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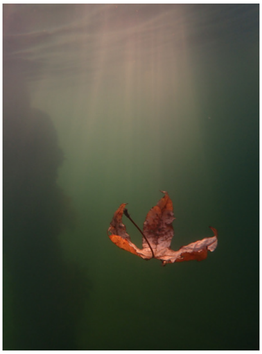
Frances Milat is an endocrinologist, researcher, and writer from Melbourne, Australia. She has over 90 publications in scientific, medical humanities, and literary journals and is an avid ocean swimmer and photographer. She is currently completing her Master of Creative Writing and is interested in nature and healing. Her "Ocean Swimming" photographs were taken with an Olympus TG-6 and are unedited.



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Editorial

The Natural Order of Things: Nature as a Metaphor for the Body, Illness, and Renewal

Here is calm so deep, grasses cease waving . . .

Wonderful how completely everything in wild nature fits into us,
as if truly part and parent of us.

The sun shines not on us but in us.

John Muir (1938)

Nature has long been our most intuitive and evocative metaphor—a mirror to the inner workings of the body, a terrain onto which we project illness, healing, and the search for meaning. In this issue of *Ars Medica*, our contributors turn to the natural world not only for language, but for logic, solace, and structure in making sense of the fragility of the human body, the burden of illness, and the quiet possibilities of renewal.

Paula Holmes-Rodman's powerful memoir, "Storytelling on the Borders," begins in a domestic scene at the edges of death and memory. In their shared series of *Scotch and Stories*, she and her mother co-narrate, mingling her mother's final days with memory. They draw not only on familial narrative but on rooted landscapes—the Tsolum River, the pine-scented air, and the blooming of fawn lilies—as sites of scattering and remembrance. Nature here is not just background; it is inheritance, metaphor, and balm. A child's death by medical error, a misplaced faith, and a final return to soil suggest that death holds its own rhythm and fertility.

Frances Milat's "Ocean Swimming" distills this sentiment through image and gesture. Her photographs of a leaf adrift in a winter sea are deceptively simple. Beneath their quiet, we find an elemental metaphor for release: the weary body buoyed by cold water, pain diluted in waves, the sun's refracted light signaling some small transformation. The sea, Milat reminds us, is both origin and sanctuary; the sea is a body unto itself, one that receives and renews.

In Kate E. Johnson's "Prognosis in Passing," the sonic world of the of the hospital, where "fluorescents hummed like dying insects," is read for the meaning of diagnosis and prognosis. In "I Dream of a Needle," "Articulate, Please," and "When the Screen Retracts," Susan J. Sample's triptych of poems uses elements of the natural world—moaning wind, bruised skies, and joints like unhinged doors—to echo the visceral disruptions of illness and caregiving. Her language is elemental, tactile. In the clinical space, grief lingers not only in language, but in the breath between doctors and nurses as the screen retracts, exposing raw human emotion beneath procedural formality. The natural imagery pulses with feeling, bringing corporeal weight to pain and compassion alike.

Gabriel Francisco Nibungco's essay, "2 + 2 = Streptococcus," beautifully captures the intergenerational web of illness and care, using microbial metaphors and childhood recollections to explore causality and meaning. The memory of a sickly boy, a grandfather's emphysematous lungs, and the mystery of streptococcus blend into a theory of love, exposure, and resilience. Here, the metaphor shifts inward: the body as host, the home as ecology, and healing as both biological and relational.

In “Gravity Rounds,” Sruthi Valluri delivers a devastating and lyrical meditation on the act of witnessing unexplained suffering. Her “rounds” through hospital floors are mapped like topography—ascending and descending the body of a hospital, a metaphorical mountain that both offers and withholds answers. Faith, like flesh, erodes under pressure. Her patients’ bodies become contested landscapes that are unmade, dissected, and mourned. Yet amid this entropy, her writing plants a seed of resistance: even in the absence of cure, there can be reverence.

Zed Zha’s visual and conceptual intervention, “The Embodied Pain Scale,” takes on the artificiality of quantifying suffering. Through tattooed images and patient quotes, Zha evokes the emotional, historical, and social layers of pain that evade numeric capture. The body here is inscribed, scarred, defiant. It speaks in metaphor because conventional language fails. His reimagining of the pain scale brings us closer to the human truth it was meant to approximate.

Read Carol Krause’s “The Art of Receiving Care” and Alisha Hiebert’s “The Hub for Dying Teenagers,” for perspectives on living with illness with fierceness, humour, and dignity. Harriet Squier’s “Code Status” provides a visceral telling of the unintended violence of attempting to bring a body back to life, from the perspective of a care provider. Language that causes us to flinch is engaged to confront the reader with questions about the integrity of the body, quality of life, and the ethics of care.

Adding a vivid visual dimension to this issue’s themes, Edison Tenecela’s artwork “*Rendezvous* *with the Senses: A Brainstem's Journey*" offers an imaginative fusion of neuroanatomy and the natural world. Through a visual interplay of sensory organs, limbic structures, and environmental motifs, Tenecela proposes a vision of the body not as separate from nature, but as porous to it. The piece invites viewers to consider the brain not only as a site of cognition, but as a landscape in dialogue with its surroundings.

Complementing this exploration of body and nature is Joanne Sinai's striking photographic work. A psychiatrist who finds a counterbalance to the verbal world of clinical practice in visual expression, Sinai offers images inspired by electron microscopy and made with elements from the natural world and the hands of other artists. Her photographs are abstract, organic, and suggestive of both microscopic and cosmic scales that remind us that the body, like nature, is composed of patterns, echoes, and reverberations far beyond what we can articulate.

Together, these pieces chart the contours of embodiment, loss, and healing through the metaphors of nature. Whether it is water or soil, root or scar, storm or pain, the writers and artists in this issue remind us that to live in a body is to live in a landscape shaped by time, weathered by experience, and, occasionally, renewed.

Allison Crawford, MD, PhD
Editor-in-Chief, *Ars Medica*

Reference

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Gravity Rounds

Sruthi Valluri

Fifth Floor

There is a patient on the fifth floor of the hospital. Her body is falling apart in increments, and my mind and faith are falling apart alongside her, trying to understand why.

No part of her is intact. Jagged lines of sutures hold together her feet where they have been amputated. Her kidneys are shutting down. Her heart is beating too fast. The immune cells of her body are multiplying, although there is no infection to be found. If she moves, she sometimes dislocates her joints. The far edges of her body—fingertips, heels, the weight-bearing span of her back—are ulcerating and then blackening in necrosis when her body fails to heal the wounds.

We do not understand why this patient is falling apart. We give her fluids, the strongest antibiotics, we scan every inch of her body. Still, we do not know the why and wherefores of her unmaking. She is, simply, dying.

She does this with panache. She insists on finding answers for this slow decline. She refuses to entertain the idea of dying without knowing *why* she is.

She would like, at the very minimum, some help for her pain.

“I can try talking to the pain management team,” I tell her as I examine the sutures of her foot amputations. As with the rest of her body, her feet are not healing. Despite the sutures, the skin folds of her amputation are pulling apart.

Of course, she is in pain. The mutiny in her body is cellular; no part of her wishes to stay intact.

"You just going to *try* talking to the pain management folks?" She asks. "Will you, or won't you?"

"I will." Of course I will. What else is there to do? I have consulted doctors in nearly every single specialty in the hospital about this patient: vascular surgery, podiatry, cardiology, rheumatology, infectious disease, nephrology, dermatology, orthopedic surgery, and palliative care. What none of us knows is *why* she is falling apart.

There is something supernatural about her unmaking; she has moved past science and medicine. Early in our acquaintance, I prayed. First, I prayed for us to find an answer and a cure. Then, I prayed for her suffering to ease. I am resentful towards all my gods for their silence. My anger is a spiky thing, growing hard and metallic underneath my sternum.

I rewrap the blunt edges of her feet, and prop pillows under her calves to ease the pressure off the oozing ulcers on her heels.

"That just looks worse and worse each day," she says. Her observations about her own body are always stated with a mild detachment, like she's wandering through a museum and reading aloud placards about the artwork on display: *The Failure of the Kidneys* by the painter known as Nephrology. *Uncooperative Amputations and Im-*

possible Vessels by the sculptor known as Vascular Surgery. "Lord, I hope you don't have to amputate again. I can't lose any more of my legs."

I think about a joke a vascular surgeon once told me: Vascular surgeons don't know people who get better, we just know people who get shorter.

I hate myself for knowing this joke, among others. I write down all the jokes I hear in the hospital. I imagine that one day, I'll share this list with my colleagues. I might even publish it: *Morbid Humor for the Moribund*.

I reach for the silver lining—this is the problem with us faithful; our optimism is ever-goddamn-green. "Good news is that your feet aren't infected."

Her laughter ends with a snort. "Good news is that I'm not dead," she says, picking at dead ends of her fingertips. She rips off a layer of blackened and dead skin and admires the pink flesh below. "Not yet, at least."

