

John J. Frey III, MD

2016 Writing Award Submissions

Poetry

1. **Aging** by Caitlin Regner, MD
2. **Bookends** by Melissa Stiles, MD
3. **Labor, the Fountain of Youth** by Caitlin Regner, MD
4. **Waiting** by Joan Hamblin, MD

Prose

5. **All the lonely people** by John Brill, MD
6. **Every Word, Every Gesture** by Dennis Baumgardner, MD
7. **Mysteries of science** by Jared Dubey, DO
8. **Online diagnosis is no substitute for a doctor** by Tina Ozbeki, MD
9. **Haq, Rieselbach: UW, Aurora team up for urban medicine**
by Cindy Haq, MD
10. **Visiting the home of a retired brushlands firefighter**
by Jon Temte, MD PhD
11. **Whomp, Whomp** by Kevin Wyne, MA MS

Aging

Elderly, proper, so put together.
She awaits us with her daughter,
Holding the thumb that is bent and bruised.
We ask all the questions we were taught.

I don't know,
I don't know,
I don't know.

She starts to cry.
The pain in her thumb a mere morsel
To the pain of losing her mind.

Bookends

Twenty-five years,

First and last memories, tied together

Bright blue eyes, easy smile, golden curls, not yet cut

A new life, a failing heart

It can't be, it shouldn't be

An ache so deep, it is still felt

Last day, boxes packed, knew she would be the last, should be the last

Generations surrounded her, most were familiar

Always insisted on a hug, she was ready

Bright blue eyes, easy smile, curls, only grey

Four days later, peaceful, at home, how she wanted

How it should be, they say, the ache lingers never the less

In between two lives, so many stories, emotions, so many ties

So much life....

Labor, the Fountain of Youth

Born in 1913.

A farmer's daughter.

I married a farmer.

With whom I raised four children.

Hard-work was my mode of operation.

And still is.

With a failing heart,

and an aching body,

I continue to exercise, play, and laugh.

Join hospice? Okay, I suppose.

One hundred and two is a good time to go.

Waiting

Mary's first labor

The nine month wait took forever.

Especially last two weeks.

Doc said no induction for healthy pregnancy

Finally, contractions come. Contractions go.

Waiting.

Contractions come. Contractions go.

Cervix not complete.

Not time to push.

Contractions come. Contractions go.

The clock strikes midnight.

Didn't want my baby born on Friday the 13th anyway.

All the Lonely People

John Brill, MD, MPH

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*All the lonely people,
Where do they all come from?
All the lonely people,
Where do they all belong?*

—The Beatles, “Eleanor Rigby” (Aug. 5, 1966)

The call from the medical examiner’s office was all too familiar. “Your patient, D.B., was found dead at home. The landlord checked his apartment after not seeing him for several days and discovered the body. It looks like he was on medicines for diabetes and high blood pressure; anything else? Well, there were no signs of foul play so the examiner plans to get a toxicology panel and sign it out as complications of diabetes. You don’t want an autopsy, do you?”

I open the patient’s chart to pronounce D.B. as “deceased.” Two clicks cancel his overdue diabetes tests and that optimistic colonoscopy referral made many months ago. Noticing his birth date, I reflect that D.B. was younger than he looked; it ages you terribly, social isolation. In fact I will soon be older than him.

“Are you sure you want to close this encounter?” the computer screen asks. I hesitate before sealing his chart for the last time. It feels like I should offer some final service. A memory arises from Catholic funeral rites: “Eternal rest grant unto him, O Lord, and let perpetual light shine upon him.”

There will be no other personal closure. I gave up looking for my patients’ listings in the obituaries a long time ago. One of the sad truths of our world is

that someone has to request and write an obituary, and in the realm of the urban underserved many of our patients do not have anyone to do so. There will be no funeral, no wake, not even a sermon that no one will hear. Many of my patients die this way, unmissed until eventually found dead by a landlord, a social worker, a pastor or the police doing a welfare check — someone whose job it is to care.

