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The Illnesses and The Oddities

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THE ILLNESSES AND THE ODDITIES

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by

Reina Lipkind

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To: Dean Michael R. Heithaus
College of Arts, Sciences and Education

This thesis, written by Reina Lipkind, and entitled The Illnesses and The Oddities, having been approved in respect to style and intellectual content, is referred to you for judgment.

We have read this thesis and recommend that it be approved.

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Michael P. Gillespie

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John Dufresne, Major Professor

Date of Defense: March 12, 2020

The thesis of Reina Lipkind is approved.

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Dean Michael R. Heithaus
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Andrés G. Gil
Vice President for Research and Economic Development
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Florida International University, 2020

ABSTRACT OF THE THESIS

THE ILLNESSES AND THE ODDITIES

by

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Florida International University, 2020

Miami, Florida

Professor John Dufresne, Major Professor

THE ILLNESSES AND THE ODDITIES is a linked memoir covering two decades the author worked as an Emergency Room physician before her unexpected retirement. Included are glimpses into the formation of the author's initial career as well as her prospective career.

Working in an overwhelmed system impacts treatment of patients and staff morale. Like Viet Nam in Tim O'Brien's "The Things They Carried," the ER can be a war zone, causing moral injury to those who deal with endless illnesses and odd events. Youthful experiences are recalled as the author encounters difficult situations, as in Jeannette Wall's "The Glass Castle."

Readers are offered new perspectives on the inner workings of a busy ER, its patients and staff, and insights into challenges encountered transitioning to a different vocation.

TABLE OF CONTENTS

Chapter I Back Story

It's quiet for a Saturday until Fire Rescue arrives with a critical patient at the Emergency Room where I work as an attending physician. They bring him from the county prison due to arrest—respiratory arrest. He is incarcerated in the prison psychiatric ward for reasons unknown to the ER staff. He was noted to choke on his meal, perhaps had a seizure, and stopped breathing. When Fire Rescue first arrived at the prison, they pumped oxygen into him manually with an Ambu (artificial manual breathing unit) bag and got his heart beating.

As soon as the patient arrives in the ER, I attempt to establish a good airway by placing a plastic endotracheal tube down his trachea, his windpipe, towards his lungs. Trouble is, corn filled vomit keeps coming up through the tube.

"Nope, doc. You're still not in!" the respiratory tech tells me, sounding annoyed that it is taking me so long to properly intubate the patient.

The tech thinks I put the tube in the patient's esophagus, leading to his lunch filled stomach. The patient's neck is short and thick, his jaw clenching and his mouth filling with partially digested food matter and cloudy liquid every time I try to peer in with the laryngoscope. We've been suctioning him over and over; the fluid continues to rise.

"How much did they feed this guy?" I mutter.

I sense the nurse and tech rolling their eyes at each other, a silent comment on my skill. A quarter of a century I've been doing this, and I'm still rather sensitive to criticism. But I really think the tube is in. The X-Ray proves I'm right. He's intubated,

just has lungs full of food, aspirated most likely while having a convulsion, a not uncommon occurrence.

"Please keep suctioning him, put down a nasogastric tube and call for a pulmonary consult. He might need to go to the operating room for bronchoscopy. Call the intensive care unit to see if they have a bed," I tell the intern standing nearest me.

He also rolls his eyes. The chance of the intensive care unit taking this admission is not great. This is a county hospital with limited resources and rarely enough beds for all those who need to be hospitalized. This guy is not a priority. Maybe later, maybe in a day or two, he'll finally get a unit bed. It's a constant battle, one of many between the ER and the rest of the hospital. The ER patients are viewed as a necessary evil, the population we serve. I've been leaning over this patient for ten minutes and now can't stand up straight. I stumble away from the critical zone towards the desk.

"You okay, doc?" the hospital secretary Laraynne asks me.

We share a chipped Formica counter that serves as our desk; she answers the telephone; I write my notes. We've known each other for over a decade.

Laraynne pushes a chair towards me, her rhinestone rings glittering in the fluorescent light.

"You want some Tylenol? I got some right here," Laraynne says, reaching into the pocket of her too tight lavender scrubs.

She hands me two tablets with no name marked. I look at her.

