My Patient, My Friend

Category: Stories
written by Larry Zaroff | November 7, 2008

Death is not always the same. Quantity, fixed: one per patient. Quality, variable.

Doctors see many deaths, of different kinds. This is true of any doctor, whether or not he or she is a surgeon, as I am.

It’s easier for the doctor when death is expected, following a long illness, a chronic disease. Harder when it’s unforeseen—the heart attack, the accident, the gun shot, the sudden death in a young man or woman who seemed a conqueror.

Sometimes, in a long-term patient-doctor relationship, the two types of death merge: Death becomes the harsh, abrupt end to a journey taken by two travelers.

M was a special patient—thirty-something, warm, charming, brave. At our first meeting, an office visit in the early Sixties, she gave me her special homemade pickles, just to my liking, medium sour with a dill flavor. Over the next decade, she and her family and I became close. She was generous, always patient. The operations I performed to treat her mitral valve disease, a manifestation of previous rheumatic fever, reflected cardiac surgery’s progress over that time.

In her first operation, I incised her chest between the ribs on the left side. I opened her calcified blocked mitral valve—the gateway to the left ventricle, which pumps blood to the body—by blindly inserting my finger through the left atrium, the heart’s upper chamber, breaking open the valve’s fused leaflets.

M was better for five years. I followed her closely at regular intervals until her increasing shortness of breath and fatigue signaled that the valve blockage had recurred. When her cardiologist and I suggested another operation, more complicated than the first, she did not hesitate. And when I explained the greater risk, she smiled and passed the pickle jar across the desk. Her trust, her belief was complete.

I replaced M’s diseased valve with a mechanical prosthesis of metal and plastic, this operation done through an incision in the midline dividing the breastbone. She again recovered swiftly, resuming her busy life as a wife and mother.

Another five years of follow-up, of friendship, during which M and I became even closer. We talked about more than just her medical care, kept up with what was happening with each other’s families and children.

Ten years after her first heart operation, five years after her second, M came to the office thin and weak, having suffered—and only partially recovered from—two small strokes. Despite her being on blood thinners, small clots were breaking off from the plastic and metal valve and traveling to her brain. She was more frightened than she had ever been, and seriously ill, so sick that she brought no pickles.

Serious consultations followed between patient, family, cardiologist and the surgical team. Reoperations carry greater risks because of the adhesions that join the heart, pericardium (the sac encasing the heart) and surrounding lungs in a mass of scar tissue. An operation to remove M’s mechanical prosthesis and replace it with a bioprosthesis—a pig valve, less prone to form clots—posed greater dangers than the first two. She, courageous, had expectations of full recovery.

As Susan Sontag has argued, caring for the very sick has consequences for the physician. Those consequences are magnified when patient and doctor are friends and enjoy a long relationship. I shared M’s suffering, her pain; I wanted to help.

The third surgery, through the right chest, was difficult. Extensive adhesions, plus the need to remove the previous valve embedded in the heart muscle, made for an epic procedure.

An epic procedure. And a technical error.

In excising the first prosthesis, I damaged the heart wall. Though I repaired the tear, I feared complications. M was taken to the intensive care unit in stable condition, but a few hours later a massive, sudden bleeding occurred.

My friend M died in the intensive care unit.

Any death in which a doctor participates has a powerful impact. Somehow, when the death is surgical and acute—a hands-on death resulting from a technical error—the onus and the guilt feel greater. Atul Gawande, MD, in his superb book *Complications: A Surgeon’s Notes on an Imperfect Science*, reminds us that the best doctors in the best hospitals make mistakes, serious blunders that kill people.

I find no solace in knowing this.

Would I have felt less devastated, less depressed, better able to move on to the next patient if M and I had not been friends for ten years? I think yes.

But I would have missed the best part of medical practice—a long relationship, the sharing of an illness, the traveling of a road together.

That is my consolation.

Halloween Horrors

Category: Stories
written by Paul Gross | November 7, 2008

Paul Gross

One October evening last year, I went to our local pharmacy to pick up a prescription for my daughter. I made sure to bring Cara’s insurance card because my employer had switched us to a new health plan.

I wasn’t sorry about the change. Our prior plan had been operated by incompetents—although they might only have been crooks, I couldn’t be sure—who also managed our flexible spending accounts. These accounts, you may recall, collect pre-tax income from your pay and then return it to you to pay for out-of-pocket medical expenses.

With that plan, nothing ever worked as advertised. I would submit a dental bill for reimbursement and the company would review it for three months before sending me a denial notice, stating that my health plan had no dental coverage.

“I know that I have no dental coverage,” I’d tell the representative on the phone. “That’s why I put a big X in the box labeled Flexible Spending Account.”

“You sure did!” she’d say cheerfully. “I don’t know why they did that. You’ll have to submit it again. This time, put my name on it….”

Or I’d submit a claim for a medical expense that was covered, then hear nothing for months and months.

“We’ve fallen behind,” a weary-sounding representative would lament. I could picture the ceiling-high stacks of claim forms swaying on her desk. “You should be hearing shortly…”

No one ever said “I’m sorry.” No one ever acknowledged the annoyance of the paperwork or the aggravation of waiting on hold for a representative. No one ever said, “Gee whiz! We hoped you wouldn’t notice, because if you forget to contact us, we get to keep your money,” although I suspected that this was one of their operating strategies.

So I was happy with the change in health plans. And there at the pharmacy, I optimistically produced my daughter’s new plastic card.

