AN ABSTRACT OF THE THESIS OF

Yuko Iwanaga for the degree of Honors Baccalaureate of Science in Biology presented on May 26, 2009. Title: Multiple Personality "Order": Various Approaches to Patient Care.

Abstract approved:

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Eric Hill

As an observer shadowing a physician in the Emergency Department, I witnessed many patients coming to the hospital with various diseases, conditions, mental and emotional states, and background. At the moment I am watching the scene happening right in front of my eyes, I tell myself I will never forget what just happened. Yet, as time goes by, my memories begin to slowly fade and my thoughts and feelings are forgotten. In order for me to remember my precious experiences, I knew I had to write it down, which is why I decided to write a compilation of short stories for my Honors College Thesis project. The following are four stories about my shadowing experiences in the Emergency room and experiences at a nursing home facility, where I worked. The overall theme that runs commonly throughout the four stories addresses the questions, "What does it mean to be a professional in health care?" and "What does patient care involve?" Such issues are discussed in addition to ethical and personal issues that arouse while I was reflecting back on my experience.

Key words: patient care, ethics, emergency room, medicine

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Multiple Personality "Order"

Various Approaches to Patient Care

by

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I understand that my project will become part of the permanent collection of Oregon State University, University Honors College. My signature below authorizes release of my project to any reader upon request.

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Yuko Iwanaga, Author

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Case #1: No Room for Tears

I walked into the ER department at 7am and one of the first things I noticed was how quiet it was. I had imagined this area of the hospital to be chaotic and filled with people running up and down the hallway, with patients screaming from their rooms in pain, just like on the show, "ER." Contrary to my expectation, it was quiet, relaxed, and peaceful. Just when I thought my first day of shadowing was going to end with no drama, the entropy of the atmosphere increased quickly.

Some RNs started getting the trauma one room ready, while another RN wheeled in a "full-code" patient from the front. The woman was in her sixties, wearing glasses, gray, curly hair, and was wearing a flowered dress. She was completely unresponsiveness in her wheelchair. The medical team immediately placed her on the stretcher and cut her clothes open while calling out her name to determine if she was conscious. I was standing by her foot, witnessing the full exposure of her body. Her clothes were shredded in pieces, on the floor, and she had no control of her body. She was just lying exposed on the stretcher.

That's when one of the nurses asked me if I could find a pulse in her groin. Startled by this request, I placed my two fingers on her right thigh, trying to locate a pulse. Nothing. I moved my fingers upward a little, picturing the human anatomy diagram from my textbook. Still nothing. Frustrated with myself, I searched for the thumping of the blood, but I could only feel the warmth of her leg conducted towards my fingertips.

Then all of a sudden another wave of people came rushing into the room, including the EKG technician, an anesthesiologist, a surgeon from cardiology, and more

nurses, all working on different parts of her body. I felt out of place just standing there, so I took a couple steps backward toward the corner of the room, hoping to get out of their way. The team did everything, from trying to get I&O in her legs to CPR, shocking her with a defibrillator, putting an IV-line in her arms, hooking her up to a monitor to observe her heart beat, and placing a mouth piece for oxygen.

I'd seen this "scene" many times on medical shows, but this was nothing like television. When I see someone dying on TV, I feel sad, but the next moment I am laughing at a commercial or at a joke told by my friend. That was not the case here. What I was seeing was real. Usually, I can identify which emotion I am experiencing at the moment, whether it is joy, happiness, anger, etc. But I couldn't, not now. I was experiencing too many emotions at once; horror, distress, anxiety, panic, shock. It was like my sympathetic nervous system decided to release multiple alarming emotions simultaneously. I caught myself coughing a couple times and experiencing dyspnea. I was so concentrated on everything that was going on in front of my eyes that I had forgotten to breathe. As I just stood in the room like a statue, I was pushed farther towards the corner as a nurse told me to get out of the way. I felt useless because I couldn't do anything to help be part of the team and revive the patient. All my knowledge from biology and chemistry classes was useless here. I'd wished I was already in medical school so I could at least receive the proper education and training in order to be able to do something in a crisis like this.

