

A winter scene at a university. The foreground is a snow-covered lawn with several people walking. In the middle ground, there are large, snow-laden trees. In the background, a prominent Gothic-style building with two tall spires is visible against a pale, overcast sky.

VOICES

a literary journal

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VOICES

about us

Voices is a literary magazine of the Duke University School of Medicine. We publish varied forms of creative expression from the medical community, and welcome submissions from patients, students, health care providers, employees, families, and friends. Our goal is to publish a range of unique voices in the healthcare system. We hope that as you read through the pieces published in this issue, you will be inspired to submit something as well. All submissions can be sent to dukemedvoices@gmail.com or online at sites.duke.edu/voices

letter from the editors

As *Voices* comes upon its seventh year of publication, we have been reflecting on how we have changed over the past few years. We have transformed from a newsletter for the Duke Chapter of the American Medical Association to a fully functioning literary magazine supported by the Trent Center for Bioethics Humanities & History of Medicine and the Davison Council. Since our founding by medical students, we have grown into a full team of associate and faculty editors. As we grow, we will continue to reflect on what has shaped who we are today.

In this issue, we reflect on the paths that we have traveled. For the first time, in the form of a graphic novel, Kelsey Graywill reminds us of the motivation that drives healthcare providers. Andre Agassi similarly reflects on his first procurement and its inherent ethical dilemma. Courtney Williams and Arthi Kozhumam communicate via poetry their thoughts and emotions, reminding themselves to not let that hinder their futures. Julie Uchitel remembers an encounter with a pediatric patient during a shadowing experience, and Dr. Govind Krishnan relates his experience on the wards with something that his father had once shared with him. We hope that our stories will also inspire your own reflections. If you have any comments, please do let us know at dukemedvoices@gmail.com.

Your co-editors-in-chief,
Rui Dai and Thao Nguyen

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The First Procurement

We were to harvest a willing donor's liver and kidneys. She had consented to the operation prior to her brain death and lovingly wanted to give her organs in the hope that they could live on in another. It is a beautiful gift to give. Having met many prospective recipients in the weeks leading up to this procurement, I was fully aware that organs were invaluable objects. As the medical student on the transplant surgery team, I would get to know these patients and come to understand their stories. The disease processes varied, but all the patients came to be bound by a single fate. A transplant meant survival for the recipients, an urge burned so deep into human beings that it lives in our flesh and blood. The recipients hoped for another chance at life, and the aforementioned donor had provided this glistening opportunity.

When we, the procurement team, arrived in the operating room, she rested on the table; mindless but heart beating all the same. I saw an individual on the table—not a shell that simply housed organs. She was intubated and draped, the fact that no thoughts raced in her brain soon was replaced in my mind by protocol and structure that the operating room demands. I transformed from an observer to a surgeon, assisting as needed. We made two large incisions and carefully dissected out the unnecessary abdominal contents. The chest was exposed and instead of palpating for a pulse, one could simply count the

heartbeats. The surgeon's hand was gifted, her dissection meticulous. She was still operating to save lives though the life on the table was lost. The vessels were exposed, and the anatomy was evident. It came time to perfuse the organs with a solution that would better preserve them for their future recipient. This segment of the operation was crucial; a proper donation could not be performed without it. The inferior vena cava needed to be transected at its junction with the right atrium. The lifeblood of the donor would be replaced by a synthetic solution that would preserve the specimens until they found their new frame. Once this piece of the operation occurs, the procurement team, bound by time and expertise, takes the place of the student.

The chest and abdomen were open, and the moment to perfuse the organs with preserving solution had come. I was given proper instruction and knew my role, but I felt inadequate all the same. I was handed a large pair of shears and I promptly cut the IVC with the heart still beating in place. There was no time for contemplation, and any hesitation would have been in error. Blood came quickly, like pushing an empty basin into a body of water. The heart soon lost its being, and its rhythm was replaced by a cruel dance that was more of a shiver than a beat. Had I just stopped this person's heart? I had done what I was told. I had executed my task and now others could benefit from it, but a small piece of me still could not

help but feel that I had taken life. The surgeon continued on.

If you ask a person on the street what happens when we die, many would say that our heart stops beating. Indeed, I had caused someone's heart to stop beating. Had I committed the ultimate fault? Human beings see an individual as a whole, but a transplant surgeon must see the body in pieces. The aspiring physician in me understood the utility of my actions, but my soul could not help but experience the distaste of the previous desecration. The thought of ending another's life grew heavy on my mind.

In the moment, I was lost in the ecstasy of the operating room, filled with wonder and curiosity, thankful for the opportunity to serve alongside the surgeons. Reflecting back now, it was a tall order to shear the vessel and watch the consequences. I will carry the moment with me forever just as the recipient will carry the organ.

Ethical dilemmas present a unique challenge to medical students on the wards. We are in a position to observe our physician colleagues but often feel too helpless or ignorant to intervene. We may be unsure what the correct course of action is, and only after the moment has passed do we realize that a mishap occurred. These moral conundrums represent a sort of gray zone that all too often have no absolute answer. During my major clinical year on the wards, I have been fortunate enough to be guided through this gray zone by ter-

Let the Tears Flow

rific mentors and colleagues. I find myself continually seeking advice for these ethical dilemmas. Often, if I do muster up the courage to say something about a potential mishap, I learn that the action in question is actually standard operation. I emerge from the situation more competent than before and willing to take on new challenges.

