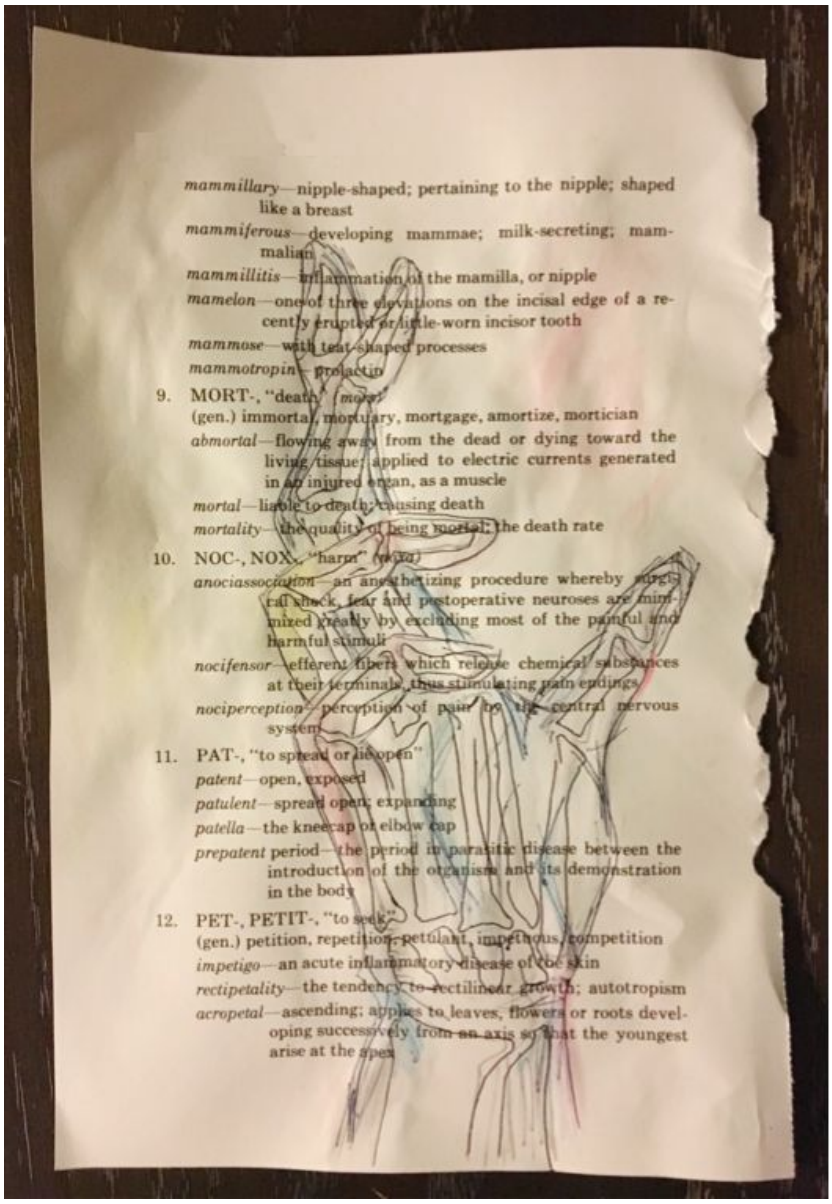
Longview Spring 2017

STUDIO ART

"Recti-PET-ality: hands on approach"



mammillary—nipple-shaped; pertaining to the nipple; shaped like a breast
mammiferous—developing mammae; milk-secreting; mammalian
mammillitis—inflammation of the mamilla, or nipple
mamelon—one of three elevations on the incisal edge of a recently erupted or little-worn incisor tooth
mammose—with teat-shaped processes
mammotropin—prolactin

9. MORT-, "death" (*mors*)
(gen.) immortal, mortuary, mortgage, amortize, mortician
abmortal—flowing away from the dead or dying toward the living tissue; applied to electric currents generated in an injured organ, as a muscle
mortal—liable to death; causing death
mortality—the quality of being mortal; the death rate

10. NOC-, NOX-, "harm" (*nox*)
anociassociation—an anesthetizing procedure whereby surgical shock, fear and postoperative neuroses are minimized greatly by excluding most of the painful and harmful stimuli
nocifensor—efferent fibers which release chemical substances at their terminals, thus stimulating pain endings
nociperception—perception of pain by the central nervous system

11. PAT-, "to spread or lie open"
patent—open, exposed
patulent—spread open; expanding
patella—the kneecap or elbow cap
prepatent period—the period in parasitic disease between the introduction of the organism and its demonstration in the body

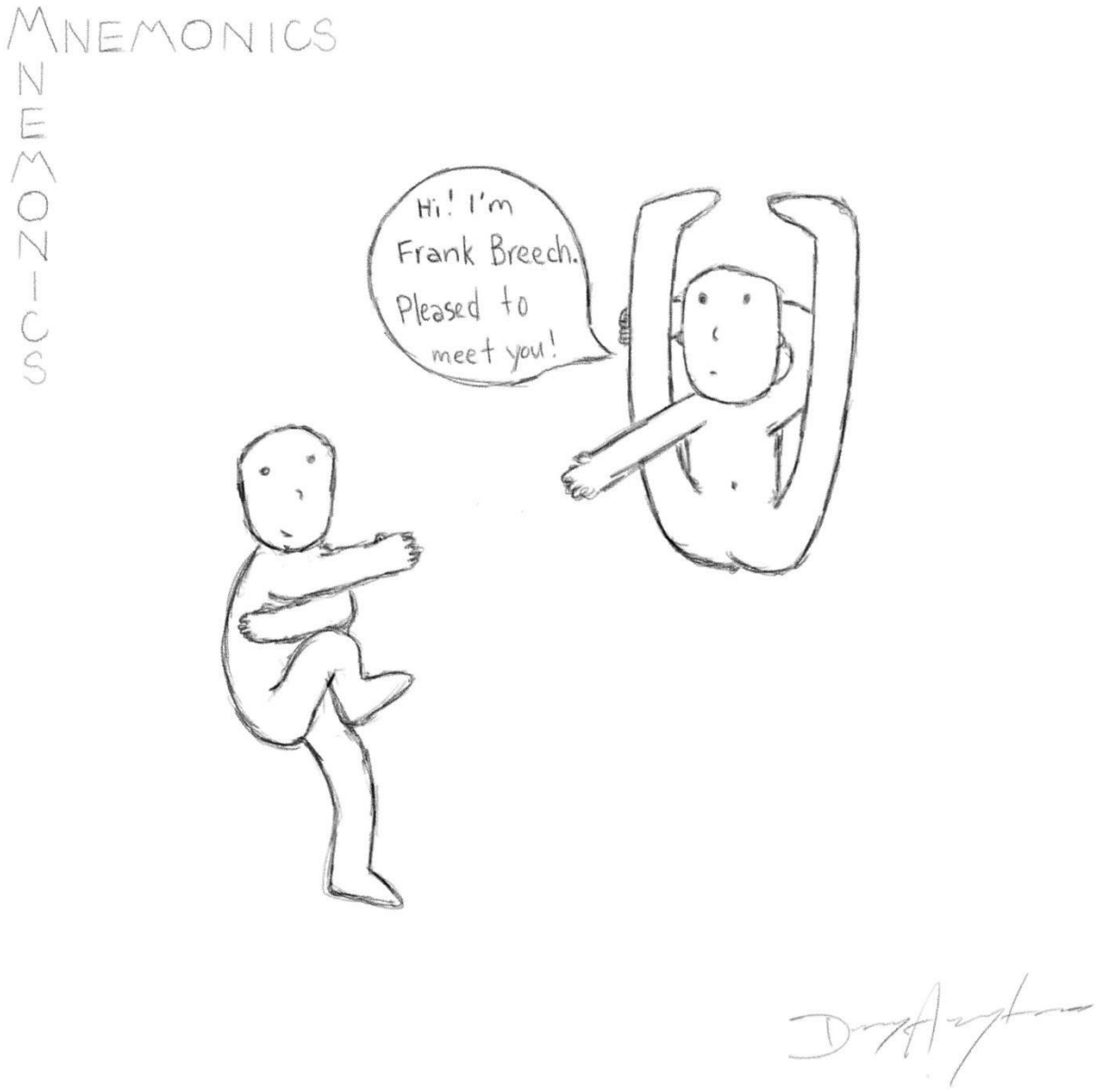
12. PET-, PETIT-, "to seek"
(gen.) petition, repetition, petulant, impetuous, competition
impetigo—an acute inflammatory disease of the skin
rectipetality—the tendency to rectilinear growth; autotropism
acropetal—ascending; applies to leaves, flowers or roots developing successively from an axis so that the youngest arise at the apex