The team worked on the woman for about 30 minutes but she died on the table as the doctor called, "Time of death, 10:42am." When I saw the nurses wheeling her out,

her face was pale, and cyanosis of her lips had begun. Everything happened so quickly I still couldn't believe that someone could die just like that.

When I walked back to the nurse station, something wet and warm started rolling down my cheeks. At first, the tears came out slow and in tiny, beaded drops. I wiped them quickly and tried to hide it, forcing myself to stop them from coming out. A couple of seconds later, it turned into a leaking faucet: messy and unstoppable. I was shocked, sad, angry, confused, all jumbled together at once. Millions of questions raced through my head. Was there anything else that could have been done? Could another shock with the paddles have brought her life back? Was it really time for her to die? Another shocking thing was how the medical staff "got over it" so quickly. The nurses went back to seeing other patients, the room was cleaned like nothing had happened there, and the calm, peaceful atmosphere returned. Still to this day, I can hear the family members mourning over the death of their loved one and the warmness of the woman's leg.

As I reflect back on this experience, two subjects surface regarding practice in medicine. The first issue regards respect and dignity for a person, specifically for an unconscious patient such as in this case. After watching many forceful procedures imposed on the patient simultaneously without consent, I wonder where trauma cases fall on the spectrum of respect and dignity. Is there a different "type" of respect for those that are unconscious and are on the verge of death? Is one allowed to do *anything* as long the patient revives? In other words, do the ends justify all means?

I believe that everyone deserves respect, whether the person is conscious or not. Being unconscious is sort of like being asleep; lacking sensory perception, movement, and allowing the body to rest. We treat respectfully those that are sleeping because they

are still alive. When an unconscious patient enters the hospital, equal treatment with respect is expected. Actions such as covering the body with a blanket during treatment, closing the door for privacy, and calling out procedures being done on the person should be standard practice. The patient may not be able to see or talk, but they are known to be able to hear and "feel" what is going on, just like any one of us.

The Emergency room is a very special place. Most trauma patients come to the hospital in critical conditions with only limited time before permanent brain damage or death. The medical team does not have the luxury to follow the usual, proper bedside manner of taking a detailed history, finding out what medication they are on, or allergic to, and simply introducing names to each other. Though one cannot gain a verbal or written consent, we assume that the patient is in the hospital because they need to be treated. As physicians and healthcare professionals, we are to give, under the beneficence principle, the best possible care for each and every patient for their well being. Consciousness should not be a determining factor for the amount of respect one receives.

This respect should be extended to the family as well. Many times family members are not included in the "circle" of what is going on; they are only part of the beginning and the end of the whole incident. Giving updates of the current situation and, what is being done throughout the long, stressful process would help alleviate their emotional distress. Respect also includes providing a detailed, thorough explanation of what procedures were conducted and the cause of death, which I feel are crucial parts of medical practice. Studies show a majority of the complaints and lawsuits from family members stems from lack of communication between the medical staff and the family.

Based on my personal experience with my grandmother's death, I know that only being told "We did everything we could" just isn't enough.

The second matter revolves around the emotional detachment essential to professionalism. This inquiry stems from my observation of the behaviors of the medical staff postmortem of the patient. I was the only one who broke down crying in the whole department. Why wasn't anyone else deeply affected by this event? Was it because everyone was older, more emotionally mature than me? Is my lacrimal gland hypersensitive compared to others? Are they being paid not to cry?

Initially, I thought the significant difference in emotional reaction was due to experience. As a physician or a nurse in the ER, the staff probably has witnessed many similar cases involving death. With prior experience, one can know what to expect, have an idea of what it is like, so it doesn't shock or take you by surprise the next time it happens. ER personnel recognize that crises and deaths are part of their job, a practice of desensitization. If this theory were true, I should not be so distraught if I saw another traumatic death because I'd gone through it before. Yet, I couldn't guarantee myself that I wouldn't. I felt as though I still didn't quite have the whole picture. What was it that made me different from the medical team? What makes them professionals?