It occurs to me that I could write an obituary for D.B., but what would I say? “D.B. went to his eternal reward...” I don’t know what his beliefs might have been, what kind of undiscovered realm he foresaw for himself. “Born in...” I know when but not where. “D.B. is survived by...” Who? I think he mentioned a niece once. Looking for his emergency contact, I find someone only identified as “Jim.” The number is disconnected.

I realize that I spent D.B.’s infrequent visits trying to motivate him to watch his diet and take his pills; I know his medication doses better than his life story. I knew exactly how poorly his diabetes was controlled but not why or if it mattered to him. Why was he alone, and was he actually lonely? I guess I never asked.

Or perhaps what keeps me from memorializing him is the frightening reflection that we are not so different, D.B. and I. Does it really matter when and where and how we die? A hundred years from now, probably no one will remember much about either of us. We lived, we died. We both had our struggles and, I hope, moments of happiness and joy, where it all made sense. But if only a few paychecks separate each of us from homelessness, how quickly could the slings and arrows of life or our own choices and frailties condemn any one to isolation?

“Are you sure you want to close this encounter?” Yes. More words flicker in, this time from the final salute at military funerals: “Sleep in peace, comrade dear. God is near.”

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Every Word, Every Gesture

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Abstract

Two nonverbal patients teach a novice clinician the power and often hidden impact of the physician-patient relationship.

Keywords

physician-patient relations, communication, physician role, patient care

Thirty-five years ago, I took the requisite patient interviewing and social-medical courses in medical school. Even then, as detailed more recently,^{1,2} the importance of a background in humanities, the process of ethical reflection and the personal connection of the patient interview were emphasized. However, like most novice clinicians, I was ill-prepared for the practice, mutual impact and profound power of personal encounters with patients. Although it took years for the full impact of these “professional” relationships to be appreciated, two patients whom I encountered very early in my clinical practice taught me the most enduring lessons. I share them here in the hopes they provide similar value to others.

His nurses told me he couldn’t talk. Mr. C was a middle-aged man, a nursing home resident with long-standing hydrocephalus whom I was helping care for as a medical student while he was on our inpatient service for several weeks. There was a vague history that his condition had been neglected for a time in the past, leading to further deterioration of his functional abilities. He was cognitively handicapped and a “brittle” diabetic maintained on an unusual insulin regimen. Every morning during my rounds, I would greet him with, “Hi, Mr. C, how are you doing?” then busy myself with checking him over and making small talk to which he never responded. Still, every visit I would explain to him what was going on with his health and what we were trying to do. This went on for several days.

One night when I was required to stay on call in the hospital, I was paged by Mr. C’s nurse regarding hypoglycemia. His blood sugar was disconcertingly low, but not critical. Going to his bedside, I noted that he remained alert and able to follow simple commands. Intravenous access was usually impossible, and this night was to be no exception. We scrambled to find something

to safely feed him that he would accept. We hit on ice cream, and for the next two hours I spoonfed him at his bedside while the nurse checked his blood sugar at frequent intervals until he was stable. While I was a little bit sleepy, Mr. C was thoroughly enjoying himself. He had never smiled like that or been animated at any time during our previous encounters. Several times that night he looked right at me and gave me a great big smile. In many ways we were worlds apart; but I felt a bond, a genuine and personal human bond.

A morning or two later I entered his room and proffered my standard greeting: “Hi, Mr. C, how are you doing?” Anticipating another nonresponse, I started turning to his examination. “Not too good” was his slow, growly retort. I almost keeled over. They said he didn’t talk! Well, he did talk, and he continued to converse a bit more and for longer intervals each day. His physical status had not otherwise changed. To this day I have no idea why he started talking, but I will always feel that our 2 a.m. ice cream-fest had much to do with it.

My initial reflections on this “case,” other than the rather unexpected personal reward I felt from connecting with this patient, were superficial. I did get the sense that I should not ever “give up” attempting to communicate with a patient. Clearly, despite the struggles some face in relating to minimally conscious patients,³ it was perhaps possible to relate to any patient regardless of any perceived barriers. And I realized that I had a lot to learn about effective communication with patients with disabilities,⁴ a discussion beyond the scope of this essay. But it was only later that I realized my encounters with this gentleman went far beyond these technical issues. It was a lesson in the inherent dignity of each patient, regardless of circumstances, and their potential to positively influence all of those around them, including me.