Original painting (water color and black ink on standard paper).

This painting is meant to juxtapose the two aspects of our medical career; the aspect that we read and write, and then the aspect that of which we feel. I chose to color the hand to represent the different ways we *feel* medicine, with our fingers, but also with our values and our ideals – our *bones*, in a sense. The hand is intentionally, seeking, reaching, spreading towards and growing from the words on the page, but inarguably existing in a different frame than the text. The page chosen in the background is an original edit and adaptation of the text Bioscientific Terminology: Words From Latin and Greek Stems by Donald M. Ayers, a common undergraduate text.

Gaya Narendran
MD Program, Class of 2018
Cumming School of Medicine, University of Calgary

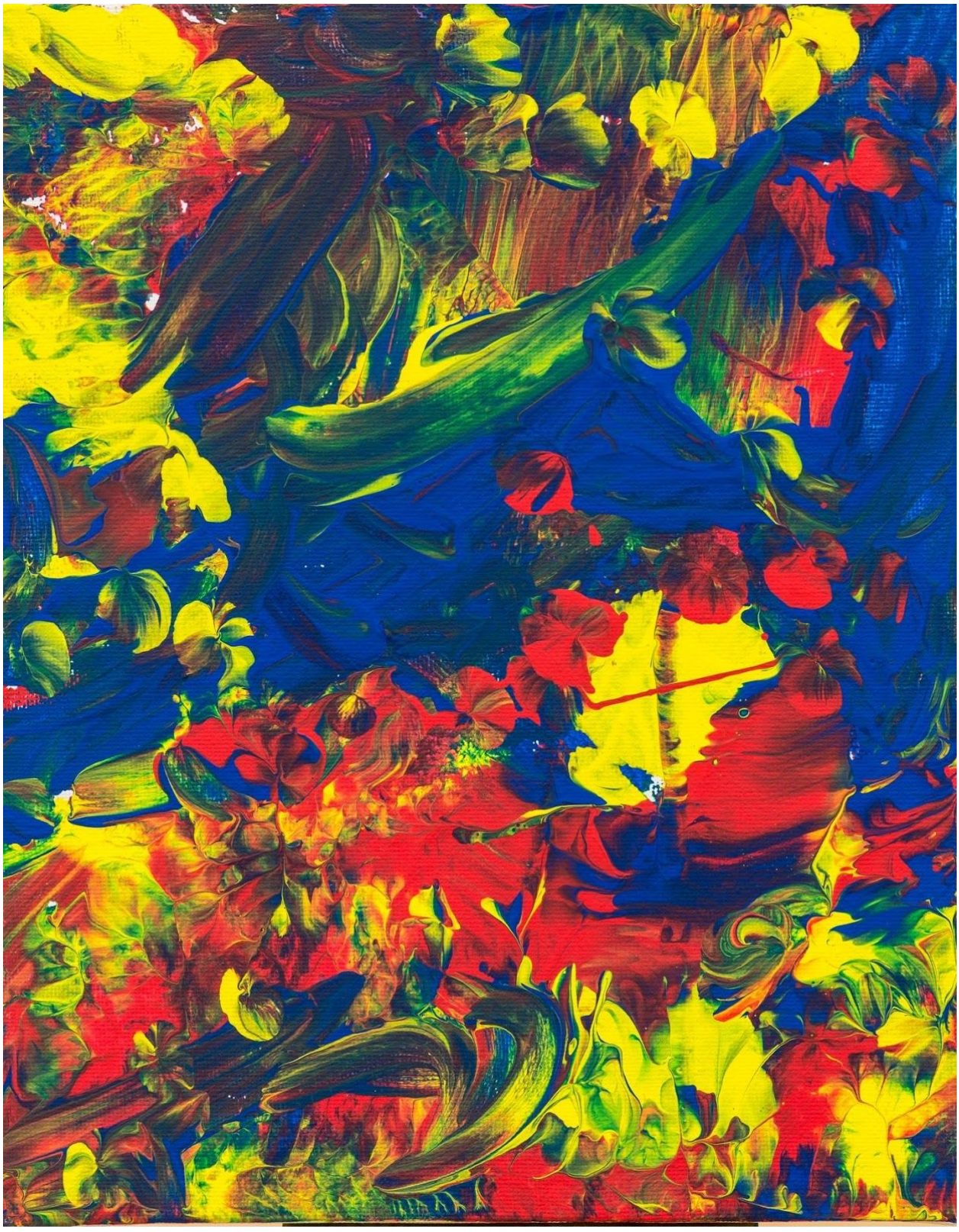
MNEMONICS



I considered the Longview's mission of "expressing the unique student experiences of modern healthcare" and took a lighthearted approach on the theme. The submission is my comic representation of something presumably common and essential to the worldwide medical student experience: MNEMONICS! Specifically, it is my take on the bizarre things that our minds do in the feeble struggle to remember the mountains of material that we are responsible for. (The drawing was inspired while studying for the Obstetrics and Gynecology final exam.)