I feel that I have done no wrong but cannot help but entertain the counterargument in my mind. So many questions loom in reflection: How had this come to pass? Whose fault was it? Was there someone at fault? I searched for an answer, only to find the gray zone to which I had become accustomed. Ethical dilemmas do just that to individuals; provoke thought without clear solution. It is an enigma that has no correct answer, and fortunately just working on the solution was enough for me to find peace with my actions. I am thankful for the experience and would do it again in a heartbeat. Just because the brain is dead does not mean the heart stops beating.

Andre M. Agassi is a current 4th year medical student at Duke planning on applying into interventional radiology.

Let the tears flow, though I'd rather not cry
Scream my pain, my sorrows up towards the sky
It's strange how I had a notion
To hold back my emotion
And let my soul wither and die

It's clear when the tides of emotion run high
It won't be held back, no matter how hard you try
No one can hold back an ocean
Let the tears flow

I look back to my past, shake my head and wonder why
I had tried so hard to keep my eyes dry
Because the mad sea inside stirred up too much commotion
And left my soul in a state of decay and erosion
So I promise my feelings I'll no longer deny
Let the tears flow...though I'd rather not cry

Courtney Williams is a technician II and a graduate of the Duke School of Medicine Master of Biomedical Sciences program.

Walking on a Tightrope

I spend my life walking on a tightrope stretched by the forces of two pillars: sticking out of traditional Indian ideals and can't fit the mold of the American Texan drumline, reinforced by a conflict in identity between my parents and band directors, and questioning the stability of my role in mediating both. In moments I stray further from my roots, the pillar starts to break, and the tightrope begins to fall. Upon return, not feeling "Indian enough," my other identity cracks, a cymbal about to shatter. My world is kept afloat by cultural conflict. Choose one, lose both.

