

ISSUE SIX • FALL 2012

ABATON

DES MOINES UNIVERSITY LITERARY REVIEW



Editor's Note

THE SIXTH ISSUE

Dear reader—

First of all, I want to thank three people involved with the production of *Abaton*: Kendall Dillon, Julie Probst, and Barb Boose have been indispensable and contribute design expertise, consistency, proofreading acumen, and persistence.

The submissions in this year's issue reflect the power of the medical humanities. The intimacy and rawness of some will be challenging. The wonder and nostalgia of others will be nurturing. In total, though, their insight and thoughtfulness echo the focus necessary for healing work.

Lastly, I will end by saying goodbye to our readership – this will be my last issue as Chief Editor. It has been a joy to assemble the journal and I look forward to seeing it continue to develop as I enter residency. I am excited to welcome next year's co-Chief Editors: Kelly Bowen and Brittini McLam.

Sincerely,

A handwritten signature in black ink, appearing to read "John De Mott", with a long horizontal flourish extending to the right.

John De Mott

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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.

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ABATON

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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 and 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

Bloom

ANNA SCHULEIT

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Predators

Dr. Beth Abernathy awoke around 2 a.m. to the ululating howling of coyotes. A full moon shone through the skylight. The coyotes sounded very near. Their calls went from one individual to another, cascading, escalating and then falling apart into a chorus of yips. These sounds had not been part of her East Coast megalopolis upbringing but were common here in the suburban Midwest. Like tornadoes, another thing she had learned to live with. Beth shuddered in the sudden silence and nestled closer to Jonathan, her husband. Slept.

Twenty-four hours later, well into her on-call stint at the hospital, Beth took a seat on an empty gurney, positioning herself so she could see directly down to the ambulance bay doors, and waited for the next trauma to arrive. It was said to be a hunting accident, although what this guy was hunting late at night in mid-winter was unclear. Shotgun blast to the abdomen, eviscerated. The chief resident sat down a respectful six inches away.

"Bet you saw a lot of this at Bellevue," he said wistfully.

"Not shotguns, but certainly lots of penetrating trauma...we did have a busy trauma service." She chuckled, shook her head, and continued, "You know, when I was there, they brought in this new guy to run the emergency room, and he set up all these protocols..."

"Research protocols?"

"Some. Mostly they were just protocols to tell you what labs you could order. To cut down on waste and inefficiency, maybe improve patient care. His name was Nelson, and he had this big, thick red pen and he'd come in the next morning and go through the charts from the night before and write 'WTF' in big red letters all over the order sheet if someone had ordered something he didn't agree with...right on the chart, WTF, WTF."

"WTF?"

"Stood for - What the fuck? So that's what we all called him - WTF -

he died of an MI, right there in his office. Was going through a chart where someone had ordered a troponin level on a patient who was hypotensive after a stab wound, wanting to rule out an MI, and old Nelson just started yelling ‘WTF! WTF! Doesn’t anyone know how to treat hypovolemic shock?’ and keeled right over. Say, I thought somebody told me you were a former SEAL. Didn’t you see any trauma?”

“I wasn’t a SEAL, Dr. Abernathy, but I worked with SEALs. I trained as a combat medic. They had us doing these simulated exercises off the West Coast – we’d be trying to start IVs on each other, all hypothermic, in wet suits, nighttime, heavy surf, guys firing over your head simulated rounds... gets a bit old. Weapons aren’t designed to kill anymore; they’re designed to maim. That way you take three guys out with one shot – two guys taking care of their buddy so he doesn’t exsanguinate. I never saw combat. One time – you know, they have these little submarines, they call them SEAL Delivery Vehicles, about the size of a VW bus, and they just stuff the SEALs into them and off they go. Well there was this guy, kept puking. Just kept puking and puking, and I couldn’t feel a pulse, tossing around in that little sub. He made it through to the end of the exercise, but he lost 10 pounds, puke and sweat. I dunno how much I lost...” he stopped talking, realizing that Beth had stopped listening.

They both stood up suddenly, just as the big double doors at the end of the long hallway opened. Two dark navy jump-suited young women came barreling down the hall toward the trauma room, propelling a gurney with what looked like a huge, bright orange quilted burrito on it. IV bags hanging. Their patient.

Beth watched them pass and thought about Jonathan, wrapped up warm in bed, under their big down comforter. Wondered if the coyotes were howling. She pushed that thought firmly out of her head and stood for a few moments, letting them get the patient into the crowded trauma bay. Saving her energy for the OR, when it would be needed.

She elbowed her way to the side of the patient and opened the quilted

burrito wrap. Inside the burrito was a scrawny little guy, mid-30s, with a couple of tattoos. Hunter, or hunted? Large white gauze dressings covered his belly, and a ribbon of blood snaked down his flank. She lifted one corner of the dressing, just enough to peek underneath. About four loops of small intestine, dusky and purple in color, lay out on his abdominal wall. One loop had a hole blasted right through it, she noted. Succus, Betadine and blood combined in small streams along his flanks and puddled on the side of the gurney. She replaced the dressing.

"Yup. Eviscerated. Needs to go to the OR. I want a chest x-ray, abdomen, and I want blood ready and I want him in the OR in 10 minutes. What do we have for access?"

The chief resident was already busy getting a large bore IV line into the patient's inner elbow, the tender area where the big veins were close to the surface.

"We need to get him unwrapped and check him over quick before we go up. Check his back. Might be more than one hole in this guy. Ten minutes, no more. What's his BP?"

"90 over palp."

"Let's move it, people. Hang a unit of O-neg."

In less than 15 minutes, the team unloaded him onto the OR table in good old OR #3, the biggest OR, where the blood warmer and rapid infuser and all the trauma stuff stood ready. Kim Sook, the anesthesiologist, was an older man, steady and fast. His formal precision of language dated back to his undergraduate days at Oxford, but he had done his residency at one of the big inner city hospitals of the U.S., where trauma was a constant companion.

Beth barely had time to check the labs and x-rays on the computer screen before Dr. Kim said softly, "You may cut when ready, Dr. Abernathy." He made an expansive gesture with his left hand toward the belly of the patient. His right hand moved busily across the anesthesia record, making little marks

for pulse, blood pressure and respiration. The circulating nurse drew in her breath sharply, a little “huh” sound, when Beth peeled off the dressings and exposed the bowel.

“Uh, how do you want me to prep?” the nurse finally said.

“Just pour it over the whole belly, bowel and all, Betadine. We’ll drape wide in case we need a vein patch or something. Both groins, lower chest.”

Another nurse burst into the operating room, arms laden with blood bags. “Here’s your blood,” she said to no one in particular, and started putting the units into the OR refrigerator.

“I’ll take that, if you don’t mind,” said Kim, holding out his hand. He reached up and took down a flaccid, empty blood bag and replaced it with a fat new one, opened the IV drip regulator wide open. He had the rapid infusor up and running, so that the blood would be warmed as it went into the patient’s veins, and it would pump in a liter in just over a minute if you wanted it to. The blood was flowing at a moderate rate, but he was obviously ready to dial it all the way up if he had to.

The scrub nurse had draped the patient with sterile green towels and sheets, and now all that was visible was a squared-off omega-shaped expanse of flesh, with the eviscerated bowel at the center. Beth took her place on one side and motioned for the medical student to come stand beside her. The scrub nurse and the chief resident stood opposite.

“We’re starting,” the chief resident said, and made an incision from just under the breast bone to the upper aspect of the hole through which the bowel protruded. Beth held the bowel back with her hands, placing a malleable ribbon retractor between the bowel and the skin so that he could cut without fear of injuring the bowel. He followed a similar process at the bottom, making the incision from the eviscerated area down to the pubic bone, so that when the incision was opened, the entire abdomen opened up like a book.

They quickly put Babcock clamps across the two holes in the damaged bowel, and Beth gave the eviscerated loops to the medical student to hold. “Here, take these,” she said. The intestines had already started to feel cold.

Dying by inches, this man was. Blood poured over the edges of the incisions, dark, partially congealed. “Old blood,” she said. “Couple of liters.” Kim nodded and watched closely.

They rapidly packed the abdomen off in quadrants, using clean white cotton pads to contain and isolate the areas. There was fresh bleeding from the root of the mesentery of the small bowel, an evil place to get hemostasis. Take a stitch a bit too deep, and you might permanently damage the blood supply to the entire intestine. Beth pinched the bleeding area off with thumb and forefinger, temporizing while they looked for any additional damage.

“Found the bleeder. Now we need to find the wadding,” she said. And, out of long-standing habit, started talking to the medical student just to compose her thoughts, slow her pulse rate, prepare for the next phase when they would have to find and repair all the injuries, carefully get meticulous hemostasis. “Do you understand how shotgun shells work?” she asked him. He shook his head no. “Well, it’s something like this. The shot is propelled out of the gun. The diameter of the shell corresponds to the diameter of the gunbarrel, and that is the gauge of the shotgun, you see. The shell looks like a hollow cylinder. Often it’s made of lightweight plastic. Inside the cylinder, it has a small charge and a lot of small pellets. The size of the pellets differentiates birdshot, which is small, from buckshot, which is large. This guy looks like he was shot with birdshot, because the pellets we found in his clothing were tiny – remember? Lucky for him.” The student nodded. “Well, inside the cylinder with the pellets there is a small charge to disperse the pellets, and this charge ignites just after the shot leaves the gun. You can tell how far someone was from the gun by the scatter pattern. He was shot almost pointblank, because the hole is small. Even though the pellets were small, the aggregate mass plus the exploding charge blew this hole in his belly. You see, the hole in his belly was almost big enough for me to stick my fist into, if it hadn’t been full of his guts. So the shotgun casing and wadding, which holds it all together, is probably inside him somewhere, and we have to get it out. It’s a foreign body, potential source of infection, plus the sheriff will want it for evidence.”

Meanwhile, they were moving rapidly throughout his abdomen, scooping up clots of blood and tossing them into a waiting basin, looking for fresh bleeding, searching for holes.

"I've got it!" the resident yelled, holding out a twisted plastic cylinder.

"Good work," Beth said. "Now, where's the wadding? It ought to be nearby."

They were still searching, feeling and looking between coils of bowel, still cool to the touch from shock, down in the pelvis, up under the diaphragm, when a hospital security guard came uneasily into the room. She had put on a gown over her uniform, shoe covers, OR hat, mask, all a bit askew. A normally confident woman, pushed out of her comfort zone. Beth looked up, recognized her. "What's up, Anna Marie? Here to collect the evidence?"

"You know it, Dr. Abernathy. Guy's a pedophile. Registered sex offender, out on parole. Dunno who shot him, but I bet he had it coming."

The medical student silently held out his hand to Beth. On the bloody palm of his glove lay a ragged cylinder of felt. The wadding.

After they resected the damaged bowel and made a last check for hemostasis, Beth backed away from the table, leaving the chief resident and student to close up. Kim nodded at her.

"Thanks, everyone," she said, leaving without waiting for a reply.

Kim joined her out at the scrub sink, leaving the patient to his own very able chief resident. Beth and Kim stood side by side, looking into the OR through the windows over the sinks. Once they had had coffee together after another tough case, and he had told her about his childhood flight from Korea into the West. Months of his childhood spent hiding from soldiers. From his own countrymen. Ultimately, a new life and safety in the UK. His father and mother, both physicians, opened a Korean grocery store and sent their son to Oxford, where he majored in anatomy. He had wanted to be a surgeon, but had considered himself lucky to get an anesthesia residency at Cook County.

“This man’s wife awaits you in the Surgical Intensive Care waiting room,” Kim finally said. Beth drew a sharp breath. “You will be able to assure her that he is doing very well indeed,” he continued. At their feet, three suction canisters full of blood sat waiting for proper disposal. She realized she had tracked blood out into the hall, and bent over to take off her OR booties.

“WTF,” she muttered.

“I beg your pardon?”

“Just an old Bellevue expression. Wonder how she’ll take the news.”