Danny Aceytuno
MD Program, Class of 2018
Cumming School of Medicine, University of Calgary

"Primary, Clarity"



Tempera on Canvas

This work aims to capture the difficulty in humanizing modern medicine. The primary colors represent the intention of the healthcare industry to simplify care and create human connections when treating patients—however, the complexities of modern healthcare work to blur these same values, as seen in this piece.

Grace Wang
MD Program, Class of 2017
Cumming School of Medicine, University of Calgary

"Thrive"

This painting was created as a reflection on my pre-clerkship global health experience in which I travelled to Guyana for a pediatrics elective. While I was there, I was working on a research project related to pediatric cardiology, and had the pleasure of meeting and learning from many pediatric patients suffering from congenital heart disease. I was inspired by those children and their families to create this painting.

During the post-operative clinics, I distinctively remember the bustling waiting room filled with children and their families. Many of the families had become quite close to one another, as a result of going through the unique experience of having a child undergo pediatric cardiac surgery together. As much as the surgery can be frightening to the patient, it can be just as scary, if not more, for the family. Often these families have had limited exposure to the Guyanese healthcare system due to many reasons, ranging from long distances and high financial cost, to a lack of trust in the system. The culture in Guyana surrounding healthcare, particularly for those living in rural Guyana, is that medical attention is not sought out unless direly needed. For instance, it is common after suffering a poisonous snake bite, for some to not make the trek to the country's only tertiary care hospital located in its capital, Georgetown, because they know they will not survive the journey. I cannot imagine what would go through a parent's mind, waiting for hours while your child receives surgery.

Skimming the waiting room, all you see are happy, normal children. Upon closer inspection, you can identify those children that have received surgery. A child will bend down to pick up a toy and you can see a scar peeking up out of

the top of their shirt. You notice a parent pick up their child, not under their armpits, but by grabbing the sides of their abdomen, in order not to put pressure on the sutures as they heal.

Most of the patients that underwent cardiac surgery were left with a significant sternal scar. In infants, this scar seemed to envelop their entire body. The sternal scar was the defining and unique characteristic that unified all of these patients. At first, when I saw these scars, I was surprised at how big they were. I came to learn that in order to have sufficient access to the heart, surgeons have to cut through skin and saw through the sternum- the scar is unavoidable.

I took an abstract realism approach for my painting. The literal aspect is the scar running down the middle, through the anatomical heart. I choose to utilize blue and red to portray deoxygenated and oxygenated blood, respectively. Many of the children had very low oxygen saturations prior to surgery, a common symptom of congenital heart disease. My goal was to capture this dynamic transition from a cyanotic heart to an oxygenated healthy heart in my painting. As you move vertically from the bottom of the painting to the top you see this progression. I also wanted to portray the astonishing resilience and quick recovery of the children with the bright flowers growing out the top of the heart. Flowers can signify many things and can be interpreted in many ways. In the context of this painting, they are meant to depict growth, recovery and thriving of life - not only of those kids, but also myself.

Vikhashni (Winnie) Nagesh
MD Program, Class of 2018
Cumming School of Medicine, University of Calgary

POETRY

"A Sonnet for a Night Shift"

When the night stretches across the sky and the misty chill rubs up against the windowpane,

Lamplight licks the corners of the night, lingering in pools on the parked cars outside the door.

When Queen Mab casts strands of spider's web and moonshine across sleeping men like rain,

Who dream of faces yet to come, and little voices, at which they wake and sleep once more.

In the darkened room the nurses come and go, gossiping of their favorite show,

Checking pulses, in a minute, measuring out new life with a finger's span.

Evenings, mornings, afternoons, time for decisions, the doctors come and go,

They say, fear not, let go, Macbeth was not of woman born, you know.

And in the moment there are ten thousand prayers, helped by long fingers,

Visited by that fairies' midwife, as she gallops night by night, curled up in a cry of delight.

Not half so big as a little cat, met with the yellow light of the morn that leaps and lingers,

And realizing now that there will be time, time to touch, and kiss, and love, and write.

And later when I lie asleep and dream things true, I realize,

I have known this day already, but now know it with new eyes.

Ashleigh Frayne
MD Program, Class of 2018
Cumming School of Medicine, University of Calgary

"That Darkest Night"

~01h00, August 17th, 2014

The air is thick with anticipation,

Some nervousness, adrenalin;

We focus on the task ahead:

Can we restore this girl to life,

Bring her back from the land of the dead?

The stage is set, supplies at hand,

Chest tube, central line, resuscitation planned.

Soon the page rings out loud and clear:

“Pediatric patient to R1, ACLS in progress!”

–The little girl is here.

The room is packed with all sorts of people

Students, doctors, nurses, is every one needful?

The emerg team takes over, the paramedics’ jobs are done,

Report is taken, patient moved,

Compressions re-begun.

Her face is ashen grey

Her mouth contorted by tube

Her eyes, open, stare at nothing

Her beautiful blonde hair

Spilling

Backwards over the stretcher

Pushing on that little chest is so easy;

I need no rest, I will not weary.

Con **C**en **T**rate

Do **Y**our **J**ob

Pass **T**he **L**ine

Save **T**his **L**ife

My fingers moved

Chest swabbed

The scalpel slices

Drawing red

The physician pushes now, while the second tube goes in.

Her little arm flung out, risks being crushed under him.

I pull it gently to one side, hold it out of harm:

The small white hand,

The little lifeless arm.

Shortly after, the end has come, the parents now inside;

The call is made, no more is done, the little girl has died.

The mother shrieks in grief and pain, the father holds her tight;

Black grief enfolds us one and all, the blackness of that night.

Oh, God, why?

Why did this happen?

Why this torment?

Why this torture?

This precious little creature,

Your handiwork–

Suddenly snuffed out,

Her light extinguished.

All is black

All is dark

We cannot see.

* * *

Later

Her delicate little body:

Cold grey face and blonde hair,

Covered in a beautiful quilt,

Lifeless, still, lying there.

The parents' pain is unimaginable,

Yet empathy urges to fathom the unfathomable;

This visceral sadness of which we all partake–

It's nothing intellectual, but a deep, throbbing ache:

There are no words for this.

The Brothers

There are two brothers

Here to say farewell to their sister

They have blonde hair like hers.

Comfort

Upstairs

Under the arched glass ceiling

My spirit crying out to God in agony

Suddenly, an answer–faint but clear:

"She is with me."

