In Greek antiquity the word “abaton” was used to describe inaccessible places, including the enclosures in the temple of Asclepius where patients slept. Thus, Abaton is a fitting title for a collection of literary works dedicated to those touched by health care experience. When so much of what we say to one another is idle chatter or routine dialogue, it can be uncommon for us to share stories that deeply touch the soul. We seldom find the right time, place and trusted listener for this kind of intimate exchange. For some it may seem that all the profound conversation comes after the third or fourth helping of small talk or glass of wine. Others may feel no one in their life can understand their innermost thoughts and feelings. This is the mystique of Abaton: no fog to blow over, no waiting for comfort or rapport, just honest expression of the creative treasures that may otherwise be held so tightly.

It isn’t easy to assemble this caliber of material into a finished publication. It takes a team of editors, graphic designers, marketers and, of course, artists who are willing to allow readers a glimpse into their hearts and minds. Thank you to all of those who submitted their works to Abaton. It is never an easy task to put one’s creation forward for consideration. Special thanks as well to Julie Probst, graphic design; Kendall Dillion, marketing and communications; and Barbara Boose, editing. Your work on this year’s edition is unparalleled. Finally, sincere thanks to our faculty adviser, Dr. Gary Hoff, who provides inspiration for and support behind Abaton. Without each and every one of these individuals, this publication would not exist.

We present to you Des Moines University’s ninth annual edition of the literary and artistic review Abaton. You are invited to explore these narrative and visual testimonies and to embrace the lessons and insights they reveal about the human experience we all share.

Sincerely,

Matt Stuart and Elizabeth Eastman
Would you like to continue to receive this publication?

At Des Moines University, we strive to be good stewards of our resources. In an effort to be both fiscally and environmentally responsible, we mail the printed version of Abaton only to those who sign up to receive it.

Abaton was initially mailed to all DMU alumni and friends, but with growing numbers and increased printing expenses, we need to manage its cost.

To receive the 2016 edition or read the journal online, visit www.dmu.edu/abaton.
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Guidelines for submissions

The following types of submissions will be accepted:

1. Forms of literary expression (fiction and non-fiction) such as narrative, prose, poetry and essay. All literary submissions should be no more than 3,000 words. Abaton is not a publication that serves as an outlet for opinion or advocacy editorials and essays; such entries are discouraged.

   It is important to recognize that health care providers have legal and ethical obligations to maintain the confidentiality of information relating to patient interactions. In order to comply with those obligations, a written authorization is necessary for any submission that relates to patient information. As a prerequisite for publication, the author should provide a HIPAA-compliant authorization for the use and disclosure from the medical entity where the patient was seen for the patient interaction.

   Additionally, if a submission reasonably identifies an individual, a consent for publication, executed by that individual, must be provided as a prerequisite for publication.

   Literary submissions should concern the subject of health care. Topics may include, but are not limited to, medicine, illness, healing, aging and pain. More broadly, writers should reflect on the human condition.

2. Artwork or photography. All artwork should be submitted in digital format (preferably JPEG). Images that are scanned should be at a resolution of 300 dpi at 100 percent or greater and no larger than 6 inches by 6 inches.

   Any artwork or photography which reasonably identifies an individual should be accompanied by a consent for publication, executed by the individual pictured.

   Art entries should seek to evoke emotion from the viewer. The subject matter should also examine the human condition.

Submission instructions

- Up to three unpublished works may be submitted by each artist/author per publication.
- Please send all submissions via e-mail to abaton@dmu.edu.
- Include the following with the submission e-mail: name of author and title of submission, a short biographical paragraph, mailing address and e-mail address.

Each submission will be reviewed by an editorial board. The submitter will be notified of acceptance for publication or for editorial suggestions. (NOTE: Not every submission will be published.)

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Front Cover

Glomerulus

LAUREL WHITIS

Laurel Whitis spent many hours in the histology lab at Luther College, taking photos of slides that she found particularly intriguing. The images shared here are oil paintings based on those photographs. She is currently studying for her first D.O. board exams – the extraordinary amount of knowledge that medical students learn stems from the complexity of these miniature worlds. Her work also appears on page 24.
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Coronation

My moment had come.
The Dean lifted up a lithe white medical coat,
Hoisted high for the crowd to see,
He lowered it lovingly onto my shoulders,
Like a royal garment.
Harnessing the Energy, 1

JAY DILLA
Jay Dilla is an employee of Solar City, a company devoted to sustainability. He sees the importance of sustainable energy as an essential adjunct to reducing costs and powering health care in the future. Imagine the savings patients could experience if hospitals, clinics and medical technologies were powered by free energy harnessed from the sun!
In the hospital bed, wearing an oxygen mask, Melody appeared to be resting comfortably. Brother held her right hand, his eyes red from carrying and spilling over grief the last few days. Three days without sleep hadn’t helped. Brother, however, seemed oddly at peace. Sitting to Melody’s left, in one of those beige rectangular chairs universally found in all hospitals these days, was husband. Perched on his head was a Cleveland Browns cap, which seemed absurd and clashed with the solemnity of the moment, like wearing white socks with brown dress shoes, which he was also wearing. He stroked her hair gently. Oncologist sat at the foot of Melody’s bed, watching her carefully.

He had come earlier that morning for his daily rounds on the oncology ward. Stepping out of the elevator, he was met by the bustle of activity usual on any modern academic hospital floor. Resident physicians were hurrying to prepare for morning rounds. Nurses who had been working the evening shift were giving reports to nurses coming on for the day. The race toward greater efficiency and use of electronic medical records now necessitated mobile laptop work stations be everywhere. The oncologist felt no nostalgia for “the old days” when there were physical charts—colored plastic binders with the patients’ names handwritten on the spine. What he lamented, though, was that computers decreased actual interaction among the staff, since their focus during rounds appeared to be on the monitors. And even during rounds, presentations were done by reading information from the screens, which curbed actual face to face discussions and reduced patient presentations to a review of data. The computer screen was just that—something that divided, something that concealed.

The oncologist walked past the unit desk, toward the resident work area down the hall and to the left. Inside, the housestaff were busy preparing for rounds and entering progress notes and orders into the computer. They managed to interact with each other while staring directly at their monitors.
The residents who had been on call the night before summarized all of the major events that had transpired the night before. The oncologist asked about Melody. The residents had informed him that last night she took a rapid turn for the worse; she now required a 100 percent non-rebreather mask, the only thing that seemed to make her comfortable.

Summaries from resident physicians were important, but it was the oncologist’s strong preference to form impressions first-hand. Relying too heavily on the experiences of others was a dangerous habit in life. He could hear Beck singing “…drifting along in the same stale old shoes.” He turned left and walked down the glimmering alabaster hall to see Melody. The door was wide open, an invitation for him to enter and become part of a familiar tableau on the cancer floor—not as familiar to him this February morning as waking up to a few more inches of snow.

Over the years, he had learned from his many mistakes, developing a process to prepare himself before entering into discussion with a dying patient and their loved ones. It was a psychological pressurization process, where all potential distractions that would detract from the gravity of the moment would be shut out. He would first silence his pager, and turn off his cell phone. If a large team of pharmacists, students, or resident physicians were on rounds, he would select only one or two others who had some direct involvement with the patient to enter in this experience.

Medical interventions were now futile and the oncologist thought of any experience with a terminal patient as primarily a spiritual one. He imagined exchanging his stethoscope for a flask of anointing oil—a priestly physician in a white tunic.

He gently tapped on the open door. As he crossed the threshold and entered the room, he looked at Melody. Her eyes closed, her consciousness seemed to be sealed away from everyone in the room. She was breathing in a labored fashion, meaning that when she took breaths it was not a normal shallow breath, but a massive inspiration where her whole chest heaved out with her neck muscles flaring in tandem, which then came crashing down
like high tide with each exhalation. This rather violent breathing pattern contrasted starkly with her placid facial expression, which at the moment was akin to that of a canonized saint in the Vatican resting inside her glass and silver casket. Oncologist watched this for a minute or two. It amazed oncologist how the perception of time in these rare moments when one is witnessing the death of another human being, was distorted. Seconds flowed seamlessly into minutes like an existential sieve. It was a rarefied and intense experience, oncologist thought, that should never be tainted by buzzing pagers, beeping infusion pumps, or any of the other omnipresent technological gadgetry—like so many toxic smokestacks polluting the dying process.

In silence, oncologist turned and put his hand on brother’s shoulder. He asked if they thought Melody was comfortable, if there was something he could help with. Husband affirmed that she was comfortable now. Brother shared that he was glad to have spent the night in Melody’s room because he was able to talk with her, for about an hour, about things they had evaded discussing over two decades. He was “baby” brother, she was even teasing him like she did when they were children. Melody had very clearly told him that she knew she had terminal cancer and didn’t have much time left. She wanted to die peacefully, and at home if possible. Melody had shared this same wish with oncologist during a similarly lucid moment, but her family was not present. At the time, brother had been very skeptical of what oncologist had communicated to him about Melody’s wishes. Brother now believed. And exhausted after their hour-long talk, Melody had gone to bed.

A few hours later she suddenly sat up in her bed, staring straight at the wall in front of her and spoke in Latin. She was a retired Latin teacher and a devout Catholic. Brother, a less devout Catholic who didn’t speak Latin, couldn’t understand what she was saying, but to him it seemed as if she was reading from an invisible book held in front of her. He was grateful that Melody had already received her last rites and asked oncologist, “Doctor, do you believe in miracles or is that against your scientific principles?”

Oncologist reflected on how philosopher David Hume had answered that
question. He said miracles were events not yet properly explained by science. It was a view that oncologist had largely subscribed to in the past, but the more he practiced medicine, the less he felt he really knew. Oncologist then responded, “Sure, I believe in miracles. There are lots of things I don’t understand, and science is only one way of looking at the world. A scientific perspective is usually helpful; sometimes it isn’t. I think that the three of us being here next to Melody is a miracle of sorts.”

Oncologist’s thoughts then turned to Milan Kundera’s *Unbearable Lightness of Being*, which he had read the week before. The narrator made a distinction between “heavy” and “light” experiences. Most people erroneously sought out the latter and considered them good, when in reality what imbued life with meaning were the substantive, “heavy” experiences, like this one. It was these heavy experiences that were oncologist’s compass. Without them, he was sure that his soul would have been washed away long ago in a tidal wave of tears.

At that moment, one of the residents came in and tapped him on the shoulder. There was a newly admitted patient that had to be discussed. Oncologist looked down at his watch like a diver looking at his depth gauge. He had been with her for just 15 minutes. He touched Melody’s hand, knowing she wouldn’t be there tomorrow, and silently prayed for her to have a good death, without more suffering. Oncologist then said farewell to the brother who didn’t speak Latin and the husband with the Browns cap and white socks.

The oncologist ventured out into the hallway, depressurizing in order to begin rounds with the team of residents and their roving computer stations.

*Alberto Montero is a practicing medical oncologist at the Cleveland Clinic. In addition to having an active clinical practice caring for breast cancer patients, he devotes considerable time to teaching residents and engaging in clinical research. He also has an abiding interest in writing poetry and short stories. He finds them therapeutic and a way to sublimate so much suffering he encounters as an oncologist.*
Altered State

Me, one of the millions
who have diabetes. Not grossly
overweight, not a junk food
addict, my antirejection
meds gave me the disease.

Diabetes rules my life, I told
my sister, who can eat anything
she likes, grilled cheese
sandwiches on rye and Archway
cookies straight from the box.

She has no idea what happens
to me in the dead of night
when I awake and am “low.”

The “low” killed Bobby’s roommate,
found face-down on the floor,
a promising pharmacist, like Bobby.

With the purple light of dawn
filtering through my drapes
I arise like Lazarus from what
might be my tomb, pause a
moment, and close my eyes.
Something is wrong.
Very very wrong.
Aha! I am low. I bound
down the stairs in my
pre-owned striped pajamas
that make me feel like George
Elliot. If only I could wear them
to the Vietnamese restaurant.

Switching on the kitchen light,
the room vibrates
boink boink boink!
I reach for the foods
that will save me.
Rip open a new bag of
pretzels, flood them into
my mouth, then grab some
chocolate raspberry yogurt
from the fridge, dripping it
onto my jammies.

My sugar level is 35. Normal
is 80 to 120. I step onto
the front porch in my pink
diabetes socks, then run
down the sidewalk to
talk to the stars.
Jupiter, I wave, with its many moons. I am saved. I am saved!

Lying in bed, body heaving, I think this must be like taking drugs. Cocaine with the bloody noses. Hands on chest, I am lulled to sleep by Charlie Rose humming in the distance.

