THE MEDICAL RECORD

A THESIS IN
Creative Writing and Media Arts

Presented to the Faculty of the University of Missouri-Kansas City in partial fulfillment of the requirements for the degree

MASTER OF FINE ARTS

by

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THE MEDICAL RECORD

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ABSTRACT

A collection of personal essays, “The Medical Record” is an exploration of my life in medicine. It has three primary goals. First, to portray an accurate account of my training and practice as a female physician, with all its difficulties and rewards, through interrogating real and false narratives about myself in particular and women in medicine in general. By contrasting what I believe to be an objective recitation of facts with the subjective story as I experienced it, I hope to show how the loss of narrative in the practice of medicine has left us unable to care for ourselves or others.

Second, my stories illustrate how physicians are their own worst enemies, offering themselves and their peers none of the compassion and understanding given to patients. Through examination of how I dealt with my own illnesses, and how those illnesses were handled by my superiors and peers, the dysfunctional way in which physicians deal with human fallibility becomes clear. We create and believe false narratives about both ourselves and our patients, and this influences our expectations and outcomes.

Lastly, I want to emphasize the importance of story in caring for patients. We have lost a valuable tool by resorting to reimbursement and metric-based check-lists for our patients’ histories, and this has affected our empathy and compassion as well as hampered our ability to think outside protocols for the correct diagnosis.
Recognition and understanding of these things came at a great cost to me. By sharing these stories, I would like to change the adversarial way that society views physicians, and alter the way in which doctors and patients see each other. Only then can we have the health care system we both deserve and desire.
APPROVAL PAGE

The faculty listed below, appointed by the Dean of the College of Arts and Sciences have examined a thesis titled “The Medical Record,” presented by Maureen A. Hirthler, Candidate for the Master of Fine Arts degree, and certify that in their opinion it is worthy of acceptance.

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# CONTENTS

ABSTRACT ........................................................................................................................................ iii

ACKNOWLEDGEMENTS ........................................................................................................ vii

INTRODUCTION .......................................................................................................................... 1

ENTRY 1 - Chief Complaint/History of the Present Illness .......................................................... 12

CHAPTER ONE ............................................................................................................................ 14

ENTRY 2 - Review of Systems ..................................................................................................... 19

CHAPTER TWO ............................................................................................................................ 21

ENTRY 3 - Past Medical History .................................................................................................. 24

CHAPTER THREE ........................................................................................................................ 26

ENTRY 4 - Social and Family History .......................................................................................... 92

CHAPTER FOUR .......................................................................................................................... 93

CHAPTER FIVE ............................................................................................................................ 98

CHAPTER SIX ............................................................................................................................. 103

ENTRY 5 - History of the Present Illness, Part II ......................................................................... 124

CHAPTER SEVEN ....................................................................................................................... 125

ENTRY 6 - Assessment and Plan ................................................................................................ 170

CHAPTER EIGHT .......................................................................................................................... 172

EPILOGUE ....................................................................................................................................... 177

VITA ............................................................................................................................................... 184
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Last, but never least, I thank my husband and my father for their love and encouragement.
Memoir isn’t the summary of a life; it’s a window into a life, very much like a photograph in its selective composition. It may look like a casual and even random calling up of bygone events. It’s not; it’s a deliberate construction. —William Zinsser

INTRODUCTION

Stories occupy the core of the art of medicine. Like prospectors panning for gold, doctors listen and swirl and sieve through what is said and unsaid until they uncover valuable flakes of information. Once she has gathered the pieces, the physician forms a narrative and compares the story of the patient to the archetypal stories of illness that she has learned. Is it the gallbladder tale or the heart attack one? How do those stories usually end? What can be done to alter the natural plot for a better ending? Doctors are hearing, writing, and telling stories every day.

Today’s reliance upon evidence-based medicine has prioritized science over narrative. Evidence-based medicine (EBM) is a form of medicine that aims to optimize decision-making by emphasizing the use of evidence from well-designed and conducted research. The good of the many outweighs what is best for the individual; doctors are increasingly denied the ability to care for their specific patient in a distinct manner. Although this approach works well for third-party payors, it seldom serves the needs of the patient.

Narrative-based medicine (NBM) is a form of medicine that aims to optimize decision-making by emphasizing the unfolding and interwoven story between health care professionals and patients. It supports individualized care influenced by science, and leaves room for communication and cultural appreciation. It recognizes that we are all different.
Narrative-based medicine acknowledges that doctors have their own stories that impact their personal lives and influence their practice of medicine.

Doctors have written about medicine from the time of the Greeks. There have been great physician authors—Chekhov, Conan Doyle, William Carlos Williams—in modern times as well. Medical writing assumes many forms across a common theme—the human condition in all its beauty and horror as seen from the front lines of medicine. Stories about patients as curiosities (Sacks) are most popular with readers, closely followed by those dealing with the education of young doctors (Collins). The doctor-as-patient stories are often best-sellers, with their mix of schadenfreude and redemption. There are a few adventure stories (Kamler on Everest), and many collections of short stories (Austin, Aronson) in print as well. These stories are about patients and their experiences, and what those experiences tell us about humanity. But there are few stories told by doctors about themselves. *A Country Doctor's Notebook* by Mikhail Bulgakov, written in the last days of the Russian Empire, remains one of the truly unflinching accounts of the fear and uncertainty that go on in a doctor’s mind. Terrence Holt, in a recent fiction collection entitled *Internal Medicine*, gives readers a glimpse into the emotional and physical fatigue of a medical resident, but the experience is diluted in service to the story arc. All the rough edges are filed smooth.

Physicians remain an enigma. Like the Wizard of Oz hiding his own humanity, we conceal ourselves behind a curtain of stereotypes generated both by society and us. These beliefs often conflict—infallible/flawed, dedicated/uncaring, saintly/greedy. Patients have a poor understanding about what physicians do, and doctors are reluctant to tell them. We keep our stories secret.
Even in ostensible autobiographies (Holland), the doctor/author remains aloof, separated from the story, an observer, rarely a participant, and seldom the actual subject.

There is an excellent reason for this. Patients need to believe their doctors are perfect; how else can they be saved by them? This desire to believe in infallibility and self-sacrifice, in the ultimate goodness of the doctor, is one of many reasons our health care system fails to satisfy both patients and doctors. With the media trumpeting malpractice, medical errors, and even criminal conduct, patients are forced to acknowledge that physicians are imperfect human beings and do not always meet expectations of availability, charity, and expertise. As a result, belief in our health compass has been lost, and patients spin this way to alternative treatments or that way to the latest miracle cure touted by media doctors. They don’t know who to trust.

Doctors are affected also. We find ourselves in an adversarial position with those patients that no longer trust us. There is little positive feedback for the job we do. Government and insurance regulations snatch time away from patients and limit the interpersonal interactions essential for job satisfaction.

This is not a new phenomenon. In their paper “Poets, Doctors, and the Rhetoric of Money,” Nicholson and Selden examine Pindar’s portrayal, in his Third Pythian Ode from the 5th century B.C.E., of the ancient physician Asclepius as heroic but morally flawed. Pindar presents another imaginary physician, one not involved with money, in contrast. The authors tell us, “Where Asclepius provides a service to some unnamed individual on behalf of another unnamed individual in answer only to the temptations of gold, the second doctor is to be sent by his mentor.... There is no suggestion that any money will change hands.” The description of Asclepius here mirrors our current government/hospital/insurance based system
with its unnamed middlemen. Nicholson and Selden demonstrate that the role of the physician was ambivalent even in ancient Greece, and that there was controversy about ethical and social transgressions tied to economic rewards. That is, was the physician an altruistic professional, dependent on others for basic needs, or a trader, offering a service for money? Patients today are still caught in this dichotomy. They believe insurance should pay physicians, and so have little understanding of a doctor’s worth. Doctors who value the relationship between doctor and patient are frustrated by having to compromise care and occasionally ethics, in order to earn a living. As long as society views medicine and health as a commodity exchange rather than a professional bond between doctor and patient, both sides will remain unsatisfied.

Pindar emphasizes that both practitioners provided high-quality medical care. The difference was in society’s perception of the motives of the doctors. Nicholson and Selden state, “Today’s doctors are at the mercy of societal groups that influence public opinion but operate, at least in part, based on their own self-interest (e.g., the popular press).” Media coverage is also tied to public perception of excessive wealth of physicians. Much like the physicians of ancient Greece, we need to find a way to garner respect and trust for our intentions. Patients need to believe that our primary goal is to help them, not to earn more money.

There is a defensive lack of insight about this issue within the medical community, itself partially derived from the belief that we must be extraordinary always. In Doctored: The Disillusionment of an American Physician, Sandeep Jauhar looked at the patterns of reimbursement that endanger the availability of primary care, but then detoured into a denial of his own flawed expectations that led to moral lapses, exonerating himself but leaving the public to believe that greedy doctors cheat the system for money.
The non-fiction press also features books that address the health care system (Gawande, Groopman) and its effect upon patients, and much is written about what physicians can do better, reinforcing those all-powerful and all-knowing stereotypes, leading the public to believe that if only we physicians tried harder that all would be well.

What is missing are the true personal and professional stories of doctors, stories that patients need to hear if they are to understand how they and their physicians are truly partners in this business of health.

We doctors have bad days, make mistakes, get sick, feel frustrated and angry. We have to family obligations, medical school debt, and bills to pay. The insurance companies and federal government demand that we capture medically unnecessary data for their metrics, taking time away from direct doctor-patient interaction. Yet, we are expected to control emotion, subjugate our feelings and hide our real stories while living a false narrative of perfection.

As a result, physicians have higher rates of clinical depression and suicide completion than the general population, and suicide is the second leading cause of death in medical students (accidents being number one). Colleagues turn away from a physician in pain while medical boards slap a virtual scarlet “M” for mental health on the license of anyone who comes forward to say that they do need counseling (Andrew), enrolling them in unnecessary and intrusive monitoring programs. Medical students fear losing the chance they have striven their whole lives for and so they hide their anguish from their teachers at a time when help should be easily obtained and most effective.

I believe it is essential for physicians to tell their stories and for patients to hear them. We need to renegotiate our emotional contract and expectations; we need to know and see
each other as fully dimensional people. Then we can have real dialogue about what our health care system should do, and how it should do it.

My stories, then, are about me as human being, living my life and practicing medicine. They are not meant as a critique of health-care policy. Through storytelling, I want to change the way patients and doctors view each other. There is nothing new here other than the telling; doctors have always been fallible. We must allow ourselves to acknowledge that, be unafraid to say so, and we must be accepted as such by ourselves and our patients to be effective.

Placing yourself at the center of the story, indeed, telling your own story, requires a certain amount of hubris. You must believe that one’s individual experience has relevance to the audience. You have to have something important to say, and a way to tell it that is engaging. The stories must reveal something about the author that surprises the reader, and opens the door to greater understanding of both the specific and the universal. Hippocampus editor Donna Talarico says, “Stories need reflection, they need tension, they need detail. It can’t just be “this happened, and that happened.” It can’t just be “read this and feel sorry for me.”

I began the MFA program at UMKC in the summer of 2011 with certain goals in mind: to decide if I had a story to tell that was both interesting and important, and to gain the skills and tools to tell that story in an appealing way. I had had some publishing success in medical humanities; I believed I had the medical material to appeal to readers, but I struggled to find the personal narrative and appropriate voice to compose a cohesive memoir.

To become a better writer, I first had to become a better reader. Faculty book selections introduced me to authors, topics, and styles that I had never encountered, and workshops taught me how to read critically and use criticism to improve my work. I explored fic-
tion as a possibly way to tell my story, and discovered essential information about writing the story itself: arc, theme, reveal, ending. My forays into poetry helped me refine the images in my pieces and draw connections among them. The study of literary theory led me to feminist authors who provided me with a lens to see my experiences more clearly. Non-fiction workshops introduced me to the wide variety of memoir styles as I searched for my own. Most importantly, I learned the value of precision and clarity in writing.

I threw away all the autobiographical pieces I had written, and began to write the real stories, the difficult ones that I had avoided telling, the ones about me. Some of the new stories were polished early; others remained half-written, waiting for the courage to be finished. I continued to search for both form and theme. How could I tie these disparate stories together? There were medical stories, family stories, personal stories, unrelated on the surface, but all united by...something. What was it?

I did the only thing that I could think of doing: I read. After months of identifying the kind of memoir I didn’t want to write, I discovered three books that held clues to the type I did want to write. The first was Jeanette Walls’ Glass Castle. I began to see that I could pick and choose how to tell my story; it didn’t have to be linear. I didn’t have to include everything—it was, as Zinsser said, not my life, but a story of my life, focused on the events that were important to the theme of story.

Bluets, by Maggie Nelson, allowed me to see that I could use various formats and voices for different sections—more freedom from a rigid biographical form. Anne Carson’s Nox, however, influenced me the most. Pictures, snippets of writing, souvenirs, and other mementos were interspersed with prose, sweeping the reader along on a journey of discovery. I decided I could be more flexible and invent a format that would work with my essays
and stories. Finally, a short story, “Likes/Dislikes” by Christie Hodgen in *Normal School* and *The History of the Present Illness*, by Louise Aronson, an MD with an MFA, provided the final pieces. I would write this memoir as a medical record. Imposing this structured form provided great freedom in construction. It conveniently had slots for family, job, health, and illness. I could tell my story from the outside—what I thought would be in my medical record from a major hospitalization—and the inside—who I was, what I experienced, and what I learned from those events.

Medical students spend a great deal of time learning how to obtain specific information for a medical record. I have included at the beginning of each entry some of their instructions. Bullet point electronic medical records are the norm today; data is all important for reimbursement. There is no place (or space) for stories; in fact, the computer itself weaves the bullet points into a narrative style that provides little or no useful information about the actual patient.

After each such entry in my medical record (the entry I would have made as the patient’s doctor), I have written that story, the one not there, the one not told, the only one that is possibly true.
Works Cited


Entry 1

CHIEF COMPLAINT AND HISTORY OF THE PRESENT ILLNESS

INCLUDE:

IDENTIFYING INFORMATION.

CHIEF CONCERN: THE PATIENT'S PRINCIPLE CONCERN, SUMMARIZED IN ONE SENTENCE. DO NOT CALL IT THE CHIEF COMPLAINT.

HISTORY OF THE PRESENT ILLNESS: DETAILED CHARACTERIZATION OF THE PATIENT'S CURRENT PROBLEM IN PARAGRAPH FORM.

USE CHRONOLOGICAL ORDER.
**CC/HPI**

**November 7, 2010, 10:00 AM.**

**Patient** is a fifty-three year old female physician admitted through the Emergency Department with an altered level of consciousness. Father heard but did not witness fall in the bathroom about an hour ago. Patient apparently struck her head. Responds with withdrawal to painful stimuli, incoherent vocalizations.

EMS stated possible overdose. Only drugs on scene were Lunate® (empty bottle) and Zoloft®. Found by father and housekeeper, who called EMS. Patient's husband is in Oklahoma; has been notified by ED doctor.

History obtained from father, who lives downstairs from patient. He states patient recently lost job and has been depressed. Last seen the evening before, expressed no suicidal ideation. Has a history of depression; currently sees psychiatrist. No prior psychiatric hospitalizations. No hypoglycemia, recent illnesses or exposures to infectious diseases. No history of substance abuse.
Chapter One

History of the Present Illness, Part I:

The first statement in my hospital chart is true enough; I'm not aware of being in the Intensive Care Unit and I'll take their word for it that I'm breathing and moving. It's obvious that I fell; Dad heard it and I have this huge lump on the back of my head. Still, EMS decided “overdose” and “suicide attempt” were much more dramatic complaints than “banged head” when transporting me into the ER that had fired me four days earlier. Truth and speculation combined in competing narratives that supported what people needed to believe. My own version of the story suffers from the same limitations.

Being in the hospital came as a surprise; being fired did not.

The details of what went wrong at that job are familiar to many doctors—falling in badly with a clique of powerful nurses, a clipboard administrator compiling a transgressions folder that those nurses were only too pleased to fill, patients solicited for complaints, case after case sent to the Medical Quality Committee even though every one was found to reflect good care, a referral to the Physician Wellness Committee whose positive assessments were simply ignored.

It was the harassing pettiness of life in a hospital where the label of “disruptive physician” is a weapon followed by the increasingly tawdry abuse of peer review as employed doctors become widgets in corporatized medicine. Gears with glitches require replacement, not repair.

But how did I end up here, at this desperate end?
When I woke up, I saw my family doctor sitting next to me. I realized that I was in the hospital, attached to wires and catheters, and that my husband and father were also in the room. My head ached and pain shot through my left shoulder when I moved. I had no idea why I was there.

“What happened?” I asked, after hugs and kisses from my family.

“We’ve been waiting to ask you,” said my doctor. “How’s your head?”

“It hurts. I don’t remember anything.”

“What’s the last thing you do recall?”

“Brad visiting Tuesday night. Why can’t I remember anything?”

“You have a concussion on top of too many sleeping pills. You don’t remember calling your psychiatrist on Thursday?”

“I did?”

“Several times. She says you were worried about hurting yourself. I have to ask—did you try to kill yourself?”

“No, I just wanted to sleep.”

I noticed my husband could barely contain his rage, not at me, but at the situation that had driven me past his comprehension. He told me about getting the call from the ED. He was in Oklahoma City, doing advanced training in surgery of the hand that year.
“I was furious!” he said. “They were treating the fall as nothing. I told them I wanted a full trauma evaluation, and only our doctor, Joe Bishop, to admit. Then I called Joe and told him I expected him to be at your bedside to protect you from those people until I got there.”

“I understood Rick’s concerns,” said Joe. “You were in a very vulnerable position with people in charge that you couldn’t trust. I came right over after office hours.”

“Thanks, Joe. I’m glad we have you.”

Turning to my 83 year-old father, I said, “Dad, I’m so sorry to put you through this. Are you okay?”

“As long as you are good, I’m fine. I called your friend Viola from the ED—thank goodness her number was in your phone. I didn’t know what else to do. I didn’t understand when they said you had tried to kill yourself. She came right in and told me they were fools. She stayed with me until Rick got here.”

I had made one good friend here, I thought.

“Well, let’s get you out of this place,” said Joe. “I’ll do the paperwork.”

While he was gone, one of my psychiatrist’s partners stopped in. He looked annoyed at having to come to the hospital—which they rarely did—especially on a Sunday afternoon. He assessment was perfunctory, impersonal, and worthless. “Call Dr. B. tomorrow,” he said, leaving as quickly as he arrived. I wondered if all his patients got the same treatment, or if he just didn’t want to be associated with me. That possibility hurt.

My discharge from the hospital was the quickest I’ve ever experienced. It was as if the staff and I were the opposite poles of magnets that found themselves too close together and repelled each other with all the force we could muster.
I don’t remember coming home. After a long sleep, I awoke and wandered through my home, but I felt like a stranger. Everything looked different, felt different. I had difficulty remembering that we had just completely remodeled the bathroom where I fell. Where was the mauve tub? What had I hit my head on? Why couldn’t I remember?

My husband gently sent me back to bed, where I slept without dreaming. A few days later, he had to return to his fellowship in Oklahoma City; Dad would take care of me again. I filled in the details provided by others, but huge gaps of time remained missing. According to gossip, I had had a heart attack, a stroke, tried to kill myself, and needed a psychiatric admission. My co-workers were forbidden to visit me by the ED director, and so my side of the story stayed hidden. They believed what they wanted to believe, and went on about their business. I came home and faced the future by accepting the past.

Over the next few weeks, I slowly pulled myself out of the morass. Dad made certain I ate and slept regularly, and we drank tea together at night while we watched NCIS reruns. I saw a therapist weekly; Dr. B had increased my anti-depressants. After Christmas, Dad and I flew to Sanibel Island to see my old friends Esther and Steve. Unfortunately, I had developed a severe post-concussion headache, and Dad contracted pneumonia, so I didn’t get the break I had hoped for. After we returned, I developed trouble parking my car—I couldn’t adequately assess the space needed and would end up with five feet in front of the car and the rear hanging out. There were other issues identified on neuropsychological testing, enough that I qualified for disability under my insurance policies, which were specific for the practice of emergency medicine.
It was a great relief to not have to be a doctor; I was in no shape to do so, and it felt good to be able to acknowledge that. But I still had some serious work to do. I needed to understand what had happened here, and I had to figure out what to do with the rest of my life.
Entry 2

Review of Systems

**Organized in a head to toe sequence. Symptoms that relate to the chief concern should be included in the HPI as pertinent positives and negatives.**
ROS

Patient is unable to cooperate. Review based upon last office visit with her primary care physician, two weeks prior to today's admission.

Head: occasional non-migraine headaches, no dizziness

Eyes: Lasik surgery, no history of glaucoma, no change in vision, no eye pain

Ears, Nose, Throat: No tinnitus, rhinorrhea, sore throat or trouble swallowing

Chest: No shortness of breath, cough, or chest pain

Abdomen: No pain, no nausea, vomiting, diarrhea, Blood in stool. Heartburn relieved by antacids

Genito-urinary: Post-menopausal. No pain with urination. History of interstitial cystitis

Neurological: No history of seizures, weakness, confusion

Psychiatric: Major depressive disorder; anxiety. No hallucinations

Musculoskeletal: intermittent back pain/sciatica.
Chapter Two

Narrative in the Review of Systems

As medical students and residents, we spent a great deal of time asking the questions that comprised a head-to-toe review of the patient. Today, we give patients a checklist to fill out themselves, a list we barely glance at as we concentrate on what we have already decided is important.

Data is paramount for reimbursement—a certain number of bullet points and systems must be included in the electronic medical record to meet Medicare/Medicaid requirements. In emergency medicine, this conflict between good medicine and profitable medicine is particularly evident. When a patient with chest pain comes into the ED, the doctor reads their EKG and reviews their lab tests to diagnose a heart attack, begins treatment with aspirin, nitroglycerine and morphine, notifies the cardiac catheterization lab, and has the patient ready for them in less than thirty minutes, none of which requires knowing that the patient has been troubled by hemorrhoids in the past or that he had an appendectomy. However, without a documented ten-system review, that physician and, more importantly, the hospital, will be paid half of what the encounter is worth.

In the right setting, an appropriate review of systems can be invaluable. There are stories behind every bullet point, stories that identify each patient as a real flesh and blood hu-
man being. The fear of malignancy, the loss of a miscarriage, the dimming sight and sound of old age are all there, but no one listens.

Traditional Western medicine increasingly discounts narrative in favor of those data points. Many physicians are uncomfortable with this approach but feel powerless to effect change. I never thought much about it until my hospital admission, where I discovered that none of my stories were told in the review of my body. There was no sense of me as a person.

Near-sightedness, diagnosed in first grade when I couldn’t read the blackboard, doomed me to pre-teen years wearing those pink cat-eye style frames and enduring the inevitable bullying, but that’s not in the ROS. Neither is the thrill when, an hour after LASIK surgery I looked across my bedroom and saw something I had never seen before—the time on the alarm clock.

Drinking antacids like water while caring for cardiac arrests or major trauma isn’t there either in the checked box for heartburn.

“Interstitial cystitis” doesn’t include peeing that felt like passing broken glass, unless I laid spread-eagle on the bathroom floor with a mirror angled just so to do weekly bladder washes with stinky DMSO, cortisone, bicarbonate, and lidocaine. Being terrified to have sex because it hurt so much isn’t there either.

Menopause in my early forties is there, without acknowledgment of facing the loss of the chance to have children.

All those stories, and a hundred others, played a role in bringing me to this bed in this hospital on this day. They remained untold.
The stories in the ROS contain the humanity of patients. The business side of medicine tries to make those stories irrelevant, reduced to standardized check boxes. When we don’t hear them anymore, we lose a valuable piece of the doctor-patient relationship—the opportunity to know more about the person than simply their illness.

Looking at my medical record, I realized that this loss of narrative had reduced my life to an emotionless, formulaic, and generic story. I began to wonder, if I were the doctor I truly wanted to be, what I’d like to know about myself as a patient. Perhaps by learning about the events and people that had led me to this ICU stay, I could understand my story, and creatively look for a way out. This is my version of my medical record.
Entry 3

Past Medical History

The PMH is in list form and brief. Use chronological order in each category. Include medical and surgical illnesses, injuries, hospitalizations, medications, allergies and immunizations. Include employment history and family and social history under separate headers.
**Medical History:**

Pyelonephritis 1985

Recurrent thrombosis right arm

Hypertension

Depression

**Surgical History:**

Appendectomy 1985

Microdiscectomy 2002

First rib resection 2006

**Employment History:**

Emergency Medicine physician

Medical School: University of Pennsylvania, 1983

Internship: University of Pennsylvania, 1984

Residency: University of Connecticut 1984-1988

Fellowships: Texas Tech, Lubbock, Texas, 1989-90, Buffalo Children’s Hospital, Buffalo, NY, 1991, Columbus Children’s, Columbus, Ohio, 1992-1994

Board Certified in General Surgery, Surgical Critical Care, and Emergency Medicine
After the closing of Philadelphia General Hospital in 1977, the Philadelphia Veterans Administration Medical Center served as the primary training hospital for the city’s many medical schools and residencies. Located between my third-floor two-room apartment and the University of Pennsylvania School of Medicine, the VA sprawled like a burnt-out junkie over the block behind the Baltimore Avenue trolley barn, across the street from the empty lot where PGH once served Philadelphia’s indigent. This was West Philadelphia, home to Wilt Chamberlain, the MOVE burning, and a thriving drug trade, but during medical school, once I crossed the tarmac around the trolleys, I was safely enveloped in the brick and ivy walkways of Penn. I walked past the Biochemistry Research building and its pond filled with ducks and onward to the doorway of the main hospital. In contrast, going to the VA required a right turn at the trolley barn and a dangerous trek past an abandoned cemetery with crack vials and used syringes crunching underfoot.