Jonathan Craig
MD Program, Class of 2019
Cumming School of Medicine, University of Calgary

"The Grandfather"

I am learning to pretend I understand life and death

Did you believe me when I told you what would happen?

I didn't

"Fake it 'til you make it" is how we learn

We both knew he had already left

Yellow, not moving

Efforts to nourish failing

I imagine the bile ducts overgrown with cancer

Green bile backing up

Staining the dark red liver

The body consumed from inside

Did you believe my explanations for why he could not go home?

I didn't

I did cry

Perhaps because he reminded me of my grandfather

Wasting away

Part of the white linens on the bed

I saw fear in his eyes

Though everyone pretended it would be alright

Because death comes for us all

And he was old

I didn’t cry for my grandfather when he died

I had pretended to understand

That death comes for us all

And he was old

But I am crying for yours

Because now I don’t understand

And pretending isn’t working

Home

Where decades of relationships are intertwined in the old furniture

That your father might have sat in as a child

Home

He didn’t go home

He died without tasting another bite of his favourite dish

Made by the loving hands of his wife

He never sat in the furniture filled to bursting with past lives

Now gone

I am pretending

I play at wisdom with the undeserved status that it brings

I pretend to understand

But I don’t

To the grandfather who never went home…

I am sorry.

Joshua John Schultz
MD Program, Class of 2017
Cumming School of Medicine, University of Calgary

PROSE

"What does the Trump Presidency mean for my CaRMS application?"

I grew up wanting to be a difference maker; someone who can help others through service and the use of my knowledge, skills and time. I want to be an advocate of justice, equality, human rights and expression. I want to help the weak, the disadvantaged, the disheartened. How can I work for equity, security; for the wellbeing of the most marginalized and frustrated people today? By becoming the *next* President of the United State of America. I might have to wait up to four years; by then I will be a qualified doctor, and may also simultaneously qualify for role of Housing Secretary.

Much like governance, medicine is fundamentally a human endeavor; an art and science. Undergraduate medical education allows us to explore and immerse; in new knowledge, new exposure, and new experiences. Although junior in my journey, there have been several moments of triumph (i.e. where are the lungs on the chest x-ray?), struggle (i.e. where are the lungs on the chest x-ray?) and everything in between. It has been humanizing (witnessing a new life being born) and dehumanizing (declining trajectory in in end-stage disease); and has routinely laid bare my vulnerabilities and weaknesses; but I wouldn't change a thing.

Admittedly, my feelings have been mixed recently. The American Presidential election has raised questions of tremendous importance as they relate to identity, values and policy related to health, security and everything in between. The discourse has become instantly relevant in Canada, extending our lexica with new terms like "Trump-style politics" and officially ushering in a post-fact era. They have forced me to pause, to introspect, and to ask, "Who am I?" and "Who do I want to be?" The answers to these questions have never been so vitally important, especially as I near CaRMS (Canadian Residency Matching Service) and the inevitable "why do you want to be a doctor" question. I continue to be reminded by an incident that I will never forget.

As a first-year medical student, in one of my first patient encounters with a handful of other medical students, I met a recently-arrived Canadian diagnosed with large b-cell lymphoma. His prognosis was uncertain. He had just undergone a lumbar puncture, and completed one round of chemotherapy, with more treatment to come. His disposition was unmistakable – simply grateful and filled with undeniable hope. He was grateful, and praised his nurses and physicians – for the respect they accorded him, for the dignity they helped him maintain, for their rigour, compassion and demeanor. As I left his room, with his wife and mother by his side, I was in tears. Just before the door closed behind me, he implored me and my peers, "Be a good doctor; if not…what's the point." Those words have buoyed me in my moments of joy and helplessness – feelings I know inevitably I will face as I proceed through my training in my journey towards becoming a physician. I am getting better at welcoming them, but am careful never to get used to them.

They will invariably change as we transition from being early medical students to clerks to residents and into practice, with each stage being a rigourous training ground for the next: what we put in is what we will get out. Arguably, the transition from being a clerk to a resident is like the transition from fake-firing celebrities on TV to becoming the President. Sure, you're deciding if Lil Jon was a team player, and firing Gary Busey because he didn't 'bring it,' but it doesn't quite compare to holding the launch codes in your hand.

Clerkship is a time for supported learning; where you take everything you read in a textbook to the wards and then learn that our patients don't match a single page. You learn that the patient experiencing shoulder pain after playing a game of baseball hasn't torn his rotator cuff but rather, is having an inferior STEMI, and the young healthy woman who has a feeling of anxiety has a submassive pulmonary embolus. This is both a jarring reality of medicine but also the beauty of clerkship; you're there to learn and for most of clerkship, everything you see will likely be our first exposure to that particular illness. As the most junior learners on the ward, you are entitled to, and receive the best teaching from junior and senior residents as well as staff. It is the ideal time to ask questions and learn to ask "why?" because that foundation of clinical knowledge will be paramount for when you transition to residency.

Almost two years into residency and I'm still not sure I've got the hang of it. The pace increases, as do the expectations; there is a sudden overnight transition of responsibility in medicine on July 1, when residency begins. Instead of being asked to interpret the arterial blood gas (ABG) in the classroom, you're now being asked to interpret the ABG and decide between calling a code or trying to manage the patient yourself. Decisions and medication orders are being made without having to have them verified. My first ever order as a resident was an order for an extra-strength Tylenol. I looked it up both on my phone and computer before inputting it. And then I double checked with two other residents. Ironically, one of my friends called and asked for some Tylenol on November 6, 2016 having stayed up too long watching the election results; I couldn't find the dose for "national headache." I've since become more confident with my Tylenol orders but I still feel that responsibility on my shoulders when I interpret the chest x-ray of a sick patient and decide to diurese them at 3 AM. The autonomy of residency is both terrifying and exciting. It is also during this time that our values, physician identity and approach to medicine truly begins to solidify, and it is

for this reason that we must be deliberate in asking ourselves about the kind of medicine we would like to practice, and about the kind of physician we would like to be.

The bridge between clerkship and residency is the wonderful and chaotic CaRMS process, which we begin hearing about from our first days in medical school. *And while the Trump presidency invites serious consideration of identity and power, it also reminds would-be CaRMS applicants of the poor prognosis of foot-in-mouth disease.*

There are strategies one can follow to maximize the application quality and to assist with a smoother experience. Included below are a few pro-tips that have been compiled based on personal experience (CaRMS match #1) and gathered from others for my upcoming Internal Medicine CaRMS process for subspecialty matching. They have been revised and updated in honour of the election of the 45th American President.