_Ruth Z. Deming, winner of a Leeway Grant for Creative Nonfiction, has had her prose published in literary magazines including Hektoen International, Literary Yard and Creative Nonfiction. A psychotherapist, she lives in Willow Grove, Pennsylvania, a suburb of Philadelphia._
Sugar

During my years at Another Chance, I grew to loathe the telephone, and this was in the days before cell phones had infected the world like AIDS.

In my small studio apartment above Pogue’s Bar, I had an old push-button model with built-in answering machine atop a wobbly end table I bought from the Salvation Army Thrift Store. If I ever entered my apartment and the message light wasn’t blinking, I damn near threw a party. Whenever it rang, I cringed. In the world of the poor and homeless, a ringing phone meant trouble.

But today was Sunday, a day to at least try to shove my stress to the far corner of the room. My Kansas City Chiefs were playing the Jets in New York, a noon kickoff. It was Dick Vermeil’s first year as head coach. I prayed the man’s Super Bowl experience would pay off, but so far they had a record of 2-6. I feared another year out of the playoffs (they hadn’t won one since 1994). Starting today, if they won the rest of their games, they’d finish 10-6. I was the eternal optimist when it came to the Chiefs. Pogue called me a delusional fool.

I was ready, too, with a six of Guinness Extra Stout and a six of Bass in the fridge. I was decked out in Chiefs Zubaz pants, red Converse high-tops, a throwback Bobby Bell jersey (#78), a worn Chiefs cap purchased in 1989 when Marty Schottenheimer was hired as head coach, and even a pair of Chiefs boxer shorts. I was a walking talisman for victory.

While the announcers on CBS did their pre-game, I headed into the kitchen for a second beer, and—

The damn phone rang.

I closed my eyes and moaned as if knifed in the gut. Shuffling back, my hand hovered above the receiver as if I had a choice. I plucked it up. “Hello, this is Mac.”
“Mac, it’s me, Keri! That new guy’s fucked-up out of his mind! Oh, my God, he—”

“What new guy?”

“Heller! That Donald Heller guy!”

“What did he do?”

“He ripped the downstairs bathroom sink out of the wall, brought it in the kitchen, and told me that it needed to be repaired! We have water shooting everywhere! He is so fucked-up I can’t—”

“Keri, listen to me! Call 911 now! He’s not drunk or on drugs. He’s diabetic! Call them now and I’ll be right over. Then shut the water off in the bathroom—those two knobs under the sink. Shut them off!”

I hung up and glanced at the TV. My Chiefs had the ball. As I pulled off my cap and jersey, I screamed, “Win one for a fucking change!”

I turned in my Chiefs garb for faded Levis, off-brand Doc Martens, a long-sleeve T-shirt, and a battered Indiana Jones leather jacket. Before leaving, I frantically brushed my teeth, scrubbed my tongue, and chewed mints so the residents wouldn’t smell liquor on my breath.

Rushing into Another Chance, I saw a few residents with Keri, the weekend day shift supervisor, down at the end of the hall cleaning up water from the downstairs bathroom and hallway rug. “Where is he?”

Keri moved a strand of hair from her face and tucked it behind an ear. “The EMTs got here, saw the shape he was in, and got him the hell out of here, Mac.”

I entered the kitchen. The bathroom sink was on the counter under the microwave. I muttered, “What in God’s name was he thinking?”

“Mac, he was a zombie,” said Keri. “He walked to the bathroom, ripped out the sink, mumbling the whole time, carried it in here, and kept saying he had to fix it. Can high blood sugar really do that?”

I nodded. “Think about that when you buy your next Big Gulp at the Kwik Shop or down that bag of M&Ms you keep in the desk.”
At the ER admission desk I smiled at the receptionist, Nadia, a pretty blonde with gorgeous dark skin, huge almond eyes, and long flowing hair. I’d been there so many times in the past with residents, she knew me by sight. “Hi, Mac. I take it Mr. Heller is yours?”

“Yeah, can I go check on him?”

She stood. “Let me see.” As she walked away, I admired her strong back and fine bottom. Even in an emergency, a man has to take some pleasure in life, however fleeting. I would carry that image with me for weeks, maybe months. They say it’s a man’s world, but women hold the true power—primal and raw.

She came back, smiling. “They’re working to stabilize him. Can you wait a few minutes?”

I took a seat in the ER waiting room surrounded by the sick and wounded—all poor. Not a middle- or upper-middle class person in the bunch. My job constantly reminded me of an article about Rudolf Virchow, a doctor in Berlin who in 1848 was sent to study the spread of a killing fever. His conclusion: poverty breeds disease.

I glanced up at the silent TV in the upper corner. The Chiefs were already behind; running back Curtis Martin of the Jets was running all over them. I poured a cup of bad vending machine coffee and Nadia thankfully called me to the back before the Jets scored again, leading me past several curtain-shrouded exam cubicles until we arrived at Mr. Heller’s. Poor Donald was out of it, on his back with bags dripping into both arms and hooked up to beeping medical apparatus.

Donald moaned, head bobbing around like a cork in a pond. “Donald? Donald, you awake?”

Donald’s eyes flickered. “Oh, hi, Mac. What’re you doin’ here?” He scanned his surroundings and asked, “Where am I?”

“You’re in the hospital.”

“Oh.” His gaze went fuzzy and he cocked his head. “Why?”
I told Donald about his elevated blood sugar and what he did to the bathroom sink.

Donald closed his eyes. “Oh, my God.”

“You back again?”

Lynn, a balding ER physician who resembled an aging athlete, walked in. “Yeah, I’m like a bad penny,” I said.

“You keep this up,” Lynn said, checking the monitors, “they’ll give you a reserved parking space next to us doctors.”

“What’s up with Mr. Donald here?”

Lynn cleared his throat and made a millimeter gap between his thumb and forefinger. “Mr. Heller, you were that close to lapsing into a diabetic coma. Your blood sugar was six-20.”

“Jesus,” I said.

“Usually it’s low blood sugar that creates irrational behavior, but needless to say, Mr. Heller, you need to make some major changes, especially your diet. I’ll write up recommendations in your release packet.”

“When can he go home?” I asked, hoping we could leave now.

Lynn shrugged. “Once his sugar levels are stable.”

Lynn moved off to check on another patient. I sat in a hardback chair and considered Mr. Heller: only 39 but diabetes had aged him like a rancid potato. His red hair looked brittle and his skin possessed a yellowish pallor. The man was six feet tall, but he could not have weighed over 150—a walking definition of string bean.

I rocked in my chair, anxious to get home and watch the Chiefs, but Donald’s eyes would start flickering, his head loll, and then he’d be out of it again. This went on for over an hour. I periodically left to check the game, but the Jets were up 27-0 in the fourth quarter when the Chiefs got a worthless TD to make the final 27-7.

When they finally released him, I helped Donald out of the hospital and into my car. “That was scary,” he said.

“Hey, man, don’t worry. From now on, just follow the doctor’s orders.
Donald considered this and nodded slowly as he slid into the passenger’s seat of my car. He grabbed my arm, “Can I still drink my Coca-Cola?”

“It’s bad for you, man. Bad for any of us, but especially for a diabetic.”

“I gotta have my pop, Mac.” His hands shook. “I get so down if I don’t have it.”

“How much Coke do you drink a day, Donald?”

“I dunno. I start when I wake up. You have coffee, I have Coke. What’s the big fucking deal?”

“You looked at your teeth lately, man? The acid in it is eating your enamel.”

“I don’t care. I gotta have my pop.”

“It’s a damn soft drink, Donald. It has no nutrition. None. Nada. It’s killing you.”

“It makes me feel alive. It’s the only thing in my life that does. I’m twice divorced, my two kids hate me, women look through me, I can’t hold a job, and I’m in a fucking homeless shelter.” He slapped himself in the head. “And you think me drinking Coke is the problem?”

The next day, I set up an appointment for Donald with the nutritionist at the Clinton County Health Department, Dora Perdue, who explained how to amend his eating habits. She even gave him sample meal plans to follow. I set up free visits to the YMCA per her exercise recommendation. Since Donald signed a release, I was free to speak to her. She was appalled the day she caught me on the phone. “He’s drinking at least three two-liters of Coke a day,” she said. “Sometimes more. He looks skinny, but no muscle tone. Half of his body mass is fat. The average is 25 percent. Look at his skin color. He is living on Coke and junk food. He is as addicted to it as an addict to heroin. Can you and your staff monitor him? Please.”

I said we would try, but it was useless. Donald would smuggle two-liters
into his room, hide them in the closet, in drawers under clothes, under his bed, and even stashed them in bushes outside. He wouldn’t sip or drink it. He’d chug it to get his fix. Even two more trips to the ER did not deter him. He received notice of Social Security disability about the same time his housing voucher from HUD arrived, so he was able to move into a small apartment just a few blocks from Another Chance. His sister, Anna, repeatedly called, imploring me to do something to save Donald’s life. I told the poor woman I was out of ideas. “It’s up to Donald now,” I said. “It all boils down to choice. His choice.”

“Can you at least go by and talk to him? Please.”

Driving to Donald’s apartment the next day, I wondered if anyone on a modest income had true choice. I sure as hell knew it took money to eat well. I tried constantly to improve my eating habits, but it was a bitch.

I knocked on Donald’s door, the TV blaring inside. No answer, so I knocked again. I tried the knob. Unlocked. I entered.

The apartment was a wreck. A small coffee table by the couch had been flattened, chairs overturned, a lamp broken. The TV was tuned to talking heads on PBS. “Donald? Hey, Donald, you here?” I entered the small kitchen and saw open cupboards, dirty dishes in the sink and on the counter, broken glasses and dishes on the floor, empty two-liter cola bottles strewn everywhere and full ones lined up on the counters. “Donald, where are you?” I turned to enter the living room and WHAM!

Hit in the face, I dropped to the kitchen floor, dazed. Blood poured from my mouth and forehead. I looked up to see Donald standing, swaying, over me with one of the coffee table legs in his hand. Jesus Christ, he’s out of his mind again! “Donald! Donald, it’s me, Mac! Mac from Another Chance. Put the table leg down and let’s talk, okay?”

Donald breathed as if he’d just run a marathon, his eyes darting in their sockets like water bugs. “What’d you want? Who are you? What is all this?”

I slowly got to my knees and Donald swung the leg like a bat. I dodged the blow and got to my feet. “Donald, goddamnit, stop it!” I held out my
hands, palms up in a display of I mean you no harm. “Put the leg down and let’s talk.” My mouth and chin were covered by blood still flowing from my nose, dripping down the front of my shirt. I swooped a dish towel from the counter and applied pressure to my nose. When I spoke, I sounded absurd, like Muskie from the old Deputy Dawg cartoons. “C’mon, man, put that thing down and let’s talk.”

Donald didn’t see, didn’t hear. He couldn’t. He was as out there as a paranoid schizophrenic or an addict high on meth. I needed to call 911. My eyes darted in search of Donald’s phone in the midst of all the clutter until I spied a green phone receiver sticking out from under the crushed coffee table. Now, if only the phone itself was not crushed, too.

I slowly crossed one leg over the other and carefully stepped into the living room (slowly I turned step by step, inch by inch) while Donald grasped the wooden leg with both hands like George Brett. “I’m just gonna use the phone and call for help, okay?” I blabbed and blabbed, hoping the loud noise would distract Donald’s addled mind.

Donald lunged and took a swing. I dodged and screamed, “No.” For some reason, that outburst backed him off. I grabbed the receiver and pulled. Nothing. The weight of the crushed coffee table held the phone to the carpet. I stuck my toe under the table and flipped it up.

Donald gasped and moved in, teeth bared.

“I’m just using the phone, Donald!”

Donald growled and began to tremble.

I went down on one knee and started punching in numbers. Nine . . . one . . . one. I heard the first ring. Answer, goddamnit, answer!

And then it all went to hell.

Screaming gutturally, Donald dove, wooden leg raised. I dropped the receiver (hearing Clinton 911, what is the address of your emergency? as it fell to the floor) and lurched back just in time to kick out my left leg defensively, driving my foot into Donald’s stomach, knocking the air out of him.

I pushed him away, grabbed the receiver, and gave Donald’s address
twice, screaming, “Get an ambulance over here now!” She asked some other annoying questions that I answered in that cartoonish voice, and then Donald stopped moving. I tossed the coffee table leg across the room and stood up.

Donald’s breathing grew shallower, and he was as still as a lawn ornament.

I kneeled beside him. “Donald? Donald?” No response, so I took his hand in both of mine. I didn’t know what else to do.

I mulled over all this while driving in a funeral procession to the rural cemetery where Donald would be buried. Donald lingered in a diabetic coma for a week before he died. His sister was despondent. “What a waste of a life. Killed by soda pop.”

In the too-short procession, as if on cue, I noticed a huge Coca-Cola semi at an intersection held up by the line of mourners.

At least the driver turned his headlights on out of respect.

Or maybe guilt.