The second encounter occurred when I was an intern at an urban hospital. One of the patients I “picked up” was Mr. S, a man about fiftyish in age who had been stricken with Guillain-Barré syndrome. He had nearly complete paralysis, was on a ventilator and was essentially noncommunicative. After weeks of ICU care without improvement, he was moved to a regular hospital room. Mr. S was nutritionally very poor. Several attempts at central line maintenance and hyperalimentation had failed due to blood stream infections, recurrent aspiration and intractable diarrhea. He could tolerate no more than 60 mL per hour of enteral feeding, and was markedly edematous in all extremities. For this reason, maintenance of intravenous access had progressed from difficult to impossible. Some time before, when he was more communicative, it had been decided to avoid further ICU care or treatment with central lines.

I saw him nearly every day during my 2-month rotation. All of us did our best to keep Mr. S comfortable and at homeostasis, despite being limited to liquid and intramuscular medications and supplements. At his daily examinations, I always greeted him by name and would briefly describe anything new we were doing and why. Sometimes I would talk about the weather or an item on the news. It was nothing special, my time was usually limited by a heavy patient load. He would listen impassively, his face puffy and mostly paralyzed. I never saw any family or friends visit him.

The end of the rotation finally came. I was convinced that I had made no personal impact on this patient whatsoever. Following my examination, I faced him and explained that this was my last day on service and that I would no longer be taking care of him. I mentioned the new resident’s

name and expressed that it had been a pleasure to care for him. When I looked into his eyes, they were streaming with tears. I was completely taken aback. Several days later, I received a page while working at another hospital. Mr. S had died. I knew that it was a blessing. I also had a sense that I had lost a great teacher, but could not completely comprehend in what way.

In the decades following these encounters, I eventually learned that the clinician-patient relationship, even if based on a single encounter, can be therapeutic.⁵ As Donald Sessions put it, “connection even for a brief moment produces the powerful enchantment of presence for patients and physicians,”² however, achieving such a connection seems to require the willingness to see the person behind the patient. This requires empathy, a quality Seamus O’Mahony states “cannot be taught”,¹ as well as a distinctive physician compassion.⁶ Fernando and Considine state that compassion “involves empathy, but includes the additional step of wanting to help and/or desiring to relieve the suffering of others” and conclude that “the capacity for compassion appears to be hardwired among humans.”⁶

But is it always true that empathy and compassion cannot be taught? Perhaps patients have the power to teach these virtues. For at least a century, there has been tension within societies between “population-based medical prioritization” and compassionate individual care of a patient, sometimes to an unfortunate extreme.⁷ In light of this dichotomy, the concept of “hardwired compassion”⁶ is a hopeful one. It is the thought that *care*, in the sense of compassionate regard for the dignity and well-being of the patient, trumps technological management. Petra Gelhaus stressed that compassionate care is “an attitude as well as an activity.”⁸

These two patients taught me that simply caring about them enough to make attempts to relate to them as people was meaningful. I learned that “activity” may be simply giving your time and presence. As film producer Martin Gabel was fond of instructing flailing actors: “Don’t just do something; stand there.” When you care, you wish to give. What you can give is your time and concern. To me, these patient encounters were lessons in compassion.

Medical technology is sometimes futile. Never futile are your best attempts at compassionate care for your patient. Every word, every gesture can have an impact — on both of you.

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Jared Dubey, DO
Family Medicine Resident

Mysteries of Science

Science is the collection and application of a certain kind of knowledge – that which is gained through observation and which can be repeatedly and consistently verified through prediction of natural phenomenon.

Science has progressed human knowledge and technology to previously unimaginable heights, but lest we lose sight of what science does not provide, here is an exploration of exactly that. The more sophisticated the theory, the deeper you may have to dig, but at the heart of all science, mystery awaits.