The Executive Orders:

1. **Don't build a wall around yourself. Explore and gain exposure** - Try and see as much as you can during clerkship, even if you have already made up your mind about the specialty to which you are applying. If new specialties immigrate on to your differential, don't ban any options. You never know what specialty might pique your interest; something may change your mind, and there's nothing you will see or learn that won't be useful to you.
2. **Examine the fit** – How well you fit into your residency program is a key factor in how much you will enjoy the next 2 to 5 (or more, I'm looking at you, neurosurgery) years of your life. Do you feel like you'd get along with the residents? Do you feel like the staff are collegial and supportive? It's not an objective measure, but your gut feeling when interacting with people from a program is very telling. Rank carefully, you (and the world) will have to live with the results for 4 years – or, for however long your (p)residency lasts.
3. **Present a holistic picture of yourself** – Give your prospective programs an idea of who you are, and use all 1000 characters to do so. Don't stop at 140. Be authentic and genuine in your personal letters, link your interests with your experiences, let your determination show, but also be sure to show the programs that you're more than just a person who does medicine. Share your interests, your passions and highlight the things that make you a well-rounded person.
4. **Be honest in your CV and personal letters** – If you didn't do a lot of research, it's OK. Don't make it up. Otherwise your CaRMS application will be a bigger disaster than scotch tape on your tie.
5. **Dress to impress** – Gentleman, a bold red tie is not a bad choice, but maybe try to find one that doesn't extend a foot below the waist. Ladies, a nice power suit with a pair of Ivanka Trump shoes will surely impress; though I'm not sure you can find a pair so easily anymore.
6. **Behave on the tour** – 3AM tweets will reflect poorly on you. From your interview to the socials, your interactions all count. Chances are that you'd do a better job than your Press Secretary and campaign manager defending yourself to your medical school, but why take the risk?
7. **Be collegial** - Do not refer to your fellow applicants as 'bad hombres' or 'nasty women.' Be kind and friendly to the people you meet; you're all in the same boat. There's no sense in turning them into competition. Chances are you'll be working with at least some of them in the future.
8. **Watch out for alternative facts, there's a lot of fake news** – Everyone's mother's cousin's nephew's friend will have heard something or another about a program and the 'secret' CaRMS agenda. (A real life example during my tour: people get evaluated on what kind of drink they order at the social. No, they don't.) Get your information about programs from reliable sources: program directors, residents and during the Q&A period.

Ultimately, take the experience for what it is. You'll be travelling from one city to the next and it will be stressful and emotionally challenging. Oftentimes you'll feel like you're being examined under a microscope. Know that the programs are trying to recruit you just as much as you're trying to recruit them. Have fun. Relax. If you have a few hours, take some time to explore the cities you're in. Or an extra nap. Or to find the lungs on the chest x-ray. Whatever you need.

I look back at CaRMS with fond memories but I remember struggling through it at the time. Hopefully some of these tips will make the experience a little less daunting and a little easier. Whether you are doing Round 1 or Round 2, try to make the most of this experience and the opportunities it provides for reflection, introspection and preparation for the future.

Let's make CaRMS great again.

Zaheed Damani
MD/PhD Candidate, Class of 2019
Cumming School of Medicine, University of Calgary

Farheen Manji
PGY-2 Internal Medicine
Cumming School of Medicine, University of Calgary

"Half Marathon Promises"

0 km. Mind buzzing with anticipation, trepidation. A half marathon in the middle of winter, what was I thinking? This is ridiculous. No, I remember. Interview offers are to be released soon. My veteran applicant nerves need a distraction this time, another long-standing goal to complete. Here goes nothing, and yet everything.

3 km in. My muscles are limber, breaths even. This feels comfortable. I catch up to a lady who is wearing an eclectic pair of tights. Sky blue with snowman prints. I plan on simply passing by, expressing how much I appreciate her tribute to the bone-chilling cold. She strikes up a conversation instead and in retrospect, I'm glad she does.

4 km in. Mindless chatter slowly becomes more in-depth questions. Several kilometres stand between us and the finish line, might as well. I discover she's a running veteran, a casual half marathon to keep her training interesting. I'm amused, but I reciprocate, revealing my reason for being here, and this gives her reason to tell me her story.

6 km in. How her life had been seemingly well one morning and not the next. How she had lost multiple family members over the span of a single year, the last being her significant other. How she remembered the doctor who gave her the time and space she so desperately needed to say goodbye amidst the chaos. She makes me promise to be kind.

8 km in. How she had been in a car accident a few weeks later. A mild traumatic brain injury. Seems like a paradox, she laughs. The months of recovery and stress that followed. The lawsuits she filed to survive financially. The dependence on alcohol. How she remembered the doctor that invalidated all that she was and all that she was striving to be, choosing to focus on her method of coping instead. She makes me promise to listen.

11 km in. How she had ballooned to an alarmingly unhealthy weight. Her tiny 5-foot frame sodden with shame and grief when all was said and done. How she remembered the doctor who quietly broke the news of her newfound diagnoses, providing the opening she needed to make a change. She makes me promise to be gentle.

13 km in. How she ran for the first time in a decade. Only tolerating five strides, then stopping to walk. How she added another five the week after, and five more after that. How she remembered the doctor that implicitly belittled her attempts, comparing their own fitness goals as if to provide a source of motivation. She makes me promise to be humble.

16 km in. How she ended up traveling and running marathons across North America just two years later. She makes me promise to persevere.

18 km in. She concludes by saying how life was meant to be lived one stride at a time. How timelines mean nothing, and everything. How we all have to come from somewhere, and are going somewhere. She makes me promise to remember my humanity.

20 km in. I lose her. Her seasoned running prowess proves a little too much when she increases her pace. I don't see her approaching the finish line either, but it seems like a fitting end to a fleeting philosophy.

21.1 km done. I attend my first medical school interview two weeks later, promises in mind.

Esther Kim
MD Program, Class of 2018
Cumming School of Medicine, University of Calgary

"The Night"

I still remember the night before admission offers went out. Like many of my peers, my attempts to rest were thwarted by the prospect of being offered a seat. My quaint basement suite was quiet, with little more than the sound of an antique clock to cut through the seemingly endless stream of silence. I remember that night.

There is a calmness that blankets the world when you realize that everyone around you has settled for the evening. It allows for all of the stressors of the day to fall away, freeing your mind to wander as it wishes. That night I decided to let my subconscious take the helm, and I found myself on a meandering path through the past decade of my life.

My journey to medicine started many years before, and was by no means a direct one. Twelve years prior to that night, I had lain awake in what was then my childhood home, with similar thoughts dancing through my head. I had no idea what the road to medicine would bring, but I was excited about my “decision” to enter a profession that I had seen on television. Their lives seemed glamourous, their jobs exciting, and their status revered. There was no way that I could have foreseen the true nature of the profession and the sacrifices one had to make to succeed.