"Don't worry. I save the good stuff for myself."

I swallow them without water.

I don't know this is the last intubation I'll ever do or how much I will miss the patients, the many languages spoken, and the people I've worked with. I'll even miss the smell of fried catfish on Sunday mornings in the hospital cafeteria, served with the best cheese grits I've ever eaten.

A couple of days earlier, I had injured my back working in my yard. I hadn't thought twice about moving sixty-pound cement pavers one afternoon to make a sitting area with a French style café table and pair of folding chairs near the blooming jasmine vines that covered the chain-linked fence in the back corner of my yard. When I heard the faint crunch and felt sudden severe pain in my lower back, I thought I had pulled calcified muscle fibers. After all, even for big strong me, lifting the fifth or sixth paver was a little much.

Bending over while intubating that patient a few days after injuring my back was difficult but not as difficult as trying to stand upright afterwards. I went to an orthopedic surgeon that Monday and an X-Ray revealed a chip fracture of my lumbar spine. The orthopedist ordered an MRI. In order to get my hospital funded insurance to pay for it, the MRI had to be done on an emergency basis. Crazy, me, to be registered as an ER patient. This was far from what I would define as an emergency, although due to the fracture, I couldn't perform my work duties, like intubate patients, without pain. All those uninsured people I have cared for and now to find myself, a taxpaying upstanding citizen who never got into an altercation, never drove drunk, never did drugs, having trouble getting the insurance company to pay for this study.

It was strange to be lying there in a clanging MRI machine in the cold radiology suite. I was always on the other side of these stretchers. Dun colored particles dangled

precariously above my head. I closed my eyes and wondered if a trauma patient had sneezed their brains out while encased in this body-sized tube. Like old carrot scrapings, they jiggled above me as I lay still inside the machine. I'd worked as an Emergency Room physician for decades and knew whatever those hanging scraps were, I didn't want them falling on my face.

I remember it seemed the MRI was taking a long time. I'd ordered hundreds for other patients but never before had I had one. The technician sat in cubicle, a safety enclosure next to the MRI machine where I lay strapped to a board. Me, strapped on a board, unreal. He said he needed to repeat a few views.

"Why?" I asked.

He didn't answer.

After a while longer, the MRI was completed. I took off the hospital gown and dressed back into my black silky pants and top, a nice outfit for a warm spring day. The Neuroradiology Fellow looked at the films while I peered over his shoulder, breathing down his neck, something I hated people to do to me.

"There's no neurological impingement from the fracture. But there's an abnormality in your pancreas," the Neuroradiology Fellow said.

He pointed out an area in my pancreas, visible on the films that were taken in order to see my lumbar spine. I didn't know how to read MRIs beyond the most basic findings. He stood up quickly and took the films into the adjoining radiology reading room to show his attending. I followed him, feeling very out of place but not wanting to miss a word of what they said to each other. I knew the difference between information

discussed between physicians and the information given patients, the lack of precise detail, the differential diagnosis not quite fully explained.

The reading room was dark except for the background glow from the big metal machines that held the actual hard copies of the films on rotating lit screens. At that time, radiological studies were not yet fully digitalized on computer screens.

The somber room held the attending and radiology residents and a couple of medical students. There were different white coats, some short, some longer. I wasn't wearing a white coat but had attached my employee ID to my blouse.

"Hi. I'm one of the attending physicians from the ER," I said to the seated attending. "I injured my back a few days ago."

The attending introduced herself but didn't shake my hand. I didn't catch her name. She spoke with a foreign accent, perhaps German, and mumbled something about mass, nodes, cysts. I didn't really understand. I felt fine except for pain in my lower back when I moved. I wasn't even taking the strong analgesic the orthopedist had prescribed. It made me feel both nauseated and tired.

Suddenly, I was a patient, not a doctor. In this cold, dark room, multiple sets of eyes avoided contact with mine. I knew that meant bad news, that gaze avoidance when delivering information. Although trained professionals, doctors are still human and it is a natural and difficult to control response when being the bearer of bad news.

Just then, another physician, an elder statesman of ultrasound, happened to walk by. He looked like Ricardo Montalban in a crisp and spotless white coat. It was serendipitous that he strolled past us that moment. He was the best specialist I could