2015 Intern Impressions

“Committee Care” by Tess Cersonsky, July 30, 2015

It’s hard to believe our 10 weeks are almost up, and we are getting ready to say goodbye to TCC for the summer (I say summer because it’s likely that many of us, including me, will come back). In 9 weeks I can say for myself that I’ve learned what I liked doing this summer, didn’t like at all, and want to come back to do in the future. Wearing the hats of 10 different jobs for a week or so each gives you that kind of knowledge.

As we get ready to go, more and more things pop up. We’ve become a part of this place just like the patients, and, even though we’ll leave and go back to school and our lives, I truly believe that part of us will stay here in some way, and undoubtedly pull us back in (I can’t speak for the others, but I know this is true for me).

I started 9 weeks ago going to committee care plan meetings with representatives from social work, dietary, recreation, nursing, and psychology for each unit (sometimes medical too). In these 9 weeks, the fly on the wall has become a member of the pack. I’ve worked with each of these people on advance directives and support groups and so many other things that have not only made me feel like one of them, but like part of the unit. I feel responsible for a little bit of those residents’ lives, almost as if I were there social worker or recreation therapist or psychologist. I can’t say I at all have the tools to do these jobs, but I feel inclined to take part in their care because I’ve grown to be such a part of their care.

They’ve all been asking when I’m going, and I know it’s about a week away now. And now that I’m off the wall, that I’m at the table, and that I’m part of the discussion, I wish there was only another week, a little bit more time to continue the work that I’ve been so dedicated to. You can’t do that when you’re a fly, but you can sure do it when you sit, among others working toward your same goal (caring for the patients), working together as a whole.
Random Musings on Patient Happiness by Netana Markovitz, July 28, 2015

John Wayne* moved from the sub-acute floor to the long-term floor last week. I know it was necessary because he will probably live here for the rest of his life, but it’s sad to me because the sub-acute floor is much more social than the long-term floor. On the sub-acute floor, every time I walk by there’s at least five patients hanging out with each other at the nurse’s station; there’s so much more life. John was almost always one of those people. Now, when I go visit him on the long-term floor, everybody is in their rooms, including John. Yesterday when I went to visit him he was taking a nap. On the sub-acute floor I never saw him taking nap. I know it is not because he has gotten weaker, but because the floor is less social. The sad part is John used to always tell me how he loved being by himself, but I know he really enjoys being around people because the only time he was in his room on the sub-acute floor was at night when he was sleeping. He loves happy hour on the sub-acute floor where they serve ice cream and soda. It is so interesting how the environment a patient is in, how accessible social interactions are, really changes a patient’s lifestyle, especially when traveling in a wheelchair, for example, is difficult. John wouldn’t actively go up to his old floor to seek out social interaction, but when it was right there he participated, and this seemed to have a big impact on his quality of life.

On another note, I was walking home on Friday and I saw a young woman I’ve gotten to know on the Huntington’s unit out in the park with her family friend who came to visit her last minute. It was really wonderful to see her out and about.
“Reflecting on Reflection” by Tess Cersonsky, July 24, 2015

“Reflection,” as I tell the 9th-graders I teach, means “stopping and thinking.” We also say that reflection gives you a chance to think about your life, and your choices, and decide what you care about.

Reflection, as it seems, is a two-way street… bear with me while I utilize this metaphor.

Say your house is on one end of a street. You and your friends drive to the other end and let some people off. Then you drive home by yourself.

Your house is your thoughts, feelings, and emotions. Driving is reflecting. Those friends are the people that you’ve impacted. You can reflect and just reach the end of the street and only think about what you’ve done for someone else and how that made them feel. But in order to get back to you and who you are (your “home”) you have to turn around and reflect on how they’ve made you feel – how your experiences have impacted yourself, not just others.

It’s so easy to only focus on the impact (however enormous) we have had on the patients and residents at TCC, and reflect on that. But they have made an even stronger impact on us, which can be incredibly powerful to realize. Whether positive or negative, inspiring or depressing, the experiences we have with people here affect us in some way, somewhere on the spectrum between positive and negative. Neither end of this spectrum is particularly better than the other, but just the awareness – even awareness of the negative – can make an experience already so meaningful in it’s wealth of knowledge and learning, even more illuminating into what it means to interact with someone else, to be part of a community, to form a relationship with someone.

Reflection, more than anything – more than books, more than media, more than education, shows us what it really means to be part of a species with such a capacity to feel and think – what it means to be human.
“It’s like a hotel,” I’d said.