I was twenty-six years old, divorced for a year, and had graduated from medical school two weeks earlier. On July first, like every other new doctor, I began my first year of training in general surgery, called internship. After internship, I would have four more years of training, called residency, and two more years if I did a fellowship in a sub-specialty of
general surgery like pediatric surgery. All that was a long way off. Mostly I was concerned about not killing anyone during my first week as a physician.

My team included a chief resident, Andrew, in his fifth year of training. He was tall and thin, and planning a career in plastic surgery. His obvious hair plugs provided us with something to stare at when he lectured us. Sam, a fourth-year resident, was dark and stocky, and rumored to be an excellent teacher. The other intern, Tim, had studied at another Ivy medical school, and was Jamaican with a full Afro and a neat beard. We two interns were responsible for all forty surgery patients on the wards and another five to ten in the Intensive Care Unit. We were on call in the hospital every other night.

The Penn residency was hierarchical and rigid, a system that had been in place since the days of the Agnew Clinic in the late 19th century. Interns and junior residents were beneath notice and expected to rarely leave the hospital. There was no sick time—you were at work unless you were a hospital patient. Personal time didn’t exist, either; one resident missed her father’s funeral because no one would cover for her in the SICU. Our only free time was from after rounds on Saturday, usually around one p.m., and Monday morning at five a.m., on the one weekend we had off each month. Most of us slept the entire time.

Tim and I were categorical residents—guaranteed only two years of training, after which we’d have to find another spot at a different program. The Penn system gradually eliminated two-thirds of its fifteen residents, ending up with only five chief residents per year—what was referred to as a pyramid system. The competition was intense among those wanting to stay. Since Tim and I were already identified as expendable, we got the worst possible rotations as interns, months spent doing only floor work at the VA or the Children’s Hospital. One of our cohorts spent nine months over two years on the cardiothoracic service at Chil-
dren’s, and never saw the inside of the operating room. There was no effort made to educate
categorical residents.

Andrew and Sam operated all day and Tim and I did the routine work of patient care we called scut: orders, labs, and dressing changes. There was no support staff at the VA; no phlebotomists, IV teams, or EKG techs. Interns were viewed as cheap labor, so we drew all the blood, started all the IV’s, hung transfusions, and did the cardiograms.

Rounds began at 6 a.m., so Tim and I arrived by 5 a.m. to collect data and draw blood. Vets often had poor veins, either from prolonged illnesses or drug abuse, so Tim and I developed the “VA stick.” We accessed the radial artery, a reliable high-pressure vessel at the wrist and drew an arterial blood gas, blood cultures, routine labs and 2 extra tubes just in case. It was a lot of blood, but it covered all the possible tests the chief resident might want and would save us having to go back and draw more blood. The facts that it was painful and had a definite rate of complications didn’t matter if it saved us a few minutes. We briefly felt guilty, but no one cared how we got the blood, and we were in survival mode.

For a cardiogram, rubber straps secured thin metal plates with an alcohol pad underneath to the legs and arms and the chest leads were metal cups held on precariously by suction via a crumbly red rubber bulb. A continuous paper strip was produced, one lead after the other, until all twelve standard tracings were obtained. The quality was as variable as our interpretation. We cut a sample piece and taped it in the notes then rolled the rest up, clipping it to the chart for anesthesia to read.

We then walked around, seeing every patient with Andrew and Sam, making a list of everything we had to do that day while the senior residents operated. We wrote simple orders—soft diet, stop furosemide, do chest x-ray—as we went along. Next, we start-
ed/restarted IV’s, changed dressings, and did the more complex orders like parenteral nutrition, which required mathematical calculations of individual electrolytes, vitamins, and protein for pharmacy to add to a sugar solution for each separate patient.

At noon we headed to the lab where our morning lab results were filed in vaguely alphabetical fashion in tattered old shoeboxes. The afternoon was for admissions—histories and physical exams, more IV’s, blood draws and EKG’s, then a 4 p.m. trip to the lab followed by a visit to Radiology, where we organized all our patients’ films on a light board for viewing.

If we were taught anything about surgery it was only by accident. Mostly, we were the ancillary workers the VA would otherwise have had to hire. We became master sleuths and manipulators of the VA system and also accomplished liars when the need arose. Tim and I became co-conspirators in our plots against the patients just to get through the work. We discovered creative ways to survive. Tired of being yelled at every morning because our ICU patients had elevated pulses, we gave every one a small dose of medication to slow their hearts down during rounds. We started new IV’s every afternoon to limit the number of times we got called at night because one fell out. We looked the other way when our patients with chronic pancreatitis scored dope in the basement because they slept happily all day and took wonderful care of their IV lines. We would do anything to simply get by.

Tim and I hated the VA. We felt used by the government that was supposed to be providing care for these men damaged by Vietnam, but instead had their care designed and given by the least qualified people. As a black man and a woman, we learned quickly that “intern” was an even lower spot in the hierarchy of our world. We were abused by our residency system that taught us nothing and asked us for everything. We were hungry and ex-
hausted, not to mention scared of making a mistake that might harm a patient simply because we didn’t know any better. Asking questions was a sign of weakness, they said, and so we swallowed our doubts and did as we were told, or made it up as we went along.

Surgery was usually finished between 5 and 6 p.m. There were no elective or emergency cases done after 5 p.m. or at night; there was no OR staff. Andrew and Sam met us in Radiology, then we proceeded to make rounds on all the patients again, ending up in ICU around 8 p.m. with the post-operative patients and a new list for the on-call intern to finish by morning.

Andrew was a difficult chief. If we obtained forty-four pieces of information rather than the forty-five on our list, Tim and I heard about it in painful style. There was no credit for spending time with patients; only data mattered. It was much later, as a chief myself, that I realized Andrew was terrified by how poorly he was prepared for the amount of responsibility he had been given. He was trying to provide adequate care in an impossible system by controlling everything. I recognized and identified with his style, ignoring the fact that I certainly didn’t like working for him.

I cannot recall a single story told to me by a VA patient; I’m certain I never had time to hear one. Tim and I barely had the opportunity to acknowledge that there was something terribly wrong, and that we only had each other to rely upon. The vets were just more work waiting to be assigned.

Sam tried to find the time to teach us; he found a few small procedures we could do under local anesthesia, like varicose veins and small lumps and bumps. He helped with the scut work when he could, but he had his own responsibilities, including his own operations to
perform. He needed a certain number and type of cases to be eligible for the Surgery board examinations, and the VA was the place to perform the larger and more difficult ones.

One morning, Tim forgot to order blood products for the patient having the first operation of the day. He had worked the prior day, then the entire night, and this one thing had slipped by him. Anesthesia cancelled the case, even though the need for fresh frozen plasma was nil, and would not reschedule it for later in the day (they went home at 3 p.m.). Andrew was furious. He berated Tim until Sam stepped in and Tim escaped to a different floor, where I found him later, in time for us to do more work.

Because the patient’s surgery had been cancelled, he now needed a tube placed through his nose to empty out the contents of his stomach. In the days before routine CT scans, his upper GI contrast study had shown a mass at the exit to the stomach, completely blocking it, and Andrew and the radiologist believed this was a cancer of the stomach itself. He would vomit repeatedly without the tube.

Tim and I admitted to each other that we had never actually placed one of these tubes ourselves, although we had a general idea of how to do it. “See one, do one, teach one” was our chief’s motto. We gathered our supplies and approached the patient. The tube was clear plastic, about the diameter of a pencil, five feet long and marked with black lines for placement. We lubricated the tube and gave the patient a basin in case he had to throw up. It was easy to stimulate the gag reflex if the tube entered the trachea instead of the esophagus.

The tube went in the patient’s nose and Tim fed it gently around the C-shaped sinus cavity and into the back of the man’s throat. I then had the patient drink water through a straw, hoping that the tube being advanced by Tim would be carried into the stomach along with the liquid. It didn’t work.
The patient gagged and retched. His false teeth flew out into the basin—we hadn’t thought to ask about dentures—and then he began to vomit, not stomach contents, but stool, actual formed, smelly feces. Tim and I were shocked, scared, and nauseated. In panic, we looked at each other and ran out in the hall, followed by the awful stench, skidded around the corner and collapsed in the alcove that held the restrooms. We had no idea what went wrong. Had we somehow perforated his colon? Was the colon even near the stomach? On the floor, wrapped in each other’s arms, the horror of the entire VA situation and our internship overwhelmed us, and we both cried, big wrenching sobs of misery. Suddenly, Tim said, “False teeth,” and we began to laugh until we were exhausted.

We cleaned up and found Sam, who expertly placed our tube in the good-natured patient, then took us to Radiology. We reviewed the upper GI study with the radiologist after Sam told him about the unexpected finding, and soon it was apparent that the man actually had a colon cancer that had eroded into his stomach, making a large opening into which the colon emptied its contents. Surgery was rescheduled for the next day.

Sam, perhaps the one decent resident in the entire program, said, “Home. Give me your lists and I don’t want to see either of you until tomorrow at five a.m.. Get out of here.”

A writing professor asked me years later, “What happened to the patient?” I didn’t know; Tim and I rotated off the service the next week. Longitudinal care didn’t exist; we never received any follow-up information, nor had the time or capability to find it.

Physically and mentally exhausted as interns, we were caught in the residency system, too tired and too afraid to challenge what we experienced. I was driven to succeed and self-critical when I wasn’t able to keep up with the work and hours, especially because this was used to perpetuate the belief that women weren’t tough enough for surgery. I bought into
the idea that we needed to work long hours to see all the cases and learn how to care for people even when we were too tired to care for ourselves. I accepted that caring meant getting the data, being decisive, doing the operation, and moving on to the next case. I would be strong; I would survive. The patients were incidental.

Now, I realize that those vets had wanted to tell their stories, and I regret that there was no time to hear them. I would have learned so much more about people, about healing, about myself, if I wasn’t so busy finding that normal potassium result for rounds. When I look back, I am angry at a system that treated both the patients and the residents as expendable.
The sky of South Philadelphia filled with flames. The neonatal unit of Children’s Hospital of Philadelphia faced the junction of the Schuylkill River and Interstate 95, where the oil refineries sat, burning off waste gas twenty-four hours a day. That section of town was dirty and smelly, but seen from the sixth floor of the hospital, it was eerily beautiful, with blue, orange, and yellow tendrils jumping against the black night like a greasy aurora. I had been a doctor for six months, and I began my mornings now in a room full of critically ill babies, staring out the windows at the fires.

“Baby Pond, TEF, day 8. Weight 3.45 kilograms, up 10 grams.” The surgical resident stood over the tiny raised bed and began to recite the litany of data involved in the care of an infant that could not eat or drink.

“Total parenteral nutrition at 15 cc’s per hour. Intravenous fat emulsion at 2 cc’s per hour. Carbohydrate calories at 100 kcal/kg/d and protein intake of 3 grams per kilo per day.”
Baby Pond had been born with a tracheo-esophageal fistula; that is, her milk went from her mouth into her lungs instead of her stomach. She would need surgery, but had to weigh five kilograms first.

“Urine output 2 milliliters per kilogram per hour. Oxygen saturation 97% on 2 liters via cannula.”

The day at Children’s Hospital of Philadelphia began at six in the morning, here in the neonatal intensive care unit, where infants were either being prepared for or recovering from surgery. The only lights were low wattage goosenecks clipped to the glass sides of the bed, aimed at the nursing clipboard hanging down below. Monitors beeped at the very edge of human hearing. These babies did not tolerate stresses like bright lights, noise, or even touch; their heart rates would drop and their oxygen levels fall at the slightest disturbance. I would often feed the older babies at night when I was on call, but these infants couldn’t eat or be held. Residents whispered a lullaby of Latin and Greek—omphalocele, gastroschisis, duodenal atresia—words for something gone terribly wrong in utero, as we stealthily moved from bed to bed.

“Baby Morse, malrotation. Weight 4.2 kilograms.”

“Baby Anderson, imperforate anus. Weight 3.9 kg.”

As the intern, I had little direct responsibility for the care of these patients. My job was to gather the data and do the mathematical calculations of caloric and fluid intake and output twice a day. By the time rounds began, I had already been at work for an hour, copying information by flashlight from the nursing notes at the bedside and synthesizing it into the standardized format for the senior resident to present to the fellow. Then I took my place
at the rear of the group of fellows, residents, and medical students, straining to hear as they made decisions and plans for the day ahead. Mostly I looked out the windows.

I don’t know why I was comforted by this post-apocalyptic landscape. Before me were babies dependent upon tubes and machines for life, indistinguishable except for their congenital abnormalities. Without their families nearby, they seemed industrialized, small components in the factory of human life, reduced to a recitation of emotionless facts and numbers. We were so limited in our abilities to treat their illnesses, and these patients so fragile that even touch was forbidden. But outside, the flames were alive, writhing, beautiful.

It was that contrast, I think, that drew me to the windows. Each of these babies had a flame inside them, turned down so low as to be invisible. Did I imagine them whole and healthy, burning brightly, unfettered by lines and tubes? Or was it the juxtaposition of the small and weak against the large and powerful? More likely, I was exhausted and sleepy, and liked looking at the patterns burned by the flames in the sky.
I left Penn after that first year. Now I was in my third year of surgical residency at a busy community hospital in Connecticut. I was on call when a patient with gangrene needed an above-the-knee amputation, and it was my case to perform as surgeon with the assistance of the attending doctor. Amputations are not finesse operations, but it’s important to do them correctly to comfortably fit a future prosthesis.

I made the traditional incision—shaped like a wide fish-mouthed smile with the lower jaw hanging open—in healthy tissue well above the dry-rot blackness. There was very little fat, and I divided the muscles, tapering them to provide padding over the end of the bone. I ligated the artery, vein and nerves to the lower leg, making certain the artery was both stitched and tied closed. Bleeding here could be fatal. Finally, I cleared a section of the femur for the final step, scraping off the periosteal fiber protecting the bone itself with a chisel-like instrument called an elevator. The attending surgeon refused to let me use the power saw ("No special treatment because you're a girl"), and so I stood on a high stool to use a fine-toothed flexible saw like a garrote to cut through the body's densest bone. As I pulled back
and forth, bits of bone dust, marrow and blood flew from the wound and spattered my mask and gown as the saw crunched and ground its way through the cortex, the central cavity, and cortex again. With every tug and pull of the saw, I felt a knife-like pain jabbing into my right side and swallowed the bile rising in my throat. I thought I might pass out, but the leg finally dropped into the waiting biohazard bag. I filed the rough edges of the femur until smooth, then closed the flap of muscle and skin over the raw bone.

That same day an East Coast hurricane pounded central Connecticut; the hospital was running on auxiliary power. Later that night, after vomiting for hours, I called the chief resident and told him I thought I had appendicitis. I had an appendectomy while the wind and rain rattled the hospital windows and flickered the lights.

I was discharged the next day. My surgeon asked, "Who will help you at home?"

"The same person that always does," I replied. I had been a resident for eighteen months and no one had ever shown any interest in how I managed my life as a single woman. There was no interest in my personal narrative unless I was a patient, and even then the concern was more academic than real. What really mattered was how soon I could return to work.

I found my bedroom covered in shards of glass, the furniture dripping rainwater on the tile floor. The window in my apartment had been shattered by the storm.

I cleaned it up myself.

Afterward, I developed a high fever and the shaking chills we call rigors, because your muscles contract so much that you are rigid with pain. It was a kidney infection, and I was back in the hospital for intravenous antibiotics, missing more days of work.
My fellow residents were unhappy about more call. I understood their feelings; they were exhausted, too. After all, illness was another weakness, another way to fail.

We’d normally allot four weeks for a patient to recover from an open appendectomy plus another two after sepsis, but I had to prove to them all that I could contend with anything, so I struggled to get back to work in a week. When I could not physically stand in the OR, I finally took time off to go home to Pennsylvania to recover.
“Well, young lady, what are you gonna’ do now?” asked the Chief of Surgery in his slow West Texas drawl. “You got yourself a good one here.”

I had finished my general surgical residency and gotten remarried a short ten months earlier; the job at Tech was my first independent position. The Chief decided that I could do all of his vascular operations—he hated them—and I had picked up one of his patients the day before.

Mr. Walsh was a true West Texas rancher: short, sinewy, hard-working. He came to the hospital because his leg went dead and he couldn’t stand up to bale hay. He was so thin that the ED doctor immediately saw a large abdominal mass and consulted Surgery. The Chief turfed the patient to me.
By the time I met Mr. Walsh, he had had a CT scan of his abdomen which showed a very large aortic aneurysm, a balloon-like weakness in the body’s major artery caused by atherosclerosis. Pieces of the hardened cholesterol deposits and flakes of calcium broke off and blocked the arteries to the feet and legs, causing weakness. The progressive decrease in blood flow lead to pale, cool, and hairless legs, and would eventually cause gangrene. Worse, a symptomatic aneurysm had good chance of rupture which meant instantaneous death. Mr. Walsh needed an operation. Now.

“You can send him to Dallas, you know,” the Chief said, “if you’re afraid to do the operation.” I didn’t know how to interpret this offer; surgeons were never afraid, and I briefly worried that I was being set up to fail, one way or the other. Would he have said the same thing to a male surgeon? I knew I had the technical expertise to do it, but I also knew it would be a challenge for even a more experienced surgeon. Part of me suspected that I was not this man’s best hope for a good outcome, but there was no acceptable way to express this without impugning my courage or disparaging my gender.

“Let me see what the anatomy is first; then I’ll decide,” I said.

“Don’t dilly-dally. That thing can blow anytime. Then you’ll be in a real pickle. Might as well get a shotgun and shoot him—less suffering that way.”

The procedure, although harrowing, was straight-forward. A tube graft was sewn into the normal aorta above the aneurysm and into either the normal aorta or normal iliac arteries below. The tricky part is cross-clamping the aorta so you can sew, wiggling the clamp through the connective tissue binding the aorta to the delicate vena cava along its side. One places the clamp below the arteries to the kidneys; they do not tolerate interrupted blood flow and will break down quickly. However, the lower extremities can go without blood for about
thirty minutes. I had performed a dozen of these operations successfully, but this one was
going to be different.

Mr. Walsh’s CT scan showed that he had only one kidney. Instead of being in the
upper back section of the abdomen, the lone kidney was down in the pelvis, obscured by the
aneurysm. We would need to do an arteriogram—contrast dye placed directly into the aorta—
to see which artery and vein supplied the kidney. The dye itself can be dangerous to renal
function; we had to be very careful in our pre-op evaluation, too.

Mr. Walsh sat in bed, looking concerned; no one had really spoken to him yet. I
introduced myself, then said, “Mr. Walsh, what did you think about this big lump in your
belly?”

“I thought it was cancer,” he said. “I didn’t think anything could be done about it. You
sure it’s not cancer?”

Painstakingly, with drawings and X-rays, I explained what he had, and the
complication that presented itself. I made certain he understood that the operation had some
risk of death, and a high probability of damage to the kidney, which would mean dialysis. I
offered to send him to Dallas.

“No,” he said. “You sound like you know what you’re doing. I been here in West
Texas my whole life. I just want to get back to work.”

This was unusual for me—talking at length with the patient, discovering their fears
and hopes. It was not how I had been trained. We often joked that surgical consent was
telling the patient we were going to “find out what’s wrong and fix it.” I had already learned
through residency that I wanted to practice differently. A complex aneurysm, although scary
for me, was much more acceptable to the patient than a diagnosis of cancer. He trusted me,
not because I had the best skills, but because I was there, explaining to him the difficulties and risks involved.

So I returned to the Chief’s office to figure out how to do this operation. The arteriogram showed that both iliac arteries and the sole artery to the kidney came out of the aneurysm wall. All three would have to be implanted into the graft. I brought in another vascular surgeon and a renal transplant specialist to assist me in the case; I was not so arrogant as to believe I could to this alone. The transplant doctor would treat the kidney like a donor one in a transplant. By circulating a specialized cold oxygen-carrying fluid though the severed artery to the kidney, he could prolong the time I had to sew—we hoped. This auto-transplantation procedure had never been done before, and required additional consultation with anesthesia, who would manage the blood loss and metabolic changes associated with the plan and have to deal with no urine output.

Mr. Walsh was just happy he didn't have cancer, and listened to our technical chatter with amused resignation. “Jest do your thing, Doc. I’m not worried.”

We began the operation early in the morning. Mr. Walsh’s lack of fat made the anatomy clear. The aneurysm was ten times the size of the normal aorta, and the iliac arteries and the renal artery arose from the front, where we could easily see them. Everyone was ready. I clamped across the aorta easily; no renal arteries or veins in my path. Then I removed the renal artery from the kidney with a healthy circle of aneurysm wall and the transplant surgeon attached his catheter infusion system to that end. We clamped the leg arteries and opened the aneurysm, cleaning out the old clotted blood, glistening pieces of cholesterol and crunchy calcium deposits until we could see the openings into normal aorta. My partner and I worked together on the proximal anastomosis of our Gore-tex graft to the upper aorta, sewing
rapidly with near-invisible nylon suture, then I punched a tiny hole in the graft and sewed the renal artery to the graft. We moved the clamp below this new junction and began to work on the legs. The anesthesiologist let us know our patient was making urine, a very good sign. Quickly we restored blood flow to the legs, closed the aneurysm wall over the graft, and finished the case. Exhausted and amazed, I reported in to the Chief. “Hell, girl,” he said. “I never would have done that case. That was something.”

Mr. Walsh’s kidney function remained normal, and six weeks later, he was delighted with his warm feet. “You sure it wasn’t cancer, Doc?” he asked. I assured him it was not. “Know the best part?” he said. “I got hair on my legs for the first time in years.”

I had been proud of myself for doing this complicated case, but that didn’t matter to my patient. It wasn’t that he didn’t appreciate what I did, he simply viewed it differently. What was important to him was that he didn’t have cancer, and now had hair on his legs. I began to see that the patient’s narrative was not the same as mine, and that it was unfair to expect it to be so. We had a bond, a successful interaction, not only because I was a talented surgeon, but because we had listened to each other’s stories.
Narcissistic personalities succeed in high-pressure, high-stakes careers, and medicine is a perfect example. Patients appreciate absolute confidence. Believing that the rules of society apply solely to lesser mortals is the downfall of some of them, but not until they’ve managed to create misery for others. My very first ED director, a mild-mannered middle-aged guy, lost his license for fondling women during employment physicals. Another got both his wife and girlfriend pregnant, and the women gave identical names to the baby boys born two weeks apart. One day as I frantically tried to call another married director to help with three teen-aged trauma victims, I learned he was on the phone with his girlfriend—the triage nurse. They had a good laugh about why he was unavailable as I watched a boy die. It was standard for some directors to take prolonged breaks during shifts, accompanied by a nurse, in their offices or cars, leaving the other doc to see patients. Finally, there was my married director in New Mexico that was having an affair with the nursing administrator from our department, effectively sabotaging my employment.

Pediatric surgery was the most demanding, most competitive, and most difficult of all surgical subspecialties, and of course, the one I chose, thinking hard work and talent would help me obtain one of the few available fellowships. The matching process for pediatric surgery was held two years in advance of the start date; very few surgeons were qualified to
get a position before they had done another year or more of research after five or six years of general surgery.

I turned down a prestigious trauma fellowship at Baltimore Shock/Trauma to join a pediatric surgeon in West Texas that specialized in ECMO—extracorporeal membrane oxygenation—a high-tech technique to bypass an infant’s heart and lungs until they were strong enough to support life. During that time, I assisted on the pediatric operations and did adult cases once a week. I studied for and passed my written and oral boards in general surgery and obtained an additional certificate of added qualification in Critical Care. Peer-reviewed journals published my research, and I presented papers at national conferences.

Unfortunately, my boss was a first-class narcissist. She viewed her fellow as an extension of herself; no contrary opinions were tolerated. She had trichotillomania—that is, she pulled out her hair and eyebrows—often a sign of obsessive-compulsive disorder. Her imaginary children visited only when I was out of town. On every holiday, she found a baby, usually from Mexico, who needed ECMO; all of the nurses and I were called to work. She didn’t like me covering adult surgery, going so far as to tell other doctors to take over my on-call cases the next day. Eventually I discovered that she was angry that I was not interested in a personal relationship with her.

Living in Texas was a dramatic change for someone raised in the East. Gun culture and fundamentalist faith both confused and frightened me. My fellow general surgeons were a bright and hard-working bunch, and they made my time there as enjoyable as possible and tried to protect me whenever the pediatric surgeon went on a rant.

During my second year, I applied for a position as an official pediatric surgery fellow. This involved travel across the country to all sixteen programs, all on one’s own time and
expense, and within a three-week period. It was exhausting. During this time, my second husband and I divorced; my random schedule and prolonged travel challenged his accountant’s view of the world.