Take for example, gravity. Newton discovered (or invented?) a formula for predicting it, but shed no insight onto how or why the force existed. Then Einstein, reasoning from a radical and new conceptual model (mass warps space-time), refined the equations further. Einstein's more sophisticated theory seems at first to explain the etiology of gravity, but the question of why or how mass warps space-time...? Who knows. Even the elusive unified field theory, that materialist's dream, the holy grail that physicists hope will someday explain all natural phenomenon through the behavior of its most simple and irreducible parts – even this theoretical theory-of-everything would necessarily have at its very core, mystery.

I realize this comes off as quite damning. But I don't mean to be. Not at all. I'm a big fan of science. I love to learn about how things work. And I love all the math. All the predictability. Love it. And as for the application of science, well, it's all in the hands of the users... The costs and benefits of technology and industry, they are what they are (a discussion for another day). It's not my intent to pass judgment on the discipline.

If I thought that science was suffering from low self-esteem, I'd be at the front of the line to reassure and encourage. The issue here is with how people perceive science, and what we seem to mistakenly believe science has given us: an explanation for life, the universe, and everything.

Let me preempt you here: I'm not advocating for religion, per say. But, I am a big fan of mystery and wonder. I value what these feelings do for the human spirit; and unfortunately,

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these sentiments, which have been at the core of human experience for a long time, seem to be evaporating.

I am skeptical by nature; and I think that this makes me a good critical thinker. Before medical school, I worried that the education would make me even more of a traditional materialist. After all, wasn't medical science based on a biochemical model of the human body? Whereas before I had looked at my grumbling tummy with wonder, I expected that as a physician I would see neuropeptide hormone levels and smooth muscle contractions. Mystery solved right? Well, I couldn't have been more wrong. In fact (and this is really what I've been getting at) the more I've learned about the what (e.g. what makes your tummy grumble) the bigger the mystery of the why, how, and wtf.

So here is my hope: That we may simultaneously embrace the intricacies of our material world with the admission that we have no clue how or where it all comes from. For every bit of light that a new discovery sheds, let it be tempered by a deepening realization that the extent of our ignorance can never be measured. And may this realization allow us all to approach our lives with a renewed sense of wonder and reverence.

Online diagnosis is no substitute for a doctor

I've only been a resident at Verona Clinic for four months, but almost every day, I hear some version of this complaint: "I wasn't planning on coming in, but then I read on WebMD that this numbness and tingling could be a sign of diabetes!"

That's just a side effect of the Internet-heavy world we live in, where information about anything – maybe too much of it – is just a click away. But just like with everything else online, you have to be careful not to make too many assumptions about what you read. More and more patients are looking up their symptoms online, whether via Google or online symptom checkers such as the ones offered by WebMD or Mayo Clinic. Online symptom checkers can provide patients with information about possible conditions they may have, or they may direct the patient as to whether the symptoms need urgent or emergent care.

A recent review of online symptom checkers from a Harvard study showed that over one-third of American adults use the Internet to diagnose health conditions. The review concluded that across the 23 symptom checkers that were studied, the tools usually encouraged users to seek medical care in situations where self-care at home would be a reasonable option.

This is important to remember because self-care at home, when it is safe and reasonable, has the advantage of saving patients both time and money. Not only that, the symptom checkers provided the correct diagnosis in just one-third of cases. Compare that to physicians accurately diagnosing patients in about 85 percent of cases.

The vast difference in accuracy can partially be explained by the fact that symptom checkers use algorithms, much like we learn to follow in medical school, but without the ability to integrate aspects of the history and physical exam that physicians can when we see you in office or the emergency room or talk over the phone.

Family members, friends, and patients ask me about what they have read about online all the time, and I usually respond by acknowledging their concerns and explaining my thought process and rationale for my medical decision making. My colleagues and I sometimes struggle when patients come to the office fully expecting to be diagnosed with what they read on WebMD and are almost disappointed when we provide them with a different diagnosis.

Still, for some patients, the fact that the symptom checker brought them to me is a good thing. One was experiencing numbness and tingling in her feet, and I was glad that after a few years without seeing a physician, she had identified that she may have a concerning symptom of diabetes. Her visit was an opportunity to talk about risk factors for a chronic disease that ran in her family, as well as evaluate other symptoms she had. But she also could have been better served by having regular visits to her doctor, where she could have had ongoing conversations about her risk factors for diabetes and possible testing if necessary.

