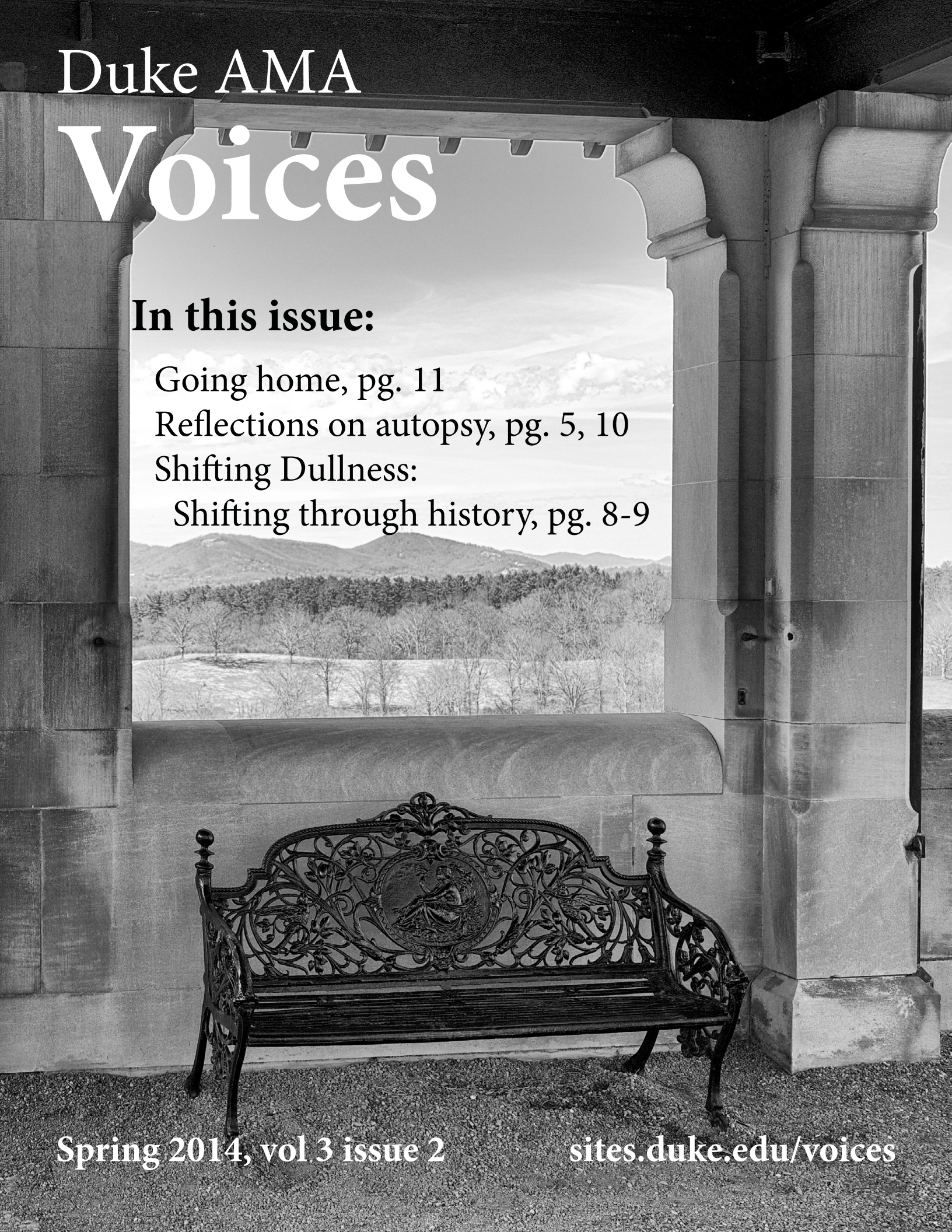
Duke AMA
Voices



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Voices

Special Thanks to

Richard "RDubs" Wallace and the Duke Med Office of Admissions
Duke University School of Medicine Davison Council
Duke Chapter of the American Medical Association

For more information on joining Voices, please email **rd74@duke.edu**

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Background photography by Neechi Mosha, an MS4 who hopes to pioneer innovative technologies that will improve the health care experiences of patients and their providers. When not thinking about medicine, he loves driving cars, taking awesome photos and greatly appreciates beautiful design.