I didn’t get a fellowship that year, but was second on the list at a Northeastern program, and was invited to spend another year there in research, with the understanding that I would get the fellowship the next year (to begin two more years in the future). I packed up again and moved to upstate New York, where I met the narcissist that destroyed my self-worth, and my dreams with it.

Dr. X had it all: director of one of the country’s oldest training programs, Surgeon-in-Chief of an excellent children’s hospital, two fellows, three research fellows, and a staff of talented surgeons. He was charismatic and enthusiastic, and offered me rent and a barely livable salary to join the department as a clinical (unaccredited) fellow. I settled into a first-floor apartment in a stately old house within walking distance to the hospital, since the promised carriage house was unavailable.

Dr. X, it seemed, had a penchant for telling each person what they wanted to hear, then lying about it after. I found this out when my landlord asked me for my moving date. I had no idea I was moving, and asked my director’s secretary about it, who took me to see the carriage house. It was a single room with a galley kitchen, as small and spare as a college dorm room, suitable for a visiting student for a few weeks, but not a place for a surgeon with furniture and a dog. We eventually worked out other arrangements, but the bait-and-switch tactics persisted. Dr. X soon informed me he was moving to Ohio to be chairman of the department in Columbus and hoped that I would move there as well, and wait another year for a fellowship. I believed that I had no choice, and moved again.
The head of the ECMO program in Columbus was a brilliant surgeon who had a fully-staffed pig laboratory for research, and we soon became (and remain) friends. He and another senior surgeon were often in conflict with the director over financial issues; I knew there were tensions in the department but didn’t see how they would affect me.

I re-interviewed for a fellowship that year, this time only at programs that I knew had looked favorably upon me two years ago. Both applicant and hospital ranking lists were supposed to be anonymous, and I naively had no idea this wasn’t true. Although I did get the fellowship as promised, somehow the director discovered that his program had not been my first choice. Things got ugly quickly.

For a year, I had been doing an occasional ED shift—moonlighting—to earn some extra money. This soon became an issue with the director. I found my office ransacked on several occasions, with research data removed. I missed an important presentation because I had never gotten the notice. Suddenly, the director never had time for me; I would sit by his office for hours while his secretary made excuses for his whereabouts.

My research mentor and his partner had developed serious ethical issues with the chief and elected to leave the department and form a private group. They would still be affiliated with the children’s hospital, but would act much like competition. The chairman declared war.

The current fellows were told they could no longer work with those two surgeons. This had impact on their number and variety of cases, and also meant that my friend and his partner needed to sleep in the hospital every other night. The fellows were not about to directly challenge the director and risk their status, although they occasionally did secretly help out the private group.
My research from my first year was abruptly stopped; I was informed that they would find something else for me to do, although exactly what was never discussed with me. I finally had a meeting with the director and was asked to write a letter to the Association of Pediatric Surgeons informing them that my friend’s research had been fabricated and request that they deny him membership. I refused.

I discussed with my friend and his partner what I should do. They advised me that they had heard from the fellows that my offer for training was going to be rescinded, and thought I should simply do something else for a year and return as scheduled for the fellowship. Later that same day, I received a letter from the director revoking my fellowship.

After a legal battle, I received a cash settlement, but no fellowship. I had spent four years of my life on this road, and it was time to get off.

The year after I left the children’s hospital, one of the director’s patients needed an emergency operation while he was unavailable, and another surgeon took the case and found an old sponge from a prior operation causing an intestinal obstruction. A lawsuit followed. Discovery revealed that the sponge count at the original operation had been incorrect, and an X-ray had been taken and looked at by the chief. Unfortunately, the film was missing from the file room, and had never been officially read by a radiologist, so the case was settled out of court.

Two years later, after Dr. X had left for another position, a fellow found the X-ray behind the sofa in his former office. He had known all along that he left a sponge in the baby’s abdomen.

His death from pancreatic cancer a few years later went unmourned.
I briefly tried private practice in surgery, but my heart wasn’t in it, and I had begun to distrust everyone. I moved back to Ohio and full-time emergency medicine.
Columbus, Ohio, 1996

I walked to the doorway to Room 12 where a small child was screaming in terror. Her parents looked frightened, tears running down the mother’s face as she tried to console her daughter. “Arm pain” read the chart, and I smiled. Let the show begin.

In 1995, disillusioned and dealing poorly with the responsibility of being a doctor, I left the practice of general surgery and transitioned to Emergency Medicine. My boyfriend at that time lived in Columbus, and so I returned to Ohio.

The single most satisfying thing I did in emergency medicine was reduce a nursemaid’s elbow. Because the bones and ligaments of a child are not fully formed, a sharp tug on the outstretched arm of a toddler can cause the head of the radius (forearm bone) to slip out of place. The ligament gets trapped, locking the elbow straight. The child screams and won’t use the arm; the parents are convinced it’s broken, and the family tumbles into the emergency department in panic mode.

Nursemaid’s elbow is a doorway diagnosis; the child holds the injured arm in a distinctive, easily recognized way. No X-rays are needed, and the techniques to relocate the ligament and bone are simple. The art, the skill, the story, is in how you approach the distressed child and the anxious parents. It’s all about narrative.
I could just barge in and yank the bone back into place, but that’s no fun for anyone, and the child has already learned to distrust white coats. The parents don’t want their child to endure any more pain, either. But a lot of doctors are of the “rip the band-aid off” school, knowing the hurt will be over in a few moments. I’d try to do better.

I knew that best way to calm a child is to calm the parents. So I let the parent hold the child in her lap while I introduced myself and began to tell them what I was going to do. I then gave all my attention to the screaming child, and told her a silly story in a happy tone of voice. This didn’t distract the little girl, but the parents started to believe I loved children and would never hurt their baby unnecessarily. The child felt her parent relax, and calmed down a bit. I continued in my sing-song voice, and examined the toddler’s doll, then her knees and the other arm and fingers. By the time I got to the injured arm, everybody, including the child, was following along with interest. Next I examined the involved hand and shoulder, staying far away from the elbow. Finally, I quickly slipped my thumb over the dislocated head of bone and gently bent up the forearm and rotated the hand while keeping eye contact with the child. There was a pop felt when things returned to position, and the parent heard the click of successful reduction. The child thought about screaming again, and I slipped out the door, indicating to the parents that I’d be back. Five minutes later, I peeked into the room, where the child was happily using the arm and the parents were smiling. I felt like a superhero while I explained to the parents about what just happened, and that no further treatment is needed.

This is the beauty of medicine, when education, experience and skill click together like the tumblers in a safe and the door swings open, revealing the tiny miracle of an actual
cure. These moments, unsullied by doubt, remind me why I became a doctor. I wish my days were all filled with stories of nursemaid’s elbows.
Now married to my third husband and working in Ohio, I had been home from the night shift for only a few hours and was dead tired. The night before, Coco the chow had bitten Jellybean the sheltie who needed to go to the vet, and as I changed my clothes to take her, I noticed my arm felt slow and heavy, with a dull ache. I thought about ignoring it, seeing if it would go away, but it was difficult to open and close my right hand. Peering into the mirror, my right arm resembled a fat summer sausage from my shoulder to my fingertips. There was a line near my neck with white skin on one side, purple on the other. When had that happened? It looked similar to arms that I had seen with blood clots, but why would I have one? Effort thrombosis, clotting of the subclavian vein usually seen in baseball pitchers, required, well, effort, and I hadn't expended anything close to that. No fastballs or change-ups. Maybe I picked up a cup of coffee the wrong way.

My then husband, a nurse, had already left for work. I drove to the hospital, where it took several hours and multiple tests to locate the massive thrombus just a few inches from my heart. I watched the strands of clot waving like jellyfish tentacles in the dye stream flowing into my superior vena cava, threatening to break free any minute and cause a fatal lung embolism. For treatment, the radiologist inserted a fat tube called a cannula into the vein in
my arm and infused the clot-dissolving drug TPA (tissue plasminogen activator) directly into the thrombus for eight hours.

It was critical to make sure that I did not re-clot. The next day, after the infusion was stopped, I was supposed to start on heparin, an immediately-acting intravenous anticoagulant, and warfarin, an oral one that would take longer to have an effect. However, the heparin couldn’t be started until after the cannula was removed because I could bleed around it. The radiologist was busy, and over several hours I watched my arm turn purple again as my husband and I tried to find someone to remove the cannula and start the heparin, all of which happened too late. I would rely on warfarin and time to dissolve the clot, and hope that I did not develop the debilitating swelling and pain associated with post-phlebitic syndrome.

There was another worry, though.

Spontaneous clots mean cancer to a doctor. We call it occult malignancy—a hidden cancer without symptoms—and clots are often the way the cancer reveals itself. My doctor scanned my entire body and we repeated my recent mammogram, without finding any cancers. My blood tests for clotting disorders were all negative. There was no explanation for my illness; I was what no one wants to be: an interesting case.

I returned to work after two weeks, heavily anticoagulated and still with a clot in my arm. I had gotten the message clearly after my appendectomy—time off was for the weak.

There were things I could not do, and the orthopedist on call complained when I asked him to come in to reduce a dislocated shoulder because I was unable to pull hard with my right arm. “You shouldn’t be at work if you can’t do your job!” he said.

After six months, my arm looked normal, but I couldn't walk down the freezer aisle in a supermarket without pain as the cold constricted my subcutaneous veins. My chest was
spiderwebbed with blue collateral venous channels that bypassed the blockage. I always worried about a pulmonary embolism or breast cancer.

It was six years before we identified the cause using an old-fashioned positional dye test, and I would have the surgery that removed an abnormal first rib that squeezed the vein closed whenever I raised my arm over my head.
Many patients don’t use the Emergency Department appropriately. Even though it says EMERGENCY in big red letters, they come to us for many of the wrong reasons.

Sometimes it’s because they don’t have insurance and they know that we can’t turn them away. The ED may be the only place they can get any kind of medical care, or a sandwich and a blanket.

Sometimes it’s because we are like the 24-hour diner at the truck stop, always open. The patient with some pain during an early pregnancy, who already has her ultrasound appointment set for the next morning but doesn’t want to wait, comes to me at 1 a.m. and doesn’t mention her 8 a.m. appointment until I’m done.

Sometimes we are the after-hours extension of doctors’ offices. We get the gentleman "sent for labs per PMD" on a Sunday evening because his doctor wants him to have a test to see if his warfarin level was correct. He had a slight nosebleed after he took an antibiotic that can increase the effects of warfarin. It turns out that our patient stopped taking his warfarin a month ago and just never told the doctor who sent him in for the test. I had to explain to him
that he doesn’t need a test for a drug he isn’t taking as he got angrier and angrier because “My doctor told me to have this!”

Sometimes we are the object of TV fantasies. Patients expect that, House-like, we can just pull out a result, slap on a diagnosis, write a prescription and send them on their way, hale and hearty again, all in an hour. When a young man with a long history of IV drug abuse is brought in by his mother for fever, nausea, vomiting and dark urine, I discover that his primary doctor already did a hepatitis panel through an outside lab that I cannot access. His mother wants results now. She will not accept that the first set of results will be in tomorrow and will be sent right to his doctor and that even if I do another panel now it will only come back later than the one already being processed. I don’t need my translator to know that I am being cursed as she stalks out with her son in tow.

Sometimes we are just geographically closer. My next patient has newly blurry vision. I can work her up for a stroke and look for some ophthalmologic causes but it would help a lot to know her medical history… but that history is tucked in at another hospital and in the offices of the doctors she sees there. She came to us tonight because it was more convenient than waiting for EMS to take her across town. “You should be able to figure this out yourself. You’re a doctor,” she tells me.

It’s hard to remember that we all suffer, patients and doctors, and that most patients are not scamming but are truly scared and in pain and are frustrated themselves. I’m angry at myself when I lose patience with the rambling historian, or the patient who cannot remember his medicines and tells me to "just look it up," or the private doctor who sends in his uninsured patient for a hypertension work-up because we can’t use ability to pay as a criterion. I
feel guilty and irresponsible when I order unnecessary tests or X-rays just because the patient wants them and I imagine myself in a malpractice dock trying to explain why I denied them.

I often feel like I did when my fellow interns and I struggled through our scut lists, just moving the endless assembly line of sickness along until that shift ended and before another one began. There is never enough time. The waiting room is always full; disaster lurks outside those double electronic doors.

But then you get the case that makes you remember not just why you became a doctor but why you chose to work in an emergency room.

Midwestern farmers are tough, and my next patient was certainly that. Rangy, leathery, bulging with muscle, he'd only agreed to stop his work now and come in because his wife was worried. He'd told her to stay home because he'd be right back and drove himself to the hospital.

I glance at the triage note: “Pt. c/o flu”.

I look at the patient. He is pale under damp skin, and looks uncomfortable. He doesn't look like he has the flu.

“Can you tell me what symptoms you've been having?” I ask.

“The flu, Doc. Don't you know what the flu is?”

“Well, some people have different symptoms than others. Just tell me the story.”

“I have a fever, I ache all over, and I vomited.”

“When did this start?”

“I was shoveling hay this morning and I had this pain in my chest and I got real nauseous and sweaty and I threw up. You know—the flu!”

58
I wasn’t going to argue with him. Those symptoms meant something much more serious than the flu to me.

“Nurse, could you set this gentleman up on a cardiac monitor, please?”

Together, we watch his acute inferior myocardial infarction appear. He was having a heart attack.

I call the ICU for a bed. “We need to get him started on TPA,” I say to the nurse. That’s a drug that can dissolve a clot blocking a coronary artery, which was causing his heart attack. The drug is administered over thirty minutes; before it was even finished we could see the EKG returning to normal.

A few days later I pass him leaving the hospital as I’m coming in. “Hey, Doc” he says, “That medication you folks gave me really cured my flu!”

Once again, his narrative was not mine, but only the ending really mattered. I had ignored his self-diagnosis and asked him for his story—nausea, sweating, pain. Together we had saved his life.
Ohio, 1998

Out of the crowd came a wailing projectile—aimed directly at me. Her kick to my chest knocked me out of my crouch, and I crab-walked backwards to escape but was trapped by the wall of people in the room. Heart pounding, I curled into a ball and let my arms absorb the blows aimed at my face until a security guard forced his way to me and dragged me out of the melee.

Earlier that evening, someone tossed a Molotov cocktail into a house where a drug dealer lived with a woman and their three children. As the place lit up, the man jumped out a window, spraining his ankle, and was now in an exam room with a police escort, waiting to be seen. He would be there a long time.

The woman and her children, asleep upstairs, did not escape the house. The flames ignited chemicals stored there—a basic meth lab—and all four were not gently suffocated by smoke, but burned by the flash of the explosion. Firemen managed to carry them out of the blaze into ambulances waiting to deliver them to the Emergency Department. The mother and oldest child were dead, gray skin cracked and peeling, features melted by the heat, and (thankfully, we believed) no signs of life. But the two younger children, maybe three and five years old, still had weak pulses and so we tried to save them.

We struggled frantically, recklessly, intensely, to help those children, an ED doctor and a pediatrician for each victim. We peeled off fragments of burnt clothing fused with skin,
assessing injury, looking for a place to begin. The smell enveloped us as we worked to secure an intravenous line through swollen and charred muscle. The smell of burnt flesh is like no other odor: acrid, metallic, meaty, and primal in the reaction it elicits. It is much worse than the sight of burned bodies. You want, no, need, to run away, but there is no way out.

Fire seared the child's lips, mouth, and tongue. The tiny windpipe was swollen shut; we couldn't pass even a newborn sized endotracheal tube. We had to open the trachea with a scalpel and it was full of black soot, mucosa destroyed by super heated air. Our gloves were filthy with blood and human particulates. There was nothing more to do. The tiny bodies looked alien, no hair, collapsed eyes, skin disintegrating onto the floor. Babies born from the sun.

There was no time to reflect; paperwork waited, as did a department full of patients, most upset at the delay, a few somber and apologetic for bothering us now. I washed my face and arms and threw my dirty coat under the desk, but that smell followed me everywhere. I chewed the inside of my cheek and swallowed words made from ash as I examined, treated, and discharged the window jumper to the police. He didn't ask about his family.

Violent tragedy brings large, loosely related groups of people to the hospital. They congregate outside in the ambulance bays—sisters, brothers, friends, neighbors—and violence occasionally begets violence. Doctors prefer to talk to immediate family in a small grief room, but hospital administrators, in an attempt to appear inclusive, insist that these groups be accommodated somewhere in the hospital. That night, some forty agitated people, not searched for weapons, not limited to close relatives, were herded into the empty endoscopy suite. Someone needed to talk to them, and because the pediatricians were finishing paperwork and the other ED doc closing out his shift, I was elected. Although police swarmed
the department (I had no idea what they were all doing there), I was sent into the room with a lone security guard.

The family matron, a bird-like lady with tight gray curls, sat in a chair in the center of the group. I introduced myself and knelt next to her, taking her hands in mine, and told her how sorry I was that her daughter and grandchildren were lost. I didn't see the other daughter rush forward until it was too late.

I took a half-hour break to be examined by another physician and make a police report. At the time of the assault, I was taking the anticoagulant warfarin so my bruising was pronounced, and there was a risk of internal bleeding—I wanted this documented in a medical record.

There were patients to be seen, and I was the only physician left after 3 AM. Returning to work was not negotiable. The coffee was burned and I was too tired to make another pot. I may have eaten some candy, the sugar replacing my exhausted stress hormones, as I went on seeing patients.

When I got home, my husband was at work. I ran to the shower where I washed my hair twice, then in my ears, even up my nose. Not even my lavender and vanilla soap could dilute the smell. I admired the shoe print bruise on my chest and the stripes on my right forearm. I had to sleep because I was working again that night, but I needed several glasses of wine to grab even a few hours. Exhausted, I burrowed into the covers, only to be awakened by that smell, and nightmares of dead children.

My medical director, who was out of town, phoned that afternoon and asked me if I was going to press charges against my assailant; it never occurred to me not to do so. He told me the hospital's CEO thought it would be bad for community relations and that it was just a
cultural difference that led to the assault. I told him that I knew of no racial or ethnic group within which attacking a physician was acceptable, and that whoever believed that was the worst sort of racist, and I would be filing charges. Neither he nor the CEO asked after my well-being, or commented on the earlier tragedy. Those children, that family, my experience—forgotten already.

I had to forget, too. The assistant director called to ask me if I would be working my shift that night. He could find someone to replace me, if I was still upset, but it would be an imposition on other docs. He didn't mention the deaths. He didn't offer me time to see my doctor or recheck my warfarin level. I went back to work.

I began shaking as soon as I pulled into the parking lot, and continued to do so all through my shift, seeing as few patients as possible, asking that all visitors be removed from the rooms, standing next to the door, being hyper-vigilant. My heart raced and I took a step back from every person of color. Everything had changed; I was afraid of the patients, afraid of being in the ED. I didn't realize then that this was the onset of PTSD, and that it would get worse. And then I went home to the smell of my dreams.

There were many shifts like this, so reminiscent of my residency. No time to be ill or in pain. No time to eat, to sleep, to pee. No time to grieve over murdered children. No time to deal with the mental and physical effects of a workplace assault. No acknowledgement of the normal human responses to the awful things we saw and did and had done to us every single shift. No time to cry, to heal even a little, before the next crisis arrived. No time at all.
During the Ohio winters, my right arm throbbed painfully every day. My husband and I had discussed moving to a more temperate climate, and in 1999, I was offered an attractive job on the Gulf Coast of Florida. I had been working a series of night shifts there when the leg that hurt on the first night and felt numb on the second night now burned and throbbed like a red hot poker driven into my thigh.

“Let me stretch this out,” my partner said, moving my bent left knee over my straight right leg. I whimpered as she manipulated my spine, and when she saw tears spurting from my squeezed-shut eyes, she stopped and said, “You need an MRI.”

I thought I had a backache. Even when my left leg collapsed under me and I had to drag it around like Igor in *Young Frankenstein*, I continued to work three night shifts in a row. No one would cover my shifts for me; the other doctors were already working too many hours and the system had no plan for emergencies. Only after I leaned across a hospital stretcher to do a spinal tap on a two-month-old wriggling like a tadpole was the pain severe enough to make me lie down and wait for my partner to arrive for day shift.

Doctors don’t give in to physical weakness. The belief in a marginal benefit to our patients when we able to do our jobs overtired or ill had mutated into a demand that we never take time off when scheduled to work. I know a few doctors who worked through labor and
miscarriages, kidney stones, and heart attacks, and every doctor has ignored the flu, colds, and gastrointestinal illness. We were told by the system that there was no one to replace us, and this was true only in the fact that the system wouldn’t pay for it. Staffing was always thin, and extra hours and shifts the norm. Major illnesses were regarded as personal failings, an imposition on co-workers. Then there was the fact that if one didn’t work, one didn’t get paid. We had no paid time off or short-term disability. Illness meant working twice as many shifts when you came back in order to repay the doctors that worked your shifts and to pay your bills. The psychological pressure to never be sick was oppressive.

Some doctors would try to help other docs, but then find themselves regretting the decision. I once covered for an “emergency” that turned out to be a baseball game. I’ve been called in to work shifts because it was egg-retrieval day for a colleague undergoing infertility treatment. But I also sent a doctor home and worked a second shift after I found him crying in the break room. He had pronounced dead a young man who was a classmate of his son.

The radiologist asked me, "Does your left leg hurt?" The MRI showed an acute herniation of the disc between the L3 and L4 vertebrae, pushing on the nerve. “Hell, yes.” I said, then drove my manual transmission BMW directly to the neurosurgeon's office, cursing the clutch with every gear change. The doctor discovered that I had lost both my patellar reflex and some of the ability to extend my knee. I needed urgent surgery to decompress the nerve and physical therapy to regain the strength in my leg.

Two months earlier, my mother had died and I had taken four days off for the funeral back in Pennsylvania, and I was still shaken. Now I was looking at more time off, and my co-workers were annoyed at having to pick up my slack again. I was unhappy with myself for being imperfect, for not being strong enough to work through this issue, for needing surgery.
Of course, I was also worried about the operation and walking normally again, but those fears paled beside that of not being able to work my shifts.

I was needed back to work as soon as I could walk; I could get physical therapy on my days off. “How are you?” quickly became “When are you coming back?” I was not expected to have pain, nor allowed medication for it. My bosses and co-workers expected a miraculous recovery that they would have never have required of any other patient.

I tried to return after two weeks. I believed I should be better by then, too. But I had a wound infection, and I could not get up out of a chair easily, and after twelve hours the pain in my back and leg was worse than ever. In my own dysfunctional way, I became even more controlling, wanting my patients in rooms near the front so I didn't have to walk to the back; the bed at a certain height, a few minutes to lie flat. The more I struggled, the more depressed I felt, and the angrier I became. I hated the patients who kept coming in spite of my physical agony so much that I decided to take a three-month disability leave. Somehow the ED managed without me, and I took the time to heal my physical and mental wounds. And felt guilty for doing so.

Other physicians have shared with me similar stories of illness and recovery. To many, it is a game to see who can work the sickest or return the soonest. Our training has made us believe that we are not subject to the same physiology as other humans, we are better than that. We are immune to illness, pain, sorrow, and time. We despise co-workers that do not follow that dictum. Perfect; we must always be perfect.
Tampa, Florida, 2005.

Everybody in EM dreads working the day after a holiday. This Tuesday at a small hospital in Tampa—part of a new system I had joined—was unfolding as expected. High volume and high acuity, interspersed with the routine: those needing work excuses or hangover remedies and treatment of yesterday's injuries. Finally, the last hour of the day shift arrives, and we start to exhale.

"Code Blue" startles us out of our end of shift paperwork. EMS barrels in with a young man in full cardiac arrest. As we move him off the gurney, slap on the monitors, and continue chest compressions, I notice the cervical collar. The partial story unfolds. He was found in his parents' bedroom, hanging from the ceiling fixture. Full Advanced Cardiac Life Support in the field had not restored a pulse. His parents were with him, and I allowed them to be present as we continued the resuscitation. They wandered in and out, father on his cell phone, mother crying, occasionally touching their son's cooling feet. It was clear to us that he was not going to respond. I waited until the realization came to his parents. Eventually we stopped our efforts, and I told the parents that he was gone.

EMS filled in parts of his narrative. He had lost his best friend to suicide a year earlier, and had made a prior attempt to end his own life as well. It wasn't clear if he had any hospitalizations or psychiatric care. There was no apparent history of drug use. His mother had
seen him earlier that day, and had talked with him casually. It was she who had discovered him hanging.

We thought we shared in her horror and grief. A young man, troubled and hurt, but still supported by his parents, had died a meaningless death. The nurses offered comfort to the parents, and gently tried to explain the next few steps in the process of losing their son.

I went off to my cubbyhole, to find peace in the routine charting of another patient encounter. No loss is easy, but certain deaths affect us all to a greater degree. We acutely feel unnecessary loss, and we see our own limitations as physicians stretched out on a bed in front of everyone.