She suddenly remembered looking outside their bedroom window after hearing the coyotes. Had it been just the previous morning? Or the day before? She had lost track. The fresh snow had been pock-marked with tracks, and there was a patch of blood on the snow where the coyotes had torn some small animal to pieces. A weasel, perhaps. A rabbit. Or maybe a house cat.

A week later, one of those late autumn warm spells blew in from Missouri, to the south, and she biked to work. She was racing along the river, the flat trail paralleling a major throughway, when she saw a car pulled over in the lane closest to her, facing her. She slowed and warily edged a bit farther away from the road.

Once, as an undergraduate, she’d responded to a man in a car pulled over on the shoulder of another thoroughfare running along another river in a different city. He’d pretended to ask directions, but as she leaned into the open passenger side window, the rhythmic motion of his left hand drew her eye to his crotch and his unzipped fly. Even as she mechanically responded to his bogus query, she froze her expression and backed off, walking fast in a direction opposite to traffic so that he could not follow her. The tears and anger came out later, when she rejoined her boyfriend...

But this man was simply staring away from her, across two lanes of traffic, where a coyote walked slowly down the median strip toward incoming traffic. She stopped and dismounted her bike. The coyote had no business out there in daylight – was it rabid? It looked tired. Cars avoided, and when a long gap

came in traffic, it edged over to the shoulder. There a steep grassy slope led to a wooded area. Beth tried to will the animal to run up the slope, out of danger. Its coat was ragged and the slender muzzle was brindled with grey. It stepped briefly onto the rotten snow that edged the shoulder and stepped back, shaking its forefoot just like her cat did when going out, reluctantly, into the snow.

ACKNOWLEDGEMENTS: This story was first published in Volume 5 of Buffalo Carp, a literary journal formerly based in the Quad Cities and no longer in existence. It was then reprinted in my short story collection, *A Few Small Moments*, published in 2011 by Rachel Lord Press.

Carol Eh Scott-Conner completed her surgical residency in 1981, at a time when very few women entered general surgery. When she was appointed head of the Department of Surgery at the University of Iowa in 1995, she was the second woman in American surgery to attain such a position. She is the author or coauthor of nine major surgical texts and a book of short stories, A Few Small Moments. Her fiction explores the intimate space in which surgeon and patient, surgeon and colleague, or professor and student come together. She is professor of surgery at the University of Iowa and lives in Iowa City with her husband.

Inscribed in the Book of Life

Brian's skin is pale and bruised like the pages of his Bible. His hair appears to take on the yellow highlights of something, perhaps the verses he quotes to me. Is acute leukemia a biblical concern, I wonder?

Brian returns today to talk about chemotherapy. He has recovered from pneumonia. He wears a white polo shirt, which hangs loosely on his shoulders like a preacher's robe. His faded khaki pants match the color of the exam room walls. Two weeks ago at his bedside in the hospital in Columbus, I told Brian, "Without chemotherapy you won't live more than two or three months." Now, his wife, Brenda, a few months pregnant, sits next to him. She is approximately Brian's age, 26, and appears devout – round face with small brown eyes, no make-up, Brunette hair pulled back in a bun, and thin lips moving silently with every verse Brian reads.

"I admire your strong faith."

"Thank you. Doctor, do you believe in God?"

"Sort of." Already I'm uncomfortable, shift in my chair and put his chart on the table. "I'm not inspired by prayer."

"Do you read the Bible?"

"Not really." I sense Brian avoids talking about his acute leukemia as much as I don't want to reveal my religious habits. I try to keep him focused on the purpose of his visit. "Do you have any questions about chemotherapy?"

"I know I'll probably die, but I'm not afraid." Brian's calmness in the face of his own death unnerves me. His open Bible rests on his arms as if he were infusing himself. When I was his age, I was in medical school where death was the enemy. *Harrison's Principles of Internal Medicine* was my Bible, but it didn't protect me from fearing my own demise.

He flips through pages in his Bible, points to a highlighted passage as if his fingertips were blessed with radar. He reads aloud, "Then said Jesus unto his disciples ... For whosoever will save his life shall lose it: and whosoever will lose his life for my sake shall find it." His lips are parched, and his tongue

reveals tiny patches of white, the remnants of thrush. Looking up from his Bible, he asks me in a quiet voice, “Why should I take your poisons?”

Six years in practice in Ohio don’t prepare me for this battle of words. I want to shout, “Don’t you hear me? For sure you will die without chemotherapy” but contain myself with, “These are good ‘poisons,’ Brian. They can cure.”

That’s his prompt to find another verse, his fingers energized. His face remains passive until, his eyes widening, he leans forward and says, “A good name is better than precious ointment; and the day of death than the day of one’s birth.” I think to myself, the language in the Bible is poisonous if it blinds the believer. I don’t share my cynicism with this couple. My neck muscles tighten. I am hoping for a reaction from Brenda. She complies, turns her head toward Brian and puts her right hand on her belly. Swearing on the Bible comes to mind. Her eyes narrow her gaze, a stare at the Bible as if to erase the passage Brian just quoted. Her words that follow grab his attention. “Brian, I want our baby to know you. God would want that for us.” She reaches over and pulls Brian’s right hand onto her belly near her resting hand. He startles, his Bible starting to slide off his lap. With both hands he rescues his book and posture, resumes a stoic appearance. Brenda tears up, accepts the box of Kleenex I offer her.

I plunge further from their world, pushed by his words and his Bible’s messages. My screams fade into echoes – “Don’t forget, there’s a very good chance chemotherapy will get rid of your leukemia for a while. Even as long as one or two years. Without it you will become weaker, start to bleed and finally have another infection that will kill you.” I pause. Brian’s face is unconcerned, his forehead unfurrowed. With both feet I push my chair back toward the sink. There is nothing comforting about the gray metal table or our three gray-padded chairs squeezed into the space between the exam table and sink. I wish my pager would beep, an excuse to leave the room to temper my frustration with Brian – an impasse, not knowing how to refute his biblical responses. “Do you want to talk with someone whose leukemia was cured

with chemotherapy?” He shakes his head and refers to Jesus again, “I am the vine, ye are the branches: He that abideth in me, and I in him, the same bringeth forth much fruit: for without me ye can do nothing.”

I tell myself, abideth and bringeth tether one to God, much like synapses tether nerve endings. My nerves are getting more frayed. I think of those who suffered during religious crusades, their piercing sounds mingled with the precision of swords and words. I make every effort to keep my anger hidden in less than a mystical realm, the volume of my voice increasing. “You understand, without trying chemotherapy you probably won’t live more than two or three months?” Brian’s forehead forms a faint crease. His blue eyes remain focused on me, his voice sounding less firm, “I’m ready to die if that’s what God has planned for me.” I feel cornered by his words. God is testing me.

I glance over at Brenda. Her face is flushed; she is fidgeting with her ring. I am surprised by her response to Brian’s readiness to die. She purses her lips, releases a gentle barrage of anger. “Why should he suffer even more with your poisons? We know what chemotherapy does. I saw what it did to my aunt. Sick all the time and then she died.” Brian reaches over to Brenda, holds her hand and nods. The sparkle from her small diamond ring is not concealed by his touch. Returning attention to his Bible, he selects a page with several highlighted verses and says, “And some fell among thorns, and the thorns grew up and choked it, and it yielded no fruit.”

I summon up my courage to sound less doctorly, more spiritual, but such words avoid my tongue, as if only available to the Holiest of holy. Instead, “Brian, have you told your minister you don’t want chemotherapy?”

Brian responds with irritation in his voice. “We know chemotherapy can kill. Why should my minister go against God’s word?” He lets go of Brenda’s hand, finds another passage and reads aloud, “The preacher sought to find out acceptable words: and that which was written was upright, even words of truth.” I say, “Maybe he would have a different interpretation.” Or refer to more hopeful and supportive verses crosses my mind.

Turning toward Brenda, Brian says, “My wife is four months pregnant.

Our first. I want to see my child before I die.” His voice is shaky, a rhythm I recognize in other patients confronting death. Brenda reaches over and squeezes Brian’s hand, allows more tears to form. I take in a deep breath, exhale, press my feet flush to the floor, as if I might be pushed off my chair by his revelation. Is Brian convinced that chemotherapy, and not leukemia, will kill him? Maybe I can guide him with modern thought, not ancient wisdom. “Remember what I told you? Chemotherapy sometimes cures leukemia.” I divine that I am like a heathen, preaching medical data, not biblical parables. I ask myself if the information I quote is any less dogmatic than the passages from Brian’s bible.

I listen as Brenda whispers to Brian, too softly for me to hear. Then they look at me. The silence, brief, is healing, filled with possibilities. They stand up. The scraping of chairs brings me back into the moment. “Brenda and I will pray on this. Then I’ll call you. It’s so important to Brenda and me that I get to hold our baby.” Their handshakes are less firm than their religious convictions. My smile is less revealing than the gloating I conceal, not wanting to insult their faith. The spiritual influence of their unborn child reveals itself – the baby’s skin the parchment on which Brian’s voice will inscribe verses from his Bible.

Lorence Gutterman is an oncologist/hematologist who teaches creative writing to medical, nursing and physician associate students in the Humanities in Medicine Program at Yale University School of Medicine. He also teaches writing workshops for prison inmates. He has previously published creative nonfiction pieces in River Teeth and in The Country Doctor Revisited. Dr. Gutterman has also published a book of poems, Small Circles of Time: Poems from a South Dakota Childhood. His poems have appeared in River Oak Review, JAMA, Journal of Medical Humanities, The Healing Muse, Common Ground Review and Caduceus.



Bloom

ANNA SCHULEIT

In 2003 I was a visiting artist in a psychiatric institution in central Massachusetts when I got a call from another institution in Boston that was about to close. I was asked if I would consider creating a project for the closing of the historic building—the Massachusetts Mental Health Center. I said I needed to see the building, learn about its history and people and its particular architecture. I had done this sort of work before, at the Northampton State Hospital in 2000, a project that took me almost four years to complete. But here I had no more than three months to do the entire project, start to finish. So I started immediately. I asked for an office in which to crash and brainstorm, a key to every door in the building and a person who knew all its stories. It took me about a week to create the concept for the project, and then three whirling months to make it happen.

I was hoping to create a work that would bring aspects of play into the seriousness of the institution, an element of the absurd. It would have been infinitely easier to work with just a few hundred flowers, or a few thousand even, but I wanted to reach my goal of 28,000, because it had occurred to me at the beginning of the project that that was the minimum number that was missing here. If it had been a project merely for photography, we wouldn't have needed so many. But it was really a project for the passing visitor, someone coming in, in real time, from the street and finding this sea of color inside the building and throughout. A multitude of greetings on every floor. Really, simply, a work of the imagination.



The concept for “Bloom” came to me as a site-specific installation to mark the transition of the life and history of the institution toward its closure, from its physical state to the remembered. I imagined the project on a 1:1 scale with the building, on all floors and hallways. Twenty-eight thousand flowers arrived on trucks in the span of a few days, all needing to be watered as they came in, all having to be placed in the building, unwrapped, arranged, watered again. I had a team of about 80 volunteers to help me with this. After four public days of “Bloom,” the building was closed for good and we delivered all 28,000 flowers to shelters, halfway houses and psychiatric hospitals throughout New England—which is why I didn’t want to work with cut flowers. I wanted these flowers to continue onward, after the installation. “Bloom” was a reflection on the healing symbolism of flowers given to the sick when they are bedridden and confined to hospital settings. As a visiting artist, I had observed an astonishing absence of flowers in psychiatric settings. Here, patients receive few, if any, flowers during their stay. “Bloom” was created to address this absence, in the spirit of offering and transition.