After having some tests done in office, she was reassured that she did not have diabetes. But since she did have a family history of diabetes, that laid the groundwork for a discussion about monitoring it in the future. Even better, she and I were able to start evaluating and treating her back pain, which she had been self-treating and was the real source of the numbness and tingling in her legs. Her office visit was a great opportunity to establish care, begin to treat an acute problem and work to prevent a chronic disease that runs in her family.

Whether you start with an online symptom checker or simply have a question about a symptom, you can always call the clinic and speak to a nurse. The nurse can direct your question to a doctor or advise you that yes, that crushing chest pain you're feeling probably means you should go straight to the emergency room.

Those of us in the health care profession recognize that online symptom checkers are not going anywhere anytime soon, and knowing how Internet use is growing among all age groups, I expect them to become even more prevalent. They can be a great resource for patients, but they are not a substitute for going to the doctor, and they are often wrong. So if you use symptom checkers to give yourself a preliminary diagnosis, make sure you follow up with your physician to get an opinion you can trust.

Tina Ozbeki, published in Verona Press on September 10, 2015.

Haq, Rieselbach: UW, Aurora team up for urban medicine

Cynthia Haq and Richard Rieselbach 7:23 p.m. CDT August 27, 2016

TRIUMPH program promotes health equity for disadvantaged communities.



(Photo: Tim Brinton)

The cauldron of poverty, segregation and racism in Milwaukee boiled over Aug. 13, and the whole world witnessed the frustration and anger expressed in Sherman Park.

Milwaukee has many positive efforts underway to address the painful realities in our city. One example is TRIUMPH (Training in Urban Medicine and Public Health), a University of Wisconsin School of Medicine and Public Health and Aurora Healthcare program designed to promote health equity in Milwaukee. With its enhanced role in the new UW Medical School curriculum, TRIUMPH is poised to sustain and eclipse its previous record of community engagement and healing when it is most sorely needed.

TRIUMPH embodies one of the most valued principles of the University of Wisconsin —The Wisconsin Idea. This idea encourages education as a vehicle to improve people's lives beyond the boundaries of the class room. This idea has been a guiding philosophy of university outreach efforts in Wisconsin for more than 100 years.

TRIUMPH provides a unique and challenging educational experience for UW medical students who are dedicated to serving urban, medically underserved communities. The program integrates clinical, community and public health, leadership and personal skill development in the Milwaukee setting.

TRIUMPH was established in 2008 as an evolution of the medical school's Milwaukee clinical campus established in 1974, with the goal to promote health equity and reduce chronic shortages of physicians in urban Wisconsin. TRIUMPH recruits and trains community-based physician leaders who will promote health equity in Wisconsin and beyond, working in partnership with more than 30 community organizations.

Students apply to TRIUMPH after joining the medical school. Sixteen new students are selected to join each year based on their commitment and capability to work with urban, medically underserved communities. They move to Milwaukee to complete clinical and community work in Aurora hospitals, Milwaukee area clinics and federally qualified community health centers during their third and fourth years of medical school. Students work closely with community-based physicians to gain clinical skills, working with patients from diverse backgrounds in the urban context. TRIUMPH students may also pursue MD-MPH and MD-Global Health options. Students collaborate with a variety of community partners to engage populations in community health improvement projects. They meet regularly with community and faculty mentors, devoting at least 160 hours toward their projects throughout their time in Milwaukee.

Students learn and serve in clinics committed to providing patient-centered care and delivering the latest care management and health care quality initiatives within Aurora. They also learn to respectfully engage with community organizations and members, and to apply public health skills to conduct population-based health improvement projects. TRIUMPH prepares students to become effective clinicians and community-engaged advocates with skills to address the social determinants of health and to promote the health of urban populations.