Suddenly, there seemed to be an increase in activity in the department. I heard raised voices, and the nurses seemed to be agitated. My recovery period disrupted, I went to investigate. Apparently, our patient's mother was upset by the fact that we did not have a grief counselor immediately available. Our small hospital has only 10 beds in the department; we lack a number of both medical and social services. We offered to call a minister or priest; the delay was unacceptable. We also did not have enough space to accommodate all the people who had arrived to comfort her. When offered a large private area just outside the ED, she was incensed that we would ask her to leave her son's body and demanded it be moved, too. The nurses explained that the body needed to remain as it was until the police had made their report. We tried to explain to the people milling about the room's entrance that we had other patients entitled to privacy and respect. We showed them our "quiet room" at the end of the hall. This was still too far away. The mother then demanded we remove all tubes and medical equipment from the body, which we explained we could not do until the body was released by the medical examiner.
We thought we understood what the mother was doing; faced with unimaginable loss she must be trying to control the uncontrollable. However, compassion and understanding have their limits because now the other patients and families in the ER were upset.

As the mother's list of needs grew, the nurses tried very hard to be understanding of what they hoped were displaced feelings of anger and grief. Eventually, though, administration had to be called to deal with the mother. Meanwhile, I was repeatedly paged to the phone. I handled calls from various important people, other doctors and community leaders, that the young man's well-connected parents had called. I wasn't sure what I was supposed to say, or allowed to say, to these people, and I certainly didn't understand what they had expected to hear. However, I was glad the new shift had started to care for the remaining patients in the department.

I watched from my corner in my little world, as this young man's mother demanded and got all the attention available. Administrators and family friends gathered around her. It seemed as if the son's body became a prop in a different narrative. Maybe this was just a strange grief reaction. It was my fear, though, that this was the story of the young man's short life. If even in death he was unable to penetrate his mother's narcissism, how difficult it must have been for him to feel noticed and important when he was alive. I reminded myself not to judge harshly, especially when seeing people under extreme stress. But I could not look at the body, alone in Room 2, and not wish that we doctors and nurses had had the opportunity know our patient’s entire story and to tell him how very important he was to us.
After fifteen years in Emergency Medicine, I knew that I was suffering from “compassion fatigue.” My emotional response to patients and nurses was increasingly negative, and I need to reconnect with what I loved about being a physician. I decided to use two weeks of vacation and work for the Indian Health Service. During my two years in West Texas, I had fallen in love with the Southwest and the history of the Ancestral Puebloans. I signed up for a locus deal in New Mexico.

One of my first patients was dressed in layers—white petticoats, floor-length full skirt, long-sleeved, high-necked blouse—and more turquoise than any trading post had to offer. A traditional Navajo elder, she considered a trip to the Indian Health Service Hospital to be a ceremonial occasion, and her trouble breathing would not allow her to disrespect me by not dressing appropriately.

“Grandmother,” I said, using the preferred term of address, “That is the most spectacular necklace I have ever seen.” Her daughter translated as the woman showed me several other necklaces under her outer blouse, four pure silver bracelets on her arms, and finely inlaid earrings.
“I have to wear all my jewelry when I leave the house, or my lazy grandchildren will steal it to sell for drugs.”

Welcome to Navajoland, where two worlds collide.

The new hospital in Fort Defiance, Arizona, was situated on a plateau not far from the Navajo capital of Window Rock. It was a fortified government installation on the outside, a bunkered and razor-wired bastion of the U.S.A. in the middle of a foreign nation. It could be locked down in a few minutes, sheltering the non-Navajo doctors from natural or man-made threats. Out here in the middle of nowhere the fortifications seemed both excessive and insulting; only the proximity to Los Alamos and NORAD indicated some strategic importance to the site. Despite this, the Navajo Nation was scheduled to take over control and management of this hospital within five years, and was intensely proud of that. Inside, it was the cleanest hospital I’ve ever seen. All day long, smiling Navajo were sweeping floors, cleaning windows, even shining door handles. The high desert dust never had a chance to settle anywhere.

There were few Navajo doctors at the hospital; most physicians were Caucasian and fresh out of residency, paying off student loans through public service. Unlike the VA system, the Indian Health System attracted bright and eager young doctors who wanted to experience another culture while working in an underserved area. The IHS also offered loan forgiveness and a generous salary, along with federal benefits and free housing.

There was a single Emergency physician in town; others, like me, rotated through on a locums tenens contract. The nurses were mainly Navajo and approached their job quite seriously, since they never knew what quality of physician would appear on shift.
Grandmother’s family undressed her and got her settled in bed. I had never seen anything like that. The nurses here did nursing—medications, vital signs—and nothing else. Families (who always accompanied their loved ones) were expected to undress the patient, bring them food, transport them to X-ray, and pick up their meds at the pharmacy. They knew better than to bother the nurses for non-medical concerns.

A Navajo elder in the ED was always seriously ill, and Grandmother was no exception. She needed emergent kidney dialysis—she was smothering in her own fluids—and would have to be transported to Tucson, the closest facility that had a full-time dialysis center.

Chronic renal failure requiring dialysis is a common problem on the reservation, probably a result of genetic factors. We had a protocol for treating these patients. Traditional Navajo medicine was considered an essential adjunct to Western practice, and Grandmother’s other healer hung fetishes and sang the Blessing Way right in the Emergency Department while I arranged transfer. I was included as an equal partner in the search for a cure; the people were open to what modern medicine could do for them when religion faltered. The delay in treatment would be put to good use, as I gave her medications and her culture provided spiritual support.

Narrative was central to Navajo culture. The doctor-patient encounter took time, because there were stories to tell about the illness, the family, and the clan. Traditional Navajo could not be rushed, and would often be insulted if the formalities were ignored at the start of an evaluation. The time required for translation often gave room for this process. I had to adopt a new approach to my patients here. I had to sit and listen and learn, almost a reverse interview. There was only this simple interaction; no demands, no entitlements, only
the expectation of respect, an expectation that worked both ways. I had listened to
Grandmother’s story about her grandchildren; now she agreed to my treatment and I
participated in her sing.

Within that culture of mutual respect, my professional self felt at home for the first
time. The practice of medicine here was fundamentally different from that in the world
outside; we were in this thing united.

A few days after Grandmother left for Tucson, because I had demonstrated respect for
the Navajo culture, the rugs appeared. Women brought museum quality pieces, made on a
traditional loom from the wool of local churro sheep and colored with plant dyes, for sale at a
fraction of retail cost. A rug was a woven story and the weaver gladly explained the pattern
and its symbolism. Every rug had a deliberate flaw; one did not tempt the gods by being
perfect. There was also a thin thread that ran off the edge of the rug. This was the Spirit line,
an escape route for the soul caught in the weaving. I did not see the relevance to my own life
until years later.

There was another story, too, of the weaver’s family: how the children raised the
sheep for 4-H, the men sheared them, the mothers and grandmothers dyed the wool and spun
the yarn, then wove the rugs over a period of months. The families saved part of the money
so their children could attend college. The weavers were shrewd businessmen, and knew
the value of their work; I made several purchases.

The contrast between old and new was always in play. One afternoon, I walked into a
room where a young woman was garishly painted like a nightmare clown. Her face was
smeared with red and white paint and she was dressed in baggy old pants and a threadbare
checked shirt. I immediately thought she was drunk or drugged. She laughed at the
expression on my face and spent ten minutes teaching me about the symbolic meaning of Navajo clowns and their role in ritual narrative. There had been another type of ceremony that day, one designed to bring rain to these high, dry, plains, and the Watersprinkler was an essential component of that sing. My clown had fallen off her horse and twisted her knee. I quickly got her set up with a splint so she could return to her essential role.

Alcohol abuse remained a serious problem, but on the Reservation, it was primarily considered a family issue, not a medical one. The Navajo had a genetic abnormality that made them both sensitive to alcohol and very tolerant of it, and most people had a close friend or relative trapped in alcoholism. Intoxicated Navajo tended to be very peaceful and non-violent, and so had little negative contact with the tribal or county police. If the Tribal Police brought an unconscious person to the ED, the nurses quickly instituted a protocol with sugar, fluids, and vitamins that had them walking and talking in about an hour. They called the family to pick the patient up; if they were unable to do so, the Tribal Police took them home. Intoxicated patients didn’t stay long in the department; the goal was safe, not sober, and the community took responsibility for that safety.

The Rez had other significant problems, of course. Methamphetamine use had decimated an entire generation. The addicts were not culturally embraced like the alcoholics; most eventually left the Reservation for the city because their relatives had zero tolerance for their behavior. Theft in particular was a huge issue, primarily because of the disrespect it involved.

This wave of addiction had a profound effect on the Navajo, and threatened their traditions, but the people responded unexpectedly. Grandmothers raised their grandchildren when parents disappeared to Gallup and Albuquerque. Weaving, once dominated by women,
is now often done by men who were brought up sitting by their grandmothers’ looms. The Navajo language is being spoken again, and the traditional ceremonies are being performed more frequently. Children are back to being part of extended clans.

At the same time, the Nation has built its own college, so that Navajo seeking higher education do not have to travel to Albuquerque. The already established nursing school thrives, and the first wave of Navajo doctors are returning to Fort Defiance.

The hospital had a robust clinic system, and continuing care usually meant a walk down the hall. The pharmacy filled all prescriptions on site; as a doctor, you wrote for what was on hand in the formulary. The single-payor system worked smoothly here because everyone had similar goals. The patients were invested in the hospital; they were active participants in its creation, maintenance, and function. The doctors were self-selected in their desire to provide care while immersed in a different culture. In Fort Defiance, I saw how doctors, hospitals, and the community can work together; I was never happier.

Medical care was adequate, sometimes excellent, rarely poor, but often limited by available resources. Advanced treatment—chemotherapy, heart surgery, complex fractures—required travel off the Reservation. Not all medications were carried by the pharmacy. And yet, I never heard a complaint from a patient or a family.

The integrated health care system at Fort Defiance gave me something that I never had in my career—time. The number of patients was never overwhelming. I didn't have to call outpatient doctors or make follow-up appointments. I knew exactly what was available at any given time, and the transport protocols were solidly in place. The nurses proudly did their job; there was no intrigue or gossip, at least outside of the community. They only cared that you were competent and respectful. Since I didn't have to bird-dog their actions, nor
spend time arguing with and cajoling consultants to do the right thing, or tracking down family, my stress level plummeted. I could focus on the patients, who forced me to learn to engage them in that space between cultures. I didn’t tell them what to do; they rarely disregarded my advice. I never felt like an adversary; no one cursed at me for not prescribing narcotics. I began to see that there could be a different way to provide health care, one that worked better for both doctors and patients. For once, it wasn’t so important to be right, to be perfect. It was more important to be human.
Florida, 2007

The attitude adjustment from New Mexico didn’t last long. Soon I was back in the pressure-cooker department in Tampa we called “The Hole.” We were always busy and understaffed, and critically ill patients filled the rooms and tumbled into the hallways like potatoes from a sack. There was always one more patient to see.

The rotating medical students in the ED always ended up working with me. Many doctors thought medical students were a burden—slowing them down and cutting into the amount of revenue they could generate. Others felt that the students distracted them and kept them from providing good care. Some simply weren’t interested in teaching, forgetting about all those that taught them. I wasn’t surprised when William started following me around; no one else wanted him.

I loved teaching medical students. I remembered how marginalized I felt on rotations, and tried to provide a better experience now that I was an attending. No one had ever asked me about myself, or how I was doing, or what I thought about what I was seeing. Because of
that, I had volunteered to be part of a program that assigned clinical mentors to students who worked with them over two years, and so I often had a first or second-year student on shift with me. In spite of the fact that my co-workers felt I was often arrogant or uncooperative, they grudgingly recognized that I was a superb teacher. They mockingly called the students my minions.

William was a visiting student originally from Taiwan. His English was technically good, but he lacked a grasp of American culture and idiom. He spoke formally and carefully. He was also painfully shy and earnest. At times he would bumble about, trying way too hard to please, or irritate people with his questions and requests to repeat themselves. He was a difficult student, and the system was not set up to provide what he needed—time and attention—to succeed. We had no designated teacher for students who were there on rotation; they had to latch on to whoever was working. No one oversaw what they were taught or verified that they learned anything at all. William wandered the department, unsuccessfully trying to engage with someone, anyone, but the doctors avoided him.

I noticed him one day and told him a medical joke, not realizing he was Taiwanese. The other doctor on duty sighed loudly.

“He won’t get it. You’re wasting time.”

“Hey, William. What are the four great birds of the thoracic cavity?”

He looked at me and wrinkled his forehead, concerned because he was certain no birds lived in our chests. Based on prior experience, he suspected that this was a trick question, designed to embarrass him.

“I don’t know,” he said, shaking his head.
“Well,” I said, “there’s the esopha-goose (esophagus), the va-goose (vagus nerve), the azy-goose, (azygous vein) and the thoracic duck (duct)!"

Thirty minutes later, I hear laughter, and William comes running over. He had gone to his textbook in search of understanding.

“This is a joke! I get it! Birds—goose and duck. You told me a joke and I get it!” He continued to laugh, delighted at his discovery and very proud of himself. I heard him muttering “Thoracic duck! Ha, ha.” as he moved around the department. His joy in getting an English joke reminded me of the pleasure of accomplishing something you never thought you could do. “Ha, ha. Goose,” went on for days. Somehow, humor had forged a connection between us.

I had a general outline of what I taught to the medical students based upon their year of training. For first and second year students, I worked on physical examination skills and patient interactions. I also spent time giving emotional support and helping them navigate through the system. One of my female students had to repeat her second year of school, even though the men that failed the same class were offered remediation. I think that I helped her successfully handle this disappointment; she’s now board certified in Emergency Medicine.

Third and fourth year students learned differential diagnosis and procedures by watching and doing under my supervision. It often took longer this way, but watching someone do something new, and knowing that you taught them how to do it correctly and humanely, was incredibly rewarding.

I already had a student through the mentorship program; now I also had William. Although he was in his last year of medical school, he needed instruction in all areas of practice. No one had ever looked beyond his awkwardness to see the intelligent young man under-
neath. No one listened to his story about how he hadn’t seen his parents in almost four years, nor how difficult it was to learn in a foreign language. If he asked me a question, I would assign him something pertinent to research at night and he would report back to me the next day. We read X-rays, talked to patients, looked at cardiograms, and drew blood. I continued to see a high volume of patients at the same time. William kept the printer full of paper, got coffee, helped the nurses, and relaxed into the rotation. He soon became a departmental favorite, primarily on the basis of his unflagging enthusiasm. His skill remained questionable.

No one thought I would teach William to insert a breathing tube into a patient, even though I did this routinely with senior students. Perhaps because of his language difficulty, or his cheerful demeanor, or plain racism, he was not viewed by the department as someone who would graduate from medical school in a few months, but more as a mascot of sorts. William needed the skill of intubation, one skill that an emergency physician must master, and one of the few things we can do that might save a life. I had no doubt that he could learn anything if taught with patience.

We began slowly discussing the indications for a breathing tube. Low oxygen, high carbon dioxide, trauma, overdose—William learned them all, along with the laboratory values and observation and examination skills that helped in decision-making. We worked on using alternative methods of helping someone breathe. He became adept at bag-mask ventilation, a vital technique where a mask attached to a bag receiving oxygen can be used in many different situations. We discussed the ethical issues involved with mechanical ventilation, and reviewed all the possible complications and how to identify and correct them. Every day we did a little bit more, until I was certain that William understood the greater picture of air-
way management. At the same time, he began to lose his trepidation over intubation as the subject became familiar.

He never asked when he would get to try the procedure. I don’t think he ever expected to have the opportunity. Culturally, he was not programmed to be as aggressive as most American medical students, so he was easy to ignore. He had become used to taking whatever scraps of education he could grab; no one had ever actually had a plan for him. He was happy just to absorb everything he could through observation. I had been the same way; it was difficult for me to accept that little was offered or given in medical school or residency; not only did you have to ask, but often you had to take, in order to get what you needed.

William would watch me when I placed a tube; reviewing all the preparation steps—correct size tube, working suction, light bulb that lit, position of the patient—all the steps that increased both success and safety. He handled all the equipment and practiced the movements, and reviewed the pros and cons of the medications available to assist us. If things were going well, I would let him look down the blade in the throat and visualize the vocal cords, through which our tube must go. When difficulties occurred, he saw alternate ways to approach the problem. Familiarity takes time.

I began to look for the appropriate patient for William to intubate. The anatomy had to be clear—no patients with short necks or morbid obesity. They needed to be relatively young and healthy—overdosed patients were a good choice. I had absolute confidence in my own skills, but the patient’s safety came first. I wanted William to succeed; I had the feeling that this was essential for his self-esteem. We kept reviewing and practicing until the day a young man, unconscious and barely breathing, arrived.

Wide-eyed, he followed me into the patient’s room. I hand-bagged the patient while William did the assessment. He told me why this patient needed an airway placed and evaluated the anatomy for tube size. He checked all the equipment that the respiratory technician laid out; he asked the nurse to draw up the correct doses of medications. So far, he had done everything correctly. In his gown and gloves, he was ready. I let him bag the patient with 100% oxygen while I talked him through the critical steps ahead. The brain only tolerates six minutes without oxygen; the procedure must be done as quickly as possible. I reminded him that I would not let anything untoward happen. He needed to relax and do his job; I would alert him if I thought he was using too much time. I did not paralyze my patients for intubation; I preferred a drug that provided sedation and amnesia, but left the patient able to breathe on their own. This was a safer technique, but required placing the tube through moving vocal cords. I reminded William that he must see the vocal cords to put the tube through the vocal cords. If he could not see, he needed to take the scope out and try again. A tube hitting closed cords could bounce into the esophagus; that could be fatal. There was nothing wrong with stopping, giving oxygen, and trying again.

Unless a student is learning intubation on a rotation through anesthesia, they rarely get the type of instruction that William needed. I understood that he would not do something without preparation—he was no cowboy. I was confident that William was as prepared as I could make him; now it was his time to demonstrate all that he had learned.

I stepped back as William stepped up. He positioned the patient at the right height for his own comfort. The nurse gave the medications, and William inserted the short scope and lifted up the upper jaw and soft tissue of the neck. After suctioning out some saliva, he reached for the tube that I handed him, eyes never leaving the cords, just as I had taught him.
The tube slid gently in and William removed the scope and inflated the balloon that kept the tube in place. He then held the tube with one hand and breathed for the patient via the bag controlled by his other hand, until the respiratory therapist secured the tube in place. The whole procedure took less than two minutes.

William then finished his checklist of things to do, including listening to the chest to hear air moving on both sides, giving orders as to ventilator settings, checking the vital signs on the monitor, and ordering the chest X-ray. We didn’t notice that our nurse had left the room.

Like Clark Kent emerging from the phone booth as Superman, William had gone into the cubicle a fourth-year medical student and come out transformed. A wave of applause greeted him when he opened the sliding glass door and walked out into the Emergency Department. I had never seen the nurses applaud a medical student, and I marveled at how this awkward young man had won the hearts of this once-hostile group. He wore his newfound confidence with pride and a wide grin, and even those who once had found him to be an annoyance had to celebrate.

“Good job!” I said. “Are you finished yet?”

“No, I need to order an X-ray and confirm the tube position,” he answered in his slow and precise English.

“Haven’t you already done that?”

He smiled broadly—he knew the answer to this question.

“I have listened for bilateral breath sounds, checked the oxygen and carbon dioxide levels, but the X-ray is the final step.”

“OK, go write your note, then we’ll look at the film.”
William’s smile reflected the reasons I became a physician—a job well-done for a patient, a skill successfully taught to a student—but that day I realized something else. You didn't become a doctor the day you got your diploma. You became a doctor when someone took the time to teach you something you needed to know, and others recognized that knowledge in you.

William completed a residency in Emergency Medicine and is now practicing in Florida. I like to believe that I made a difference by teaching him in the way that I wish I had been taught, rather than in the haphazard, one-size-fits-all way that the system chooses to use.
Right First Rib Resection with Scalenectomy, 2006

By now, I had divorced my third husband. Although we had been happy for several years, eventually I felt more valued for my income than person. When he complained about being bored on safari, I had enough. It was an expensive and painful end to what I had hoped was a life-time relationship.

Shortly after the divorce, an old friend from Philadelphia came back into my life, and I remarried. He lived and worked in Michigan, while I stayed in Florida. See Social History.

My right arm clotted off three more times. By now my body had opened bypass channels around the obstructing thrombus and I took daily blood-thinning injections, so the symptoms were less severe. The third clot was frightening, though. For the first time, I was dizzy, and the MRI showed clot not only in the large vein of the arm but also in the jugular vein coming from my head. These were now life-threatening clots that could extend into the veins around the brain, causing seizures or a stroke; I needed to find out why they kept happening.

Thoracic outlet syndrome is a complex condition. Somehow, the subclavian artery, vein, or nerve is compressed between the muscles of the collarbone and the first rib. Symptoms range from numbness of the hand to cold, dead fingers. The causes are varied; the th-
racic outlet itself may be too small, the rib, collarbone, artery or vein abnormal, or an extra rib, called a cervical rib, may be involved. Pressure on the outlet by standing too long with your arms at the side, or by pulling or lifting, can also lead to symptoms. Baseball (overhand) pitchers commonly get the vascular type of thoracic outlet as the muscles of the head and neck hypertrophy from repeated throwing. The sports press refers to this as a “dead arm.” The variety of symptoms and causes makes diagnosis difficult; there is no one test that is definitive. The inelegant surgery may do little to help the nerve type, but is curative for the vascular symptoms. Selecting the patient that will be helped by surgery can be problematic as well.

Although we considered thoracic outlet syndrome from the first clot on, none of the ultrasounds, CT scans, or MRI’s confirmed the diagnosis. My friend, a pediatric surgeon, advised an old-fashioned test called a positional venogram. Dye is injected into the arm and a movie made as the arm moves from straight down, to ninety degrees, then overhead. It is a functional test of the blood flow, rather than an anatomic test like a CT scan or MRI.

“Wow, that’s cool,” said the radiologist as we watched the dye column become blocked when my arm moved overhead, collateral vessels snapping open like a bamboo fan to bypass the obstruction. I had clear evidence of thoracic outlet syndrome.

“Oh, sorry,” he said. “I guess it’s not cool for you.”

Actually, though, it was. Now I knew what was wrong and, like the perfect doctor I was, I could set about fixing it.

The operation for this condition is both ugly and dangerous. The first rib lies in the middle of a complex that contains the subclavian vessels and several nerves to the arm. The lung lies on the other side of the chest muscles where it can be punctured easily. There are
two approaches to the first rib: one through the armpit, the other behind the collarbone. The rib can be felt, but not seen, and it is removed roughly by cutting and tearing at it with a sharp pliers called a rongeur, avoiding both the nearby structures and the artery and vein under the rib itself. The scalene muscles which hold the collarbone and first rib together also need to be removed. It doesn’t help as a patient when you have personally performed this procedure on someone else.

I found an expert in this surgery at the local university hospital. He was reluctant to operate until he saw the positional venogram.

“Hey, I can cure this!” he said enthusiastically.

The operation was a week later. The surgeon detached my neck muscles—the ones that make the triangle when you turn your head—and removed the two smaller scalene muscles and the first rib. He found a ridge along the back of the rib that was big enough to cause the problem, and he sewed my neck muscles back to the collarbone.

My post-operative course was uneventful—until I got the hiccups. I get near fatal hiccups, violent and lasting for hours. The hiccups nerve also passes near the scalene muscles, and might have been irritated by the dissection. Every hiccups pulled and tore at my neck incision; I was miserable. The resident on call ordered diphenhydramine; just before the nurse gave it, I pointed out my allergy bracelet clearly noting penicillin and IV diphenhydramine, the latter giving me the known reaction of extreme, pull-off-your-clothes-and-run-screaming-down-the-hall anxiety called akathisia. The nurse was not pleased, and refused to call the resident back, even though I told him chlorpromazine would work. I hiccups until morning, when my husband arrived.
“How long have you been hiccuping?” he asked, looking around the room and noting the dirty pile of betadine-stained linen from the OR still in the corner and the unemptied trash can.

“Six-hic, hours, hic,” I said, telling him about the diphenhydramine.

“Be right back.”

My husband is terrific. I wasted too many years not understanding that he will always have my back and that he loves me although I’m not perfect.

He must have thrown a glorious fit, calling my surgeon directly. “My wife is in agony—she’s had hiccups all night. Her room is filthy, she has vomit on her gown. Is this how you care for patients?”

A few minutes later, nurses scurried in to clean the room, change my gown, and finally give me an injection of chlorpromazine. I then slept for eighteen hours, blissfully free of hiccups.

This time, I took four full weeks off. My perfect facade was badly cracked by now as I suspected that the system would function as usual without me, despite the protestations of my director and co-workers. I also realized that it helps to have a fresh and visible scar to prove you’re not malingering.
Entry Four

SOCIAL AND FAMILY HISTORY
**Social history:**

Married to fourth husband, pediatric hand surgeon

No children, one step-son
If medical internship was like boot camp then surgical internship was Parris Island. Alphabetically linked on rotations during that miserable year, another intern, Rick, and I became friends. When I dictated charts, I’d find funny little animal drawings that he’d hidden on the pages with the information I needed. He’d taken time that he barely had and gone through my charts just to make me smile. He told me years later that I was the only person that ever acknowledged his existence.

It was never romantic, though. He was married and I was divorced and we eventually went our separate ways into residency and fellowship. He went to Cincinnati via Camden and St. Louis, and I landed in Columbus via Hartford and then Lubbock and Buffalo.