Later, when I finally get home, I touch my fingertips to the fat, spiked edge of the aloe plant tilting towards the window. The pads of my fingers are plump, ripe with oxygenated blood. The nerves are intact. A spike pierces flesh and I watch the blood ooze out slowly—and then a clot forms, knitting the skin closed.

I heal. She does not.

Fourth Floor

My faith has a hard edge. The mind boggles at how quickly I reach the precipice.

I used to believe in the gods my grandmother named. My grandmother raised me to believe in a multitude of gods, a whole pantheon of them. They clutter the skies and my imagination. In graduate school, I learned to believe in neat rows of statistical code, finding answers in a melee of numbers using an ordered line of equations. *If X, then Y*. In medicine, I am taught to believe in evidence-based algorithms. Science, too, is a dogma, and I was among its most faithful.

I believed my faith to be endless, as deep as the oceans and as expansive the skies. Now, I lose it in bits and pieces, day by day. It rattles out of my body with each step I take during rounds—up the stairwell to the top of the hospital with the sunrise, and down with gravity to visit patients on each floor.

With each day's descent, I am startled by how quickly I am dissuaded of my own convictions.

Third Floor

There is a patient on the third floor of the hospital. She, too, is dying. Like most patients in the hospital during these dark days of the pandemic, she is dying from Covid-19. It is not the *why* of her death that is unnerving. The answer is obvious. It is the *how* that I cannot comprehend. Her dogma fortifies as her lungs harden.

Every day, she asks for monoclonal antibodies, oxygen, vitamin C, vitamin D, zinc, Ivermectin, and hydrochloroquine. "God wants me to receive this care," she tells me. Her family, chiming in from the nearby iPad on a group zoom call, agree. They have all prayed on it, and they agree this is the best course of action.

This God is strange to me. My gods, the gods I grew up believing, rarely care about any of us. Presumably, they have better things to do—comets to hurl, stardust to crumble, universes to expand.

As always, she insists I pray with her before I leave. These were the dying days, and it seemed like everyone in the hospital was finding their way to their gods.

I am sweating under layers of personal protective equipment—face shield, N95 mask, gown, and gloves. My stethoscope is heavy around my neck. Any minute now, my pager will startle awake, and the day will start its inevitable spiral.

These were the dying days, and a prayer is sometimes all I can offer. More often than not, I accommodate her prayers. Out of respect, I have disclosed to her that I am not Christian. She insists on praying with me regardless. *For we live by faith*, she insists, *not by sight*.

I sit at the edge of her bed and hold her hand. "Dear Jesus," she begins immediately, grasping my hand.

My thoughts are still, my heart empty.

Second Floor

I tell my sister that my faith is dwindling. Send me happy videos of babies and puppies and sea otters holding hands, I beg her.

My sister obliges, as sisters are wont to do. She sends me a video of my niece, still a toddler. My niece clumsily lifts a cup of water, but it is canted at an angle. She remains unmindful of the water dripping down the sides, focused solely on the task of bringing the cup closer. When she finally brings the cup to her lips and finds it empty, she looks surprised.

I find myself sympathizing.

First Floor

There is a patient on the first floor of the hospital who is dying from Covid-19. At one point, everyone is dying from Covid-19 (except, of course, the patient on the fifth floor; no one knows what she's dying from.) He thinks I look like his daughter. He thinks I have the same laugh.

He tells everyone who walks into his room that he has a doctor who looks and sounds and laughs like his daughter. No one has the heart to tell him otherwise. No one even points out the obvious fallacy of his logic: He doesn't even know what I look like. Between my mask, goggles, face shield, gown, and gloves, all he sees are my eyes and a small portion of my nose. The only thing that matches between us is the shade of our brown skin.

He is fully vaccinated, but it does not matter. Not too long ago, his brother gave him a kidney. He is taking medications to suppress his immune system so that his body does not reject this loving gift. Not too long ago, he had his leg amputated because of an infection that wouldn't heal. His body does not have the capacity to survive this infection.

I press the stethoscope to his lungs and hear the crackles of airways popping open. He is the last patient on my list and his lungs always sound the worst. Imaging shows his lungs are getting worse. Labs show that his transplanted kidney is failing.

I update his family every day. Our conversations are wrought with guilt and grief. His brother does not understand why the kidney is failing; he blames himself for giving a weak kidney (I tell him the kidney is working just fine; this virus just wreaks havoc). His granddaughter, who recently visited him for dinner is wrought with guilt over his death. She blames herself for giving him Covid-19 even though she did not test positive. She is convinced she is the reason for her grandfather's death (she is not the reason; I cannot convince her of this).

The daughter who looks nothing like me says that her father will survive this. She is praying. They are all praying. I tell her I am praying too. I do not tell her that I doubt any kind of god is listening to any one of us anymore.

The patient tells his brother, his daughter, and his granddaughter to get a grip. He's dying anyway, not much to do about it. Mostly, he is pissed that he has to die in this hospital, alone.

Every day, when I walk into his room, he says by way of hello, *Daughter of mine!*

As the days go by, it gets harder and harder for him to say this sentence. On the day he barely makes it to *daughter of* before having to take a breath, I tell him, "You have to sleep on your side or stomach to help with your breathing."

He points to his amputated legs. "It's funny when I try to roll onto my stomach."

"A hoot and a holler, I'm sure." He is incredibly frail, so it is easy for me to help him roll onto his stomach by myself. He grumbles the entire time about how uncomfortable the bed is. I grumble right back and tell him he is becoming more of a curmudgeon every day. This is our routine: we grumble at each other. “On the count of three.”

On *three*, he settles on to his stomach. “I’d better not die on my stomach. As if this bed wasn’t uncomfortable enough. How are the beds in the ICU?”

Out of instinct—out of what remains of my faith—I correct him. “You’re not going to the ICU.”

“God strikes down liars and sinners, child,” he chides.

It’s empty skies overhead. I’m sure of it. I make a show of looking towards the ceiling. “I’m waiting.”

He tuts under his breath, disapproving. “Now, I *know* you know better than to be disrespectful like that.”

I put my hands on my hips, tap my foot in exaggerated impatience. “Is this supposed to be a literal righteous thunderbolt, or a metaphorical striking of my conscience?”

“Nothing to make fun of,” he chastises.

I’ve seen him reach for the Bible on his bad days. His faith fortifies with each passing day, while mine diminishes in tandem with his plummeting oxygen saturation. “It was a bad joke, sorry.”

“I’ve got a good joke for you. What do you call a bad amputation?” A long pause (a wheezing breath). “A rip off.”

It’s a bad joke. I laugh anyway. “That one’s going on my list of jokes.”

He adjusts the oxygen mask over his face and takes another deep breath. “Any amputation jokes on that list of yours?”

I sit down at the edge of his bed. “A vascular surgeon told me this one,” I begin.

He laughs so hard, his oxygen levels plummet.

* * *

I return to the hospital after a day off. The patient on the fifth floor is quickly dying now. While she had been slowly dying before, now she is unraveling at a speed that is no longer sustainable under my team’s care and has been transferred to the ICU. The patient on the fifth floor has died after a brief stay in the ICU. Her family had asked to speak to me over the weekend to thank me for my daily prayers. The patient on the first floor is also in the ICU. He has been intubated; he is unlikely to survive.

I contemplate calling the family of the patient on the fifth floor to offer my condolences on the loss of their matriarch. I also contemplate calling the daughter who looks nothing like me to reassure her that I am praying for her father.

But then I remember having a loved one—multiple loved ones—in the hospital. The mind unravels, with or without the helpful thoughts and prayers of strangers. What use am I or my slowly eroding faith in this time of their loss?

I call no one.

Instead, I print out a new patient list for the day and fold it in half lengthwise, so that it fits into the back pocket of my scrubs. I draw a circle next to the names of the sickest patients under my care. With each circle that I draw, I fortify myself with the knowledge that although the universe favors entropy, this amount of death and despair cannot stand. It is too great a disequilibrium. I pray that today, there will be respite.

And then, I climb to the highest floor in the hospital to begin my day.

About the Author

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The Art of Receiving Care

Carol Krause

It doesn't come easily to me. Being on this side of things.

The first time we meet, it is on the computer. I feel uneasy, as she goes through her list of questions. Her head is not the size of her real head, and I can't see her shoulders or her elbows. Her eyes seem tired, yet alert. I sense she has been through this routine many times. While she is polite, the exchange feels distant. We are far away from each other. She asks me many questions I don't like, such as: "Do you have any dangerous behaviours? What is the name of your disability income support worker?" I hesitantly answer her questions so that my predicament can be detailed and categorized. I dislike it when people type down the things that I say. I don't know what will happen to the words that come out of my mouth. She later tells me they will be stored in a secure online system. This does not make me feel any better.