Mrs. M

erik h. knelson, MS4

Everyone who read her file had to shake their head. A 75-year-old mother of seven, and a pillar of her community with metastatic breast cancer, brought in for respiratory failure after a malignant pericardial and pleural effusion. Just the thought of the liquid tumor surrounding her heart forces the corners of one's mouth into a grimace. And then you meet her. From her quiet and polite introduction you would never know there was anything wrong with her. She was always careful to thank each person in the room as they left, even if they didn't say a word to her or quickly dashed off to some more pressing matter. I first met her the morning of her discharge. She had calmly and politely asked to go home, and we agreed. Her surgical site was recovering and she appeared to be able to move around, somewhat.

I went back to Ms. M's room later in the day to pull out her central line. Since I was going to have to cut stitches on the side of her neck and hold pressure there for five minutes, I decided it might be more comfortable for both of us if I started a conversation. I asked her if she had plans for the rest of the week as I started to remove the stitches holding the line to her skin. She explained that she was excited to get started with her exercises; she was a very active person, always on the go. When the stitches proved difficult to unroof, I apologized for the delay.

"It's no problem," she told me, "I have nowhere to go but home or heaven." I complimented her on her attitude and she quickly replied that there was no other way to be. She told me about how her faith had gotten her through her 75 years, through an abusive marriage and raising 7 children, "When you're laying in bed and he comes in to beat on you, your faith is all you have."

I didn't know what to say. I told her I couldn't imagine how anyone could treat her like that. "But I forgive him," she said at last, "there's no sense in holding onto that anger." I asked about her children and grandchildren. She told me about her son the preacher and her 89-year-old mother who still got around fine. "I hope I get to live that long," she said wistfully. She asked about my family and of course it wasn't long before I told her how my mother also had been diagnosed with breast cancer, how I shaved my head when her hair fell out, how she was in remission when she died in a car crash, and how I missed her every day. I didn't intend for it all to come out so quickly like that, but Ms. M. had such a peaceful and welcoming tone to her voice, like you could tell her anything. "I could make friends with anyone," she said softly at one point, "they might fight it at first but I just keep trying." I didn't have much fight in me and let myself fall softly into her embracing conversation. I told her I had learned a lot from my mother, and confided that my brother, my father and I had been struggling since her death. She looked at me with complete understanding and perhaps some foresight into how her loved ones might similarly react.

It was a special feeling to bandage Ms. M's neck—a very sensitive place. I took extra care not to catch her hair in the tegaderm covering I placed over the hole where her line had exited. I secretly wished there was more I could do to care for this sweet lady who had so much to offer everyone she might collide with.

As I finished the dressing on her neck, Ms. M started to thank me. She reached out for my arm as she told me I had been good to her. As her arm touched mine she pulled me closer for a hug and the tears started to flow. I held her there, stooped over for a few moments as she cried. I can't imagine her doing this a lot, being such a strong and optimistic person. I felt the weight of her 75 years on my chest and all I could think of to say was "I know it's scary." When she straightened up again she said, "I'm ok." She asked for the names of my father and my brother as well as my own name so that she could pray for us at church on Sunday. "I'll never forget you," she said. I assured her the feeling was mutual.

Erik Knelson is a MS4 MD-PhD candidate who is interested in a career in translational oncology.

A Good Friday Autopsy

kelly ryan murphy, MS1

Gowned and ready for ceremony, we gather.
Not friend enough to know her name, we gather.
Humanity in her nails, we admire—
Perfectly trimmed, perfectly polished.

Exposed body—palms up, tools poised.
Coming infliction, she rests serene.
There I stand—scared. Uncertain.

Still somebody, still a person.
Recently lost. Recently given,
Given for us, for us to find proof.
Proof we belong, an answer to 'Why?'

Locks flipped forward,
There he goes, so fast at work:
Precise, calculated, robotic.

Ready for judgment, her organs splayed
Ready for answers, we seek causation.
Here I stand living. I seek vocation.

They cut & slice. Not fast, but faster.
My legs I pump. Not fast, but faster.
I swear I'm breathing, also learning.
Absorbing more than just smell.

Her submission to science soaking.
Body, blood, cleansing water.
Quenching our need to know.
Feeding our desire to answer.

Cause unknown? Not possible…
We must have answers. But sometimes we don't.

Kelly Ryan Murphy is a MS1, reflecting on seeing her first autopsy, which occurred on Good Friday

Neechi Mosha, MS4

(Blue and Gold) White Coats

neil ray, MS1

If you've ever met me, you'll know I'm pretty big on stories. So I'm going to tell a story about a day in the life of a Duke medical student.