Then, recently divorced with a three year-old son, he tracked me down through the state medical society and we began to vacation together. We saw Steve Young throw a touchdown pass to Jerry Rice at Candlestick Park, did homage to Elvis at Graceland and got drunk in the Russian River Valley. We explored similar interests like microbreweries and botanical gardens. His kindness, humor, and intelligence charmed me.
Dissatisfied with his work in Cincinnati, he decided to move and asked me to join him during an unattached period in my life, but going all the way to Fairbanks, Alaska was a deal-breaker for me. He wanted to get far away from civilization; I needed a Starbucks on every other corner. Over the next 12 years, we never lost contact. We bought holiday and birthday gifts for each other and we even visited each other with our next set of spouses, both nurses. I even sent Dad on an Alaskan cruise to stay with him.

Then one day, while he was in Chicago at a medical conference, his wife moved out, taking most of their furnishings and all her belongings. I was surprised at the intensity of my anger at her for treating him so poorly. After my own divorce the next year, I travelled to Fairbanks twice to see him.

We rediscovered our shared history, in which time was not lost but was entwined with our separate lives. We had always been together - we just didn’t know it.

That winter he arrived at my door in Florida, announced that he was moving back to the Lower 48, and that we were getting married because obviously - after 5 marriages between us - we were clearly the only people who could tolerate each other.

Dad said, “It’s about time!”
New Mexico, 2009

After we married, Rick sought a job in Florida. Opportunities for plastic surgery were mainly cosmetic—face-lifts and breast augmentations, and he had difficulty finding a position for a reconstructive surgeon, one who specialized in breast reductions and post-mastectomy options, and surgery of the hand. He felt too old to invest in a private practice of his own.

My professional life was in turmoil again, too. My board certification was obtained through testing; I had not done a residency in Emergency Medicine. My group in Tampa did not recognize this “practice-track” and was gradually getting rid of non-residency trained physicians. I was still surprised when I was given a 90-day notice via our no-fault contract. We were both free to go wherever and do whatever we wanted.

Rick and I found new jobs in New Mexico, and planned our move, taking my dad with us. We loved the Four Corners area, the weather, and the Native American diversity and we had travelled extensively in that area. The hospital was large but isolated, and we were impressed with the commitment to quality demonstrated by the administrative staff. Right before we arrived, the hospital changed chief administrators; we ignored what in retrospect was a flashing danger sign that signaled the waning chapters of my professional life.
**Family History:**

Mother: deceased, 74. Osteoporosis, polymyalgia rheumatica

   Grandfather: deceased, 82. Anthricosilicosis (miner), prostate cancer

   Grandmother: deceased, 84. stroke


   Grandfather: deceased @ 57, coronary disease

   Grandmother: deceased @ 92, congestive heart failure, diabetes

   Paternal siblings: diabetes, heart disease, high cholesterol
My mother, Mary Patricia Killeen, was the baby girl in her family of four much older brothers. Her Irish roots kept her locked in a traditional role, one where the men called all the shots. An example: she wasn’t allowed to ride a bicycle because her brothers said she might fall and get hurt. She went to business school despite a full college scholarship because her brothers didn’t think she needed the education as a wife and mother. She grew up afraid of everything and uncertain what to do without her brothers’ directions.

With black hair and pale skin, she was lovely and intelligent, and caught my father’s eye in high school. He was a skinny redhead, over six feet tall, and she said he was “the homeliest kid I’d ever seen.” He was also bound by tradition. In many Catholic families of that era, the eldest son and daughter were expected to join the Church. My aunt left for the convent when she was sixteen. Dad enrolled in the seminary at eighteen, and my mother refused to see him again until he made up his mind about a vocation. When he was home on vacation, he would bicycle the five miles across the Susquehanna River from Wilkes-Barre to Luzerne, and sit on her back porch, but she would never come out. Her brothers took pity on him and would make sure he got a meal before he cycled back home. Finally, he left the seminary after two years and they were married. The Korean War then separated them for anoth-
er few years. Mom finished business school, as secretarial academies we called then, and worked for an insurance company while Dad sailed on the USS Missouri.

Eight years later, I was born. The arrival of a child after ten years of marriage provided the drama in my parents’ relentlessly middle-class life. A year after my birth, shortly after my parents purchased a house, my father suffered an acute herniated disc in his back with paralysis and underwent one of the very first laminectomy/fusion procedures performed in Philadelphia. He spent the entire year in a full body cast.

My maternal grandparents, Mamie and Harry Killeen, moved in with us to help care for me while my mother worked, and brought with them their Old World Irish views of female roles. Mom stopped working as soon as Dad went back to meat-cutting for a supermarket chain. He soon felt outnumbered at home, particularly when it came to raising me. I didn’t understand the tension.

When Dad was bedridden in his cast, the only thing that he could do with me was read, and by the time I was three, I was reading along with him. After he recovered, I would sit next to him in his chair and guess at words in the New York Times crossword puzzle. I was an odd child—intelligent, socially awkward, stoic. My mother didn’t know what to do with me, while Dad was constantly finding new things for me to learn. Under his tutelage, I became quite the good carpenter. My grandparents—well, grandmother—were horrified.

My mother was critical of the intelligence and independent spirit my father encouraged. “You have no fear,” she would tell me. That was not meant as a compliment, although I took it as such. “If you don’t fit in, you’ll end up alone.” This reflected her deepest concern—that my father would leave her and that I would go away and never return. A woman needed a man—a brother, a husband—to take care of her. “You need to be more humble; you need to
be kinder,” she would say, all those old lessons reinforced by her own mother. I didn’t know my place. And in the way of those things, the harder she tried to pull me into her world, the more determined I became to get away. I began to see any expression of those traditional feminine traits as a threat to my freedom, and I valued independence. I was a child, and the only way I could find to avoid my mother’s plan for me was to eliminate all traces of those things she identified as desirable, even those things that were a natural part of my personality, like kindness and cooperation. Any perceived weakness, softness, gentleness would limit my options, and staying home with her or marrying some man would soon be my only choices. Long before I understood the dynamic, I embraced the “work harder, stay later, never let them see you sweat” ethic, and simply had to be the best at everything I did so that I could get away. Perfectionism dominated my life.

When I’d fail, she’d demand “What did you do now?” and remind me that I wasn’t nearly as smart as I thought I was. She could never love me, the real me, and I could never be what she would love. We both were doomed.
Florida, 2003

Now my mother was dying, the osteoporotic bones of her chest and back disintegrating into agonizing dust. Her chest was now too small for her lungs, and she could barely move the air in and out. The tiny cavity constricted her heart; it pumped very little blood. Her oxygen level remained dangerously low.

After I brought her home from the hospital, tucked her into the guest bed and turned on the oxygen to keep her from gasping for breath, the only magazine I could find was *Sports Illustrated*. So, lying in bed next to my mother, I read aloud a story about retired NBA star Charles Barkley while I waited for her to die.

"Every black kid thinks the only way he can be successful is through athletics. That is a terrible thing." I say “turrible thing” in my best Barkley voice, even though I know my mother won’t get the reference. She never understood my interest in sports—sports were for boys—and that was one of the many ways in which I disappointed her. If my mother had been conscious, she would not have appreciated the irony of hearing Charles Barkley in his own words, but instead would have chosen to note that I loved her so little that I couldn’t be bothered with appropriate deathbed reading.

I count the seconds between agonal breaths and know it won’t be long. My mother was proud that I was a doctor—if only I had come back to my hometown and been a family practitioner. She listed ambition among my flaws, right after being too smart and not afraid to show it. A lack of humility, she said; over-reaching, thinking too highly of myself. Never satisfied.
“What did you do now?” Her typical response to all my failures and disappointments hovers over my head. Some of them certainly were my fault, but not all of them, even though it has taken years for me to intermittently believe that. She was a spotlight aimed directly at me, a continuous interrogation of all my decisions. I couldn't help but believe that I was responsible for every poor medical outcome, every failed relationship—I wasn’t intelligent enough, hadn't worked hard enough, hadn't given enough—“What did you do this time?”

“You are so uncaring. You love your father more than me. You just want me gone.” No, I just couldn't bear to watch them both suffer. There was nothing I could do for her except let her go. The other doctors wanted to put her on a ventilator, but I knew she wouldn't recover, and if she did, the pain would be unbearable. I am the only child, the daughter, the doctor; the decisions were mine.

It is thirty seconds between breaths now; her pulse is weak and tired. The doctor knows; the daughter goes to get her father. I am on one side, him on the other. The magazine flutters to the floor. I hold her hands; the wait is short. I take out my stethoscope and listen, a full minute by the clock as I have been taught.

My father asks with tears in his eyes, “How will you know?”

I smile sadly. “I'm a doctor,” I say, recording the time and witnesses as I pronounce my own mother dead. Only then can I, the daughter, cry.
Chapter Six

My father was eighty-four years old when he discovered that he once had an Uncle Frank, who was killed in 1911 at age 12 by a chauffeur-driven Model-T. Frank and his older brother were waiting for their father, George, to walk up the hill after work, when Frank darted into the road and was struck by the car. He died instantly. "The brother's screams," said the local paper, "could be heard for blocks away." One hundred years later, we learned that the brother with Frank was my grandfather Ralph, who had never mentioned the incident to his wife and children. My father and his brothers rode their sleds down that hill every winter, and their father never said a word.

That was my father’s family. They kept secrets. My grandfather was disowned by his family when he converted to Catholicism to marry my grandmother and I never knew I had aunts, uncles, and cousins living in the same town, with the same last name, until after Grandpa died. I only heard about my father’s time in the seminary from my mother’s brother Dan. My father and his siblings never talked about my grandmother’s nervous breakdown,
nor about my aunt Josephine’s husband, who had died in a car accident with another woman in the passenger seat. While talking to my paternal cousins this year, one of the youngest said she didn’t know my Dad had been in the seminary and one of the oldest replied, “Of course not. No one ever talked about it.”

Growing up, I learned that we didn’t talk about personal things, to others or even to each other. Appearances were important; feelings were not. I remember my maternal grandmother interrupting late night discussions between my parents to remind them “the kid might hear.”

As an only child, I learned to keep my thoughts to myself and never show emotion. Once my mother praised me after I walked home after falling off my bike, cradling my broken wrist, because I hadn’t cried in public.

We never talked about my father’s drinking, nor about why he changed jobs suddenly. My mother’s aunt in the state mental health facility wasn’t mentioned, either. I was a teenager before I learned how my father had gone to New York City to bring my Uncle Dan back from Skid Row. My whole house was filled with secrets on both sides.

As a child, though, I did not realize that I was dealing with appearances; the message I internalized was that I had to be perfect in order to be loved. I was a very good child, a straight-A student, yet disliked by many of my classmates. I possessed a knack for doing and saying the wrong thing, often making my situation worse. No matter how hard I tried, perfection eluded me, and I suspected that all I did brought shame to my family.

My father tried to convince me that I was loved, but between work and alcohol, he was often unavailable. Still, he waited up for me when I went out at night, and we would sometimes talk when I got home. His support never balanced my mother’s disapproval.
When I was in medical school, my father quit drinking. By then I was married, soon divorced and on my own in Philadelphia, and struggling mightily to free myself from my mother’s expectations. I seldom went home; working holidays was a fine excuse to avoid conflict.

When I decided not to pursue Pediatric Surgery and returned to Wilkes-Barre to practice General Surgery, I grew close again to Dad. He shoveled my snow, fixed up my condo, and we spent hours watching golf on TV. But I missed my boyfriend in Columbus, and disliked private practice, and after two years returned to Ohio and Emergency Medicine.

In 1995, my world fell apart. My former partner biopsied a lymph node in my father’s neck. The phone call came during a shift at work.

“I don’t know what to say,” said Mark. “This node is obviously cancer. I’m sending him to an Ear, Nose, and Throat surgeon. We’ll work this out.”

For once in my life, I couldn’t work; I couldn’t even breathe. I ran to the Doctor’s Lounge and cried. I didn’t care about the patients or the nurses. After a while, the Chaplain came and sat with me; eventually I sleepwalked through the end of my shift.

The pathology was disastrous: poorly differentiated squamous cell cancer metastatic to the lymph node. There was a primary cancer somewhere that we needed to find. Dad was scheduled for triple endoscopy—direct fiberoptic examination of the sinuses, mouth and throat, and esophagus—followed by resection of the primary, if found, and a modified radical neck dissection. Prognosis depended upon the site of the main cancer; if no primary was found, survival was two percent at five years.

I spoke with my father on the phone.
“Dad,” I said, “If you die and leave me with Mother, I’ll never forgive you.” Then we talked about surgery. I had seen head and neck operations before; the results could be un-speakably awful. Sometimes the jaw or cheek or voice box had to be removed, a tracheostomy placed to breathe, a feeding tube to eat. Even the neck dissection alone could lead to paralysis of the vocal cords, the shoulder, or the arm. And the patient still died.

Dad and I shared the belief that some things were worse than death. He knew his prognosis was dismal. I gave him a list of questions for the surgeon, then asked him an important question.

“Dad, if you’re going to die in a few years, what do you want to be able to do?”

“Golf. I want to golf for as long as I can.”

“OK. Tell the doctor that. Be sure to tell the doctor that.”

Dad had surgery two weeks after the biopsy. The endoscopy alone took three hours; no primary was ever found but multiple biopsies were taken. The only parts removed were lymph nodes from his neck in a two hour operation. His surgeons were pleased but cautious.

That night Dad couldn’t urinate—acute urinary retention in medical terms. His blood pressure was very high from the discomfort. He needed a Foley catheter to drain the urine; unfortunately, the floor nurses were female and refused to place the catheter. The charge nurse looked for a male orderly while Dad got worse and worse.

Finally, I said, “Give me the damn kit. I’m a doctor first; a daughter second. I won’t have him suffer.” The orderly arrived as I was getting started, so I let him do the procedure. Dad soon felt better as over two liters of urine drained into a bag.

The attending surgeon had the nurses disciplined the next day.
The surgery was a success. No evidence of residual cancer was found, and the cosmetic result was perfect except for minor nerve damage to the lip. Dad was back on the golf course in two weeks, and shot his lowest score ever. His surgeon had made small changes to the operation—taking the front neck muscles but leaving the rear ones intact and saving the nerve to the shoulder. Dad discovered not being able to move his head made a big difference in making par.

Unfortunately, his prognosis was still poor. After much discussion, we elected for radiation therapy. From below his left eye to his waist, radiation would burn away all the squamous and mucous cells, taking any cancer with it. He had small tattoos placed to mark the field.

One day in a store, a child asked him about the marks on his face. “Getting ready for Halloween,” he said with a laugh.

A month later, in May, Dad and Mom came to visit me in Columbus. Through a friend, I had gotten tickets for the PGA tournament at Muirfield Village. Dad had never gone to a tournament before, and for three days we trudged through rain and mud, seeing all his favorite players: Greg Norman, Paul Azinger, Nick Price, and that new kid, Tiger Woods. It was glorious fun.

Like most cancer therapy, the curative doses were high and complications inevitable. By December, Dad had lost over sixty pounds. His mouth and esophagus were burned raw, and a temporary feeding tube was in place. He tells me he doesn’t remember coming to Ohio for the holidays. When he got back home, his treatments were over, and he did hyperbaric oxygen therapy for four hours a day to speed healing. He was one of the few people who loved the chamber—he and I share a talent for stillness.
He regained his weight, lost his sense of taste and ability to make spit, but was alive. First every three months, then every six, then twelve, he had endoscopy to look for a recurrence. He trained many ENT fellows as he was a very cooperative patient while they manipulated the tiny lighted scope up his nose and down his throat. And he lived. First five years (a technical cure), seven years (a definite cure), and at ten years he was told not to come back to the ENT, because he wouldn’t be dying of head and neck cancer.

Now, after twenty years, radiation therapy has left him with many other problems, all getting worse with age. He takes six different pills for blood pressure since the nerves that send information to the brain about body position have died from the radiation. Multiple skin cancers plug him, including one the size of a doughnut on his temple that oozes and bleeds, and causes pain. He gets most of his calories through a permanent feeding tube directly into his stomach, because his throat is scarred and food goes into his lungs instead of his esophagus. The doctors tell him, “You weren’t supposed to live this long!”
When I was a child, I believed my father controlled time.

In his favorite home movie, I'm sliding down a six-foot tall snow pile in front of our house in Northeast Pennsylvania, dressed in a snowsuit, laughing and waving at my father. He would show me coming down, then reverse the film and show me sliding up, then down again, over and over. Time forward, then backward, entirely at my father's command.

He loved home movies. In 1960, this meant a bulky camera and real film. He would shoot a family gathering, and then deliver the film to the locally-owned drug store, where it was sent out to be developed. Several weeks later, he would bring home a tightly wound roll of film and we would have "Movie Night."

The set-up involved a retractable white screen held perilously unsteady by a dented aluminum tripod. The projector was an immense contraption with two huge reels, a light bulb that burnt out frequently, and a frame at the front to hold the film. My father fed the end of the film strip, which was the end of the movie, into a slot in the top reel and brought it around the bottom reel, then placed the spool of film on a post. He turned on the projector and very slowly the film moved from spool to reel. When the reel was full with all the film, he reversed the attachments, slotting the film strip into the holder in front of the light bulb, and started the movie. He had to focus the lens, and if the film was moving too slowly, it would
melt, so it wasn't until several minutes into the movie that we actually saw anything. Going through all these steps took a very long time.

The film wasn't very sturdy, and often the strip would break during the show, rattling and flapping like a trapped bird until Dad turned off the power. He would get out another device called a splicer. This was a long board with a sharp knife on one side, like a mini paper cutter, and a series of rollers and clamps that met in the center. After the film was wound off the reels and onto two spools, the torn ends were trimmed and glued with the rolls and clamps holding things together without tension. A day later he would try again, winding and focusing and hoping to avoid another disaster. I remember other movies—birthdays, holidays, First Communion—but that snow pile remains the most vivid.

Dad has seen camcorders and digital cameras replace his beloved equipment, as time moved on relentlessly. My mother has died and his health leaches away. There is no rewind here, only fast forward. But we continue to play the movie of our lives, laughing together, still that father and daughter in the snow.
I’m walking very slowly down the produce aisle at the local supermarket, past the colorful waxed apples, Mexican mangos and Rainier cherries, and trailing an invisible stream of blood onto the floor from the unseen gashes in my wrists. As I pass by the misters spraying bins of green, red, yellow and orange peppers, past the lady reaching for carrots, past the stock guy balancing the tomatoes into a tilting stack, I want to scream. No one notices.

I am grocery shopping with my father, and this is what I’m imagining as I watch him struggle to find the items that he needs. He has a list, always incomplete, written on a gray scrap of paper from one of his puzzle books, and he reads it over and over again. He insists on pushing his own cart, although today he is so short of breath that I wonder if we’ll make it to check-out. I make a mental note to start an antibiotic—he gets frequent lung infections because he eats despite being unable to swallow correctly.

I hate taking him shopping, or for a haircut, or even to a ballgame. There, I said it. He looks so diminished, his pride dented like a kicked pail, unsteady, unsure. Not like my father at all. Drip, drip, drip goes my lifeblood. I am a coward; I wish I were dead and didn’t have to do this. I can’t stand it; I want to scream and run away. There is no where to go.

We played pinochle last night with my husband and step-son at Dad’s request. He’s played the game his entire adult life, and is a formidable opponent. Or was. Now I bite my cheek and force back tears when he misdeals or makes an error. My husband catches my eye and smiles gently. Drip, drip, drip. I bleed even at home.
I want to hide, not from him, never from him, but from *it*—old age. I despise what it is taking from us both. I’m pick my way across the tightrope between respecting his independence and keeping him safe. How much longer can we leave him home alone? I can’t bear the thought of having to take over administration of his six-times-a-day insulin and the other dozen meds, his tube feedings, his hygiene.

I hate this, but I hate the thought of not doing it even more, because then he will be gone. What will I do then? It is more comfortable to think about slowly bleeding to death myself as I make our last memories out of the remaining time. Drip, drip, drip.

We watch baseball together most nights; Dad can still call strikes and balls better than the home-plate umpire. He enjoys taking the helm of our pontoon boat out on the lake; my husband sits beside him to prevent any close encounters with swimmers or other boats. We say I love you every day. I’m excited to see him open his birthday gift—a Joe Maddon Tampa Bay Rays Mr. Potato Head to join his Maddon bobble head and JoeGnome.

Yesterday he called me downstairs to show me a huge hibiscus bloom on our deck, the orange and yellow colors of sunset, and told me he didn’t know how I grew such beautiful flowers. With blood and tears, I think, the same way he raised me, the same way I take care of him now.
“They took my dog.”

I overhear my father, who lives downstairs, talking on the phone to his brother in Philadelphia.

“She doesn’t think I can take care of him. He’s had me up five or six times the past few nights, and she thinks I shouldn’t be outside in the dark.”

“She” is me, the one who took the dog. Let’s be clear: I moved his crate up a flight of stairs. No theft is involved; no severing of the grandfather-granddog relationship. A simple relocation of home base has occurred, that’s all. And still I feel like a dognapper.

“I’m alone all day. They don’t come down here,” he tells my uncle.

They are similar, Dad and Tasker. They are old and sleep most of the day. Dad kept the dog locked in his crate most of the time, and took him out to visit the yard a few times. If he left him free in the house, Tasker barked and growled at squirrels outside the sliding glass doors that might be attacking and Dad cussed at him, using words I’ve never heard from him before. He has even walloped him on his butt a few times. Then Tasker goes back to crate. It’s impossible for me to do any writing between the barking and yelling. They get upset. So do I.

I don’t like Tasker locked up all day, and I certainly don’t like him being hit. I understand Dad is angry and frustrated at his declining health and has no patience, but the current situation is deteriorating.
Tasker cries four or five times at night to go out, even though he doesn’t need to pee. Dad doesn’t want him to wake me, so he gets up, puts him on a leash, and takes him out in the dark, down a flight of steps. Dad needs a cane and isn’t very steady. I don’t want him to fall; I know a broken hip will start the final cascade of illness.

Tasker is a different dog when he is occasionally upstairs with my husband and me. He lays on his bed and naps or plays with a toy. He rarely barks. When I write, he lies on the floor next to me, gently snoring as I type. I suspect he doesn’t feel the same need to protect me that he does for Dad.

My husband is allergic to dogs—and cats, flowers, grass, trees and dust. That’s why Tasker has always lived downstairs. I know bringing the dog upstairs will make it difficult for him to breathe. There aren’t a lot of good choices here, and I suspect all three of my men will be unhappy with whatever decision is made.

I talk with my husband. We agree Dad needs his sleep and shouldn’t risk a fall catering to our spoiled pet, and that all the upset over barking isn’t good for anyone. We don’t want to give the dog away; that would break everyones’ hearts. Dad won’t change, and my husband’s allergies can’t get any worse. He says he’s not losing sleep over the dog; I promise I’ll work on retraining him to sleep through the night. Moving him upstairs is the best solution.

Dad hates the plan. He thinks there is no reason he can’t keep responsibility for the dog. I took away his car keys and now I’m taking his dog. I understand, I really do, but how else can I keep him safe? How else can I do what’s best for both him, my husband, the dog, and me?
We move the crate. The dog adapts quickly, and Dad continues to tell his brother how he lost his pet. Tasker wakes me at four a.m., crying; my husband gets up first and heads for the crate. I expect to hear stern words, but instead I hear a song:

“Crate is great, crate is great. Tasker loves his crate.”

I smile as I hear him singing a lullaby for Tasker, for Dad, for me. Decisions in our family are difficult, but love is not.

I don’t need to see the liver, tossed out onto the road about a foot from the body. I knew Tasker was dead from the moment he leaped off the curb into the highway. The screeching of the brakes, the thud—so loud for such a little dog—had told me nothing I didn’t know from the instant when he saw something (who knows what a dog really cares about?) on the other side of the road and jumped out, the moment I saw him run from me and into the car’s path.

I want to scream, but now I have jobs to do.

I go into the house to get my phone. I come out. Tasker needs a blanket, I think. I go back in. I take my best throw and I go out again. I’m shaking too hard to put 911 into the phone. And what would be the point?

The driver of the car is sobbing. We hug and I make sure she’s not hurt. I offer her coffee.
Turning my eyes away, I pick up Tasker’s liver and I toss it onto the pile of what has poured out of him and wrap it all and carry what’s left of my little dog and lay it down under a tree.

Why didn’t I put on his leash? Because he hated traffic, because he never went near the road.

I text my husband who says he’ll cancel his next case and and come home. Now I have to tell Dad that his friend is gone. He’s still doing his morning tube feeding, so I climb into bed next to him and together we cry for Tasker.

My husband comes home and takes Tasker’s corpse away and then he silently packs up Tasker’s toys and crate. Finally, we put a little statue that looks like Tasker on the piano.

Only then does he begin to cry too.

As I’ve begun to write I’ve been thinking about how different who am I am is from how I’ve been so often perceived. Now I wonder if, like the doctors and nurses who have seen me as arrogant and aloof, the neighbors who clustered around to watch thought that I was inhuman when I seemed to go so coolly about putting Tasker’s death into order. Would they have also thought that of my husband when he too so methodically set about to do what had to be done, not allowing himself to cry until his work was complete?

I think back on all the times that, as a doctor, I did my job and then did my crying unseen.

Patients want someone who takes charge, who picks up the severed finger, who opens the chest, who reduces the grotesque fracture, but also want them to share their pain.

But doctors must keep our wits about us and do our duty first. It’s who we are, who I am.
Then we cry. Alone.