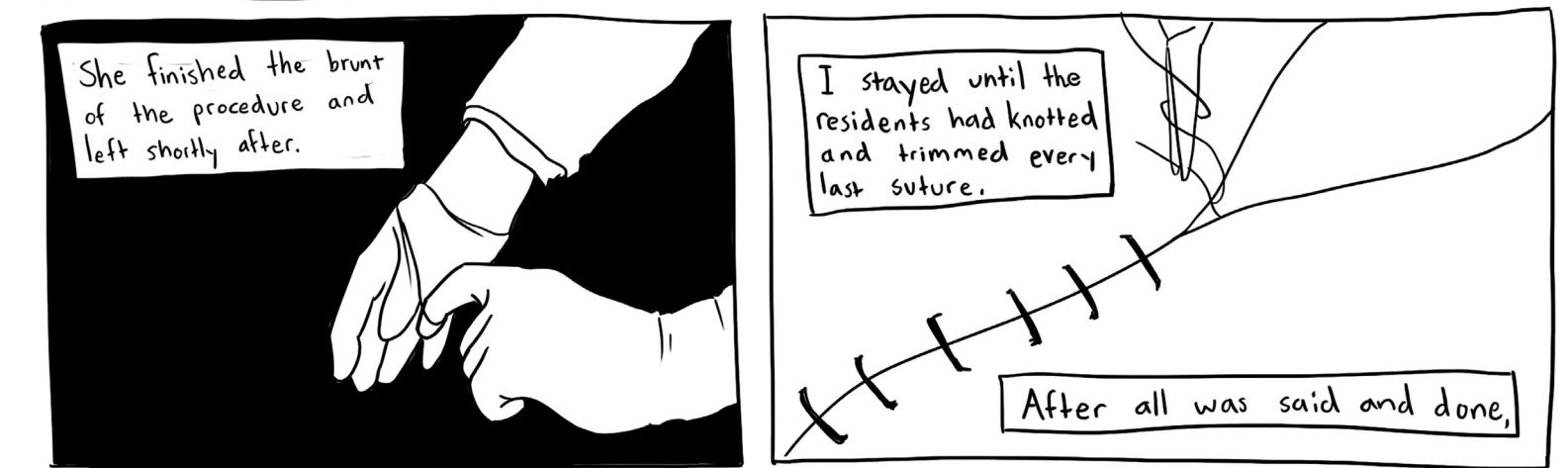
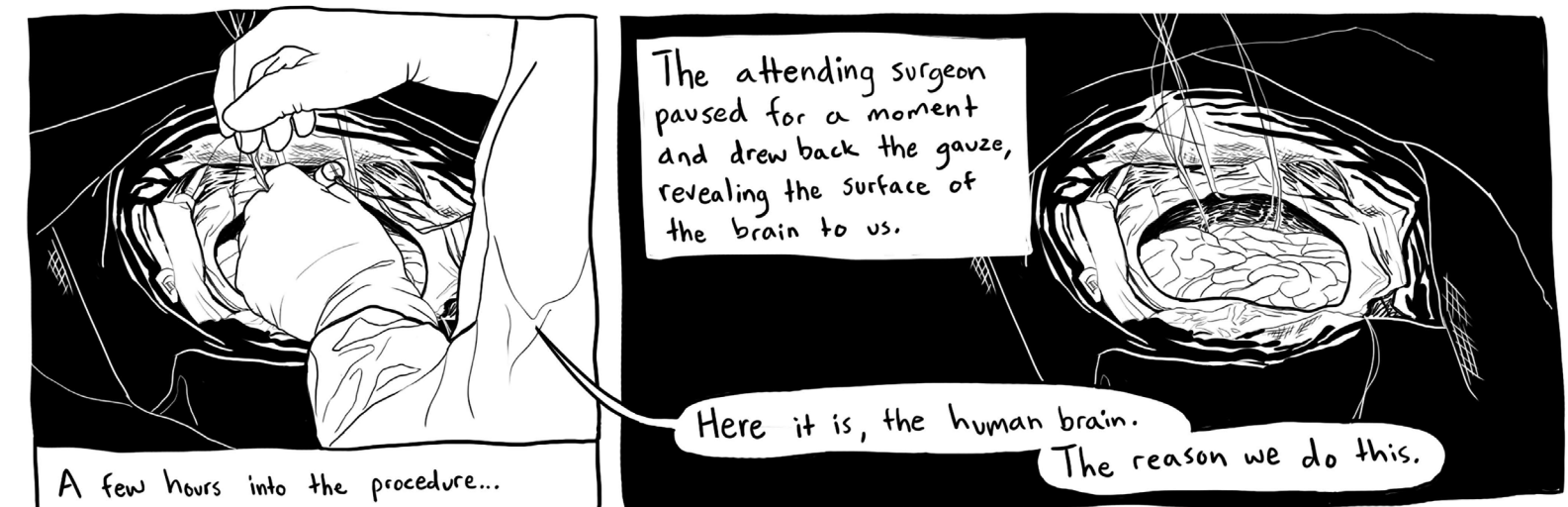
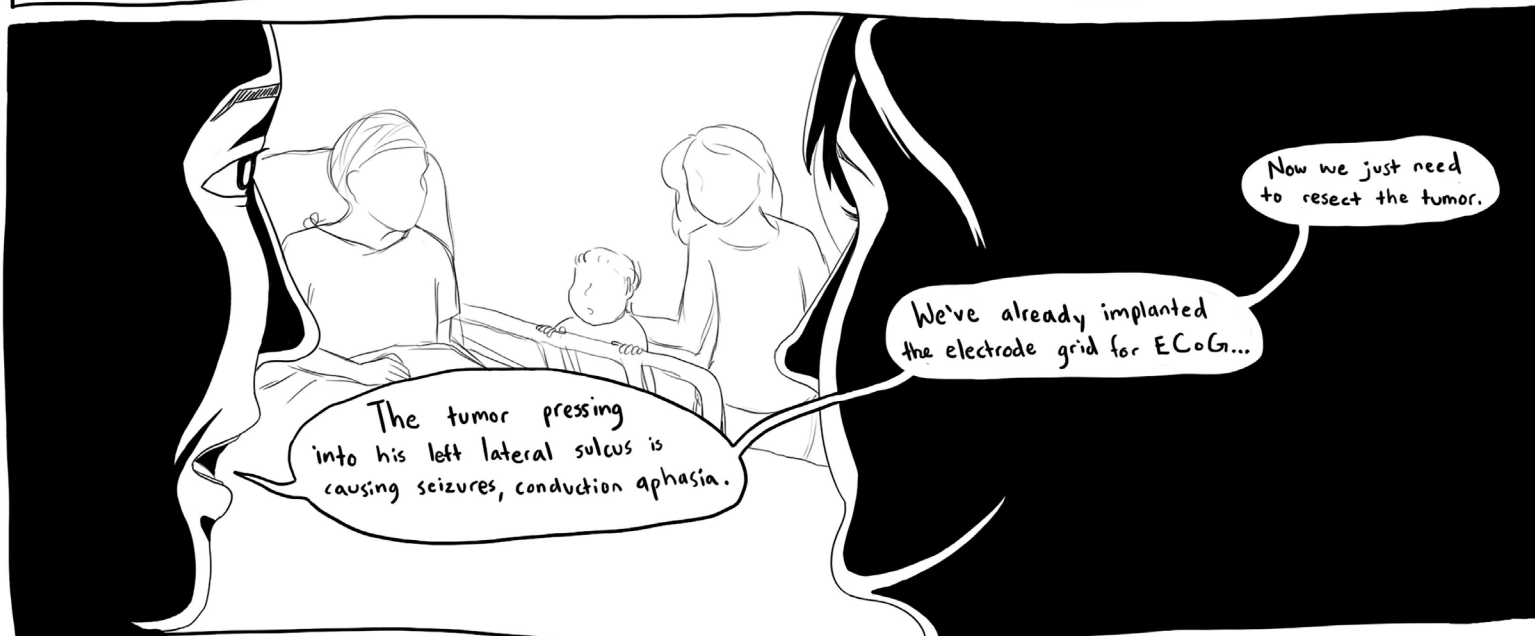
I live a tightrope not dissimilar to that of a patient's, One that balances between traditional beliefs and occupation, financial burdens and medication adherence, the life of your children or your own -- walking along a wire from where you were to where you want to be, holding a pole of comfort that dissolves in your hands. Choose one, lose both, and the tightrope begins to fall.