When I analyzed this subject further, I reached two possible reasons that will explain such phenomenon: the need for objectification and separation of external and internal self. We have all heard of surgeons needing to perceive their patients as "objects" in order for them to cut into a live body. I noticed a similar behavior in the ER as the team poked, probed, and shocked the body from head to toe. In order to be able to treat a person in such a way, a person is required to view the patient as a tangible object.

One must concentrate on the physical mechanism of the treatment, not the psychological or emotional aspect of it. The moment one develops an attachment or relates him or herself with the patient on a human-to-human level, the door to personal vulnerability is fully exposed. This could lead to a cascading effect, potentially causing harm or pain to either the patient or the self. It is essential for one to keep this door closed and even locked, so overwhelming emotions cannot dominate one's medical practice, as well as causing harm in the work of others. Imagine working with someone who cries every time he or she encounters a trauma patient, not being able to control themselves. Not only will it cause distraction, but the medical team would not be able to function efficiently and effectively, which may lead to an undesired outcome that could have been prevented or treated. Being professional is not just about your behavior and attitude towards your job, but it is also about how one interacts and works with other staff members as well.

By keeping one's emotions shut out from practice, one creates a defined distinction between the internal and external self. Is it really possible for one to consciously or subconsciously be conditioned to not feel anything? Is it possible for one to see someone suffering or dying and not feel *any* sadness? I have a hard time believing that such thing can be possible, especially for everyone working in the medical field to uniformly achieve. Doctors and nurses are human beings too, not mechanical robots who can be programmed to "turn off" emotions. Perhaps the medical team still feels these emotions internally, but is conditioned not to express them on the surface. This will allow them to maintain their professionalism, but at the same time still be a human being.

As a professional, it is important to build this wall between the internal and external self once you step into your work place. This is different from putting a mask on

to portray something you really aren't or don't have inside. This wall helps one from breaking down and prevents one from not being able to do their job. I was not able to build this wall in the ER, which is why my internal self directly flooded out towards my external self. The next time I encounter a traumatic situation, I might not be able to control what I feel, but I will definitely try to control my emotions from being outwardly expressed so I can be professional.

Case #2: My favorite resident, Bob

One of the golden rules as a healthcare professional is to set a boundary between personal and professional relationships. As we interact with the same residents everyday, caring and helping them with their daily activities, it is easy to become attached. They become more than just residents you have to care for. Even the grumpy, screaming, abusive residents seem approachable as persons when you get to really know them and empathize with their situation. But where does a professional draw the line? How do you control your emotions so you don't cross into a personal relationship?

As a college student, the majority of my daily interactions involve people who are similar to me: healthy and mobile. When I take a step inside my workplace, suddenly, it is as if I am in a different world. The people I interact with have AIDS, Alzheimer's, Parkinson's, dementia, depression, paralysis, arthritis, and the list goes on. One of the unforgettable memories I have is of Bob, who is one of my favorite resident of all time. This is the story of Bob, a person suffering from Rheumatoid arthritis, who helped me see a different side to patient care: one with room for empathetic emotions. . .

When I first started working with him, my first impression was, “He must really like TV,” because Bob would sit in his wheelchair and watch whatever was on channel four from breakfast to when he went to bed at night. He was quiet, calm, compliant, and reserved. He didn’t interact with other residents or with any caregivers. He never complained, caused trouble, or asked for anything except for one thing: shaving his facial hair every morning. At the beginning of our encounter, he was able to shave on his own using his own shaver. As his arthritis progressed, his fingers became curled and twisted, prohibiting him from doing the one thing that brought light to his eyes.

I could sense his frustration and anger as he gradually lost control of his body. I felt useless because I couldn’t do anything to stop the progression or cure his condition. I thought the least I could do was to get his mind off of his arthritis, even for a brief moment. I began asking him not just the usual, “How are you?” questions but more personal questions, such as what his favorite color was, where he was from, what his childhood was like – trying to find a topic that would trigger him to talk to me. When I asked him about his family, children, grandchildren, bingo! Bob started telling me about every detail of who was who, and what they were like. He showed me a picture of his family as he talked about his three children, whom they all lived out of state and only came during holiday seasons. He said he would like to see them more often, but he understands that they are all really busy with their own families and life now. He said it’s “just how things are” with such an impartial face, but I knew deep down he was lonely and would like his family to visit him more often.