“Yeah, a hotel for the dying,” my friend replied.

At Calvary Hospital, where the average life expectancy is about 20 days, the place truly feels like a “hotel for the dying,” a last stop on people’s life journeys. At Calvary, the main goal is to make people as comfortable as possible in their last days: physically, emotionally, and spiritually.

This is not to glamorize people’s lives at Calvary. Although the hospital attempts to make people as comfortable as they can and does an incredible job, the hospital is filled with pain, often times more emotional than physical.

Yesterday, when we visited for the day, we went into one man’s room with his doctor. He was about 60 years old with cancer that had metastasized to his spine.

“How are you feeling today? Do you have any pain?” The doctor asked.

“Last night was a good night. I slept like a baby. There’s just one thing doctor,” the patient said. “Yesterday, when I was walking down the hall, I couldn’t make it all the way. It was too hard.”

“Well,” the doctor said, “They’ve talked to you about your disease, right?”

“The cancer’s gotten to your spine, so you should expect that it’s going to get a little harder for you to walk as it progresses. Just do what you can handle.”

The man began to cry. Although he intellectually seemed to understand his disease, the doctor’s words seemed to hit him and remind him that his disease was getting worse, that
there was no cure, that he was dying. The verbal acknowledgement of these things took the patient out of the place of denial. The cancer was going to progress.

As we walked out of the room, the man said, “I hope you guys have good days.” He paused. “Better days than mine.”
If you asked me at the beginning of this internship if I could identify psychosocial distress in patients, I would have said, of course! I work in mental health awareness year round at Columbia. But ask me if I could’ve estimated its immense burden on patients, and I wouldn’t have been more wrong.

It’s true, I can’t really go back and decipher exactly what I felt about the impact of mental illness and psychosocial distress months ago, but I can sure estimate it. It’s easy to internalize so much distress and difficulty patients are experiencing and not realize the impact it has on them until you learn that it has had a profound impact on yourself.

Take my patient Sammy*, for example. Sammy is really depressed, and often acts like a young child in his needs and speech. I’ve spoken with Sammy almost 3 times a week for my time in the internship, and he often displays the same desire to go home and depression. I hope that talking about his depression eases his burden even a little bit, but, not being a mental health professional, I don’t know if it is helping him, and if it is, I don’t have the tools a psychologist, for example, has of distancing themselves in order to prevent transfer of that depression onto the therapist.

This is not something we’ve learned in our talks about palliative care, or advanced directives, or anything else. We’ve been told to get invested in the patient’s lives and their stories, not distance ourselves in order to protect our own psyche. But when you work so closely with a patient or a patient population, it’s very easy to take off some of their burden by absorbing it yourself.

I am in no way saying that I know exactly how it feels to be as depressed as Sammy. Even if I was depressed, all of this exists on a spectrum on which Sammy and I would not be at the same point. I’ve taken in only a fraction of what he feels, and yet that’s enough to debilitate a person. If I feel only a bit and it takes me over, what does the entire illness do to them?

*Patient name has been changed
*Patient name has been changed (and he chose his own pseudonym!)

It all started during my first week at TCC when Dr. Lechich introduced me to John Wayne* in occupational therapy. After I returned later that day, I began to visit with Mr. Wayne nearly everyday. A few weeks in, he started to express frustration that he was unable to go to the bank to pay his rent.

“I’ve paid my rent on time every month for more than fifty years, and now, I haven’t been able to pay since I got here. They keep saying they’ll take me and then never do.”

This was not the fault of TCC. Because this was not a medical need, there was no internal escort service to take him. In order for him to go, a staff person would have to take him during their lunch break or after their already long shift. A seemingly easy trip to the bank was a challenge. Mr. Wayne was on palliative care for his prostate cancer, and the inability to pay his rent was causing him stress and anxiety.

“Oh yeah,” he said. “And I want to buy Nabisco wafers, Oreo cookies, and ginger snaps.”

After investigating all the options, I began my two-week soiree as social worker/patient advocate, which included sending emails, speaking to the actual social worker, speaking to Mr. Wayne many times a day to update him, calling various escort services. I told Mr. Wayne that I’d do the best I could, but I couldn’t make any promises. Finally, I got the name of an escort service who said they’d take him for twenty dollars an hour. After a few phone calls to the facility and coordinating with the social worker to get an ambulette, Mr. Wayne went to the bank.