Cultural communication is a buzzword sometimes used to tick a box on a provider's checklist of human decency and respect but a tightrope cannot be coiled into a cultural cage and still maintain self-respect. A patient ethnography is necessary.

I am a musician, a patient, and always Indian enough. A pre-medical student who will use her tightrope to understand her patient's.

Arthi Kozhumam is a current undergraduate student at Duke, studying Global Health and Biology





I had nearly forgotten there was an entire person underneath the layers of sterile drapes.



When the Brain Cannot Breathe

Patent ductus arteriosus. Pulmonary edema. Hypoplastic left heart syndrome. Extracorporeal life support. The jargon hit my ears, ringing a string of nonsensical syllables.

But apparently these words are the norm here in the pediatric intensive care unit at the Children's Hospital of Philadelphia (CHOP). I normally work in the clinical research building across the street, but today my PI invited me to join in on rounds.

Pediatric intensive care was not a foreign place to me—due to birth complications, I spent the first day of my life in the neonatal ICU. But I can't shake the feeling that I don't belong here.

You see, I'm only eighteen years old. Sure, I'm wearing an ID badge that says "Julie Uchitel, Research Assistant, Pediatric Neurology," and I'm a part of the CHOP National High School Summer Scholars Program, but I can't help but feel like an imposter. Maybe I feel this way because my highest level of education is a high school diploma. I've learned that the more educated you are, the more letters they put after your name, stitched in cursive on a white coat. I have no coat, no letters.

Diffuse Optical Spectroscopy. Near Infrared Spectroscopy. Cerebral Autoregulation. Periventricular Leukomalacia. Neonatal Stroke.

That's what my research is on. I know that much. And I know that I applied to this program because I love neuroscience. I like to think about my brain thinking about itself. I like to

think about all of the little cells and chemical signals that somehow make me all that I am, or how my thoughts flow from neuron to neuron to form my stream of consciousness. But I also like kids. I want to be a doctor, for kids—maybe—but definitely the kind of doctor that does something with the brain. A neurologist? A psychiatrist? I suppose I'm here to find out.

Well, here on rounds, these medical terms just hit me. Hit me and hit me and hit me and all I can do is stare.

The attending leading the rounds is my mentor Dr. Daniel Licht (but you have to call him Dan). He's wearing a tee-shirt with a Sriracha bottle on it and a smile that makes you think he just got back from the beach, but I know that he's been up all night on call. He doesn't remind me much of the doctors I saw growing up, but I know that he's one of the top neurologists here.

His research is incredible—the research that I also work on, I suppose. He uses optical imaging to monitor blood flow in the brains of babies with congenital heart defects. These heart defects cause limited blood flow to the brain, which can reduce oxygen delivery to tissues and cause hypoxic-ischemic injury. So even though a baby can breathe, their brain isn't getting enough oxygen—their brain can't breathe. But Dan thought to make an optical probe that can noninvasively measure the brain's oxygen levels in these babies. He's one of the few researchers in the world to do this.

And that's part of the reason why in the circle we stand in—resident, resident, resident, medical student, research assistant, me (incompetent), medical student—he's at the head of the circle. At the moment, he's silent. As I've learned, the resident always presents the case, Dan gives his opinion, and that's the verdict. That's how things go here in the pediatric intensive care unit.

The resident's name is Alex, but he likes to be called Dr. Porter. I saw the questioning look he gave me when he realized I was coming on rounds. He presents the first patient. Room 406.

"Patient is a four-year-old female who had status epilepticus two days ago. Status from 9:37 am to 12:14 pm, required intubation, Ativan to stop. Episode began as a focal seizure."

I blink. I think I got most of that. Dan nods once. One nod means continue, I want more information. Two nods mean stop.

"vEEG during showed left temporal phase reversals. Prior history of seizures, once per year, yet this was her first episode of status. Mom says that she complained of being overheated that morning. On 40 mg of Keppra daily and was seizure free for the past 8 months. Previously on phenobarb, but it didn't reduce her seizure frequency or duration. At the moment she's awake, but has right hemiparesis and difficulty breathing. MRI showed some mild gliosis in the left temporal area. EEG this morning was normal."

I blink. What the heck is a phe-

nobarb? Phase reversal? I guess the medical students know, they haven't stopped scribbling on their "Penn" leather-bound notepads. Dan nods twice, then speaks.

"Bump up her Keppra. Let's monitor her another day, keep an eye out for any more GTCs."