Over the next couple months, Bob and I would have “mini-updates” of both the good and bad things that happened that day as I worked on the range of motion of his

fingers and joints. Then he would tell me a story from when he was a soldier during World War II. He was beaming with pride and confidence when he spoke about what it was like back then. At one point, he was stationed in Okinawa, where he said he ate strange foods he had never had before, such as dried seaweed and *miso soup* with lots of seafood inside. Bob said he learned how to say thank you "*arigatou*" in Japanese. It was amazing how the two of us from completely different background, culture, and generation could have something in common. It felt like Bob was more than just a resident for me; he was like an old friend who I hadn't seen in years and we were trying to catch up with our life stories.

As midterm season began at school, I had to take two weeks off of work. When I told Bob this, he looked down at his hands and didn't say anything. As the end of my shift came, I went to check on Bob once more to make sure everything was set for bed. When I got to his bed, he was still awake, which was unusual since he usually went to sleep early. When I went over to him to tell him good night, he looked up and asked me when I was going to be back. I told him in two weeks. He then quietly said he was going to miss me a lot. I told him I would too and that we were going to have a lot of catching up to do. I left that day from work with Bob's sad face in mind.

On the day I came back to work, one of the first things I noticed was Bob's growing beard. I immediately asked him why he was looking like Santa Claus and was shocked to hear that he hadn't been shaved at all for the past week. I didn't care if I was missing my fifteen minute break, shaving Bob was top priority for me. When I turned on his shaver, the batteries were dead. It made me angry to think that he was left like this, that no one noticed his facial hair growing. When I was done shaving, I brought out a

small mirror from his drawer and told him how handsome he looked. Bob quietly viewed his reflection, slowly touching his face with his curled fingers. While I was cleaning up my equipment, he softly said, "*Arigatou*, Yuko, for always helping me." Until then, that moment, I never knew that "thank you" could have such a significant meaning and be so rewarding.

Reflecting back on this special memory with Bob, two topics come to mind for further discussion. First, based on our current societal trend in America, a different degree or level of human dignity exists. This amount of dignity seems to have a negative correlation with one's increasing age. Much of the societal focus is on the younger generation, those who can work and contribute to the larger good. The elderly population is pushed aside to an invisible corner, as if they are not worth anything to the community anymore. As rational human beings, we should all be aware of the fact that one day, we will be there, in their shoes. Instead of accepting the natural development of the body, surgical technology and anti-aging products flourish because people do acknowledge this fact and fear not being treated with the dignity of a whole person.

Aging doesn't make people become less human or have less dignity. It actually makes them "more human" because as they get closer towards death, they don't have to put on a mask and worry about what other people think of them. They can be who they are and let their innate, natural being shine through, thus the more reason for them to be given higher levels of dignity and respect in this stage of life. I long for our society to create a better environment and attitude for the elderly population via providing more facilities and/or various foci of care to meet the needs of this age group, allowing them to

feel wanted, loved, and a sense of belonging in the community. I have seen too many people disconnected from the community, treated without dignity, and dying alone.

The second issue, as stated earlier, involves professionalism regarding relationships with people one is caring for. Both in the ER and in the nursing home, the main goal is providing treatment that benefits the patient. Yet, the definition of treatment is different in the two facilities. People come to the ER because they are seeking medical help and consider the visit to be temporary. They don't come to the ER to look for friendships. However, it is a different story in a nursing home. Many residents are staying there permanently. Stripped down to a box of personal belongings that they can bring with them, far away from their home and family, sometimes they need more than medical assistance. Different residents have different needs. Some prefer not to have any relationships with anyone, while others seek the chance for any human interaction possible. The important thing as a healthcare professional is to be flexible, adaptive, and listen to the voices of the residents.