The pharmacist punched something into a computer and stared impassively at a screen. After several minutes, I wandered off to look at vitamin capsules and cold remedies.

When I returned ten minutes later, the pharmacist was on the phone with my insurance company. Ten minutes after that, he was on hold for a different company, the one that manages the pharmacy plan.

While the pharmacist waited, I browsed the magazine rack. Then I made my way to the Halloween aisle, where I saw candy similar to the trick-or-treat leftovers desiccating in our freezer since the previous October.

The pharmacist finally beckoned and rendered a verdict: “Your daughter isn’t covered under your pharmacy plan.”

“What?”

“They’ve got *you* on their system, but no one else in your family.”

“I can’t believe…”

“They say you’ve got to talk to your benefits representative.”

I thanked him for his thirty minutes of trouble. The next day I called my benefits representative, who reassured me that our entire family was in their system. Days later, my wife tried to fill a prescription—no luck.

The following pattern repeated itself over the next few weeks: (1) I’d call my benefits representative and receive assurances that the problem had been fixed; (2) we’d try to fill a prescription for my wife or daughter; and (3) the pharmacist would tell us that she wasn’t in the system. Finally, weeks later, somebody somewhere flicked a switch and—*voila*—the pharmacy plan kicked into place.

Which brings me to the upcoming presidential election.

One of the candidates for our highest office is advocating new deregulations that would encourage Americans to comparison shop for health plans in all fifty states. This is nifty, if your idea of a simpler, more efficient health system is more health plans.

My first reaction was: who has time to spend evenings and weekends comparison shopping for health plans in all fifty states? And who wants to repeat the shopping trip in a year, when a plan’s sticker price is sure to go up? Each change in plans, of course, means new cards, new forms, a new list of covered doctors….

The last medical comparison shopping I did was to hunt online for a Medicare Part D prescription drug plan for my 83-year-old mother. It was a nuisance. Years later, she’s still using the same plan. Not because it’s still the best for her—who knows?—but because it’s just simpler that way.

The suggestion that some nimble shopping in a health-plan emporium is going to fix our health-care system would never occur to anyone who’s wrangled with prior authorizations, changing doctors when one plan flips to another, or getting inappropriate bills because last year’s insurance company was incorrectly charged for this year’s blood tests.

Most people understand that each new plan—even a better plan—is a new bureaucracy. One more snarl in a tangled health-care web that already boasts hundreds of commercial health carriers and thousands upon thousands of different plans.

The only person I can imagine embracing a “more-plans-the-merrier” system, aside from insurance investors, is someone to whom it won’t apply. Someone like our current presidential candidates—who as senators have a government-financed insurance menu that appears to suit them just fine.

For this Halloween season, the notion that we should flood the nation with more health plans seems like a horror-film plot rather than a long-term strategy for better health care.

Once Halloween is over and we put away the costumes and candy, I could go for fewer health plans. Fewer phone numbers. Less rigmarole. And an end to evenings spent wandering the pharmacy aisles, waiting for an okay from Health Plan Number 3,011.

About the author:

Paul Gross MD is founding editor of *Pulse—voices from the heart of medicine*.

Story editor:

Diane Guernsey

In the Taxi to the MRI

Category: Poems
written by Rachel Hadas | November 7, 2008

Rachel Hadas

I try to concentrate on the weather. Everything
deliquesces into simile.
Sleet ticks onto the windshield like a clock.
Truth blinks on/off like a stuck traffic signal.
It is better to live in the light but the light is flickering.
Anything more than the truth would have seemed too weak-
Poetic paradox understood too late
or maybe just in time. What time is it?
A small white poodle in a quilted coat
lifts a leg to pee against a hydrant
on Sixtieth Street, and we are nearly there,
early, of course. And since (she said) my heart
has been wrung out, no, broken, this is the …
this has to be … The sentence will not end.
The mind pulls, stretches, struggles, and returns
not to any absolute beginning
but a blank wall. Is there a door in it?

A future? How to get there? And once there
how to escape? When flickering stops and steady
light shines, that may be the worst of all.
Anything more than the truth would have seemed too weak,
but mercifully the blinking begins again.

About the poet:

Rachel Hadas is board of governors professor of English, Newark campus, Rutgers University. The latest of her many books of poems is *The River of Forgetfulness* (David Robert, 2006); *Classics* (WordTech Communications), a volume of selected prose, was published in 2007. Her website is www.rachelhadas.com.

About the poem:

“My husband’s MRI signaled the early stages of the process of diagnosing a progressive dementia. Even before he took the test, I instinctively knew the news would not be good. Poetry helps me to understand what I am feeling and thinking; it helps me to not feel overwhelmed and purely reactive. I would be delighted were the poem to prove of help to anyone.”

Poetry editors:

Judy Schaefer and Johanna Shapiro

Entry from an Intern’s Journal

Category: Stories
written by Jennifer Reckrey | November 7, 2008

Jennifer Reckrey

Editor’s note: Over the next months we’ll be carrying occasional pieces by Jennifer Reckrey, a family medicine resident in New York City. Each week while she was an intern, Dr. Reckrey recorded some of her experiences as a brand-new resident. Today’s story is from week number six.

How do you convince someone to do something they don’t really care about?