She is the case manager. I am the case, apparently. Though I don't look like a case, and I certainly don't fit into one. It's not that she isn't kind. Because she is. But perhaps her kindness makes this whole exchange more eerie. Am I supposed to feel comfortable being asked about my mental health history by a stranger?

When our session is over, I close the screen. I can sense a cluster of eyes staring me down. I am being watched. I begin obsessing about what I said and what she said and what we did not say together. Why would she ask to speak to my disability income support worker? Why does she want to ask my psychiatrist questions?

Days later, I decide how I actually want to respond to her questions. I don't want her to have the name of my disability income support worker. And I don't want her to talk to my psychiatrist without my consent. I do my best to articulate my concerns, and she retreats easily. She tells me what she meant by her questions. Maybe I misunderstood. She agrees to my terms, and I start to feel a little less like a case. She says she wants me to feel in control, whatever that means.

I suppose it is happening clumsily, learning the art of receiving care. It is different, being on this side of things. I was once the one asking questions. And, though I have had a psychiatrist for years, this system of information gathering somehow feels different.

* * *

I gather information about my workers with my senses. Are they safe? Are they trustworthy? How do they see me? I try to see them without seeing them as my workers. Since they are also human. I feel their eagerness to be of help and their wish for me to avoid harm. I like them, for even though we are on different sides, we are on the same side … I think.

I have lots of supporters now. I am embarrassed to list them all. It was only recently that I was welcomed into a community health centre. I had been on the list for at least two and a half years and had been struggling with a lack of support. My new worker connected me with a number of supports, including a case manager at another organization.

I didn't want to take too many services or be a "drain" on the system, but I hesitantly accepted the care that was offered me. I was already getting help with cleaning and a lot of support from my family with basic tasks. Now I have workers who assist me in other ways, like finding my way around the hospital. Some of my supports are meant to help me do more things on my own. I receive this help so that I can progress towards the person I want to be. Or is it the person I am expected to be?

* * *

I struggle to write about my experiences receiving care. I want to write something beautiful. I want to be grateful. But, when I sit with the experiences of being a care recipient, I am uncomfortable. I don't know what's expected. I don't know who I am in this relationship. There are moments I feel I am not welcome as I am, such as when the woman at the hospital asked my Primary Care Coordinator why I needed support, as if I wasn't there. I answered the question myself. I wanted her to know that I was there.

When I meet my case manager in person, we talk about my life. She speaks with a soft voice and looks at me in just the right way. It almost feels as if I am meeting a friend for a walk, but it doesn't. We talk about what I want and what I don't want. She says all the right things in response to what I say. She has learned these things along the way. I do not have a problem with the things she says. They are usually good things to say. But I wonder if they come from a script of what you are supposed to say to people like me.

I wasn't always the way I am now. I was once the person providing care. I graduated from law school and had a management-level job. After that, I was a support worker and then a peer supporter. Over time, my mind became more sensitive, and I struggled more with the basics. My journey, though difficult, was not a downward slide, but a deepening. While I experienced a loss of status, it also led me to the path of being a writer. My brain is more attuned to poetry these days.

I feel the world differently now, and that's not a bad thing. But sometimes it feels like it is. The person I used to be was not sitting across from a case manager answering questions about her disability income support worker. That person knew the questions to ask. She knew what to look for. And how to look back without looking down.

I remember meeting with youth I supported and asking them questions. Did I always help people feel comfortable? Was I always easy to talk to? I fumbled at times, and I am sure I had lots to learn. But I really cared.

I tell myself that I am comfortable being the person receiving this care, but am I really? It feels like the difference between a worker and everyone else is what they write down. They have a template. There is space for your name and room to write down your perceived mental state. There is also space for what you want and what you don't want and whether you are getting what you want and avoiding what you don't want. In this space is your life. Condensed. Compartmentalized. Codified. You will never see the words written about you, but they form a trail. This trail can be followed by the other workers who are allowed to trail you. There's no need to be suspicious. This is just a way of making sure you get the care you deserve, right?

Am I getting the care I deserve? Yes, I am mostly getting very good care. Despite my own discomfort, I want it on the record that I'm grateful. My workers are kind. They really can be adept at providing care. I don't want to complain about the support I am receiving. It is helping me have the things I want. I just wish I was the one writing the notes.

* * *

There is a meeting happening. The workers are talking about the clients. They are talking about what is moving along and what is moving along too slowly. They are helping each other move things along. In this meeting, they talk about the people who are receiving care. I don't know if they ever mention my name. But I'm there, in the background. I am one of many clients whose details have been summarized and placed into boxes. You can't place a person in a box, but you can place the details of their life into a box.

I am not invited to the meeting. I wouldn't want to be there anyway. It's only a shadow of myself that is present. This shadow can't talk or move her eyes. She can only exist silently within the terms of the arrangement.

* * *

There is a way of speaking where you don't speak to change what's happening. You speak what's happening. When I hear someone speak this way, I listen. It feels like no one is trying to change me. And, when no one is trying to change me, I am welcome as I am—which is the best invitation to change.

We sit in my living room. She is new to her role and open to me, Carol. She has perceptive eyes that are gentle, yet affirming. I find her presence grounding, without expecting me to be grounded. Her voice has a softness to it. I watch her lean out of her comfort zone to learn something new. Her humility helps me feel at ease. I tell her how hard it is for me to join a new group and how I don't know how to date with so many restrictions. And do I even have the energy for a partner? We talk about my goal of cooking and how it just feels too much for me right now. We talk about how hard it is for me to go grocery shopping. She is steeped in compassion, and it doesn't feel like she is staring at me. She is sitting with me. When she says things, they are not the right thing or the wrong thing. They are her thing. And that truth rings clear and makes me feel at ease.

After we talk about what it is like to be me, she says this helps her understand. When we get to the next steps, she says she will help me organize my refrigerator. Then we can talk more about me cooking soup. I don't mind that she is an occupational therapist who is helping me. Or that I am the client who is being helped.

She wants me to have an easier time doing the things that matter to me. She doesn't speak as if there's something wrong with me. Instead, she looks at the world around me and how I am in the world and sees how to create more harmony.

* * *

I move around the city more easily now. Most of the time, I take public specialized transit for people with disabilities, though I only have support under certain conditions. I do this, because I get painfully overwhelmed when I take regular transit. When I am inside a Wheel-Trans vehicle, I do not want to tear my eyes out. I see the city around me from my back seat. Sometimes the drivers are kind. Sometimes they are rushed.

I remember one of the drivers very well. He called me Carol Anne, as he narrated the city from the front seat. When he welcomed me, I felt like a special guest. I leaned back and saw the city through the eyes of a warm stranger. His voice was animated by the world around him. He treated his cab as a limousine. I don't even remember much about what he said, but it was how he said it that meant something. I felt valued. When I made my way out of the vehicle, we said goodbye as if we were old friends. He taught me something about offering care that day. Because I felt no hesitancy in receiving it.

I am aware of the privilege of being able to receive so much care. Not everyone has access to the supports they need, and sometimes people are mistreated or dehumanized when they do receive supports. I think of all the people who deserve to be welcomed and wish we would ride in that-Wheel-Trans vehicle together.

What needs to happen so that more people can receive quality care?

* * *

I am also trying to receive care by taking care of myself. There are many ways I already do this. And I have recently started making sandwiches again, thanks to my occupational therapy sessions. There are a lot of steps to making a sandwich. You need to buy the ingredients and put them together in the right order. My occupational therapist teaches me that when you go through a task, it can be handy to break it down into small steps, like this:

1. Buy gluten-free bread.
2. Buy cucumber.
3. Buy cream cheese.
4. Put the gluten-free bread in the freezer.
5. Put the cucumber and cream cheese in the fridge.
6. Take the gluten-free bread out of the freezer.
7. Put the gluten-free bread in the toaster oven.

8. Take the cucumber and cream cheese out of the fridge.
9. Take the gluten-free bread out of the toaster oven and put it on the counter.
10. Open the cream cheese container.
11. Get a knife.
12. Spread the cream cheese on the bread.
13. Slice the cucumber into four slices.
14. Put the cucumber on the bread.
15. Put the other piece of bread on top.
16. Enjoy!

Now I realize why it takes so much motivation to make a sandwich. Eating takes a lot of motivation in general. I am not sure I understand why preparing food is so demanding. It takes so much energy to put the soup in a bowl, and place it in the microwave. I am uncertain about how I am going to get to the point of cooking regularly. Was it a bad idea? I move my occupational therapy appointment back. Hoping that in a few weeks I will feel up to the task.

I want to end this piece with the accomplishment of making soup. I want to narrate making soup and describe the delight of eating it. Then this piece will be complete. I will have received the care that I was given and produced something valuable that I can share with someone else.

Maybe, in a few weeks, I will make soup. Or three months. Or a year. Maybe I will be able to start doing more of the things I want to do. Like go to the queer social group I signed up for. Or go on a date. But right now, I feel that keeping up with what I already do is an amazing feat. I live on my own, with practical and financial help from my parents. I visit friends. I exercise regularly. And work hard on my writing.