Case #3: Handcuffed Patients

"Let me go you son of a B****!" "F*** you all!" One would not think to hear such harsh, insulting words in a hospital environment, but I heard them, lots of them, loud and clear. Over the last six months of shadowing my physician in the ER, I have witnessed many patients come through the door, led by police officers. Majority of them were extremely intoxicated, incoherent, uncooperative, and desperate. The following stories are about two patients who came to the ER . . . in handcuffs.

When I still think back about this event, my heart starts to thump a little faster because my memories of him are vivid even to this day. It was a Friday night, the time of the week when the ER is packed with patients, both inside the rooms and outside in the lobby, waiting for their turn to be seen. I was following behind Dr. T, taking notes, asking questions about his diagnosis, when suddenly two big police officers came through the door. In between them was a man in his late forties, barely able to walk on his two feet. The police officers led him into trauma 2 room, where he was told to lay down on the stretcher. I remember going into the room with Dr. T and one of the first things that hit me was the smell of alcohol. It was very strong, sour, and overwhelming. The nurses were trying to get his history, clean up his dried blood on his forehead and scratches, but the man kept on fighting them off. He repeatedly told the nurses that he didn't need help and that "no one listened to him anymore." One of the officers was telling the doctor how the patient had gotten into a fist fight at a bar with another customer. By the time the police officers reported to the scene, the patient was extremely agitated, aggressive, screaming and yelling towards everyone who came near him. When they tried to calm him down, he made an attempt to run away, so the officers had to "take him down," which was when he got a deep cut towards the back of his head from hitting the concrete. The officers brought him in to the ER so he can get stitched and receive medical clearance before they can take him to jail.

As Dr. T was getting ready to treat the wound, I was trying to figure out where to stand. I wanted to see the procedure up close because I had never seen such a huge cut, but simultaneously, I was scared to be too close. Should I stand near the door as far away from the man? Or should I stand next to Dr. T? I decided to take my chances and stand

next to Dr. T because my curiosity beat my fear. The man noticed me standing near him. He looked at my name tag and started asking me one question after another. "Yuko . . .is that Japanese? Are you Japanese? Are you a student? Where do you go? What are you studying?" I could feel my fingers and toes getting really cold. I was really scared. I know that you have to treat everyone equally, and that once the person comes through the ER doors, he becomes a patient, no matter who they are or what they do. I know you shouldn't be rude when someone is talking to you . . . but I was scared. I can usually engage myself in a conversation with anyone, but with him, I had a hard time giving a full response. I answered his questions with a smile, nod, or a one-word response like "yes" or "no." I couldn't look into his eyes for more than two seconds. I felt nervous being around someone who was potentially "harmful." With police officers outside the door and other medical staff in the room, it was highly unlikely for anything to happen. Yet, my instinctive fear dominated my rationality.

After what seemed like a long time, the nurses had the tools set up and ready for Dr. T to suture. Yet, they were not the needle and thread-like setup that I was used to seeing for other cuts. It was white, gun-shaped equipment, which almost looked like a piercing gun that one uses to pierce their ears. I asked him why they didn't use sutures using a surgical needle for his wound, and the doctor said that for head injuries where there the skin is firmer, they use the surgical skin staples. After cleaning and numbing the area, Dr. T picked up the equipment, and started to literally staple the wound together! Grunch, grunch, grunch. I cringed every time I heard the loud sound. My eyes blinked every moment the staples were going in, so I kept on missing out how the staples stuck to the scalp. The whole process didn't take more than couple minutes until the

wound that was once severed was fully closed. I was amazed at how fast, consistent, and accurate the staples were! The line of staples in the head looked like railroad tracks that led to an unknown world that I had never been exposed to before.

Another patient that I remember who came in the ER with handcuffs was a . . . murderer. In Corvallis! Right before my eyes!! You hear and see about serial killers and murderers, but I had never seen them in person. The police said he was part of a gang and was cutting through Corvallis to run to a bigger city. They didn't give a lot of details about the killing, but they said he had killed one person in the past and served time for it. This man was young, maybe in his late twenties or early thirties, dark, tall, skinny. He looked "normal" just like anyone else in the room or on the streets. If I had not been told about his background, I would have never guessed that he had such a violent history.

