# A TEAR IN THE UNIVERSE

A Play in Four Acts

A thesis submitted to the Caspersen School of Graduate Studies
Drew University in partial fulfillment of
the requirements for the degree
Master of Medical Humanities

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This play is dedicated to my mother,

Renee Mendelsohn Fishman

1926-2011

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# INTRODUCTION

Several years ago, Susan Rosenthal, M.D., a friend and colleague, directed the medical education department at a large community teaching hospital in New Jersey. When she began working in that position, the patient satisfaction scores in her hospital were well below what was considered satisfactory, and recent changes in reimbursement criteria left the hospital at risk.

Rosenthal and I had two mutual acquaintances; she knew each as former medical students, I knew them as actors. Both were extraordinarily adept at medicine as well as theatrical performance. Additionally, both were exceptionally competent in communicating empathically with patients. It occurred to Rosenthal that there could be a useful link between theater arts training and empathic communication in the medical context. Additionally, many of the residents in Rosenthal's charge were international medical graduates, which imposed further barriers to effective communication. Aware of my background in theater arts and of Arts Across America,[1] the organization of which I am executive director, Rosenthal reached out to me to explore possibilities of using theater arts as a training platform for medical residents. She hoped that I could bring my thirty plus years of expertise in theater arts education to effect a change in the way interpersonal interactions were managed, and ultimately increase patient satisfaction scores.

We may think of communication fundamentally as a tool to overcome the

[1] Arts Across America is a non-profit organization with the following mission: *To enlighten the community of educators and the public on the value of theater arts education in curricula and to provide strategies, tools, and support for the implementation of theater arts programs in schools*.

powerful barriers that stand between caregivers and their patients. Once we appreciate that communication is bigger than both parties in the interaction, we become open to improving, learning, and growing. There is an increasing presence of humanities classes in medical school curricula. Health care professionals learn how to recognize the barriers to effective communication and how to break these barriers down. This is a positive trend; however, translating this into skill development is the challenge. In a field where "hands-on" learning is a vital component of acquiring expertise, it follows that communication skills should be "hands-on" as well. An ideal model comes from the field of theater. For example, improvisation and role-playing classes are gaining ground in medical education curricula aimed at guiding medical students, residents, and practicing physicians through the murky waters of effective communication techniques.

Learning and acquiring effective communication skills is a process. Having practitioners participate in improvisation and role-play workshops over a period of time may prove crucial in ensuring that these skills are incorporated comfortably and naturally into their daily interactions.

Thus, with some trial and error, and much input from Rosenthal, the actors-turned-doctors, and a team of physicians, I developed a program which incorporated techniques from theater arts into training medical residents in interpersonal skills. In 2010, FSEE[2] (Facilitated Simulation Education and Evaluation) was born.

In keeping with the pedagogical model with which medical students are trained, FSEE training is comprised of three components, each of which relies on the other two for a successful training experience: Didactic, Simulation, and De-Brief. The initial component is the interactive didactic session in which the importance of communication,

[2] Amy Eisenberg, Arts Across America, 2010.

the consequences of miscommunication, and the things which inhibit and get in the way of effectiveness are discussed. It is stressed at the outset, that when it comes to communication descriptors such as "good or bad" and "right or wrong" have little place in training. The focus of FSEE is on how to be more effective communicators, therefore, discussion centers on identifying strategies and techniques for eliminating *less effective* styles and bolstering *more effective* methods of communicating. Sharing anecdotes from the learners' experience is an essential element in the process and, therefore, is encouraged. Their honesty was frequently cathartic for the residents and revelatory for me.

These anecdotes were often provocative, frequently moving, and always insightful. As I heard the residents' stories of their challenges and triumphs, I began to wonder about the impact of the medical education experience on the learners' attitudes and behaviors toward patients and their families. Some research has suggested that the medical school experience can strain one's aptitude for empathic behavior. One study pointed to third year medical students as particularly affected by this phenomenon.[3] The third year of medical school is the point in the curriculum when interactions with patients becomes the more dominant aspect of the educational process. The first two years are focused primarily on the sciences and didactic approaches, and it is in the third year that medical students are assigned to treatment teams in the various departments, which include medicine, pediatrics, obstetrics and gynecology, psychiatry, family medicine, and surgery. They serve as junior members of teams which include interns, residents, and

[3] The Devil is in the Third Year: A Longitudinal Study of Erosion of Empathy in Medical School, Hojat, Mohammadreza PhD; Vergare, Michael J. MD; Maxwell, Kaye; Brainard, George PhD; Herrine, Steven K. MD; Isenberg, Gerald A. MD; Veloski, Jon MS; Gonnella, Joseph S. MD, Academic Medicine: September 2009, 84:9, 1182-1191

attending physicians. Empathy is most essential during this period of the training.[4]

I began collecting and cataloguing stories from residents, medical school students, physicians, nurses, and many other health care professionals. Rosenthal provided a boon, sharing a collection of blog entries posted anonymously by third-year medical students in a Humanism in Medicine course she taught a few years prior. I was interested to hear all of the personal stories as well as those related to their profession. Why did they enter the field? What was their most inspiring moment? When did they feel most defeated? What ethical dilemmas have they faced? How did they respond? What person had the most influence over their lives and careers? Hundreds of stories from dozens of students were gleaned. I extrapolated and condensed these narratives into the experiences of six students. Their narratives congealed and coalesced and eventually morphed into this play, "A Tear in the Universe." Through the six student characters, the play offers testimony and insights into the cloistered world of these students.

"A Tear in the Universe," an original play in four acts, captures and portrays the manner by which medical students' process the trials and tribulations they experience during their final years in medical school with particular emphasis on their interactions with patients. Some believe that empathy is innate, one either is an empathic human being or is not. Others believe that those who are born with the capacity to behave empathically may lose the ability as they deal with life challenges and circumstances. Some contend that those who are not intuitively empathic communicators can be taught

[4] The term, empathy, is derived from the Greek *empatheia*, literally, passion, from *empathēs* emotional, from *em-* + *pathos* feelings, emotion.[4] Pathos is the quality which causes people to feel sympathy or sadness. Empathy, therefore, is perception and response to the emotions of others. Empathy has been described as both a cognitive and affective attribute. Cognitive empathy refers to the ability to understand someone else's suffering, whereas affective empathy refers to the ability to share another's pain, proverbially expressed as "walking in someone else's shoes."

to be and still others assert that true empathy cannot be taught although behaviors that look empathic can be learned.

The experiences reflected in this play may indicate that all of the above and none of the above are the case. To each experience an individual brings his or her culture, language, family history, and values, as well as personal attributes such as patience, tenacity, social fluidity, and emotional balance. How the medical school experience is received is as individual and unique as each student. It is not the experience alone that has an impact on empathic behavior, but rather, the interaction and conflation of the student with the encounters.

Aspiring physicians enter medical school for a host of reasons and with a variety of expectations. Some believe they have had a "calling" and had always known they would become doctors. Some have succumbed to pressures from parents or, more generally, from society. Some are "good at science" and believed this to be the next natural career move. Some have lofty ideals of saving the world one person at a time. Others believe it will be lucrative and provide for an attractive lifestyle. There are some for whom none of the above apply and others for whom some or all are motivating factors. Those entering the field come together from many places with separate agendas. Over the course of the medical school career, realities phase in and many of those initial reasons are challenged and expectations for what a career in medicine will be like undergo inevitable adjustments.

Included are critical themes such as delivering sad or bad news, overcoming cultural differences, death and dying, birth, domestic violence and abuse, and dealing with gender, ethnic and racial biases, as well as personal insecurities. Attitudes formed

and changed over time are depicted through the characters' words. The goal is to bring an audience close to the experience of people who must adapt to a profoundly demanding role. Medical students are forced to engage in critical self-examination which tests their ethics, sense of self, and ability to manage the demands of caring for people within a context of limits, personal achievement, and disappointment. Additionally, the essential component of humanism, as it evolves in students' thinking and their self-definitions, is a foundational theme and echoes throughout the project. The overriding theme, however, are the stages – the passages – medical students journey through from idealistic, even romanticized, views of the practice of medicine to some of the harsh realities with which they must grapple.

Each of us, at some point, has to interact with the medical community, either for ourselves or for a family member or friend. It is my hope that, by illuminating some of the challenges faced by medical students, this play helps to cultivate an understanding of their transformative journey. By considering the experience from both the perspective of the doctor and the patient, we can, perhaps, find a way to bridge the communication divide in more meaningful and human ways.

It is my hope that this play accomplishes my goal: to enlighten, educate, and entertain while maintaining accessibility in content to those within and external to the professional medical community.

# A TEAR IN THE UNIVERSE

## Characters

Professor/Patient

*Third Year Medical Students:*

Catherine Valery
Mikayla Gallo
John Marcus
Siddarth Shah
Andrew Shaffer
Steven Alexander

## Setting

Current day. Down stage center: a free-standing IV pole from which hang six fresh, new, white lab coats. Center stage: a hospital bed, head of the bed faces down stage. Six lecterns form a row across the stage down stage of the bed.

## PROLOGUE

The scene opens with the traditional *White Coat Ceremony*. As lights come up, the Professor is in place down stage center, next to the pole with the white coats. He calls each student by their full name and one at a time, each enters from stage right. As each walks towards the professor, s/he stops, introduce him/herself, and then continue toward the professor to receive his/her white coat. They each ceremoniously receive their coat, shake the professor's hand, and take their place at their lectern. Each hand-shake is underscored by (pre-recorded) applause.

*(Introductions)*

Catherine: When I was six all I wanted for Christmas was a box of Band-Aids so I could, as I told my parents, "fix everyone's boo boos."