A graduate of the Rhode Island School of Design (RISD) and Dartmouth, Anna Schuleit has created numerous installations and site-specific projects, including “Intertidal” for the military ruins of Lovells Island in Boston Harbor and “Landlines,” which brought dozens of children together with artists, telephones and the public in the forest surrounding the MacDowell Colony. She has been a fellow at the MacDowell Colony, Bogliasco, Blue Mountain Center, The Hermitage, Yaddo, Banff and the Radcliffe Institute for Advanced Studies, and a visiting artist/guest lecturer at institutions including Brown and Boston universities, MIT, Smith College, Harvard, Brandeis, McGill, RISD, Pratt, Bowdoin and Syracuse. She was named a MacArthur Fellow in 2006. She is based in Brooklyn and her photos can be found at www.anna-schuleit.com.

The Selzer Prize

BY GARY HOFF, D.O.

Medicine, like life itself, is composed of stories. When we interview a person in our clinics, when we obtain a history of an illness from a person, we are asking for the story of a problem or complaint and, by extension, for at least a brief recounting of a considerable part of their life story. As physicians, we connect with our fellow human beings by hearing their narrative. “Narrative medicine” is a concept that has begun to attract considerable emphasis in medicine since narrative actually is what we are busily engaged in obtaining most of the time. Moreover, hearing the stories of others is an important way to reach a profound understanding of our patients and of their lives.

Several years ago, *Abaton* initiated the Selzer Prize in recognition of the contribution of Richard Selzer, a former surgeon who has written artful narratives of medicine and of the culture surrounding it that, at their best, provide sharp insight into those who practice medicine and into the lives of those who seek their help. For over four decades, Dr. Selzer has shone a light on the culture of medicine, told us about how the love of one’s fellow humans can be embodied in the art of medicine, and delineated some of the joys that await the attentive student and committed resident. And he has written with astonishing clarity and art. Dr. Selzer is a writer who has been intoxicated by the beauty of language and by nuanced meanings. Thousands of physicians and students have found his beautifully cadenced and moving prose in essays, memoirs and stories. In fact, many have been so moved by his work as to eagerly embrace a career in medicine. Many who encounter Richard Selzer’s work realize (perhaps with surprise) that one can combine a career in medicine with a career in art.

Dr. Selzer is a prime example of the “physician-writer,” a breed that today is considerably more commonplace than when he began his work in literature. Importantly, his example has inspired many more physicians to write their own narratives. Successful writers about medicine such as Abraham Verghese

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or Jerome Groopman might have written anyway, but without the inspiration provided by Dr. Selzer their words and ideas might as easily have gone unpublished. Instead, owing no doubt to his example, those voices and many others have been added, and American medicine—indeed the American culture—is considerably richer for it.

Additionally, Dr. Selzer has given encouragement, time and energy to medical students and physicians who are gripped by the same burning desire that propelled his own literary success. Many who have encountered his prose while undergraduates have been moved to enter our profession. The founding editor of this magazine was one of those whose lives were altered by his work. It is probable that a sizeable number of practicing physicians today discovered their vocation in reading Selzer.

In this issue, we are again proud to award the annual Selzer Prize for Writing. The prize honors Dr. Selzer for his contribution to the art of medicine and to medicine in art. In the pages that follow you will find the exceptional winning story by Rebecca Minardi and six others receiving honorable mention. Clearly, the quality of these works demonstrates beyond doubt that the legacy of Dr. Richard Selzer continues and that “narrative medicine” is robust and has a bright future.

Gary Hoff, D.O., attended Oklahoma State University, where he majored in physiology and minored in English literature. He later attended the Oklahoma College of Osteopathic Medicine in Tulsa and completed his internal medicine and cardiology training in Chicago. He has published short stories, articles and editorials for many years. Dr. Hoff is also a professional artist whose subject matter ranges from landscape to portraiture. He is currently chair of the Department of Medical Humanities and Bioethics at Des Moines University and faculty advisor for the Abaton.

What We Have

I had just made pancakes when I got the call. Or rather I noticed that I had three missed calls, including the one I was quickly trying to answer. “Hello?” It was Peter. “Rebecca, Rebecca. Can you come over? Please? I need you to come over.”

It was Saturday afternoon, and while at my job during the week where I work with teens on living skills, I was not used to receiving phone calls during my weekend off-hours. “Uh, hey, Peter...what’s happening?” I asked through bites of pancakes.

In between shouts of “shut up” and “fucking leave me alone” (and through a brief intervention on the phone from his brother), I learned that Peter, at 16 years of age, was being unceremoniously kicked out of the family home. I thought back to a few weeks earlier when I read through his chart at the office, a chart that broke this complex boy down to the mere sum of his parts: diagnosis, social history, functional assessment, formulation of needed services. A child is perfectly compartmentalized to fit between colored tabs and sticky labels. Diagnosis: reactive attachment disorder, oppositional defiant disorder, PTSD. Social history: born in Romania to a biological mother who suffered from alcoholism and substance abuse, a childhood full of physical and emotional abuse, a history of being dressed in costumes by the father for visiting neighbors to have their way. I slammed the chart shut. I had read enough.

So. Here is Peter. Now safe and adopted in America. Peter, a regular kid in high school with the average friends and the standard extracurricular activities. Peter, a typical kid who enjoys French fries and rock music. Peter tried really hard to be normal. His adoptive parents tried really hard to treat him like he had a completely ordinary childhood, trying valiantly to ignore the history of homelessness and orphanages, of physical trauma and gross sexual abuse. And though the family hoped that all this trying would pay off (we’d like to think kids forget things) and that Peter would prove to be

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another resilient success story, things were falling apart. I was now on my way to a household crisis. I drove over to Peter's apartment watching amber leaves pool alongside the road, rushing up in a fury as I passed. When I arrived, Peter was rocking back in forth in the grass in front of his apartment building, head in hands; a twirling leaf was caught in his hair, tugging to break away. "Hey, Peter," I called softly as I walked up to meet him.

He walked back to the car with me and got in, his already throaty voice all the more hoarse muttering a simple "hi."

We drove to an empty park. The other children had already gone home for supper, and we sat alone, side by side, on the creaking swings. I listened as Peter told me what I already knew; his adoptive parents had reached a breaking point with his frequent elopements and sexual contact with far older men, with his screaming and unpredictability, with his disrespect and his sudden profound despair. He had to go somewhere else, anywhere else. My stomach felt leaden.

Here was Peter. Skinny legs pumping on the swings, pushing off to go higher and higher; an old man in a boy's body. The most broken of humans. His parents were good people, they would say after he'd gone. It just takes too much to fix these sorts of people. It was too late, the damage was already done, people would reassure themselves. At least they tried. People like Peter are a lost cause. Dry leaves swirled beneath Peter's head as he leaned back, eyes closed tight, taking in the waning sun. "Peter," I said with sudden urgency, "what are you good at?"

"What?" he countered, looking off, slowing his swing. His hand picked at a scab on his arm.

"Like, what do you like to do that, you know, makes you happy and stuff?" There was a pause. I sat expectant. His swing slowed more and then stopped.

"Well, um," he began hesitantly, "when I go grocery shopping with my dad, I always find the best deals." He sat still. A plane droned low overhead.

"Didn't you say you run?" I said, watching the plane leave trailing clouds behind it.

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“Yeah,” Peter answered, slightly louder, “I’m pretty good at that.” The words started tumbling out then, unbidden. “I’m a good uncle to my brother’s baby. I can color in the lines and I make my dad laugh. I help my grandma clean her house. I’m really good in speech class. I can make sandwiches.”

He sat triumphantly, swaying on his swing. “You can do a lot of things,” I added, looking out across the yellowing field.

We headed back in silence; his grandma would be at the apartment to take him and a few of his things in boxes back to her house. I pulled up and saw a man sitting on the porch steps. “That’s my dad,” Peter said, no longer triumphant, now sullen and resigned, “and I’m staying in your car.”

I walked up the yard without Peter. The man’s face was hard and unflinching. He drew on a cigarette. “I can’t take it anymore. I’m losing my mind. I thought we could do it. He’s just,” he paused taking another drag, “he’s just so difficult. So we tried. I tried so hard as a father. But I...” and here his voice caught.

I waited, clutching my bag awkwardly to my chest, the day’s last rays pulsating on the brick wall behind me. A sparrow swooped and dipped, silhouetted by the sun; a falling arrow.

“I failed him,” the father finished, letting the words fall like a sigh.

The man’s face crumpled and folded like a tent. I turned away again, feeling shamed like I was seeing this intensely private thing. While looking at the small boy hunched over in my car, I heard myself say, “He came to you with such...such a heavy past, and sometimes what we do seems...well, it seems pointless. I guess we work with what we have. You had all the pieces of Peter and you tried as best you could to put them, these broken parts, back together.”

The man closed his eyes, tears pooling in the lines on his face. I walked away as Peter’s grandma pulled out in a rumbling truck and watched as Peter got up from his seat; the two hugged briefly. I climbed into my car wishing for Peter...anything. That he would know he was loved. That it wasn’t too late. That the pieces would one day mend. That we all didn’t fail him.

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The car radio sounded tinny and shallow compared to the man, the cigarette, Peter and the swings. I drove in silence, knowing that if I had to go back to my apartment I'd lose myself. I thought of a poem I had read long ago by Richard Wilbur. A bird was caught in his daughter's room. He and his child stole in to open a window and retreated behind a cracked door to watch with bated breath as the bird tried again and again to get through to the sky. We provide what we can, we give all we have. But in the end we can just watch and wait, eyes opened. The bird cleared the sill of the world, as Wilbur wrote. I drove slowly. Silent houses with glowing windows, still frames into strangers' lives, slipped past. I drummed my fingers against the wheel, unable to keep still.

I pulled off the road and stopped the engine beneath a creaking oak, its leaves sighing. I grabbed my gloves from the back seat and pulled a knit cap low over my eyes. I walked along a river, realizing that at some point I had picked up a stick and was now trailing it behind me. My eyes were looking for patterns in the leaves layering the earth when I saw the bird. The dove was small and listing precariously to one side like a ship that had taken on too much water. Slowly I stretched out my hand and stroked its glistening gray-blue head. One eye peered out at the rushing water, the world. I picked up the bird; its warmth filled my hands as I felt the heartbeat steadily, surprisingly strong for such a tiny creature. I turned the dove over and noticed the bloody mess between its feet. I wildly thought that I must rush to the veterinarian and save this bird's life. I must nurse it back to health, help it recuperate. I must fix this. This was my poem, my broken bird. Its heart beat and one wing reached out, fluttering dimly. It was my turn to close my eyes; I stood very still, the wind breathing for me.

I set the bird behind a fallen log; its eye could continue to watch the flow of the river. The bird still listed. I placed one glove beneath it and one to blanket its sleek back; it would know that someone loved it, I assured myself. It would know that it mattered and that someone sacrificed something

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for it. It would know, I whispered to the leaves, to the water. I walked away. Don't look back, don't look back. I turned. The wind lifted the fingers of the glove into a purple salute. An I'll-be-all-right-you-did-the-best-you-could wave. Did I? Do we? The moon flickered in and out of the treetops. Clouds drifted across its face like tendrils; a celestial jellyfish. I flexed my ungloved hands open and closed, open and closed, accepting the chilling bite of the dark air. I wished what I wished for Peter earlier, but now more fiercely. The wind stirred the earth and the leaves sang softly beneath my feet.

Rebecca Minardi is finishing her master's degree in public health at Des Moines University. She is passionate about working with adolescents to help them become independent young adults.

Twelve Minutes

It only takes 12 minutes to perform a below the knee amputation.

The words circle around and around in my head. A random, almost meaningless fact that I heard once. But somehow, in this moment, that fact is like a bee buzzing in my head — small and dangerous. No matter how hard I try to think of other things, it follows me. Thousands of hours studying and when my patient looks up at me, that fact is the only thing I can seem to remember.

The patient sits in a chair, a nervous expression on her face, her son's hand gripped tightly in both of hers. I observe my mentor, Dr. X, carefully examining the wound on her right foot. The sounds of a busy clinic are unmasked by the curtain that surrounds us, yet somehow that lone dirty piece of cloth is enough to create privacy. In the tension of our little makeshift room, we are alone.