Fast forward to the years of leaving home and densely-packed lecture theatres full of eager students all vying for the same spot in the College of Medicine. People I met introduced themselves, and, as if it was a continuation of their last name, presented their four-year plan. I had walked into the wrong room at a conference centre, and found myself amongst a crowd of strangers. I felt less adequate with every conversation, not knowing that I needed to follow a prescribed regimen that everyone else already seemed to know so well. It became clear that the proceeding years would be far different than anything I had imagined.

Semesters came and went, each bringing the same stressors. At first, the sacrifices I forced myself to make seemed valiant, and I praised myself for demonstrating resolve in the face of temptation. “I want to be a physician,” I would tell myself, “this is the way you have to be to get in.” However, as time passed, I did not need to pat myself on the back any longer, as self-deprivation became habitual. I simply believed that this was the only way I could reach the end, and so I did not question it. It was satisfying to be pious, and I equated that feeling of false superiority to worthiness.

What I did not realize, however, was that this constant rejection of the outside world fundamentally altered my development as a human being. I had reneged on my commitment to mature as a whole person, allowing some areas to grow like weeds in an untended garden, whilst others atrophied. The relentless pursuit of this profession had changed me.

As the first few rays of light passed through the curtains, I knew that my time for self-reflection had come to an end. Soon, I would know if all of this was worth it; if all that I had done would pay off. I started my computer, sat down, and tried to convince myself to open the inbox. With one tap on a trackpad, my future would be strewn across the screen. When the email finally came, I said a silent prayer, and opened the tab. “Congratulations…”

Dillan Radomske
MD Program, Class of 2018
Cumming School of Medicine, University of Calgary

"The Universal Truth"

Quiet.

Quiet.

So quiet that the staff are playing on their phones, doing online shopping, and making phone calls to check on their children at home.

This is the ED. The Emergency Department.

I feel like I have just entered into an alternate universe where there are no patients in the ED, not because there are no sick people in the city but because they can't afford the high cost of care at this American-owned international hospital located in Beijing. The cost of an average emergency department visit at this hospital ranges from $200-$1000 Canadian. Suddenly, I'm secretly thankful for universal health coverage in Canada.

The side effect of the high cost of care is that the ED feels like a family medicine clinic. It is calm; there's no rush and patients are seen quickly. On this particular day in the ED, six adult patients walked through the doors in 12-hours. It is difficult to imagine such a phenomenon in any hospital in today's day and age. But this particular hospital in Beijing mainly caters to foreigners and Chinese elites, all of whom tend to go on vacations during the summer to escape the hot humid weather in Beijing. My preceptor told me July is their slowest month of the year.

All of the six patients had a combination of sore throat, cough, or mild fever. They were all high-functioning adults with no red flags. One of the nurses rolled her eyes when she showed me their normal lab results.

"Our patients are *special*, especially the wealthy ones. They can be demanding and are used to going to hospitals for IV saline for the slightest of aliments. Saline is the magical placebo drug that cures everything." She chuckled. Yet, my preceptor did not dismiss the patients' complaints for being too minor. Instead, he took his time to address each patient and educate them about self-care at home.

"This type of presentation in Canada normally does not warrant a visit to the ED," I mentioned to him after the fact. He agreed.

"You likely won't see them present to an ED in the United States either. However, all patients who come to the ED present with problems that seem like emergencies to them, and that's why they are here. Their worries and concerns should be addressed; not dismissed; even if all they have is the common cold."

This is what it means to care. In most simple ways, it's an act of kindness. It is to prioritize others' concerns, however minor they may be simply because they are important to them. Prejudice and judgement have no place when it comes to providing care. Regardless of who you are caring for, the physical act of doing so translates across cultures and breaks down barriers. My preceptor was an American physician who spoke limited Chinese, I am a Chinese-Canadian medical student, the nursing staff were all Chinese, and our patients came from all over the world. Caring is one of the fundamental human characteristics that is truly universal.

When I shifted gears to working at a local Chinese hospital in a small city outside of Beijing, I was taken back by both the lack of space and time.

Farmers. These were my patients. They had little resources and even less money. But like everyone else, they wanted the best medical treatment. So they came here, to the hospital in the province with the best reputation, and yet one of more challenging hospital environments. The buildings are old and cramped; some sections are literally falling apart. But people still came.

"They always do," my preceptor at this hospital would tell me. "People in need can always find a way."

A week after I started working at the Chinese hospital, the city experienced the largest flood it had seen in over half a century. Rain came pouring down for three days and nights. The streets flooded. Buses stopped running. Three-quarters of the city had no running water. This included the hospital. The Gastroenterology Unit alone had more than 150 beds. A firetruck would come by twice a day – once at lunch and once at dinner – to supply the hospital with water. The rest of the time we were left to fend for ourselves. Toilets went unflushed. Hands went unwashed. Bottles of water were brought in for emergency procedures. Elective procedures were cancelled.

Imagine the smell of melena. Now imagine that smell mixed with the smell of other bodily fluids on a hot, humid summer's day while you are carrying out bedside paracentesis on a patient suspected of having hepatic tuberculosis in a crowded eight-person multi-patient room. We did our best to ensure a semi-sterile procedure by donning precious sterile gloves. There were no containers for the peritoneal fluid so it got dumped into used water bottles. Sweat poured down my face and into my eyes. I blinked, accidentally spilling some peritoneal fluid onto the bed sheet. I sighed out loud. The sheets won't be washed until water is turned back on.

"The patients are suffering more than you are," my preceptor reminded me after the procedure. "You can leave the hospital in a few hours and go home. She is stuck here, in this facility, receiving basic palliative care services with little chance of a full recovery. Going home is a luxury. In a world with constraints and inequalities, we need to work extra hard for our patients to give them a fighting chance of a healthy life." I nodded in understanding.

My preceptor was right. The context in which care is provided may be heterogeneous, resources may be constrained, and languages may be foreign, but the physical, psychological and emotional act of doing everything in our power to look after the well-being of others is the same humanitarian principle that is unchanged for centuries. It will remain constant for centuries to come. On a midsummer's night in China, the simple raw truth of caring hit home.

Jennie Ding
MD Program, Class of 2018
Cumming School of Medicine, University of Calgary

"The Universal Truth"

Quiet.

Quiet.

So quiet that the staff are playing on their phones, doing online shopping, and making phone calls to check on their children at home.

This is the ED. The Emergency Department.

I feel like I have just entered into an alternate universe where there are no patients in the ED, not because there are no sick people in the city but because they can't afford the high cost of care at this American-owned international hospital located in Beijing. The cost of an average emergency department visit at this hospital ranges from $200-$1000 Canadian. Suddenly, I'm secretly thankful for universal health coverage in Canada.