Mikayla: My father was chief of surgery at Jefferson in Philadelphia, my mom head nurse in the OR there, my brother is a lawyer on Capitol Hill, and I, well, I am quite good at science.

John: My first cousin, Dean, had his leg amputated when he was thirteen. He was captain of his Little League baseball team. As he made the winning catch at the Little League World Series, he fell and broke his leg. That's when we learned he had cancer. I wanted to try to make sure no other kid went through what he did.

Andrew: I have always been attracted to the good life – fancy cars, fancy clothes, international travel. I am not afraid of hard work and med school will lead me to those rewards.

Siddarth: My family philosophy greatly values achievements and success. Being a doctor equals success.

Steven: It was an MBA, a JD, a PhD, or an MD. Everyone in my group will have letters after their names. I hate numbers, hate writing, hate arguing. I am much more comfortable looking into a microscope.

*All are now in place behind their lecterns.*

Professor: *(booming)* ANY QUESTIONS?

*A piano-only version of Rachmaninoff's arrangement of Rimsky-Korsakov's "Flight of the Bumblebee" underscores. Medical Students take copious notes (on laptops?) as slides with words, formulae, photos etc. pertinent to the various courses flash on the screen behind OR a scrim in front.*

*Anatomy.*

Professor: ANY QUESTIONS?

*All hands shoot up.*

*Stylized movement:*

*Students get up and circle their own lectern. New book. Open – write, write, write (or type, type, type) – Slam closed*

*Physiology.*

*Students get up and circle their lectern. New book. Open – write, write, write (or type, type, type) – Slam closed*

Professor: ANY QUESTIONS?

*(Six of the group, hands up)*

*Students get up and circle their lectern. New book. Open – write, write, write (or type, type, type) – Slam closed*

*Other core subjects followed by ANY QUESTIONS? (fewer hands after each until finally not one hand is raised)*

Professor: No questions? Excellent!

*Slide Flashes: Second Year - Same as the first a little bit louder and a little bit worse*

*"Flight of the Bumblebee" begins anew as the "dance" above repeats, action doubletime. When the dance is complete, the students push their lecterns like wheelchairs and circle the stage followed by the Professor. The students take their places forming a semi-circle around the front of the patient bed, three on each side. The professor sheds his white coat, dons a hospital gown, climbs into the bed, the coat rack becomes an IV pole to which an IV bag is attached. And, voila! The professor becomes the patient, toes*

*bare, uncovered by the blanket, exposed. The students split, pushing lecterns off stage, returning to form a semi-circle at the foot of the patient bed, three on each side. Music out. Lights up a notch.*

## ACT I

Andrew: My transition from the first two years of medical school to the third year has been far more encompassing than I could have imagined. Other than looking forward to this jump, I had not put much thought into how different my days would be; and why they would be so different. Seeing patients with various health issues fortifies what we have already learned. But, at the same time we are merely scratching the surface of things like the politics of health care, working in teams, and managing the care of patients and their families. It all really underscores how challenging our future careers will be.

Mikayla: There seems to be a huge difference between knowing *about* things and knowing things. I am really starting to appreciate why they call the first two years "basic sciences." What will my decisions as an intern be based on? What I know from books? What I have seen clinically? What I have read in journal articles? Do most physicians consciously integrate this information? What will I do if I'm faced with situations I have never studied?

Siddarth: I have never felt shorter.

Mikayla: It's been three weeks. During two of those weeks, every single patient assigned to me ended up on hospice. Apparently I have the touch of death. Why do all my patients have one of only three disorders? Could this be because all the interesting cases are good ones for the intern to present so I get left with the less exciting cases? Should this really bother me? I *am* getting really good at treating Congestive Heart Failure, acute renal failure, and COPD. My patients are all elderly and dying. Shouldn't I want to be there to support them and their families during their last days? Do I want cases I can learn from or cases where I can actually have an effect on someone's life? *What am I supposed to be doing here?*

Steven: It seems that the residents appreciate it more when I do their busy work rather than spending time with my patients. The whole point of the clerkship is to learn and get as much clinical exposure as possible. This busy work is very frustrating. Next week there will be a new crop of residents teaching us. Maybe things will change.

Siddarth: Sometimes, when I am presenting on rounds, I feel like I would be perceived differently if I were taller. People respond differently to tall people. Tall people seem to command more respect. I feel like the only field I can go into is pediatrics!

Steven: Some patients I have are really great and others are not so great. For example, I witnessed a patient actually thanking an attending right after being told he had cancer. I've also had a patient order me to leave the room and never come back just barely after I introduced myself.

Andrew: I know that being sick is a horrible experience and that it is a difficult time for our patients. However, being sick is not a free pass to do whatever someone feels like doing. It isn't right for some patients to think that just because they are in the hospital that they can overstep the boundaries of common decency. Basic courtesy is not asking too much.

Steven: I think it would be appropriate to let the patient know that this kind of behavior is counterproductive to their care and well-being. We're here to help them, and part of that is establishing good, honest relationships.

John: Ultimately, humanism is a balancing act. While taking a personal interest in your patients can be a great and rewarding experience, it can also be a difficult and tedious process. When you go the extra mile to become not only a doctor but a friend to a patient it can be a wonderful experience. On the flip side, it makes the difficult patients more frustrating and I find myself getting resentful. It is hard, sometimes impossible, not to take it personally.

Andrew: Lately, I am haunted by this question: When did our patients become the "Enemy?" It really bothers me when a resident uses phrases like "OTL" meaning "Off the List," or more colorfully "OTFL" or if he is particularly cranky, "OTMFL" to express their joy at finally having gotten rid of an especially troublesome patient,

Mikayla: or when they call a patient "crazy,"

Steven: or when they make fun of an extensive list of psychotropic medications,

Andrew: or when they make a beeline out of a patient's room while the patient is still speaking, leaving his voice trailing off,

Mikayla: without even a goodbye.

Andrew: That's when it feels like the patient is "The Enemy."

Siddarth: And it isn't only the patient who is the enemy. I can't help feeling bad for the junior residents that get reamed out when they didn't handle a situation as well as they might have. In the OR yesterday an attending blasted a resident in front of everyone instead of taking her off to the side. It makes me feel so…so diminished. It reminds me of when parents scold children in front of guests.

John: I remember hating that when I was a kid. Why does the entire world have to know? A little restraint could make for a better teaching opportunity – and foster more respect for supervisors when they see how well she handles difficult situations.

Siddarth: Until then, I had only had positive interactions with that attending and I admit I was a little surprised. It seems that there is a pattern in the surgery teams that as people move up in the ranks they revel in embarrassing those junior to them. Why? Why would this happen?

Catherine: I saw Ms. Finello this morning, a spunky woman with a malrotation of the gut, a congenital defect which sometimes can cause the bowel to twist up on itself and become obstructed. Three weeks ago she had coronary artery bypass grafting, but her hospital stay has been complicated by a small

bowel obstruction requiring a second surgery. When I saw her at 5:30 this morning she was really upset. Yesterday she had been able to eat clear liquids and was walking all up and down the halls. She couldn't wait to be able to eat again and to go home. But during the night she had palpitations in her sleep and her heart rate was in the 140s. Another set back!

I was only supposed to spend fifteen minutes with her but a half hour later I was still sitting there. Honestly, what could I do to help her anyway?

Andrew: I bet there was no one else in this whole damn hospital who could do what you did for her this morning – spend a whole extra 15 minutes listening.

Catherine: She needed to talk. She felt horrible that she hadn't asked the nurse to call her husband in the middle of the night because what if something was critically wrong and she was about to die? He would be so upset! But, she didn't want to wake him up, especially with his congestive heart failure, in the middle of this bitter cold winter night to come watch her sleep in the hospital. And she was so tired of being in the hospital, can you imagine being in a hospital for three whole weeks? And her IV had to be moved to her right arm but one of the IV lines had a long catheter than kinked when she bent her elbow, so her right arm had to be splinted to keep it extended, and now she couldn't even knit anymore to pass the time.

It was late by the time I got back to my team to make rounds and I hoped my residents would understand. How horrible must it be to be a patient in a hospital! Can you imagine not being able to eat for a week? And to think, we go around all day long declaring patients NPO –

Siddarth: NPO -- From the Latin for nothing by mouth. Nothing! Obstruction? NPO! Diverticulitis? NPO! Cholecystitis? NPO! Pancreatitis? NPO! We toss NPO around like it's a volley ball.

Steven: But do we ever stop and think about what that means, physically and emotionally, for the patient? To not be able to eat? Eating is nurturing. Eating is comforting. NPO? Nothing by mouth!

John: And blood draws. How about we come and poke you with a needle at five AM every morning for the next two weeks? Forget the hospital bed, we'll even do it in your home, see how you like that.

Mikayla: Not to mention resident rounds. Try waking up with a start to a crowd of residents and medical students gathered around your bed, talking about you. They were in too much of a hurry to give you even the courtesy of a knock on the door before entering the room let alone a gentle wake up with a request for an audience to your suffering. That actually happens.

Andrew: And those luxurious, crunchy, plastic beds. Try sleeping in those for two weeks. Stir in a heaping cup of intractable pain to the mix.

Catherine: Anyway, after I left Ms. Finello, I explained and apologized to the residents that I was late and hadn't written my notes because my pre-round with one of the patients had taken much longer than anticipated. My senior resident nodded understandingly. So I continued, "Ms. Finello was really not feeling well…" He rolled his eyes with the air of an old soul sharing a

dirty secret. “Oh… Finello? She’s fucking crazy!” The junior resident, sucking up, snickered. What? Sure she’s crazy. She’s crazy because she complains about not being able to eat. She’s crazy because she’s depressed, lonely, and bored and can’t even knit while she lays in the bed. She’s crazy because she feels guilty about worrying her husband! She’s crazy because she’s scared out of her mind. I tried, but I can’t make it make sense. I locked eyes with the other med student on my team. His look acknowledged my frustration and in that moment, with a deep breath, I felt human again.