The scar was the first thing I noticed. Drawn like a line of chalk in the brown fur, it encircled her body in front of her hind legs. She was found with a wire imbedded so deep in her flesh that the skin had grown over it. No wonder the hair had turned white.

Someone had loved her once. She was housebroken and crate-trained, and liked her ears rubbed. She recognized a soft bed, a warm lap, and table food when she saw them. Her tail wagged and she walked on a leash easily.

Someone had abused her once. Her posture was submissive; she wouldn’t look me in the eye. She backed up when approached. If I reached for her collar, she snapped and growled. She preferred being in her crate, as if wandering out was dangerous. She had no idea of what a toy was about, or how to chase a ball, or roll wildly in the grass. She had never seen indoor stairs. She showed her belly if I got too close.

We met one Saturday while I was mourning my dog Tasker. She had his eyebrow spots and face, but was bigger and colored differently. We had everything she needed at home: a crate, beds, blankets, bowls, and empty hearts. She jumped right in.
I’ve never had an older shelter dog, only puppies. It is a fine negotiation. She has a
new name, Riversong, that she must learn. It is difficult to get her out of the crate except for
walks, which she seems to love. Maybe she remembers the escape and the freedom that liv-
ing outside gave her, before the wire and pain. She knows squirrels; I imagine they were a
dinner staple. She has never barked, whined, or made any other noise than a low growl. She
doesn’t even snore. She is a ghost dog, invisible, silent, the way she has learned to survive.

I understand how she feels. I, too, prefer to stay in my soft corduroy reading chair,
venturing out only for a good reason. You get hurt outside of the safe place; we both know
that. It is better to be quiet; maybe you won’t be noticed.

She comes out of the crate sometimes and wanders the house, sniffing and licking,
then heads back in after a few minutes. She has taken two toys into her lair, although she
doesn’t play with them. At least she knows they are hers and she keeps the stuffed bear under
her head. Just in case.

Today she has learned to gnaw on a rawhide bone. Finally, some noise from the crate
to fill the silence.

Only at night does she sneak onto the dog bed by my reading chair to nap. Twice she
has gotten into my lap, hesitant and wary, then fallen deeply asleep. The next morning she is
a stranger again.

I do what I can. She has a home now, plenty of food and water, and all the love she
can handle. Last night, when I came in late, she walked out to greet me. There may have even
been a tail-wag in that brief moment of hope before she ran back to the crate, which is in my
office. She sleeps now as I write, as if making up for lost time.
This is how we begin, silent companions, warm, well-fed, and conscious of the cost of safety. The rest will come, people tell me, and I can wait for her, however long that takes, as she will wait for me.
Our high school had no guidance counselor; less than half of my senior class would go on to college. I had no idea what my future options might be. Professional role models were rare in my life; I knew no lawyers, scientists, or writers, only my family doctor. I attended Catholic school for sixteen years—medicine seemed like a good job for an intelligent person infused with the service ethic of 1960s Catholicism.

College had a happier dynamic, at least until my long-term roommate said she didn't want to live with me anymore because I was clueless about people, especially her. I never talked about anything. I was so involved in getting the best grades to get into a good medical school that I couldn’t see what she meant—I couldn’t see past my own issues to understand someone else’s struggle or need for communication. I moped for a few months, but soon was applying to medical school and moved on.

Acceptance into an Ivy League medical school proved to me that my approach to life was working. I was moving away from home and starting my own life. I packed my perfectionism and took it with me, along with an increasing need to control everything so that I never made a mistake. This became more difficult as I struggled with biochemistry and felt awkward with patients, whose needs reminded me of those of my mother. I identified with the male-dominated culture of surgery, choosing a field in which science and skill were paramount. Surgery valued those things I thought I believed in—hard work, self-sacrifice, per-
fectionism—and de-emphasized the emotional and traditionally feminine. There was no narrative in surgery; when in doubt, cut it out. I chose the most difficult path available to a woman of my generation, fighting for an A in my senior rotation when the chair of the department gave me a B because “girls don’t go into Surgery.”

Mentors, or even advisors, didn’t exist at Penn Med in the 1980s. Reading, studying, and testing ruled our days. Although Penn was graded pass/fail, competition was fierce. No one ever asked or cared how we were doing, not even after a suicide wracked our first-year class. There was no discussion of strengths and weaknesses, no career guidance; you were expected to choose a specialty on your own. I often felt like there was a rule book available to people from medical families or Ivy League universities that a first-generation college student from the University of Scranton could never access.

I was not accepted into a surgical residency. At the time, this felt like a disaster. Obviously, I had not worked hard enough, studied enough, been good enough. Although I found a slot the next day at Penn, I was deeply shaken, and resolved to do better in the future. I did not want to end up as a family doctor back in Wilkes-Barre, Pennsylvania, with my mother.

In my desire to be as unlike my mother as possible, I bought whole-heartedly into surgical culture of hierarchy, rigidity, and impersonalization. I over-identified with the traditional medical culture even though I began to suspect that this was antithetical to me. After all, I had eschewed hard science as a career, not wanting the isolation of the laboratory. I wanted to work with people, but I could not see others as anything other than a threat to my carefully constructed persona. Patients were uncontrollable variables, and that frightened me.

I knew there was something wrong about the endless work hours, verbal abuse, and drudgery of residency, but I could not separate those beliefs from what I saw as personal
weakness. Only whiners complained. I became increasingly dysfunctional and depressed as perfection slipped from my grasp time and time again. The body didn't follow the rules of physiology; patients didn't follow instructions, and I became angry and resentful, wanting just a little co-operation from them. I became obsessed that only I could care for my patients, that I could not trust the nurses or other residents to keep them from harm. Of course, patients still died and I knew that it had to be my fault because, after all, only I was capable of saving them, so I plunged harder into my work.

I didn't get the fellowship I desired in Pediatric Surgery and ended up entangled in a legal battle with a program director because I couldn't separate his narcissism from that of my mother. He enticed me with promises for a fellowship, then left me without a position when I refused to plot against another faculty member.

Having failed miserably (again), I left the practice of surgery and entered the field of emergency medicine, where I believed that I had real-time control of everything that happened to my patients.

I became a damn good doctor, and I waited to be told that I had done well. Instead, I was called “controlling,” “demanding,” “sarcastic,” and “hard to work with.”

Now it was thirty years later and I had a string of firings behind me. I had ended up lying on a gurney while staff who had been my co-workers only a few days ago discussed me, deciding if I had actually tried to commit suicide.

I actually felt insulted—after all, I was a good enough doctor to kill myself properly if that was my intention. They should have known that.
Entry Six

HISTORY OF THE PRESENT ILLNESS, PART II

NEW MEXICO, 2010
Chapter Seven

There is a long history in medicine of learning by shadowing a senior physician; indeed, apprenticeship was how medicine was taught until the early twentieth century. Most medical students have briefly followed doctors on rounds or worked in their offices outside of official programs at some time in their young lives. This is how we experienced the art of medicine.

Teaching one-on-one is time-intensive, and practicing physicians are pressed for time. During surgical residency, I was taught primarily by other residents, not by the attending. Hazing was frequent, and bad habits were passed on. Lectures were rare; you taught yourself through reading. This system made no excuses and left no room for anyone who didn’t fit the traditional idea of a surgical resident. The focus was on getting the data and doing the cases—not on taking care of patients.

Medical school and surgical residency caused a Stockholm-like syndrome in many physicians of my era. We were sleep-deprived, living on junk food from snack machines, separated from family and friends, and subjected to daily encounters with things most people never see. We were verbally abused, pushed beyond our limits, forced to compete for cases and residency spots. We labored under the belief that one mistake, our mistake, could kill someone.
As so we identified with our masters in order to survive. I found protection from my own fears in that system, even though it didn’t support much of what I valued in myself. It was so ingrained in me, that even as I saw my own ethic separate from what I had been taught, I was unable to consistently act on that ethic. I simply didn’t know what to do.

As an attending, I now believed it was essential that students and residents learn from the people actually working in the field, those who can show you the ways to succeed and help you cope with failure. It’s important to have mentors who will look out for you. I’d been teaching medical students for many years. I would pick certain patients that I thought were an example of something I wanted to teach, introduce my followers, get the patient's permission for them to be present, then later discuss the findings, differential diagnosis and plan with them. I never included junior medical students in gynecological procedures nor any student in psychiatric cases. Residents saw patients with me that were appropriate for their level of training.

Alan, my step-son, had accompanied his physician father to the office and hospital since he was a child. He was bright and eager and I knew that his experiences with my husband had taught him to be respectful of patients. Now a pre-med student at Yale, he was interested in seeing another type of medical experience—the depth and breadth of cases that present to an ER—so he asked if he could come and spend some time with me at my new job.

I was happy to agree. I asked the ER director if Alan could spend a day with me and he said that that was certainly possible. I did not, however, ask the nurses. It never occurred to me to do so, and this was the first of many mistakes at this hospital.
When I had arrived three months earlier I was an outsider—an Easterner in New Mexico, a liberal in a conservative town, a nominal Catholic but irreligious in a workplace where the first question after your name was usually where you went to church.

Add to that my reserve, and that I retreated into what looks like aloofness when I was under pressure, and I immediately felt uncomfortable in that ED. Even when I tried to reach out I often got it wrong. This was not a new problem for me.

The nurses quickly divided. Those born and raised in the Four Corners felt so looked down upon until they convinced themselves that when I brought in Smarties candies it could only mean that I was saying that they were dumb. Meanwhile, the nurses who had trained or worked in larger settings were glad to have me because of the skills I had brought with me from very demanding places.

They were, of course, all correct in what they saw, just through very different filters, since what made me a good doctor was precisely my need to control, my belief that only I could do things as they needed to be done.

I did try to adjust, to give fewer orders and instead make more requests, to ask for opinions while offering explanations, but now I was unsure of myself. My efforts at changing my perfectionism were stymied by my desire to be right. So much of what I tried came out badly, sounding forced rather than collegial.

I introduced Alan, in his shirt and tie, to the nursing staff that day and explained that he would see some patients with me that morning. At first, things went well. We evaluated a lady with sciatica, who was delighted to have Alan in the room. Next, we reviewed an arm X-ray and splinted the fracture. I was explaining the electronic medical record to Alan, showing
him how we charted, placed orders, and retrieved prior visits when my director stormed into
the department.

"We need to talk," he said to me, indicating his office. "The nurses called me."

Alan and I dutifully joined him in private.

“He can’t be here.”

“Did you tell them you had given permission for Alan to shadow?” I asked.

"That was only if no one complained, and now they did. They are concerned about
privacy."

"Alan is from 2000 miles away, and will never see any of these people again. He's
aware of the nature of what he sees and hears in the medical setting; he's been seeing patients
since he was five."

"Well, the hospital requires his immunization records and attendance at a compliance
class before he can be here. And the ED is one of the places off-limits to students."

"Where is this coming from?" I asked.

"The nurses called the administrator. There is a policy for this and you need to follow
it. I didn't think it would be an issue, but it is. He can't be here."

"Why don't you tell them you gave permission, and it's only for a few hours?"

"Look, he needs to go."

Alan hugged me and left, and I finished my shift, feeling angry, resentful and be-
trayed. Intellectually, I knew I had failed myself: I should have asked to see the policy; I
should have called my director on his duplicity. I did none of those things, trying to get along
rather than stand up for myself. I didn't want to be a disruptive physician; I just wanted to do
my job.
Once again I found myself floundering in a system that I did not understand, one of conflicting internal and external messages. I was doing something I felt was important, something that should have been done for me. Why couldn’t I just do it? Why did the nurses go through so much trouble to hurt me? Why wouldn’t the director support me? Of course, I was a weak woman because I didn’t resist the bullying, but that posture would have only made me more disliked. Trapped again.

A few weeks later, my husband, a staff plastic surgeon, discovered that the hospital routinely allows shadowing and that the quoted policy only applies to high schoolers, I got angrier, first at the nurses for using it and then at myself for not confronting them about it.

What I missed is that I had, simply, never asked the nurses if Alan shadowing me where they also worked would be OK with them. My training had no room for that type of thought. We were too busy learning how to be “Captain of the Ship” and my own psychopathology helped me to buy into that wholeheartedly. Despite my awareness that this style wasn’t working for me, and that I was becoming more intrenched and more depressed, I was unable to change, no matter how hard I tried. I just couldn’t see it.
New Mexico, 2010.

“If you don't do something right now, I'm going to hurt my children." Standing at the window of the police station, this is what she says. The policewoman comes out to get her, hand resting casually on the taser at her waist, and she follows the officer calmly to the room in the rear. The padding does not escape her notice, but that and the pat-down don't upset her. Whatever is happening, all she knows now is that her children are safe.

She can't remember when her thoughts first ran fast and hot like a run-away truck down a hill. She accomplished so much—she had unlimited energy. She even went back to school. Everything seemed possible, new and exciting. When did she start to think about killing her children? She doesn't understand the compulsion that she feels when she is with them. She is their mother; she loves them. They need to lock her up right now before she hurts them.

The police call an ambulance to take her to the hospital for an evaluation. She remembers the last time she was there, about three months ago. There was a woman doctor who saw her; she didn't like her at all. She wanted to send her away to a psychiatric hospital, all because her stupid husband complained that she talked too much and didn't sleep more than a few hours, and brought her to the hospital instead of church. She threatened to call the hospital C.E.O, her good friend, if the doctor wouldn't let her go. Finally a male doctor came
in and told her the woman physician wasn't qualified to diagnose a mental illness, and that she could just call a local psychiatrist on Monday for an appointment. She never did that; it was a stupid idea, wasn’t it?

**Three months earlier:**

I am standing outside the room, listening to the woman talk non-stop for ten minutes, watching the nurse squirming to get out of the room. Mania, I think, but why? There was no psychiatric history on the chart, no medications listed, just the chief complaint: "Husband states patient not acting right."

"I just can't believe how talented Jefferson was," she says as I walk into the room. The nurse scurries out gratefully. "He invented so many things. Did you know he kept up a correspondence with Andrew Adams? And they died on the same day? He owned slaves, you know, not Adams, Jefferson, and he had a black girlfriend..."

"Excuse me," I say. "I'm Doctor Hirthler, and I'd like to talk to you for a minute. Do you know why you're in the Emergency Department?"

"My husband thinks I talk to much, but he's just a bore. I'm back in school and this history class is so interesting. I'm getting all A's. We just finished the Revolutionary War and Declaration of Independence. I could get a Ph.D. next. It was signed in Philadelphia. You know, where the statue of Rocky is. Well, not right there, but by the Liberty Bell..."

"Slow down a bit, Mrs. Smith. How long have you been feeling like this?" I look at the husband and he mouths the words "two months."

"Like what?" she says. "I feel great. I'm getting so much accomplished, did I tell you I'm back in college..."
I sigh and explain to her husband that I will order some tests and escape the room before she gets to the Constitution and Bill of Rights.

Mania it is. Flight of ideas, pressured speech, grandiosity. I speak to her husband privately. “My wife is not sleeping, eating, or taking care of the children,” he says. “She is obsessed with history.” He denies any past episodes like this, but says she has been depressed at times. She doesn't use drugs.

I explain that I will do tests to look for any illness that might cause mania, but I suspect this is a psychiatric problem, and that his wife will need hospitalization. He agrees with this assessment. He is worried she might do "something crazy."

When all the tests return normal, I call the psychiatrist to admit my patient. Unfortunately, there are no beds available at the hospital today, and our psychiatrists do not do consultations in the Emergency Department. I have to certify the patient is a danger to herself and others, then transfer her to another facility about two hours away. This is always a nightmare scenario. It takes hours to find an accepting facility, and the patients and families complain about being sent three hours away, like it’s my fault they live in the Four Corners.

"I am not going away to be admitted!" she says. “You have no idea about all I have to do. There is a paper due tomorrow, the kids have school…I thought I'd get a prescription and be out of here. I don't understand all this talk about mania. I’m fine. I’m not about to kill myself or anyone else. What do you mean I can't leave? I have important friends. Do you know the CEO? I'm calling him right now to get me out of here. You can't keep me against my will."
I explain that I do have the power to keep her, because I believe that she might hurt herself without proper treatment. It will take her several months to be seen as an outpatient, and I am concerned about her.

Her husband agrees to take her home; he doesn’t want her admitted anywhere but here. I try to explain that the decision to commit someone can’t be based on convenience or preference; it’s important to do the right thing in the face of difficult circumstances. I tell him that this is psychosis, that it can only be managed well at this point in a hospital and that there is only one hospital possible at this time. He seems to be not hearing me now. He wanted the problem solved, but not this particular way, so now there is no problem.

I recognize that this doctor-patient encounter is not going well. The narratives are in opposition. I can give in and discharge her and hope nothing bad happens, even though I am experienced enough to see where this is going, or I can restrain her, generating all sorts of complaints. My ethic—do the right thing—is only going to get me in trouble again. I don’t need more complaints; I seem to get a lot of them.

There is one other option, and I grab at it like a drowning man grabs a life-line. I am working with my director today. True, he has been doing his level best to get me fired but this isn’t about me—this is about the welfare of the patient and, yes, the liability of the hospital if she harms herself or someone else.

If I ask him for a consultation, maybe I can get out of this situation without being split between right and expedient.

I am not surprised when he tells the patient and her husband that I’m not qualified to decide that she is mentally ill and needs to be admitted. He thinks that a follow-up appoint-
ment with a psychiatrist will be adequate. He doesn't tell her that getting this appointment will take several months in our town. He apologizes for my ineptitude.

I discharge the patient, documenting carefully my opinion and the role played by my director. I hope I never see her again, that she gets the help she needs, and that she gets better and not worse.

**Three months later:**

One morning my director says, just in passing, “Remember that woman you thought was manic? Turns out she never went to a shrink, thought it was stupid. I admitted her last night. The police brought her in because she said she was going to kill her children.”

I shook my head and walked away; better to be lucky than right. I thought about the children and the effects that their mother’s three months of mania must have had on their development. Was “customer service” worth it? I felt as if I had let them down somehow, even though I knew I had no other options. Could I have changed this outcome, or would I have made it worse by asserting control and alienating the patient and family? Questions like these were consuming more and more of my mental energy, tightening the noose of depression as I could not seem to figure out the correct way to practice. All of the options appeared wrong.
New Mexico, 2010

My tug-of-war with the nurses had continued. Eventually, I learned to not even try to talk to the director, to instead simply keep my head down and hope that things would blow over without yet another petty complaint.

Work became the Twilight Zone, a place without reason. I felt things slipping away from my control, even as I tried harder and harder to conform.

An older woman mentioned chest pain to me; she had been evaluated by another doctor forty-eight hours earlier for nausea and vomiting. Her electrocardiogram was abnormal, but identical to one done a year ago. I documented this in her chart, along with the laboratory values that showed she had already had her heart attack two days before. Once admitted to the monitored unit, a nurse decided she was having the heart attack now (she hadn’t read my note) and called cardiology to take her to the catheterization lab. The admitting hospitalist was furious, as was the cardiologist, both of whom agreed with my assessment. Since the catheterization personnel were already there—and being paid—the patient was taken to the catheterization lab at 3 a.m. Her ventricle ruptured and she died.

My director approached me a few days later. The first complaint was that I had not documented the old electrocardiogram. I showed him my note—“unchanged from prior EKG.” My sin? I used the word “prior” instead of “old.” I shook my head in frustration. He
then informed me he was referring the case to the Quality Assurance Committee because it took longer than thirty minutes to get the patient to the cath lab, and I had “missed” her heart attack (that had happened two days earlier). This was surreal; I showed him where even the cardiologist and written that the heart attack was old, and that he had done the catheterization in the early morning for convenience. The case was dismissed by the QA committee, leaving me pleased but increasingly disturbed about what was happening here.

One Friday, an elderly patient was brought in with a cardiac arrhythmia. Atrial fibrillation is a condition in which the electrical impulses that cause the heart to contract are disorganized as they pass through the upper chambers of the heart. The heart beat gets rapid, but the pumping of the heart is less effective. Clots form in the areas of poor blood flow. Atrial fibrillation is a condition that can cause strokes and heart attacks and it gets more dangerous when the heart rate is higher.

Once on a monitor, the patient's heart beat at 180 beats per minute, well above the normal rate of 60 to 100 beats per minute. It was essential to get that rate down before more damage was done to the already stressed heart. I ordered 20 milligrams of diltiazem, the usual drug and dose for this problem.

About half an hour later I checked back on her, expecting to see her heart rate reduced. It wasn’t, so I checked her chart and saw that the drug had never been given. I spoke to the nurse and saw her go in to administer the medication.

A half an hour later the patient was still tachycardic so I checked the chart again. I saw that the nurse had given only half the dose that I had ordered.

Doctors can make mistakes when we write out a dosage and so there are protocols for when a nurse thinks that a doctor's order is wrong. They are supposed to point it out to the
doctor and if they are still not comfortable administering it, they are to take it to the charge nurse, who is the ranking nurse on duty. They may not, however, just decide to ignore what the doctor ordered.

However, I knew better than to try to settle this with the nurse so I went to the charge nurse, who agreed that the full dose was required and gave the other half of the dose herself.

The lab results I had drawn on the patient came back and showed elevated troponins, proteins that rise in the blood when heart muscle is damaged. All that extra time with a rapid heart beat caused a mild heart attack. After she was transferred to the ICU, I wrote a memo to the senior nursing administrator, who had told me to bring any issues with the nurses to her attention.

I noted that the dose had been first withheld and then deliberately halved without informing me, that protocols had been neglected, and that the dose was itself less effective even when the charge nurse gave the rest because diltiazem is a bolus drug that works best when the entire dose is given at once. I asked if she could review the matter.

I felt confident that at least this time I would be supported—protocol had been breached by the nurse and a patient had been endangered; a more senior nurse had agreed that my treatment was proper; only my intervention had kept the patient from a full heart attack.

I went home for the weekend.
The words Navajo, young, male, and drunk often clustered on medical charts in this hospital just east of the Rez. High up on the plateau, the days were warm and sunny, and our patients often drank and passed out leaning against the wall of the place they bought their liquor. At night, the temperature dropped like a free-falling sky-diver, and the police would cruise by the parking lots waking the sleepers before they froze. Some didn't wake easily, others not at all; we added the word dead to their chart. A drunksicle, we irreverently called them, hiding our true feelings about a society which allowed this to happen. When you get mad enough at watching people slip through society’s cracks and no one caring except to dump them at your ER and drive away, you start saying stuff like that.

Tommy Begay was luckier than most. He passed out in a tent in someone's yard, the empty bottle of rot-gut vodka nearby. An early riser called 911 when they found him. EMS had managed to restart his heart, and he arrived in the ED with a pulse below thirty beats per minute, comatose, and with a body core temperature of 88°F, so low it could only be measured by a special rectal probe.
The body's response to hypothermia is ancient and reptilian. The heart slows markedly and the blood vessels constrict and shunt oxygen to the brain. This process, called the mammalian diving response, allows people to survive drowning as well as other types of hypothermia without brain damage. Severely hypothermic people can appear dead; hence the origin of the medical maxim "you're not dead until you are warm and dead."

Warming a hypothermic patient has to be done slowly. If the temperature rises too quickly, the heart can start to fibrillate, contracting wildly and meaninglessly without actually pumping blood to the lungs or the body, a condition that is fatal if untreated. As circulation to the abdominal organs and muscles improves, toxic by-products are flushed into the circulation, causing kidney and liver damage if not diluted by intravenous fluids. Careful attention to blood pH is required. The person also needs to be evaluated for associated trauma, drowning, drug overdose, and other causes of hypothermia.

We began the rewarming process with intravenous fluids heated to 100°F, and a warming blanket. I assessed Thomas for injury and illness; all I found was a blood alcohol level still over 0.4%, four times the legal limit of 0.1%. He had no signs of drinking methanol, isopropyl alcohol, or antifreeze, so if he woke up, he should recover without any long-term problems. Several hours later, I sent him to the Intensive Care Unit when his core temperature was 92°F, the point at which hypothermic complications were less likely to occur.

When the transporting nurse returned to the department, the muttering began. "She was the one that wanted warm saline," one said on the phone. I overheard snippets of conversations, but paid little attention until the hospitalist that admitted Mr. Begay approached me.

"The ICU nurses want to know why we're not cooling Mr. Begay," he said.

"Because he froze to death?" I replied unhelpfully.
"I know. But they think because he had a cardiac arrest he meets the criteria."

The concept of induced hypothermia after cardiac arrest became popular after several studies in 2003 showed a benefit in neurological recovery. Our critical access hospital provided this service, cooling patients to 93° after resuscitation from heart attacks and other causes of sudden cardiac death. The nurses were great proponents of this incredibly expensive technique, but like most physicians, I retained a skeptical attitude toward the next best thing to come along.

"So, they think after warming him up to barely human levels, we should cool him back down?" I asked. "He's at 92° anyway. Maybe we just shouldn't over-heat him. It says right here in the criteria for induced hypothermia that presenting hypothermia is a contraindication."

"Technically, he was cooled after his arrest because he was already cold," the hospitalist said.

"Exactly."

Then I couldn't help doing what I do when I feel under stress: I have to prove that I'm right.

I mentioned to one of the ED nurses that I heard the ICU had a silly idea to cool our cold patient. The response shocked me.

"You need to get with the program! I told them you were wrong. That patient needs to be cooled."