When he came in, he was drenched from head to toe because when the officers were chasing him, he tried to get away by running into a river. The nurses immediately got him changed into dry clothes and made him warm and comfortable. He was very quiet, unlike the first patient who I mentioned above. Maybe it was because he wasn't drunk. Or maybe he knew he couldn't escape now. He closed his eyes after he got changed and cleaned, and sat on the bed silently. There were two officers in the room and one by the door. There was no way out.

While everyone was waiting for the lab results to come back, there was peace, calmness, but that was just on the surface. The next thing I knew, I heard officers yelling "Stop! Don't move! Get down NOW!" and the Bzzzzz sound came from the room. I didn't know what was going on, because everything was happening so fast and the hospital staff was heading in multiple directions. One of the nurses came out, holding

both of her hands around her neck. She was pale and was coughing really hard as if she was choking. Her neck was red, with what looked like a shoe imprint. It was as if someone had kicked her. Her brown glasses were broken in pieces. She was quickly taken to a different room by two other nurses for treatment. When she had calmed down a little, she explained that she was trying to get some fluid started on the patient's arm for his dehydration. When she bent over to inject the IV needle in, he had kicked her right in the throat. I couldn't believe what I was hearing! The man had seemed so quiet and cooperative! An officer came to the room, apologizing what happened and asking if she was ok. He said that they had tased him (by three officers) and that the man was now unconscious and under control.

As I reflect back on this night, I would have to say that this was probably the craziest night I had ever experienced in the ER, just because there was so much chaos and commotion unrelated to medicine. Or is it related? Is this part of medicine too? One of the things I learned from this experience is that it made me re-realize that appearance can be unreliable and deceiving at times. When I first compared the two patients, my first impression was better towards the latter patient I described above. I did not feel scared or in danger at any point during the examination as I followed the doctor into the small room. He was quiet, calm, and compliant at first, which instantaneously allowed my guards to be let down. In contrast, even with police officers outside the room, I felt nervous and shaky with the former patient as he struggled and fought with the nursing staff. Yet, he ended up being the more obedient one and he did not make an attempt to escape. We say that first impressions are important, that judging people by their "looks" is a natural, humane instinct. Yet, those judgments are reversed or incorrect so many

times that it's almost not worth making them at all. Though we know this and we can rationalize our reasoning, it's something that we can't help but do. The important thing I learned is that one can have preconceived notions about people, but it should not be expressed outwardly towards the person, especially if it has the potential to hurt them in anyway, and also have flexible thoughts that there is room for change to happen.

Case #4: Waiting. . .Just Waiting. . .

I know the day will come one day. It might be tomorrow or not for another couple decades. It's not something you think about on a daily basis – but when you do think about it, you realize that every breath you take, every beat your heart pumps is bringing you that much closer . . . closer to the end. Or is it an end? Is it just another beginning? Why are human beings so fearful of death? Why do we become so emotional towards death of a family member or a close friend? Yet, at the same time, we are capable of murder and brutal killing as one fight in a war. What differentiates us from those that mourn over death and those that don't? Connection with Humanity? Compassion?

As usual, it was crazily busy in the ER, especially during prime time, which usually begins around 6pm. There were a long line of patients and their families waiting in the lobby and all eleven rooms were completely filled. They even had to see a patient outside in the hallway because there were not enough rooms. Amongst this chaos, I met an elderly couple. As I stepped a foot inside the room with Dr. T, I sensed something special about them. I couldn't quite grasp what it was or why I had felt that way, but I knew something was different about this case. The wife was lying on the bed with her

eyes closed, as the husband sat quietly next to her, holding her hand with one hand and holding his wooden cane with the other. They both looked possibly in their late seventies or early eighties from their white hair, deep wrinkles, and frailness as gravity pulled on their loose but fragile skin. As Dr. T began his examination, he called out her name, wanting to check whether she was conscious or not. She did not respond. She didn't even blink or open her eyes. The husband continued to hold her hand with such hopeful eyes that you begin to hope with him for any slight movement. I didn't quite get what her condition was, but she was a hospice patient who had been brought over from a facility because she was not acting normal in the last couple of hours. After examining the patient, Dr. T said there was nothing they could do at the hospital at this point. I thought I hadn't heard him correctly. What did that mean? No treatment? Why? That's when I heard that she was a DNR (do not resuscitate) with no further invasive treatment. According to her chart, she was on comfort measures only. She was dying. She didn't seem like she was in pain – covered fully in the blanket, her body slightly curled, she looked as if she was taking a nap. I never put death and peacefulness together, but watching her, I thought that it might actually be possible.