Siddarth: Perhaps we forget, in the chaos of the sleepless nights how incredibly frightening and uncomfortable it actually is to be in a hospital. Perhaps we have become blind to the mortality our patients face because we see it day in and day out. Perhaps we forget that patients are human beings, too. My greatest fear is that I will become like that someday, that I will forget how to empathize with suffering; that, caught up in my own tasks and troubles, I will have no energy left to be compassionate – and worst of all, that I will be okay with it, laughing along with everyone else, cracking jokes at my patients’ expense, anything to break up the constant unrelenting tension. Oh, God, don’t let me ever laugh like that. I am so afraid that in this struggle to become a surgeon – a superhuman – I may somehow end up less than human.

Andrew: Some days there is just so little to do. Sometimes there are like four patients on our census for a team of two residents and two students, few

new admits, so I basically see one patient all day. There are still lots of required lectures and meetings, but if not for that, I could be done at 8:30 in the morning. I can't think of any way to combat this – you can't *make* patients come into the hospital.

Steven: Some days can be boiled down to one word: Exhaustion. Today is one of those days. I woke up at 3:30 and ran around the hospital until 5 with no break. No bathroom, no coffee, nothing. Then I went to the clinic feeling comatose. On top of this I am expected to study for my shelf exams and prepare for my cases. Impossible and impossibly exhausted.

John: I always thought by the time I graduated from medical school I'd have mastered the "art" of medicine and physical diagnosis. Or, at least, be well on my way to knowing what I was doing. However, I've found that I spend very little time examining my patients, and I am quickly falling into the trap of technological advancements. I look around the floors and see nurses charting more than they are in patient rooms – the same goes for us. We rely so heavily on technology like CT scans and MRIs that actually touching our patients is becoming very old-fashioned.

Andrew: Is it bad that every time the trauma pager goes off, I hope for mayhem. I hope for multiple stab wounds, or gunshot wounds? I sometimes hope for just a terrible accident with amputated limbs. Is that bad? Is it bad that I always keep my fingers crossed for the chance to head into the OR hoping the attending will decide we have to operate. Is that bad? Is it bad that I

think the "worst" days on surgery are the days when no one needs to go to the OR? Is that bad? Is it bad that I am hoping for terrible trauma and wishing illness upon patients for the benefit of my education?

Siddarth: I am often asked how old I am by both doctors and patients. And every time someone asks I feel as though my height (or lack of) and youthful appearance somehow diminishes my abilities as a doctor. Not a day goes by in the hospital without someone making some sort of comment about how young I look.

Catherine: In an attempt to play philosopher, I've been trying to come up with a metaphor for what the surgery rotation has meant to me. The best way I can really capture how I feel is to tell you about a four-year old patient of mine. Imagine a little boy in his too-large PJs walking hand-in-hand with a nurse down the hall. Engrossed in a conversation about Spongebob Squarepants, he doesn't know they are heading for the OR. Before he could say "Mr. Squidward," he was up on the OR table, a mask over his face, with one skinny little arm extended so they could start an IV. Despite being in a room with five grownup people in blue gowns and face shields, and despite all the daunting machinery and bright lights, it wasn't really until that moment that he started to get scared. And that was the moment there was no one there to hold his hand.

For the past four weeks, *I* have been this four-year old, in my oversized scrubs and my enthusiastic attitude. Chasing my residents' coat-tails has felt neither rewarding nor educational. At the end of the day, there are just

a lot of frustrated residents and attendings, and mostly a lot of frightened patients. I've seen a few interesting cases in the OR but really what I've learned is the importance of a smile, a reassuring touch, and, of course, the value of observation. Had that nurse not noticed and responded to that little boy's yellow Spongebob pajamas, the long walk down that hallway probably would have been a lot rougher.

Siddarth: I frequently feel like others see me in those yellow PJs.

Mikayla: A patient vented her frustration that all these people wake her up and ask her all sorts of questions. I began to explain that it was important we ask questions so we could give her the best care, but I soon got the hint. I am sure I ask the most questions of them all. I tried to be brief and stay focused to get my job done, but after several days of laying in that bed, the patient was fed up and noticeably upset. I tried one of the psychiatry tactics we learned, asking "how does that make you feel?" coupled with "tell me more…" It backfired. "Why are you asking more questions?" She then composed herself but refused further questions and physical exam. I tried once to reason with her, then I apologized and left.

John: Sometimes patients don't know the "customs" of being in the hospital and might have ill-conceived ideas of how they are supposed to act or be treated. Also the hospital is a strange place, outside most people's comfort zones; patients may become defensive or fearful or hostile. It is important to explain the situation to them and comfort them as much as possible.

Mikayla: The next day, I tried again. She became really angry the second I stepped into her room. I asked if I had done something to upset her and she said, "It's bad enough I have to talk to all those doctors, but I don't want to answer to a nurse as well." So *that* was it. She thought that because I am a woman, I am a nurse. She was absolutely shocked when I told her I am a medical student and will soon be a doctor. But I also told her that nurses, too, have to ask questions and that we all work as a team to help her.

Steven: Today a patient confided that he was not fully confident in the medical care he was receiving. He had been admitted for shortness of breath two weeks ago and the workup revealed an anterior mediastinal large B-cell lymphoma. Treatment for this condition was going well, but in the fourteen days of his hospitalization, he had not once had a bowel movement. Every morning, along with the other usual questions, I would ask him if he had a bowel movement and every morning the response would be the same – "no." Every morning, I would report to the team that he did not have a bowel movement and every morning I would make a recommendation to modify the treatment. And every morning, I sensed that no one was even listening to my presentation; that the team was just waiting for the intern to interrupt me. Well, as it turned out nobody did listen. Nobody read either, because it was in all those notes that nobody co-signed. Today, he is vomiting and has an abdomen the size of a watermelon. And when the attending asked what happened, the response was "He never told us he didn't have a bowel movement!" But you know,

ultimately, I feel responsible for not being more insistent and aggressive.

Andrew: I was on call when a forty-six year-old woman with sickle cell disease came to the ER for pain crisis. I have had multiple patients in pain crisis during my previous rotation, so I felt confident in providing her care. When we first met, she was irritable and sarcastic. I understood that she was in a lot of pain, and did not take her comments personally. With proper care, her pain was expected to improve in the next few days. But, even after four days of high-dose pain meds, oxygen, folic acid, and transfusions, her pain did not improve. Each day she became more cantankerous, treating nurses and doctors like servants, expecting things to be done immediately, refusing to talk to the team except to chastise them for not being able to stop her sickling. Watching her was like seeing a little kid in the supermarket throwing a temper tantrum when he doesn't get the sugary cereal he wants.

Turns out, she was not getting better because she wasn't taking her oxygen treatment nor her pain meds! She needed both. If a nurse did not appear within seconds of her call she became incensed, punishing the nurse by refusing to talk. I tried to explain to the patient how the treatments prevent sickling. I also made a big deal of formally introducing the patient to her nurse hoping they could start over. Despite it all, the patient remained non-compliant and she did not treat anyone with respect.

I learned a lot from this patient. I learned that to treat a patient successfully, you need caring doctors but you also need a cooperating

patient who is willing to do *her* part to get better. I learned that some people expect to feel better without having to do anything. They expect other people to make them feel better. I learned that I cannot help people who are unwilling to help themselves. Her irritable mood did not bother me. Her childish tantrums did not bother me. But her lack of motivation to get better was something that made me want to give up on her.

John: Most, if not all, of us med students have encountered the pain med seekers, and I'm pretty sure we've all been educated on how to deal with Mr. or Mrs. So-and-So without even actually ever meeting the patient. I spent some time with a patient in clinic who had pain that I believed was real and symptoms that I know were difficult to feign. I know this because I've had them myself. This patient was waiting to have the surgery he needed so that he could eventually go back to work. He needed pain meds in the meantime. I presented this case in the clinic to my attending and a few residents and they all but laughed me out of the room. He was just looking for drugs, they chided, and I was so naïve! The truth is though, I have had more life experience than ninety per-cent of the residents in that room. I lost it! I said that at this stage in my career, a third year med student, it would be inappropriate for me to *not* believe or to *not* give patients that benefit of the doubt. It got really quiet for a few seconds. Then, to my surprise, I pretty much received a group apology. But, it just makes me wonder: Will the day come when I stop giving patients the benefit of the doubt? And if that happens, what kind of damage might I

inflict by missing a diagnosis where pain is the only symptom?

Steven: On the other hand though, this week I was stunned to learn how doctors can play a major part in patients' drug habits. I realize I am only a med student and I'm not in any position to judge or criticize decisions made by experienced doctors but sometimes there are choices which baffle me.

What was the family practice doc thinking when she prescribed Oxycontin to an eighteen year-old girl complaining of menstrual pain? Maybe she wasn't thinking. Or maybe she was just thinking, "This girl seems so innocent." I bet she wasn't thinking that this academic, white girl from an affluent family would become so easily addicted and then supplementing her habit with drugs bought from local dealers and paying for them by stealing from her parents and eventually needing to be detoxed for a 320 milligrams a day habit.