She has a deep ulcer on the plantar side of what is normally the midfoot. Only she's already had a transmetatarsal amputation, and you can't really tell anymore where the midfoot is. But in the grand scheme of things, precisely where the cuneiforms are hardly matters. What matters is that the wound is big, probes to bone, and the smell alone is enough to diagnose infection.

Her son holds her hand as he translates for her. But it is like a bad play, where everyone speaks a part, drawing out the act so we don't have to get to the final scene.

"When did you notice this wound?" Dr. X asks.

She answers, her son translates, Dr. X cuts at the dead tissue surrounding the wound. I stand there, trying to pretend this is just another day, another patient, another ulcer.

"You can't feel this? This doesn't hurt?" Dr. X's 10-blade continues to debride.

She answers, a stream of words in Spanish. "No." Her son translates.

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My Spanish is limited, but even I know that's not all she said. But it's all that matters. Dr. X's debridement continues.

We all know where this is headed. Even the patient and her son. She's had an amputation before. She knows this scene better than I do. The work-up of the ulcer, measuring its length and depth, debriding it — it's like a grand charade. The answer is obvious. *Twelve minutes...*

Suddenly she breaks from the charade, her eyes boring into mine. She doesn't speak any English, but when she looks at me, I can feel her — understand her better than any words could ever describe. And what I see in her gaze makes me want to shrink away, to hide in some corner like a coward and not have to face this moment. She shouldn't be looking at me anyway. I'm nobody. Just a clueless student, rotating with a brilliant physician. It's Dr. X she should be looking at. But her eyes don't leave mine, and even though I'm lost in a fear that matches hers, I at least have the courage to meet her gaze steadily.

She asks in broken English. "Bad?"

I pause, trying to find words to tell her what there are no words to say.

"We won't know for sure until we take an x-ray." I say. A cop-out.

"But this ulcer is very deep." I wonder if I need to say more. Wonder how to say more.

But she turns away from me, tears in her eyes, and I know she understands. "This?" she asks, making a chopping motion just below her knee. The tears are flowing freely now.

"It is a possibility. We have to wait for the x-ray, but because your wound is so deep, it is likely you will need a below-the-knee amputation." I force the words to sound calm, reassuring, professional. But as her son translates, she begins to sob in earnest, and calm is the furthest thing from my mind.

There is a speech I'm supposed to give now, explaining why this is happening to her. How her diabetes and her peripheral neuropathy and the wear of a thousand steps have caused an ulcer that won't heal. But even as I speak the words, I know she's not listening. The scene even strikes me as

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preposterous as I tell her something she's learned by rote, like a hardened criminal hearing his Miranda rights from a new cop who stumbles over the words. Only this patient is no criminal. Just an old woman, with an old disease, and an old solution.

In this moment she seems so old. Much older than her 66 years. Christ, my parents are almost that old, and she looks like she could've been their mother. But she's beautiful, not in spite of, but because of how worn she is. Like you can somehow tell that a hellish life beat her down, and she came out the other end of it with a grace and strength that are tangible in the elegant lines of her face, the worn set of her thin shoulders and the gray streaks in her hair.

She murmurs something, over and over again, as her son pats her hand. It takes awhile for the phrase to filter through my limited Spanish and distill into something that makes sense. "I check it everyday," she is saying. "Everyday." I realize in a flash of understanding that she is talking about her diabetes and checking her blood sugar everyday. And something in the simplicity of her repeated phrase breaks my heart. Like a child asking, "Why?" or a teenager screaming, "It's not fair," like a 66-year-old woman clinging to the one thing she thought she could control.

She is thin. It is easy for me to believe that her diabetes is under control and has been for awhile. It is easy for me to sympathize, to get wrapped up in this moment, to shake my fist at the universe and ask why, and scream no fair. And for just a second, I am on the brink of doing just that. But somehow I pull back and say calmly, "It's time for you to go upstairs and get an x-ray taken."

Next to the computer screen, Dr. X explains the x-ray to me. His voice is calm and even, and somehow it irritates me that he is so much more professional and experienced than I am. Does he not feel what I feel? Is he so used to these traumatic events? To patients crying? Does he not see the injustice of it all? Something in me can't stand it, and

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I say, “I wish we didn’t have to do this.”

“It’s what’s best for her,” he says and begins the speech about diabetes and peripheral neuropathy, as though he has to explain to me the pathomechanics of ulceration, infection and the things that lead to amputation. But his words, the explanation, the science behind what is happening don’t reassure me. If anything, it makes me angrier.

“She’s just a sweet old lady,” I say, and I feel somehow that I am accusing Dr. X of something, only I don’t know what.

“Yes, it’s very sad, but she’ll be fine. You’ll see. She’ll be able to get around better than she does now once she has a prosthetic.”

“It’s not fair,” I say stubbornly.

“Today we get to save a life,” he says, and the calmness in his voice is gone. Instead, his tone carries an underlying ferocity that belies his patronizing words. And I realize finally that although he has seen this before, the woman’s tears move him. He recognizes just as surely as I do that 12 minutes on an operating table will change our patient’s life forever.

And with this realization, I suddenly am the one who needs to speak the reassuring words to him. “Yes, this is what’s best for her.”

I scrub into the surgery. My first BKA. Below the knee amputation. While the procedure itself will only take 12 minutes, the total surgery will take much longer. I ready myself mentally, going over what needs to be done. I do my best to push everything out of my head, and as I enter the OR, I am successful in focusing only on the leg, on the surgery. But somewhere, deep below the surface of my concentration, I see my patient’s hands clinging to her son, her eyes boring into mine as she faces her fate with dread and fear.

So much easier than the emotions, the surgery is quick. Cut the leg two thirds up. Contour the tibia. Shorten the fibula. Leave the gastroc as a flap behind. Match the ends. Sew the flap. Secure the blood supply. Close the skin.

So simple, so focused. Seamless and controlled. Twelve minutes of surgical skills that are almost beautiful and our patient’s leg is gone.

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A few months later, I'm hurrying through my last patient before my lunch break which was supposed to have started 20 minutes ago. "Excuse me, Doctor?" It takes me a second to realize someone is addressing me. I'm still not used to the title.

I turn to find my amputation patient and her son standing, smiling behind me. I almost don't recognize her for a moment, because she looks younger than the last time I saw her. Like 20 years have disappeared. She stands straight and tall, confident on her prosthetic leg, which is indistinguishable from her real leg. She is smiling at me.

"We heard you were in here. We just came for our physical therapy appointment downstairs and we wanted to drop in and say hello," her son says with a smile.

"Right, of course! How are you?" I ask.

She speaks rapidly, her hand motions animated, and I am once again struck by how much more lively she is than I remember. So youthful.

"We are great!" her son translates with a beaming smile. "The amputation turned out to be such a blessing. It is so much easier for my mama to get around now, with her prosthetic leg. And she walks so quickly now! Hardly a limp at all. She gets to the bus stop from home in no time at all."

"Really?" I say, smiling, laughing with them. "That is fantastic — I'm so glad! It must be wonderful to get to the bus stop so quickly."

She nods vigorously and says in English, "Twelve minutes."

"Twelve minutes." I repeat, awed.

Michelle Tsou is a third-year podiatry student at the California School of Podiatric Medicine. Clinical rotations have offered her the opportunity to integrate her interest in patients' interior lives with her academic work.

Bodies

What were we doing then, the four of us,
sweating over you with our blades gone dull?
Chest or abdomen or neck,
something like that, not that it mattered.
We were tired, resigned.
Our white coats were stained brown
around our arms and waists.
With forceps and steel probes,
we whittled away at the fat, talking about football,
and cars,
and movie blockbusters.
A piece of fascia flicked on my face.
And you—you weren't looking so hot either,
by that point not much more
than a pile of scraps with some legs sticking out.
And we'd be getting to those next.
But as I stood up to stretch my back,
I found myself holding your hand,
your tiny hand,
wondering who had held it before
and if anyone else would hold it again.

*Michael Eastman is a second-year medical student at Des Moines University.
Before going to medical school, he worked for 20 years — a period of time that included
his training to become a Master of Fine Arts in creative writing.*

Mobility

“As one of your health care physicians, I have to enforce the fact that dancing is causing a lot of problems with your feet. You are doing a lot of damage and, honestly, it will get to a point where you’re not going to be able to walk anymore,” said Stevens.

Mae, sitting in the treatment chair, just stared at him. She wore no emotion on her face. She played with her necklace by wrapping it around her index finger and gave a glance at the clock that was located above Dr. Stevens. Giving a big sigh, she said, “You don’t understand. Dancing is my life. I have always been a ballerina and a damn good one. It’s what I love.”

“Mae, your career makes you susceptible to bone spurs, hammer toes, bunions, sesamoiditis, Achilles tendonitis, you name it because of your career. All of those things that you love about dancing put so much stress on your lower extremity.” He knew that the constant stress of dance, specifically ballet in Mae’s case, caused a tightening of the central portion of the plantar aponeurosis. When this tightening becomes inflamed, plantar fasciitis, the bone tries to mend itself and a bony growth develops. It becomes painful when the growth presses against surrounding nerves. “What you love causes more harm than good.”

“What I love is worth it. What about you? What about all those adventure marathons that you run? Where was the latest run?”

Stevens knew exactly where she was going with this. “The Great Wall of China this past May.”

“You know what I think, Doc; I think you’re doing more damage to your feet than the damage I’m doing to my own.”

“But I’m not the one who has had two surgeries done.” He hated arguing. Never argue with a patient. How was he supposed to do his job and fix her when she purposely kept breaking herself? “Look, you’re my patient and I want to see the best outcome for you. What can I do to make you stop?”

She gave a smile. The same smile she flashed at her first visit with Stevens.

It still affected him in the same manner. Bright. Bold. Beautiful. “You stop running, I stop dancing.”

This is what had to be done for the patient. “Deal. Let’s do the surgery.”

Dr. Stevens hung up the phone ending his dictation and closed the patient’s file at his desk. It held the details of her most recent surgery, which was another one to add to the growing list. This time it was a bunionectomy with offset Vogler osteotomy of the first metatarsal of the right foot and an Akin osteotomy of the proximal phalanx of the right great toe. He made sure to note that Dr. Johnson aided throughout the whole procedure. The surgery count was currently at three for Shelly Mae, and Stevens hoped that the latest addition would be the last. Being a longtime patient of Stevens, she was frequently reminded that her lifestyle was the reason for her foot problems. He made it known that she could be without pain if only she pursued a different professional ambition. If she didn’t, she would have to keep revisiting surgery till she could no longer walk, let alone dance.

Dictation was one of his favorite parts of surgery days. The actual surgery was, of course, his favorite, but dictation required a certain skill, a certain art form. He dictated after clinical visits as well, but those were not exciting. Clinical dictations were basically all the same. “Saw patient so-and-so, administered twenty cc’s of hydrocortisone in right/left calcaneus...” Even more exciting was “Nail care for patient so-and-so was performed and patient will return in eight weeks.” Surgery was a completely different spectrum on the prism. It never became boring. Never became dull. One procedure would have him using a hammer and chisel to remove heel spurs while the next would require him to drill in surgical screws for proper bone alignment. Every procedure and patient possessed differing qualities that made it easier or harder. Complications sometimes came into the redox equation; he loved when they did.

He was a doctor of podiatric medicine but took the majority of his pride in being a board-certified podiatric surgeon. He knew that the majority of

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people's initial thought of podiatry was one of repulsion. He knew that they considered other jobs to be more fulfilling and more aiding to those who were sick, but he did not care. This chosen profession was more than satisfying to him. The field offered countless opportunities for areas of focus. Sports medicine, geriatrics, pediatrics, surgery, wound care, orthoses and biomechanics. All offered variety and diversity. This is why he was never bored as a physician. In his mind, it was what he was always meant to do. With this, he never let the disapproval of others cloud his love for his career.

Podiatric medicine was about preventative care, surgery and knowing that a person's life was being improved by first improving their mobility. It was primal. A hunter-gatherer confided on mobility to bring together edible plants and animals from the wild. Being capable of movement was everything. It was physicality. It was mentality. Dr. Stevens strongly believed that mobility was the most important function a person possessed. He knew that he relied on his own two feet, which he considered to be fine-tuned motors in his love for running.