I cannot tell you about the Moroccan tomato soup I plan to make again one day. I can't even think how many steps are involved in making this soup. Have I failed at the art of receiving care? Should I try harder to become the person I am expected to be?

* * *

It is a fierce lesson to lose many of the abilities you once had. When I was younger, I was considered impressively capable. I was sure of myself in the way insecure people are. I knew how to shake hands with the "brightest," even as my spirit grew dimmer.

Still, I have a rich life, and I know joy down to my bones. I can listen to a tree unfold from my toes to the top of my head. I can climb inside caves and revel in being filthy and wet. I receive gifts I could not even begin to tell you about with words, just by being in the forest. I am not built wrong. I am just created for a different world than the piercing city I find myself in. The frenetic noise gathers inside me, making it more difficult to do the things I want to do.

That said, I can only meet life here. The things I struggle with are teaching me to be more fully human. Perhaps the lessons from being on this side of the exchange are even deeper.

* * *

I did not make soup by myself. But I did not give up. I asked for help.

The spicy soup is simmering on the stove. It is a Moroccan tomato soup, like I used to make. My friend and I, we made it together. I appreciate the care she puts into assisting me. Her good humour and natural ease help me meet the task at hand. She chopped the garlic. I chopped the onions. She pointed out that one of the cans of tomatoes expired in 2020. I lined the new cans of tomatoes on the counter. She suggested we put the parts we wouldn't be eating in a bowl. Then the parts we would be eating in a pot. She stayed with me for moral support while I went through each step on the list I had printed out. She didn't expect anything of me, but she was confident that I could do this.

It wasn't a glamourous thing, me slowly slicing the onions with a dull knife. The onions were hard to cut, and it took me a long time. My friend helped peel off the top layer of the small ones. The onions in the soup were a little hard to chew. I'm not sure why. No matter. The spicy soup is simmering on the stove. I did not make the soup by myself. My friend and I, we made it together.

Once the soup has simmered, I decide that—though it is not perfect—it is tasty. I place it in plastic containers. I put some of the containers in the freezer and some of them in the fridge. My sink is filled with dishes I will finish tomorrow. Or the next day. I feel a sense of satisfaction because, with some help, I made it up my summit of chili powder and tomatoes. My hands smelling of onions. I will tell my occupational therapist of this accomplishment, and she will be happy for me. My difficult feat written down in a computer system somewhere. She will document my progression to the person I have set out to become. It will only be a few lines. There will be no way to fit the tomatoes and onions inside. But, maybe next time she comes over, I will invite her to taste a spoonful of soup.

About the Author

Carol Krause feels most alive crawling through caves. Her poetry collection, *A Bouquet of Glass*, is published by Guernica Editions.

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2 + 2 = Streptococcus

Gabriel Francisco Nibungco

I used to believe that my grandparents had put in a good word for me in heaven when they passed away. My maternal grandparents lived next door. I saw *Tatay* (father in Filipino), my grandfather, and *Nanay* (mother in Filipino), my grandmother, practically every day of my life from birth to age 11. I was a very shy little boy, usually quiet, rarely hard-headed, and always a picky eater. I probably wasn't the most pleasant grandchild to have around. My sister was much nicer. She was cute and articulate at a young age. She liked being indoors, but wasn't reserved like me. Like my Mama (how we referred to our actual mother), my sister loved to read. Mealtimes were also no problem at all, since she loved to eat. I would pout when I didn't like the food on the table. Yes, definitely, she was altogether more pleasant. Still, I showed a few good traits. I worked well with my hands. I memorized jokes that I knew adults thought were funny, even if I didn't understand them myself. Plus, I had a bowl haircut!

Part of my shyness might have come from being sickly. My parents didn't keep a good record of my hospital admissions, but I've been able to put together medical knowledge and a few memories and stories. My diagnoses ranged from pneumonia and childhood asthma, to glomerulonephritis and kidney stones. Later in life, I would learn that my primary pediatrician was a nephrologist. I had no idea what that was, but having received the best of care, I knew I wanted to be like him.

Tito (Filipino word for uncle) Joel was my pediatrician. He was a big man and often late for clinic hours. “I will never be late when I become a doctor,” I thought to myself in the cool waiting room. While that room was cool in temperature, it was not cool at all in terms of decor. It was small and gloomy, with only the height chart stuck to the wall offering a touch of color. “I will fill my clinic with drawings and paintings,” I promised myself in silence. Clinic design aside, I had no other complaints! Tito Joel wasn’t really my tito. We weren’t related. It was my unusual constellation of illnesses that would land me, repeatedly, in his waiting room. He was also much more than my doctor. He made me feel better. I was cooperative in that clinic. I didn’t understand much of what he said to the adult I was with, but I listened in anyway. I drank more water, refrained from junk food, and only had sugary drinks on weekends. Those were much easier to deal with than painful blood draws and medications that were hard to swallow. I still got sick.

Tito Joel wasn’t to blame, but I wondered what it was. Maybe I would figure it out when I become a doctor. This all changed after fifth grade. My next sick day, from a bad case of diarrhea, wouldn’t be until my first month of pediatric residency. For years, I’d attributed this to Tatay and Nanay interceding for me when they went up to heaven.

Tatay died in his sleep. He was a chronic lunger, suffering from Chronic Obstructive Pulmonary Disease (COPD) from years of smoking cigarettes.

He had a pacemaker, which I thought was pretty cool because it had batteries that could last for years. I was lucky if the batteries in my toys lasted a few weeks. He also suffered a major stroke on the day of my first birthday. He walked with a cane, coughed a lot, had oxygen on standby, and a caregiver on duty 24/7, so I grew up with Nanay doing most of the talking. Tatay passed away in November when I was eleven years old. It was my first encounter with death. It wouldn't be the last. Apart from being a breast cancer survivor, Nanay was healthy as could be. That she died of grief, and great love and longing, was the only conclusion when she passed away only three months after Tatay.

As doctors, we memorize thousands of facts, and it's often the ability to recognize the relevance of a particular fact that most requires the years of training. Our mentors would call it developing our "clinical eye." Putting two and two together is easy when it always results in four, but not always as simple when it might add up to hypoxic-ischemic encephalopathy or a dozen other complex problems. When I was a resident in the Philippine Children's Medical Center, we always began evening hospital "edema" rounds at the neonatal ward. We would start there because we didn't want to bring in pathogens from different parts of the hospital. Residents had only two jobs when dealing with neonates: know what you're talking about, and keep your hands clean. Edema rounds were called this because we would walk the whole way, and edematous feet weren't uncommon after covering the entire hospital. One of my favorite questions to ask junior residents was about our little chronic lungers. “Apart from prematurity, what other factors contribute to the development of bronchopulmonary dysplasia?” I loved questions like this because there were many answers and a good number of them weren’t immediately apparent. Thinking through them was a good exercise in connecting the dots. I would review the different answers in my head as I waited for my peers to chime in. It was during one of these reviews, as I checked off relevant pathogens in my head, “Ureaplasma, chlamydia …”, that I remembered Tatay.

The most common pathogens associated with COPD exacerbations are streptococcus pneumoniae, haemophilus influenzae, and viruses that cause colds or other flu-like symptoms. The most common causes of childhood pneumonia are mostly the same. Tatay coughed all the time. The residual weakness from his stroke during my first birthday left him often unable to cover his mouth. I saw Tatay daily and gave him a kiss on the cheek soon as soon as I saw him. We would then eat at the same dinner table. Of course, he coughed there, too. After the meal, we would move to the living room where Tatay would control the TV remote. Once the evening news was over, or sometimes even before that, he would hand the remote to me. I would change the channel, of course. Our nights would end with Tatay deciding it was time for bed. My sister and I would give him a kiss good night, then watch him slowly make his way upstairs, before we headed home for bed.

Practically every day of my life from birth to age 11, I was exposed to the chronic pathogens of emphysematous lungs. I wonder if my doctor, Tito Joel, figured that out. I wonder if he put two and two together and came up with streptococcus pneumoniae. I wonder what harms could have been prevented by limiting that exposure. Maybe I wouldn't have missed as many football practices in those younger years. Maybe I would have made the varsity team earlier than I did.

After all the questions, discussions, and debates that occupied edema rounds, we would pray. We would pray for each other, especially the residents in charge of difficult patients. We would pray for our patients. We would pray for the families we leave behind at home as we struggled to care for children not our own. During prayer, I concluded that Tito Joel knew what he was doing. He knew, as I often tell parents about their children, that "they're sturdier than you think." He added up 2 and 2 and got to streptococcus, but also surmised that wasn't what was most important. An ailing grandfather needs a good night kiss. A shy little boy needs to get the dinner he wants from time to time. The doctor in me also puts two and two together and thinks that I was sometimes sick in childhood because of the occasional bug caught from my grandparents, or even their TV remote. I also still believe that Tatay and Nanay whispered a kind word up there for their grandson with the bowl haircut. The doctor in me knows that too.