Mikayla: And what was the psychiatrist thinking when he placed a young girl on 20 milligrams of Ritalin four to five times a day? Apparently that high dose was necessary since he complemented with 4 milligrams of Ativan four to five times a day and another 3 milligrams of Xanax three to four times a day when she developed the somewhat expected jitteriness, anxiety, and insomnia. Now she needs to be detoxed after years of believing that her doctor knew best.

Steven: How often do doctors play a role in creating or continuing patients' addictions?

Catherine: What if the patient has to exaggerate pain to get attention?

Mikayla: And what if they've become addicted to opioids with help from the medical community in the first place?

Steven: Who takes the blame in that situation?

Andrew: And does an addiction to pain medications necessarily imply that the ailment causing the pain is no longer to be considered?

Siddarth: I think some of my most difficult patients are the ones who continually engage in self-destructive behaviors, despite coming face to face with the possibility of severe health consequences or even death. Within my first week of my medicine rotation, I had two patients who could just not give up smoking. I actually personally liked both of these patients – they were friendly, talkative, open, but at the same time I always had the nagging sense that they both were manipulative people. My first patient, a forty-four year-old woman, was completely crippled by COPD as a result of a serious smoking habit. She was admitted for over a week to get her severe wheezing under control. Her condition never improved during her hospital stay – she went outside of the hospital every few hours to smoke. Despite almost every resident and attending who saw her admonishing her daily to stop smoking she continued to smoke. She told me that she really wanted to quit saying "But, one cigarette a day isn't that bad, is it?" Her actions certainly spoke louder than her words. On the day of her discharge, she flat out asked me when she was going to die. She pulled out her cell phone

so I could talk to her sister. I told them both the truth: I didn't know, but she would continue to get worse if she didn't quit smoking. She just nodded.

Steven: I find myself constantly running. I'm always tired and I find myself getting annoyed with my patients. Is this normal?

Siddarth: My next patient, also a smoker was admitted for chest pain and syncope a couple of days after my other patient left. I went to see him in the ER, but guess what? I found his girlfriend sitting there instead. She said he went to the bathroom, so I came back a few minutes later. Halfway through the interview, I asked him when he had his last cigarette. I was shocked when he admitted he wasn't really in the bathroom but was actually outside smoking! Barely a month prior, he had suffered an intra-cerebral hemorrhage which has a fifty per-cent death rate. He had three or four myocardial infarctions over the past five days. I asked him if he wanted to quit smoking and he told me he was 99% "there" showing me his last cigarette. Without even thinking, I immediately grabbed it out of his hand. He was completely stunned. My resident came in to follow up and as we were leaving his room, to my surprise, the patient grabbed my hand, looked me in the eye, and said, "Thank you so much. Really." I felt great!

Steven: I think the psychological aspects of medicine are really almost as complex as the physiological aspects sometimes. I think this applies to doctors as well. Sometimes these patients are so frustrating, and I've noticed how

this affects my interactions with patients. At the end of the day, I guess it's just okay to know that you did what you could, and many times you just cannot save people from themselves.

John: Recently, while I was on call and writing progress notes with my intern, I heard the words you hear on every TV drama over the loud speaker: Code Blue CCU! Code Blue CCU! It was still early in the morning, my intern and I looked at each other and realized that we needed to quickly find our way to the Critical Care Unit. This was not a TV drama, this was real. As we ran, breathless, into the already crowded room, everyone seemed remarkably calm. This was my first code. Where was the chaos? Where was the commotion? Where were the people yelling for things "stat?" Where were the shock paddles and the "all clear?" My resident encouraged me to take a turn performing chest compressions and I began to realize that a fog of death had silently slipped into the room. As I continued to pound on her chest, people began to ask about the timing of events, how long between medications, how long had compressions been performed. Shortly thereafter, the physician running the code asked, "Does anyone else have any ideas?" and then "Does anyone have any objections?" And then we stopped.

Siddarth: Time of death: 8:47.

John: As I walked away with the team, I felt numb. And later, too much later, I realized I didn't even know her name.

Andrew: So far, I've covered two patients who most likely will die. One is eighty-nine years old, and the other one who has ovarian cancer, is forty-six. Does it make me a bad person that I feel greater compassion for the one who is forty-six?

Mikayla: I'm amazed by how much of medicine revolves around "the list" - that piece of paper the team prints out each morning with ample space to record vitals and lab values and to compose to-do checklists with little boxes that we can check off as we make sure to follow up. Forget the patient's name? Don't bother asking them, just consult the list. Your patient suffered a massive intra-cerebral hemorrhage and has to be transferred to the ICU? Well, good. One more name to cross of the list so we can sign out earlier. Have nothing better to do in the afternoon? Let's run the list one more time. It is interesting how often people's lives get reduced to little more than some notations on a piece of paper. I find myself doing it all the time. How can we remember to maintain the right perspective on the people we take care of when the pace of our rotations is so hectic?

Catherine: I have been lucky during my rotations. Lots of patients and their families have been very willing to let me talk to them and perform exams on them. I have also been fortunate to learn a great deal from my patients. Often as I am sitting taking a shelf exam a question will jog my memory about a particular patient I saw on a rotation. Every once in a while though, there is a patient or a family member who doesn't seem to understand why a

medical student needs to be part of the team. The question is, how do they think the attendings have so much knowledge? Do they even think about it? I want to tell them that medical school is essentially the foundation for all that information, and they can help me become a good doctor.

John: Today was a particularly frustrating day. The mom of a sixteen year-old girl told the resident that I was not permitted to see her daughter anymore. She said that I didn't know any more than she, a nursing student, knew and therefore I shouldn't care for her daughter. The resident explained that as a student I wouldn't be making decisions about her daughter's care, but that I work with the team to develop a plan before any decisions are made. Unfortunately, the mom still refused. What is really frustrating to me is that the mom is a student herself. She had even told the nurses that she would soon be rotating through this floor as part of her training. I am sure that she is as eager to learn as I am. I wonder how she would feel if a patient refused to let her be a part of the care.

Mikayla: I just finished one of my pediatric ER calls. How is it that there are doctors who choose to work with children every day when it seems apparent they don't really even like kids? Why would they continue working in the field? When someone is unhappy, people can tell. Children can definitely tell. Can you really even be a good doctor if you're miserable all the time? Can you really not care about a sick child anymore?

Catherine: I struggle with the term "incidental" on the operative report. Does

reporting a nicked and irreversibly damaged spleen as an "incidental splenectomy" absolve the surgical team of responsibility? Does it absolve them of the need for recognition of a mistake that could have been prevented? The way I see it, it really just means "accidental" but is it that I don't have an appreciation of how difficult it was to avoid the spleen in this particular operation? Are there surgeons who never have this problem? And if there are, is it because they're simply trying harder to avoid that complication? I often wonder if most surgeons are even capable of treating each surgery like it was "Mrs. Smith's hernia repair" rather than "my 277$^{th}$ hernia repair." Thinking of the surgery as number 277 creates distance and diminishes any errors making them less significant. The point that people can live without a spleen is irrelevant, really. If twenty extra minutes could have prevented this, isn't it worth it? I worry that it is not to some surgeons. And that's pretty hard to accept.

Steven: Today we had our humanism in medicine discussion about how the "hidden curriculum" of medical school slowly changes our professional behavior. I've been giving a lot of thought to my own humanistic path over the past year. I went from feeling shocked and horrified when hearing inappropriate things said by attendings or residents, to being unfazed by the comments, to accepting the comments. I wonder if during the next few years, I will start thinking these horrible thoughts and worse, start actually uttering them out loud – first probably to my peers, but then maybe even to medical students.

Catherine: I'm concerned about this, too, and hope that it never happens to me.

Mikayla: I need to always think before I speak and when I have frustrating thoughts about patients, I need to look at the big picture and always look at the situation from the patient's perspective.

Steven: It is upsetting that this process is slowly becoming less natural for me.

*Lights dim a notch. Medical students circle the patient. Rapid-fire questions and barely-audible responses:*

| Medical Students: | Patient: |
|---|---|
| How are you feeling? | Well, today, I… |
| Last bowel movement? | Um, I think it was… |
| Fever? | Maybe, a little… |
| Chills? | Not really… |
| Nausea? | Um, well… |
| Vomiting? | Not today, but yest… |

In unison: Okay, then! See you tomorrow!

*Students turn in unison to face upstage.*

*Blackout.*

## ACT II

Steven: On a tour of the Neo-natal Intensive Care Unit, the NICU, the resident showing us around mentioned that premature babies born after twenty-one weeks are automatically resuscitated by the NICU. She also said that most of these babies have developmental disabilities. I asked whether or not a woman whose baby was around twenty-three weeks could choose to have child resuscitated. She said that the obstetrician could be held liable if they don't call the NICU and if the hospital has a NICU they have to call and that once they are called, the NICU has to resuscitate. She told us about a recent case of a woman whose cervical stitch began to open at twenty-two weeks. She did not want every measure to be taken in the event the baby was born. Since our hospital does have a NICU she had to make a decision whether to stay or go to another hospital which does not have a NICU. She chose to leave the hospital.

Mikayla: I saw a patient today that most likely had viral upper respiratory infection. According to the chart she was in last week for the same issue. Big problem was that she and her mother only spoke Spanish and the medical student they saw last week didn't speak any Spanish. He saw the girl then used a translator to relay the information he and the attending had discussed. So I saw them today and I speak Spanish. I told the mom all about Viral URIs and asked her what she was told the last time she was in. She said she had never heard about a virus and didn't think the last visit helped at all. So where was the confusion? Did she understand and wasn't

satisfied, essentially fudging the truth to me? Did she just not understand? Or, maybe she didn't listen because the person in the white coat didn't speak Spanish? And was that first visit a complete wash? I guess I will never know the answer, but at least something was accomplished today. Overall it all turned out fine but leaves me wondering how many more times this has happened and how many more times will this happen again?