I wake up every morning at 8:00am to the sound of blaring fire trucks. The only way to turn it off is to hit my alarm several times. After brushing my teeth, eating breakfast, and getting dressed, I drive over to school. The routine is practically a science. I walk 15 minutes (also known as exercise) from the parking garage to the lecture hall. Along the way, I pass the hospital lobby, where I am greeted by one of an ever-changing cycle of receptionists.

The people in and around Durham are amazingly friendly. Wearing a Berkeley shirt is practically equivalent to walking a dog around a park. Someone always shouts, "Go Bears!" or stops me to have a quick conversation. One such person I met during the beginning of the year was an elderly Cal alum and whose daughter was a medical student at Dartmouth. What started as a 5-minute excursion to Target turned into 20 as we reminisced on our experiences about Berkeley, including how it has changed over the years and how our experiences remain with us to this day. It's fascinating that Berkeley is such a highly-regarded and well-known institution, even in Durham. Across the country, 2800 miles away, it still brings people together—Berkeley Alumni license plates are abundant in the parking garages and on the streets.

I usually stumble into the lecture hall with a few minutes to spare. If there is a mandatory event that day, the rest of my class is usually already there and I am relegated to a seat in the back row. My cohort consists of 113 of the brightest people I have ever met. My class ranges in age 21 to 39 with the median being around 27. A handful have already earned PhDs before coming to medical school, one founded a nonprofit organization in India tackling iron deficiencies with inexpensive nutritional bars that she developed herself, one was a Fulbright Scholar who did research in Switzerland, one traveled all the way from Uganda to be here with us, and one is a Julliard-trained world-class pianist. I'm sitting next to experts, leaders, and visionaries.

A fellow Berkeley alum and a DukeMed MS4 told me that since I am the only one from Berkeley in my class, I had the sole responsibility of representing Berkeley Engineering. At the time, I was flattered, but I'm beginning to understand the implications of what he said. To varying degrees, my time at Berkeley colors the way I discuss medicine with surgeons, the way I interact with my classmates, and the way I understand the course material. Blood flow through vasculature is an application of Reynold's Number and Bernoulli's principle, the area underneath P-V cardiac curves translates to the amount of stroke work that the heart does with each beat, and deciphering EKGs is based on decomposing the electrical vectors of the heart; the list goes on and on. Even being associated with the entrepreneurial culture of the Bay Area has its benefits. I frequently have conversations with my classmates about topics such as venture capitalism and get invited to do start-up challenges with them.

On Wednesdays, we have Practice Course, where we wear our white coats and go into the hospital to record histories from patients. It's our weekly dose of humanism in medicine. I enter the patient's room clutching a small notebook and a syringe-shaped pen (I think it's pretty funny), and ask the patient to recount their experiences.

One of my colleagues told me about how he wears a tiny golden bear brooch on his white coat. One of his most memorable days in clinic was when a patient actually started talking to him about it. To me, that is fascinating. The fact that they graduated from Berkeley, or even know about it, is a valuable intersection point – where both of our stories overlap. We both sat in Dwinelle struggling through finals, laid down on Memorial Glade to catch our breath from the hectic schedule, or even stared at the Golden Gate Bridge during sunsets. Our duty as physicians is not only to treat the ailments of patients, but also to learn their story and give them the ability to continue it.

Berkeley is an extraordinary experience. You learn from some of the leading experts in the field and take classes with some of the brightest students in the country. When you graduate, you represent the #1 public university in the world. People'll look to you for advice, knowledge, and insight, and it's up to you to deliver it. Strangers will become co-workers or even friends because of this common thread. You'll meet other people who once called Berkeley their home. When you're feeling homesick, you'll realize that that home travels with you wherever you go.

That's why if you ever get the chance to see me sitting in a patient's room scrambling to take notes about their present illness – you'll see a small golden bear brooch placed on my white coat.

Neil Ray is a MS1, Berkeley alum, who is interested in the intersection between engineering and medicine.

Rui Dai, MS1

Shifting Dullness

jacqueline zillioux, MS3

Shifting Dullness is a classic sign for ascites found on physical exam: if a patient has intraperitoneal fluid, the border between tympanic and dull resonance with percussion will shift as the patient's position shifts. Shifting Dullness also happens to be a cleverly named former Duke medical student publication. Started in 1968 as a weekly announcements bulletin for the School of Medicine, it evolved over three decades to include creative writing, artwork, humor, editorials and opinion pieces contributed by medical students and other members of the Duke Med community.

