing up. And over time I got to know the ongoing pain and brokenness endured during a complicated marital relationship. I learned of a highly educated and erudite bilingual woman, whose career aspirations were prematurely thwarted due to childcare responsibilities. I came to understand the impact of acute medical issues that resulted in increased limitations in the setting of living with an unusual chronic disease diagnosed in early childhood. And while this seemingly ornery, caustic woman might joke about her behavior and the expected response from others, I believe that she understood that we had entered into a covenant, defined by our relationship of care, commitment and trust.

Paul Kalanithi writes in “When Breath Becomes Air” about informed consent, “it became not a juridical exercise in naming all the risks as quickly as possible, like the voiceover in an ad for a new pharmaceutical, but an opportunity to forge a covenant with a suffering compatriot: *I promise to guide you, as best as I can, to the other side.*”

I was struck by the author’s choice of “covenant” as I read his experience of participating in the ritual of signing a consent form. In my work of more than a decade as a chaplain, I have often thought of this word to describe the relationships that I develop with patients and families. From my first moments as a hospital chaplain, I have been struck with what I believe happens when I enter a room, introduce myself and offer a visit. Simply being a representative of spiritual/religious life seems to offer the message that what we are about to engage in is sacred and covenantal. The story that then unfolds and emerges provides insight into who is in front of me : it may be of deep connections to one’s faith tradition or the ways that faith and clergy have fallen short; it may be of the twenty year estranged relationship with one’s child and the fears of not reconnecting prior to death; it may be of the pride in describing one’s accomplishments as a dancer and choreographer, while currently finding it difficult to breathe upon attempting to simply get out of bed; or it may be of long held fears of what it actually feels like to die. Unlike most members of the multi-disciplinary in-patient team, I am in the unique position of being able to develop and maintain relationships over many years. What may begin as an initial visit with a patient for a spiritual assessment, lays the foundation, opportunity and possibility for a deepening relationship over time. It is my practice to round on patients who identify as Jewish, even if they have not asked to

see a rabbi or have denied a need for spiritual care. I reach out because I have learned that the word “chaplain” is not familiar to many of these patients or their families, and also that the term “spiritual care provider” has been understood narrowly as one who only administers to faith based ritual, liturgical or sacramental needs.

Ms. R. was not yet eighty when I first met her on a rounding visit or routine introduction. She was striking in her appearance as she always came to the hospital with her own, colorful bedclothes, a magnifying make-up mirror and special brushes and combs to fix her hair. She was communicative, upbeat and competent, not someone who would necessarily trigger a referral to spiritual care. In our initial visits, we easily connected around her strong Jewish identity, and her years of participating in Jewish communal and religious life. While early admissions were for issues such as fluid retention, cellulitis, and wound care, over the five plus years that we came to know each other her presentation and demeanor increasingly changed. I knew that the person lying in front of me had been an accomplished nightclub singer, a city council member, a *maven* at canasta, and a synagogue president. She had a wry sense of humor, sprinkled her conversations with colorful Yiddish and Hebrew phrases, and loved to “hold court” with family and friends who would visit her in the hospital. However, to the newly assigned Resident who entered her room a few months ago, the picture of this elderly woman huddled under the covers told a much more limited story. She was disoriented and occasionally hallucinating, her grooming supplies were likely left at home when she was brought in to the ED, and her robust personality was hidden far beneath the surface. My visits that week consisted of holding her hand (I knew this was something that brought her comfort), gently reminding her of my name, and singing one of the liturgical tunes that she enjoyed.

It was during my final visit that I sat with her devoted daughter, one of the patient’s three adult children. It was on an afternoon when we both knew that her mother’s time was limited. Her daughter shared memories that were familiar and meaningful, while also acknowledging the immense impact that this loss would have on her life. “You know my mother loved you”, she said and I smiled, as so many of my visits had ended with Ms. R. blowing me a kiss and saying, “we love each other”.

“You became a valued confidante for my mother, during the most awful time in her life”.

“I’m glad you got to know my dad before his illness robbed him of his great spirit”.

“I’m sorry I was so dismissive on that first visit... over the years you’ve filled a need for my sister”.

“The family meeting today would not have been effective if Nancy was not present.