That week, the dynamic change was astounding. Since I’d known him, Mr. Wayne had been very talkative and friendly. When I began working to get him to the bank, however, he began to view me as part of his “team,” as he liked to say, rather than just a companion. There was a newfound mutual respect that we were working together to help him accomplish something.
During the month or so I’d known him, I’d mentioned that I liked Paul Newman’s Oreo Cookies when I saw he’d turned down the offer of another resident of a package of these cookies despite his love for brand name Oreo cookies. “You should try one!” I’d said. He’d been astonished I could like what was in his opinion a heinous copy of something great. “But they have fewer chemicals!” I’d said.

“You know, when I go to the bank, I also want Nabisco wafers, Oreo cookies, and ginger snaps. And some of those Paul Newman cookies for you.”

He returned from the bank that Tuesday at around 4.

“I did everything on the list we made together, but I couldn’t find the Paul Newman cookies!”

“It’s okay, Mr. Wayne. How about we settle for one regular Oreo cookie and call it a day.”
I could tell you that we have 609 beds at TCC. I could tell you which doctors cover which units and how many patients are Medicare Part A, Medicare Part B, or Managed Care, or whatever other insurances there are (I’m aware there are more).

I could tell you all of these things, and if you’re not a fan of numbers, you might say “that’s nice” or “that’s fine” or even yawn. It’s true, these numbers aren’t incredibly interesting if you aren’t an administrator or a statistician or someone else looking at the numbers of this or any facility.

You could tell me that people aren’t numbers, that you can’t boil down someone’s incredibly rich life story into a number on a page. And you’d be right! We can’t bring people down to be a number that someone adds to their calculations, a digit that we divide out, a decimal that tells you 2.5 people out of 10 does this, so now we have half a person. We can never diminish the human capacity to live or be into a number, or the capacity to suffer or to be in pain.

But numbers, like the percentages and reports and all these other statistical analyses I’ve been doing over the past few months, can show us that we need to be better at making beds, or we’re good at prescribing appropriate antibiotics, or just even that patients are 97% satisfied with their experiences. These numbers help us create an environment wherein patients, and real patients with names and stories and lives, can have as positive of an experience as one can in a nursing facility. 100% isn’t a person, but it sure is something to strive for.
In my last post, I stated that Robert seemed like one of the happiest patients in the world. I still believe that Rob generally carries a positive disposition, especially compared to most of the residents on the Discrete unit, but today I saw a side of him that I wasn’t aware existed.

After morning report and attending an AA meeting with Eddie, I spent most of my time hanging with Robert, mostly watching Maury and Jerry Springer (two shows that make me cringe inside) with him. Rob is cognitively impaired and has difficulty physically communicating. I’ve gotten better at being able to understand most of what he says. This morning, however, as I was watching Maury, a jumble of words spilled out of his mouth, and the only word I could really discern was “cashier.” I thought maybe he was asking if I was ever a cashier, or that he once worked as a cashier, or something like that. Anyhow, when I don’t know what he’s saying, I just smile and nod saying “yeah.”

After visiting a few other patients, Barney came and asked me, “Hey you gonna go to the cashier with Rob?” “What? No…?” I said confused. Did Rob hallucinate? “Rob said you gonna take him there to get money.” I paused and recalled that he had mentioned “cashier” to me, and it all clicked.

I went back and told Rob that I had misunderstood, and that what Barney told me was incorrect: “I’m sorry Rob, I misunderstood you. I don’t know where the cashier is, and I’m not even sure if I’m allowed to escort you there to get money…” Did he even have his own money? Or was he being like so many of the residents here who have a penchant for talking about/imagining money–and often large sums of it–in their bank accounts?

“Why of course you can Sophie of course you can. I can show you where it is I can show you.” Rob mumbled. “How much are you trying to take out?” I asked. “Thirty dollars.” “Thirty dollars? For what?” “Father’s day.”
Usually Rob isn’t a serious guy. He’s the guy on the floor that laughs hysterically whenever he sees that you’re laughing, and tells you five different jokes at once if you meet him for the first time. He’ll do a shoulder dance when he’s in a particularly saucy mood or give you a high five if you beat him at Pitty Pack.

But I could tell this money matter was important to him, and that he was desperate to take out his thirty dollars from the cashier. We were watching Jerry Springer, but he was even pulling his eyes away from the screen to return to the topic of how to retrieve his cash (and that’s how I know it’s serious).