It was in his blood. Running. In high school, he ran track and cross country. Long distances. They were his specialty. It was mind over matter. It was about telling the body that it can go farther and longer. That it can go 26 miles, that it can go 50 miles. All it took was determination. It was what he had. Physicality came in second. Every day needed a run; without one, he felt empty.

Just a couple of insurance and prescription forms to sign and he would be all done with Shelly for the day. He couldn't wait for his run later and decided that he would go an easy five today. He quickly signed all the forms and left them on his desk for his head surgical assistant to handle as he walked to the break room. Dr. Stevens immediately saw that his partner and friend, Dr. Johnson, was already there.

"That bunion was bigger than expected, kind of like my..." proclaimed Johnson, leaving a slight pause, "bank account." He smiled and slipped a wink at Stevens.

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Stevens couldn't help but laugh at the sheer inappropriate and sexually implied statement. He sat down next to Johnson and accepted the cup of coffee that was handed to him by his old friend. They both went to medical school together in Chicago, Illinois at Scholl College of Podiatric Medicine. The school possessed a reputation of molding some of the best podiatric physicians in the country. The professors who taught at Scholl were not only leaders in their respective field, but were compassionate about providing the knowledge required to be an outstanding physician. Still, they did not hold themselves at a level higher than the student. Johnson and Stevens met the first day of orientation and instantly clicked. They had all clerkships together during the third and fourth years, ran in the running club together, and even had residency positions in close proximity of one another the three years after school. It was only right that they would go into practice together.

"The size of her bunion reminded me of Seal Suzie. I mean, how could anyone forget about Seal Suzie in our class, especially you after that one night in Chi-town?" said Stevens.

Johnson's mouth dropped, which let out a bit of coffee. "Low. That's low, my friend. You know very well that I wore two pairs of beer goggles that night. Studying for pharm second year devoured my life, and the only alleviator was drinking my face off every now and again."

"It may be low, friend, but I'm not the one who was sucking her face in the middle of the bar." Stevens smiled as he sipped his drink. He was only playing and he knew that Johnson would be able to handle the joke. He was always able to handle the joke.

Both doctors sat in the break room at the table nearest the hanging television. They regarded the break room as the lair of the surgery center. It was where physicians, assistants, student shadows all came to relax and converse. There was the coffee machine with black stains fully decorating it, the fridge that was barely seen behind the taped-on pictures of pets, the overfilled garbage cans being ignored by housekeeping, and the tack board with postings of football tickets for sale. Stevens thought it was great.

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Surgical assistants came in and went out. The two never really paid attention to them. They were too caught up in important matters. The weekend. Each discussed his plans and whether or not they would be able to squeeze a run in somewhere. Stevens talked about how he had to re-tile his bathroom ever since his dad busted a good amount of them helping him install a new sink vanity last weekend. He didn't mind it, though; his father was only trying to help. Johnson had to help his sister move into her new apartment that was about an hour away. He made it clear of his hatred toward moving and compared it to his hatred of diabetic foot ulcers. The smell of the ulcers alone was enough to make a man go blind, Johnson said. Moving had comparable effects on him. Stevens laughed and reminded him that it was part of the dirty work of podiatry. Johnson responded with a remark about his mother.

The conversation ended, as it often did, with talking about the profession.

"You know what I love, how a person wants you to cut their foot open and chisel away bone. They actually want you to do it," Johnson said. "They give you consent."

It was funny because it was the truth. Most often, patients chose surgery over other options because it was a long-lasting solution. They go through surgical consultations and when they are cleared, they sign away.

"I know. Thank God that they do. I love cutting people open. I would be lost without my surgeries," said Stevens.

"Just keep Mae. She'll keep you occupied with all the surgeries you could ever want."

Stevens shook his head.

Johnson paused for several seconds. "She's going to have trouble ambulating soon, big guy."

"I know, but what the hell can I do? She said that she would change her ways if I stopped running."

"You can't make deals like that with a patient, even if she's a friend. And why would you even make that one? You and I have always been runners. It's our passion. Hell, you and I were just talking about running this weekend.

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BOBBY RAWSKI

You don't even remember your own deal."

"It's just that running is my excitement. My relaxer. Next to my job, it's the most important thing to me."

"Maybe she feels the same way about her career, Brad."

Stevens paused. "Our passions define us." He got up from his chair.

"Run later, Teeny Stevie?"

"Does a one-legged duck swim in a circle?"

Both laughed. Dr. Stevens left the break room and made his way through the surgery clinic. He entered the post-operating room. There were several patients in the room, all separated by curtains, but he found the one he was looking for. He walked up next to the bed where Shelly was lying. He removed the hair out of her face and placed a hand on her shoulder. She was awake and he could see that the anesthetics were wearing off.

"Shelly, hey, it's Brad. You're out of surgery. You did great. I fixed you."

"Great." She was groggy but was quickly regaining awareness.

"I was wondering if you were still considering changing your ways."

She laughed and gave that smile. "Never."

Stevens laughed. "Good."

Bobby Rawski is a podiatry student at Dr. William M. Scholl College of Podiatric Medicine at Rosalind Franklin University of Medicine and Science, Class of 2015. Aside from being an avid runner, he has always enjoyed writing short stories and his own music.

Learning

Maggie's pillow had a silk-screened photo of her three dogs and, underneath, the words "we miss you!" Those dogs were her babies. When she talked about them, she would get a far-off look and her mouth would scrunch up like a little girl's.

When I met Maggie during my month on an HIV/oncology ward as a third-year medical student, she was 54 and had battled leukemia for years. This hospital stay had been the worst — months long, complicated by seizures, a stroke and multiple cardiac arrhythmias. The soft tissues beneath her skin were so full of fluid that pressing a finger into her wrist or ankle made a deep, deformed pit.

Maggie was a pistol and I adored her. Though I never saw her standing up, I could tell she was built like a linebacker — broad shoulders and short, muscular legs. Multiple rounds of chemotherapy had left her skin sallow and her gray hair thin and patchy, but her blue eyes were fierce and her smile was infectious, even in the worst of circumstances. Her partner, Ellen, sat by her bed every day. Some days they fought like siblings, but I often felt that the love they shared was the deepest and most real thing in that whole hospital.

In the mornings, when I asked Maggie how she was doing, she would always say, "Fine and dandy" or "Never better" in her tough-girl Queens accent. When I asked if she needed anything, she would say, "Scotch and soda?" I felt guilty laughing, but I had a feeling she wanted me to.

Weeks into her hospital stay, Maggie's labs showed that her organs were shutting down. Her heart was weak, her kidneys weren't working, and more fluid was building up in her lungs and under her skin. The interns, residents and attending physicians on the team had seen enough to know that this was the end of Maggie's life. They were confident that they had done all they could. For the most part, I took their word for it, but I secretly thought she might get better. We gave her medicine for her pain and agitation and

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tried to keep her comfortable. Ellen didn't leave the bedside for anything but trips to the bathroom.

A few nights later when I was on call, Maggie didn't want to wear her oxygen mask. She was too delirious to understand the explanations that Ellen pressed on her, and she struggled against her favorite nurse who was trying to keep her hands away from her face. She kept saying, "Get it off! Get it off! I can't breathe!" I knelt down in front of her and took her hand. "Maggie," I said. "Do you want to sing a song?"

Maggie nodded.

"Ok, what should we sing?"

"I don't know," she said. "You pick." For some reason, I suggested "Leaving on a Jet Plane." Maggie nodded emphatically.

I sang slowly, "My bags are packed and I'm ready to go, I'm standing here outside your door..." Maggie, her mouth struggling around the consonants, sang the entire song along with me. She stopped fighting her oxygen mask. When it was over, she was calm, but Ellen and the nurse were sobbing. I apologized for picking such a sad song and excused myself awkwardly. In the employee bathroom, I sobbed, too. Fifteen minutes later, I pulled myself together, hoping my team wouldn't notice my puffy eyes and red nostrils.

That was the last time I spoke to Maggie. Her morphine was increased that night and she didn't wake up anymore. Ellen and her sisters stayed with her and played the soundtrack from "South Pacific," her favorite play, on loop. Four days later, she passed away.

Maggie's death settled deep inside me, loud and permanent. Its presence in my gut was both nauseating and satisfying. I was accepted to Mount Sinai Medical School through the Humanities and Medicine Program, a unique opportunity that permits applicants to bypass some pre-med requirements in favor of humanities classes. "Humeds" are encouraged to explore our culinary, literary, artistic and socially responsible passions in the hopes that we will become compassionate, humanistic physicians. Throughout medical school, I have clung to my compassion like a security blanket. Biochemistry baffled

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me. Learning anatomy was like trying to memorize a string of hundreds of random polysyllabic words: pterygoid, ischiococcygeus, laryngopharyngeal. Loving Maggie, crying for her, was proof of my compassion and empathy. It felt like a private badge of honor.

* * *

Maggie's death was the first I encountered as a medical student. The second was different. A 65-year-old Polish man had gone into cardiac arrest, and the medical team was called to resuscitate him. I was always aware of the daily overhead pages that sounded through the hospital loudspeakers: Team 7000 to 8 West, Team 7000 to 8 West. Team 7000 is the medical team on-call that day and responsible for running the code. When they hear the page, they drop whatever they're doing and run to the patient's room. I chased my residents down the stairs as fast as I could, one hand holding my stethoscope tight around my neck, the other mashing the pocket of my white coat against my thigh to prevent my penlight, reflex hammer and little notebooks from tumbling to the floor.

The man lying on the bed wore a diaper and hospital gown. His sheet had been thrown hastily aside, exposing his body. His head was tilted back so that I couldn't see his face, but his mouth hung open as though he were sleeping. The room felt chaotic. The senior residents called orders and moved quickly. Everything was beeping. I pressed my back flat against the wall, fascinated, panicked and still.

The code lasted an hour. As they pushed various drugs and mashed on his chest, he briefly regained his pulse. Inevitably, it faded and disappeared after a few moments, and the resuscitation would begin again: drugs, ventilation, chest compressions, shock. At some point, the urgency of the process was lost. By official definitions, the patient was alternately alive and dead, but it was clear that our efforts would be unsuccessful. However, unless instructed otherwise by the patient's family (they were on their way to the hospital), we were obligated to continue our efforts as long as his heart was beating.

In that room, the distinction between life and death felt astonishingly

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arbitrary. “There’s a pulse,” one of the interns would say. “He’s alive.” But he wasn’t alive. His wide eyes were glassy and still. His body did not protest against the tube in his throat or the violence with which the brawny interns slammed his sternum. So what if there’s a pulse? I wanted to say. There is no life here.

When it was over, all his ribs were broken, and there was blood on his neck and face from where an intern had placed a central line. The resident called time of death, and everyone filed out of the room. They had other sick patients who needed their attention. With no responsibilities ourselves, another medical student and I stayed behind to help clean up the body before the patient’s family came in to say goodbye. We covered him with a crisp white sheet. We used alcohol pads to wipe the dried blood from his face and earlobes. With my fingers, I pressed his papery eyelids down over the globes of his eyes. I did not cry. A few hours later, I went home. I slept dreamlessly that night and woke up the next day to continue my unshaken life.

The difference between my experience of Maggie’s death and watching the unnamed man die during the code is obvious. I knew Maggie well and cared about her. I was entangled in her life, and it wasn’t easy for me to let go. The man in the code was anonymous, unconscious, almost inhuman. But he was human. He was a person who died while I watched, unmoved.

I hope that what I have become inured to through my study of medicine is shock rather than feeling. The sensationalism of seeing something horrible — geysers of blood, the vacant stare of a lifeless face — has already begun to fade, gradually, with time. As I move through my training and my career, I cannot collapse in tears at every death. Still, I hope that suffering and death I encounter will not dampen my capacity for feeling.