Her long term relationship with the patient and family- her knowledge of who the patient was when he was well ( more well) made all the difference”.

As I reflect on these quotes from family and staff members, I am struck by what I see as the sentiment being expressed. It is not unusual for patients and families to thank me, either during a hospital stay or later through a note, for my support, presence or care. But perhaps more importantly, the statements above speak to the value, over time, of providing the space for a story to unfold, enriched and enhanced by each detail and memory. In his article in the New York Times “Letting Patients Tell Their Stories” (4/12/16), Dhruv Khullar M.D. asks, “how much more effective would we be as diagnosticians, prognosticators and healers if we had a more longitudinal understanding of the patient in front of us?” He describes that we need to understand “patients as people... in the context of their long, messy,

beautiful lives”. As a chaplain I have the privilege of entering into these lives and the luxury of time to do so in a way that encourages their stories to be told. I am repeatedly struck by tales of courage, strength, competence and resilience, whether in an intimate moment of whispering, “I’ve never really let myself express this fear out loud”, or an instance of pride and accomplishment in sharing a picture, “I designed all of the furniture for this study”. Recently, I was walking toward a patient’s room and saw her spouse standing by the door, appearing despondent and sad. I’ve known him and his spouse for six years, his spouse a patient who has survived a transplant as well as someone who lives with a number of physical limitations. “I’m afraid this is going to be the end of the story”, he quietly says. In that moment I am reminded that each story is unique and precious, and that I have the honor of being a witness as these stories are articulated. I become a sacred vessel, filled by the long, messy and beautiful lives of the patients and families to whom I minister.

# United in Chaos

Supriya Rastogi  
Internal Medicine, PGY-1



# Hands of Service

Rebekah John

Unit Coordinator, Farr 3 Inpatient Cardiology Unit

**O**ur hands are tools that provide service every day in so many different forms to patients, colleagues and visitors on a daily basis. Sometimes, we might take for granted how truly amazing our hands are. Below are just a few of the services they provide daily in The World of Healthcare.

Physicians use their hands to examine their patients and through the aid of a stethoscope they are able to listen to heartbeats and respiratory sounds. Primary care physicians use their hands to palpate the abdomen of their patients and other parts of the body for routine care or if pain exists. Surgeons use their hands and surgical instruments to perform lifesaving surgeries on their patients and sometimes that surgery can be complicated. Cardiothoracic surgeons use their hands to perform heart transplants holding and massaging the human heart. The hand of the obstetrician is the first to touch new life when a baby is born.

The many nurses whose hands are used to provide care in an assortment of ways for their patients such as giving medications, taking their vital signs, providing compassion and empathy through holding a patient's hand, massaging their necks, shoulders, back or feet. They use their hands to perform a sternal rub on a patient's chest if they become unresponsive and if that patient doesn't respond back then their hands are used to provide chest compressions because that patient has cardiac arrested. Their hands provide care in washing and cleaning their patient's bodies along with the assistance of the PCT's and that same care is given when a patient has transitioned out of this life and their bodies are sent to the morgue.

The hands of the PCTs provide an array of care to their patients. Their hands are used to take the patient's vital signs and weight, put them on and take them off the commode sometimes with assistance from the nurse. Their hands are used to wash and clean their patients sometimes with assistance from the nurse and their hands provide nutrients by feeding their patients when necessary. Their hands are used to turn the lights off and put them on and turn televisions on and take them off and adjust room temperatures. Their hands bring cups of ice chips, a can of ginger ale, juice or a cup of coffee, fresh towels, face cloths, or clean jonnies.

There are many hands that handle pagers, telephone calls from a mixture of departments and external places every day and night. The many families calling in to check in on their loved ones, physicians answering questions and clarifying orders and public safety being called for code purples. The many UCOs who multitask on several levels every day and night and sometimes having two telephones receivers on each ear. The hands of the many UCOs that are used to assemble and disassemble charts for admissions and discharges, that prepare new admission packets and the ordering of supplies from external sources and internally from distribution. Hands that update the board with each shift change as new nurses and PCTs come on duty.