*James Kanady has worked with a transitional housing organization, New Beginnings, since 1997. To him, poverty and poor health are as linked as DNA. He has published two novels.*
As an art student, Laurel Whitis was fascinated by the miniature worlds inside of us; we are made of trillions of cells, all from one original cell, each with different tasks. She spent many hours in the histology lab at Luther College, taking photos of slides that she found particularly intriguing. The images shared here are oil paintings based on those photographs. She is currently studying for her first D.O. board exams – the extraordinary amount of knowledge that medical students learn stems from the complexity of these miniature worlds. Pathology is just one tiny step away from physiology; medical students are learning how to recognize that small, harmful change; find a remedy; and then work with patients until their health physiology is restored.
GLIOBLASTOMA MULTIFORME grade 4

one day she CAN’T SPEAK
    forgets things
worries about her children
    and herself
    she’s only thirty-four

mom tells her to see the doctor

who tells her not to drive
    but she can’t wait

for mom to pick her up
    so she drives herself

the doctor tells her
    something
    and she CAN’T SPEAK

today she awakens in a hospital

husband smiles
    mom holds her hand
    the children are at school

surgery leaves a plate and staples
    in her head

    words and memories return for now
more treatment will follow
    another day
eighty percent of the tumor removed
the rest wraps around her
SPEECH
like creeping charlie in my garden

I CAN’T RIP IT ALL OUT

if I want the primroses to bloom
I’ll have to try

something else

Marilyn Baszczynski, originally from Ontario, Canada, teaches and tutors French in central Iowa. She has won awards for her poetry in National Federation of State Poetry Societies and Iowa Poetry Association contests. “Gyuri,” a work based on the experiences of Hungarian refugees, appears in the Geste Series published in spring 2015 by Whistling Shade Publications. Her poetry has appeared in The Auroean, Lyrical Iowa, Tipton Poetry Journal, Midwest Poetry Review, other print journals and online. Baszczynski is currently president of the Iowa Poetry Association.
The Selzer Prize for Writing

The Selzer Prize, 2015
by Gary Hoff, D.O.

Literary writing about medicine and about the milieu of health care has become increasingly common during the last several decades. Doctors have always written; in fact, quite a few famous writers were better known for their words than their medical degrees. Anton Chekhov, for example, although known as a physician was revered as an explorer of the human condition. In our own times, Michael Crichton (who held an M.D. from Harvard) is another well-known example. Numerous others have explored how illness affects both the patient and the healer; how service enriches the lives of those who serve; and how the need for understanding motivates us.

Abaton established the Selzer Prize for literary writing about the field of medicine several years ago to recognize and encourage the creative impulse in students of the health professions. The prize is awarded annually in honor of Dr. Richard Selzer, whose example as a physician, as a writer and as a human being has contributed mightily to the widening range of literature regarding medicine. The prize is given to the outstanding student submission—fiction, memoir, poetry, etc.—including a cash award and publication in these pages.

Dr. Selzer has been an inspiration and a role model for many medical students during his lifetime of medicine and writing. He began writing during his first career as a general surgeon in ultra-early morning writing sessions followed by a full day of surgical practice—an exhausting schedule showing how strong the need for expression can be. Building on early success in fiction, Dr. Selzer eventually began producing poetic and evocative pieces about the heart of medicine, full of raw emotions and ethical dilemmas, exploring the uncertainty of medicine and the struggles faced by all of us. Dr. Selzer’s experience as a surgeon informed his vision of the world of healing. His tales about the deep, personal implications of illness to how the sufferer and the healer experience it transmute human experience into art.
Like all of the best writing, Selzer’s work provides a window into the hidden, unsuspected heart of medicine.

In the tradition of Dr. Selzer, Abaton is proud to encourage and support the writing efforts of students of the healing art, wherever they may be. Again this year the staff had a pleasingly difficult task in selecting this year’s finalists and prizewinner that appear in these pages. Each piece has much to recommend it, but only one prize can be given, alas. This year the Selzer Prize is awarded to Anna Delamerced, a student at Brown University, for the piece, “1 in 160.”

Thanks to all who submitted manuscripts.
1 in 160

I hate silence
when it’s unwelcome
unwanted
uninvited.

My mother kisses his tiny eyes
and tiny nose
and I think of what he could have become.

My father touches his tiny hands
and his tiny feet
and I think of how much he could have grown.

Someone in the delivery room
addresses my mom,
you’re not to blame
for the death of your son.

It’s a 1 in 160 chance
for a stillbirth to happen
for the baby to die before he could even
breathe his first breath.
I see his tiny head
and his tiny ears
and I think that maybe he can still hear me
say goodbye,
my brother.

You’re supposed to be crying,
but all I hear is
silence.

Anna Delamerced is currently a senior at Brown University, studying for a bachelor of arts in public health. Through Brown University’s eight-year program in liberal medical education, she will graduate Brown in 2016 and Alpert Medical School in 2020. Delamerced is committed to a career in medicine but is passionate about writing, listening to and sharing stories.
Positive

“Can we speak in the next room?”

We lead her into the corner room of our busy city hospital. The room is hideous but for the shining skyline, barren but for a single crooked table and silent but for a deafening electrical buzz. Within seconds of entering, I realize that I hate this room. I consider suggesting an alternate meeting room, quickly recalling that there are no other rooms, and that in any case, this feels fitting for the grim task we are about to undertake. We file into the room and gently shut the door behind us.

“Please have a seat”

Five young women settle into un-matching chairs, neatly spaced around a circular table like test tubes in a centrifuge. Five stomachs churning, five hearts throbbing and five minds knowing they are not prepared for what is about to happen. The formal setup makes it feel a little like an awkward conference. I fold my hands and rest them on the table, quickly replacing them in my lap, recalling that this is not another “breaking bad news” lesson, it is the real thing.

“We have your test results”

Pregnant silence. The ice-cold words have not yet been uttered, but they were scorched into the silence since the moment we escorted her from her room. A lump rises in my throat and I can’t shake the feeling of being at the top of a roller coaster with an impending plunge. A moment of silence before the drop of a loaded bomb, a moment to enjoy the bliss of that which has been unconfirmed, a moment to hope with abandon.
“You have HIV”

A solar flare of catecholamines. Myocardia pumping, aortas thumping. All eyes on her, as we watch her downfall before us, visible to the naked eye and palpable to the four hearts that have been stripped bare. Our neat spacing is maintained. I sit, quietly, professionally, with a whole being of empathy distilled down to a pained look on my face. It is not enough. I want so badly for her to feel my pounding heart reaching out to her, my neatly folded hands embracing her. I want to tell her that I am a young girl like her, one that has also made poor choices, that it may as well be me sitting in that ragged hospital gown in this hideous room with tears streaming down my face. I want to sit by her bed all night, keep her company in this unfamiliar hospital in this unfamiliar country far from her homeland. But as a medical student, I am obliged to be calm, “to be aware of my transference,” not to overstep the boundaries of professionalism. So I sit quietly, hoping that a pained look will suffice for the thousands of emotions bubbling up behind my collected exterior.

“I know how hard this must be to hear”

The classic line, employed by sympathetic physicians everywhere, myself included. But this time, I do not. Yes, I know the gut-wrenching disappointment of a bad grade or the unsettling feeling of hearing unexpected news. But do I know the feeling of being informed of a diagnosis that, some might say, you brought upon yourself? Do I know how the alcoholic feels when he is told he has cirrhosis, or the smoker feels when he is diagnosed with lung cancer? No, I cannot pretend to know that guilt and shame. I badly want to be able to feel what she feels so that my statement is no longer a lie, though I know I cannot truly do that, and probably will never be able to.
“You will have many questions in the coming days; we are here for you.”

Concerned faces stare her way, furrowed eyebrows and pursed lips that seem somber enough to scare the virus out of her T cells. If only. It is true, we are here for her, crunched up in tiny carrels like mad machines, desks scattered with empty coffee cups, scouring the web for sensitivities and specificities, prevalences and PCR protocols, trying to find an explanation of why this happened, for why it can’t be true. We are at home, picking through the depths of the Internet for HIV laws in her country and details of traveler’s insurance coverage. Where we are not is by her bedside at two in the morning, making small talk about her favorite website, Humans of New York, or her dreams for higher education. We are not there to give moral support when she dials that long distance call to tell her parents that she is okay, that it was just a viral bug, or to comfort her as she tosses and turns in bed, worrying about whether she herself will ever have a family someday. No, we remain behind our screens, in our rooms and on our phones, hearts bursting and fingertips thumping, helping that sobbing girl from the hideous room in the best way we know, all the while wanting something more, to touch, to hold, to laugh and smile, to bond and sometimes to cry, something to make us feel human again.

Meleha Ahmad is a fourth-year medical student at the New York University School of Medicine. Originally from Karachi, Pakistan, she received her B.S. from Brown University in biomedical engineering and spent a year before medical school working as a medical assistant in a pain management practice in Brooklyn. She plans to pursue a career in psychiatry upon graduation.
Bright Wings

There is only one heart in my body, have mercy on me.
- Franz Wright

From the top of the Treeport water tower, Dixon can see the basin drain into river, the river drain into the bay, and the bay drain into the ocean. On stormy days, he can see great columns of rain rolling across the open water—conduits between the sky and sea. He finds comfort in the gray-green continuity.

The view is nice, the solitude nicer. In the cool rarified air, way way out of reach, Dixon sighs as the voices in his head grow quieter and more distant. They soften until they softly reverberate like the whispers of holy men in a marbled mausoleum. The fall wind blows gently. From his perch, the river-bank forest in autumn is a vast conflagration.

He watches a balloon lift until it is absorbed into a cloudless sky—then he begins his laps. Dixon is searching for cameras in the screw-holes of the tower’s hull. Dixon has been suffering.

Dixon has a delusion;
Dixon has a heart.

Dr. Spector wakes from a familiar sequence of neural firing. In the dream he is frantically running around freeing beautiful, vibrant birds of every color from cages: metal cages, plastic cages, velvet-lined cages, barbed-wire cages. When he returns home, out of breath, he finds a thousand cats hissing at his doorstep, all with lifeless birds at their feet.
Dixon watches as sudden purple clouds gather in near distant east. He licks his middle finger, holds it up to the wind, smiles and furrows his brow.

Dixon was an engineering student at Treeport Community College. In August he aced his first exam on electricity, magnetism and fluids; two months later he was in Spector’s office, ripping the doctor’s diplomas and abstract paintings off the walls.

Dr. Spector assured Dixon’s mom that they were knock-offs he picked up at a garage sale. He joked that the frames were more expensive than the art and that if he had real de Koonings and Picassos, he’d close his practice today.

Dixon has a delusion; Dixon has a heart. In Dixon’s heart he holds a delusion. He believes, with a fanatical conviction, that he was put on this earth to save the township of Treeport. He believes that the local water supply has been poisoned. He believes that consuming even trace amounts of this poison is deadly. He believes that he must sound the alarms.

He unzips his backpack, takes out a can of spray paint and all of his unopened meds. He launches the meds over the railing, aiming for the slow river, 150 feet below, and starts to scrawl his message.

Blue paint hisses out of the canister and the smell, strangely sweet, gives Dixon a pleasant headache.

Dr. Spector dreams that he is in the corner of a giant birdcage. The cage’s gate creaks slightly open. When he tries to move toward the threshold, the force of
gravity crushes him. He can’t lift his gray-feathered wings. He is paralyzed.

Spector has a delusion;
Spector has a heart.

He fears he has been bystander—a rubbernecking gawker in the stepwise deterioration of a decent boy named Dixon.

He is starting to think that he has never helped a single patient, let alone saved one. He believes, with bone-level certainty, that he’s never uncaged a single soul. On some days he feels strongly that his patients would be better off without him. These days he feels that everyone even tangentially connected to him would be better off without him, that each second carries less and less meaning than the last.

Dixon is painting the blue belly of the number “5,” when the deep vibration of rolling thunder reaches his ears. The completed message on the tower’s western face reads:

THEREFORE, THIS IS WHAT THE LORD OF ARMIES, THE GOD OF ISRAEL, SAYS: LOOK, I WILL MAKE THESE PEOPLE EAT WORMWOOD AND DRINK POISONED WATER. JEREMIAH 9:15

The sun is now fully tucked behind the high dark cumuli, and as the minutes pass the contrast is turned down across the horizon. The wind is insistent, whipping against the tower’s metal body. The voices in his head have become quieter still and he can sense the pink vault of his skull filling with purpose.

Now cease small whispers, he commands.
Dr. Spector wakes to the whipcracks of a thunderstorm and the apocalyptic notes of Treeport’s tornado sirens. He’s fallen asleep on his office couch again—the velvety pillow is wet with a small pond of drool. He wobbles toward his desk chair when his secretary enters wide-eyed. Dixon had called the office and left a bizarre message: tell Dr. Spector to turn on Channel 7 so he can finally hear me say what I’ve been trying to tell him all along.