I did what I could to try and get Rob his thirty dollars. I talked to two social workers, but both denied Rob’s wishes, mainly because he had already taken out ten dollars the other day to order Chinese food. The other reason was that it was Rob asking for his own money, and they were skeptical of Rob’s ability to handle his own money due to his mental condition; with actual cash in his hands, Rob would either hallucinate and think that he had more money than he did, or be careless with his money, end up losing it, and later blame staff that they had stolen his money.

Rob was very patient (and grateful) when I said I’d come back with an answer from the social workers. But when I finally told him the verdict, he started muttering swears and punching his fist into his other hand. He was already in a crummy mood because Maggie the recreational therapist wasn’t at work today, and he had expected her to come and pick him up for Bingo on the sixth floor.

To distract him, I suggested we chill in the dining room, play a few rounds of Pitty Pack maybe. Rob agreed, but against his own visceral emotions. When we settled at a table, Rob kept cursing the staff and facility. He did have moments of wisdom during his escalating episode, in which he reminded himself of his famous phrase, “I’m too blessed to be stressed,” to which I responded, “Yeah, that’s the attitude!” But generally, things were going downhill:

“I’ve been here ten years Sophie ten years I’ve been here too long Sophie ten years Sophie it’s f***ed up every day they’re like this every day they want my money you know
they want my money I gotta call the cops file a lawsuit… [more incoherent murmurs] I’m not crazy Sophie I’m not crazy!” And then he cried.

I was stunned and didn’t know how to best respond.

Interestingly, Rob’s unusual and “crazy” meltdown was what helped me see him more as a sane human being. When I first briefly met Rob as a volunteer, I had noted in a reflection that Rob seems to be “perpetually stuck in a state of glee and giddiness,” like a broken record replaying the same, happy chorus of a song. But I was definitely wrong. Rob, just like any other human being, despite his condition, has his ups and downs. And though Rob at first glance may seem like an oblivious, happy-go-lucky resident, he has enough wit to keep tabs each time something he desperately wants can’t be provided to him.

During Rob’s meltdown, I tried to calm him by saying, “It’s okay, Rob, it’s okay, everything’s gonna be just fine. Your money is safe, and no one’s out to get you. You’re not crazy! And remember? You’re ‘too blessed to be stressed!’ That’s what you always tell me!”

Trying to calm Rob down felt more like waiting for a storm to subside; I’m not sure that any of my words really helped, because he only seemed to get better at retorting what I said. I patted his shoulder, gave him a hug, and played several rounds of Pitty Pack with him during his episode (he’s remarkably great at multitasking). I think that was probably the best thing I did for him today—just be there and serve as an outlet for distraction. Pitty Pack was the one activity that most successfully quieted Rob’s cries, even if only for a few seconds at a time. I was glad I was able to play it with him while waiting for his episode to taper.

Through it all, Rob consistently battled an internal war that I will never come to understand. Though I felt that his pessimism got the best of him today, I was sincerely impressed at Rob for at least having made an effort to turn things around in his head. It’s hard… we’ve all been told that “happiness is a pursuit,” but sometimes even repeating “too blessed to be stressed” a hundred times may not bring you happiness when you need it…
People are people – no, I am not being redundant or cliché. People are indeed all people, all worth being heard and understood and cared for. This is a mentality that (should) accompany anyone going into health care. People have feelings, emotions, needs, pain, realities that may not be comprehensible to all of those around them but are still meaningful because they are people, and people are humans like myself, like my fellow interns, like the Pope, like the President, like anyone else.

It may seem rather simple, yet sometimes I feel like it’s not understood. 67% of residents/patients at TCC have a diagnosed mental illness. Many of these are in combination with other illnesses, or are caused by a more chronic illness, but it’s well known fact that mental illnesses are influenced by a variety of factors, including genetics, environment, background, culture, etc. We know these things, but from what I’ve seen I worry that we forget that when someone has a mental illness, the reality that they experience is as real to them as what those who don’t, or do and aren’t affected as much, observe every day.

In my few weeks now here, I’ve seen and heard a lot of people talk about the “psychotic” or “depressed” patients and residents and treat them with a different attitude than some others. If someone acts out, it must be because they have depression and therefore the only thing we should look at is their therapy and medication. But we overlook that maybe there is something about being here at a nursing facility – about living a life that is not your own – that inherently causes someone to become depressed and have no other outlet for their anger than to act out.
“Dying Okay” by Netana Markovitz, June 17, 2015

“I have cancer. I’m gonna die. Dying okay.” Maria* did not have cancer (she’d been in remission for ten years) and was not dying, but the power of her words, “dying okay,” stuck with me. She had dementia and believed her mother was 50 years old when Maria herself was nearly 80. Nonetheless, the poignancy of her words, “dying okay,” shocked me. Even though she was too confused to know her age or her marital status, she could internally accept the possibility of death.