"But the protocol excludes hypothermia."

"That's your opinion."
I let it drop, but brought it up to my director that night. He agreed that there was no role in this case for induced hypothermia. Two weeks later I find a note in my personnel file addressing the nursing complaints about this case. My director stated that although I was technically correct, I had not "communicated effectively" with the nursing staff, and a reprimand was placed in my folder.

Mr. Begay left the hospital without any sequelae from his adventure. I wasn't so fortunate.
New Mexico, 2010

One evening I had the opportunity to work with a doctor freshly minted into Emergency Medicine. It hadn't always been easy for me to get used to words like "resource" and "experienced" but there they were and I tried to make the most of them. I directed him through the maze of the electronic medical record and over the hurdles of nursing and radiology, and we were working a companionable shift when some interesting information filtered over our EMS radio. A gunshot wound! Although to most people this would be news, to any good-sized ED, it's excitement. Big trauma! Blood! A chance to save a life! Even old docs like me perk right up.

Bits and pieces of updates filtered through via radio traffic and finally I fielded a call from the scene. Young woman, left chest, faint pulse, now lost. EMS wanted to stop resuscitation, but I requested transport when they told me that no medic was present to do a pericardiocentesis—a technique where blood around the heart is removed, allowing it to beat against less pressure—a procedure that can be life-saving. The night was busy and challenging, but I don't like dead young people. My younger colleague looked up expectantly at me, and it was easy to read his mind.

"You ever do one?" I asked, referring to what is popularly called "cracking a chest".
"No, only assisted."

"Then it's yours. I'll steer, you drive."

He ran off to get ready, and I sat down to wait.

Our patient arrived, and the young doctor and I breezed through the procedure. A little "cut here," a little "move that," and soon the irreparable damage to the heart was revealed. Blood, clotting and smelling of metal, pooled at our feet. The lungs were pink and normal, but the lower chamber of the heart had been shredded by the bullet. There would be no heroics tonight, I thought; our young lady was certainly and irreversibly dead. Quietly, slowly, the nurses and techs filtered out of the room, and the other doctor went off to do his paperwork, leaving me with our patient, my hands still in her chest. I was thinking about how lucky I was to be on such intimate terms with the human body. I knew what lungs and heart really looked like, how they felt, both alive and dead. So few people, even other doctors, had this opportunity to see inside us all.

My reverie was interrupted by one of the nurses, who asked if I would show her the anatomy. As we took a tour of the open chest—lungs still inflated with the last breath, diaphragm, shiny and strong, and finally the heart, with its gaping injury—a line gradually formed. I looked up to see many of the techs, nurses, EMS personnel and even a few police officers patiently waiting their turn to see. The absence of sound was striking. I covered our young lady decently, leaving only our thoracic opening on view as our department filed by, some just looking, others requesting permission to put on gloves and touch the precious organs. I realized that I was writing a new narrative, now acting as her representative, as my co-workers paid their respects, appreciating the opportunity to have that precious glimpse
inside the human body. There were no jokes, few questions, and every person said, "Thank you," not so much to me, but to the person who had once been alive.

I don't know how our patient met her end. The wound was possibly self-inflicted, but homicide was also being considered. I only wish she could have seen the line filter by her body, and heard the words of gratitude spoken at the bedside, and read an unexpected coda to her tragic story.
New Mexico, 2010

"Doctor, there's something growing in my head. I can feel it. No one believes me, but you've got to help me."

The thin anxious woman in front of me wasn't the typical down and out patient that commonly presented with this kind of complaint. A woman I knew had accompanied her. Mrs. West had no history of mental illness and was well-spoken, with excellent eye contact. Her shoes were expensive. The only thing not right was they story she was telling me.

"I know it sounds funny. But there's a pressure in my head, and it's getting worse. My doctor say's there's nothing wrong–I had a CAT scan last month. But I know something is in there."

The woman with her raises her eyebrows and shakes her head as I sit down. I don't know how to approach this story. I'm not known for my subtlety or tact, but even I realize that telling her she's delusional won't work. I go over the basics of her history, looking for clues that will help me figure out something to do. She passes the mental status test easily. Her reasoning and judgment are normal, except for that one little problem. There's something growing in her head.
"How about we do an MRI?" I ask. "That's our best test. If it doesn't show anything, could you accept that? Would you be willing to talk some more about what you're feeling?"

She agrees, insisting that the MRI will certainly show something. It has to—she knows what the alternative would be, and that is too frightening for her to consider. We review her medication list, and I ask her if there are any drugs or other supplements that she takes that are not listed.

"Dexedrine. I take Dexedrine, too."

I sit bolt upright. "Who prescribes Dexedrine for you?"

"Dr. Smith. He's my pain doctor. The methadone makes me sleepy, so he gives me Dexedrine. I can't get by without it."

Smiling reassuringly, I back out of the room, only to be confronted by her hovering daughter and son-in-law.

"Have you seen our mother? My father's leaving her—he can't take it anymore. What's wrong with her?"

I wonder if truthfully answering the question is a good idea. Probably not at this point. I get more history from the family—insomnia, weight loss, agitation—and share the plan for lab studies and the MRI. Everyone is happy.

"Doc, can I give you these?" The son-in-law appears behind my desk, hand extended and filled with several different sizes and shapes of pills. "These were in my mother-in-law's pocket. Maybe they'll help." I send them to Pharmacy for identification. Methadone, Xanax, and dextroamphetamine, generic Dexedrine. A very dangerous combination of medications.

After the normal MRI, I speak first with the daughter and son-in-law.

"Did you know she was prescribed Dexedrine?"
"No, what is that?"

Carefully, I said, "Well, it's speed, pure amphetamine. I think it has made your mother psychotic—delusional, really"

"Is that why she hasn't slept for three days?"

"Yes, and the lack of sleep also increases the psychosis."

"Why would Dr. Smith prescribe that drug?"

Another minefield. I tread carefully, my brain screaming malpractice.

"There are a few indications, like narcolepsy, but very few doctors write for this drug because it's so dangerous. You might want to ask him about it later."

"What do we do now?"

I ask them to go back to the patient's room as I call Social Services. My patient would need a medical detoxification unit as well as a psychiatric facility, and her insurance (or lack of it) would determine where she could go for treatment. Our social worker would take care of that; I needed time to decide how to present this diagnosis to the patient herself. How do I tell someone still actively crazy from a drug her doctor prescribed that she is crazy from a drug her doctor prescribed and get a sensible response?

We filed into the room, the social worker and I, and I pulled up a chair next to my patient.

"Mrs. West, the good news is that your lab tests and MRI are normal. There's nothing growing in your brain. But I think I know why you feel like it is. Is it true you haven't slept in three days?"

She nods, eyes wide.

Do you know what kind of medicine Dexedrine is?"
She shakes her head no, watching me, waiting.

"It's speed, like pharmaceutical grade meth, and it's causing you to believe things that aren't true. It's not your fault, but you're addicted to it, and probably taking more than you should."

"I need help, then," she said, appearing relieved, as a collective sigh escaped the room. Maybe this wouldn't be difficult after all.

"Yes, and Anna here will help you make arrangements to go to a treatment facility tonight."

Her expression changed as the reality of what we were suggesting became clearer.

"My doctor prescribed that medicine. I don't want to stop it. Are you sure it's a problem?"

Now I'm in the familiar territory of the addict's litany—denial, bargaining, and manipulation. Anything to justify keeping the drug.

"Yes, I'm sure. People who aren't addicts don't carry their pills all mixed up in a Kleenex in their pocket. They keep them at home in a medicine chest."

"I thought I might need them."

"I know—you don't want to be separated from them. That's one of the signs of addiction."

"Can I still have methadone? I have pain, you know, all the time."

"I think you'll need to find other ways to manage your pain in the future, but let's not worry about that now. I'll give you some medicine while you're here to start your treatment."

I left the family and social worker to their plans, and went back to work.
There are many days when I tire of cleaning up the detritus left behind by others: the wreckage of driving drunk, the bruises of domestic violence, the gasping of long-time smokers. It is especially disheartening, though, when the patient suffers as a result of medical indifference, incompetence, or malpractice. I want to call the State Medical Board, scream and yell, but there are other patients waiting, and too much to do before I leave.

Everything ends up in the ED, sooner or later, where the physician has to filter through what came before, like an archeologist bent over a screen, searching for the one item that will illuminate the diagnosis. Today I had found it—that buried clue, the deeper story—when all the shaking and sifting of dirt had uncovered something ugly. I regretted finding it and wished I could have tossed it into the fill pile with the unwanted twigs and rocks. But my patient needed the truth. The physician, like the archeologist, must go where evidence leads, even if the result is something we wish we had never known.
The patient in Room 17 arrived by ambulance from the local community college complaining of one year of knee pain. She was well dressed and spoke articulately, saying that today she was unable to put any weight on her knee at all. She had not seen a doctor for this problem before and had no known injury. Her knee was painful, and had a small amount of fluid in the joint on exam. EMS had given her some pain medication, and I gave her more.

There's not much to do for this kind of concern in the ED, especially when the patient underestimated her weight at 280 pounds. The most dangerous problem causing leg pain would be a blood clot, so I ordered a test for that. X-rays might show a fracture or arthritis, but don't give any information about the ligaments or the cartilage, which are far more common problems. Even though none of those diagnoses (other than the blood clot) would warrant admission, the patient was so insistent about her problem that I ordered an MRI of her knee. We rarely do that in the ED because it is so expensive and time-consuming, but I wanted to give this woman a definitive diagnosis.

Several hours later the MRI report arrived. The patient had a small to moderate amount of fluid in the joint, and degeneration of one half of the medial meniscus (cartilage)
without a tear. Although this explains pain and swelling in the knee, it really wasn't a very abnormal study. Rest and ibuprofen should do it.

    Somehow I missed all the clues that my patient had her own narrative: she insisted that she needed an immediate total knee replacement, an operation her husband had just undergone. She was tired of waiting on him. I tried to explain to her that her MRI didn't show that severe of a problem, and that the orthopedist that I had spoken to about her would try other modalities first.

        "Like what?" she snapped.

        Physical therapy, ultrasound, injections, I replied.

        "How can I do PT when I can't walk?"

        I explained passive ROM exercises and that based on her MRI she should be able to bear weight soon. I offered crutches and even a wheelchair.

        "How did I get this?"

        As gently as I could (really), I explained about repetitive trauma due to her, um, larger size.

        "I need surgery!"

        "That's why you're seeing the specialist. But you are at high risk for knee surgery, because you are female, and, well, large. Your chance of getting blood clots is high. I'm sure he'll advise some other things first, like exercise and, um, well, weight reduction."

        "I don't like your tone. I think you're unattractive, but I'm not calling you ugly."

        How to answer this one? I should have left right then, but I'm trying for service recovery here.
"I thought large was the most objective and least offensive term I could think of," I said.

"Well, I'm leaving!" There was more, but you get the idea. I sent the charge nurse in to see what she could do to salvage the encounter.

"That bitch will regret the day she met me!" she said, amazingly able to walk out without assistance.

So I sit here three days later waiting for the inevitable call from my director about another patient complaint. Patients want instant relief and are annoyed when they don't get it. Weight is both a clinical fact and a touchy subject, but how patients see doctors really has changed, and only for the worse.

When my father was growing up doctors were like gods. Patients took off their hats and stood up for doctors. Now, medical care is a commodity regulated by third-party payors and we are "providers" and administrators roam hospital halls getting "client satisfaction" grades on us.

Of course, as in all things that matter, the truth is somewhere in between.

We physicians are, through years of intense work, the bearers of very specialized knowledge and skills and we deserve to be respected for that. We are also human and sometimes we don't act at our best.

What matters is that patients know that we are in their care with them, that we are on their side. We're not trying to insult or belittle them. They need to see themselves as our partners, not—as the system is now training them to do—their adversaries.

An angry patient yelled at me, "It's your job to put up with this!"
No. It isn’t. My job is to help you get well, and I can’t do that without your understanding and co-operation. Those hidden narratives trip me up every time.
Women in White, 2011

I thought a lot about my white coat in New Mexico. I left it at home one day, and I remember searching frantically through my car—front seat, back seat, trunk—without success. I called my husband, who found it neglectfully tossed over a chair in the study, and he agreed to deliver it to me. With a sign of relief, I entered the department, but found I still couldn’t work until I finally slipped my arms into the comfortable starchiness of my coat, rolled up my sleeves, checked my decorative pins, and filled my pocket with my rolled-up stethoscope.

When I began to notice the coolness and resentment of the nurses in the ED, I asked one of the other female doctors, who got along well with them, what she thought was going on. She mentioned that I was the only member of the ER staff who did not wear scrubs on shift and that this was considered arrogant, that I was putting myself above everyone else.

During my surgical training no one wore scrubs outside the OR. It was considered beneath a doctor’s dignity and disrespectful to the patient. When you went to see a person, you put on your suit or your dress and your pressed white coat and you strode down the hall with eyes on you in the role of “physician.” My white coat was an essential part of my medi-
cal identity. Unfortunately, what I viewed as armor against disease, mortality, and personal failure, others interpreted as an assumption of royal robes.

Why was this coat essential to my identity as a physician, when it had been identified as an impediment in this particular department?

I decided to do some research about white coats and found a surprising number of online discussions about them. One day I stumbled upon a conversation about who still wore a white coat in clinical practice. Practical doctors liked coats because they had pockets and helped to keep clothes clean. Others felt that the white coat indicated a degree of professionalism and respect for one's patients. Some saw it as a hard-earned reminder of their medical education, and many felt that their hospital/clinic/patients simply expected them to wear it.

A significant number believed that white coats were both outdated and elitist, the sentiment expressed in my Emergency Department. They felt their patients were more comfortable with a doctor dressed in casual attire. Many physicians referenced articles in medical publications that discussed the competing goals in medicine of humanism, aiming to link the doctor to the patient, and professionalism, whose goal is to separate the two.

On the other hand, some insisted that this entire concept of not wearing a coat was the reason that doctors were no longer respected and why medicine was going to hell in a hand basket.

There were a few physicians who echoed my personal feelings about my white coat. They spoke poetically about its transformative power, its greater meaning both to them and to their patients. They found themselves quickly dismissed as believers in magical thinking.
As I read through the comments, several things were clear. Pediatricians and psychiatrists had stopped wearing white coats when they learned that they were perceived as threatening by their patients. Some doctors felt that they were prone to spread infection, especially if not changed frequently. Younger physicians viewed them as “old school,” a symbol of the patronizing power of physicians, and chose to wear scrubs as a comfortable alternative. Others believed the white coat had lost its ability to differentiate physicians from other health care providers. Indeed, you are much more likely to find a nurse or an administrator in a white coat these days, especially in the ED.

Unless your doctor is a woman. I was surprised as I looked through the postings and realized that the majority of white coat wearers were just like me: female. Other women professionals were just as deeply attached to their own white coats. What was going on?

Female physicians, particularly those over forty, referenced the issues that still persist for women in medicine. Where do women stash their pen, phone, wallet, tissues, and other needed items if they don't wear a coat? Many women wore street clothes and appreciated the fact that a coat helped keep them clean. Eventually, though, the discussion centered on one unifying reason why we women wore white coats: it was to be identified as a doctor.

This is an issue totally foreign to male physicians. It simply never happens to them. When starting clinical rotations, male students begin wearing ties and immediately look like doctors. Women, in their street clothes, are still simply female. Throughout their entire careers, women encounter staff and patients who refuse to “see” them as physicians and insist that they fulfill a more traditional female role. It doesn't seem to matter that a woman introduces herself as “Dr. X”; we all are asked when the doctor will be in to see the patient. Fe-
male physicians are often called “nurse” and asked for bedpans, food, and blankets. Although few female nurses would expect a male doctor to interrupt his work to respond to those requests, they often consider a female physician a snob if she declines to deliver coffee to Room 10. Patients and families glare with indignation when a female doctor is unwilling to assume a service role. If we are not very good at handholding, we are called harsh and cold, and yet any softness often undercuts our authority even more.

Women physicians like me had done all the studying, completed the training, passed the examinations, and practiced successfully for many years. Yet our gender required us to prove our identity as physicians every day in situations both great and small. Consultants, patients, families, female nurses—each day was a battle simply to uphold our identity. No wonder I held on so tightly to my coat; it wasn’t merely a symbol, but the actual item that made me a doctor.

The fact that this issue is less important to younger women in medicine signals an important change, but the battle to arrive at this point cannot be forgotten or minimized. To many of us older doctors the white coat is also a symbol of what women endured while training in the 60s, 70s, and 80s. Criticism by nurses and younger physicians is painful to us because they don’t recognize the personal and communal difficulties we overcame in order to wear it.

A discussion about what one wears, without examination of the reasons, serves no purpose except to further divide health care professionals at a time when we are faced by other more important issues. I decided to waste no more of my time on it, and wore my coat proudly until the final day of work.
I was fired the Monday after I had complained in writing about the nurse giving the incorrect dose of medication. I had not known the chief nurse administrator was having an affair with the ED director. At the end of my shift, the director appeared and escorted me to the office of the hospital attorney, where I was offered a three-month severance package and asked to sign paperwork. I refused and requested an attorney of my own, but I knew my time there was over.

I had struggled with depression throughout my life; most perfectionists do. By now I had spiraled to a very dark place. My psychiatrist told me that I spoke to her several times after I had been fired and that she told me that I sounded worried about suicidal ideation but rational enough to contract for safety. She said I believed that I loved my family and my sweet little dog and that I would not want to hurt them by leaving them. She told me that we discussed hospitalization but I knew that it could end my career, so we decided to wait.

The night before I was admitted I took medication which I had been prescribed to help me sleep, along with several glasses of wine. I still can't be sure why I did that. After all, as a doctor I knew better. What I do I know is that I did not want to die. I think that I wanted to escape for a while.
Sometime the next morning, I fell. I don’t remember the fall; in fact, I don’t remember anything after Tuesday night, including conversations with my doctor, my husband, and my father.

Short-term memory loss is a known side-effect of hypnotic medication (sleeping pills), as is a form of sleep-walking where people can do complicated tasks like driving without remembering them. I don’t know if my memory loss was due to that or to the concussion that I sustained when I fell, a combination of both, or to something else entirely.

In the past, you see, I had also lost time, a few hours, a day, and in college, three months after the rejection by my roommate. I must have functioned well—my academic success proved that—but chunks of my life were lost to these lapses.

They worsened during periods of stress. Losing time—actually stepping outside my life—was my last best defense against the hopelessness I often felt. I had no idea that my rigid perfectionism had become a stronger trap for me than anything my mother could have designed.

When I didn’t match into a residency, I was devastated by this clear (to me) evidence of my inadequacies as a doctor and as a person. I wanted to hide from everyone and everything and so I slipped away yet again. That I was separating being an ideal doctor and being a fallible human never occurred to me and dissociation became a refuge.

I’m told that during the times that I now know that I was gone that I actually interacted very well with colleagues, with nurses and with patients. I was the consummate actor; I fooled everybody. When the facade cracked, I was called a bitch, mean, lacking in compassion and emotional intelligence, and cold-hearted. The cost of attempting to hold the pieces
of myself together, to survive another day, had become burying the best part of myself, the part that cared, because that was the part that could hurt.

Admitting that I was depressed was the ultimate assault on the self-image I had created. I had convinced myself that to be a good doctor what I also was—a person in pain—had to be disappeared, taking all that I also was—a person with a good heart and a sense of humor—with it, leaving only a dissociated shell or an unfeeling automaton.

Seeking psychiatric care as a physician is dangerous on many levels. Mental illness is both stigmatized and punished. Medical students fear losing the place they have sacrificed their youth to gain, and so they hide their anguish or view it as a rite of passage. Credentialing Committees of hospitals require depressed physician participation in peer Wellness Committees as a “disruptive physician,” without confidentiality, and committee evaluations are often used as the first stop on the paper trail to termination. State licensing boards dictate that those who have sought mental health treatment enroll in a monitoring program that includes mandatory random drug screens and participation in twelve-step programs even when addiction is not an issue. Colleagues consider mental illness a sign of weakness far greater than that of physical maladies, especially during residency, where even absence for a therapy hour triples the work of others.

The traditional male-dominated culture of medicine that demands that doctors “suck it up” prevents many physicians from seeking treatment. Some doctors find care out of their immediate location, use aliases, and pay cash so that there are no insurance records. They lie on their license applications to avoid Board sanctions. Sometimes they abuse alcohol and drugs, and sometimes they die.
I recognized by residency that I had a serious health issue, and I dealt with it just as I dealt with everything else in my life, without fear. I believed that I could fix this, too. I became the perfect patient, seeing my therapist, taking my meds, and working diligently to get better. I took communication classes, wellness classes and read voraciously about burn-out, and tried to change. Unfortunately, I had lost sight of the frightened child at the heart of my issues, and so never allowed anyone else to see past my competent persona, until everything collapsed.

The only thing that I ever feared was not being perfect, because I would then be consumed by my mother. Every not-perfect thing about me, large and small, pushed me closer to an abyss that terrified me. What the nurses at my final job would see as ego was actually dread that I would end up alone and dependent. I was beginning to discover that the persona I had chosen to protect me was no closer to my true self than my mother’s concept had been. The inherent contradictions in these internalized messages finally reached the point of combustion.

Medicine enabled me to do great good but I did not understand that the consequences of one kind of failure—the death of a patient—was so great that my anxiety about error was increased exponentially. I had the education and intellect to make few mistakes, but I could not be perfect. Nor could those around me, who I demanded meet my high expectations. For many years, I could not control the fear or objectively look at the reasons I was so intolerant of error. Now I was forced to do so. Yet how could I change my career? Wouldn’t that be a spectacular failure? I had finally slammed into the wall that I had been barely avoiding for so many years and I was still trapped by my one measure of myself.
I decided to think like a doctor. After all, when we are deciding on a treatment we look at the risks and the benefits to the patient, the best case scenario and the worst one.

What was the worst that could happen if I wasn’t perfect? My mother and her anger were gone. My father had stopped drinking years ago precisely because he loved me and now finding me collapsed had terrified him and he never wanted that to happen again. My husband and my step-son wouldn’t think less of me—in fact, they worried about the blackness I would fall into and they wanted me to be happy. My husband’s a doctor so I certainly wouldn’t end up homeless or starve even if I took on a less remunerative way to make my living.

Who did I care about that would see me a failure? Only myself.

I was defining failure as being imperfect, but being imperfect means being human and being human wasn’t worth dying over.

I made choices.

I chose to understand that courage does not mean desperately hanging on to what is broken, measuring strength by the capacity to suffer, but to face the truth.

I chose to be who I really was.
New Mexico, November 4, 2011

The day that I left medicine is the day that I learned what it truly meant to be a feminist.

I had always believed in feminist theory. I let nothing hold me back. I went to an Ivy League medical school and chose the most macho residency—general surgery. I supported all the right causes: equal pay, the right to choose, LGBTQ issues. I thought I was gender neutral in my approach to others, but I was wrong about myself.

The feminine mystique infiltrated my psyche like a cancer. Even though I didn't fit into that traditional female mold, a deep, almost atavistic part of me insisted that I should, and that conflicts that arose from that discordance were not only my fault, but could be remedied if only I tried harder.

That was my mother's message to me growing up. I was smart, competitive, and had no tolerance for fools. My mother tried to form my mind into something more traditionally feminine, always telling me to be modest, get good but not great grades, be kind and considerate and deferential. I was none of those things, and clearly not the daughter she had wanted. When she said that I was fearless, she meant it as a condemnation. I felt like the alien child
left with a human family in a poorly thought out experiment as I internalized her values and continually failed to meet her expectations.

The depression that began in childhood never left. In residency, I sought help for the first time through CBT (cognitive behavioral therapy) and antidepressants, and things improved for a while, but my symptoms recurred with regularity. Over the next thirty years, I saw various therapists and psychiatrists, all well-trained and well-meaning. They taught me coping skills, communication techniques, self-care. I tried and tried to be different, to be more....something. The message was always that I needed to adapt, to try a different approach. I now see how Freudian psychoanalytic beliefs subliminally supported the traditional female archetype, and how my inability to conform led to increasingly severe episodes of depression. No one ever told me it was acceptable to stand up for myself and demand equal treatment—including from other women.

The relationships between female nurses and female physicians are often tense precisely because women are not taught to respect other women. There is a bristling—she thinks she is better than us—that is not applied to male doctors.

My male superiors pointed out to me that I had to ask instead of order, that I needed to be more collaborative and less dogmatic. The nurses didn't mistreat other female physicians, they insisted, so the problem had to be me. And so I gave away power, and felt powerless as a result.

With the echoes of my mother's voice in my head, I tried to accept what I was told. I became a sexist, judging myself a flawed woman because I did not fit.

Waking up in the ICU, though, brought new clarity. I could keep repeating my experiences, knowing full well the results would be the same, or I could walk away and live.
The one thing I couldn't be, however, was someone else.

Because of who I was, who I was born to be, some women, like my mother and some of the nurses, would always find me unacceptable. However, they would continue to succeed in feeding my depression only if I accepted their version that I was not deserving of respect. Now the chance to change that, to get off a train of repetition, was in my hands.

I had worked long and hard through college, medical school, residency and fellowship and I loved being a physician, but now I was afraid to go back to work. I could not see myself as a success, because I wasn’t perfect.