Dixon opens his mouth, sticks out his tongue, and catches fat raindrops. He breathes deep when he sees the Channel 7 news van advancing along the dirt road toward the tower’s base. As planned, he called Channel 2, Channel 9 and Channel 50 as well, just for good measure. Calling Dr. Spector was an improvisation.

Dr. Spector sits nearly 23 hours a day, but somehow his knee cartilage is still disappearing. He is a heavy-set, indisputably depressed man, engulfed in a slow burn. Yet his secretary watches him bound toward his Volvo with surprising swiftness and can see him recklessly peel out of the lot, his back wheels hydroplaning.

As Dixon paces the catwalk, a new voice, perhaps of reason, sings out in his head: under a glass slide and the discerning eye of an electron microscope, the heart of the savior and the saved are indistinguishable.

Rain. Heavy rain.

The blue paint is starting to drip. He wonders if the news cameras can make out his message at all. He strips down to his briefs and begins to strike the side of the sphere with his fists. He then climbs over the catwalk’s railing
to sit on the open ledge. Looking out he can see lightning strike a patch of riverbank decidua, and he can see the black sky twisting into a knot. Looking down he can see the river madly churning and a round man plodding through the marsh.

Dr. Spector is acrophobic, and in one of his most salient nightmares he is falling from a great altitude, flapping his feathered arms to no avail, squawking and spinning, but never ever hitting the ground.

Sitting on the ledge, watching the ever-encroaching lightning, Dixon turns to see that his message has washed away completely. Dixon’s heart aches at the thought of everyone he knows in Treeport dying—painfully dying because he couldn’t warn them in time, their body’s cells poisoned and slowly leaking, dying because he was too dumb to check the forecast before leaving today.

Dixon rises to stand and feels his heart beating in his throat. Dixon puts his hands to his sides, like he used to do at the edge of the Treeport Golf Club high-dive. Dixon closes his eyes and can hear nothing but a symphony of laughter rising in his ears, a crescendo, louder and louder and louder and louder until he feels arms wrap tight around his torso.

If you had tuned in to the news that day you would have seen two men in a strange embrace. You would have seen the branch-breaking wind testing their balance. You would have seen lightning striking the tower’s grounding rods.
If you looked closer, you might have seen their hair standing up on edge. You might have seen their eyes locking for a split second, pupils dilated, filled to the brim with fear and love and will to live.

If you looked even closer, you might have seen their respective cages swinging open and two bright-winged things cutting up through the clouds.

Amir A. Tarsha is completing his M.D. at the University of Miami, where he is a member of the Gold Humanism Honor Society. His academic interests include gender identity and transgender mental health. He received an M.S. in bioethics from the Icahn School of Medicine at Mount Sinai and a B.S. in psychology and liberal arts from the University of Wisconsin-Madison. His writing has been featured or is forthcoming in Neurology, The Journal of General Internal Medicine, Psychoanalytical Perspectives, The Intima: A Journal of Narrative Medicine, One Throne Magazine, Chiron Review, The New Yorker and elsewhere. He is a regular contributor to 2MinuteMedicine.com.
A Thousand Miles to Boston

During my third year of medical school, I followed a nurse practitioner (NP) for a day as she conducted home visits for patients on palliative care. This piece was a real-time transcript (later typed up) of my observations during one of these home visits, located in North Carolina. Asterisks mark where details have been generalized in observation of confidentiality.

Patient: 50-year-old male
Prognosis: two weeks – two years
Diagnosis: metastatic cancer*

1. NP to me: “This is my third time here.” We knock. The man who opens the door looks younger than I expected from reading his chart. Hair is matted. Cheeks are hanging, like melting wax. Round brown eyes.

2. It smells like body odor and GI excretions. We are invited to sit at the kitchen table.

3. He has a very fancy, very big flat-screen TV in the living room. Comfy armchair. There are no pictures of faces anywhere.

4. A real estate agent once told me that it’s always a good idea to take off all pictures of you, your family and your friends when you’re selling. It’s the future potential of the space, not what the space means to you, that buyers want to see. Family portraits, she said, are the worst. Don’t show a snapshot of your personal past to people who only care about their own future—that discourages them from buying your house.

5. He held a high-paying job,* but he’s living in a one-bedroom apartment.
He lives alone. I don’t think he is financially strained. He has no partner, no kids, no pets.

6. A mustard-yellow DNR (Do Not Resuscitate) sheet is stuck on the fridge like a centerpiece.

7. He has a littered kitchen table. There are one-centimeter lesions of dried soup on the tablecloth. Minestrone, perhaps. Macule-like.

8. Why am I seeing all these small, menial details that are medically irrelevant?

9. He’s lost 10 pounds in two weeks. That’s medically relevant. Very much so.

10. A Nikon DSLR sits on his living room table not too far away. Does he like photography? I must remember to ask. I like photography.

11. Below the DNR sheet, there’s another sheet on the fridge. It says: HUMAN TISSUE FOR RESEARCH.

12. He’s wearing a gray, wrinkled T-shirt with the words: Property of NC State. I recall from his chart that he was professionally affiliated* with the university.

13. He has an NC State-red hoodie slung over his armchair. And a pile of quilts and blankets as well. Maybe he prefers layering it on versus turning up the heat. Or maybe the heat isn’t enough. It probably gets cold regardless when you’re that sick.

14. He says he never has an appetite anymore.
15. He says he has loose BMs about five to 10 times a day. I interject and ask about volume. Low-volume, usually, but they’ve been bulking up these past two days. I ask if he’s always been diarrhea-prone before the cancer. No, the opposite.

16. I see why the kitchen table is littered now. I’ve gotten a closer look: lots and lots of loose cereal and associated powder, probably some sugar. Did I read he is diabetic? No, that was someone else. Good. Total of three open cereal boxes, one of which is lying on its side—Cocoa Puffs spilling out. I feel like I am attending an arts-and-crafts class on beads.

17. A straw-woven basket hangs from the kitchen ceiling. In it is a pile of magazine-grade papers with torn edges. I think they’re recipes. He’s got a couple of Food Network magazines on the carpet by his armchair. I look back at the cereal on his table. That’s a lot of cereal. His stovetop looks cold, spotless.

18. A rack of spices decorate his kitchen wall. Eleven bottles. The Organic Foods brand. Cinnamon, ground red pepper, marjoram, peppercorn, thyme, sage, bay leaves and the rest I can’t read from here.

19. He says he thinks the past couple of days have been better. The oxycodone might not be enough for the pain.* I ask about the fentanyl patch. We talk about the fentanyl patch. He stares at us when we talk, which reminds me of an article I once read about eye contact. They say it is in fact normal to break eye contact during conversation. If we don’t, things often get uncomfortable. I stare back, unwavering, as I explain the differences between short-acting and long-acting pain medication. I feel like my eyes belong to one person and my mouth belongs to another.

20. The NP gets up to obtain vital signs and I listen to his heart and lungs.
I palpate very lightly where it’s* painful. I notice the masses. I ask if he enjoys photography.

21. He says he used to do a lot of photography while backpacking. He used to love traveling.

22. Pill bottles everywhere. NP to patient: “I know we talked about this last time, but what are your thoughts today on switching over to hospice care?” He still wishes to stick with palliative. He repeats, again, that he is feeling better.

23. There are two dime-sized pills interspersed among the Cocoa Puffs.

24. The bottles of spice don’t look too different from the pill bottles, if you were to just take a glance.

25. He has a HAPPY BIRTHDAY card stood up on the counter. I almost say, “Happy Birthday, by the way” but then recall reading his date of birth on his chart. It’s been many months* since his birthday. The card is the only artifact of outside communication I can see.


27. That was too quick. I bring it back. I go through the individual S.I.G.E.C.A.P. and S. He cannot give a straight answer to most of these.

28. Three potted succulents wait by the window. Another one sits on his counter. I remember reading a Wikipedia article about succulents, the most well-known example being the cactus—they’re hardy. They can survive in environments other plants can’t.
29. His succulents are sagging.

30. The NP is ready to go. She has a final question. “Do you get out at all?” He says, “Yeah, I walk around the apartment complex.” The NP clarifies her question, asking if he ever gets out from the apartment complex. No, he says, he cannot. He’s too tired. We look at him and nod.

31. Thirty minutes earlier, he had said, “My only last wish is to drive up to Boston before Christmas.” NP: “How far away is that?” The NP does not think he can even drive across town without complications. He adds that his mother lives in Boston.

32. *Boston*, a song by Augustana, has a section that goes, *You don’t know me, you don’t even care, oh yeah… You don’t know me, and you don’t wear my chains… oh yeah, She said I think I’ll go to Boston… I think I’ll start a new life, I think I’ll start it over…* It’s not a happy song. I like to play it on repeat.

33. We say our goodbyes and reassure him that a social worker will be calling him within the next two days to help arrange for the move north. It’d be a long drive. Boston, I learn, is a thousand miles away.

\footnote{SIG E CAPS is a mnemonic for the diagnostic symptoms of depression. The letters stand for Sleep, Interest, Guilt, Energy, Concentration, Appetite, Psychomotor, Suicidality.}

Jenny Shen is a fourth-year medical student at the University of North Carolina, planning on specializing in psychiatry.
Remembering My Hospice Patient

Beep... Beep... Beep...

The monitors chirped. At that time I didn’t know what all of them meant, but that hardly seemed to matter. His breaths came slower now, and the time between kept increasing. It wouldn’t be long. Cold, thin, and still splotched with blooms of deep purples and blues from last week’s fall out of bed, I held his hand anyway; I hoped that on some level, he knew I was there.

In the four years before I entered medical school, I had served as a hospice volunteer in various capacities, including being charged with my own patients as well as sitting vigil with those departing the world without having family members present. This was not my first time sitting with someone through the process of death, but this was “George” (not his real name), my first and longest continual patient. I had been George’s companion for 18 months.

Although I knew the day would come, I had been dreading that inevitable phone call.

Being present with someone as they transition through the final stages of life has never been easy for me, even though I’ve done it several times. I hope that it never becomes easy, but sitting with George was especially difficult. Sadness filled me, but I had witnessed George’s suffering for so long that I hoped he would pass peacefully. While holding his hand, I reflected upon that awkward first visit when I wondered how a young girl could make a connection with an elderly man. Was I even capable of befriending him? Would I be the companion he deserved?

That first day, he was having trouble putting on his favorite hat. It was worn from years of wear and too floppy for him to put on by himself, though he tried. I asked if he would like help. He told me how he wore it, to make sure I put it on just right. He smiled. I remember that smile. Although he was legally blind, some days he would remember me or even ask his nurses for
me by name. Other days, he did not. Either way, I was there every Thursday afternoon after work. On his birthday, I made sure he did not spend it alone. He deserved that much.

In that year and a half, George had never had any visitors. As I reminisced and the monitors continued their beeping, he received a visitor—his first in that timeframe. An elderly lady, an old neighbor, had come to say her goodbyes. The person she had known was already gone. She sat beside me on the bench. Her eyes glossed over with tears as she said to me, “I… I wish I had come sooner.” She brushed aside a tear. She whispered, “Why didn’t I come sooner?” I offered to leave so she could have her own time with him, but she declined.

Regret. I understood this feeling. At that point, I wished I had spent more time with him, too. What really mattered, though, was that we were there in those last few hours.

After a time, she left. I stayed. The monitors continued to chirp.

Once a week I made my visit, his room always in the dark with “Jeopardy” on the television, the room covered in photographs of generations of George’s family, his legacy. This man was greatly loved. The man in the photos did not seem to resemble the man in front of me now.

The final stages of life are just as important as the beginning and middle. In all that transpired over the course of my time with George, I hope I helped give him a meaningful quality of life. His stories were important, and those I will never forget. I became a companionship volunteer to give of myself, but he accepted me into his life and I feel that he gave me so much more over those months. Having had that time with George, I am mindful of keeping patients and their needs in the forefront of my mind as I am learning the myriad concepts and information in the preclinical years. There will never be enough time to hear the full story for every patient I see, but those stories are important. Of all the lessons that I learned from George, this will always stay with me.

To this day, I still think of George often.
My experience with hospice has already affected my interaction with patients now that I am a medical student. The cadaver lab had an entirely new meaning for me, one that I did not anticipate. Having been with so many people during the transition from living through death, all of the cadavers reminded me of my former hospice patients. At times, especially during emotionally difficult dissection days, I found myself absentmindedly holding my cadaver’s hand. My level of respect was heightened for these people, who at the end of life were still not done giving of themselves. I saw George in every one of them, and I wondered about their stories, who they left behind, and why they chose to aid in my education.