Hearing "GTC" jiggles something loose in the depths of my memory, the face of a childhood friend, Julia, and I draw in a sharp breath. When I was twelve, I saw Julia have a GTC—a generalized tonic-clonic seizure. We were sitting on her living room floor watching a video of a dance recital. We ate chicken nuggets, mine with ketchup, hers without. It's so weird how precise memory can be. Julia stands to get a drink, and suddenly, she freezes. She falls, her head smacks against the coffee table, and then she begins convulsing. Seizing.

"Next room." Alex's clipped voice breaks me out of my head. Room 407. Resident reports. His clunky words rattle in my brain before fizzling into smoke, reminding me yet again of how unsuited I am to be here. Dan nods once, twice, then we move on and repeat. Room 408. Report. One nod, two nods. Repeat. Repeat. Repeat.

Our final stop is a room at the end of the hall, just across from a window looking out over Penn's main hospital. As our circle approaches the room, I internally breathe a sigh of relief. Last stop. My head swims from the bombastic words, my feet swell from standing for the past two hours, and the constant feeling of inadequacy has really started to put a crick in my neck.

As I reach my hand up to the hand sanitizer dispenser by the door, something catches my eye. The name Emily is written on a pink piece of paper taped over the room number. How is it that this the first time I've met a patient by their name before their room number?

Dan catches me staring at the name and smiles. "Sometimes the parents put those up. We normally don't recommend it because of privacy, HIPAA, et cetera."

I nod, three nods. Three nods means thank you for this information, I'm genuinely appreciative.

The wooden door in front of us is closed. I trace its borders with my eyes, wondering if Emily can hear us on the other side. Does she have family members inside with her? Who sits by her bed and holds her hand?

Dr. Porter clears his throat. "Female, ten months old. Admitted to ER yesterday after she was found unconscious in a pool. Mom says that her grandmother was watching her, but the grandmother went inside for a couple of minutes and when she came back out, the patient was in the pool unconscious. Ambulance was called at 2:43 pm yesterday and the patient was transported here. Still unconscious upon arriving in ER, lungs pumped, and she was put on life support. MRI revealed diffuse hypoxic-ischemic injury. EEG this morning, results pending."

As he finishes, I belatedly realize that his voice had dropped to a harsh whisper. I look up at him and find a crease of strain inked between his brows and three

symmetrical curves under each of his eyes.

I look at the other members of the circle. For the first time, the medical students' pens aren't scratching. I'm unsure if they're preparing for action or already admitted defeat.

I look at the research assistants. Maddie bites the inside of her lip, sucking her cheek inward to form a crease in her face. The other stares at the door as if his eyes could penetrate through the wood. It reminds me of how Dan's optical probe uses light to penetrate through babies' skulls.

In all of this time, Dan has said nothing. No words, no nods. I don't know what no nods means.

He knocks on the door. A woman—must be Mom—responds. "Doctor, is that you? Come in."

Dan opens the door and steps inside. "Hi, I prefer Dan, not doctor. How are you doing today?"

He opens the door. I can't see within from behind his frame. Mom speaks. "We're holding up! Emily here hasn't moved a bit, but she always has been such a heavy sleeper! Do you know what's wrong with her yet? Do you know when she'll wake up?"

"It's hard to say, ma'am, but we've run multiple tests to figure out what exactly is going on in her brain. It seems that being underwater that long did some damage to her brain. We have some thoughts as to how to proceed, but we're going to have to wait a bit more to see if she wakes up on her own."

I hear a stunted rush of air through taunted lips. "Alright. Thank you. These nurses have sure been taking good care of

her. I know Emily really likes them.”

“I’m glad to hear it. Nurse Rachel explained to you the research we are doing? Using the new technology? Is it okay with you if a few of my research assistants come in and check on it?”

“Yes.”

Dan steps back outside. Maddie, the research assistant, glances at me, then back at Dan.

“Yeah, that’s okay. I think it’ll be good for her to see.”

Maddie looks doubtful, and I don’t blame her. This morning was supposed to just be me shadowing rounds, I didn’t know I’d also help her set up the ICM Plus software. Up until this point, my research been mainly clinical—I reviewed patient charts and entered information in an excel sheet. But last week, they told me that I was engaging on a level higher than they expected me to, that they didn’t expect me to do that good of a job. They let me help set up our optical probe on a baby in the neonatal ICU.

That baby was just like a little doll. A little, unmoving doll in a crib. It was easy to pretend that it wasn’t a real child, a real baby waiting for reconstructive heart surgery. But this one... ten months old. Maybe if I just think about the body and the brain, and not about her.

Okay, so the patient’s brain has diffuse hypoxic-ischemic injury. That means it was deprived of oxygen for so long that a significant proportion of the neurons died. Not in a specific area of the brain, but all over.

Wait. The neurons died. But she isn’t—hasn’t. She’s alive. Emily is living with dead neurons.

Stop, Julie. Stop. Don’t think like that.

The sound of a smack against linoleum breaks my thoughts. One of the medical students dropped his notepad, earning a schadenfreudian stare of satisfaction from the other student. He mumbles an apology. Dan smiles easily, and he and the group walk away, leaving us there.

Maddie enters the room and motions for me to follow her. As I pass under the door frame, I think about how much a door frame can look like a gate. Or maybe it’s just a door frame.