TRIUMPH outcomes have been most impressive, with more than 120 students enrolled to date. This diverse group of enthusiastic and highly motivated medical students have been well prepared and committed to working with urban, disadvantaged communities. Graduates enter top-tier residencies serving urban medically underserved populations to complete their training. Most have selected primary care careers and many have pursued MPH degrees. TRIUMPH graduates subsequently practice in central city clinics, community health centers and urban hospitals, with some becoming TRIUMPH faculty. They have become physician and community leaders and teachers in Milwaukee and nationwide.

Earlier this month, several articles in The New York Times described the crescendo of anger and frustration in Milwaukee. We believe that TRIUMPH, and other programs such as the Goldin Center of Children's Outing Association, should be widely recognized for their efforts to address these community challenges. These efforts can continue to grow with sustained and even greater support from Milwaukee philanthropists. Now is the time to invest in our community and to expand successful programs that are already making a difference in Milwaukee.

Cynthia Haq is director of TRIUMPH and Richard Rieselbach was the founding dean of the UW School of Medicine and Public Health Milwaukee campus. Both are faculty members.

Read or Share this story: <http://on.jsonl.in/2bOzdDK>

Visiting the home of a retired brushlands firefighter

Jon Temte, MD/PhD

The day was undecided between sun of mid-August and blustery sprinkles of late October, reminding us of our transitory nature. I really hadn't the time, but had made the promise to his mother, and she was traveling 45 miles to meet with us. I arrive 3 minutes early, despite missing the driveway on my first pass and having to navigate a cumbersome turnaround. I park, retrieve my black leather bag, find the entrance to the gathering of apartments, and dial #13. After about a minute of uncontested rings, I decide to go out and walk the complex. Number 13 was tucked behind a small courtyard. I find the screen door unlatched, knock and let myself in (*doctors are still given the benefit of the doubt*).

The home health assistant comes around the corner to greet me. "He's in here," she says, with only a trace of an accent. His world at 25 was that of a brushlands firefighter. He became aware of his condition while on a fire line in Yellowstone. By his late 30s, his world was defined by the motorized wheelchair, the limits of battery and accessible curbs. Another debulking surgery, another risk, sometimes another loss. At 47, his world contracted to the tether of a ventilator tube and skilled medical transport. My visit this day was in partial protest of the \$5,000 charge to transport him the nine blocks to our clinic for a post-hospitalization follow-up.

Instead, I am transported into his small world. The last I saw Josef had been in the hospital prior to his relocation to an out-of-town ventilator-support rehab facility. His mother petitioned to have him back to his apartment, and so it was. His eyes are exactly the same as at our last meeting nine months previously: twinkling kindness and mischievousness tarnished by melancholy. With the cuff deflated, he is able to talk fairly well; I can understand. After a few niceties, his mother arrives; she had managed to get her battery jumped after leaving the ignition on the night before. She carries the grit of an elderly immigrant with a voice stained by the old country. She is tough, maintaining through the loss of her daughter and husband. Josef is the last of her family in this hemisphere; she will likely outlive him. We both think this without saying. She lives away and on a rural acreage. Her home is a refuge in the south central Wisconsin sand country for birds and other animals. In her, I see the landscape from whence this firefighter came.

I spent the day before reviewing his records. I touch upon all the systems, the potential problems and possible modifications. In his microcosm, he sometimes thrives; sometimes descends into blackness. I keep notes on a 3x5 card in my pocket. The after-visit calls and documentation will come at a high cost to my limited time. I realize the delicate nature of medicine; the visit with the neurosurgeon with no planned follow-up; how he went to the urologist a month earlier to wait as the doctor was behind schedule and to leave at the demand of the skilled transport crew without being seen. I learn of the ultrasound ordered in haste; another trip, but for the wrong image. A renal CT is now pending.

I hold his hand as we chat. He cannot squeeze back, nor even feel my touch. It is there for me. He brings up his desire to be DNR. It is reasonable. Not for his mother—not at this time. We discuss the

particulars of such an order, the forms and wristbands. Perhaps for another day. I mention the fires burning across Washington, Oregon and California. Three young men—firefighters—had just died in a flare up. His eyes connote understanding. On my way out I get a warm hug from his mother. “Home visits... I thought they didn’t exist anymore.” Another hug; a heartfelt “thank you” on my way to the door. I will be back, every three months...