There is something you lose when you train to be a doctor. You routinely perform tasks that might have once made you shudder, cry or faint. You break someone’s ribs with your hands to pump their blood; you push tubes down their throat; you stick them with needles and cut them with knives.

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The changes that occur are necessary. Without them, you could not do your job. But they change you in ways that you don't plan or expect.

* * *

Last fall, my mother had open-heart surgery to repair a leaky mitral valve. With great reluctance, she agreed to let me see her in the ICU after the operation. Ever the nurturer, she didn't want me to be traumatized by the image of her unconscious with all those tubes. I reassured her that I would be fine. In my gut, I wasn't so sure I would be.

My father and I went to see her together. Her usually bright and youthful face was pale, drawn and swollen, distorted by the breathing tube in her open mouth. There were more tubes in her neck and wrist, and the machines around her beeped and wheezed with a familiar rhythm. When I took her hand, she knew it. I asked if she wanted me to stay with her, and her nod was emphatic. My stoic and rational father twitched every time the bedside monitors emitted a new sound. The color drained from his face when she coughed and gagged, struggling against her breathing tube. "Can't they give her something to knock her out until the tube comes out?" he asked me.

"No," I said. "She has to wake up enough to breathe on her own before they take it out." He nodded. Then her IV bag beeped and he nearly jumped out of his skin. "Dad," I said, as the nurse came in to check the tubing. "Why don't you go home? I'm okay here."

And, to my own astonishment, I was. It was a strange feeling to sit in that ICU chatting with the nurses and checking my e-mail, with my mother, intubated and unconscious beside me. I felt the phantom ache of a part of myself I'd lost. Beside it, a proud, strong new feeling was hatching. I'm still not sure just how it will grow.

Lauren Stossel is a fourth-year medical student at Mount Sinai School of Medicine, where she was accepted through the Humanities and Medicine Program. She has written creatively since high school. She wrote this piece during her third-year medicine clerkship while struggling to understand how watching patients die affected her.

Lithosphere

Our hearts are not so smooth
they glide over another
in soft tango.

Rough and jagged
they scale each other
scarring the earth.

Subdue the quake
plunge the pressure
deep in the soil
where the roots grow.

Our hearts are not so fragile
they crumble
with every collision.

They are limestone pits
that collapse inward
in the course of time.

Fracture the crust,
collide surreptitiously
endure an oasis
swallowed by the dunes.

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DUSTIN MATEL-ANDERSON

Our hearts are not so rigid
that eons of layers
stoically persist.
Flush with water,
the creek happily drains
any loose sediment.
Slacken the foundation
the river will eat
until the thin rift
is a canyon of sorrow.
Though not so empty
since the minerals
glisten underneath.
Dig in the loose soil
till the surface
careful not to scratch too deep.
Our hearts are not a quarry
do not excavate there
all there is to unearth
is the cavity
of the soul.

Dustin Matel-Anderson is a medical student at the Medical College of Wisconsin. Writing has offered a fuel to sustain him during his training – to help him take the pulse of his patients' inner lives.

Swimming

As the current gently guided me at my back, the sun warming the waters around me, I could smell the pine trees and the crisp mountain air. I drifted along. My body lifted afloat by the hopes of others and the support of my friends. My world was painted with bright colored strokes of smiling faces and a healing touch. As the river began to narrow I couldn't help but see that there were many streams I was headed toward, but I knew that the stream I was drifting toward was the one to carry me through. The current slowed down just enough for me to decide through which stream I shall swim. I chose the one that enticed me. Carrying me through the waters and bringing me to my destiny, the waters helped guide me. My eyes open wide, glistening. My heart was pounding. I am surrounded in joy, in celebration, for this is the stream that will carry me through to my destiny.

What is it about destiny? Who gets to choose? I dreamt of a place where I would be learning the inspirational moments of others and what drew them to a field. As the waters surrounded me, I could only help but dream. As the waters sloped off of the mountains and into the land, my mind began to talk. What was leading me away from the calm of the mountains and the crisp clean air? Well, destiny, of course. As I drifted, I knew that a field of helping, healing, caring, touch, emotions and understanding was something I was about to embark on.

Billboards were posted along the stream in bright colors reading "modern technology," "the healing touch," "community," "making a difference," "building leaders." This is it! There is a purpose, there is a drive. My motivation and energy were what kept me swimming along a stream that was beginning to lose its push from the surging glaciers atop the mountains.

I decided to take a nap and dream of the friends, the memories, the reasons and the aspirations that led me to my destination, thinking I had such a long time before my arrival. It was as if my dream shifted from one of hope and success when I awoke to the sound of quiet, softened voices. The vibrancy

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and the outspokenness, the multiple colors and tones of voices I had once recognized were no longer. Failure. Difficulty. Challenging. Honor. Work Hard. I opened my eyes, my body felt as if it had began to sink, for the waters were no longer carrying me. I noticed that the crisp air and smell of evergreen and pines were not here. Yet within the crowd I began to recognize my own tribe. I recognized those that believed in me and saw through the stirring waters.

The building opened, the profession I had dreamed of was now right in front of me. As I entered through, my nerves began to tingle. This is a difficult journey, I kept hearing, but one that will allow me to heal others, a place of empathy and understanding, the wonderful land of destiny. Everyone filed in line. All of us were herded through the room and then we each had a cloak thrown atop us. Each of us felt uncomfortable, a little bit weird, almost as if the cloak was not ours. We tried to access its magical powers but soon realized that the cloak had not bestowed us the opportunity to have special powers. The instruction card not included.

As the journey continued on and the words of difficulty, failure, intensity and strength were repeatedly stated, two mentors reached for a set of doors they were about to open. Where was the excitement, I thought? Who is that sitting next to me? Are there others like me in this group? What about the healing?

As if slowing the world down to the slowest of speeds, all eyes turned to the doors as they were pulled open. For here is my destiny, I thought. All eyes were stuck to the doors in thought of what was behind it.

There was no time to begin to think of what could be ahead; instead it rushed forth. Even when time seemed to stand still I stood there bracing myself as what I saw coming at me was a tidal wave. It washed up across the group tossing us around, flipping us over and throwing us into walls. For some it was the ride of a lifetime, almost as if it were a new rollercoaster installed in a park. For others, it was something that rattled the peace inside of our hearts and shook us to our core. Then all of the sudden a realization came to my mind. This is not my destiny. This is not a “place” that I call home, a

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place where I smell the clean, crisp air and lay afloat with the sun shining on me. Of course I can appreciate the beauty of my surroundings, but what was it that made me whole? Just as the doors opened to my new destiny, I unlocked a secret. The truth of this journey is not in settling where you ended up; it's about swimming back to where you came from. The tidal wave that threw me up against the wall was the same one that was going to make me wake up and battle its currents every day. For this time I was not gliding along the path of the current, I was swimming upstream.

Medicine, such a regarded field of study, was proclaimed to be one in which you can really understand the humanism behind disease. I am not a robot or a computer; I am a being who laughs, who jokes, who gets angry and cries. Yet in this swimming race I began to look around and see that I did not have the time to process this side of me. What is my grade, how many points did I earn, what rank do you hold? As if it were a trophy or some godly gift describing the superpowers you possess. I began to lose sight in who I am. Such small glimpses of those “on my team” made me question whether I even know their name.

Names, feelings, emotions, laughter, they are not important. There is no purpose in healing, in health and in caring for getting to know one another... or so it seemed. Battling the rivers I would get tired, yet there was no turning back. Who is swimming alongside me, I do not know. I stop and ask others questions of their past, their aspirations, of the community that they came from, yet everyone has blinders on battling the waters. This is not the time! Continue fighting the waters. Continue fighting, for you have entered this destiny. You must battle through just as everyone has in the past and will continue to do so in the future.

As we fight the waters, we pick up tools such as understanding our bodies, our physiology. We learn how to cram information into our minds and throw it out for continual border crossings in which we are asked each time if we can make it through this journey.

Of course there was a sacrifice, so I thought; a time of dedication to a

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field of study. A sacrifice in location of my hometown, a sacrifice in the community I had surrounded myself in. All for the benefit of those whom I shall help heal in the future. Yet what sacrifice does it take? How many beings have I helped touch to this point? What do I do to help myself in my healing? Do I have time to laugh, to cry, to paint and to smell? Has the battling water torn off the layers of my life that made me who I was? Will I be a healer or will I be a machine?

I stop. No one stops to ask why. They have all kept going, for you, you don't matter. There will always be another to outswim you. I lay in a green field asking myself, is this the only way? Who am I? I just want to breathe. I just want one moment for my heart to slow down and for me to breathe and have another being stop by, put their hand on my hand and ask if there is something they can do, for they have entered a profession of healing, touch and empathy as have I.

Gaddy Noy is a third-year medical student at Des Moines University. He has a deep interest in the healing partnership between doctor and patient.

The “Repository” Series

SARAH SUDHOFF

I examine the body within a medical context by exploring through large-scale photographs four main themes: pathological waste; containment of the body and its parts; fragmentation and violence against the body; a subject’s relationship to a specific environment.

Following my surgery in 2004 for cervical cancer, I began to photograph and perform in hospitals, morgues, medical museums and my doctors’ offices. Through self-portraiture and self-performance, private rituals are revealed to the public only through documentation. Personal experiences with illness and mortality are intertwined with unfamiliar environments.

The same character’s presence in many of the works allows for an introspective look at these, in some cases unfamiliar worlds in comparison to one another. The repetition of spaces, procedures and a central character highlights and reshapes our thoughts on medical environments, the treatment of our bodies in these spaces, what role we have at protecting our bodies and the lengths we will go to achieve a sense of health.



Sterile

SARAH SUDHOFF



Exam
SARAH SUDHOFF

Clean 2

SARAH SUDHOFF





Leep 1

SARAH SUDHOFF

Monday 2

SARAH SUDHOFF



Sarah Sudhoff is a fine art photographer and educator based in Texas. Her work has exhibited internationally and nationally, and her images have been featured in print and online. She hopes that her work inspires viewers to challenge their assumptions about their personal health and health care.

In 2008 Sarah was chosen for Photolucida's 2008 Critical Mass Top 50 Photographers award. Images from her "Repository" series were selected for the exhibition "New Art in Austin: 20 to Watch" at the Austin Museum of Art; "31 Under 31: Young Women in Fine Art Photography" at 3rd Ward Gallery; "Self Evident: Contemporary Self-Portraiture" at the Claypool-Young Gallery; followed by a solo show in 2009 at Art League Houston in Houston.

In 2010, Sarah's ongoing series, "At the Hour of Our Death," debuted at De Santos Gallery in Houston during Fotofest. Also in 2010 the work was awarded two honorable mentions from Daylight Magazine/Center for Documentary Studies and En Foco's New Works Award, followed by a visual arts grant from the Artist Foundation of San Antonio to continue the "At the Hour of Our Death" series. A short film documentary on this series was released in October on Glasstire.com. Sarah's current series has also been featured online at Feature Shoot, Wired.com, the Shpilman Institute for Photography and Esquire Russia. In early 2011 she was awarded the Flash Forward Prize by the Magenta Foundation. Most recently, she was chosen as an artist-in-residence at Artpace in San Antonio. The residency takes place in the fall of 2012, concluding with an exhibition.

Sarah holds a master of fine arts degree in photography from Parsons The New School for Design in New York City as well as a bachelor's degree in journalism from the University of Texas at Austin.

Cofounder of the Austin Center for Photography in Austin, Sarah is a full-time faculty member at the Art Institute of San Antonio.

More of her work can be found at www.sarahsudhoff.com.

“How Will They Take Me?”

How Will They Take Me?

she says, after they
see me. She
has a point, thin
as a diagnosis,
no admission
committee I know
would be pleased, if,
as she says, she
even got
the interview. How

does she do it, sitting
in my chair like a young
girl talking
about chemistry and medical
school and at the
same time the time
her mother threw her
down the stairs.

Which mind am I
talking to, I say. She smiles
and turns the mind
inside out into the one
which resists logic,
logic the country
I was coming from.
Of course.