The cooks whose hands are used to prepare meals and the nutrition assistant hands that are used to collect menu choices from the patients and then deliver their trays. The many hands that are used to wash the dishes and the many hands of EVS workers that are used to clean the patient's rooms and lots of other areas, the hands that are used to push the machines that strip and clean the hospital's floors.

Radiology and MRI, X-ray, and Ultrasound technicians whose hands are used to record the internal images of disease in our bodies when they are present and when they are not. There are still lots of hands used to provide a variety of service daily that are not mentioned here. So let's take a moment every day to appreciate our functioning and amazing HANDS and the services they provide and our wonderful bodies our creator made.

# Quarantine Walks

Rahul Maheshwari  
Internal Medicine, PGY-2



One small silver lining from this pandemic was how much the pace of life slowed down. I took this picture on my daily walks around the neighborhood during my weeks of Work From Home. I'm not really an outdoors guy - growing up from Midwest suburbs, the fields of corn and crop on a flat landscape quickly grew dull to look at, but in these small beats of peace on my daily walks I gained a newfound (small) appreciation. Have you ever stopped to smell the flowers? Like really actually *stopped* to smell the flowers?

# Humanism at BIDMC

## Correcting a potentially traumatic patient experience

Stafford Cohen, MD

Cardiology

I am one of the many drones among the BIDMC family that roam the corridors of the hospital. When I noticed a patient in a hospital- issued robe, I was forced to ask myself, what is the proper response when confronted with something that might offend an ill patient or their concerned family? I suspect that any of our empathetic and compassionate BIDMC working community would try to rectify the situation. Sympathy is understanding a patient's problem, empathy is feeling the emotion that has seized the patient and compassion is doing something about it.

I noticed patients walking under the supervision of nurses or aids. The patients wore hospital robes that bore black and white vertical stripes. Those robes did not seem right! They resembled the outerwear of death camp inmates during the World War II Holocaust. Six million Jews were murdered as were another six million Christian men, women and children who opposed the Nazi regime or were unable to contribute to its success. Priests, the physical or mentally disabled, the resistance fighters and others were expeditiously murdered, worked or starved to death.

BIDMC has a heterogeneous patient population. Among the many might be a death camp survivor or certainly the family of a survivor. I shuttered with thoughts and feelings of the emotional trauma that they would experience at the sight and memory of a Holocaust death camp uniform.

Administration was alerted, understood the concern and immediately placed the issue under review with the expectation of a corrective action.

That's the BIDMC way; that is just another reason to be proud of BIDMC.

# Fall Magnolia

Nazila Shafagati

Internal Medicine, PGY-1



# Artificial Intelligence:

Technology in the workplace automated nursing activities vs. non-automated

Arindell Arnold-Penny, RN  
CC7 Staff Nurse

Groundbreaking technological advances are happening around us every day. Technology has certainly modernized the way health care is delivered and in doing so the nursing profession evolved drastically. The integration of the automated medication machine, electronic health records, telehealth etc., in the healthcare arena to assist nurses in performing their duties efficiently will only continue to advance. It is up to nurses to remain relevant amid the technological explosion. Glauser (2017) warned that nurses need to be a part of the decision-making process of what can and should be delegated to technology.

**Nursing activity that can be automated:** Traditionally, nurses provide a great deal of patient education and in keeping with the technology momentum and the scientific platforms such task can be an automated. **Rationale:** Using technology such as an interactive video to illustrate and educate patient on disease management can facilitate learning and knowledge retention thereby increasing health promotion in individuals. However, one must keep in mind patients' literacy, socioeconomic background and access to technology.

**Nursing activity that can't be automated:** Human are complex organisms. The therapeutic nurse-patient interaction cannot be automated. Nurses are superbly positioned to see more than the physiologic aspects of a patient, something no artificial intelligence (AI) can replicate (in my opinion).

**Rationale:** Therapeutic nurse-patient interaction create rapport when the nurse shows genuine empathy towards the patient and promote that caring human connection, AI are unable to think critically and foresee human feelings. Nurses need to remain marketable in this technological phenomenon by keeping abreast with the advances in technology.

As pointed out by Glauser 2017, "we have to plan our own obsolescence to some extent because some predictable nursing work and activities that aren't extremely complex will be automated" (p.25).

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# CADUCEAN LIGHTS

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