The side effect of the high cost of care is that the ED feels like a family medicine clinic. It is calm; there's no rush and patients are seen quickly. On this particular day in the ED, six adult patients walked through the doors in 12-hours. It is difficult to imagine such a phenomenon in any hospital in today's day and age. But this particular hospital in Beijing mainly caters to foreigners and Chinese elites, all of whom tend to go on vacations during the summer to escape the hot humid weather in Beijing. My preceptor told me July is their slowest month of the year.

All of the six patients had a combination of sore throat, cough, or mild fever. They were all high-functioning adults with no red flags. One of the nurses rolled her eyes when she showed me their normal lab results.

"Our patients are *special*, especially the wealthy ones. They can be demanding and are used to going to hospitals for IV saline for the slightest of aliments. Saline is the magical placebo drug that cures everything." She chuckled. Yet, my preceptor did not dismiss the patients' complaints for being too minor. Instead, he took his time to address each patient and educate them about self-care at home.

"This type of presentation in Canada normally does not warrant a visit to the ED," I mentioned to him after the fact. He agreed.

"You likely won't see them present to an ED in the United States either. However, all patients who come to the ED present with problems that seem like emergencies to them, and that's why they are here. Their worries and concerns should be addressed; not dismissed; even if all they have is the common cold."

This is what it means to care. In most simple ways, it's an act of kindness. It is to prioritize others' concerns, however minor they may be simply because they are important to them. Prejudice and judgement have no place when it comes to providing care. Regardless of who you are caring for, the physical act of doing so translates across cultures and breaks down barriers. My preceptor was an American physician who spoke limited Chinese, I am a Chinese-Canadian medical student, the nursing staff were all Chinese, and our patients came from all over the world. Caring is one of the fundamental human characteristics that is truly universal.

When I shifted gears to working at a local Chinese hospital in a small city outside of Beijing, I was taken back by both the lack of space and time.

Farmers. These were my patients. They had little resources and even less money. But like everyone else, they wanted the best medical treatment. So they came here, to the hospital in the province with the best reputation, and yet one of more challenging hospital environments. The buildings are old and cramped; some sections are literally falling apart. But people still came.

"They always do," my preceptor at this hospital would tell me. "People in need can always find a way."

A week after I started working at the Chinese hospital, the city experienced the largest flood it had seen in over half a century. Rain came pouring down for three days and nights. The streets flooded. Buses stopped running. Three-quarters of the city had no running water. This included the hospital. The Gastroenterology Unit alone had more than 150 beds. A firetruck would come by twice a day – once at lunch and once at dinner – to supply the hospital with water. The rest of the time we were left to fend for ourselves. Toilets went unflushed. Hands went unwashed. Bottles of water were brought in for emergency procedures. Elective procedures were cancelled.

Imagine the smell of melena. Now imagine that smell mixed with the smell of other bodily fluids on a hot, humid summer's day while you are carrying out bedside paracentesis on a patient suspected of having hepatic tuberculosis in a crowded eight-person multi-patient room. We did our best to ensure a semi-sterile procedure by donning precious sterile gloves. There were no containers for the peritoneal fluid so it got dumped into used water bottles. Sweat poured down my face and into my eyes. I blinked, accidentally spilling some peritoneal fluid onto the bed sheet. I sighed out loud. The sheets won't be washed until water is turned back on.

"The patients are suffering more than you are," my preceptor reminded me after the procedure. "You can leave the hospital in a few hours and go home. She is stuck here, in this facility, receiving basic palliative care services with little chance of a full recovery. Going home is a luxury. In a world with constraints and inequalities, we need to work extra hard for our patients to give them a fighting chance of a healthy life." I nodded in understanding.

My preceptor was right. The context in which care is provided may be heterogeneous, resources may be constrained, and languages may be foreign, but the physical, psychological and emotional act of doing everything in our power to look after the well-being of others is the same humanitarian principle that is unchanged for centuries. It will remain constant for centuries to come. On a midsummer's night in China, the simple raw truth of caring hit home.

Jennie Ding
MD Program, Class of 2018
Cumming School of Medicine, University of Calgary

"Connecting with Others Through Personal Memories"

My name is Vivien and I am a transfer-nursing student at the University of Calgary. I began my education at the University of British Columbia majoring in Biology, but shortly realized that nursing was my passion. This term, second year nursing students had the opportunity to work at a long-term facility for older adults.

“Ouch! It hurts! How can the pain be this bad?” Annette whined as she wiggled her back against the pillow. “Make the pain stop!” she repeated. Annette is one of the residents at our long-term care facility. Today she woke up with acute back pain. She had taken all her medications, but the pain persisted. Her nurse was beginning to think it was a part of Annette’s hallucination.

I joined Annette later at lunch, after she had been wheeled to the feeding table. Her sore back prevented her from moving her limbs and I was there to assist her.

“Annette, open your mouth. Let’s try some of your carrot muffin,” I said as I scooped some food into her mouth.

She took a few bites and continued to complain, “I can’t take the pain anymore. Why can’t the pain stop?”

The familiarity of those words lingered inside my head and I was reminded of my childhood. I had acute migraines when I was a child, which became more and more frequent as I entered high school. Every time I had my reoccurring migraines, my mother would kneel beside the bed and hold my hand.

“Vivien, it’s okay, the pain will go away.” Her voice was mellow and warm.

“Mom, I can’t take the pain anymore. Make the pain go away,” I whined as tears slid out of my eyes.

“The medication just hasn’t made it to your brain yet. Do you remember the time you got through your last migraine? This one will go by very soon. You just need to wait,” she said patiently.

“I can’t take the pain anymore, why can’t the pain stop?” I whined again.

“It will, Vivien. It always does,” my mother replied.

I understood the pain Annette was going through and I wanted to bring her comfort. “Annette, open your mouth! Let’s try some delicious cheese. Do you like cheese?” I asked.

“Yes, I do like cheese. Oh the pain! Make the pain go away!” she shouted.

“Oh Annette, I’m really sorry to hear that. The pain will go away. Remember all the painful encounters you have gone through before. You can definitely get through this one,” I replied.

“Oh, are you sure?” she questioned.

“Yes, I’m sure, Annette. Now take another bite for me,” I said.

I tried to detour her thoughts away from the pain with conversation. We talked about her favourite food, the weather, good snacks, drinks, fruits and her family. She continued to whine but there were moments when she was more concentrated on our conversation than on the pain. In the end, I was able to get Annette to finish her whole plate of breakfast, half a cup of milk, and half a cup of apple juice.