Sometimes you have to face the truth. Maybe I did try to kill myself halfheartedly before I fell and hit my head.

I was a highly intelligent woman but I also had a life-long mental illness. I had done everything in my power to overcome it but the illness itself had tricked me into the worst possible choices as it insisted that I prove my worth by blaming myself and pushing harder. A career defined by high-stress situations, irregular shift work, and unreliable periods of sleep and nutrition had just made me sicker. Medicine as a field showed little compassion or understanding for those who were deemed different. Desperate attempts at control had made me a demanding, intolerant perfectionist, and my fear of inevitable failure led to anger and self-loathing and so to a greater desire to be perfect, driving me back into the cycle.

After my hospitalization, I joined a group of physicians in an online forum. For the first time in my career, other women told me similar stories. Not every female physician, but enough of them to let me know I had experienced something real and uniquely female.

First wave feminists were reluctant to tackle the issue of female/female bullying because it made women look bad and gave credence to the prevailing "they're all crazy bitches"
belief. Second and third wave feminists see that this reluctance to acknowledge women as humanly flawed has led to us having unrealistic expectations about female behavior, especially in the workplace.

Clearly, being male would have mitigated some of what I experienced. Much of my difficulty arose from having more traditionally positive masculine traits, anathema to certain other women. But most of it was me, and I needed to look fearlessly at who I was…and wasn’t.

I wasn’t an evil person, rude and mean. I had a great love for humanity and a desire to serve it. I wanted the best for my patients, but I wasn’t all powerful. I couldn’t control everything, and I couldn’t avoid mistakes.

I wasn’t cold-hearted. I loved my family, friends and husband. I was not a great daughter to my mother, but I am a wonderful one to my father. I was an imperfect wife to my earlier husbands, but I am a better one to my last.

What was I? I was in pain. I was human.

That’s the point of these stories. Life happens. It’s unfair to expect perfection in ourselves or others. Being a doctor doesn’t make you perfect any more than it makes you greedy or lazy. Sometimes those who appear most confident are the ones who are most afraid. It’s not only possible to fail, it’s inevitable, and it has no bearing on what kind of person you are.

I was finished hating myself for who I was. I had to accept living with my illness, and change the things I could in order to survive. It was time to quit.

The day I understood what it meant to be a feminist was the day I walked away from my medical career with no regrets.
ENTRY 6

ASSESSMENT AND PLAN

ONE SENTENCE SUMMARY OF THE PROBLEM FOLLOWED BY DIFFERENTIAL DIAGNOSIS AND CLINICAL REASONING
This 53 yo female with recent life stressors presents with an altered level of consciousness and evidence of head trauma from a fall. Differential diagnoses include intentional/accidental overdose, concussion or other central brain event, metabolic derangements, cardiac or pulmonary events with hypoxia, infection, or neoplasm.

Clinical reasoning:

Patient has a history of depression, recent job loss. Empty bottle of Lunesta found on scene. Full toxicology, including alcohol and drugs of abuse ordered.

Patient struck head in fall. CT scan of the brain ordered to rule out stroke or bleeding.

Patient has a history of blood clots. Arterial blood gas and CT of chest with IV contrast ordered to rule out embolism.

Pt is an age-risk for heart disease. EKG and cardiac enzymes ordered.

Unable to assess abdomen. CT scan ordered.

Blood chemistries, complete blood count, liver studies and urinalysis ordered to rule out metabolic process.

Patient to be admitted to ICU, with Dr. P. as the physician.
Chapter Eight

The differential diagnosis section of the medical record used to be a list of a few things that the doctor was considering to be wrong with the patient, the most likely first. Today it has morphed into a list of everything that might be wrong, with a test matched to each possibility. It has become unacceptable to rely on knowledge and probability alone; tests are needed without regard to likelihood of finding anything. So I had multiple labs and imaging studies performed during my hospitalization, some of which were unnecessary, all of which were negative.

After discharge, my own assessment was simple, the plan less evident. Looking back over the past five years, I had taken several breaks from medicine but returned reluctantly to practice after a few months, ignoring the message my subconscious was sending. My intellect and work ethic were increasingly unable to control my overwhelming fear of failure. Battling this fear for twenty years had depleted me mentally and physically. I was certain that a return to active practice would be fatal, but what else could I do?

My husband and I discussed options.

“You’re a great doctor; no one takes better care of people. Try going back.”
No. Not possible. I had tried for too long. The system had never worked for me; it did not value those things important to me. Only my strength of will kept me in it this long, and that will was broken.

“Try Urgent Care.”

Just the Emergency Department by another name. I won’t do that again. I can’t.

“You can’t just sit around and do nothing. I don’t care what it is, but you can’t declare your life over. Maybe you can teach. You’re great with students.”

I don't know. I can’t think. My neuropsychological assessment after the fall showed problems with concentration and short term memory; unfortunately, my long-term memory was fine.

My husband completed his fellowship in hand surgery and had been offered an excellent position at a hospital in the Midwest. He knew that I was happiest in the warmth and sunshine of Florida but there were practical matters to be considered. “If you’re not going to work, I need this job. You can take all the time you need to figure out your next step.”

Over the next few months I looked for the answers to the questions I had never asked myself. I had always wanted to be a doctor, hadn’t I? What were my true strengths and weaknesses? How could I minimize the triggers of my depression?

I could accept all the blame; that was a comfortable, if ultimately dismal, place for me to reside. Or I could say it was all depression, or my childhood, or some gauzy combination of both. I could cite the system that encouraged emotional numbness and interpersonal distance in the name of facts and data. Or I could accept that it didn’t matter, that blame and guilt were bastard cousins of responsibility, and that I had always tried to do my best. That my best wasn’t good enough was a fact, not a reflection of effort, talent, or worth. The over-
whelming feeling of relief I had, once I decided to never practice again, convinced me that there still was a good life to live.

I had always thought that quitting medicine would be the end of my life—I was astounded to see that it was the beginning.

I recognized how lucky I was to have options. The people I loved did not judge me a failure but, rather, were glad to see me finding a place that didn’t hurt. It was time to face what I could no longer do, but also acknowledge what I could do with my future.

Medical Humanities is a new concept in medical education. Initially based upon Rita Charon’s work in narrative medicine—stories of illness and healing—medical schools have begun to see that exposure to writing, art, and music do not just broaden medical education but also help doctors cope.

Doctors, residents, and students enmeshed in the traditional system resist this concept. “Doctors have too much to learn already,” some say. “They don’t have time for that stuff.” But that’s the point, isn’t it? To create time for ourselves? Because when I look back at my career, I can sum up my disillusionment in one phrase—not enough time.

Not enough time for the patients. Not enough time for me.

It’s getting worse. The data is endless, the pressure relentless, like the flow of patients into an ED. It keeps on coming. The work can never be finished. There is more to learn, more to fear, every day.

I’m not an expert in healthcare policy; I only have my own experiences as evidence of dysfunction. What I do know is that doctors leave medical school deeply in debt, and the current rates of reimbursement force them into procedure-heavy specialties and away from pri-
mary care. We need more physicians, and we need to reduce their debt and pay them a fair salary that values their time and decision-making as much as the procedures they perform.

Hospital systems and physician management companies staff at minimal levels to maximize profits. Productivity requirements reward quantity over quality. Compliance with government regulations that questionably improve safety or care prioritizes data collection. Specialty boards and state bureaus add onerous maintenance requirements for continuing licensure. There needs to be a system-wide commitment to reduce the non-patient centered work-load of doctors and nurses without sacrificing income. These reforms must come from the profession itself. Government interventions, like mandatory restrictions on residents’ hours, tend to fix one issue while ignoring all the repercussions of the act. Recognizing that residents worked too many hours was important; the mistake was in not understanding the time-wasting drudgery that filled many of those hours. Rather than make their time more valuable, the regulations have simply made it less, undermining the ability of residents to get the education needed for successful practice.

On a personal level, doctors perpetuate the dysfunction by expecting themselves to be superhuman, to never be sick, or have family obligations, or need a vacation, or be sad. Ours has been a failure to recognize our own humanity and to acknowledge that many of us need help to survive. We must look more kindly upon our human characteristics, and support our colleagues during the vagaries of life.

Medical Humanities programs at the medical school level show students that time for reflection, creativity, and camaraderie is valued as much as time for physiology and anatomy. These students will be the ones to change the system from inside, demanding more time for
themselves and their patients. They can always look up the Kreb’s cycle on the Internet; why waste the time memorizing it. They will know that the stories are more important.

Through reflective writing, we can put the emphasis back on narrative. What is the patient’s story? What is the impact of what we experience in medicine on our personal story?

I’d been writing stories about my experiences for years as a way to understand some of what I felt. My husband secretly submitted one to the Annals of Emergency Medicine where it was accepted for publication. The Yale Journal of Humanities in Medicine and Oklahoma University School of Medicine’s Blood and Thunder had also accepted pieces.

At a week-long writing retreat, a physician-poet who had completed an MFA in Creative Writing and is now Director of Medical Humanities at a prestigious university suggested this career path as a possibility for me. I did some research and discovered that I was excited about the practice of narrative medicine, but that I also wanted to become a better writer and teacher. Thirty years after medical school, I decided to enroll in graduate school.
Epilogue
Nightmares remain the legacy of my time in emergency medicine. If I don’t get out of bed the minute I wake in the morning, I fall back to sleep and inevitably have exquisitely detailed dreams about the job. The outrageous clashes with the mundane, and I am always rushed, wrong, and unpaid. Three years after I left medicine, and still I have the dreams.

An example:

In Room 7, two teenage girls sit, troubled by the condition of their hands. They work in a restaurant kitchen, primarily washing dishes and scrubbing countertops, and their hands are chapped red, painful, and peeling. Their boss doesn’t appreciate bits of dried skin floating through the air, and something must be done or they will lose their jobs.

I look carefully at the skin, fissured and flaking. This is some combination of contact dermatitis from the soap they use, along with immersion injury from spending too much time in water.

“Do you wear gloves?” I ask.

They exchange glances. “No.”
I am shoved aside by an older man who, without introduction, tells me, “They have necrotizing fasciitis (the flesh-eating bacterial infection). You’re going to give them antibiotics, aren't you?”

“Are you a doctor?” I ask.

“No, um, yes. Antibiotics?”

“I don’t know yet.” The unproductive and adversarial conversation continues and he gets more and more agitated.

“They need antibiotics. A steroid cream. What is wrong with you? Don’t you know anything?”

Finally he grabs me and sticks his wet, slimy tongue into my ear. I run screaming from the room, only to find my way blocked by other family members trying to get into the room. I stretch out my arms, barricading the door, as people crawl underneath and ignore my admonishment “Two people at a time!”

Fade to the nursing station. I am searching in vain for the chart of a patient I saw with an injured wrist. It has been moved several times, but I finally find the clipboard under a book. I go to find the man’s X-ray, which shows no fracture, but somehow all the tendons to his fingers have been sliced apart. I try to find the patient, but he has also been moved several times, and I seem to always be in the wrong hallway. When I do locate him, an orderly has confused him with someone else and is trying to take him to the inpatient floor. I straighten out the mess.

My patient had no open wounds when I first saw him, but now he has cuts on his face and abdomen, and his tendons in his hand are flopping about like octopus tentacles. Had I done a neurological examination of the hand? His laboratory test results are very abnormal;
why hadn’t he told me he was diabetic? My director walks into the room and says that I have ordered the wrong dressing for his wounds. I try to explain my choice, but the chewing gum in my mouth has hardened into a sticky brick and I cannot speak clearly. I try to dig it out, managing only to dislodge a tooth in the process.

I look for the police to report the assault on my ear.

“Oh, they’re gone,” says the unit secretary. “Your boss told them not to bother because you weren’t really hurt.”

An outside hospital calls about a transfer that is unnecessary. I spend thirty minutes on the phone talking to them, and another fifteen documenting the call in case they complain. I will never get home.

“Spinal trauma in Room 1,” says the charge nurse.

“Can you try someone else?”

“They said you take it.”

I remember that a billing company error means they never pay me for my work, and that this is my last shift ever at this hospital.

I wake up.

My husband calls these my “sick” days (much to my annoyance) because all I want to do is throw a blanket over my head and hide. But now, I can write, so that is what I do, and the images and emotions that hurt lose their power.
“Local Attorney Disbarred” read the headline. I knew only a few lawyers in town—two of whom had worked for me and one married to a friend that I hadn’t seen in years—but I looked at the article anyway. Shockingly, it was my friend’s husband, a man I knew socially, the man who represented my ex-husband in our divorce. Worse, there was a warrant out for his arrest over financial improprieties, and the next day’s paper featured his mug shot on the front page. What happened during the few years I’d been gone from Florida?

I was obsessed by this story. Something about it bothered me, but I didn’t understand what that was. I felt uncomfortable calling her up after so long; I wasn’t certain I even had her number. What would I say anyway?

Internet research showed that my friend divorced her husband three years ago, about the time his legal troubles began. Last year I heard that their adult son had been badly injured in an accident, and there was newspaper coverage of that event. But public records didn’t help me understand why I couldn’t stop thinking about my old friend and wondering how everything in her life got so off-kilter.

I have this story and I don't know why I need to tell it. Somehow it ties into what I’ve learned about myself and how my desire for control of my life took me to a place I never want to see again, but I’m having trouble making that connection. This story is like a box with a hidden lock; I turn it this way and that, shake it, bang it, and still can’t get to the kernel
of wisdom inside. It’s as if I know there is a jewel of self-knowledge in there, if I could only open the box, read the message, and understand this feeling gnawing at my soul.

Sandy was the person I wanted to be. We met at work, where she was the assistant director of the ED. An excellent physician, she was universally loved and had a true gift for working with people. She never seemed to have the issues that I did with certain nurses, and had found a way to deal with the stress and chaos of our large department. Her career was on the fast-track to director and beyond. Married to her college sweetheart Joseph—a moderately successful attorney and accomplished oenophile—she had two children, a girl and a boy. Her husband was on several local boards, and she was a member of the country club and Junior League. Her husband wrote a weekly column on wine for the local paper. Their house had a great location, but was nothing special as long as you didn't include the step-in climate-controlled wine cellar, the salt-water aquarium, or the outdoor kitchen complete with wood-fired pizza oven.

I remember a Christmas party at my house one year. Sandy was sitting out by the pool, surrounded by other laughing guests. Joseph had brought an expensive bottle of wine to drink himself; one other person was allowed a small glass. As they huddled together in a corner of the kitchen, I thought it a bit strange.

I wasn't jealous of Sandy; she was a warm and ethical person. She had the golden touch around people, with humility and generosity tacked on. I was amazed that anyone could pull off her life. From my point of view, it was as if she had super-powers that I could never understand, much less possess. Although I knew that often people had a finely crafted public persona that hid the reality of their real lives, I think I believed Sandy had managed to have it all.
I knew there were issues. Joseph’s law practice struggled. Occasionally she implied that he didn’t work very hard, and then there was his behavior at my Christmas party. Her son became a handful, kicked out of all the local schools for various reasons, but she seemed to deal with it well, treating it as a bad joke life had played on her. When I last saw her, five or so years ago, she looked healthy and happy.

What happened to Joseph? Like losing your medical license, disbarment is a terminal event. You lose the only thing you know how to do. I know how physicians get to that point—usually alcohol or drugs, sexual impropriety or plain old greed, and I suspect it’s the same for lawyers. In some way, I can empathize more easily with him than Sandy. Maybe that’s why this story bothers me so much. I can see how an overwhelming sense of frustration and disappointment could led to some very poor decisions. I’ve been there. My heart aches for whatever he felt that brought him to this point. I can’t imagine being a criminal defendant in the court where you practiced law, nor how you pull your life back together when you’re this low.

I’m not feeling schadenfreude; there is no joy in this, not a feeling of comeuppance. It's a deeper emotion I'm feeling, almost existential. If Sandy's life disintegrated, what hope for the rest of us? Why do we even try to be happy, to be successful, and how do we define those terms?

I see now how that idea relates to what I’ve been exploring in my stories—how futile it is to try and control things. Life is too large, too chaotic, too random. Entropy rules. So how do we avoid despair?

I admired what Sandy had, but also who she was, and I imagine that hasn't changed. I look at the trajectory of our lives over the past fifteen years—starting out rather parallel, me
falling, her rising, and wonder how we ended up at a similar point in our fifties. No matter how certain we are of the choices we make, life throws a spanner into the works. It's not a reflection on our internal worth. Bad things do happen to good people, and there, I think, is the connection for me.

I'm obsessed with this story because I always believed that whatever happened to me was my fault, something deserved. Bad choices, wrong actions, lack of character—all this bringing upset and misery to my life. I still believed that I had some sort of control over things, that events were a reaction to an action on my part.

But if something this disastrous could happen to Sandy, whom I could never blame for bringing it on herself, then maybe some stuff just happened to me, too. I didn't deserve it and it wasn't my fault. Oh, not all of it, not even most of it, but some of it. All Sandy ever had was herself; in that way we were and are similar. The other stuff—husbands, jobs, social status—are just things, subject to the whims of the universe.

If you had asked me about this at any other time in my life, I would have told you that, of course, life was random, while believing and acting as if the opposite was true. It’s clearer to me now why I was often frustrated by my career.

Then why do I live, if I can’t control what happens to my patients or myself? It’s because I believe I do have a purpose in life, just one much smaller than saving the world. Do I have any influence in my life? Only over the kind of person that I am. Do I smile at the grocery clerk? Visit an old person? Shovel a neighbor’s driveway? I’m thinking this is all I’ve got, how I behave at individual moments in time. Everything else is a random crap shoot.

We can only do so much in the physical world. We can save for retirement, but might lose half of it in a divorce settlement, or die before we use it. We can give our children every
advantage and they can still end up with a GED and a marginal existence. We can be married for a short time and realize the mistake, or we can be married for 25 years too long.

The idea of relinquishing control is not new; everyone from Buddha to New-Age gurus preaches it. It sounds so simple, but it is not, and incomplete understanding can lead to nihilism or worse. It’s not a concept with which we humans are comfortable. Religion offers solace to some, who believe deities have the power they lost, but those of us who do not believe in the mystical must search within ourselves and the natural world for a raison d'etre.

Inside this story of Sandy and Joseph was a key that I needed, not to understand what I learned about myself, but to believe that what I discovered was true, and to finally accept it. Control is an illusion—get used to it.
My companion for twenty years of medical practice was a black leather briefcase, corners rubbed raw gray, handles oil-molded by my grasp. Three years ago, I had upended my professional life, leaving medicine to study literature, and now I had to trade that beloved bag for a tote more suited to my new career. A carry-all more artistic, more colorful, and definitely smaller.

Cleaning my briefcase out and putting it away had a sense of finality that I had avoided for months. I had only a vague idea of what was in the black bag—medical tools, a turquoise multi-compartment bag that served as a checkbook wallet and personal tote, cheater glasses for reading EKGs—but I knew emptying it wouldn't be easy. A shoebox and a similarly-sized coral purse sat on a nearby chair, a trash can rested on the floor, mouths open, waiting for me to start sorting through my doctor life.

I dumped the mess on my round kitchen table, and the pile spread like a lumpy, wrinkled tablecloth pulled from a too-small drawer: stethoscope, turquoise bag, keys, cookie crumbs, old tissues, information cards and *The Sanford Guide for Antibiotics*. I searched the zipper compartments and card slots for strays, then placed the bag on the floor, empty.
Throwing away garbage was easy. Out went the gum wrappers, grocery store receipts, business cards from people I didn't remember and logo pens that didn't work. Maybe this wouldn't be difficult.

I picked up my favorite stethoscope, my last stethoscope (how many had I owned in 25 years—three? four?) and placed it in the shoebox, the black tubing curled permanently from being coiled in my white-coat pocket. Only TV doctors carry stethoscopes on their necks. I put my orange rubber reflex hammer in there, too. Checking reflexes was often a useful doctor-looking thing to do when you needed time to think. I could foresee needing these in the future; at least the stethoscope, maybe, if my father were sick. I was tempted to keep the Sanford Guide and the other information cards: one with pupil sizes in stark black order, another with dosages for the drug used to treat acetaminophen overdose. I never could remember that. Our son might need them for medical school in four years. They were already out of date, but I set them aside.

The remaining medical items were small reminders of daily practice. I knew I would have no use for replacement stethoscope parts, a clamp, or stool occult blood cards and the developer liquid that made them turn blue when positive. Be ruthless, I reminded myself as I threw them away, ignoring the gnawing in my stomach.

Then I found the baggie containing the dozens of lapel pins that had decorated my white coat. Each week I sported a different group as a personal expression of the woman inside the doctor. I stopped to sift through them: 2008 Obama, Disney Doc and Dr. Mickey, Graceland, the Albuquerque Balloon Festival, Route 66. A personal history in pins; into the shoebox they went.
The turquoise bag held everything I could need for back-to-back days in the emergency department where I had worked. I couldn't simply transfer everything to the new purse; I didn't want to be one of those women rummaging in her handbag at check-out lines and gas stations, looking for money or a credit card, like a dog digging for a bone. I bought a sleek coral wallet to hold my essentials. It was a fourth of the size of the bag. I knew I didn't need to carry the extra doses of routine medications, the naproxen or acetaminophen, the toothbrush and toothpaste any longer, but I had some serious work ahead to figure out exactly what I did need.

I put my money, credit cards, insurance cards and my driver's license in the spaces and slots. My passport didn't fit. I started carrying it after 9/11, the stamp of American citizenship providing both solidarity and safety. I felt anxious without it. Although I rarely left the country, there was something reassuring about knowing that I could go anywhere, anytime. I decided to put it in the zippered compartment of the main purse so I would always have it with me.

I struggled over what to do with my medical license and DEA registration, both still active. The years of training and practice didn't vaporize when I decided to change careers. I put them in the wallet; after all, I was still a doctor, wasn't I?

My membership card to Selby Botanical Gardens in Sarasota, Florida, which allowed free admission to many other gardens in the United States, went into a slot. Botanical gardens attract me like hummingbird to nectar, requiring repeat visits for full satiety. The print was faded, even though it was only a few months old, from my twice-monthly visits there this past winter.
I found multiple ticket stubs from Paul Westerberg's last tour, almost ten years ago. Most people either have no idea who he is, or remember him as the frontman for the '80s band The Replacements. Critics call him the second-best songwriter from Minnesota, after Dylan.

There was a time when I was deeply depressed, struggling to hang on, and waiting for Westerberg's official first solo album was what kept me from swallowing every pill in my possession. I promised my doctor that I wouldn't commit suicide before I heard it. Listening to "Knockin' on Mine" on the first day it was available, I knew I had made it through that miserable time. I couldn't let go of those stubs that remind me that my episodes of depression are temporary.

Twenty-three years after we met, my husband and I had our first date. He took me to see performer Howie Day at Michigan State University, knowing that I had this thing for singer-songwriters. I fell in love with both of them that night. Several years later, my husband drove us through the southern Rockies into Colorado so I could see Howie perform both in Denver and Boulder. We dodged blizzards and elk in the road to get home. I put those ticket stubs in my wallet, too, a testimony to how far my husband will go to see me smile.

I sort through the other ticket stubs. I can put these in the shoebox—the Tampa Bay Buccaneers tickets from my father's first pro-football game, a stub from Mike Alstott's last game as a fullback for the Bucs, a Texas Ranger game featuring Nolan Ryan. Other concert tickets—Sting, REM, Matchbox Twenty—end up in the wastebasket. You can't carry everything with you forever.

I transfer my few pictures. One is of my deceased chow, Coco. She was a beautiful redhead with a black tongue, exceedingly gentle with most of the family, but viciously pro-
tective of me as well, quick to snarl if she perceived a threat. When I look at her picture, I
remember her between me and my violent ex-husband, baring her teeth and daring him to
take one step closer. Her spirit still protects the vulnerable side of me. The picture of Tasker,
my rat terrier, carries no such burden. He is twenty-five pounds of fun, but also a little tyrant.
He always makes me laugh.

There is a photograph, taken by my ex-husband, of my current husband and I, walking
down a beach, snapped when we were all friends. It's a melancholy photo, filled with
dark clouds and rough water, yet it also has a shaft of sunlight, a promise. It exemplifies how
things are not what they seem, even if you think you notice what's happening around you. It's
 endings and beginnings, the past and present, captured on Anna Maria Island. That one stays,
too.

The wallet goes into the belly of the bag, easily accessible, to be followed by my cell
phone when I leave the house. I make certain there is room for Uni-ball gel pens that work, a
folder to hold syllabi and assignments, and my journal.

As a doctor, I carried a stethoscope; as a writer, a journal. Mine is a handmade book
from Costa Rica, with a kaleidoscopic cover and pages stamped with butterflies and toucans.
It holds memories of wild orchids, blue-crowned Motmots, and walks in the cloud forest,
along with notes (commas save lives), fragments of poems, grocery lists, ideas, and names of
books to read someday.

I find my mother's funeral card. I still hear her in my mind, telling me I wasn't humble,
wasn't kind, wasn't the daughter she wanted. I wasn't good enough for her, or for me. After she died, I understood that I would never have a different kind of mother, and was finally able to recognize her voice as reflecting her own fear and insecurity. I try to throw this card
away, but I can't. I'll keep her card to remind me that I am fine the way I am. I can be myself—physician, writer, both or neither—without fear of judgment, disappointment, or failure. Today, I choose to be a writer.
VITA

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