This week I took care of a 58-year-old woman who came to the hospital with one week of fevers, diarrhea, burning with urination, and abdominal pain. Though she probably had an infection, the CT scan she got in the ER didn’t reveal its source. It did, however, show that something was wrong with her uterus and ovaries. If the odd-looking mass was an abscess, it needed to be drained. If it was a cancer, she needed a very different sort of treatment plan. And to find out what was going on, she needed an MRI.

When I first asked her about it, she quickly agreed. She’d had MRIs scheduled in the past (her outpatient gynecologist was concerned about her too), but had always missed her appointments. She seemed glad for the chance to get this cumbersome test over with while she was stuck in the hospital anyway. But when they called her down for the scan, she refused to go.

I went to her room, where she was resting comfortably on her bed and watching TV. I explained what the test would be like and why it was so important that she get it done as soon as possible. I tried to be gentle yet firm. And she wouldn't budge. When I asked her why she wouldn't go, she said that she didn't want to miss her soap opera. Without knowing how I got there, I found myself playing the bad cop.

"Do you really think watching your telenovela is more important than trying to find where your infection is coming from and making sure that you don't have cancer?" I asked.

"Yes," she answered.

About an hour later, my supervising physician went to talk with her, and she told him that she was afraid of feeling claustrophobic in the MRI machine. Thinking the problem solved, I gave her some encouragement and a sedative to help her relax and sent her for the test. An aide wheeled her down to the radiology suite, but just ten minutes later wheeled her right back up to the floor again. From down the hall, I could hear her complaining that the line for the MRI machine was too long and that she didn't want to wait for yet another test. I left the hospital that day wondering what I could have done differently, better.

When I came in the next morning, she'd had the MRI overnight. No fanfare. No sedation. No big deal. (And no big help either. The MRI confirmed neither abscess nor cancer, and gave no further clue as to what might be causing her pain and fevers.)

There have been many other patients like her this week: the diabetic with the huge, gaping sore on his foot who refused antibiotics and insulin; the young sickle-cell patient who wouldn't go home until her pain cleared completely; the family who insisted that their demented, dying mother have a feeding tube inserted; the chronic schizophrenic, now stable, who refused to take his antipsychotics.

I must respect each individual's right to make decisions about his or her care, but I must also make sure that these patients understand the consequences of the decisions made. My training gives me a perspective on the big picture that patients often don't have. For me to pretend that all options are equally good would be just as dishonest as pretending that, since I'm the doctor, I should have the final say.

Balancing these competing demands—the patient's right to freedom, the doctor's duty to provide guidance—is not easy.

About the author:

Jennifer Reckrey MD is a second-year family medicine resident who graduated from SUNY Stony Brook School of Medicine. “I started writing these reflections to keep in touch with friends and family, but the process of putting my experiences into words has also helped me to better understand my own practice of medicine.”

Story editor:

Diane Guernsey

Carmen’s Story

Category: Stories
written by Carmen Diaz | November 7, 2008

Carmen Diaz

I used to be a shy woman who didn’t like the spotlight and never did any public speaking. Ovarian cancer has changed all that. Now I look for opportunities to tell my story.

I am a 62-year-old, Puerto Rican-born, New York-raised mother of two. I was diagnosed with ovarian cancer in 2004. But for more than a year before that, my symptoms weren’t recognized.

In January 2003, I started to suffer from abdominal discomfort, back pain, indigestion and heartburn. My primary-care physician told me to change my diet and prescribed medication for my indigestion. After weeks with no improvement, I went to a gastroenterologist, who diagnosed gallstones. In March, I had gallbladder surgery.

Most people go back to work within ten days, but it took me a month. My fatigue, heartburn and stomach cramps, I was told, were probably a result of the surgery. Over the following months, I kept returning to my primary-care doctor, who prescribed antacids. Eventually, fearing that he’d brand me a hypochondriac, I stopped going.

That fall, during a routine gynecological check-up, I told my ob-gyn that I was feeling pelvic pressure and a burning sensation in my bladder. My pelvic exam and Pap smear revealed no abnormalities; she told me I had a urinary-tract infection and prescribed antibiotics.

By early 2004, I was having trouble eating: even after small meals, I felt full and bloated, and my stomach swelled. Family members began to ask jokingly if I were pregnant.

All my life, I’d been an avid tennis player and skier and exercised regularly. Now, fatigue and shortness of breath forced me to cut back on my workouts. My primary-care physician ordered a stress test, electrocardiogram and blood tests, which showed that I was anemic, so I took iron pills and began to feel better.

I hired a personal trainer to concentrate on abdominal exercises. After several weeks, though, I realized that no amount of training was going reduce my stomach. That April, determined to get my flat stomach back, I had a tummy tuck.

A few weeks later, the right side of my abdomen began to bulge. “It’s probably a hematoma—residual blood,” my plastic surgeon said, but he also ordered a CT scan and a blood test for CA125, a tumor marker.

The results were shocking: my abdomen was filled with fluid, and my CA125 was sky-high.

My plastic surgeon delivered the news: I had stage IIIC ovarian cancer that had metastasized to my pelvis, lymph nodes, bowel and liver. I was so stunned, I can barely remember a thing he said.

He also informed my primary-care doctor, whom I’d known for fifteen years. When I went to see him the next day, he was devastated. “I don’t know how I’m going to talk to Carmen about this,” he’d told his wife.

We spent a long time discussing the cancer. Reviewing my healthy lifestyle, he told me, “You did everything you were supposed to do.” And he had already made an appointment for me to see a wonderful surgeon that very afternoon, so I couldn’t be angry with him.