Sadly, publication of Shifting Dullness ended in the late 1990s for unknown reasons, leaving behind only memories and a treasure trove of paper archives in the student lounge on the 7th floor of the Davison Building. Rumor has it that these archives were re-discovered by the Davison Council while cleaning out the lounge in 2011 and turned over to the Duke Medical Center Library for safekeeping.

I first heard about Shifting Dullness when I started at Duke in 2011. Keen to keep the non-science part of my soul alive during medical school, I asked around about a student literature publication and eventually caught wind of the long-lost Shifting Dullness. A few of my classmates and I met with the Duke Medical Center Archives to discuss digitizing the collection in hopes of a 21st century re-boot. We sifted through the collection, discovering a fascinating time capsule of life of the Duke Medical Student in the 70s, 80s, and 90s. I was surprised to find that by the late 1980s, the publication had become a rich forum for the School of Medicine. Amidst routine school and club announcements were debates about physician-assisted suicide, commentary on the importance of computers in future medicine, poetry, cartoons, and plenty of comedy and satire.

As the issue we've included here from March 1991 shows, not too much has changed in the past quarter century at Duke Med. This issue and others from the era are full of opinions and satire regarding the ever-changing curriculum, worries and opinions about the boards and the match, and content on the numerous volunteer activities and unique social life of medical students. I find myself laughing (out loud!) at all the comedy and satirical content, because it's still so relevant to my experience as a Duke Med student today.

"Rumor has it that these archives were re-discovered by the Davison Council while cleaning out the lounge in 2011 and turned over to the Duke Medical Center Library for safekeeping."

What stands out to me as different is that these perspectives and issues are captured in a centralized and regular publication, in an uncensored and unadulterated voice. Where is that voice now? I'd argue it has become lost in the fragmented yet unrelenting barrage of emails we all receive daily. Perhaps we're now too overexposed to media and overwhelmed by the ever-increasing demands placed on us as medical students to be able to sustain a forum like Shifting Dullness anymore. It's true that AMA's VOICES now provides a creative and intellectual outlet for Duke Medical students, but it is biannual and submissions are not easy to come by. Where is a centralized, safe place for us to communicate: our complaints, ideas, stories and fantastic jokes, even those that may be controversial? Is such a place even viable today?

I urge you to check out the Shifting Dullness archives housed in the Medical Library's digital repository, particularly those published after 1987. They're fun, thought provoking, and sometimes shocking. If you're inspired, have ideas or answers to the questions I've posed above, or are interested in a 21st century Shifting Dullness re-boot in conjunction with AMA VOICES, please get in touch with me or one of the VOICES editors.

Shifting Dullness digital archives: https://medspace.mc.duke.edu/search/site/shifting%20dullness

I can be reached at: Jacqueline.zillioux@duke.edu

Jacqueline Zillioux is an MS3 who got Animal in the "Which Muppet are you?" internet quiz.

March 1991

Shifting Dullness

Purely Purulent's Official
Answers to Interview Questions List

As Illegally Compiled by Program Directors Across the Country

Eric Weidman

1) Where do you picture yourself in ten years?

Wrong: Chairman of the department. In your chair! Splitting clinical, research and teaching duties equally. (yeah, right)

Correct: Surfing off the California coast. At Satisfaction... Unemployed/ Unemployable. Cruising chicks/dudes in Chapel Hill in a bombed out VW bus. Still working on my PhD.

2) What do you want to do with your training?

Bench 250! Sell used cars. Earn enough money to buy an attractive spouse. Become a ski bum, knowing I *could* have been a doc if I had wanted. Avoid getting a real job.

3) What are your strengths?

I bench 250! I can chug a beer in 30 seconds flat. I floss daily. I can twirl my reflex hammer on my index finger.

4) We have many competitive applicants, why should we choose you?

See above strengths. I'd be the only resident willing to try to get along with you. My Mom's a lawyer. My Dad is in the Mob.

5) How did you become interested in our program?

Who's saying I'm interested yet? I read the phone # on the bathroom stall wall. I'm a gunner and naturally attracted to your program. My mother wants me to be a _____ (fill in the blank with ortho, CT surgery, derm, etc.). I like the long hours, low pay and abusive treatment.

6) Who has been a role model for you?

Elvis Presley, Arnold Schwarzenegger, Kitty Dukakis, Frank Burns.

7) How do you like Duke?