In a place like TCC where death is omnipresent, acceptance of death is one of the most difficult tasks, if not the most difficult task, for patients and their loved ones. The sheer number of CPRs rather than DNRs in the facility, people who have instructed medical professionals to take every possible measure to keep them alive even in times of dire illness, has shown me that many, for good reason, have not been able to accept the possibility of death.

When is “dying okay”? Can dying be “okay” for everyone? Does everyone have the ability to accept death when they are ill? Perhaps I will have more clarity by the end of the internship.
What Doesn’t Kill You Makes You Stronger (Reflection #2) by Sophie Park, June 12, 2015

All patient names below have been changed to ensure their privacy.

After a weeklong affair of morning reports, CCP meetings, and learning how to get from the 8th floor of Cohen to the 9th floor offices, I can say so far it’s been a pleasant and interesting experience!

Being a TCC intern means that you have a lot of “downtime” on your hands, which is really another way of saying you have a lot of freedom to get your hands dirty in all the different units that make up this rehab facility. I really like the fact that there’s no set schedule for each day, no busy work. TCC feels like the Google of medical internships; you have “nothing to do” and all the while have everything to do in the world.

After morning report, I am anxious to visit the Discrete unit and check up on my two favorites Rocky and Barney—Rocky, a tall, lanky, intimidating-looking dude who’s always looking for Coca Cola on the outside, but really is a soft, tender sweetheart on the inside, and Barney, one of the friendliest Spanish-speaking patients at TCC who surprisingly remembers me from a few months back when I was distributing resident surveys. But of course along the way there I fist-bump Hector and do my best to interpret his rapid, full-of-meaning whispers as he sits in his wheelchair by the entrance. Hector is also a sweetheart and is always pleased to see me. Chances are I’ll also run into George, a blind, retired hairdresser, who for the twelfth time since I’ve been here will ask me whether I’ve heard of the Vietnam War and will tell me that he turned 21 during the war just 90 miles south of Saigon while handling an M14 and 49 or whatever those guns are called! I love running into Robert in the dining hall, who seems to me like one of the happiest patients in the world. Today he made me repeat “too blessed to be stressed” out loud (I think he stole that line from Eddie, another resident, but he won’t admit it). He’s got a mouthful of “What did the ___ say when..” jokes and an endless supply of sass and giggles when he sees me. Pretty soon Harry, once he sees/hears me, will come waddling into the dining hall and start telling me everything from how to conduct in 7/8 to how to grow marijuana in your backyard. Occasionally Albert from Cuba will be sitting at the table as well, smiling and listening to what Harry’s telling me, but also confused inside as to why the hell he’s
even trapped here in the first place. And then there’s Eddie, who looks to be sheltering a sorrow that neither I nor any of the people at TCC will ever come to understand.

My favorite part of the day at TCC is probably doing my “rounds” on this unit, although I really hate calling it that. “Rounds” makes it sound like the act of saying hello to patients is some kind of perfunctory task. That’s what Harry called it today—as I was leaving his room trying to get to other patients, he said with a sigh, “Alright, you go do your rounds.” I felt bad that my walking around talking to patients is probably perceived as a job I have to do rather than as a genuine pleasure. The fact that there are so many patients I want to get to probably contributes to this perception. I can see now the value in assigning a single person to a single Long Term Companion in the TCC AYS Volunteer Program—visit just one patient, and you’ll seem like someone who belongs to only that patient. Visit a hundred, and you belong to no one.