Andrew: A patient on the floor was transferred from another hospital due to suspected child abuse. According to the mother, the patient was playing with his brother, unattended, when he rolled off the bed and hit his head on the hardwood floor. He cried immediately. The mother, in the next room, heard a "thump" and her baby crying and rushed to attend to him. Two days later, while bathing her child, she noticed a swelling bump on his head and subsequently took him to the ED. The child had x-rays and CT scans of his head, which were read as a "depressed skull fracture," which did not seem to match the given history. With such a reading, concerns of child abuse were raised as the child was transferred here. Multiple attempts of re-interviewing the parents yielded a consistent history time and again. Family Services was called as were detectives. The prosecutor's office was also notified. Upon reading of the films from the outside hospital, our pediatric radiologist gave a reading of a "linear skull fracture," which was much more consistent with the mother's story. Unfortunately, she was not cleared to take her child home without the social worker's approval. The biggest concern at this point, after having

ruled out child abuse, was the fact that this family held illegal status in the United States. With the prosecutor's office and detectives involved -- what happens now?

Siddarth: I understand the importance of erring on the side of caution, but what do you do when a mother who has illegal status is concerned for the welfare of her ill child and prosecutors become involved in the management of the case for suspected child abuse? How do you navigate such dangerous waters when weighing the well-being of a child vs. fears of being deported? On the one hand, there is an ethical obligation to investigate suspected cases of child abuse. On the other hand, given the knowledge of the family's illegal status, is there an ethical or civil responsibility to report them?

Andrew: If the prosecutor's office is to report them, I would imagine it would highly deter the mother from ever seeking legitimate medical care for her children or her family if anything should happen in the future. Should the radiologist who initially read the films as a "depressed skull fracture" be held liable for what happens to this family? This family's world could possibly be turned upside down merely because of a legitimate accident misconstrued by human error.

Steven: Recently, when I was on the Labor and Delivery floor, there was a Spanish speaking patient with no English at all. The attending on call that day was, shall we say, not in a good mood. The first time he went into the room he brought a med student from Puerto Rico to translate for him. The

first thing he said was that if she wants medical care in this country, she should learn how to speak English. She has no right to expect the best health care if she can't even speak the language. The med student was shocked and did not translate what the attending said. She told the patient something entirely different. I wonder what I would do if I were that med student?

Andrew: While the attending's method and timing were certainly awful, the content of his words is actually 100% correct. In the United States, patients who speak English get better medical care. That's just a simple fact that we've all probably heard a dozen times throughout our training.

John: I wonder if the attending meant "It's really annoying for me to have to do my job when I can't even understand you," or "Unfortunately, in many cases the language barrier can be a major obstacle in the delivery of healthcare, so if you can learn some basic English to improve communication it will be good for everyone." I have a feeling that many others will disagree, but I think the intent of his words makes a big difference.

Catherine: (*like a game show host*) "Hey! Guess what? You've got cancer." Literally, that's what one surgeon told a patient in the clinic with three students in the room. The patient started crying, saying, "Oh my God! Am I gonna die from this?" To clarify, the cancer was superficial, in the bladder, and had a good prognosis. Still, it was quite a shock for me to hear this from this surgeon whom I knew and trusted. The doctor did go

on to explain the course of the disease and the likely favorable outcome. The patient slowly regained her composure, but the unnecessary damage was already done. It did, however, serve as a warning to me to not repeat that kind of behavior.

Steven: I have been amazed several times on my surgery rotation how quickly rounds can occur. Students are expected to present but are often cut off before they can finish describing what was found on the physical exam. And unless a physical exam finding is specifically related to the surgery it isn't even worth mentioning since you will get the response "we don't care about that." Patients will be asking questions as the residents are walking out the door, leaving the students standing there clueless about what to do. Do we respond? What if we don't know the answer?

Mikayla: And if you do stay in the room even a few seconds longer than the residents, the lightning rounds can take them to another floor, leaving you alone and unsure about where they went and hoping your classmates will text you their current location. I understand that the residents are busy and have to see a lot of patients before the first cases of the day begin. However, ignoring a patient's question and rushing students through their presentations leaving them incomplete are some behaviors that should not occur. Every patient has the right to know what is going on with their health and have their fears alleviated.

John: Booker T. Washington said, "Few things help an individual more than to place responsibility upon him, and to let him know that you trust him." I

hope many others share this sentiment, but I am always surprised by how much trust and respect our patients have even for us medical students. How terrifying to be ill, in pain, and cranky, and then to have a medical student performing a procedure on you while the resident or attending is instructing him step-by-step. How must a patient feel as "Whoops" and "No, not that way!" are uttered versus the occasional "Good job?"

Mikayla: It is refreshing to think that after almost five weeks of being on the surgery clerkship, I have not had any disturbing experience. The attending I work with is an older gentleman, with an older school of thought, and who is truly dedicated to his patients. He has shown me that it is possible to be ambitious, meticulous, and dedicated without compromising the essentials of patient interaction. Furthermore, he is just as professional with his colleagues in the operating room as he is with his patients. It has truly been a refreshing experience and undoubtedly a needed experience after completing almost my first year on the wards.

Siddarth: What amazes me most is how we, as students, are allowed to be the primary "baby-catchers" in vaginal deliveries. The defining experience in most people's lives – the birth of their child – is shared with us, entrusted to us, people whom they have just met and know nothing of except for that short white coat and a brief introduction. We are in a hallowed profession, and indeed, as Peter Parker's Uncle Ben advised: "With great power comes great responsibility." I am uplifted by this responsibility.

Andrew: I have had many difficult patients, one of whom stands out because of how

he treated me every morning. The very first time I met him in the ER he made it clear that he had no interest in talking to me. When I asked him about his past surgical history his response was, “I have had 19 surgeries on my body and I am not about to discuss them with you.” Towards the end of the interview he said, “Go down to the hospital chapel and look for my name on the wall. My cousin donated that entire wing.” I now understood that he wanted me to know that he was an important person. I was assigned to follow him throughout his stay in the hospital and I went to see him every day. Sometimes he was in a better mood than others. Sometimes he was willing to speak to me and sometimes he would just say “No!” before I even finished my question. He was frustrated, feeling that not enough was being done to address his problem. One morning he said, “Maybe one day you will be somebody who can actually do something.” I was initially very offended by his comment as this was just one more caustic reference to my inexperience. Some of my classmates helped me to understand him a little better and I began to see why he treated me this way. I learned a few things about him.

Mikayla: He is a successful business man and he is used to getting things done.

Siddarth: He always knows exactly where he is going.

John: If he wants something he goes for it.

Andrew: I started to put the pieces together: In the hospital, he felt powerless and helpless, waiting for physicians to make decisions for him. There was

nothing that he could do to make himself get better any quicker. He had no control. The dread I used to feel going to his room started to abate, now that I stood in his hospital slippers. A couple days ago, he refused to let me examine him nor would he even talk to me. I complied, but as I left the room I told him to enjoy his breakfast and that I hoped today would be a good one. As I turned towards the door he replied, "Thank you for being so polite." This was the first time I left his room with a smile on my face.

Siddarth: I watched an attending deliver the news to our patient that there were cancer cells in her fluid sample that were "almost certainly due to ovarian cancer." Her eyes welled up, although somehow it seemed she anticipated the diagnosis. I wanted to hold her hand and tell her it was okay to cry if she wanted to. My attending stood across the room as he delivered his news. Perhaps he had prepared her for the possibility of the diagnosis earlier in a different way. I don't know, but I think, no matter what, if you are going to deliver news that dire, you ought to at least sit down and face your patient eye to eye. We have to put ourselves in that bed or that chair or their shoes to comprehend the magnitude of the message.

Catherine: In these life-defining, life-changing pivotal moments, it is probably not the *words* that are spoken, but *how* they were spoken, how they made her *feel*. *That* is what will be remembered.

Steven: A couple of us went with a resident down to the ER and admitted a man for possible bacteremia which we suspected he got from diabetic ulcers in

his shins. Everything was going along fine. We started him on IV antibiotics and he steadily improved. MRSA bacteremia was confirmed and we continued the IV. After about a week, all the lab cultures were coming back negative and the patient showed significant improvement so we decided to complete the six week regimen as outpatient with a PIC line.

John: Well, that's when the trouble began. The attending was reluctant to send him home since he was deemed unreliable based on his control of his diabetes so far and was not likely to take his medication. Since he did not have insurance and no one to pay for visiting nurses or other services, he ended up staying in the hospital for three weeks. Finally, the attending and the social workers were able to convince the hospital administration and an outside organization to share the cost of the antibiotic treatment. He would get his antibiotic at the resident clinic for the remainder of the regimen.

Steven: This whole episode opened my eyes about the huge amount of money lost as collateral due to lack of insurance and red tape. I guarantee you it ended up being more expensive keeping him in the hospital than had they paid for his treatment at home.

Siddarth: Friday night, one AM. Everyone was in OR holding and waiting impatiently; a couple of anesthesiologists casually chatting, one nurse complaining very loudly, "Where *are* they?? They said they were waiting for some family member to arrive…" "They should wait" I interjected.

"He's very, very sick and it doesn't look good. The family should all be here." The scrub nurse looked oh-so-happy to be woken up and back at work, sitting crabbily in the corner. Finally, the patient arrived awake and alert. The last time I saw him, he was sedated in the ICU after his last surgery for acute mesenteric ischemia. It was kind of shocking to see him wide awake now, though he was clearly terrified and in a lot of pain.