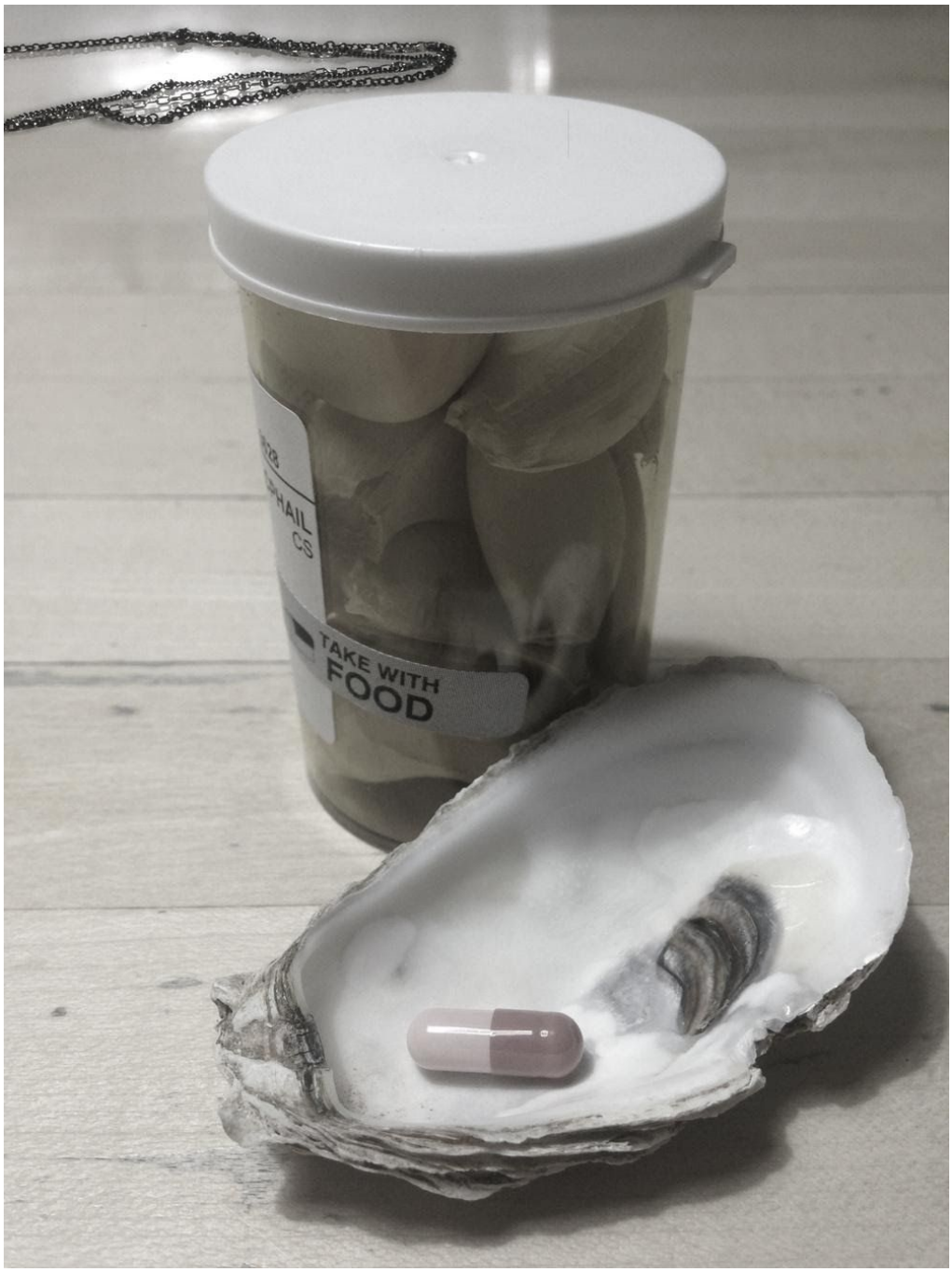
“Annette. Look! You finished your entire breakfast. See, it wasn’t that bad!” I exclaimed. She finally opened her eyes and looked at me. “Thank you,” she laughed. “I’m such a bother, aren’t I?” I smiled as the health care aid wheeled her back to her room.

In that moment I was so happy that I was able to help her finish her food and make her smile. It did take a lot of patience, time, and effort but in the end, we had accomplished something together. Through this challenge, I was able to use my experience in order to help comfort another person who was in pain. I realized that by personalizing the situation, empathy, care, and patience will come very easily.

Vivien Wong
Nursing Program, Class of 2019
University of Calgary

PHOTOGRAPHY

“Take with Food”: An Exploration of Nutrition as Medicine - Emily Macphail



DESCRIPTION:

So much of modern medical practice involves administering various tablets, capsules, and other pharmaceuticals. Many patients enter their physician's office expecting to walk out with a prescription of some sort, regardless of whether they are seeking to ease physical pain, infection, chronic conditions, hormonal imbalance, or mental illness.

Although these medications certainly have their place, and are often integral to providing the care that is needed, there is a commonplace consideration that has fallen to far to the wayside and may represent an avenue for empowering patients to improve their wellbeing in more sustainable ways: improved nutrition.

I am currently working on a master's thesis that is an exploration of the relationship between zinc, the gut microbiota, and obsessive compulsive disorder in youth, with the aim of finding evidence to support the pursuit of nutritional interventions as an adjunct therapy for OCD. This composition is a photographic, and somewhat metaphorical, representation of my research.

Oysters are the richest dietary source of zinc; hence, the pill capsule nestled in an oyster shell is meant to metaphorically suggest zinc as a "pearl" being offered as a potential OCD nutraceutical.

The other focus is a pill bottle filled with cloves of garlic, a source of inulin. Enrolled participants will take this prebiotic fibre, hypothesized as an adjunct treatment via its microbiome-mediating effects. The "take with food" label emphasizes the dietary focus of my research.

Three different chains intertwine in the background, representing OCD, heterogeneity of obsessions and compulsions, and how OCD "binds" those affected, sometimes paralyzing them with anxiety. Though distant, details of the links are still in focus, representing the vigilance and precision surrounding rituals, and how OCD can change appearance but rarely fully leaves the picture. The chains are a necklace: generally innocuous; however, patients with OCD often adeptly hide their rituals. More frustratingly, rituals can develop around any situation or object, even something as simple as everyday jewelry.

Finally, the image tone is deliberate. While nearly full grayscale, faint hints of warm colour peek through – a reminder that things appearing black and white at first glance (e.g. OCD, research), rarely are. More importantly though, the warmth exists to evoke a sense of hope – in our ability to find better, more effective treatments, and in the capacity of those afflicted to move towards OCD recovery and a brighter future.

Emily Macphail is a medical student at the University of Calgary Cumming School of Medicine.