I do feel angry at my gynecologist, though. When I’d told her that I was having a tummy tuck because of my distended belly, she’d never mentioned the possibility of ovarian cancer; she’d only commented, “The next time I see you, you’re going to have a nice, flat stomach.” And when I told her about the cancer diagnosis, she only said that ovarian cancer is very hard to detect.

She made me feel that there was nothing anyone could have done, but I don’t believe that. I feel so mad that I was misdiagnosed so many times. If I’d known about the symptoms of ovarian cancer, I could have gotten help earlier.

A month after being diagnosed, I had a total hysterectomy with debulking, followed by six rounds of Taxol and Carboplatin. Eight months later, a second-look surgery revealed more cancer cells. Cisplatin, delivered directly into my abdominal cavity, made me so ill that I had to be hospitalized for ten days. I went into remission for ten months.

Then, in April of 2006, more than a year after my hysterectomy, my pelvic pain started again. After negative MRI and PET scans, the doctor said that the pain might be caused by adhesions.

In June, during a procedure to remove them, one of my intestines got punctured, so the surgeons had to reopen my abdomen. They detected some microscopic cancer cells, and I started yet another round of chemo—six months of Doxil and Gemzar this time.

This past summer, eight months after I’d finished the chemo, they found a tumor in my liver. In August I had a part of my liver resected, and I’m still recuperating. I’ll be starting six rounds of chemo next week. Once you have ovarian cancer, it’s a never-ending cycle of remissions and recurrences.

How do I cope? I have a lot of faith, and I get strength from prayer and from my family’s support. And I never think about my illness. Even when I’m having chemo, people tell me, “You don’t look sick.” I always believe that I’m going to beat this disease.

Because of my experiences, I decided to become a volunteer at SHARE: Self-Help for Women with Breast or Ovarian Cancer (www.sharecancersupport.org). I offer counseling in English or Spanish over the SHARE hotline, because I want to help women who have ovarian cancer not to feel so alone.

I was always shy, but after SHARE sent me to a public speaking class, I went to Philadelphia and spoke before 200 physician assistants. *The Today Show* has taped me speaking to students at Mt. Sinai Medical Center, and I’ve gone to Washington, DC, to talk with New York Senators Clinton and Schumer about research funding. I also speak to Latina women in Spanish Harlem and Queens.

Every year I visit several medical schools. “Every woman can have these symptoms, but persistent symptoms are a red flag,” I tell students. “If a woman has them for more than three weeks, I want you to think about ovarian cancer.”

Unfortunately, my story is not unique. I try to live each day of my life as fully as possible. And I am committed to helping other women who face symptoms like mine: I share my personal experiences so that they won’t have to go through what I did.

About the author:

Carmen Diaz is a mother of two and grandmother of four. For many years she worked at NYU Law School as an administrator before retiring in 2004 after being diagnosed with ovarian cancer. She now volunteers for the Ovarian Cancer National Alliance (www.ovariancancer.org) and the SHARE hotline (866-53SHARE).

Story editor:

Diane Guernsey

Rx

Category: Poems
written by Veneta Masson | November 7, 2008

Veneta Masson

Politicians…were quick to rise to the defense

of a particularly vulnerable population. As a group,
dual-eligibles [Medicare-Medicaid] have incomes below
the poverty rate…and take an average of 15 medications a day.

Washington Post
January 14, 2006

This is how it works:
as wealth trickles down
to the poor and old
it turns into pills.

So M and S, their slender portfolios
long since depleted, can still
compete for bragging rights.
I take twenty a day, says M.
Ha! counters S, *I take so many*
they had to put in a port.

G presides over the corporate enterprise,
his specialty, mergers and acquisitions.
With combined assets (his own and his wife's)
filling two cupboards, he allocates resources,
tracks inventory, restocks
from Canada and Wal-Mart.

K can still indulge herself.
I'll start with one of the pale pink ones,
she tells the striped tabby,
but I might decide I need two or three.
I'll wait a while and see how I feel.
Maybe the purple would do me more good.

Honor is served.
Wealth is transferred.
The old have their pills.
And their health?

That’s another story.

About the poet:

Veneta Masson is a nurse and poet living in Washington, D.C. She has written three books of essays and poems, drawing on her experiences over twenty years as a family nurse practitioner and director of an inner-city clinic. Information about her new poetry collection, *Clinician’s Guide to the Soul*, is available at www.sagefemmepress.com.

About the poem:

When I first read the article in the *Washington Post* from which I took the epigraph for this poem, my mind flooded with memories of all the elders I’ve cared for over the years and what role their pills played in their lives. Talk about the placebo effect! It applies not just to the patient whose medication fills various roles, but to the professional who prescribes them and the society which manufactures and pays for them.

Poetry editors:

Judy Schaefer and Johanna Shapiro

In the Nick of Time

Category: Stories
written by Barry Thompson | November 7, 2008

Barry Thompson

When the ringing woke me at 3:00 a.m., I hoped that it was my alarm clock. For a neurologist on call, middle-of-the-night phone calls mean trouble; as a rule, you don’t get awakened at that hour unless it’s something really serious.

At 6:00 p.m. the prior evening, a young man had shown up in the ER of one of our satellite hospitals with a severe headache. He'd been diagnosed with a tension headache and discharged with a prescription for acetaminophen with codeine. No imaging studies had been done.