John: Everyone started moving quickly and going about their jobs and no one really said much to the patient, other than, "Do you know why you're here? We're going to operate on your belly" and "Sir, we're going to roll you now, just cross your arms."

Siddarth: I went over and squeezed his hand – he gripped mine, and I tried to think of something to say. I started explaining what they were doing and tried to fumble around with some comforting words, trying to smile and look him in the eyes. He told me he was scared. I promised he would feel better soon, they were giving him medicine to make him relax. He begged, "Please hurry!" There was a very good chance these would be his last moments alive.

John: And they were. When we opened, the smell was horrifying; the entire bowel was dead, not one pretty pink viable segment left. They simply sutured the skin closed and sent him back to the ICU intubated and fully sedated. The senior resident said, "Well, there you go. Just another "peek and shriek." The attending went to talk to the family.

Siddarth: As it all sunk in and I realized the gravity of the situation, I was dumbfounded. The surgical team treated a dying man like any other run of the mill patient. No one, not one person, took an extra second to comfort him, or to ask if he wanted to pray. Is praying even allowed in the OR?

John: Or to think of his best memories. Nope, nothing special. Business as usual. And I wondered how often does this happen? What if this man had been my father or grandfather? I would have wanted someone to treat him with extra kindness, knowing that these could be his last moments.

Siddarth: I would have wanted someone to treat these as sacred moments. This is still bothering me. Maybe no one really knew how grave this situation was, but I'm pretty sure they were well aware.

John: Maybe they see this so often, or maybe they are so well-trained that the sequence can't be disrupted to spare time for the frightened patient.

Siddarth: It is a privilege to be involved in moments such as these. Next time I will not hesitate to hold the patient's hand and provide any measure of comfort I can to help ensure those last moments are as sacred as they should be.

John: The thing I had most looked forward to was delivering a baby and the experience has not disappointed me. Being part of the joy of bringing another life into this world is a feeling that so far has been unmatched. It truly is the miracle of life. I remember these moments when I am treating a dying patient. That patient was once that baby, each life a miracle.

Catherine: A woman who had a full hysterectomy was septic two days after surgery. The surgical dressing looked fine on top but no one had ever even removed it. If they had, as they should have, they would have seen that the dressing underneath was full of feces. There had been a bowel perforation. Now, day 8 post-op, she is still in the ICU!

Mikayla: One morning, I was in the OR watching the excision of a melanoma from the scalp of a fifty-three year old woman. Prior to the surgery, the surgeon had shaved the top of her scalp, leaving enough hair on the sides so that if she wanted to wear a hat after surgery, she could without others knowing that the top of her head had been shaved. Since the excision was wide, a plastic surgeon came in to close but he let the residents place the final sutures. There was profuse bleeding of the scalp as they sutured and the residents became increasingly frustrated as the bleeding would just not stop. The patient's blond hair was saturated in blood. It was impossible to wash it out without soaking her entire head in a basin and shampooing it. Someone asked for a fine-toothed comb to brush it out but couldn't find one.

Andrew: As they tried to gently clean her hair they soon realized it was not working, so they basically demanded the nurses to clean it. The nurses couldn't find any better way to do it so one of them suggested dumping bottles of saline on the patient's head. There was saline and blood everywhere. As the residents became increasingly frustrated, they took their anger out on the nurses, who became upset.

Mikayla: Then, of course everyone's frustrations trickled down to me as they yelled at me to do a better job holding *the* head, Lift *it*! Turn *it*! *(pause)* IT!?!

Andrew: Eventually they ended up just shaving most of the blood-stained hair, but because of all of the frustration and anger, it was an unprofessional and messy job. I felt bad for the woman and I felt bad about how horribly the situation was handled.

Mikayla: With better preparation and a more detailed plan before the surgery things could have gone smoothly.

Andrew: Patience would also help. The attitude of the residents and the attending affects everyone in the room and ultimately the care of the patient.

Siddarth: Before starting this surgery clerkship, I was feeling pretty lucky that none of my patients had passed away. This clerkship is a rude awakening! I am shocked by how many patients die on a surgical service and by how complacent the residents and attendings seem about death. When my first patient died, it took a few days to hit me. I just couldn't connect that the little old lady who I had admitted three days prior was no longer living. I was haunted by her son's stunned face after seeing her with the tube in her nose. For days I heard his plaintive voice saying, "I guess this is the first of many tubes."

I wonder how he is now and how he dealt with the death of his mother. I wonder if he even knows that her death could have actually been prevented. When the surgeon accidentally perforated her bowel and fecal

matter started filling her abdominal cavity, I could feel my heart pounding as my eyes alternated between her abdomen and vitals. It felt like an eternity before the surgeon found the site of the tear. I tried to visualize her face above her abdomen. I knew her face very well, but had trouble juxtaposing that sweet face above the horrendous mess of an abdomen. She didn't die right after the surgery. I don't think I could have handled that. But she did die in the ICU a few days later. She was such a cute, friendly, smiling old lady who had a son who loved her very much. I try to focus on that.

Mikayla: I had the opportunity to scrub in on a D&C for a missed abortion. Near the end of the case, my attending handed me the curette and instructed me to scrape the patient's uterus as hard as possible. I later told some of my non-med school friends what I did, and they were revolted by it. They were also surprised that I was so cool about it. Has this happened to other people? Has being in medicine really desensitized us to what the rest of the world finds gross?

Catherine: I never see the majority of my patients again. They go home, I change services, and life goes on. Today I said goodbye to a patient who I will never see again. Today I said goodbye to a patient who was in end-stage ovarian cancer. She declined treatment, wishing to go in peace, and to spend the rest of her days with her family. Even as I said goodbye to her, I couldn't quite grasp the finality of the situation, yet my patient showed complete acceptance.

John: During my psychiatry rotation I was told by a lecturer that if I am not comfortable with death in my own life, my patients will be able to detect my uneasiness.

Catherine: I wonder if that is true. I know that I have not come to terms with death, but I don't think I carry that over to my interactions with patients. I am still able to have a positive impact in their care.

Andrew: Witnessing my first delivery, which happened to be a C-section, was truly a moving experience. I was impressed as to how carefully, yet efficiently, the OB/GYN doctors worked to get the baby out quickly. The baby was pulled from the mother's womb and I was literally speechless. I've already seen so much as a medical student, from dissecting cadavers to comfortably doing pap smears, yet this experience left me in awe as I marveled at the beauty of God's creation, right before my very eyes. I never thought I would be so moved.

Steven: I hate surgery. Hate! Hate! Hate! Let me clarify – the inner workings of the human body, exposed for me to see -- Awe*some*. Everything else – Aw*ful*. The strict structural hierarchy set in stone by the words and actions of all around me – the coldness of my supervising doctors, evaluation of every move I make – the tired, overworked residents, too hurried to give more than two minutes to a patient, unless they are doing the cutting – the 5 AM rounds on sleep groggy patients, asking the same questions, rushing to the chart to write it all down – the feeling that I can never truly be

completely prepared for anything, you have been doing this for twenty years and I am barely one week in and of course I won't know all the answers! Stress that leaves me tired and nauseated and incapable of sleep, unable to enjoy even one minute of my one day off.

John: Everyone was frustrated about this eight-year old in pediatric surgery. His post-op was dragging on and the surgical residents wanted to pass him off to the pediatric service. It was so comforting to hear the conversations the nurses and residents had regarding this. They accepted him onto the pediatric service without any push back. They even planned to put in an extra line for nutrition even though there was already access. It was a minor thing, but the fact that the nurses and residents stood up for him and then decided to relieve the other service of his care was nice -- they only cared for his well-being. It was the first time all year that I saw people go out of their way to help, taking on extra work.

Steven: Worst for me is that I find myself acquiring reprehensible survival skills just to get through. The selective deafness to anything a patient says when I am more than three feet away from them – reprehensible! The "let me tell your nurse" pass off when asked for a blanket or a position change – reprehensible! The scribing from a chart instead of actually talking to a patient for any length of time when asked to do a consult – reprehensible! If you had asked me three years ago, I would have sworn I would never do these things. I find now I'm doing them every day.

Andrew: I've spent most of the last two weeks at a day program where about fifty

patients come each day to have a place to socialize, form friendships, work in group therapy sessions, and meet with their psychiatrist and case workers. My role there has mostly been to sit in on the group sessions and interact with the patients informally between sessions. I have been a bit disappointed because I don't get to sit in most of the sessions with the psychiatrist where we could discuss medications and differential diagnoses. However, what I have learned instead I feel is much more valuable. I have gotten to know the people the patients are. We talk about sports, hobbies, families, not symptoms and medications. The med student in me wants to know what is going on medically, though, so I can learn and maybe help. One patient revealed that she is great all day but at night she goes home and talks for hours to the voices in her head.

I have learned that a mental illness is only a small part of what makes up a person. We have all heard this many times in class, but it was not until this experience that I have really understood what that means.

Catherine: Being present while a first time mother delivered her baby was amazing! I was there at a major life milestone. Birth is a miracle!

Steven: I was disappointed in the lack of relationship between the attendings and the patient. Everyone was supportive during the birth but they were out of the room as quickly as they had come. How about "congratulations!"?

Catherine: Maybe I'd feel the same way after the hundredth delivery. I hope not. I really hope not.

John: One morning on the cardiology service I remember being particularly stressed because I had a lot of patients to see and I lost an hour due to grand rounds. I was seeing Mrs. Lauzon for the first time.

Andrew: She was in her fifties, been admitted for unstable angina, and was scheduled for catheterization in the afternoon.