About the Author

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The Hub for Dying Teenagers: A Call for Change in Organ Donation and Transplantation

Alisha Hiebert

I'm reading a book about sick kids falling in love. It sounds weird, very capitalizing on the "sick lit" trend, but I find these types of novels very comforting.

When I was growing up, I read books about kids with cancer because it made me feel better about my own life. I met my teenage best friend over our mutual love of author John Green and his novel *The Fault in Our Stars*, which was about dying children. John Green was someone who could write about being a dying teenaged girl without actually being a dying teenaged girl, which was true. I was not a teenaged girl dying of cancer, but I was a dying teenaged girl who found solace in reading about teenage girls dying of cancer.

I used to be part of a club started by Steven Spielberg and I promise you I'm not lying when I say that. It sounds insane, the kind of thing people make movies about, but it was true. Cinematic marvel aside, I was part of a group of teenagers brought together by a medical company funded by Steven Spielberg. There was a website with chat rooms and games, and there was one criteria: you had to be chronically ill. We were a hub for dying teenagers.

This stipulation meant I met people from all over the world, who would join this moderated chat room at all hours of the day and talk about medical procedures or how they couldn't sleep because they were in pain. They talked about soccer and movies. They walked me through my first colonoscopy at 15, gave me the best pain relieving tips (ones I still use today), and offered up some of the wisest advice on living I've ever heard. So many things changed in that group from when it started to when it ended, but those golden years were everything.

I met the aforementioned best friend there. I met a number of other people who became my good friends. I understood them in ways not many people did, shared secrets, and song recommendations. I watched them die.

I recently saw through social media that the beloved author of my teenage years, John Green, has written a new book about tuberculosis, and it sent me down memory lane. It prompted me to reach for the "sick lit" on my shelf and scroll through Facebook pages that now say "Remembering" followed by the names of people I used to talk to daily.

One of the things I find compelling now, both as a transplant recipient and also as someone heavily involved in transplant patient support, is how many of the friends I lost were on the transplant waiting list. They spent their days waiting for organs that never came, or they died in surgery. I remember proudly changing my Facebook profile picture to show support for a friend who was receiving new lungs, only to get the news that he didn't make it. I was still young enough to believe doctors were miracle workers, that transplant cured everything. It was around my fifth memorial attendance when I became disillusioned with the idea of medicine altogether. We were all supposed to have more time, but "more time" just meant more people to remember in their passing.

This was something that never crossed my mind as I was waiting for my own transplant. I know now, and knew then, that statistically organs are not guaranteed, that we have a supply and demand issue. There are more people who need organs than there are organs available, and transplants are not foolproof. People die every single day. I know this, and for the entire time I was waiting, it was as if my brain strategically blocked out the knowing, the awareness that too many friends hadn't made it.

All this remembering made me see how lucky I am. But luck isn't good enough.

Recently, I had the opportunity to attend and speak at a medical conference hosted at NYU Langone, a renowned transplant hospital in New York City. Topics of focus included xenotransplantation, the need for better immunosuppressive regimens, and the supply/demand issue that still exists. Listening to all these discussions, hearing topics spoken about clinically and scientifically, I saw only faces. I saw my friends who passed, long before my involvement in transplant ever began. I saw the faces of everyone who has come to one of my support groups, never to be seen again, and months later I hear from a family member that they have passed. I carry their grief with me, nestled in my chest.

I always thought, when I started this work, that I did it for me. The longer I do this, the more I realize I do it for them.

I think of our little ragtag group of misfits, living our teenage lives within the confines of a hospital, and vying for any sense of normalcy in a way that was both incredibly poetic and incredibly sad. Transplant seemed to be the gold standard then, the beacon of hope. He was supposed to get better after the surgery, she just needed to get the phone call and, like the waving of a magic wand, everything would be okay.

I know now that it isn't true. It isn't that easy. I know I'm one of the lucky ones. It shouldn't have to be that way.

We all deserve better options.

We were only children.

About the Author

Alisha Hiebert is a writer and embodiment coach. She supports patients through her work at Transplantlyfe, facilitating support groups and advocating for patient centered storytelling in transplant care. Email: ahiebert@live.com website: www.alishaemerald.com

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Prognosis in Passing

Kate E. Johnson

Discharge was not a question she had to ask on those mornings when the fog crept up Parnassus like spilled anesthetic, when it numbed the edges of the hospital until the whole hulking thing floated, unmoored above the city. When all she could do was listen to the footsteps beneath the hanging hem of institutional butter-won't-melt yellow.

The attending's were *legato* notes, heel sliding into toe, trying too hard to be quiet, as if she could tiptoe around the news she carried. The residents moved in clusters, sneakers squeaking like surprised mice, stumbling over medical terms and each other's shadows. They'd gather at the patient's door like anxious pigeons, waiting for the sharp staccato of orthopedic clogs to conduct them into formation. Those clogs spoke in certainties, in firmly planted diagnoses, in you'll-get-through-this-I-promise.

The night shift brought the shuffle-thump of the janitor's boots, a death-knell patience that kept time with the drip-drip-drip of her IV. Those footsteps, God help her, those footsteps. They moved like prayers gone stale in morning-mouth corners, as if the air had turned to river-bottom silt, each footfall echoing the monitors' endless questioning: still-here-still-here-still-here? Past midnight, the cardiac monitor's green peaks carved valleys of neon through darkness, while the feeding tube pump by her bed could be counted on only for a bit of noise to quiet the mind or tear it to pieces.

Sometimes, in those hours when the fluorescents hummed like dying insects, she'd catch the sound of unfamiliar treads approaching—too fast or too slow or too lost—and her fingers would curl into the sheets, counting breaths until the curtain finally whispered aside and revealed which way the wind would blow today. For she knew, as surely as she knew the taste of plastic tubing and Jell-O that shook like scared rabbits, that footsteps never lied about the news they carried.

Note

1. This manuscript is not associated with or representative of the author's institutional affiliation. Nothing to declare.

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Code Status

Harriet Squier

Early in my time as a medical student, the days fell into a routine. I'd check test results, make rounds, wrestle with the Electronic Medical Record, do workups, write more notes, and read about my patients' medical problems, as much as I could. Everything was orderly and predictable, until one day I heard the hospital PA system announce, "Code Blue room 148. Code Blue room 148."

The senior resident jumped out of his seat. "That's us!" he exclaimed. "Come on, there's a code down the hall."

As I ran after him, a nurse came from the opposite direction pushing a bright red crash cart full of supplies and medications. Other nurses, residents, and medical students converged on room 148 in a swarm. My instinct was to hold back and observe, but my resident pushed me ahead of him.

"What's the story here?" he asked in a commanding voice as he helped pull the crash cart into the room.

"85 years old, metastatic breast cancer, full code," responded a nurse who was stripping the hospital gown from the patient's body.

My resident pointed at me. "You! Chest compressions."

"Um, OK."

"Climb on the bed if you have to."

The bed had been raised to make the work easier for the staff. It was awkwardly high for me, so I climbed up, aligned my knees next to the woman's naked torso, placed the palm of my left hand over the back of my right, lacing my fingers, and planted my right palm firmly on the woman's sternum. Her body was thin and frail; her sparse white hair haloed around her head. She was dead.

"Okay, start the compressions," said the resident.

I pressed. The idea of chest compressions is to push down hard enough to squash the heart so blood pumps out, but this woman's rib cage curved high above her sunken abdomen, the sternum not even close to touching her heart muscle. Her ribs barely flexed as I compressed. I was afraid I would break her.

"One and two and three …" I said, counting with each compression.

A nurse placed a ventilation mask over the patient's mouth; another nurse felt for the patient's pulse in her groin.

"… and four and five," I said. I paused; the nurse squeezed the bag.

"One and two and three …"

"No pulses transmitted," said the nurse, confirming my fears that the compressions weren't effective.

I pressed harder, leaning my weight onto the woman's chest. "and four and five." The rib cage remained stiff and unpliable. I noticed nodules along the ribs and wondered if they represented metastatic cancer that had spread to her bones. The nurse pressed the oxygen bag. I raised up on my knees so more of my body weight would be over the patient's chest.

"One and …" I felt a crack under my hands. "Two and three and …" Sickeningly, the ribs gave way under my hands. "Four and five…" The nurse squeezed the bag again. I could feel the gritty edges of cracked bones scraping against each other.

"One and two and …" More ribs cracked. "Three and four and …" The final rib gave way, the sternum collapsing into the woman's thorax. "Five …" The nurse squeezed the bag. I backed my weight off the old woman's chest.

"One and two and three …" I compressed, my hands sinking with little resistance. As one nurse ventilated, another told me my compressions were producing blood flow in the groin. Around us, my resident barked orders as an EKG machine spit out a rhythm strip.

"One amp epinephrine!"

"Four and five …" I said, loud enough for the nurse doing the ventilations to hear me.