George is still with me, and I am still learning from him.
Dating with Allergies

About six months ago, I started dating a guy – one of the sweetest, most thoughtful people I know. But it was maybe on our third or fourth date when I realized that he was not only allergic to peanuts, but deathly allergic. This whole dating thing became much more complicated than I thought.

The Five Rules of Dating a Guy with Peanut Allergies

1. No kissing (except after brushing my teeth really, really well).
   A few years ago, one of the seniors in his high school kissed his girlfriend right before the bell rang for lunch. But she had eaten a Nutella sandwich that morning as a snack, a snack that unfortunately sent her boyfriend to the emergency room.

2. No holding hands (except after washing my hands with soap and water, not just Purell).
   He told me one of his fellow residents at the hospital held hands with his girlfriend on a day she forgot that Chick-fil-A uses peanut oil to cook the chicken. And then it happened not just once, not just twice, but three times. Terrible rashes and swelling popped up on his hands every time. My boyfriend is not sure if they’re still together.

3. No eating out at Thai restaurants.
   Goodbye, delicious Thai chicken-with-spicy-peanut-sauce dish. You were my constant companion during finals week back in college.

4. If I’m going to bake or cook for him, no cross-contamination.
   Better yet, no peanuts or products with peanuts in the kitchen to begin with. Wash all pots and pans before cooking.
5. Learn how to use an EpiPen.

One evening, we were hanging out in my apartment. He asked if I had a spare orange in the kitchen. Maybe he’s hungry, I think to myself. Before I can peel the orange, he hands me something he calls an EpiPen. At first I tell him I’m no doctor, but then he tells me it could save his life, and I listen, and I practice, until I learn how to use the device.

I find these rules to be so hard. But then I think about the stories he told me. People can die from food allergies. I think about the times he told me he went into anaphylactic shock when he was a child and had to be rushed to the hospital all because the restaurant forgot to mention about cross-contamination, or all those times in school when his classmates brought in peanut butter and jelly sandwiches and the teacher told him he had to sit at a different table, alone.

I never realized that his life, living with food allergies, could be so hard. And yet he is still the same sweet, thoughtful person I know him to be.

I tell myself, following these rules may be challenging.
Are you ready?
Are you in?
Are you committed?
Yes.
He is worth it.
Amanda Dullinger is an artist who believes in finding the balance between nature and humankind. She believes that through this balance with the natural world, people can find clarity in their lives and achieve betterment of their health.
Without the Violence

When I first met Dolores, I was a newly minted family doctor: idealistic, impressionable and quick to bond with my patients. Dolores was easy to like. But her sunny disposition belied the brutality in her life. Her husband repeatedly held a knife to her throat while drunk, then denied these episodes when sober. She raised three daughters and maintained relationships with friends, neighbors and a large extended family. She was cheerfully competent at all of this, yet she couldn’t leave her husband. Instead, she barricaded herself in her bedroom when he drank. If the barriers held, she endured only shouted threats, but no physical violence.

I wanted better for Dolores. I referred her for counseling. Unlike most of my patients, who considered psychotherapy foreign and threatening, Dolores accepted the referral and scheduled an appointment. After a few weeks, her psychologist called me to say that she had ended Dolores’ therapy: they couldn’t proceed until Dolores agreed to leave her abusive husband. I was dismayed. Wasn’t therapy supposed to help Dolores reach the point where she’d be able to leave him? If a psychologist couldn’t help her, what could I do?

Not much. Over the years, I continued to see Dolores every month or so. We spent half our time on her largely untreatable aches and pains, and the other half on her stories: updates on her children and grandchildren, her husband’s latest violent behavior.

Then she locked him out. I was so proud of her! Yet I never figured out what enabled her to make that change—why she suddenly found herself able to leave him so long after he first attacked her.

As Dolores’ aches and pains morphed into more serious medical problems, her stories focused on new challenges: her daughters’ shifting loyalties, her jealousy of her ex-husband’s new girlfriend, financial woes. In spite of these unexpected difficulties, divorce had improved her life. She eventually found herself able to enjoy her children and grandchildren (the main focus of her life, her main source of pleasure) without worrying about their ties to her
ex-husband.

And me? I felt so different from Dolores. She grew up in the Bronx. She had a loving, close-knit family, but limited resources. I’d had an easy middle class childhood, with excellent education and plentiful support for pretty much anything I aimed to do. My parents had a solid and unusually equitable marriage. I became a doctor in part to reach other lives—I wanted active and helpful engagement with people who lacked my many privileges. I hoped to treat not just physical ills, but also emotional ones, including some of the consequences of poverty. Those grand ambitions propelled me even when I wasn’t directly thinking about them. The chasm I perceived between my background and my patients’ was my reason for being there and doing my work.

Long before meeting Dolores, I fell in love with Chris, an aspiring artist. We married at age 22. His working class parents were harsh, strict and conservative. His father, a cop, sometimes beat his kids. Did the differences in our backgrounds explain the attraction? I had a strong need to nurture, to assuage the unfixable. This need extended to romance, and for years, the contrast between us worked. From the safe perch that medicine provided, I had access to arty/bohemian pleasures. We had our first child, Nadia, just before I finished residency training and started my first (part-time) job. Until age two, Nadia spent three days a week with Chris while I saw patients at a clinic. I met Dolores during my second year there.

One night, Chris confessed that he’d had sex with prostitutes. Not just once, but many times. He couldn’t explain why. He promised to stop. He agreed to have an HIV test, which I did for him. His late nights now caused me a new kind of anxiety. Was he really working in his studio? Or was he having sex in his car? When he admitted that he hadn’t succeeded in stopping—that he had, indeed, spent some of those late nights with crack-addled prostitutes—I insisted that he start psychotherapy. Although his twice-weekly therapy lasted four years longer than Dolores’ treatment, it was equally unsuccessful: when it ended, he continued the behavior that led him there. At this point, not only had I no thought of leaving him, I wanted us to have another
child. He agreed to try “someday,” but in the meantime we used condoms, and I continued to worry every time he stayed out late. He refused to answer my questions about his sexual escapades and about plans to have a baby. Finally he saw how much it mattered, and he agreed to have yet another HIV test. A year later, we had our second child, Pia.

Pia’s birth marked the start of puberty for Nadia. She was a precocious 10-year-old. Smart, confident and eager for any challenge, she now showed the stirrings of hormone-induced defiance. Over that year, she began to have huge conflicts with Chris over small issues: table manners, slang, holes in her jeans. Chris sounded more like his cop-father than his artist-self. The worst fights centered on grades. Chris didn’t show approval of any aspect of Nadia’s stellar performance in school. When she brought home a 95 on a history test, he asked why she had missed the extra credit questions. She’d say something rude, he’d yell, it would escalate into a shouting match. Then he’d impose some huge punishment. At first I tried to intervene in these scenes, leading to a three-way battle. But he convinced me to avoid the fray. I’d leave the room with Pia and let Chris and Nadia wage their war. An hour later, I’d help Nadia calm down; and the next day, I’d renegotiate Chris’ outrageous punishment.

As Nadia progressed through middle school and high school, storms swept through our house regularly. At age 15, after a particularly bruising argument with Chris, Nadia tried to kill herself. She wrote a suicide note and swallowed the entire contents of our medicine cabinet (over 100 muscle relaxant and pain pills meant for Chris’ bad back). Two hours later, I found Nadia face down on the floor, seizing and bleeding. Paramedics carried her into an ambulance. Hospital staff swarmed around her, cutting through her clothes, pouring charcoal down her throat, intubating her. An hour later, Nadia lay in the pediatric ICU with a respirator breathing for her and several IVs delivering medication to sustain her blood pressure. Thus began the vigil over her bruised, swollen, comatose form. Terrified that Nadia would never recover, I watched every move the doctors and nurses made. I felt completely alone.
Chris tearfully demanded my attention, asking me repeatedly, “Will she make it? What’s going to happen?” I found it unbearable that after causing this catastrophe, he would test my patience with his neediness. I tried to ignore him and focus fully on Nadia.

On the third day, Nadia started breathing on her own. A few hours later, she woke up. I cried with relief. Now I knew there would be an aftermath. Once Nadia could talk, a social worker spoke separately with each of us. Then she called me into a meeting room and explained her view of our family: “You are a domestic violence victim without the violence. You must choose between your husband and your child.” My mouth gaped for only a few seconds before the rationalizations spewed forth: I assured her that she was wrong, that Chris understood what he had done, that he would change his destructive behavior. She calmly shook her head, but remained silent. She didn’t argue—she simply let her strong words stand.

Soon after Nadia’s return from the hospital, Chris yelled at her for failing to shovel snow. I watched Nadia tell Chris, “I feel as bad now as I did the night I took those pills.” He replied, “That’s what I expected. You’re using threats to blackmail me and ruin my marriage.” That was it. He had just proved our hospital social worker right: he could not change, and I now had to choose. I moved out with the girls the next day.

With the help of family, friends, teachers and therapists, both my girls flourished, and even I found myself eager for the next chapter. Struggling against my own shyness, I looked hard for a new relationship. I surprised myself by finding it far better than I had imagined.

Dolores didn’t have a post-divorce romance. As far as I knew, she didn’t want one. After a few good years alone, Dolores died of heart failure (a result of her massive obesity). She hadn’t reached age 60. In health, work and romance, I was luckier than she was; but of course it wasn’t just luck that led me to a better place. It was also that social chasm between me and Dolores, the privileged background that allowed me to push for fulfillment.

When I asked for help, I expected to receive it. I think that’s why psy-
chotherapy worked for me and for my daughters. And perhaps that’s why it didn’t help Dolores or Chris. Neither of them had my basic trust in authoritative healing figures. Looking back, I respected Dolores’ therapist (who said, “I can’t help you now”) far more than Chris’ therapist (who persisted with countless sessions that accomplished nothing). Couldn’t Chris’ psychologist see that they weren’t making progress? Why didn’t he suggest a different type of treatment? Having failed to help Dolores with her biggest problem, I simply stuck with her in a supportive role. I listened sympathetically, blind to our parallels, believing that she couldn’t improve her lot until she was ready to make one big change. How did I differ, then, from the psychologist who continued Chris’ ineffectual psychotherapy? Perhaps I was luckier—certainly, my medical-doctor role gave me something less than primary responsibility for Dolores’ mental health—and it may simply be easier to treat victims than abusers.

There’s no easy lesson here. Life is messy. Romantic love can be both the best part of life and its most dangerous trap. Abuse happens to many kinds of people, at all social levels—and while a solid upbringing lowers one’s chances of getting involved in dangerous relationships, even the most supportive parents can’t lower that risk to zero. However, we can teach our children to expect a lot from life. I want my daughters (and all their friends, relatives, classmates: everyone!) to find happiness in love, and to expect help if they ever need it.

Mercedes Frankl is a family physician working at a community health center in New York City. This essay describes parallel relationships in her personal and professional life. To protect the people involved, she has changed their names, including her own. The rest of this story is true.
Overheard

They left me there—lying
on crinkled paper—the doctor

and my mother—

they closed the door behind them.

Do you think that she

will ever... muffled off
like wisps

from a snuffed wick.

I knew

but didn’t know

what they were asking.

Their voices curled
under the door,

tendriled

into my every open place,
smoking me
  gray
    as charcoal,
  center
burnt-orange
  as an ember waiting
for me
to put it out.
Mask Print

JOANNA WHITE

Childhood surgeries left Joanna White with both chronic pain and a fear of medical procedures. At a preoperative visit last year, she burst into tears upon seeing the oxygen mask that would be used in surgery. The startled anesthesiologist urged her to take the mask home and put it under her pillow to sensitize to it. Instead, White carried it in a paper bag to the therapist who was helping her deal with the idea of surgery. When she took it out and held it at arms’ length, pressing it to the arm of the couch, the therapist commented that she looked like she was stamping “potato prints” with it. Remembering elementary school art, White took the mask home and got out her paints, quickly realizing that the mask was a perfect symbol for the pain.
I’m Smiling at You Through It

Jet to Slate
Jet black hollows to slate—striated sky like rock from ash, then to ultramarine, the waning gibbous moon set off like a stone in a ring.

Opal
Elaina opened her eyes as the first sliver of sun escaped through peaks of darkened mountains to pearl the snow opalescent outside her window. Lying on her side, she watched juncos flicker in the blue needles of the giant spruce until her pain came into focus and she remembered about today. Sitting up, she braced at the iced air and reached for her afghan, tugging it around her like a cape. Crossing the splintery oak boards to the kitchen, she turned the stove’s knob to startle the hiss of gas under the copper teakettle and sat down at the table to wait for its shriek. Too shivery to go out and get the paper, she flipped through *Cooking Light*. On every page, chatty friends perched on stools around terra cotta islands, chopped and minced, sizzled butter in cast iron skillets, hovered over tables of Fiesta ware to pour wine the color of rubies into sparkling stemware. For none of them was today a medical day.