John: I remember thinking this would be a quickie – in and out in time for rounds. Her answers to my routine questions revealed that Mrs. Lauzon had a lot of stress. For a moment, I hesitated to delve worried that I would never get out of there and my whole day would be set back. But only for a moment. I sat and asked her what was going on.

Andrew: She had recently lost both her twenty-one year old son and her mother, less than a month apart. She and her husband were dealing with the tragic death of their son in very different ways and it was her mother to whom she turned and now her mother was gone.

John: She felt so alone. I sat with her as she cried and I listened. I just listened. I didn't have all of my notes done when rounds started and I never got a chance to look up the differential that I wanted to but I felt that on that morning other things were more important. The next day, Mrs. Lauzon told me that yesterday was the first time in a long time someone had sat and listened to her and that she felt better than she had in months. She told me that my kindness was exactly what she needed.

This was the reason that I chose to go into medicine. Writing great notes

and being able to answer all the questions on rounds are important but helping patients through difficult times – that is really what it is all about.

Mikayla: Mr. Alexander died two days ago. He was my very first patient. He was a little grumpy, and hated being woken up in the morning, so over the two weeks that I visited him, I let him sleep and waited to round on him until he woke up. He said he liked me because I am Latina and I liked him because he had a good heart, well, except for the whole eventual need for Coronary Artery Bypass Graft surgery. The night before his surgery he has a massive hemorrhagic stroke. He held on in the ICU for another day or so but the next morning he wasn't listed as an inpatient anymore. I still haven't "officially" heard from anyone that he passed. I guess that's part of the job.

Andrew: So until two months ago, I had never experienced a code blue. All of a sudden I've been through about 6 code blues in the past month and a half. Miss Swenson was conscious and alert the whole time, talking with everyone in the ambulance. Her family followed to the hospital and everything was under control. She said good-bye to her family, kisses all around, and they headed up to the cardiac waiting area. Miss Swenson was talking to her cardiologist when she suddenly coded. "Call a code! Get the cart over here!" A swarm of nurses and the ED attending rushed over, Miss Swenson was intubated, CPR was started, meds were pushed, and she got defibrillated. *Very* tense! A nurse was shouting at the attending, the pharmacist was shouting orders to her students to look things up, and

things were happening rapid fire. After one shock she returned to normal sinus. Miss Swenson had the surgery. A few days later she was recovering well in the CCU.

Siddarth: I've also seen a handful of codes on the medicine service now. Sometimes there is inappropriate laughter, and sometimes staff are a little too eager to teach. But last week, I watched one nurse take about twelve nursing students and line them up to do compressions. At one point when the doctor was going to call it, the nurse asked for three more minutes so the rest of her students could do compressions. Thank god for that – those extra compressions – the patient suddenly got her pulse back!

Steven: There seems to be a phenomenon of elderly patients who are dropped off by nursing homes with a note indicating fever or shortness of breath. Many of these patients have dementia – try getting a history!

Andrew: Is it horrible to laugh at some of the crazy things they say? I told one woman the procedure would be fast and she snapped, "Are you calling me fat?"

Mikayla: Mrs. Sullivan, a morbidly obese eighty-one year old woman with restrictive lung disease was admitted with aspiration pneumonia. She was placed on a biPAP (Bi-Level Positive Airway Pressure) for oxygen. Her condition worsened and she needed continuous oxygen, only removing the biPAP for meals. She couldn't be intubated because she had DNR orders in place.

The pulmonologist talked to her family and strongly urged them to take her off the biPAP and to "let her go." We are only prolonging the inevitable, he told them, and it's not cost-effective to keep her in the hospital. Seriously? Cost-effective? This is what he says to a family? He was even telling "How fat is she?" jokes later on the floor.

The family finally agreed to take her off her the biPAP. When I saw her the next morning she was confused and very scared. She actually asked me if I came to declare her brain dead. I spent the next half hour trying to calm her down at the same time trying to maintain my own calm. I couldn't sleep at all that night – I was afraid that I wouldn't see her again. First thing in the morning I rushed to her room -- she was still there, but not for long. She died two hours later.

Andrew: Way too many medical errors! I can't seem to let it go! My resident told me that when he was a med student, he saw a twenty-two year old man undergo brain surgery which left him partially paralyzed and unable to speak. For two years, he fought an uphill battle but eventually succumbed to multiple infections. He fought for his life for two years before succumbing to multiple infections. If this isn't tragic enough, my resident said that the brain surgery wasn't even needed in the first place!

Steven: I was in the computer lab with three different doctors and I had to pass information along to each of them because none of them would just turn around and talk to each other.

Siddarth: I have a lot of trouble dealing with mental health issues. There is not enough science and the disorders don't follow rational lines. I feel like I am just eavesdropping on people sharing painful and personal stories. I actually tried to put myself in a patient's shoes but I realized quickly nothing in my experience gave me an inkling into what she was thinking or feeling about anything.

John: Patients with mental or emotional disorders are not much different from you or me. To mix metaphors, it seems we are all cards in the same deck and which card we are is a random deal. Sure, our experiences, our upbringing, and cultural backgrounds differ and contribute, but it feels like the luck of the draw.

Catherine: A few days ago, I asked my resident if I could skip some of the early morning lectures so I could attend my first delivery. She smiled and said, "Let's go have a baby!" When we got to the delivery room, there was my patient, Mrs. Thompson, a small woman loudly broadcasting that she felt pressure. Pressure! We suited up quickly and after some uneventful pushes, magic!

A tiny head emerged! Then a tiny body! Then a rush of fluid and blood right into my lap. I cradled this little girl, this magical, miraculous little girl in my arms. Little mini-Mrs. Thompson! Nothing in my life has been more exhilarating. How privileged we are to be a part of this!

John: Amidst the beeping of the monitors, the clicking of the keyboard, the scratching of the pen upon the paper, the clamoring of nurses delivering

"report" as shifts change, if you listen you can hear it. The whisper of someone in need…someone asking for help.

Steven: Only, most of the time, it isn't a whisper.

Catherine: Do you hear it? Do you hear the person… not the patient, but the person? If you can't, listen harder.

Mikayla: All too often, patients are ignored. Sometimes they are asking for something simple like help getting to the bathroom so that they don't have to suffer the indignity of soiling themselves, because they are attached to an IV pole.

Andrew: I have stood at the nurses' station and heard, "Help me! I need help!! Someone, please!" The times that I haven't answered far outweigh, I'm ashamed to say, the times that I have.

Siddarth: I want to help – that's why I'm here but that desire is often in conflict with my responsibilities. If I stopped what I was doing to respond to every patient who asked for help, I would be unprepared to present my patients on rounds, which would clearly be unprofessional.

John: How do we reconcile this desire to help others, while maintaining the integrity, work ethic, and professionalism that is so integral to the medical profession and the subsequent care of OTHER patients?

Steven: Am I being selfish, thinking that I need enough time to complete my work

and follow "my" patients? Is it unprofessional not to attend to these individuals?

Siddarth: During my surgery clerkships, I spent a lot of time in the breast clinic and I happened to see a lot of lumpectomies and biopsies. Boring! Simply taking out a chunk of breast tissue from a woman? No big deal. I even got to see a mastectomy. Not nearly as exciting as cardiothoracic surgery. In clinic, I watched the doctor tell a patient that because she had DCIS, ductal carcinoma, breast cancer, we simply had to remove some tissue. No big deal.

Andrew: One time we finished a lumpectomy and tore away the sheets and I was shocked to see the patient's face. So often in the OR we become so engrossed in the "case" we forget about the patient. I was horrified to realize I had so distanced myself I literally forgot she was a person.

Siddarth: I read an article in a magazine, not a medical journal, about a woman's fight against breast cancer. And procedures I blow off as "no big deal" become a big deal when you realize how frightening they can be to a patient and how much of an impact it can have on a person's life. Odd that it was the article and not my experience that made me realize how insensitive I had become, how it is not "no big deal." When you add the face to the case it all becomes a very big deal.

Steven: *(walks to patient, pauses, makes eye-contact)* When you add the face to the case it becomes a very big deal. (*He continues walking down stage left,*

*stopping at the proscenium)*

*The remaining five students gather around the bed and slowly rotate it 180° so that for the first time, the audience can see the patient's face. As they turn the bed, they speak pointedly, in unison):*

When you add the face to the case it all becomes a very big deal.

*The following verbal dance is spoken by the Patient, Andrew, and the medical students:*

Patient: Talking all around here

Andrew: She lies here

Patient: I lay here

Andrew: So small, so sweetly, helpless, so stoic

Patient: Trying just to hear the words

Trying but I

Andrew: Trying not to

Both: Fear the worst

Patient: What can I do?

Andrew: What can I say?

Patient: I can't do.

Andrew: I can't say.

I can sit.

I can stay.

I can listen.

I can hold her hand.

Let her know.

Patient: Try to understand.

Students: As though she's not there

As though she has gone

Then

Andrew: Her eyes lock on mine.

Patient: Flowers on the window ledge

Students: Flowers wilting on the window ledge

Tell of visitors

Patient: Long gone

Andrew: Dutiful visitors

Patient: Moved on

And I lie here

Andrew: And she lies still

So small

So sweetly stoic

| | | | |
|---|---|---|---|
| Andrew: | I can | Patient: | Please |
| All: | sit | | |
| Andrew: | I can | Patient: | Please |
| All: | stay | | |
| Andrew: | I can | Patient: | Please |
| All: | listen. | | |

*Blackout.*

## ACT III

Mikayla: I overheard a case manager telling her boss that her patient was being discharged to home hospice, and since the patient and her family spoke only Spanish she was concerned there might be confusion and unanswered questions. I offered my help as a translator.