Nine hours later, the patient presented to the ER at our main hospital. He was no longer fully alert, the ER doc told me. I told him to get an immediate CT scan of the head. I was out of bed and through the door in an instant, worrying about this young, otherwise healthy man with a severe headache and reduced alertness. It's amazing how fast you can drive in the dead of night when you're nervous that a life may hang in the balance.

I parked in my usual spot, right by the ER entrance, and ran inside. The nurse told me that the patient had been sent upstairs to get his CT. I dashed to the elevators and got to the CT suite in just a couple of minutes. By now I was running on adrenaline; as I swung the door open, I could feel my heart thumping in my chest.

Again, my timing was off; the patient now was on his way down to the ICU. I couldn't believe I'd missed him again. Luckily, his films were lying on the counter, and I slapped them up on the viewbox. When I saw what was on those films, my heart really started to pound. They showed a massive enlargement of the ventricles (fluid-filled cavities, normally quite small) inside his brain. The resulting increased pressure inside this young man's skull explained his headache and grogginess. I ran even faster down the stairs to the ICU, where I finally caught up with him.

To my surprise, he was still on the gurney, just as the transport people had left him. He was unconscious, his ER chart resting on his chest. Apparently, the nurses were in the middle of changing shift; no one there had even taken a look at him. He was just lying there, unattended. I couldn't believe what was happening; it was as if I were in the middle of some horrible dream.

After a few seconds' assessment, I realized that he was in the process of herniating: The increased pressure inside his head was pushing his brain down through the opening at the base of the skull, through which the brain and spinal cord connect. His left pupil was widely dilated and unresponsive to light, and he showed signs of damage to the motor pathways controlling his left side. Unless I acted immediately, he could be dead in a very short time.

I shouted to the nurses that he was herniating, which really got their attention. I told them to immediately give him a large intravenous dose of mannitol, a powerful diuretic.

Within seconds, as I anxiously watched over him, his pupil shrank back down to normal size. It was working!

After only another minute or two (or so it seemed; I was so amazed and overjoyed that it was hard for me to judge), he woke up! My patient, who had been on the brink of death just moments before, was now alert: He knew his name and where he was, and he could move all four limbs. I felt euphoric.

Walking on air, I approached the small room by the ICU where his mother and father were anxiously waiting. From their expressions, I could tell that they expected the worst. As I delivered the hopeful news, I fully realized the enormity of what had taken place: Had circumstances been just slightly different, I would have been informing them instead of their son’s death.

Even now, after all these years, my eyes mist over when I recall that night. If I had missed just one more traffic light, or lingered in bed just a couple of minutes longer, or if there had been no parking spot right by the ER entrance, I believe that my patient would have died. (His symptoms, it turned out, were due to a noncancerous tumor inside one of his ventricles; following a successful operation, he made a full recovery.)

On that night so long ago, it seemed to me that some higher power, or fate if you will, placed me at that young man’s bedside at exactly the right time. It seems a bit fantastic to me now, but back then it made perfect sense. I’m no longer a strong believer in fate, but when I relive that night in my mind, a powerfully spiritual feeling still comes over me.

I never again found myself in a situation in which my split-second actions at a precise moment in space and time allowed me to save another’s life. Every time I think about that night, I thank God that I was lucky enough to have done just that.

About the author:

Barry Thompson MD is a graduate of the University of Southern California School of Medicine. After engaging in the private practice of neurology for fourteen years, he left medicine in the late 1990s to become first a ballet photographer and then a psychotherapist. He lives with his wife and two children in the Pacific Northwest.

Story editor:

Beth Hadas

Antibodies

Category: Poems
written by Shanna Germain | November 7, 2008

Shanna Germain

At twenty, I started working the HIV
ward, midnight to morning. Left my husband
sleeping, mouth-open to the air, to
drive through the dark body of the city.

Every shift, the warning about infections.
Me sliding on booties, disposable
gown and gloves. Even through the mask,
you could smell decay, the way viruses

swept through bodies. I did what was needed:
held hands through double-gloves, took blood
or confessions when I could, told off-white lies
to thin cracked lips that knew the truth.

Once, a year or so into it, I stuck
myself, pointed red end of an IV needle
left in a lab coat pocket. So small a thing
it almost didn’t hurt going in, only

leaving, small pop and smear of two bloods mingled.
I put the wound to my mouth and sucked before
I thought. Fear rising, rinsed my tongue with soap,
spit someone’s dark blood into the white scrub sink,

then gave my own blood to one of the other nurses
to be tested. At dawn, I roused my husband awake
with my newly tainted tongue, let him slide bare
into me, as though nothing was between us.

I tell this all like it was an accident:
someone else’s lab coat, a needle forgotten
in a white pocket, three seconds of married
passion so strong my lips did not say, at risk.

But no. This was after I caught the cliche
of my life: his red scrawl across receipts hidden
in a desk drawer, the smell of lilacs in
his sleeves, the cleaving across the bedsides.

The things we do in fear are the things we don’t
say. Hidden and rampant as a hotel room stay
on a credit card, or a string of genes
in a coat of protein, destined to repeat.

About the poet:

Shanna Germain is a poet by nature, a short-story writer by the skin of her teeth and a novelist-in-training. Her poems and short stories have appeared in publications such as the *Absinthe Literary Review*, *American Journal of Nursing*, *Best American Erotica*, *McSweeney’s* and *Salon*. You can see more of her work on her website, www.shannagermain.com.