Lemon
Wan sun, January born, patterns the dawn sky—wheels of palest lemon flecked with pith.

Sandstone
Remembering she was not allowed to drink, Elaina turned off the teakettle and dressed. When Marla texted that she was outside, Elaina zipped her parka and dashed for the Jeep. Pulling the car door shut behind her, she sat hunched against it, adjusting the visor to block the sun’s glare through the windshield. Her friend patted her on the knee, but Elaina closed her eyes. They drove miles on frosted roads.
“I know you had terrible medical experiences as a child, but maybe this time will be better,” Marla finally said. Elaina opened her eyes but did not speak. She shook her head.

They pulled up to the Westfield Hospital, the smooth sandstone building revealing nothing of what could happen within. Marla dropped Elaina off and went to park. Elaina stepped into the airless, soundless pressure pocket of the revolving doors. Deposited on the gleaming floor of the lobby, she saw the sun slant down on the face of the man behind the desk, who glowed like a chiarscuro.

“May I help you?” he asked, and Elaina knew instantly that no one could. Marla came to sit with her in the ecru waiting room, but Elaina was silent.

**Balloons**

Age five in her head, she is wheeled to surgery on a gurney.

“Don’t cry,” the nurse in a balloon-print smock admonishes.

**Bone White**

Her name called, Elaina followed a woman with a clipboard. She eyed beds fanning down the corridor, each with a head bobbing atop a blue gown, tubes running out of bodies like lifelines. She wrenched her head straight like a horse with blinders, finally reaching the end bed, where a nurse with hair the color of charcoal and looking just as dangerous awaited.

“Put on this gown,” she ordered, ignoring Elaina’s pleading gaze.

“I need to use the bathroom,” Elaina said, and the nurse pointed back down the row. In the bathroom, Elaina locked the door and looked in the mirror, startled to see her adult self staring back.

“I could escape. I am not a child this time,” she told herself. “I could revolve right back out those revolving doors.” But she imagined the knot inside her body breaking free and spreading to every inch of her. She put on the blue gown.

Back in bed, Elaina watched every purposeful person who passed, exam-
ined each face with a mental microscope, wondering who would be the one to take her back. Finally a nurse strode right to her, cloth mask banded to her face, and Elaina locked every muscle.

“My name is Mary and I have to wear this mask because I cannot get the flu shot, but I am smiling at you through it.” Elaina saw right away that this was true.

“Do you know what white coat hypertension is?” the nurse asked, and Elaina nodded. “I am afraid of doctors,” Mary confided, and Elaina looked around at the blue-clad medical techs bustling by. No white coats here.

“I had to have polio shots as a child,” Mary explained. “My mother had to drive me the wrong way around town so I would not guess where we were going.”

“That’s awful,” Elaina said, trembling, and Mary put a cool hand on her arm.

**Aquamarine**
Shapeless bodies drown in aqua gowns. Masks silence mouths. Eyes loom.

**Amethyst**
Elaina awoke in a room with a window. An unfamiliar nurse scribbled notes at the end of her bed, but Elaina quickly closed her eyes. The nurse, seeing her patient stir, put down her clipboard and came to tuck the blanket a bit higher around Elaina, who did not yet want to know what was written on her chart. For one peaceful moment, it was enough to have slept and awakened. When the nurse lowered the lights and left, Elaina squinted out the high window. Stars prickled the dusk until clouds rolled in, cradling them in cotton, purpling the sky.

*Joanna White, a music professor, has creative works appearing in* The Examined Life Journal, Ars Medica, Grey Sparrow Journal, Milo Review, Pulse, Flare Temenos, KYSO Flash, Balloons Lit Journal, Chest Journal, Medical Literary Messenger, Minerva Rising Literary Journal and in both Snow Jewel and Naugatuck River Review as a finalist in their poetry contests. *She lives in Mount Pleasant, Michigan, with her husband and has a daughter and son in college.*
Tears on Exam

I extend my hand, palm up, an invitation to examination.
You place your hand in mine, tentatively, quivering.
I start inspecting, but you pull away.
I look up to see tears running down your face through ravines of wrinkled skin.
I’m scared, you say, looking to your daughter, now like your own mother.
Your hands, once of a master barber, shake with tremor and frustration and fear.
I let go and sit, nodding knowingly, but really not knowing at all.

Jason Liebowitz is a second-year internal medicine resident at Johns Hopkins Bayview Medical Center and a graduate of Johns Hopkins School of Medicine. He double-majored in public health studies and history of science, medicine and technology at Johns Hopkins University and continues to be interested in ethics and humanities in medicine. He was a selected participant in the Fellowships at Auschwitz for the Study of Professional Ethics (FASPE) program and in the Summer Institute for Medical Students (SIMS) program at the Betty Ford Institute. He has published in Medical Humanities, The Yale Journal for Humanities in Medicine, Maryland Medicine and LabMedicine journals.
Etiology of a Trip

My colleague, Jim Sherman, glanced approvingly around the auditorium. I noticed he wasn’t beaming with pride but rather seemed to be serenely absorbing the moment. No doubt he must be thrilled to have snagged this eminent guest lecturer for our small college in rural Maine. The speaker, Harvard’s Professor Giles Robinson, was rumored to be a nominee for the Nobel Peace Prize for his efforts to improve health care delivery in West Africa. Jim was a modest guy, though, and showed no trace of satisfaction from once again managing to one-up his fellow faculty members by his latest triumph. I knew Lady Luck hadn’t been responsible for this local milestone. It had been a result of Jim Sherman’s foresight, persuasiveness and persistence.

Jim’s flawless introduction, delivered with poise and passion, left all of us—from the freshman students to the most jaded faculty member—feeling eager to hear the guest speaker’s tale and inspired to make the world a better place as he had done. Of course, it was also a bit humbling to realize how much someone 10 years my junior had accomplished with his life.

Professor Giles Robinson arose from his seat in the front row, with a countenance of serious determination and a deliberate stride befitting a man bent on improving the health of a continent. As he approached the podium, Jim stepped back a couple of paces and nodded admiringly. What happened next is etched in my memory as vividly as the scene of the collapsing Twin Towers. As the visiting professor confidently glided by him, a poker-faced Jim abruptly extended his right foot, sending Professor Robinson toppling to the floor. Professor Robinson had no time to break his fall and hit the podium face-first. He raised his head, looking as stunned as a mortally wounded buck in a meadow. A stream of blood flowed from his nose. He remained sprawled on the floor awash with bewilderment. Shocked silence blanketed the auditorium, though I believe I recall some awkward tittering from students in the back rows.
Jim rushed to his aid. He looked as perplexed as Professor Robinson. I heard him apologize profusely as he yanked out a handkerchief from his suit pocket and pressed it to our guest’s nose. He stridently beckoned me for assistance. Needless to say, the presentation had to be canceled as Jim and I brought the injured speaker to our college’s infirmary. By the time we arrived, his nose was no longer bleeding, and he was pronounced fit to go following his examination by a compassionate but distraught physician’s assistant. Throughout this ordeal, he had avoided eye contact with the attentive and solicitous Jim.

In between desperate apologies, Jim pleaded with Professor Robinson to join us for lunch so his trip to Maine wouldn’t be a total bust. The professor appeared jumpy and hypervigilant. I noticed furtive glances toward Jim’s feet as we walked down the pathway to the parking lot. He obviously had one mission in mind—getting back to Boston and civilization pronto. He bid us a stilted, though proper, farewell and drove off without a wave or a smile.

I asked Jim what the hell had happened, but he seemed as nonplussed as I was. He recalled that his leg had shot forward and caused Giles Robinson to trip, but he could not explain what caused his leg to perform this dastardly deed. He wasn’t shirking his responsibility, as far as I could tell, but couldn’t conceive how he could have been the agent of such an act. He thanked me for my help and asked that I extend his apologies to other faculty members as he needed to head home and try to get a grip on the situation.

Some time for reflection for all of us struck me as a wise decision, but the next day I learned that the situation was threatening to spiral out of control. Apparently, the potential Nobel Peace Prize laureate’s reflections had left him seething with rage. His lawyer had contacted the dean and notified him that Professor Giles Robinson was seriously considering a lawsuit against our college. Professor Robinson had traveled widely but had generally spent those trips visiting other academic centers. He had been raised in an aristocratic Boston Brahmin family, and his patrician attitude toward others now reared its ugly head. In an interview with a Boston Globe reporter, he had the
audacity to comment: “I once thought ‘Deliverance’ made the backwoods of Georgia look frightening, but my foray into rural Maine has convinced me that Dante overlooked the 10th circle of hell—the woods of New England.”

Dean Wilson, seeking to stanch the hemorrhaging reputation of our institution, informed Jim Sherman that he had been placed on medical leave effective immediately. Later that day, following frantic negotiations with Professor Robinson’s attorney, the dean managed to dissuade him from pursuing a lawsuit in exchange for Jim Sherman’s vow to seek a psychiatric evaluation.

In the meantime, Jim’s friend in the philosophy department, Keith Duncan, took up his cause with a philosophical broadside hurled toward Professor Robinson. In this diatribe, featured prominently on the front page of our town’s newspaper, Keith lambasted the whole concept of free will. He discussed neuroscientists’ findings that a motor cortex readiness potential could be detected before conscious awareness of an intention to act. As our actions are generated unconsciously, how could Jim Sherman be held responsible for his leg’s act? In fact, our entire justice system should be scrapped as all our acts are determined by a fate of sorts—a combination of genetics, past experiences, autonomous neural activity and so on. No one is responsible for his or her actions. Jim Sherman had fallen victim to our myth of free will.

In the staff lounge, I overheard another theory. Meredith Miller, speaking in hushed and earnest tones to her colleague in the literature department, Chris Jones, observed that we might have a charming psychopath in our midst. She thought she had noticed a smirk on his face when she once told him that her beloved dog had slid down an icy staircase and broken his leg. On another occasion, she had mentioned her horror about the continued slaughter of whales by Japanese “research” ships in the Antarctic, and Jim had barely concealed his lack of interest, managing only a half-hearted “Ummm… oh.”

Jim himself stopped by to visit with me several weeks after the incident. He had chosen to see a psychoanalytically oriented psychiatrist and had faithfully kept all his appointments. Understandably, he was a bit reluctant
to share much about the content of his therapy sessions, but he did inform me that there were some plausible, if somewhat disturbing, explanations that had emerged. Apparently, his analyst thought Jim, in a moment of dissociation, had acted on a past fantasy of aggression toward his brother. Jim acknowledged he had, in the past, felt jealousy toward his younger brother, who seemed to achieve his successes effortlessly. Perhaps hints of this jealousy persisted as his brother was now a wealthy Wall Street stockbroker, whereas Jim continued to struggle to get by on the salary of an academic. Professor Giles Robinson, according to his analyst’s theory, represented his brother, and Jim had acted on a subconscious urge to trip him up for once. Jim had impulsively acted to take the snobby hero down a peg or two. His psychiatrist viewed the act as a sort of breakthrough given Jim’s usual tendency to be somewhat passive-aggressive. As his analyst had pointed out, all our actions are multiply determined, and in his case, another remote incident might have some bearing on the tripping of Professor Robinson. Specifically, back in middle school, or junior high as it was called at the time, a classmate had poked fun at Jim in class. Jim had been daydreaming and, when called on by the teacher to answer some question, had mumbled some disjointed, irrelevant reply. Joe Stimpson, the overconfident know-it-all, had quipped, “Welcome back to earth, astronaut,” to the amusement of his fellow seventh graders. After class, Jim, still feeling humiliated, had stealthily run up behind Joe and, with a well-placed foot, had launched him into a headlong flight to the floor. Joe Stimpson’s notebooks had been scattered to the four winds. Apparently, his wonderful introduction of Professor Robinson had sent him reeling into a flashback of seventh grade humiliation. I listened to all this with empathic concern but could neither confirm nor dispute these elegant and thought-provoking speculations. I could only acknowledge that I had no further insights to offer.

Reasoning that it’s better to err on the side of caution, his analyst had referred him for a neurology consultation. The neurologist suggested this could be a tic-related act. As it had only occurred once, he wondered if it
might somehow have been induced by a passing viral illness. More ominously, he raised the possibility of an emerging dementia due to frontotemporal lobar degeneration resulting in a personality change with impaired judgment and impulse control associated with inappropriate social behavior. He could not explain why there had been only one such socially inappropriate incident and noted that Jim had no other signs of cognitive impairment, but suggested Jim return in one year for reassessment. The neurologist had been rather alarmed, however, and also distressed by the inexplicability of the incident. Perhaps for that reason, he had offered Jim an empirical trial on an antipsychotic medication, but Jim had declined this option.