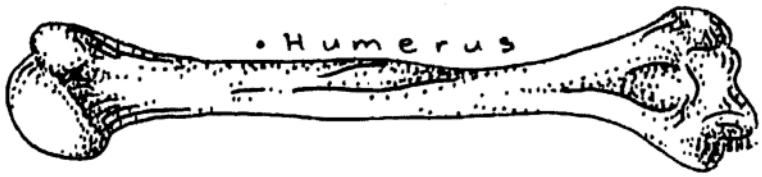
I cheer for them when they're winning. It's easy to spell. It's the best ! Depends on the day of the week.

8) Could you tell me about your research year?

Yes. I watched 250 reruns of the Brady Bunch, I Love Lucy, and the A-team. Rats (mice, cell cultures, etc.) die more easily than you'd think. I finally filled a drawer of my file cabinet with articles (other people's, that is!)

9) If you had to do it all over again, what would you do differently?

I'd take time to stop and clone the flowers.



"I don't read papers, I write them. Actually, I read them and criticize them."

- Dr. Wong

"Medicine is like theology. If it doesn't know the answers, it is forced to make them up."

- Dr. Dan Sexton

"He was paralyzed by an exquisite knowledge of the literature."

- Dr. Dan Sexton

Send "humerus" quotes from faculty or housestaff to *Shifting Dullness* at PO Box 2733 DUMC or drop off in the submission boxes in the candy room and student lounge.

Introductions with the Dead

rui dai, MS1

I have introduced myself to a total of two dead individuals in my life.

The first was during gross anatomy when we opened up the body bag in our first semester of medical school. He was an elderly gentleman who clearly had a full life and a peaceful death. He was well cared for, and there wasn't an immediate reason why he died. The scar from his cardiac bypass was barely detectable; he had good doctors. I hope he died in his sleep, surrounded by people he loved.

His rotund belly indicated he enjoyed his meals. Living in the south, he would have loved eating Carolina barbeque with his adult children while discussing basketball games and tearing apart fried chicken with his growing grandchildren. Maybe he even tried the infamous fried Oreos at the state fair, and missed them sorely when he had to give them up because of his atherosclerosis. I imagine that he still sneaked a few cookies here and there, much to the chagrin of his loving wife.

He and his family had donated his body to the education of medical students. He helped bring to life in our minds the muscles, bones, and organs that would have stayed flat on textbooks had he not made the sacrifice. I imagined him having a loving and generous personality. He loved science and medicine, giving medical students his ultimate gift. Maybe he was even a doctor.

Death is full of unknowns, and sometimes it can be uncomfortable dealing in uncharted waters. I do not know their full stories, and so I can only tell you what I have inferred. Imagined stories are sometimes all we have for the narratives we tell ourselves to give meaning to the unknown. It helps us remember individuals who have touched us in the briefest of moments.

My second introduction was second semester during autopsy. She was already on the steel table in the autopsy room when we arrived. Her skin was neon yellow from jaundice. Her liver had failed and we were trying to determine if she'd had a particular genetic form of liver disorder, so her family could be tested.

Her dissection during the autopsy lasted a total of two hours. And though we did not perform the dissection, we still called her our patient, and noted down the description and weight of all her organs.

She would have been a force of life. Though her disease was inevitably painful, she would have fought and raged against the dying of the light. Her nails were perfectly manicured with a sparkly shade of dark pink, and her hair, even in death, looked coiffed enough to attend the opera. In my mind, she did enjoy the opera, or at least musicals, at the Durham Performing Arts Center.

We know she didn't have to travel far to reach Duke, but what if she did, in search of the best doctors in the country? A lot of people tend to do that coming to Duke Med. She would not have given up her life without a good fight.

Introductions are hard.

Introductions with living patients tend to be hard, because you are asking strangers to trust you with the utmost intimate details of their lives. Introductions with the dead are uncomfortable; they tend to be the most enigmatic patients.

Rui Dai is a MS1 MD-PhD candidate who is interested in both the science and poetry of medicine.

Neechi Mosha, MS4

pg. 10

Going Home

jacqueline zillioux, MS3

"You can't go home again."
- Thomas Wolfe

I come home to find the twenty-foot tree
whose roots reached every corner of our yard
for three decades and all my memory
uprooted – a pool of mud in its place.

Father says change happens,
they told him to expect me
to have a hard time accepting it -
but that was five years ago, and I watched them glide by
intermittently with no more than a blink.

What's got me this time are the subtler changes,
unlike the mud pit in our yard, an aching realization of years past,
of familiar places and smells
in the face of absence
from which the ghosts spring.