Wait. Doorframes. Jesus told Moses that the Israelites had to kill lambs and paint the blood on their doorframes. If they didn’t, the family’s oldest child would die. I remember reading that in the children’s bible my mom got me. I wonder why I think of that passing under the door. But when I step into the room, I know why.

Her bed, all white, juts out into the middle of the room. The sheets are rumpled from use, the guard rails on the side are hoisted up. A doll lies on the foot of the bed, one leg bent, eyes up towards the ceiling. One leg passes over a black wire. I follow the wire with my eyes, tracing its path as it snakes through the sheets and trails up towards the head of the bed.

I haven’t seen her with my eyes but I know somehow I already saw and I saw and I saw and all of those tubes pouring out of her mouth oh dear God those eyes

but I didn’t look but I still know and I can’t I can’t.

“Hello, I’m Maddie, Dan’s head research assistant, and this is a student helping me today, Julie. We’ll be setting up the ICM Plus equipment. It’ll take about 30 minutes today, and then we’ll check on it every day over the next two weeks. Is that okay with you?”

Mom speaks up. “Sure, sure honey, you’re fine.” She waves her hand nonchalantly.

As we unload the wires and the box and the equipment and plug it into the wall, then plug it into one machine, then plug it into another and another, I still don’t look at the patient.

Mom smiles at me. “Hi, Maddie said that you were a student?”

I turn a bit too quickly and tuck my hair behind my ear before answering. “Yes I am, ma’am.”

“Oh, that’s so nice! What’s it like to be a medical student at Penn?”

I swallow. “I’m not a Penn medical student, I’m going to be a freshman at Duke in the fall.”

Mom blinks. “How nice”, she says. Nice. Nice. The word slices through my eardrum. You’re not good enough for me or my daughter.

Her daughter. Emily. I look at the bed.

Dark wispy hairs frame her small head that rests limply back against a pillow. Her eyelids flutter weakly, barely covering brown eyes that bulge forward. But that’s not the worst. The worst is the tubes. The thick blue and white and clear tubes that stretch her frail throat and plunge into her core. I have to remind myself that they’re there

to keep her alive, not to kill her. I can’t think.

Then don’t.

It’s just a small body. A machine, really. No different than the ones plugged into the wall.

I hear a thump behind me. Maddie speaks. “Thank you! We’ll be back tomorrow!”

And that was it. The rest of the day, the night, my mind was closed. Impermeable. The next day, we went on rounds again. Today there was a new resident, Tasha.

“Okay everyone, here we have Emily Drescher, a ten-month-old girl with diffuse hypoxic ischemic injury. Emily drowned in a pool on July 4th and has been unresponsive since. Her mom is here, and I’ve been over the case with her multiple times. Her pupillary reflexes are intact, cranial nerves functions properly. Otherwise she is unresponsive. Her EEG yesterday showed generalized diffuse slowing.”

Dan nods twice. He tells Tasha to keep her on the current treatment plan and to page him if she becomes responsive.

Maddie and I enter the room after the rest of the team leaves. Emily. I trace her face, searching for any sign of life, of conscious thought behind that blank canvas. Her eyes stare forward towards the opposite wall, the same as yesterday. Didn’t her mom dot the ‘i’ on her nametag with a heart?

From over in the corner, Mom speaks up. “Is the technology thing you’re using working?”

Maddie nods twice, smiles, and thanks her for patience.

“Did they tell you when she’d wake up?”

Maddie shakes her head, lips pursed, and says nothing.

“She’s starting to look like her doll on her bed there! All limp like that. Except there’s no tubes coming out of her dolly’s mouth. No needles in her arms. And it looks like she isn’t breathing, just like the doll.”

She sighs, then continues, her voice ragged. “How could my mom have left her alone by the pool?” Her head falls into her palms. “Lord, why did she have to do that?”

Emily looks at the wall. Her doll at the foot of the bed looks at the ceiling. I look at the ICM Plus machine. A string of numbers looked back at me. Staring at those numbers helped. It helped me not think about her. The patient. And that’s what I really needed to not break.

The next day the same. Same resident, same update. This continued for three more days.

The seventh day, a change. Lucky number 7. Dr. Porter is with us today.

“Here we have a ten-month-old female who drowned one week ago and presented with diffuse hypoxic-ischemic injury. She was unresponsive up until this morning, and can now move her eyes voluntarily, follow sounds. She cannot speak. Spends most of her time looking at her mother.”

Dan speaks up. “Yeah, I got a page at about 5am and checked in on her. It’s incredible, her recovery. Let’s try to take her off life support later tonight but keep a very close eye on her. She’s going to have some major cognitive and motor problems, but she should live.”

Dr. Porter’s eyes flash, and I see Maddie dash away a quick tear. The medical students smile hesitantly, somehow looking both constipated and overheated, as if they had no idea whether they were allowed to smile or not.

Maddie tells me that I can knock on the door today. I lift my hand, barely brushing my knuckles against the grain. A women’s voice responds. “Doctor, is that you? Come on in.”

I freeze. Doctor? She must have thought it was Dan. The thought was of being a doctor had never felt so estranged than in this moment.