On the way to the room, the case manager said, "She's a twenty-two year old with end-stage cervical cancer." Whoa! This was not the hospice patient I had imagined. I'd be lying if I said I didn't want to turn around and walk, run, the other way. I soldiered on to greet a frail, young Luisa Santiago and her older sister, Julia, her primary care taker. I translated the case manager's information, and answered the sister's questions and concerns about the patient's daily living needs. What happened next just

broke my heart.

The doctor came in, remarking on how much better she looked, despite her lack of response to the fentanyl pain patches. Once her sister arrived, her pain seemed to subside, the doctor said, as if the sister's love was the only pain medication that helped. I translated, and the patient gave a huge smile and nodded her head. The sister said that no matter what, she would stay by her side. It was an absolutely beautiful moment.

I often replay that conversation in my head and my heart breaks a little every time.

Andrew: Early on during my Medicine rotation, I was assigned to follow a patient I had not yet met. Mrs. D'Alessandro was an elderly woman with a known heart condition and I didn't expect a very emotional interaction. Boy, was I wrong. This sweet woman was in tears for pretty much our entire interaction. She shared that she and her husband had just celebrated their 60th anniversary and yesterday her daughters told her that her husband had died. She was utterly devastated and my heart broke for her.

Later that day, I found out that Mrs. D'Alessandro suffered from dementia and her husband had actually passed away some years ago. The thing is, though, the emotion she was feeling was as real and fresh as if it *was* yesterday that he died. She sobbed and sputtered, crying that she had no idea how she could go on and how her husband was everything to her. Over the next several days when I visited her, I tried to comfort her but I realized there was really nothing I could do. Her grief was palpable and

raw to her. I couldn't even begin to imagine the heartache that woman was feeling.

Steven: Last night, I was on trauma call for surgery and here I am now in a diner crying on my pancakes. A man stabbed his three children, his girlfriend, and her child while they were all asleep. He stabbed his own three children and someone else's child. I have no idea why he did it, maybe he was PCPed or coked up or maybe something just broke in his mind, I don't know. What I do know, is that what I saw last night is not supposed to happen. Seven year olds are not supposed to be rushed to surgery, not supposed to be given packed red blood cells, not supposed to be stabbed by their fathers.

Andrew: We did an exploratory laporatomy on her little abdomen and found that he had lacerated her little liver. She is just so cute and little with curly brown hair and I don't think I will ever be able to forget the lost look she had when she came into the ER, completely awake, stable but traumatized and just…*lost*. She just kept losing blood. And while we were waiting for more RBCs, the surgeon kept her alive by holding his finger in her liver. This is just not an image that seems real, a surgeon with his finger in a little girl's liver. I so badly wanted to say, "I'll take over when you get tired. I'll stand there with my finger in her liver until I can't stand anymore." The blood came and the anesthesiologist stabilized her. The surgeons couldn't repair the damage, but the liver was packed and we closed her up so she could repair overnight on her own, something that the

liver apparently has extraordinary power to do.

Steven: So, here I sit now quietly, salty tears mingling with sweet maple syrup. I couldn't cry last night – there's no crying on trauma call. But maybe there should be. I'm also crying because there is a family at the next table with little children and they are so cute and so alive and *that's* how the world should be and images from last night keep floating, floating across my mind.

John: I followed my very own patient from a quivering wreck on Dilaudid in the ER through to a happy walking on his own discharge four days later. Although everyone else on my team got a handshake, I was the only one who got a hug (I'm unabashedly proud of that – and it was a big, badass guy, not a touchy-feely little old lady). I feel integrated. I feel like I am actually making a difference.

Catherine: Mr. Bonham presented with a clear case of a tick-borne infection. We were very confident in our diagnosis of Ehrlichiosis, began the standard treatment of doxycycline, sent his blood out to Utah for serology.

John: His fevers and joint pain subsided but then returned with a vengeance. We did daily blood counts and one day the count came back with "atypical lymphocytes" on the microscope. No time to even wait for Utah – he was whisked away to Hemotology-Oncology.

Catherine: Within an instant he was diagnosed with cancer and with no time to so

much as blow a kiss, his life was changed. For us, it was with break neck speed. For him, perhaps, his life went into slow motion. I don't know.

John: I think we learned some important lessons from this. One is based on a principle we were taught last year: YCMTDIYDTOI. Don't know what that means? Here it is again: YCMTDIYDTOI. Figure it out….You can't? Of course you can't. And that illustrates the principle. You Can't Make The Diagnosis If You Don't Think Of It – YCMTDIYDTOI. You can't figure out that acronym if you don't already know it, and then, think of it!

Catherine: Here's another lesson: Cancer is never expected. Most people don't walk into the hospital thinking "I must have cancer." It is sobering to know that at any point, any one of us could walk in with a fever and some aches and walk out with a diagnosis that will change our lives. The line between health and illness is a thin one -- finer than I had ever appreciated. Every step we take on the side of health is a blessing.

John: These are good lessons to have learned now, because I will spend the rest of my life escorting my patients as they journey along both sides of that line.

Andrew: My first day in surgery a man was rushed to the OR with a ruptured abdominal aortic aneurysm. Clearly, his prognosis was not very good, and he did not survive the surgery. It was the first time I had the chance to put my hands inside a man's bloody body, but what I recall the most about that afternoon was not that anatomy lesson. I remember the face of the

man's son, red from sobbing, streams pouring down his face. I remember all the residents and attendings just walking by without so much as a nod. I guess, the loss was just too "routine" for them. This is exactly what I *don't* want to be like, I never want to be hardened to death and misery and someone else's suffering. I never want someone's death to be just another someone gone.

Siddarth: I stopped in to see a patient after she returned from having a battery of tests. I just wanted to pop in and see how she was doing. She was so surprised and happy to see me. We discussed how she was doing and then talked about family and weekend plans. As I was leaving, she said she was so grateful that I came by. I realized just how much a little bit of time can make a difference in the patient's attitude. I hadn't cured her cancer or unraveled the cause of her chest pain… all I had to offer was my concern. And, in that moment, it was just what the doctor ordered.

Mikayla: I sat down next to my patient on the hospital bed and we had a 45 minute discussion about what all the tests he had meant and what the next steps were going to be. When I left his room, it hit me that this young man was most likely not going to be alive this time next year. It was a tough hit but I was grateful to have had the privilege of explaining his situation to him, but more, that I was able to be of some comfort through this life-changing time.

John: I'm following a patient who is going to die soon. I am just a third year

medical student, but I know that he is going to die soon. I know this with certainty because I can see it in the face of his wife. Her face reads fear. Her face follows me wherever I go. I was a patient recently and I have to say that there is something about being a patient, some strange resolution, something primitive that bubbles up to the surface and makes you able to face your illness. You just do it.

Andrew: But being the *relative* of a patient, that is another illness altogether. Do family members linger longer in the stages of death than the patients? I don't know. The powerlessness, the pleading, the deep grieving.

John: That is something I hope to be able to doctor someday.

Steven: When I consider the confidence and knowledge of my interns, residents, and attendings I shudder at the gap between them and me.

Catherine: Time is whizzing by and before we know it, we will be interns and then residents before we know it.

Steven: It seems there could be another step or two before this happens.

Mikayla: Within one month we will all go from merely following several patients, not putting in any orders nor making final decisions to deciding the workup and treatment of an entire service of patients.

Andrew: I believe I am well-prepared. I am ready.

Siddarth: I feel ten feet tall!

*Students circle the bed, briefly blocking the Patient from the audience allowing the*

*removal of the IV and the hospital gown and for the return to the role of Professor.*

**ACT IV**

Catherine: All illness is a tear in the universe. Whether it is a little girl bleeding out, or a teenager learning he has cancer, or a woman so obese she can't get up from her chair, or a father with a common cold. People come to us broken – something preventing them from living their lives.

Siddarth: We definitely have to have the humanity to recognize that.

Andrew: But all of us – no matter what we do with the rest of our lives and energy and humanity – will be standing at the mouth of that tear, trying desperately to close it against the force of all order breaking and pushing against it, like we're trying to fix a hole in a county fair big moon bounce while carefree little kids are still on it, happily jumping up and down.

John: We are on the precipice of this moment and it is as exciting as it is daunting. No doubt there will be days where we are frazzled and dizzy with that responsibility.

Steven: We have to remind ourselves that along with our patients, we too have our own mental and physical frailties. There is great humanity in recognizing our own limitations.

Mikayla: When the force of the tears in the universe bearing down upon us is too much to endure, we need to step back and realize there is a world beyond these hospital walls. Go home, go to the mall, go to a movie. Go -- and be

wherever you can see the beauty and the cuteness and the humanity untorn.

*All Students, except Steven, take a stylized step, in unison, forward, toward the patient.*

*Blackout.*

## EPILOGUE - CURTAIN CALL

*The Hippocratic Oath ticks across the scrim. The Professor is already down stage center as lights come up. He is holding diplomas. One at a time, the medical students, now doctors, approach to receive their diploma and shake his hand. Names are called:*

*DOCTOR Catherine Valery*
*DOCTOR Mikayla Gallo*
*DOCTOR John Marcus*
*DOCTOR Siddarth Shah*
*DOCTOR Andrew Shaffer*

*All except Steven, who comes out in a business suit, sans lab coat. He does not receive a diploma. He passes the Professor, they nod in acknowledgment of the other, but he stands aside, down stage left. The others goes to their previously established places. Once all are in place, they bow, rise, the five students hold their diplomas in the air. Victory freeze! Steven turns to face them, then turns away.*

*Blackout.*

**THE END**

VITA

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*Signature*