Somehow things have been shuffled -
the letters on the buildings downtown are in a different order,
his car gets parked at my neighbors' instead of mine,
and the King Kong out by Natural Bridge,
that played with a yellow toy plane above me
as I fell in love for this first time,
has ended up on top of the museum downtown, waving as I drive by.

Everywhere I go in this town I find little shufflings,
changes just big enough to highlight the fact that
I am no longer the same,
and just small enough to make me wonder
if all the ghosts that haunt me have been shuffled too.

I come home in the quiet dark,
and pause on my doorstep (the meeting ground).
A welling in my chest threatens to break the night.
I feel a tightening in my gut
as I swallow, and breathe, and blink.

Jacqueline Zillioux is a MS3 from Roanoke, VA who is inspired by Koethe and Cummings.

Actors

vinayak venkataraman, MS1

During my time in Baltimore, I had the opportunity to lead and volunteer at the Charm City Clinic. It was started several years ago by a set of idealistic Hopkins students. Despite being an independent non-profit clinic, it had become the de-facto free clinic of Johns Hopkins. Its primary goal was to link neighborhood residents with state and local health insurance programs.

When standing at the clinic's bullet hole-riddled door, I could look down the street to see the Bloomberg Children's Center and Sheikh Zayed Tower — brand-new, multicolored, multibillion-dollar glass-and-steel skyscrapers. I noticed the irony of this architectural juxtaposition upon entering the clinic — a run-down set of connected rowhomes. I especially noted the irony when trying to get clients health insurance, so that they could access those skyscrapers through an entrance other than the Emergency Room.

Despite being five blocks from one of the wealthiest hospitals in the world, walking from Hopkins to the Charm City Clinic on Jefferson Street was like traversing through a war-torn region in a foreign land. The free neighborhood clinic was in the heart of East Baltimore, in a neighborhood aptly, though ironically, named "Middle East."

This was Baltimore, a quirky city of contradictions, where historical tensions and segregation — in addition to the cyclical, spreading pattern of adventurous hipsters being replaced by gentrifying yuppies — created an odd patchwork of neighborhood dynamics. One could transition from the wealthiest neighborhood to the poorest just by crossing a street. There were still vestiges of Baltimore's previous wealth in the vicinity of the clinic—British-style rowhouses with formstone-facings that John Waters famously referred to as the "polyester of brick." They used to house well-to-do, middle class African Americans, but now mostly housed broken windows and broken promise.

The patients I met at the clinic were also quintessentially Baltimorean, engaged and energetic, eager to share their fascinating life stories and colorful worldviews. For some, it didn't take much to motivate them. They desperately wanted health insurance, but they had trouble navigating the convoluted process of determining eligibility, collecting necessary documents, and choosing providers. Self-motivated patients were easy. We worked together to figure out what needed to get done, and they got it done. The first patient I met was like this. Unemployed, previously incarcerated, and a recovering addict, he was driven by a singular pursuit — to get his disabled sister a wheelchair for her birthday.

For some, health insurance was just one of many priorities, and life circumstances often got in the way. Some couldn't get jobs because of Baltimore's de-industrializing economy, prior arrests for possession, or even because of drug dealing, assault, or murder. Some had fluctuating incomes and earned just above the threshold to qualify. Many were homeless or had unstable living situations (and unreliable phone numbers). Sadly, it wouldn't be an exaggeration to say that every other patient screened had untreated diabetes and hypertension. Most patients, however, were not like Mrs. D.

Mrs. D had come with her husband from Catonsville, on the opposite side of the city. Her mother had heard about us through the local NPR station.

"She looks really familiar, but I can't place her," The medical student working the reception desk told me. "Anyways, she's all yours."

She was white, with wavy brunette hair, held back on both sides by the frame of her sunglasses. Her husband was a tall, muscular, African American man, with a quiet demeanor. They were newlyweds in their 30s. I took them both back to the dusty cubicle.

"What do you do in Baltimore?" I asked.

"He's in construction," she said, pointing to her husband. "I'm an actress."

"Oh wow, that's cool!" I blurted out. "What have you acted in?"

"Nothing major. Just a few commercials so far," she replied. I figured the medical student had seen her on TV.

But then she continued. "My main job is as a standardized patient."

She told me that although she was a contracted actress, she was able to make it akin to a full-time job. She worked at every medical and nursing school in the area, including Hopkins.

"I bet you recognize some of the students here," I said.

She smiled and replied sheepishly, "Yes, and thankfully only the students I liked."