About the poem:

“This poem came about because I was thinking of all the things that we do to protect ourselves, not just in the medical field but in life. Not just healthwise, but also to protect our hearts, our souls. And how easily that can all be undone—by someone else’s actions or by our own. And how we live with those repercussions after. Or don’t.”

Jeannie

Category: Stories
written by Andrea Gordon | November 7, 2008

Andrea Gordon

“The person with the contractions gets to pick the channel,” I reassure Jeannie, as she tries to talk me into watching *The X-Files*. It’s not my favorite, but I’m just the moral support—oh, and the doctor.

When she first came to see me, eight months back, Jeannie already had a four-year-old boy and didn’t think that there was much my little white nulliparous self could teach her about pregnancy. I’d offer her my book-learned advice about pregnancy or suggested sources of support, and she would listen patiently, then do what she wanted. She did show up for all her appointments, and she humored me at times: although she refused to stop smoking pot for her nausea, she cut down a little “to make you feel better.”

Jeannie shared everything without embarrassment. Well-trained resident that I was, I asked her about bleeding or discomfort during sex. She said that it sometimes hurt when she was on top, “But he don’t like havin’ to be up there doin’ all the work.”

Now, two weeks before her due date, she’s come into the office contracting. Sure that this is it, she’s already arranged care for her son. We make the ten-minute pilgrimage to the hospital. I ask who she’ll have with her during labor. Looking at me with one eyebrow raised, she replies, “You.”

Oh. Okay.

So I sit with her, and we watch *Wheel of Fortune* and *The X-Files* and chat. I hadn’t realized how important it is to her to have her own doctor. While completing the paperwork to be admitted, she’d informed me, “That nurse figured I was with the clinic. But I said, ‘No, my *doctor* is Dr. Gordon.’ ” A little satisfied smile at defying the nurse’s expectations.

The pigeonhole they’ve tried to squeeze Jeannie into pinches her, and she’s not about to stand for it. As we sit there, she tells me about her previous labor. They’d said she couldn’t have any pain medicine because she was too far along. “I grabbed that man by the tie and said, ‘Give me some morphine.’ And he did!” Wary of the world, she adds, “Who you gonna trust? If you’re black, you can’t trust the police. Can’t nobody trust lawyers. So you gotta trust your doctor.”

I try to express gratitude, but she brushes me off, changing the channel to a talk show.

After twenty hours of dwindling contractions, some sleep and then eighteen laps around the floor the next morning, we conclude that she is not in labor, having stopped dilating at three centimeters the night before. Jeannie and I leave for our respective homes, knowing that this is not farewell but au revoir.

Two nights later I’m awakened by a call from Katherine, one of my fellow residents.

“Your patient is here in labor, and she’s wild. Get here as fast as you can!”

Barreling into the hospital room less than ten minutes later, I see Jeannie thrashing on the bed, wailing, “Pain! Pain!”

Katherine tells me that they have been unable to get an IV into her because she won’t stop writhing.

“Jeannie,” I implore, “you have to hold still so they can do this and give you medicine for the pain.”

“I can’t, I can’t, I can’t,” she moans, tossing from side to side.

Some inner drill sergeant surfaces: I put my face over hers and bark “Jeannie!”

She freezes for a minute, then whispers, “What?”

“Have I ever lied to you?”

A pause, then: “No.”

“Okay, so listen to me. You can do this.”

A combination of commands and reassurance gets the IV placed, Stadol given, Jeannie calmed. I stay next to her, bullying as needed when she begins to push. The bizarre intensity of our connection doesn’t occur to me until she asks for some ice. I begin to leave, but my supervising attending jumps up from the rocking chair, saying, “I’ll get it. You stay here.”

Jeannie has a baby girl, Keesha, and for the next four months brings her faithfully to see me. Then it’s time for our last visit, because I will soon be graduating from residency.

Through the whole visit, Jeannie refuses to meet my eyes. She addresses her comments to Keesha: “You find a good doctor, and she just leaves.”

I try my best behavioral-science phrases. “I know that you’re upset I’m leaving…”

Jeannie will have none of it.

“Got to find a new doctor again,” she tells Keesha.

I tell her which doctor will be seeing her and Keesha, but she keeps her gaze averted and finally leaves with Keesha in the carrier.

She doesn’t even say goodbye.

As she walks down the hall I consider going after her to hug her, but realize that this is far too public a place, even if she might otherwise want me to do so. So I just watch her strong, straight back recede as she goes and think, “I love you too, Jeannie.”

About the author:

Andrea Gordon MD is on the faculty of the Tufts Family Medicine Residency Program at Cambridge Health Alliance in Malden, Massachusetts. “Although I wrote poetry in high school, I had stopped until my advisor in residency told me, ‘You should write poetry.’ That was enough to start me writing again. I feel privileged to be invited into people’s lives and to hear their stories.”

Losing Tyrek

Category: Stories
written by John Harrington | November 7, 2008

John Harrington

Tyrek’s mother and I must have spoken for two hours in the Pediatric Intensive Care Unit, covering every topic but the one that was glaring at us: death. A fourteen-month-old child is not supposed to die—and even though I knew the situation was dire, I couldn’t bring myself to face it. So I excused myself, sat down with her son’s chart and stared blankly at it.