His mother has to move her van from the parking lot to somewhere she can stay a bit longer without risking a ticket. We meet briefly beyond the courtyard and discuss the wonder of catbirds.

Whomp-Whomp

Throughout my life, I have known implicitly that my mom loves me. This love does not manifest itself in elaborate surprise parties for special occasions. Nor is it passive aggressive; she never reminds me about the times I have forgotten to call her on her birthday or my parents' anniversary. Rather she loves me with the fierceness of a quality control expert at a nuclear power plant.

Many have lamented helicopter parenting as it prevents children from experiencing loss and therefore developing resiliency. But I also feel there is a subtle wisdom in my mom's zealous approach to protection. Despite her best efforts, I have certainly experienced pain, loss, and heartache in my life. I have coped as one does and learned from these difficult times. But as I have struggled occasionally, I have also grown more appreciative of the constant of my mom's love, even as it has been revealed in unusual ways.

My mom has always embraced an approach to preparation that any Eagle Scout would admire. As fair-haired babes of Irish descent, my mom was convinced that we were destined to get skin cancer unless drastic measures were taken. As a result, the slightest thought of leaving the house on a summer day led to us kids being doused in sunscreen to the point where passers-by thought we had albinism. Winters' dangers were arguably worse. At holiday gatherings, relatives were surprised when new members of the family were unearthed from beneath mounds of layered clothing, in case of frostbite at 30 degrees. "We didn't know there were three kids!" my aunt would exclaim. "We thought that the stroller was just a convenient way to carry all of the supplies." Indeed, when leaving the house, it was difficult to tell whether we were headed out to the park for an afternoon or migrating West along the Oregon Trail. In any case we were prepared.

While she and my father were cautious, they did want us kids to have a relatively normal childhood. So we participated in most activities that middle-class Minnesotans did. But the potential for danger always loomed. Trick-or-Treating on Halloween was done, but only with the utmost of care. Candy was of course meticulously inspected before consumption for razor blades, evidence of tampering, or tell-tale signs of poison. We didn't mind when the apples from our health-conscious neighbors were tossed, but lamented the homemade caramels or cookies that were thrown into the garbage for being much too risky. Our costumes had to meet the dual roles of protecting us from the elements as well as injury. Rather than Count Dracula or a caveman, my costume was usually that of a football player so that the padding could protect me in case of sudden snowstorms, drunken drivers speeding through crowds of unsuspecting kids, and aggressive mailboxes.

Actual sports were little better. As a 6-year-old, I was the only kid on my Tee-ball team forced to wear a helmet, not only when batting, but when I was in the outfield. In the outfield! I'm not sure if she was imagining random meteorites or debris from a passing jet liner careening towards my head. But the last conceivable risk would be a fly ball struck from a tee which endured the brunt of our awkward swings. Needless to say, this wardrobe choice did not help me develop a reputation as one of the cool kids. My embarrassment only worsened as I got older. Though shocking to consider now, the Minnesota fanaticism for hockey did manage to sway my mother into letting me participate for a couple seasons in junior high. Far from the traditional hockey mom, her cheering from the stands often consisted of cries of "pass it away" or "watch out" if the puck should happen to drift towards me.

As we moved away for college, the potential for danger and therefore my mother's anxiety only increased. Still my parents endured, and let us kids fly out of their orbit, though it was clear that this was not easy for them. With the number of variables outside of their control increasing exponentially, my parents focused on mundane details related to our safety or that might affect our long term health. Sunday night phone conversations frequently alternated between questions about classes or activities, with

generalized responses like “that’s good” or “uh-huh”, before an actual worry was made manifest by asking “when was the last time you got the oil checked on the car?” or “have you made an appointment to see the dentist?” While my roommates bemoaned organic chemistry grades to their parents, my mother fixated on whether or not I was flossing. Sometimes my parents only recourse was to highlight a danger that, however absurd, was something specific that they could warn us against. When leaving on a spring break trip to Nebraska with friends, my mom re-opened the car door to warn, “Make sure to watch out for drive-by shootings”.