We spent the rest of the visit learning about her situation. She had no access to insurance as a part-time contracted worker. She played a role

in educating the future doctors of America but, ironically, lacked access to the care they would provide as future doctors. Her husband had received insurance through his old job, but he had been laid off during the financial crisis. The only job he could get now was part-time construction work. Not only did they no longer have insurance, but he was also working in a profession prone to injury.

"We have prescriptions for medications we can't afford," she said. "And it scares the hell out of me that something horrible might happen and we won't be able to afford anything that would help."

Unfortunately, their fluctuating, part-time combined income just barely disqualified them for PAC, Maryland's expanded Medicaid program. They were doomed by the arbitrary income limits (133% of the federal poverty level) set by policymakers. We tried to piece together a set of biweekly paystubs to show that they sometimes dipped below, but to no avail. They would have qualified for a special Kaiser bridge insurance program, but the program had been too popular and inactivated by depolarization block. As this was several years ago, Obamacare was not yet an option.

At the time, the only option remaining was to enroll them in a special Hopkins program (one that would soon hit pause by the same mechanism as Kaiser's). The income limit was more generous than PAC, and they could report individual, rather than combined, income. The catch was that patients had to show residency in zip codes adjacent to Hopkins Hospital.

We just needed them to find a friend who lived in those zip codes who was willing to accept a letter in their name. She didn't know of anyone off-hand, but she was confident she could find someone in her personal network. We set a goal to reconnect and reassess in a couple weeks.

"Thank you," she told us before leaving, with a slight but encouraging smile. "I think we can figure this out."

I shook her hand. "See you in two weeks."

And with that, they left the clinic.

Two week later, I called to remind her about her appointment, but she didn't pick up. I left a message. I called again the next day. Left another message. Same thing the next day, and the third time was not a charm.

Figuring she was probably busy with work, I sent an email. She thankfully replied to this, but said she had a fever and couldn't come in. She promised she would come into clinic the following Saturday. When it came time for that appointment, she took my calls but was unfortunately still consumed by her illness. A few weeks later, she thankfully felt better. Despite always being happy to hear from me, she followed the same pattern of delay and deflection.

After a couple months had passed, I learned about a new program at Maryland General without a residency requirement. As soon as I heard about it, I immediately thought of her and her husband. It was perfect for them!

I was about to leave Baltimore for Duke, and if there was one thing I wanted to do before leaving, it was to get them enrolled, but the pattern of missed phone calls, frequent voicemails, and ignored emails continued.

She did call back once a couple of weeks later. Things weren't going well for them. She had continued to have bouts of illness and trouble finding stable work in the acting profession. She and her husband could no longer afford their apartment, so they moved in with her mother. The whole situation was testing every relationship involved. Again, she promised to come into clinic when she got better. Since I was leaving, I gave her the necessary information and hoped she would follow through.

I haven't contacted them since, but I still vividly remember their story. It stands out to me as a personal failure—a failure to educate, to motivate, and to achieve our primary goal of getting insurance for people like Mrs. D and her husband. I imagine that such stories of frustration and failure will be commonplace in my future career in medicine. It is sad enough to imagine telling patients I can't help them, but it seems even worse to imagine knowing exactly how to help someone but being incapable of getting them from A to B.

In the end, as much as I may want to help, I know it is not my role to change the system necessarily, but to do my best to work within its limitations. And if my experiences in Baltimore are any indication, these may be the patients I remember the most.

Vinayak Venkataraman is a MS1 who enjoys learning about the implications of health and policy, through the stories of patients and doctors he meets.

Body Language

anonymous

first our language was
lips and hands
pulling, pressing, pushing
away

speaking our
conflict, frustration, elation
by touch and rhythm
to exhaustion

we've words now,
but always we'll back to
our body's exchange -
the things we can't say

I wouldn't have it another way.

Anna Brown, MS2

Neechi Mosha, MS4

Raíces/Roots

anna brown, MS2

Las raíces en la tierra
mueven y me mueven
a actuar como si supiera
mi propósito, mi destino,
lo que puedo hacer, ofrecer
de mi vida a las vidas
de los que quizás puedo
mejorar con mis acciones.

Cuán bella, cuán triste
son las hojas olvidadas
de los árboles, las cuales
que obtienen su sustancia
nutritiva, fundamental
de las raíces, las mismas
que mueven y me mueven
en el viento frío y ciego.