I first met Tyrek and his parents when he was just three months old. Tyrek had Down syndrome, clubbed feet and a large sternal scar on his chest from surgery to repair a complicated heart defect. Despite his bad luck, Tyrek’s most impressive characteristic was his cheery disposition. His mother was a tall African-American woman with straightened hair and warm eyes that always appeared weary. Tyrek’s father stood well over six feet, a sharp contrast to the “little man” he held in his arms.

I became Tyrek’s pediatrician through a referral from a cardiologist who knew that I care for children with special health needs and that I happen to have a son with severe autism. Tyrek’s parents and I bonded quickly, our conversations more animated and collaborative than the typical doctor-patient exchange. Tyrek always arrived at the office cradled in his father’s massive arms and with at least one foot casted. I relished these visits because his parents were always so proud of Tyrek’s accomplishments and always let me share my latest story about my own son, Sean.

Sean has difficulty communicating. Yet when we met Tyrek and his parents by chance at the neighborhood Staples, Sean wanted to touch Tyrek’s cast. Carefully, Tyrek’s mom explained that the foot wasn’t straight, so the doctor had put it in a cast to fix it. My son nodded and said, “Good boy Tyrek!” as we all smiled approvingly.

Those smiles faded from my memory as I found myself back in the ICU.

Tyrek’s mechanical heart valve had not been working properly, and the surgery to correct it was unsuccessful. I stood beside Tyrek’s bed and stared at the monitors while his mother sat on a makeshift bed. I was convinced that he’d pull through. He’d already beaten most of the odds.

When I was a resident, the nursing staff and other residents would look to me to lighten a difficult moment with humor. Now, with Tyrek’s mother, I mentioned a conversation my youngest daughter, Maya, had had with me about her older sister, Claire. She’d said, “If Claire can play the clarinet, how come I can’t play the Maya-net?” Tyrek’s mom smiled for a moment.

Even as she did so, something inside of me wanted to reach out, embrace her and tell her that I was sorry I could do nothing. Instead, I resisted it and went home for the weekend.

I came to regret that decision. Tyrek died a few hours later.

Even though I had left my twenty-four-hour pager, home phone and cell number with the parents and staff, no one contacted me when Tyrek passed away that Friday night.

Maybe his parents and the staff felt that I’d already said my goodbyes. Maybe they thought that I would be busy playing with my kids. Maybe they were worried that I would feel guilty or depressed that Tyrek didn’t make it. Or maybe they didn’t give it a second thought. I felt cheated—even disappointed—by the staff and by Tyrek’s parents for not notifying me. But inside, I felt most upset at myself for not seizing the moment earlier when I’d had the chance.

Now I had to wrestle with closure. I felt all the remorse I hadn’t expressed at Tyrek’s passing. At the same time, I couldn’t bring myself to go to the funeral or wake; instead, I sent a letter of condolence. It simply said, “My deepest sympathies, we will all miss Tyrek. Dr. H. and family.”

I wish I could say that Tyrek’s parents responded to my letter with some reassurance that they’d felt my last hours with them were important. I never heard from them, and I’m left to wonder why. I think of the words of the English writer Joseph Addison: “Friendship improves happiness, and abates misery, by doubling our joys, and dividing our grief.” I feel painfully aware that I missed a special opportunity to let down my guard as a doctor and, by acknowledging the friendship I felt for Tyrek and his parents, to share our common grief and our humanity.

About the author:

John Harrington MD is a board-certified general pediatrician and the father of Claire (fourteen), Sean (twelve) and Maya (eleven). He is the new division director of general pediatrics at The Children's Hospital of The King's Daughters (CHKD) in Norfolk, VA. "Writing has always afforded me the chance to go back and replay moments in time where I was conflicted and perhaps emotionally exhausted as a physician. It provides an opportunity to regain perspective and insight on many different levels."

Physician's Exasperation

Category: Poems
written by Howard Stein | November 7, 2008

Howard F. Stein

We know so much about you—
Your blood, your urine, your internal organs.
We can see everything.
There is precious little that
Is not wrong with you medically.
Still, you do not listen to us.
You miss appointments;
You don't go to referrals we've made.
Do you defy us or merely not understand
How dire your condition is?
You could die at any time,
We have told you more than once.
Still, you muddle along as if all we know
Does not matter. Tell me, what
Is missing from our story?
Have we failed to impress upon you
The urgency of the hour? Speak to me.
I will listen now.

About the poet:

Howard Stein PhD, a psychoanalytic and medical anthropologist, is a professor in the Department of Family and Preventive Medicine at the University of Oklahoma Health Sciences Center in Oklahoma City, where he has taught for thirty years. A poet as well as a researcher and scholar, he has published five books of poetry, including *Theme and Variations*, which will be published this October by Finishing Line Press (www.finishinglinepress.com). In 2006 he was nominated for Oklahoma Poet Laureate.

About the poem:

“The search for control—real, imagined, wished-for—is at the unstated core of much of medical ‘competence.’ Not only are diseases often “out of control,” but patients are likewise beyond physicians’ control. In the face of repeated struggles to gain patient ‘compliance’ or ‘adherence’ to medical advice, and after engaging in “patient education” for the umpteenth time, physicians wonder how they can possibly help the patient. Sometimes, a moment of grace arrives: the physician relinquishes the quest for control and enlists the patient’s help in the form of storytelling. ‘What is your story, your experience, from which I can learn how to help you?’ the physician asks in many different ways. Sometimes a remedy for physician exasperation is deep, attentive listening.”