"One amp epi!" repeated a nurse as she grabbed a vial and snapped the narrow glass neck with one hand while grabbing a syringe with the other. In one smooth motion, she gripped the plastic needle cover between her teeth, pulled it off, drew up the liquid from the vial into the syringe, and handed the filled syringe to the nurse standing at the patient's left arm. "One amp epi!" she repeated.

"One and two and …" I continued compressing.

The other nurse bent over the patient's arm, located the port in the IV, and injected the medication, running the fluids wide open. "One amp of epi!" she shouted.

"Three and four and ..."

"Time!" yelled the resident.

An intern checked the clock. "Four minutes!"

The shouting continued with each drug that the resident ordered. A nurse anesthetist pushed her way to the head of the bed, plopping her equipment next to the patient's head. She checked the light on her laryngoscope, a curved metal instrument used both to push the patient's tongue aside as well as to visualize the trachea and vocal cords. She eyed the patient's head and neck and selected a long, white breathing tube (ET tube), which she would thread down the patient's throat into her lungs, so that ventilations would be easier. The nurse with the oxygen bag stepped aside, gesturing to me to pause my compressions. Tilting the patient's head back, the nurse anesthetist inserted the laryngoscope, peered intently into the patient's mouth, and without taking her eyes off her object, she grabbed the ET tube and threaded it down the patient's throat. As she removed the laryngoscope, the first nurse attached the oxygen bag to the (ET) tube. The nurse anesthetist listened to the patient's chest with her stethoscope, first one side then the other, as the other nurse squeezed the oxygen bag. It had taken maybe ten seconds to get the patient intubated.

"One and two and three and …" I resumed the chest compressions.

The nurse administered a couple of breaths, and I pumped the chest. The broken ends of the ribs gnawed at my wrists as I reached between them; her breastbone moved easily, unmoored, against the heart underneath.

When the action paused for electric shocks to be administered, I got off the bed so another medical student could take my place. I threaded through the mob of people, staying long enough to see the patient's body jerk and flop in response to the electric shocks. I shook my arms to try to remove the sensation of the bones crunching under them. It didn't work. All these years later, I can still feel the ribs crumbling under my weight, the sensation living in the bones of my arms.

I hovered in the hallway for a while, watching the action, wondering what it was all for. I wondered if the patient had agreed to have this done to her. I wondered if the family had. I wondered why the patient's doctor hadn't insisted on a peaceful death for this elderly woman with metastatic cancer.

This patient did not make it. The code was terminated, the people left the room. A couple of nurses stayed to clean up the body. I made a silent vow that when I became an attending physician, I would fully inform my patients about their prognosis and do my best to protect them from having to withstand a futile code.

Many years later, when I worked as an attending physician in a university medical school, I found myself taking care of a 56-year-old man in the ICU. He had metastatic lung cancer, and his prognosis was grim. Still, he was alert with a lively mind and sense of humor and was still adjusting to his recent diagnosis. Medically, he was having sudden problems with his breathing, presumably caused by a plug of mucous blocking off a major airway. The pulmonary specialist wanted to perform a bronchoscopy, threading a long tube into the patient's lungs so he could remove the mucous plug. While ordinarily, the procedure was fairly routine, for this patient, it was fraught with unlikely, but possible, disaster, as hitting the wrong part of the lung—a swollen blood vessel or vascular tumor—could start a cascade of bleeding that couldn't be stopped. The patient knew the risks and benefits of the procedure and wanted to proceed. The pulmonologist wanted to have a code status established before he started. Since the patient's prognosis was so bad to start with, he didn't want to have to run a futile code on an already terminal patient if the procedure went awry. We had to have the patient's consent.

The pulmonologist, the senior resident working with him, and I, as the attending physician, circled the patient's bed while the residents and medical students on my team watched in the background. The patient was sitting up, an oxygen mask over his nose and mouth, looking at us with curiosity. "I'm all ready for the bronchoscopy, Doc," he said to the pulmonologist.

"Yes, that's good," he said. "But I have to ask you something before we start."

"Sure, no problem," said the patient.

"I just need to know what you would like us to do if we run into complications. Do you want us to do everything in case you stop breathing?"

"Sure, Doc, I want you to do everything."

The pulmonologist's shoulders slumped. This was not the answer he wanted.

Next, the senior resident tried. "When we say 'do everything' we mean push on your chest and break your ribs and give you medicines and run a code. Is that what you want us to do?"

"Sure, Doc, I want you to do everything."

Next it was my turn. "You know, you are in the ICU. We are already doing everything. You're getting oxygen, you're being monitored, you're getting all kinds of medications. What we're really asking is, if you die, do you want us to try to bring you back?"

The patient's eyebrows shot up. "No way! That would be stupid!"

I could feel a collective sigh of relief in the room, and, I have to admit, a feeling of accomplishment for myself. Not that I wished for this man to die—later that day he had the bronchoscopy with no complications—but that I had finally helped him understand what we were asking. Very few people survive a code in the hospital to walk out and live normal lives. Most die anyway or are left with brain damage from lack of oxygen. The concept of doing everything is very different, I suspect, for patients than for doctors.

This patient responded enough to chemotherapy and lived long enough to leave the hospital. He was still expected to die soon, but at least he could spend his last days with family in his own home. He would not have the threat of a code hanging over him, as he would in the hospital.

I hope I taught the medical students and residents who were with me something important that day. Maybe we don't need to be so anxious about discussing death with our patients. Maybe we don't need to sugarcoat our words. While we can feel like failures if we acknowledge that our patient is going to die, that we can't help them anymore, avoiding the issue places the suffering onto our patients, who are already thinking about their own deaths, but are too nervous to bring up the topic with us. It seems kinder to spend our energy on attending to those patients we can help and offering comfort and care to those we cannot.

About the Author

Harriet Squier is a retired family medicine physician. She now lives in Michigan with her husband and three cats in the midst of a huge flower garden. Email: flowerdocs@yahoo.com

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Storytelling on the Borders

Paula Holmes-Rodman

What is the last story you would tell? Scribe poised, pen in hand, questions open, cardboard-backed lined paper ready to go, clock ticking–what would you say?

The ticking clock was hers, not mine. I had time. I had asked before, but only in the scant week before her medically assisted death at 3:00 p.m., July fourth, did Mom want to talk about her life. For me to get it down. We spoke for just an hour each evening, or maybe a bit more to squeeze in a tale's ending. She tired so easily, and her words were cough-punctuated and whiskey-watered.

I came to think of our narrative cocktail hour as *Scotch and Stories*. Scotch for her, always and, on this occasion, for me too. Shepherding the dying, and dying itself, is ghostly, thirsty work. The stories were for me, upon my request, but told in her order. It was prescription of the highest rank. My mother was a reluctant storyteller. I was a willing recruit, desperate to learn even the littlest of the yet-unlearned lessons, hear even the tiniest fragment of a yet-unheard story. An ethnographer by trade and a literary stringsaver by heart, I knew the value of a good story, especially one gathered on the borders between two lands, two people, two eras.

My notes from *Scotch and Stories* began in bright blue pen, in an upright cursive, the rounded and childishly neat printing that belied my education and age, the letter "a" still bubbled just like the letters my favourite substitute teacher had written on the chalkboard in the third grade. Notes were made in point form, with lots of space in between, as if I might have time, as if there might *be* time later on, to fill in the blanks.

Time, like death itself, slanted in, and my handwriting became faster and more tilted as the days wore on. The ink in my first pen grew faint, and I borrowed a black one from her, the pen she used to complete crossword puzzles, then I needed another from the bottom of my purse a day later. Black and blue, back and forth, scribbles and splotches, arrows and margin shoots, faintly scrawled and deeply indented.

I began my notes for *Scotch and Stories* under one of my last, by no means my first, death-related "to do" lists. There are advantages to a medically assisted death. You get to make lists. Lots of lists. Seven days before her appointed hour, Mom wanted me to take note of the following before the endtime storytelling could begin:

- Insure the mortar and pestle separately. Grandma said it's 16th century Aztec. (It isn't.)
- Post a message on her Facebook site saying she's passed away (after the fact). Then take the site down.
- Add Netflix, World Vision, and the house insurance to the (other) "to cancel" list.
- Call Jackie and ask if the gardening group wants any of her tools.

- Make sure her death is quiet, low key, and relatively private.
- No "ocean sunset-themed cardboard scatter tube" from the funeral home for her ashes. Use the blue and white jar from the thrift store as the urn, the big one in her bedroom. Wash first. Probably covered in dog fur.
- Scatter her ashes in the Tsolum River, where the fawn lilies grow, behind the Exhibition Grounds.

Mom started young and ended old in her telling. Day by day, we moved from her childhood in Calgary and the rural areas around it, to her university days in Montana, to her life as a young mother and wife of a PhD student in St. Louis, to the decades in Ontario where our little family finally put down roots and tried farming and philosophy.