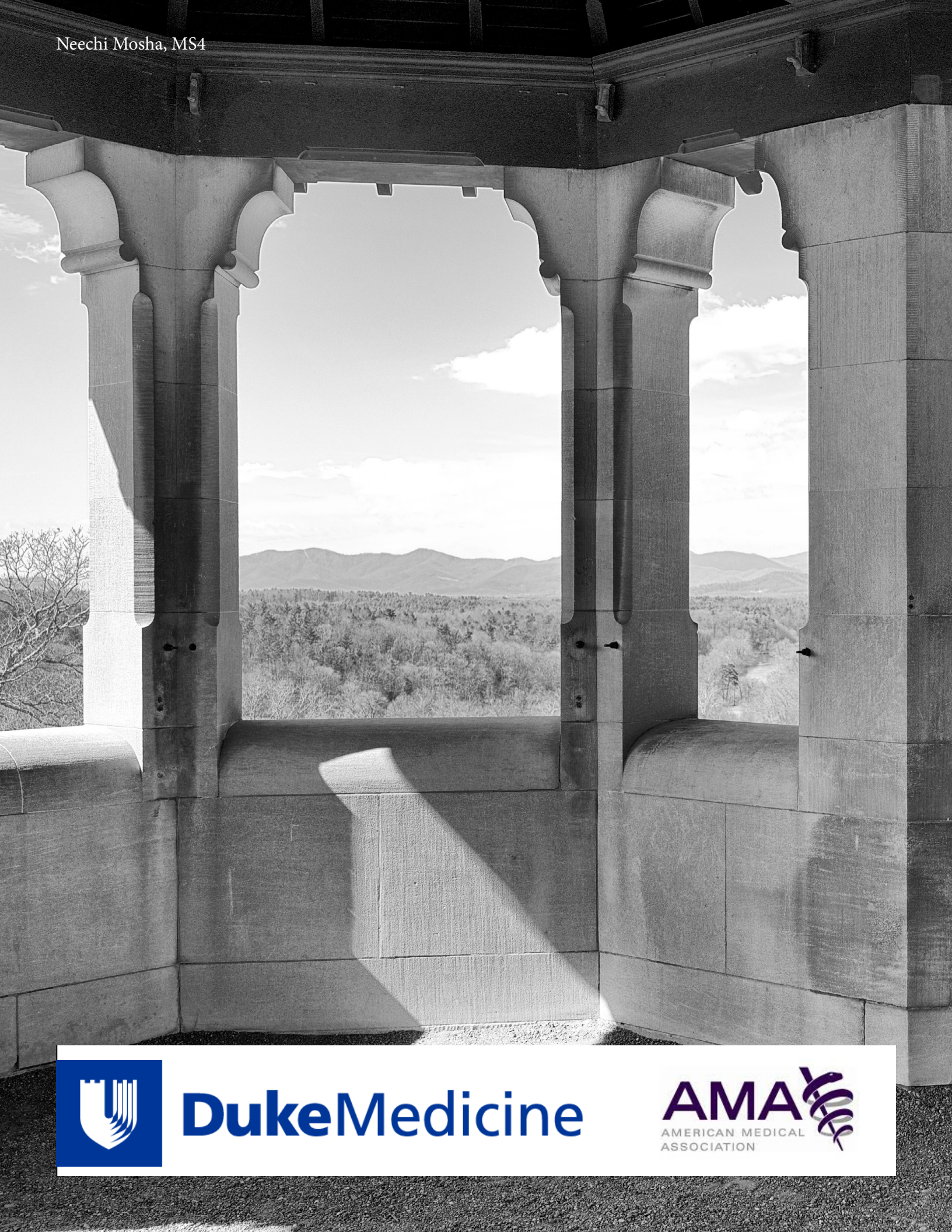
Los árboles, los pobres
padres de esa vida,
esa tristeza tan bella,
que afecta a todos
en este mundo de tanta
sustancia, tanta muerta
de la que esa vida
continuamente renueva.

The roots in the ground
move and move me
to act as if I knew
my purpose, my destiny,
what I can do, offer
of my life to the lives
of those whom perhaps I can
improve with my actions.

How gorgeous, how sad
are the forgotten leaves
of the trees, those which
obtain their livelihood
nutritional, fundamental
from the roots, the same that
move and move me
in the cold, blinding wind.

The trees, the poor
fathers of this life
this life so beautiful,
that affects everyone
in this world of so much
substance, so much death
of that which this life
continually renews.

Anna Brown is a MS2 who enjoys creative writing and sports in her free time.



Neechi Mosha, MS4

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