By the time the winter semester rolled around, the topic of Professor Giles Robinson’s unfortunate visit had faded from most people’s memories, and Jim Sherman was able to persuade Dean Wilson to allow him to return to his teaching responsibilities. The dean had already permitted him to return to the college for the purpose of working on his research. Jim confessed to me that after all the evaluations and analysis, he had reached the scariest conclusion of all. “I tripped Giles Robinson for no reason at all. I just did it.” He, nevertheless, felt confident that this unfortunate occurrence had been a singular aberration. A recurrence was as improbable as the proverbial lightning striking twice.

Jim was in my thoughts all that first day of the semester. Had he fared well? I decided to swing by the lecture hall where he was finishing up for the day. Jim greeted me with a look of pleasant surprise, and he warmly shook my hand. He didn’t utter a word but walked beside me out of the Bergman Building and down the stairs toward the college exit gate. Just as we approached the bottom step, I felt myself stumble over something that had appeared from nowhere. With horror, I realized I was suspended mere inches from the concrete sidewalk and was headed for a crash landing. In the background, like the insistent buzz of a mosquito in one’s ear before falling asleep, I could make out Jim’s plaintive screeching: “Oh my God, I’m so sorry!”
After graduating from medical school at Tel Aviv University, Steve Sobel completed his psychiatry residency and research fellowship at Long Island Jewish Medical Center. Currently, he is medical director at Northwestern Counseling and Support Services, a community mental health center in rural northwestern Vermont. He is also clinical assistant professor of psychiatry at the University of Vermont.
Cruising Down Memory Lane

In the following question and answer session, DMU alumnus Niru K. Pandeya, D.O., FAAOS, FAACS, FAAPRS, FAIS, FICS, shares his experiences during a time the University and osteopathic medicine were undergoing significant changes. A retired clinical professor of plastic surgery at DMU and at A.T. Still University, Dr. Pandeya also served as a chief flight surgeon in the United States Air Force and as brigadier general and state air surgeon in the Iowa Air National Guard.

Dr. Pandeya, a longtime Abaton contributor, has had an essay in every edition of the journal over the past nine years. This essay coincides with the upcoming publication of a history of Des Moines University, titled *Now is the Time; Des Moines is the Place*, which offers an in-depth account of the institution as well as of the osteopathic profession in Iowa and nationally.

Dr. Pandeya sincerely thanks Kristen Tharp of the Des Moines University Library, who verified the tuition for the D.O. class of 1969, and Dr. Gary Hoff, who was kind to read this essay and give his valuable guidance.

DMU: What brought you to Des Moines University, then the College of Osteopathic Medicine and Surgery (COMS), in the 1960s?

DR. PANDEYA: I had been trying for admission to medical school for five years. I had, perhaps, the largest collection of rejection letters from medical schools. During my graduate schoolwork (candidate for Ph.D. in anatomy) at the University of Nebraska College of Medicine in Omaha, I was told that I would never gain admission in medical school because I was not a regular American! I was an outsider, though I was less than one year away from becoming a citizen of the U.S. During a social visit to an intern from India at Mercy Hospital, I found out that there was a “chiropractic” college in downtown Des Moines. My curiosity got me in touch with a COMS graduate from India, and my learning about osteopathy began.

The young D.O., Verghese Mathew, drove to Omaha and gave me the whole history of osteopathy. Dr. Mathew was perhaps the first D.O. of East Indian origin. I applied and was thrilled to be invited for an interview, which took place in December of 1964. I received the acceptance letter within a week
after the interview. I cancelled my interview date with Chicago College. The other three D.O. schools at the time did not want a “foreigner,” so I applied only at COMS and Chicago College.

I had not told my Ph.D. advisers at the University of Nebraska medical campus of my decision; I was going to follow my dream! Once I told my teachers about joining the osteopathic school, the results were so unexpected. My immediate boss and director of Eppley Cancer Research Center and adviser of my doctorate program, Henry Lemon, M.D., was very understanding. His secretary, whose husband was a former drug retail man, kept reminding us that his company did not let him visit D.O.s’ offices because they were quacks. Dr. John Latta, one of my advisers, professor of anatomy and a grandfatherly figure, took it hardest. He was convinced that I had a bright future as an anatomist and, as a D.O., I was doomed as a quack and a cultist.

It was impossible at that time for a D.O. to get a license to practice in Nebraska. A letter from a D.O. was a requirement at COMS for admission, and I was very fortunate to get it from Dr. Paul Reichstadt, the only D.O. in Nebraska, practicing in Omaha.

In the summer of 1965 I moved with my family to Des Moines. I found a summer job working on I-80 with the Iowa Highway Commission, inspecting newly constructed segments of I-80 West. It was a well-paying job, over three dollars per hour. I also worked weekends and nights as a lab technician at Mercy Hospital.

**DMU:** What was your first visit to Des Moines like?

**DR. PANDEYA:** It was a beautiful morning, bright, sunny, hardly any wind blowing. Light snow was falling just as predicted the night before. We were headed east on U.S. Highway 6 from Omaha to Des Moines, the old two-lane highway that connected New York City to San Francisco. There were passing lanes every now and then; if you got stuck behind a slow-moving truck, a tractor or other farm equipment, you just had to speed up, much faster than the
posted speed limits, to make up for the lost time.

The regular programming on the car radio was interrupted by a news bulletin that a hospital in Des Moines was on fire. It was January 29, 1965. A few miles east of Atlantic we got on the four-lane highway that later on became Interstate 80. Immediately after Adair the four-lane highway gave way to old Highway 6, winding through small, charming Iowa towns. In Des Moines, Highway 6 was then Grand Avenue, going through the business district. The fire was at Des Moines General Hospital, the largest of four osteopathic hospitals in Des Moines. There were no casualties in that fire – no lives lost except for a shirt and trousers of a surgeon! Amazingly, there was a fire station next to the hospital.

**DMU:** You mention “osteopathic hospitals.” Talk about the distinction that existed at the time between osteopathic and allopathic hospitals.

**DR. PANDEYA:** In the 1960s there were five allopathic hospitals in town: Mercy, Methodist, Lutheran, Broadlawns (a county-run institution) and the Veterans Administration Hospital. Besides Des Moines General Hospital on 603 East 12th Street, there were three other osteopathic hospitals in town. Wilden Hospital was south of Grand Avenue on Southeast 14th Street; the Grimes State Office Building stands there now. The newest osteopathic hospital, Doctors Hospital, was on 48th and Franklin; it changed hands several times and ultimately became part of the Mercy group. College Hospital, the main teaching facility for COMS students, was right across from the college clinic building on Sixth and Center in downtown. Each of these osteopathic hospitals was approved for postgraduate training of D.O. graduates.

In my second year at COMS, the college hospital became a detoxification center. Prior to 1946, when the then-Still College bought the building, it was a funeral home. It is a parking lot now. The same is the fate for the clinic building and the building that housed our classrooms, laboratories and administration.
Since D.O.s were not given privileges at allopathic hospitals, all the attending at Mercy Hospital were M.D.s. They followed the official American Medical Association policy at the time: D.O.s were cultists and quacks. Interaction between the two groups of medical professionals was considered unethical. Though the Polk County coroner was a D.O., he too was not respected by allopathic colleagues.

**DMU:** What were your early COMS experiences?

**DR. PANDEYA:** The summer of 1965 ended, fall semester registration time came, we paid our fees, got to meet the faculty and our classmates, and the next day classes started. The college president was a Ph.D., and the dean was a local attorney. I do not remember seeing them, not even during orientation. Orientation was conducted by the registrar, the then-president of Iowa Osteopathic Association and a retired city police officer.

Our tuition at the time was $1,250. The next year, it went to $1,450, and by our senior year it had gone up to $2,000, which we though was outrageous! Dress code was enforced, white shirt with black tie, white jacket with ID badge, clean trousers and tidy shoes were required. Attendance was taken for each class. We had classes in the morning and most of the labs in the afternoon with class on Saturdays from 8 a.m. to noon. Anatomy and biochemistry were full one-year courses, which kept us quite busy during freshman year. We started with two females in our class, but by the second year only one survived. I and two Asian students made the minority quota. One of those Asians was born in the U.S.; his father, a born United States citizen, was relocated during World War II. He was a student at the California Osteopathic Medical School but graduated from COMS.

**DMU:** Talk about COMS faculty at the time.

**DR. PANDEYA:** The basic science faculty consisted of a Ph.D. in anatomy, one
in histology, one in physiology and one in biochemistry, each with an assortment of assistants. The wife of the biochemistry professor was one of the best teachers herself, though she did not have a doctoral degree in biochemistry. Clinical teachers were a psychiatrist and his able associate who was a trained and educated theologian. The osteopathic manipulation teacher was housed on the college side, and a radiologist, pathologist and medical residents were on the college hospital side.

The upperclassmen had done a wonderful job in gathering class notes and old examinations, which came in very handy. In the anatomy notes, they even noted the jokes the old professor used to tell and the type of response we were supposed to give. There were jokes for which we had to just clap, jokes for which we had to holler and clap and then jokes that demanded standing ovations.

In our second year we did get a husband-and-wife team, both Ph.D.-microbiologists, as well as another pathologist, a social worker, a psychologist and two other D.O.s. A very bright pharmacologist Ph.D. joined the faculty. A few clinicians also started to show up to give lectures, but they were from the community and not regular faculty members.

I do not feel that lack of adequate faculty or lack of research hindered my education in any way. My goal and the goal of most of my friends was to get our degree and get out in the real world of medicine where the real learning would begin. The college was giving us the foundation; what we built on this was up to us.

DMU: A lot was changing in osteopathic medicine in Des Moines and nationally at the time. When you were a student, for example, the American Medical Association spent nearly $8 million to end the practice of osteopathic medicine in California; in 1962, a statewide ballot initiative in California eliminated the practice of osteopathic medicine there. The California Medical Association issued M.D. degrees to all D.O.s in the state for a nominal fee.
DR. PANDEYA: Due to that California merger, no one was sure if the osteopathic profession would survive! At one time rumors were flying that COMS was moving to Arizona. There were secret meetings going on with the American Medical Association. There was a new college president, Thomas Vigorito, D.O., and we were hopeful that COMS would become an allopathic institution, granting just M.D. or M.D.-D.O. degrees. Nationally, the military was reluctantly accepting D.O.s, and rumor was that someday we might even be considered for allopathic residency programs and privileges to practice in allopathic hospitals. Every D.O. who came to lecture reminded us that we had no reason to feel inferior. We were convinced that there must be reasons for us to feel inferior – otherwise, our leaders would not keep reminding us!

DMU: You described some of the COMS faculty. Who were other people you recall from your COMS days?

DR. PANDEYA: I will never forget the kindest soul on the COMS campus, the African American elevator operator, Gussie Lamar. She always had a cheerful smile, a few kind, encouraging words and great hugs for us. Her wages were minimum, but she always had a few coins for my very young son along with extra rides on the old rickety elevator. She could read our minds; she was our family, our mental health counselor and confidence-builder. She knew our grades long before they were posted. She warned us if the anatomy professor was in a foul mood (which was often). She told us about upcoming events before they were made public. She was our guardian angel. God bless her soul!

During my second year the college hired two new teachers in psychiatry, Mrs. Tinker and Dr. Eckhardt. They both were on the liberal side of the political spectrum. Their children showed up in high school one day wearing black armbands in protest of the Vietnam War and were disciplined. They sued the school district because their civil rights were violated; they felt they had a constitutional right to wear the black armbands to show their disagreement. The case went to the U.S. Supreme Court, and the justices ruled in
their favor 7-2 in the historic case, *Tinker v. Des Moines*.

**DMU**: Talk about your later COMS student experiences.

**DR. PANDEYA**: We were delighted to say goodbye to the campus after the end of the second year. The basic science years were over. The clinical teachers were gentler and kinder, and the subjects they taught were more enjoyable.

We had to take the examination given by the National Board of Osteopathic Examiners in three parts, but passing all of them was not a requirement to graduate. Part Three of this examination required case studies in surgery, medicine and pediatrics, and it was done at the hospital where we did the internship. Some states required their own basic science certificate, and some of us took them at the end of second year while the subject material was still fresh in our minds.

**DMU**: What were the hospitals like where you furthered your education?

**DR. PANDEYA**: Doctors Hospital, where I decided to do my externship (clinical clerkship) was a large hospital with over 300 beds. The north campus of Doctors Hospital was a couple of blocks from the Ohio State University campus, its medical school and university hospital. Doctors West was in the western suburbs where two major interstate highways merged and became narrow two-lane highways, thus causing multiple major, often fatal, car accidents. Both campuses were fully equipped to do surgery and provide obstetric, pediatric and medical services. The house staff and students had to cover both the campuses.