She forgot to talk about the week-long, post-divorce road trip from Ontario back to Alberta that she, my sister, and I made (with two cats and no car radio). Perhaps she knew I'd never forget that westward resettlement, complete with its soundtrack of yowling cats and singalong folk songs. She only said that the scent of pine needles had called her back home, back West.

Mom spoke of her delayed, but successful, career at the University of Calgary as a teacher and administrator, and her much-wished-for retirement to the West Coast, to a small house three blocks from my own, where she could, finally, wear sensible shoes, grow a garden, and walk her dogs.

There we sat, in that little bungalow, sipping scotch, a grey-muzzled pre-rehomed cocker spaniel beside Mom, and me across the living room, in a red leather chair she loved. On a small table to my left was a line of used pens and a coiled notebook scrawled with the narrative entirety of my mother's legacy. She had storied us all the way to the present day, and it was finished. Or so I thought.

On July third, the last full day, Mom circled back beyond her own memories to an old family story from over one hundred years ago, when her grandparents made the long journey from Danville, Québec to the western frontier, and settled on a windswept ridge just outside of High River, Alberta.

My record of Mom's last story, placed so precariously on the edge of time, is wrought in faint black, the words slanting down, down, down, barely contained in the proper lines. Pages of dashes, messy crowding, shortened words, unjoined letters, crossed out kinship references and place names. I had to get it down. Get it right.

Mom ended *Scotch and Stories* with a fully familiar, hauntingly tragic, and well-established piece of our settler family history. It's the story of a frontier medical mistake, with deeply-rooted identity implications and lasting resonance.

***

When my great-grandparents, Fred and Lillian McKeague, first arrived from out East, they homesteaded on Gladys Ridge, south of Calgary. They started married life in a little sod hut, but, as their story goes, with ranching cattle, building fences, good luck, and good relations with the neighbouring Blackfoot people, my settler ancestors did just fine. Except for when it came to children, doctoring, and God.

It was shortly after the Great Blizzard of 1906, which had decimated the herds across the Prairies. My great-grandmother Lillian was pregnant with her first child, and the doctor had stopped by during his usual horse and buggy rounds to see her. He left a short list of written instructions (I've always wondered what that list said), colic medicine for the baby, and a bottle of morphine for Lillian, in case it was needed. The medical practice at the time was to find a local woman or midwife to be with the new mother during the birth. When Lillian went into labour, the midwife was unavailable, so a daughter from the neighbouring farm was sent to help. She was entirely inexperienced and very young.

The baby boy, whom they named Frederick after his father, was born healthy, but lived for only a few days. For some lost reason, the neighbour girl gave the morphine to the baby, instead of the medicine for colic, and killed him. No one blames anything but youth, inexperience, and the wild edges of frontier life.

Lillian and Fred were distraught because their baby had died, but their grief was compounded by the fact that he had died without being christened. They belonged to, as Mom called it, "an upper-class kind of Anglicanism," which their ancestors had transplanted from the British Isles. When my great-grandparents walked into their little church on Gladys Ridge, bearing their swaddled, poisoned infant, their priest told them, (in words Mom had remembered), "Well, of course the baby won't go to heaven. He hasn't been blessed." Not only was the destination of little Frederick's soul in question, but he could not be buried in consecrated ground. The priest offered no posthumous options to spiritually fix this mortal medical mistake. Frontier life had a harsh reckoning for all. Lillian and Fred were so incensed that they stormed out, still clutching their first child, cold and unbaptized, and never set foot inside the Anglican church again.

Bereaved and displaced, my great grandparents left the homestead, moved a short distance west to the growing town of High River, and began life again in a small bungalow they ordered from the Sears and Roebucks catalogue for CND $710. Their little house arrived by rail, sealed with red wax, complete with its own list of assembly instructions. Re-rooted, my great-grandparents joined the local United Church, and found faith and belonging there. Nine years later, to the exact day of baby Frederick's death, my grandfather was born.

It was only recently that my aunt found the baby's final resting place. His is a lonely and windworn grave, embraced by a line of cottonwood trees where perhaps a fence used to be. He was buried, ultimately—although this story *is* a blank page—across the street from the High River Anglican Church, snuggled up against the borderlands from which his wee self, body and soul, was cast out. There are no surrounding graves.

* * *

My mother's storytelling ends here. The unused portion of my coil notebook is silent, barren, tracked with the deeply indented and ghostly footprints of all that crossed geography, all that backing and forthing across distance and time.

What to do with this narrative legacy? Why was Mom's final story that of a medical mistake so many generations back? She offered no explanation. *Scotch and Stories* simply ended with the harrowing vignette of Lillian and Fred, their poor baby boy, the villain priest, and the bald fact of their churchly exodus. I have parsed the meaning of it all, to the letter, to the breath. Was Mom warning me against the Church? Or against faith? Against trusting frontier medicine? Or frontier preachers? Or offering a justification for her rebellious, "turn heel" kind of attitude?

Traced along kinship lines, faith initially appeared to be watered down with each generation. My great-grandparents' churchly swap out was a lateral, aching, searching step, danced on a harsh frontier in a time of grave personal grief and profound communal need. They raised their living children in the United Church, and my grandfather did the same, until a new preacher came to town, and his word was too fiery for my grandparents. Faith, in my family, became unsettled once more.

By the time my mom was a teenager, she and her younger siblings were allowed to make a choice about their Sunday mornings. They could either spend weekends at the little cabin west of Calgary, with Saturday nights at the old, round dance hall, and Sundays riding horses, or they could pack up the car and drive back into town late Saturday afternoon in time to go to church on Sunday. For a young woman, it was no choice all. The wildness of the West on the edges of Calgary pulled deeper than any preacher ever could, and Mom found all the blessing she sought on horseback, with the tall grasses brushing her knees, and the warm Alberta sun on her back.

By the time I was born, there was no baptism, no church on Sunday mornings for my mother's daughters. God was in the fawn lilies, on the ridges, in the community square dances, in the glory of riding your horse through the woods and then coming up over a rise—and in the smell of sun on the pine needles calling you home.

Final sign post(it)s

After all my death "to do" lists and my thirsting *Scotch and Stories*, came my swirl of yellow sticky notes, scrawled in those same fading pens over the same last week. I would walk the three blocks home, and between the calling and the organizing, the listing and the weeping, I dashed out some final remembered phrases. In searching for adhesions and attachments after the fact, I see that some of Mom's last words belong grafted onto those final, blank, hauntingly quiet pages. I realize that she entrusted me with a gentle, grounded gospel, both generational in its gestation time, and generative in its prescriptive intent.

Inscribed in this faded flurry, I found a small, life-affirming, death-rattled blessing and it is this: "I've lived on this earth. I'm grateful for the beauty I have seen, the family I have had, the music I have heard. These are no great things, just an ordinary life, coming to the end of its season. Now I'm going back to that soil so that other things can live."

What she bequeathed to me was not a faith diluted, as I originally imagined, but a faith fully rooted. Not just a story of loss, leaving, and rejection, but a story of finding, transplantation, and home. A story of faith, even on the edges.

Some of what Mom told me during *Scotch and Stories* was new to me, but the old dead-newborn story was mother's milk, a cautionary tale I'd heard all my life. What I had *not* yet heard, not yet fully incarnated, were the generational identity implications of this medical mistake, of this shearing, tragic, ancient accident. Faith survives on paper-fine edges, where death is deeply imprinted, and ghosts, both ancestral and unborn, inhabit the borderlands.

About the Author

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Rendezvous with the Senses: A Brainstem's Journey

Edison Tenecela

This is an imaginative art piece that seamlessly integrates the sensory organs, the central nervous system, and elements of the natural world. It creates a thought-provoking exploration in which the mind blends into the very environment it seeks to understand. By showcasing sensory structures such as the eyes and lips, along with the nervous system and limbic system (such as the brainstem and thalamus), the piece encourages a deeper appreciation of the connections between sensory function, perceptual processing, and the surrounding environment.

About the Author

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The Embodied Pain Scale

Zed Zha, MD

“On a scale of zero to ten, the patient finds her meth addiction to be a six,” says the medical student, presenting a patient to me at the addiction treatment center free clinic.

A six out of ten addiction? What does that mean? Amused and puzzled, I peeked at the paper he was reading from and realized that it was a formatted note. Under the “History of Present Illness” portion, there was a number scale named “severity.” The number 6 was circled.

Source: Wong-Baker, 2022

I imagined him asking, “From zero to ten, how bothersome is your addiction?”