Once

Category: Stories
written by David Goldblatt | November 7, 2008

David Goldblatt

Movement disorders can be horrifying. Afflicted persons are solidified or contorted. They may flail so violently that a fork endangers their lives. As a beginning neurologist, I assumed that all such patients curse their fate. Once I got to know Brian, though, I realized that I could be wrong.

Brian and one of his brothers had inherited Wilson’s disease, a rare, genetic movement disorder that had spared their eight siblings.

People who have Wilson’s disease can’t handle dietary copper properly. It accumulates in—and poisons—the kidneys, liver and brain. Avoiding foods rich in copper does not halt the progression of the disease, but it helps. If patients are also treated early and consistently with a drug such as penicillamine, which binds copper and aids in its excretion, they can expect to live a normal lifespan. If not treated, they die young.

Oscar, Brian’s younger brother, was less affected than Brian in his movements and speech. He looked out for Brian in an unusual way: he punched, pushed and made fun of him. (Psychiatric disorders are common in the disease.) Oscar died in his twenties in a car accident. His spleen, swollen because of Wilson’s-related liver disease, ruptured, and he bled to death internally.

After Oscar died, Brian spent some months in the county hospital, where a homeless man with a chronic illness could find care. Always, it seemed, he had a pretty student nurse at his side, and she was usually laughing. With his long, straight black hair, aquiline nose and lean, well-muscled body, he looked like—perhaps was—a Native American. Instead of showing the grace one might expect from someone with his looks, however, he moved stiffly. The harder he tried, the harder his anaconda muscles wrenched him back. Only sleep brought relief.

Speaking was especially difficult for Brian. It took him many seconds to begin to vocalize, and he often resorted to a letter board. Even then, his contrary musculature presented a challenge: his arm might snake toward the letter he wanted to touch but jerk away just as he was about to reach his goal. When he did try to speak, his tongue might protrude grotesquely. With great deliberateness, he would extend his index finger and thrust his tongue back into his mouth, then slowly and indistinctly articulate what he wanted to say. It was an exhausting experience, both for him and for the listener.

I was a member of an investigative team trying to treat the symptoms of Wilson’s with various drugs used for Parkinson’s disease. My assignment was to record Brian’s status on videotape at regular intervals. Although treatment helped him, he was not always a compliant patient.

A tape we made in the eighth year of our association shows me pulling a blue packet of cigarette papers from Brian’s shirt pocket and asking, “What’s this?”

“Pay . . . pers,” he says, with a slow, mischievous grin.

“What do you do with them?”

“They’re for mari . . .” He haltingly continues: ” . . . WAH . . . na.”

“How often do you smoke it?”

The words come more freely: “Whenever I can get my hands on some.”

Later in the session, I ask Brian about his favorite foods. He says that he loves Reese’s Peanut Butter Cups.

“What’s in them?” I ask.

“Peanut butter and chocolate”—two high-copper foodstuffs he knows he’s not supposed to eat.

“Why would you eat something like that?”

“Because . . . I en . . . joy it!”

“But if you know it’s bad for you . . .?”

Struggling to produce the words, but smiling serenely, he reminds me, “We . . . only . . . live . . . once.”

Editor’s note:

In January 2007, while *Pulse*‘s launch was still a year away, we were contacted by David Goldblatt, a neurologist living in Penn Yan, in the Finger Lakes region of New York State, who’d written a story about a patient with Wilson’s Disease. We liked his piece, agreed to run it, and made a few editorial suggestions. In a return e-mail he noted, somewhat wryly, “When you see the attachment about me, you’ll realize that I have a certain urgency about getting things done these days."

The attachment carried a brief chronology of his fight with cancer. Among the entries: "**3/3/05:** Operation to remove left kidney and ureter for urothelial cancer, regionally advanced: 3 of 19 nodes positive. **2006:** a great year until mid-December, when metastasis was detected…Only 20-30% of patients respond to the treatment I am taking…I'm shoveling snow when I get the chance. The quality of my life is as high as I could wish for-and then some."

In September 2007, eight months after David had first contacted us, his wife Ann wrote the following:

"You have all lost a friend. David died early Saturday morning here at home. His three sons and I were with him. He had had visits from family and several close friends all week long, a very busy week for a man as debilitated as he was. It was also very exciting for him: he was on an emotional high for his last two days . . .

"I want you to know that David remained himself right to the end. He was clear-headed, talkative, caring, and even humorous straight through. Unfortunately he was also terribly thin, weak, and in great pain at times."

On the surface, we at *Pulse* were connected to David by one story, a half-dozen e-mails and a couple of phone conversations. In another way, we were linked by his journey though the last stages of life, a journey that we too will make one day.

We're grateful to have known David and appreciate that he reached out to us even as time was running short. And we're grateful to Ann for following through on David's wish to publish "Once" in *Pulse*.

About the author:

David Goldblatt MD was a neurologist, writer, editor, potter, gentleman and avid slo-pitch softball player. A native of Cleveland, Ohio, he completed his medical degree at Case Western Reserve University in 1955 and his neurology residency at the New York Neurological Institute. After becoming chief of the neurology branch at the National Naval Medical Center in Bethesda, he conducted research at Johns Hopkins University, then spent thirty-one years at the University of Rochester as a professor of neurology and, later, as a professor of the medical humanities. His main medical interests were ALS, medical ethics, compassionate patient care and traumatic brain injury. David died of cancer at age 77 on September 1, 2007.