It wasn't in her chart, the part
about the two minds
and how they know each other
but do not speak. Make
yourself listen, I say. And she
just smiles.

We argue about her weight
but the argument slimes
over us like mucous
over her unfed
stomach. Both of us
got nauseous from that.

Now she brings her mother
who corrects everything
she says, the same
mother who thought her daughter
cost her her boyfriend.

And she smiles
for her mother as she keeps on
keeping on
losing weight. Don't you

see the anger, I say,
the punishment.
It was the other mind
that said no, but it wanted
my help, would I
fix her constipation, fix

her pain, would I
make an appointment for
colonoscopy. She

never came for that. And I
wondered if I had done enough
which is, I suppose, what one
always wonders
when someone dies
still wanting something from you.

A Little Health for Your Illness

I imagine
a buzzing in the night
somewhere between

the aorta and solar plexus
like health spinning inside
disease. Nodule. Kernel.

Accretion of light.
Yes! And over it
this wistful canopy

of personality, yours,
your colors,
umbrellas

of display.
I check your goods
from miles away. Listen,

I send electrons
of encouragement
like energy crisps

in your mailbox.
Read me.
I will write this message on my wrist.

What it Was

And they asked if it felt like sex
when the sperm hit the egg.
And I said no, which was true,
partly—the in body sex
and the out of body sex—But

they weren't talking physics.

She explained it,
the egg mother did,
she said she had come to believe
in benevolence, honored
to be chosen, asked me
to give the shot that would start her eggs
rolling, and I did—brief exposure
on a different bed—clinical touch,
the fluids entering.

Distance fenestrated, but kept.

—well it did and it didn't,
and a child grew
where sex was still trying
to make up its mind. And the mother
who wombed this child
wondered if sex was different
now. A new presence claiming the ache
where absence used to be.

And he grew, this child,
and was intelligent, how
openly his mother could brag
about him, she said,
because she felt no genetic
connection. What did I know?
I thought it would be the same, though
it's not the same, is it?—the womb space
connection and the egg space
connection?—a distinction by truth
and the memory of loss.

And they asked again, is it sex
when it happens in a petri dish?
And I reminded them
of the story Steven Dunn tells,
the girl's poem
about making love in a boat.
A boy in her class said it wasn't love,
it was fucking. She said
if it felt like love, it was.
And I say

two women sit on a bed.
They exchange poems—
one womb, one egg—
the one egg missing, the one
provided—
They are writing about the child
and I am in a different room
making myself
into background.

And did I tell you the part
about the boy sitting
in the lavatory this morning?
dipping his washcloth in water—
to make him warm, he said—
draping his legs, almost floating
in his steamy containment?
And the little strings
and beads of water falling on the carpet
in necklaces of abundance,
and I tell you it is
whatever it wants to be,
sex, love, lust, benevolence. . .
this waterchild, this miracle,
this family.

David Watts is a physician-author interested in the neuroscience of creativity. His past books include Bedside Manners: One Doctor's Reflection on the Oddly Intimate Encounters between Patient and Healer *as well as* The Orange Wire Problem and Other Tales from the Doctor's Office. *He also produced a documentary for PBS, Healing Words: the Power of Prayer and the Practice of Medicine.*

Memories from Bhainsalotan

Bhainsalotan, now called Valmikinagar, was an idyllic place. My father, a civil engineer working for the state irrigation department, was transferred there around 1945. It was the policy to transfer employees every three years so that they would not get familiar with the local population. WWII had ended, and the financial gloom and doom were improving for Indians. The rationing of kerosene, sugar and several other items for survival ended. My parents were thrilled to be posted to this familiar but remote area on a large riverbank, close to several places of religious importance in the dense forest. Motihari, about 150 kilometers southeast from Bhainsalotan, was the headquarters for the administration of the Champaran district, which was later divided into East and West Champaran on December 1, 1971. Bhainsalotan was in the remote northwestern corner of old district Champaran and the new West Champaran. Motihari is the place where Eric Blair (known to many as George Orwell) was born on June 25, 1903. This town was also the place where Gandhi began his nonviolent movement in India (after using similar tactics in South Africa). The white intruders grabbed the fertile land, and the old owners became nothing more than hired hands. Besides the forced indigo planting on 15 percent of the land, cruel and unusual punishments inflicted upon innocent locals by the white intruders were commonplace. If a local, called “native” by the occupiers, did not remove his footwear or turban (needed for protection from harsh and hot summers) while passing on the road in front of the residence of a white family, he was stripped naked, tied to metal poles and left in the painfully hot sun. In many parts of India, the headgear was and is still considered the “honor” of the individual, the family and the faith. Even today, the 30 million Sikh members of our society are often humiliated when they are ordered to remove their turbans (the head cover) in western courts or by TSA employees at the airports. This religious symbol is never removed in public. The religious symbols include uncut hair (Kes), a small sword (Kirpan), bracelet (Kara), a sturdy underwear

(Kachcha) and small comb (Kanghee); the five Ks are part of their culture, religion and tradition.

Forming the boundary between Nepal and India near Bhainsalotan were two merging rivers. The Hindus in the area believed that there was a third invisible underground river at the confluence. The joining of the three rivers elevated the place to extreme religious importance. Every year in the month of Magha (the lunar Hindu calendar or Shakasamhat or Saka samhat), around January, a special religious gathering took place. This annual event had the flair of an American state fair and the fervor of religious procession. Even in January, the coldest month of the year, the dip in the freezing cold water near the confluence supposedly made passage to heaven smoother. The holy place was reachable only by foot, through the dense foliage where one could smell the tigers and bears and scare the peacocks, pheasants and many species of deer (some small, some large, some with a single horn and some with huge racks on their heads). The dirt service road had controlled access. It passed through a dense forest on the banks of Tribeni Canal and was used often as an assembly place for tigers, leopards and bears. There was a telephone line connecting all sectional offices of the canal, covering about 60 kilometers. These offices were roughly 16 kilometers apart. Each office had a designated number of rings, and anyone could listen in and talk simultaneously just like old-time party-line phones in U.S.A. This telephone line was used for emergencies. When Gandhi was shot and killed on January 30, 1948, the news was relayed to us on this phone line. We mourned with all of India. Gandhi was the common thread to unite Indians, regardless of their skin color, ethnicity or religion. It was at this location that we brought down the Union Jack and unfurled the Indian Tricolor, our new flag, on August 15, 1947, and the exact time for the ceremony was coordinated by this phone system.

Our arrival in Bhainsalotan was after a long journey on a hot, sunny and muggy day. We had to travel for roughly 24 kilometers on bullock cart, a local product. Two crudely carved but carefully assembled wooden wheels

roughly four feet tall, connected by another wood beam, were tied with rope on the necks of two robust bulls pulling this contraption. The Badhais, the caste of wood-crafters, made all wooden items – including our bullock cart. This art was handed down through generations. It would have been impossible for a young man born in this caste to train for another vocation. Like any other profession, some of them were extremely creative and talented while others were mediocre. Shock absorbers had never found their way into this popular mode of rural transportation.

The dirt service road was nothing but a line connected by dirt craters and potholes that transformed into mud puddles during the monsoon season. By the early 1950s our bullock cart was replaced by WWII American-built left-hand drive Jeeps. Father often used his bicycle to inspect the canal, occasionally accompanied by one of his assistants. Often he had to yield to, very discreetly of course, groups of leopards or tigers lounging on the road. The dense vegetation of a typical tropical forest was the home for all animals, and the canal provided the water for drinking and swimming.

Bhainsalotan was situated at over 135 meters (roughly 442 feet) above sea level. It had annual rainfall of over 2,000 to 3,000 millimeters (roughly 80 to 120 inches), all within in the three months of monsoon season. The campus included a small bungalow (called the Inspection Bungalow) for visiting dignitaries and adjacent quarters for the staff including a gardener and a cook, quarters for local unskilled help, an office for my father and our residence, and a small two-room dispensary with living quarters for the medical officer and his family. Small one-room sheds were provided for the local helpers who had their wives and families in villages far away, somewhere beyond the mountains. They visited their families perhaps once every year. The helpers were mostly local tribes of Tharus and Dhangars and Nepalese people called Gurkhas. The Gurkhas carried a small dagger housed in a homemade sheath on their cummerbund – a weapon they never hesitated to use if provoked. Almost all the workers were of Hindu faith except for the cook for the inspection bungalow, who was Muslim. Tharus and Dhangars had their own

culture, much different from the Aryan or Vedic culture prevalent in India, and their own separate language. They walked barefoot, thus most of them had fissures and cracks on their feet and heels. They used to plug these cracked open areas with the sticky gum of the local gum tree, a member of *Acacia Arabica* family. Many of them had circular patchy defects on their feet, a fungal infection resembling ringworm. They put yoghurt on their feet and had it licked by a trusty dog. It did cure the problem.

The Gurkhas are known for their unconditional loyalty and fierce fighting habits. They were indispensable during WWI and WWII. Gurkhas guarded British strongholds such as Hong Kong and the Royal Palace in the United Kingdom. In the village, one of the older Gurkha men had a deformed and relatively short leg (the result of past traumatic events), causing a significant limp. People knew him by the derogatory name of “langra” – the lame one. He was a brave young man when he joined the department. He went on a tiger hunt riding an elephant with the wife of the governor. These specially trained elephants could smell the tiger and point their trunks in the direction of the prey. They were trained to stand still till the completion of the kill. Occasionally the wounded tiger would attack, but the elephant never panicked. I heard the stories of elephants grabbing the tiger with trunk and smashing it against the nearest tree. On this particular hunt the tiger jumped on the elephant where the lady and this Gurkha were sitting. The lady fell but the Gurkha did not want her hurt so he jumped with her, holding her to break her fall, thus damaging both his legs. For months he was bedridden. Mother Nature took her course and he ended up with this deformity. He was still one of the best marksmen on the campus. He could shoot anything accurately with our 12-gauge double barrel gun.

Most of the tiger hunt in that area was done the old-fashioned, conventional way, from a fixed, hidden platform built on a tree branch near the places visited by tigers. A calf, buffalo or goat was tied near the vulnerable spot visited by the tiger. Once the tiger or the leopard came near the bait, the hunter blinded the animal with a battery-powered searchlight and shot it.

I have never heard of the bait coming back alive. An injured tiger could turn vicious and revengeful. Occasionally the tiger killed the bait and returned much later to devour it, making sure that it was not being watched. At times the agonizing wait for the bait lasted two or three days. Often the wild animals stayed away from humans. Frequently, older tigers moved to the farmland adjacent to the forest where they could easily kill domesticated animals, children or old and feeble people. The tall sugarcane fields provided excellent cover for these stray animals. The young tigers living in their natural habitat who could kill their prey by overpowering and outrunning the victim never became man-eaters.

The routine tranquil surroundings of our campus were changed during the governor's annual tiger hunt. Elaborate security precautions were made. Several tents were erected. A soda water plant was installed. This ordinary river water in its new reincarnation was stored in thick, clear or light-green bottles with pinched neck; a floating glass ball the size of a play marble floated up to the pinched neck, thus producing an airtight cap. Only adults were allowed to push the floating ball down with their finger, releasing carbon dioxide gas before pouring the liquid. Limited electric lights were arranged for the comfort of the governor and his guests. Except for essential service staff and a few high-ranking officials, the campus was off-limits to the local population. There were armed guards throughout the jungle road, roughly 20 to 30 kilometers long. We were told that the governor had several "doubles" traveling with him and, except for his personal secretary, no one knew the exact bed he was to sleep in. They did not need many doubles because to us they all looked alike – all were tall, sickly pale and spoke with funny twang. The inner circle of service staff were always white people, perhaps British, and the Indian servants did not have free access to the people in the entourage. The whole campus was supercharged during this unique event. None of us had seen so many white people at one place. Of course, after they left, we went through ritualistic purification of the places and utensils touched by the white Christian folks who ate eggs, fish and meat.