During my first week, aside from attending meetings and shadowing the administrative aspects of TCC, I think I found my “sweet spot” here at the facility—a constant circle of patients that I regularly visit and who sincerely seem to enjoy my company. Besides the patients mentioned above, I also befriended Elena, a loquacious Latino woman who desperately wants to be a mentor to someone. She resides in the Dialysis unit and has the answer to almost every possible question regarding dialysis and renal diseases you could think of. She is so passionate about sharing her knowledge of dialysis to others that she invited me to come observe her undergoing dialysis. At TCC she undergoes dialysis three times a week in the evenings. Normally they only allow visitors to stay a maximum of five minutes in the dialysis room, but the NPs—who were extremely kind—let me stay by Elena’s side for an hour to keep her company. That evening I shared with her a personal dilemma of mine and sought her advice, partly because I wanted her to know that I wasn’t just visiting her because I had to or because I was an intern, but because I was genuinely interested in being mentored by her. Hearing stories from people like Elena makes someone like myself feel like a blank slate—Elena’s lived through decades of life and experienced some of the worst lows and highest ups that I have yet to run into. I realize that, though weak and severely disabled, a patient like Elena can serve as one of the most valuable go-to people for advice when experiencing hardship—chances are, they’ve experienced worse, and they can teach you how to live to tell the tale.
There was one thing that Elena said last week that has stuck with me for a while now: “Suffering does not weaken; it makes you tougher.” I know that this is just an echo of the phrase “what doesn’t kill you makes you stronger,” but I saw before my eyes someone who truly could not be phased by anything in life because she’s seen and gone through it all. She tells me that she’s never known what it is to miss someone, or love a close family member, which is why “I miss you” or “I love you” are absent in her daily language. All Elena ever talks about 90% of the time is her illness, or medical knowledge related to her illnesses. This makes me think that this is all she’s ever comfortable talking about, for one because that’s all she’s ever known in the past few decades, and two, because talking about anything else is like exploring unchartered territory for her. I am amazed at how strong Elena seems compared to how she looks on the outside, but simultaneously it’s sad to realize that it’s all been a result of years of emotional and physical hardship.
Religion is such an interesting, and incredible, and mystifying thing, especially at a nursing home (okay, skilled nursing facility). It brings those who are dying in geriatrics peace at the end of their life, and those living in long-term care something to occupy their minds. It joins them together if they so choose, and allows them to be alone and not lonely with some spiritual connection to keep them company.

I am Jewish, and I know that Jewish life is very wrapped up in the community. Even if this is just having a family dinner on Friday nights or going to synagogue three times over Shabbat, the community is very important. But I take so much for granted that I get to choose where I pray and where I want to make my community. Jews at TCC are limited to what we can give them as a general Jewish community here – a Rabbi, a loaf of challah, and grape juice. What happens if you need more? And how do you find the joy that religion can bring if you can’t choose the way you live it?
“He expired.” These two words didn’t make sense to me. These words were too harsh. People weren’t items bought in a grocery store that you threw away when they got moldy after a few weeks. People didn’t have expiration dates. The expiration date of a resident had become routine, something to be expected. People, like food, had expiration dates. Death was a fact inscribed on the bottom of a milk carton. Perhaps after the daily monotony of death in a nursing home, expiration dates had begun to feel normal until they were normal. In my third day naiveté, however, expiration dates meant that people were frozen food items in aisle nine: frozen food items that eventually spoiled. But people didn’t spoil, and death still shocked me.

People live a life and then expire. Perhaps after ten weeks this will make more sense to me.
The Beginning (Reflection #1) by Sophie Park, June 1, 2015

All patient names below have been changed to ensure their privacy.

Today was the first day of the TCC internship. My day at the healthcare center began with bloody, blistered heels from the 30-minute walk from Columbia to TCC in uncomfortable Croc flats (who knew “uncomfortable” and “Crocs” could exist in the same sentence?).

The first thing on our agenda was the Morning Report at 9am with Dr. Lechich and the HIV & AIDS/Geriatrics/Subacute units. From what I could gather, it was an hour-long opportunity for staff, such as social workers, nurses, recreational therapists, etc., to address issues or significant incidents that have happened the previous day or over the weekend involving the patients. It was like watching a version of the Today Show news segment centered around medical incidents, starring the medical staff and anchorman Dr. Lechich. He was typing away furiously at a computer while listening to the problems that were being fed to him by the staff. One question that kept running through my mind was, “So what’s Dr. Lechich going to do with a hundred or so issues? Where and how do these medical incidents get resolved?”

The next interesting event that happened was the resident council meeting on the 7th floor of Cohen. This was a much more entertaining and eye-opening experience. Whereas the Morning Report was more of a place to address the physical needs of residents, the resident council meeting was a place for residents themselves and social workers to address the living/social conditions of the patients. The meeting really makes you realize how much “care” involves things not directly related to medicine, such as proper laundry services and healthy nurse-patient relationships. I was fond of one resident during the meeting who was very outspoken at times–he was like the “Barack Obama” of the discrete unit. I was pleasantly surprised to see that Delilah was also at the meeting–a resident to whom I once administered a survey as a volunteer during the school year.

Afterwards we ate lunch and received a packet full of papers and articles to read. There were a lot of new terms and acronyms we were introduced to. Overall, our first day was calm. I hope to record a more thorough account of my days at TCC in the coming weeks.