I enter. “Hi, I’m Julie, I’m not a doctor. We’re here to check on Emily’s ICM Plus machine.”

She beams back at me. “Emily’s moving her eyes! Won’t ya look at that? My baby girl’s gonna be just fine! Isn’t that right sweetie?”

Mom looks at Emily. Emily looks back, and for the first time, her eyes don’t look like glass. They are alight with awareness, with intuition, with recognition that her mother is right in front of her. That her mother loves her.

Maddie answers for both of us. “Yes I can see! It’s wonderful news.”

Continued online at sites.duke.edu/voices/publications/

Julie Uchitel graduated from Duke in 2019 with majors in Neuroscience and French, and is currently pursuing an MPhil in Pediatrics at the University of Cambridge as a Marshall Scholar.

Watching Cricket with my Father

“Nothing in life is certain except death and taxes!” my dad always crows. When I think of this phrase, I always recall watching cricket with my dad as a young boy. I would be praying fervently for an Indian win, yet watching with increasing desperation as India somehow managed to throw away an insurmountable lead, yet again clinching defeat from the jaws of victory. My dad would show no change in his demeanor, ever the dispassionate observer, barely a quiver crossing his mustachioed lip as India succumbed to Australia in the 2003 World Cup finals. “Nothing is certain, especially not India winning,” he said, a little more quietly than he usually does. I suppose many more years of watching the vagaries of Indian cricket had imbued my dad with a somber realism with regards to the team.

Everyone who works in an intensive care unit seems to have this same air of somber realism when it comes to the certainty of death. Sometimes it manifests as a vague sense of foreboding: an octogenarian with multiple comorbidities who survives one hospitalization but may not live to see the next.

Other times, it manifests as Mr. Kesu (name changed, but not dissimilar to the original). He was a middle-aged gentleman with a wife, 2 young children, and metastatic liver cancer. He had initially received his care at a different hospital where he had undergone multiple rounds of chemotherapy. His body had been ravaged by both his

disease and the treatment for his disease, and eventually, his physicians had reached a point of certainty that “there was nothing more they could do.” He had been discharged home with hospice to spend the remainder of his days with his family.

However, his family did not share this certainty. A few days after he had been initially discharged, he had become more difficult to arouse and so his family promptly brought him to the Duke Emergency Department. As one of the residents in the ICU, I went down to the ED to evaluate this ‘potential admission.’

Like any good resident, I wasn’t walking into this encounter blind. I had glanced at his labs, seen the lactate of 16, glanced at his CT scan and seen that the entirety of his abdomen was taken up by his liver cancer. There was no space in his abdomen for anything but cancer. I walked into the room adorned with my stethoscope, my white coat, the well-acknowledged fact that lactate at 16 is bad, and my certainty that Mr. Kesu was going to die. Soon. As I walked in, Mr. Kesu’s wife, his father, his mother, and his brother all started talking at the same time. His father’s face lit up as he recognized a fellow Indian in me. An Indian doctor, who would understand everything and not give up on his son like all the other foreign doctors. He quickly started explaining, in Hindi, how his son had been completely healthy just a few months ago, playing cricket in his local league. He

asked if I watched cricket, in the hopes of forging a personal connection with me. Surely there was some way we could get him better. His brother also spoke at the same time and repeatedly asked, in English, why he was so sleepy. “Can I feed him something? Do you think he is tired because he hasn’t eaten anything?” Mr. Kesu’s wife piped up hopefully.

“Will Ricky Ponting get out?” I remember asking my dad hopefully. Desperately. Ricky Ponting, the Australian captain in 2003 was in fine form as he swatted the Indian bowlers around the field, showing no signs of getting out.

I looked at Mr. Kesu as he lay on the stretcher. He still had a full head of hair, a young face free of wrinkles. But his eyes, like his skin, were a dark, sickly yellow. The yellow of a highlighter that had long since ran out of ink. He lay there, taking deep breaths, as though he was sighing at the thought of what his life had come to be. His abdomen was pouched out, filled as I knew, with cancer and cancer-induced fluid.

I asked him how he felt. I wasn’t really expecting a detailed description of his symptoms; I was just hoping to get an idea of how awake he was and whether or not he’d be able to answer questions at all. “I want to go home...” he croaked. His brother rushed to his side and grabbed Mr. Kesu’s arm forcefully and yelled “Tell him you want to fight!”

Then Mr. Kesu’s brother

rounded on me and said matter-of-factly, “he wants to keep fighting. Please do everything you can to save him.”

“The lactate! His CT scan is all liver and nothing else! Have you seen his ABG?” But the Emergency department is no place for this. All I could offer were empty, non-committal postponements. Mr. Kesu was admitted to the MICU.

Over the next few days, Mr. Kesu’s wife agreed to make him DNAR again, then his brother forced her to revoke it. His father had a hypertensive crisis when I once again reviewed his son’s grim prognosis with him and had to be taken to the ED himself. On day 3 Mr. Kesu was once again discharged with home hospice, only to come back to the ED and get re-admitted to the MICU on day 4.