During this visit by the governor, our small dispensary was transformed into a minor trauma center with more medical staffing. Ordinarily, this rarely used facility stocked just a few medicines such as aspirin, tincture of iodine, quinine mixture and equipment to clean ears since chronic, draining ear infection was very common in local adults and children. The villagers often went for herbal treatments to their village healers. The herbs grew in the local forest; they were cheap and had no adverse side effects. The villagers had faith and complete trust in these healers who performed elaborate rituals to soothe the offending spirits who were credited with most of the diseases. Often animal sacrifice was needed, chickens for small spirits and goats or sheep for more serious cases. Many locals showed up with violent fits of nocturnal cough, eventually ending up vomiting bright red blood. This pulmonary tubercular infection was terminal since there were no medications to treat it. Even in the 21st century, tuberculosis is a major killer in developing nations. Due to lack of public education, poor food and hygiene and proper treatment, multiple-drug-resistant tuberculosis is becoming a major problem in the developing world.

Disease and death were part of our life cycle, no one dwelled on them, it was gift from God and we were made to believe that we had no obligation to better our health or living conditions. The affluent, which included only our family and the family of the doctor, used mosquito nets, while others just tolerated the stings and malaria. There were neither televisions nor radios yet, and newspapers were delivered by the mailman (who walked through the dense forest once every week). Rarely was there any variation in our daily routine of sleeping, eating, going to the canal or the river to bathe and watching for local flora and fauna. Yet we never were bored. Our doors and windows were secured with prison-like iron bars, left open during summers when it got well over 35 degrees Celsius. We looked forward to afternoon tea in our shaded verandah when we usually saw a huge python slide by us. Locals told us that the python was a protector of people living there. Once we woke in the morning to an unusual yelping, crying sound, which continued for several

long hours. A python was swallowing its prey, a small goat, the hind end first. It was a slow death by suffocation.

At the clinic a fat lady started showing up on a regular basis. She had to be carried in to the clinic because of her protruding belly but walked out on her own after the treatments. Her frequency of visits kept decreasing. Eventually she was gone. We never learned the outcome because she lived a two- or three-day walk from our campus. In retrospect, she must have died from that ascites-producing disease. The doctor drained huge amounts of fluid from the peritoneal cavity using a long needle. These needles and syringes were merely wiped with isopropyl alcohol and used repeatedly on different patients. The luxury of proper sterilization was unavailable. After repeated use, the needles were sharpened manually on hard stone. I wonder about the type of malignancy this lady had? Did she know she was dying? Did she have a pain-free end? Did even the doctor know the cause of this malady? If it was not malignancy, then was the ascites due to lack of protein in her diet? A fatty liver due to a high-carbohydrate diet? Was it due to portal hypertension?

Occasionally people came to the clinic after severe burns, especially in winter when the unheated homes were kept warm by open fires that got out of hand. Mostly the victims were children and women who fell asleep near the fire source. The typical year still has over 100,000 burn victims in India and about the same number of deaths from snake bites and from vehicle-related accidents. Some of these burn incidents are dowry-related or honor killing. We used a few plant-based products such as the neem (*Azadirachta indica*) leaves and turmeric paste as antiseptic on burns, infections and cuts. At the time we did not know that Curcumin, the main ingredient in turmeric, has several medicinal properties including antioxidation and immune-boosting. Many oncologists are using curcumin to treat cancer patients along with other chemotherapeutic agents. Curcumin is also supposed to delay or prevent the symptoms of Alzheimer's disease.

Although some of the forest's inhabitants could be bizarre, fascinating, frightening or even dangerous, its human guests were warm-hearted, kind

and hospitable. The forest was full of all kinds of killer animals – snakes that killed their victims either by paralyzing the respiratory muscles or by working on the coagulation system (thus causing their prey to drown in its own blood), ticks and leeches. It was also the abode for pretty wild flowers, wild fruit trees, parrots in many colors and the regal peacock. People who lived in or near the forest were an altogether different breed. They kept us out of harm's way. Polygamy and polyandry were not frowned upon, and it was not uncommon for the oldest brother to marry a woman and other brothers shared her. Those with means had more than one wife. Despite the primitive conditions they lived in and lack of medicines and healthy diet, people appeared happy. Prenatal, postnatal and early childhood mortality was very high. Cholera, smallpox, kala-azar (leishmaniasis) and tuberculosis were and are even today major killers. Malaria transmitted by mosquitoes' bites was rampant but rarely ended in death. The typhoid fever contracted by fecal contamination was often lethal. Chloromycetin appeared in the market in late 1940s and was used indiscriminately on children and adults. The lethal side effect of bone marrow suppression was not known yet. Quinine, the most bitter and vile-tasting drug, was used till we heard ringing in the ears constantly (signaling the therapeutic dose).

Even fevers reflected the grandiosity and mystery of our surroundings. Although treatment was basically supportive, we employed our ingenuity and materials at hand. Regular food was withheld when we had any fever. Only glucose water or weak barley water was given for nourishment. Helpers were scrambled to nearby city markets, often a two-day bicycle ride, to bring oranges and grapes, but we mostly starved. After being fever-free for two or three days, we were allowed small amounts of cooked rice, preferably from a two- or three-year-old crop, or small chapatti, the unleavened wheat bread with some milk and unseasoned lentil soup. The diet was totally devoid of fat or spices. It was planned for an easy digestion. Splitting headaches often came with high fevers. Delirium was usually a fatal symptom.

One summer I had fever for over 10 days. The quinine, aspirin and

frequent cold compresses to the forehead finally ended the fever. Once afebrile for a couple of days, I had some rice and lentil soup, the usual post-fever routine. I stopped urinating rather quickly but initially nobody noticed it. My face and body started to swell within 24 hours. My eyes swelled shut. I was comatose and – in spite of Coramine (a worthless drug that was considered the miracle cardio stimulant), injections and an Ayurvedic miracle drug makardhwaj (it had some form of mercurial compound) powder with honey paste by mouth – I was considered dead. My mother intervened before the planned cremation. She prayed all night. She even promised the Nardevi Mata, a reincarnation of the goddess Kali, that if my life was spared I would walk to her shrine in the middle of the jungle daily to offer my prayers. Unshakable faith was an integral part of our daily survival. I did survive, and the offerings of one million Baelpatra (also called Bilva or Bengal quince or stone apple, or *Aegle marmelos*) leaves were delivered daily to her shrine by me, as promised by my mother.

We did often spot wild animals, mostly during evenings when alone or with their families they went to the river. In summer when melting snow and ice from high mountain ranges of Everest started to flow, the crystal-clear cool water filled the river. This area was home to huge crocodiles who trailed our boats, a threatening sight. A huge cement and brick dam that controlled the water flow to the canal also kept the crocodile and uprooted floating trees from getting in the canal. Once, a large crocodile did escape to the canal. The reports of small animals disappearing made us extra vigilant while in the canal area. It became a dangerous situation, so the hunt for the crocodile began. The water supply at the dam was reduced and the crocodile was spotted in the muddy bed of the canal. Father shot the crocodile right between eyes using his 12-gauge shotgun. Local people cooked the crocodile meat. Several undigested items and a silver bangle usually worn by young girls were found in the stomach of the crocodile!

The local people relished fish, fowl and meat. Often they used tree bark and twigs in the canal that turned the water blue. It killed the fish. The dead

fish floated on the surface. The locals cooked it and the dye used was not toxic to humans. The kills after hunts were consumed by them, including bear meat. Tiger or leopard meat was not eaten, but some used the penises of males of the species for medicinal purposes, this of course before Viagra was invented. They brewed their own rice beer. After cooking the rice in an earthen pot, they added extra water and sealed the opening with clay and leaves. They buried this pot underground and took it out after three months. The fermented product had an awful stench that was definitely not a deterrent for the locals. This home brew had live worms, which they fried with spices and ate along with the intoxicant. The horn of the rhinoceros, tiger teeth and tiger bones were used by the local healers.

One winter evening we were enjoying the evening glow and warmth of wood fire in the courtyard. My sister, about 10 years old, who had dozed off on her easy chair, woke up with a loud scream. Much to our horror we saw a cobra wrapped around her tiny arms. It was a grave situation. The cobra could not be shot or beaten to death without harming my sister. A Gurkha risked his life to grab the head of the snake and killed it. It is believed that the dying snake stores the last scene in its eyes. One must smash the eyes of the dead snake; otherwise, as the folk lore has it, the spouse or family member of the snake will hunt down the killer. Usually after a snake bite, some local expert was called to cup his lips around the fang marks and suck out the poison. Anti-venoms were not available at the time, and even today they are unavailable except for at a handful of major city hospitals that stock them.

When we weren't confronted with deadly snakes or man-eating crocodiles, a missing Gurkha became a sensation. He had gone to a nearby forest looking for fresh wild vegetables and flowers but did not return by evening. Search parties were sent out but had to be called off because of the nocturnal killers lurking around in the forest. Adults did not sleep well that night. The next day by the early afternoon, Father was planning to inform the family of the disappearance. Suddenly there was commotion. A shadowy human form appeared in the horizon and kept coming closer, slowly but surely. It was our missing

Gurkha. He was struggling for each step toward us. This man was pale, his lips parched dry from dehydration, weak from blood loss and, most remarkably, a snout of a huge bear hanging by his left wrist. The dry blood crusted all over his clothes, he was holding his Khukri proudly in his right hand.

Apparently this particularly brave Gurkha was distracted by a huge honeybee hive. He climbed to get the honeycomb but had to fight a bear that had an eye on the hive also. The bear jumped on the man and they both fell from the tree. Luckily he fell on the huge fuzzy belly of the bear. He had enough presence of mind (and instinct) to survive in the jungle. To dispose of the bear, he hacked away on its snout. Eventually the bear fled and he started to drag himself to our campus.

My uncle, then a recent graduate of Ayurvedic medicine and surgery from prominent Benaras Hindu University in Varanasi, was visiting us. He along with the local government doctor, trained in the Indian Army, started this man's treatment. No one talked about tetanus prophylaxis or antibiotics because none were available in those days in rural India. Villagers are still not protected by routine immunizations or tetanus prevention or prophylaxis. There were a few tins of chloroform. The doctors used a tin funnel that ordinarily was used to pour gasoline in cars or kerosene in our lanterns. It was covered with thin muslin, the whole contraption put over the face. They proceeded to anesthetize the Gurkha with chloroform with the crudest open drip method. The doctors inhaled as much of the fumes as the patient. They pried away the bear snout, stopped the bleeding, cleaned the wound and left it without stitches since there were none available. A bulky dressing was applied and the arm was elevated. They changed the bandage regularly and the wound healed. He regained some use of that hand, although it healed at a crooked angle. The man and the doctors were pleased with the results.

I remember the sweet smell of chloroform and the struggle the man put up before he was completely sedated or anesthetized. I wonder if those doctors remembered the complex anatomy of the wrist.

When I went back to Valmikinagar in 2000, the whole campus had

changed. The irony of the situation was that the new generation had never heard of the “langra” Gurkha or the brave Gurkha who fought the war with a huge bear and survived. It has a huge hydroelectric power generating plant, a new dam on the river Gandak and decent roads. The places we were afraid to go even in daytime because tigers, leopards and other creatures lived there now have a college, a small landing strip (built for the late Prime Minister Jawahar Lal Nehru’s landing to inaugurate the new canal and hydroelectric plant and hardly used since then), multiple dwellings, a post office and a police station. The forest is gone forever. A paved road connects this area to nearby towns; it is considered a strategic route due to recent political changes in India and Nepal and criminals hiding in the area. The aggressive daily deforestation in India is affecting the climate. It is feared that India will become a desert within 50 years. The daily temperature still fluctuates between eight and 40 degrees Celsius (roughly 45 to 120 Fahrenheit), but people living there complain of much warmer days each year. The rain is also decreasing each year. The wildlife has pretty much disappeared. In the old days there were 50 or more Royal Bengal tigers in the area. Recent camera-trip method survey has shown that only 10 tigers are left there. Although there is room for progress, I would have preferred my old Bhainsalotan!

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Back Cover

Depression

RICK RAPP

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