One weekend when I was home visiting from college, I was at the dinner table with my parents and two siblings, both of whom were in high school at the time. My brother was telling a story about his day when my mother suddenly interrupted stating, “You know Kev, I hope you are checking your balls for lumps.” This comment was met with absolute silence. Partially chewed lettuce and bacon bits fell from my sister’s gaping mouth. My brother blinked several times while looking at my mother, dumbfounded. “Judy,” my father said. For a brief moment, I thought that he would put an end to this awkward situation by telling my mother that a reminder about feeling my scrotum for cancer was an inappropriate topic for Sunday dinner. But incredibly, his only reason for interrupting was to point out, “You should really call them ‘testicles’”.

As my sibs and I are all starting our own families, we have learned to screen information shared with my parents carefully to prevent worry. Although our spouses make snarky comments, we generally laugh off the monthly packet of newspaper clippings that arrives in the mail documenting the rise of some new virus, internet scam, or stolen identity risk that my mother has meticulously cut out and dated for our nonexistent files. Adventures on vacations, especially those abroad, are shared only after the fact. And information related to diet, sleep habits, finances, alcohol, sex, or other potential worrisome topics is kept to a minimum.

My parents have aged gracefully and have been enjoying their retirement, even as they admit that their rituals to ward off anxiety are a little excessive. Securing the house before bed involves making sure both cars are locked within the garage, that the garage itself is locked, that windows and doors are secured, that the security alarm is armed, and that a radio in the basement is turned on so that intruders, assuming they are able to make it past the above measures, may stop to think that perhaps someone is awake and abandon their nefarious plans. When my siblings and I have tried to point out that it would be about as likely for a criminal to break in as if the house was surrounded by a moat with archer towers, my parents just smile and say, “We know you think it’s silly, but we like to be careful and we have our routine”.

And who can blame them really? Who doesn’t have their inefficient habits that provide comfort and strange idiosyncrasies that their family has grown to love? If given the choice between excessive vigilance and disinterest, I’m not alone in preferring the former. Granted, my childhood might have been more relaxed had I not been fixated so much on potential disaster. When Mount St. Helens erupted in 1980, I feared that my family may be caught unawares by the slow moving lava and so I checked each night for any sign of an orange glow after the sun had gone down in Minnesota. This was not necessarily time well-spent, but the impulse to protect my family surely came from a good place.

And so I have come to see my parents’ anxieties not as the annoying fixations of OCD or another psychiatric disorder, but as expressions of affection. In recent years, my mother’s worry about the worst is usually most evident around Christmas where us kids are treated to safety equipment from “Santa” each year. A few weeks before the holiday, a large package will arrive with instructions to “please open as soon as possible”, in case the contents are needed before the holiday. Last year it was a winter survival kit for the car and included reflective triangles, 3 different sizes of batteries, a cell phone charger, a candle, a jar of peanut butter, a Snickers bar, matches, and a pair of wool socks. In year’s past, I’ve received bug spray, pepper spray, and bear spray – this was while living in Iowa, hardly known for its aggressive

grizzly population. I've gotten a foldable rope ladder when I lived in a second floor apartment, a carbon monoxide detector, emergency radios, several first aid kits, flashlights with the wattage of a lighthouse, and honest to God flares.

My mom is a firm believer that if you prepare for the worst, it is less likely to happen. Thankfully she is not a believer in the zombie apocalypse or other doomsday scenarios as I'd likely start getting actual weapons or cyanide tablets in the mail and end up on some sort of watch list. And to her credit, we have dug out the hand-crank emergency radio when the power has gone out, and I did set up the triangles while awaiting AAA after my car stalled recently (we have the family plan with free towing due to my mom's lifetime membership). Each time I have thought of her and have felt grateful for her foresight.

Thankfully, most of the imagined disasters have not occurred and the emergency gear has remained in its original packaging. Though the labels have faded and the batteries have no doubt expired, somehow I can't bear to throw them out. And so they remain, ready for rapid deployment against the chaos of the world, a constant reminder of my mother's love in the face of uncertainty.