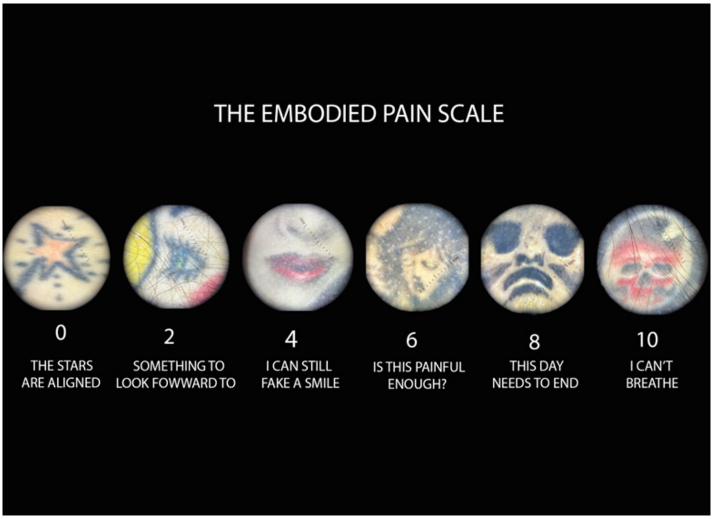
Then I imagined myself as the patient. “You mean the thing that ruined my family, took my career, landed me in jail, and for which I have been mandated by the court to come here and answer these silly questions? Hmm. Maybe a six.”

It’s almost funny.

As a science, medicine is obsessed with quantifying suffering, sometimes blindly so. There are certainly benefits to standardizing pain. For children (Garra, Singer, Taira, Chohan, Cardoz, Chisena, & Thode, Jr., 2010) or people unable to verbalize their pain (Kim, Park, Moon, & Han, 2017), pointing at a face or a number might be what they need for their care, especially in emergency settings. For research data collection, treatment efficacy tracking, and quality measurement, a numeric system can provide clarity (Gordon, 2016). However, as an art, healthcare delivery must look beyond the one-dimensionality of a pain score.

Perhaps the real question is, from zero to ten, how uninviting is the pain scale for patients who embody the multi-dimensionality of pain on a daily basis? To answer this question, in April of 2023, I asked my X (Twitter) #AskThePatient community for their thoughts. Almost 1,200 responded, and an overwhelming 80 percent found pain scores unhelpful in their medical care. Many even said they were harmful.

In this visual art piece, titled *The Embodied Pain Scale*, I hope to return the power of defining pain to the bodies that experience it. Here, the usual categorical faces are replaced by dermoscopic photos of actual patients' tattoos (with their permission). The legends underneath are quotes from people living with chronic pain, shared with me through the social media poll. The message is simple: Pain is more than skin deep, and so should be our interpretation of it.



0: “The stars must be aligned when I don’t feel pain. But I might have just learned not to show the pain and pretend for it to be 0.”

2: “I have had rheumatoid arthritis for 20+ years, and every movement hurts. I look forward to the day when my pain could be only 2. I can’t recall what that even feels like anymore.”

4: “I told the nurse my pain was 8. The nurse told me, ‘You are not an eight because if you were, you wouldn’t still be smiling and polite anymore.’ So, I told her it was a 4.”

6: “I am autistic. For years I couldn’t figure out how to put a number on pain, which was like asking which color tasted better. So, I always said six and hoped it would be ‘painful’ enough.”

> 8: “I have no idea what number to pick for my phantom pain other than ‘someone had to hold my arm for 20 hours a day so that I wouldn’t scream.’ I said eight so I didn’t get labeled a drug seeker. I just want this day to end.”
>
> 10: “I am a woman who had a a heart attack but no risk factors. My chest pain was 10 when I went to the ER, and I couldn’t breathe. They sent me home without addressing my pain. Why bother asking if you aren’t going to believe me?”

Disclaimer

The details of the medical conditions in the quotes above have been signficantly altered while preserving their essence to protect confidentiality. The dermoscopic tattoo images are a very small portion of larger tattoos, which make them unlikely to be identified. All tattoo images are given to the author voluntarily and with consent to use for artistic purposes. Additionally, the quotes and the tattoos do not match to the same individual in an attempt to further protect confidentiality.

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Ocean Swimming

Frances Milat

There is a connectedness between human bodies and bodies of water. We are interrelated. Our great oceans and waterways are our lifeblood, while our body's capillaries and vessels, like great tributaries and rivers, nourish and sustain our human form. We are part water, and we seek water.

The water near my home also sustains and heals. In the depths of our city's winter, a group of us gather at the sea's edge to share a swim. We all swim for different reasons, diluting the burden of illness or worry into the vastness of ocean. The winter sun soaks the shallows in silver light. We slip through waves, water silken, stress softening and sinking. Shards of light guide and bodies renew. For a time, we forget the weight of years.

These photos capture the journey of single autumn leaf floating through the winter sea. The image of the leaf, carried by water and basking in sun, captures the transformation of weary bodies into movement and light during a swim. We swim to be unburdened, to connect, and to heal.

Note: These photos were taken with an Olympus TG-6 and are unedited.

About the Artist

Frances Milat is a physician and researcher in Melbourne, Australia. She photographs and writes about nature and healing. Email: fran.milat@hudson.org.au

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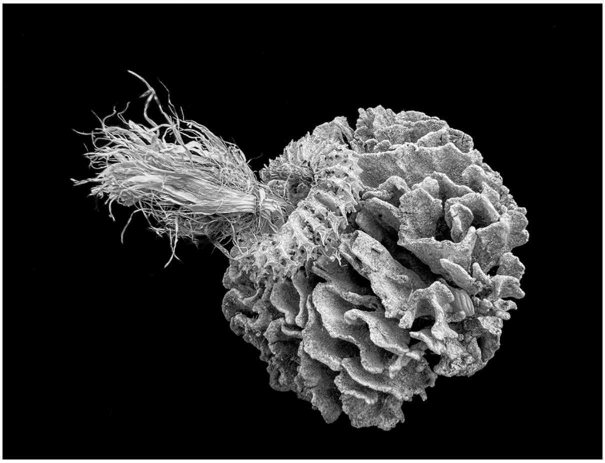
The Illusion of Resolution

Joanne Sinai

As a psychiatrist, I practice in a world of words but also images. I use photography as a form of creative expression. These photographs are inspired by the electron microscopy images I remember from medical school. They combine objects found in nature and/or handmade pieces created by other artists.



About the Artist

Joanne Sinai is a Clinical Associate Professor in the Department of Psychiatry at UBC. She practices in Victoria, BC. Her photography has won multiple prizes at the local yearly fair. Email: joanne.sinai@islandhealth.ca

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I Dream of a Needle / Articulate, Please / When the Screen Retracts

Susan J. Sample

I Dream of a Needle

boring into my back,
searching for furrows

in discs of bone. Last
week, Dad’s blood

drenched piles of gauze.
Look away,

the oncologist said,
drawing marrow

from his pelvic wing.
He feels only pressure,

no pain. Hurt
sounds different: a knock

after midnight when winds
moan ‘round the door

and joints unhinge.
I bend into notes

bruised as the winter sky.

Articulate Please

To *pronounce*, she says:
place the stethoscope
on the patient's chest
and listen for the lack

of a beat; press
fingers on arteries
in the neck and wrist,
making certain

you feel no pulse.
I begin to see
why doctors
omit the end

of the phrase.
But right now,
I need to hear
all of it—

every syllable, every
inaudible sound,
even if I, too,
must hold

my ear close
to a stranger's mouth—
so I can imagine
what I utterly am not, yet.

When the Screen Retracts

we turn to each other:
doctors, nurse,
therapists, chaplains—
nine in a hospital auditorium

for three hundred.
Photos of the recently deceased,
fully fleshed in living color,
dissolved into the digital.

What we just said
consoling unseen
family members—
not forgotten,

sadness, yes…
but love…alive—
seems safe,
our mouths re-masked,

until we gather
off stage. There,
something begins
to form, indistinct

from ourselves:
all our grief, sorrow,
and despair
stunning

as the ruby pendant
just above the neckline
of his nursing scrubs,
brilliant as it rises with his breath.

About the Author

Susan J. Sample, PhD, MFA, writer-in-residence at Huntsman Cancer Institute, University of Utah, is author of *Trapped in the Bone-House.*

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Choose Your Words Wisely

Karyssa Richardson

When you are standing there
Lecturing,
Telling of conditions, disorders, deficits

Remember,
That's someone's child.
Someone's whole world and daily experience.

As doctors we want to treat, heal, fix.
As parents we want joy, love, safety.

You say non-verbal, speech delayed, socially deficient.
I hear, he'll never say mommy or I love you;

What you don't say is that I will feel a love
So incredibly deep, he will not need words.
He shows it with his whole body.
I can feel it with my entire soul.

So please, choose your words wisely,

Teach difference, not damage
Teach acceptance, not conformance.

It may be a diagnosis to you,
But it's my child, my life, my reality.

About the Author

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Seizures or a New Brain:
There Will Be a Reckoning

Kimberly Anyadike

Unseen storm within,
Body quakes, mind's fragile dance;
Silent seismic waves.

About the Author

Kimberly Anyadike is a Doctor of Medicine with a degree from Oakland University William Beaumont School of Medicine in Rochester, Michigan.