On a personal note, this is one of the most surreal moments I have ever had in my training. I left the hospital after I had worked for the previous 28 hours with the thought that Mr. Kesu would finally be going home to die in peace with his family, only to return 12 hours later to find him back in the hospital, this time admitted to a different room.

Throughout all of this, neither I, nor anyone else in the medical team, was ever uncertain about how this was going to end. In my mind, this march towards death was as inexorable as Australia’s march towards the championship all those years ago. Had my dad ever felt exasperated, seeing my naïve hopes for the Indian cricket team dashed year after year? He had tried to reason with me from

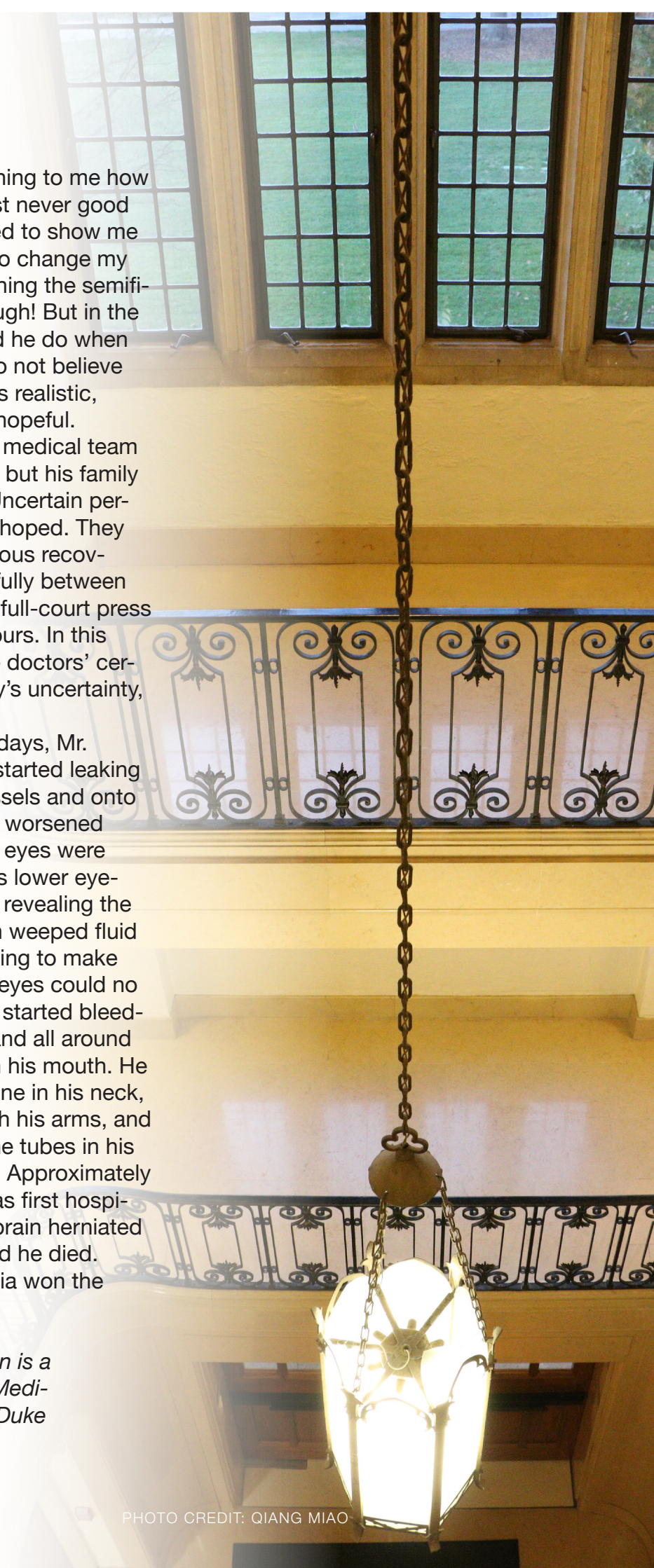
time to time, explaining to me how our bowling was just never good enough. He had tried to show me stats, he had tried to change my hopes, maybe reaching the semifinals was good enough! But in the end what else could he do when I wanted so badly to not believe him? He was always realistic, while I was always hopeful.

With Mr. Kesu, the medical team was always certain, but his family was so uncertain. Uncertain perhaps because they hoped. They hoped for a miraculous recovery, vacillating painfully between hospice care and a full-court press in the span of 12 hours. In this chasm between the doctors’ certainty and the family’s uncertainty, Mr. Kesu fell.

Over the next few days, Mr. Kesu’s body fluids started leaking out of his blood vessels and onto his skin. His edema worsened to the point that his eyes were swollen shut and his lower eyelids turned outward revealing the pink inside. His skin weeped fluid as though it was trying to make up for the tears his eyes could no longer produce. He started bleeding from his gums and all around the tube that was in his mouth. He also bled from the line in his neck, multiple lines in both his arms, and bled from around the tubes in his urethra and rectum. Approximately 2 weeks after he was first hospitalized, Mr. Kesu’s brain herniated through his skull and he died.

Later that year, India won the world cup.

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