What happened next amazed me as I watched Dr. T handle the situation when the husband began crying in the middle of the hallway. About twenty minutes after Dr. T and I had left the room, the husband came out of the room, looking for Dr. T. Limping on his right foot, barely being supported by the wooden cane, he stumbled towards Dr. T. Chocking on his words, he explained how they were together for more than fifty years, and that he wasn't ready for her to go. He pleaded, saying that there must be something they could do for her, anything. The hopeful eyes he had earlier weren't there anymore.

Dr. T quietly listened to every word the husband was saying. The husband broke down with "I don't know what to do." Looking straight into his eyes and carefully choosing his words, Dr. T said that he understands that it is not an easy thing to go through. He said that any medical treatment now would not be assisting his wife. He explained that she was in a peaceful, comfortable state and it was probably best for her to spend her last moments in her room where she would be surrounded with her personal belongings instead of in the hospital room, alone in a strange area. Touching the husband's arm softly, he said "please let me know if there is anything I can do for you." The husband thanked the doctor and the two of them stared at each other for awhile. I think we all knew that the "day" was just around the corner for her and none of us could do anything to stop it from coming. Not even the 21st century technology, medicine, or the best of doctors could prevent this from happening.

As a third person watching this interaction take place in the middle of the hallway of the ER room, it was a weird sensation. It was like the two of them was surrounded by an invisible bubble; time had stopped moving inside, while everyone outside was passing by as people ran around to send off lab samples, look for charts, and getting prescription ready.

Looking back, there is couple of the reasons why this event affected me so deeply. First, it made me realize that as a physician, one will be dealing not only with deaths that happens before one's eyes, but also those who are in the process of dying and the only thing you can do is to maintain maximum comfort for the patient. I remember a quote from my philosophy class by John Harris, who stated that medical intervention is only "prolonging death." What Harris is saying is true, but I feel that it depends on one's

perspective on life. It is similar to the "milk half full" example. For those that perceive that the end is going to come sooner or later, the glass will look as if it is half empty. For those that want to enjoy the last moments until the "day," they would perceive the glass as half full. Many times people regard the latter perception to be the preferred form, but I believe that one is not more correct or wrong than the other.

Conclusion:

Harsh reality exists in medicine. Things don't go the way you expect them to all the time - most of the time. The sense of uselessness or powerlessness frequently attacks my self-confidence the deeper I immerse myself in the medical field. There is a constant debate going on in my head. My emotional side of the brain is screaming "Do something! Anything! Help them!" as I observe people who are bleeding, in pain, scared, lost, hungry for help. Yet, my rational side is stopping my body from doing things I am not trained or licensed to do yet, inhibiting myself from inducing harm on the individual, which would be malpractice. I feel that some of my sense of uselessness will go away when I receive my medical license, and expand on things I can do, so I can actually help people with my own hands instead of just watching events happen before my eyes. Since the day I was born and to this day, I have been able to live twenty-two years with the help and support of the people around me. Without them, I would be nothing. In Japanese, the character for human beings is *Hito,* which is written with two lines meeting each other perpendicularly. The lines represent two people supporting each other for survival. My parents have always taught me to appreciate what people do for me and to give back what I have received. I have received many wonderful gifts of experiences

from many people, which makes up who I am now. I am aware that some battles against diseases are long, difficult, painful, and undefeatable. But I don't want to give up on a prematurely fought battle; I want to give everything I can, and provide the best care for the people who are living in the same century as I am who may have directly or indirectly helped me be the person who I am today.