Doctors Hospital had no subspecialists, no cardiac unit, and no intensive care unit per se; no cardiologist, pulmonologist, nephrologist or neonatologist. We had a neurosurgeon who did neurology also. We had a thoracic surgeon, an ophthalmologist and ear, nose and throat surgeons, but most of them were minimally trained. The senior pediatrician, Ben Cohen, was a gifted person...
with a photographic memory. He was often called upon by his M.D. pediatrician friends in town to consult on difficult cases, but it was all unofficial. If we did go to Children's Hospital, he could not write on the chart and was not allowed on staff.

**DMU:** Share some of your experiences during those clerkship/internship years.

**DR. PANDEYA:** I took the Missouri State Licensing Board examination in Kansas City on my way to Des Moines for graduation. I had a license to practice medicine and surgery by the end of July of 1969 in the very beginning of my internship. Several states did not require any postgraduate training for granting a license to practice medicine.

As externs, we had to wear the short white coat, shirt and tie and name-tag. For interns it was the short-sleeve old-fashioned barber shirt with the Chinese collar (similar to the Nehru jacket’s collar), our name embroidered with the D.O. after the name. If we did go to the Ohio State University hospital, we had to remove our nametags or shirt so we would not be singled out as D.O.s.

Doctors Hospital did have residency programs in general surgery, ENT surgery, obstetrics and gynecology, pediatrics, radiology, pathology and neurosurgery. Unless you were needed on the staff, it was made very clear that you would not practice within a certain radius of the hospital after completing the internship and residency. Initially, the interns were basically used to do all the scut work, complete history and physicals on new admissions and attend to various in-house and outpatient services. We were paid about $100 per month. On obstetrics service, every two weeks, we had to report on Friday morning and stay there till Monday evening and pick up the regular schedule on Tuesday morning again.

On most services we had alternate weekends off. Occasionally, at Doctors North, there were excitement in the emergency room, a shootout, a gang-related incident or occasional sexual assault victim to work on. The
hospital was situated in a rough neighborhood! The internship was full of frustrations. We were learning a few things, but it was sad to see less competent peers pretending to be our leaders and teachers. The “inherent inferiority complex of an osteopath” was deepening. Our internship class had graduates from all five D.O. schools; some of us were better educated than others! I was the only Asian in the class, so I felt marginalized most of the time. There was no possibility of my getting any residency there.

**DMU:** Then a big event happened in 1970, right?

**DR. PANDEYA:** It was mid-January of 1970. I went to bed as a “quack and a cultist” and woke up as a doctor! The American Medical Association blessed my medical education that day by opening membership to osteopathic physicians. At Doctors Hospital, many of us thought of moving on to allopathic postgraduate training. We felt overworked and under-appreciated by the staff. When the word got out of our intention of possible defection, we got a raise and were treated better. Some of the family doctors even started their pitch to recruit a few of the interns to join their practices.

**DMU:** What were your career aspirations at the time?

**DR. PANDEYA:** I wanted to be a surgeon. Most of the osteopathic hospitals were privately owned by surgeons, who incidentally were white, mostly Catholic, and occasionally and rarely Jewish. In any case, they did not want a “foreigner.” Thanks to my old friend, my teacher, the person who influenced me to become a surgeon, Norman Rose, D.O., came to my rescue. Before I preceptored with him, I wanted to be a neurologist. Every time the surgical lights went on, I came “alive”! He was and still is a dynamic teacher who has mentored several young osteopathic students. Dr. Rose accepted me for surgical residency at Des Moines General Hospital, though some senior surgeons did not want a nonwhite person. I was back in Des Moines, Iowa, again in
the summer of 1970.

DMU: More changes were under way at COMS and in osteopathic medicine in Des Moines and nationally.

DR. PANDEYA: The osteopathic scene in Iowa had changed. There was only Des Moines General Hospital (DMGH) left, and it became a major teaching hospital, working closely with COMS. There were residency programs in surgery, radiology and internal medicine. A small two-room emergency room was often staffed by residents and interns. There was a functioning ICU and a decent library. The D.O.s’ relationship with M.D. counterparts was still poor, though there were a couple of recent COMS graduates doing their “internship” at Mercy Hospital. No D.O. had privileges at any M.D. hospital in town yet.

COMS had a new president, and the old Sixth and Center campus was locked up in 1972. The facility moved to its current location on 3200 Grand, which had been a private girls’ Catholic high school, St. Joseph’s Academy. Several D.O.s were in practice in rural Iowa communities, but they had no hospital privileges in their own communities. In Iowa, osteopathic hospitals existed only in Des Moines and Davenport. If a patient of a D.O. needed hospitalization, he or she had to be moved to the nearest osteopathic facility or a deal had to be made with a friendly local M.D. for further care in a hospital. Many times the patients never came back to the referring D.O.

DMU: What was your training like at Des Moines General Hospital (DMGH)?

DR. PANDEYA: I had decent training at DMGH. The general surgery at that time consisted mostly of removing gall bladders and appendices, some gynecological surgery, some stomach, colon and rectal surgery and lots of tonsillectomies and adenoidectomies. One of the general surgeons did some
orthopedic surgery. Later on, a well-trained D.O. orthopedic surgeon came in
town. An orthopedic surgeon from Tulsa, Oklahoma, occasionally used to fly
in to do major orthopedic cases at DMGH. No one did any major hand sur-
gery till I came back from Sweden to practice at DMGH (more on that later).
Des Moines did have a world-famous hand surgeon, J. Bruner, associated with
Methodist Hospital, but as D.O.s we had no interaction with him.

My teachers in surgery were good. Dr. Howard Graney had trained most
of them. Dr. Norman Rose was very close in style and mannerisms to Dr.
Graney. I have worked with surgeons in Sweden, Norway, Germany, England,
Japan and India, but no one has matched the skill of Howard Graney. Besides
being ambidextrous, he was a true gentleman, a rare quality for general sur-
geons of that era. Dr. Graney was meticulous, fast and never made one false
move in the surgery suite. His patients had lower morbidity; he believed in
early mobility and started post-operative feeding as soon as he could.

He was trained by John P. Schwartz Sr., a 1919 ASO graduate who was
trained by Simeon L. Taylor, D.O., M.D. Dr. Taylor was a 1903 graduate of
Still College of Osteopathy (DMU), and he also earned an M.D. degree from
the University of Nebraska in 1908. He had his surgical training at Johns
Hopkins University. So in a way we, trained at DMGH, have a bit of William
Halsted/Harvey Cushing/William Osler’s way of thinking implanted in us!

Dr. Schwartz was still alive when I was a resident at DMGH. He was a
man of very few words. I often saw him when I was on night call because he
lived in the hospital. He was still a very sharp diagnostician. I was told that
he was a great technician with surgical tools also. Those were the days before
automated equipment; bowel resections were done by hand.

At DMGH, only one procedure was done as outpatient, tonsillectomy
and adenoidectomy in children. We had to bring abdominal surgical patients
in at least three days prior to surgery, keep them in the hospital, run a bat-
tery of tests, do the surgery and keep them hospitalized for at least seven to
10 days if there were no complications. If this routine was not followed, the
insurance companies denied payments.
DMU: Did your career aspirations change?

DR. PANDEYA: During my residency at DMGH I realized that I was not suited for small-town practice and that I was not welcome in any osteopathic hospital because I was a “foreigner.” I had to super-specialize to survive! There was no D.O. plastic surgeon at that time on God’s green earth, and that kind of creative work fascinated me. Every time I mentioned my desire to be a plastic surgeon, my fellow D.O.s, my teachers and my friends looked as if I had lost my mind. They all said the same thing: “It has never been done; it cannot be done.” Some even mentioned, behind my back, that as a “foreigner” I should know my “place” and be happy as a general practitioner in a small town where people would have no choice but to come to me for their health care needs.

In order to be near bigger medical facilities, I did my final year of surgical residency at Richmond Heights General Hospital in an eastern suburb of Cleveland.

Meanwhile, there was no real thawing of relations between M.D.s. and D.O.s in Des Moines. There were some COMS graduates at the local children’s hospital in residency training. There was no D.O. on the staff of any allopathic hospital yet. There were a few D.O.s in the military, but it was still impossible for a D.O. to get a military residency slot. Allopathic surgical slots were totally out of reach for osteopathic graduates.

DMU: As an aspiring surgeon, what did you do?

DR. PANDEYA: I went to Sweden for two years to complete a fellowship in plastic surgery at Karolinska Hospital and Umea University Hospital. Karolinska Institute is situated across from the hospital and is the place where the Nobel Prize in medicine is discussed.

Before going to Sweden, I was invited to observe surgery at the Cleveland
Clinic. My guardian angels were the late Drs. Robin Anderson and Shattuck Hartwell Jr. Both were famous, well-respected plastic surgeons. Unfortunately, I got only as far as the entrance to the operating room – the then-head of the department of surgery informed me in very firm language that no osteopath was going into his operating room while he was running the show! Merely two years later, the fellows in the cardiothoracic units were D.O. graduates, and later on almost every department welcomed D.O.s as trainees, faculty and staff.

The Karolinska Hospital was serving a patient population of more than 10,000. I did rotations at the Uppsala University hospital and all government hospitals in Stockholm. There were two private hospitals in the city where paying, private patients of my teachers went for cosmetic procedures. I assisted my teachers at these facilities also. My chief at Karolinska, Bengt Nylen, gave me full freedom to choose cases. There was a huge backlog of cases, inherent to the socialized medical system. I was willing to work extra hours so I got tremendous variety and volume in all aspects of plastic and reconstructive surgery, including hand surgery.

After my return from Sweden in 1975, things were better. Osteopathic graduates were being accepted in training programs based on their merits except for the specialties controlled by the American Board of Surgery. Des Moines hospitals had several D.O.s, trained in allopathic programs, on staff.

However, my personal struggle for acceptance continued in both the osteopathic and allopathic professions. The osteopathic profession had no idea what a plastic surgeon was capable of doing, and my heritage became another barrier. Local plastic surgeons were clearly skeptical of my Swedish training. Many of them did not know that Karolinska and Uppsala were two of the best teaching institutions in the world. I trained with great plastic surgeons who were widely published and had written books; there were surgical instruments and surgical procedures devised by them and named after them. In the field of plastic surgery, the names of Sten Stenstrom (correction of prominent ears), Bengt Nylen, Jan Strombeck (reduction mammoplasty), Tord Skoog
(several procedures named after him), Eric Moberg (father of hand surgery in Scandinavia) and Lars Onne (hand surgery) are still well-known. I made friends with and spent time with other great plastic surgeons in Japan, India, England and Germany. I was fortunate enough to spend learning sessions with the late Noel Thompson (treatment of lymphedema) at Mount Vernon Hospital in London, S. Ohmori (microsurgery) at Tokyo Metropolitan Hospital and Edgar Biemer (making thumbs from toes) in Munich. My training was far superior to any other training under a single trainer at any one center.

DMU: Earlier you mentioned Des Moines General Hospital (DMGH). Its history and that of the osteopathic profession took many turns.

DR. PANDEYA: It took many more years and the ultimate demise of DMGH before all D.O.s were accepted at local hospitals, even those with osteopathic board certifications. DMGH changed ownership several times. Mercy Hospital finally bought it in 1993 and later sold it to the state of Iowa, which started the demolition of the oldest osteopathic hospital in Des Moines in September 2013. This facility had been bought by the original Still College in 1909 from the Iowa Sanitarium, eventually becoming Des Moines General Hospital. Now lies a vacant lot at 603 East 12th Street by the State Capitol grounds. It had been the training ground for thousands of osteopathic physicians and surgeons.

We have come a long way in half a century since I first heard the term “osteopathy.” Now the sky is the limit for upcoming young osteopathic medical school graduates. From five private schools to more than 32 campuses, many state-supported; full support in the military, when promotions in the military were unimaginable half a century ago; new avenues open for advanced, integrated and unified postgraduate training; unified certification programs – all point to a bright future!

From the ruins of the old DMGH and hundreds of other similar osteopathic institutions, a bright new professional future has arrived. Now D.O.s
are seen and welcomed in almost every hospital in this nation and abroad! Now I do not have to remind the younger generation of osteopathic practitioners that we “are not inferior.”

I am deeply obliged to my alma mater, Des Moines University, and all my teachers who gave me the basic tools. Without them, I would not have accomplished all that I have. Now I realize that our bitterness during our basic science years was part of our education!

**Dr. N.K. Pandeya is a distinguished alumnus of Des Moines University. Though he has retired from his career as a plastic surgeon, he continues to be involved with DMU as well as in health care in his native India.**

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**Back Cover**

**Painting**

**ZAYAN MAHMOOTH**

Zayan Mahmooth has an interest in medicine and public health. He studied public health at the Johns Hopkins Bloomberg School of Public Health and will begin his medical education at Emory University School of Medicine this year. He enjoys drawing and writing as a complement to his work and studies.