

# A Day in the Clinic by Danielle Ofri

## Introduction

by Iain Bamforth

The title of Danielle Ofri's second collection of reflections on her professional life as an attending physician *Incidental Findings* comes, as she explains in the prologue to the book, from her own experience of turning up with her husband for a routine antenatal screening in one of NYU's private clinics, and discovering, to her alarm, that the sonographic image of her baby's umbilical cord reveals an anomaly. But is it an anomaly which means something? Her colleague tries to put her in the picture. 'The radiologist has already ascertained that I am a doctor and fellow faculty member. "Just one thing," he says, leaning his torso into the room, "the umbilical cord is missing one artery, but it's probably an incidental finding. The literature says that 20% can have chromosomal abnormalities, but you've already done the amnio to check for that, and 20% can have growth retardation, but we'll be able to check that with another ultrasound in 3 weeks, so it's probably a normal anatomical variant."

It is, in many ways, a classic turning of the tables. The white-coated internist loses her cool, her rationalism, the very ability to assess risk — the situation is way too personal. So Dr Ofri sets out, in her



explorations of the emotional underbelly of medicine, to show that 'nothing is incidental': her stories about the lives of some of the patients who pass through her hands as an attending physician at Bellevue, one of New York's most famous public hospitals, is full of the frustrations and fears which being a patient entails, along with her winsome ability to acknowledge when she runs up against limits either in the system (of which there are many in the US) or her own inability to alter fate. While the need to know, in person, how things are on the other side of the doctor-patient divide has been a conventional and institutional piety since the antimicrobial critiques of the 1970s, Danielle Ofri's book goes a step further: by finding out how things are in the flesh. It is not out of place to observe that this entirely praiseworthy attitude became a piety only when technology had become so powerful as to jeopardise medicine's traditional reliance on touch, much as the word 'community' is now used in settings that have moved beyond anything recognisable as such to traditional societies.

The interest of this kind of life writing (as it is sometimes called) for readers may well be in the spectacle of a doctor 'dressing down', or indeed in terms of the powerful if largely unspoken egalitarian impulse which demands that we should be equal in all things, even sickness. But it would be a mistake to see the rawness of the situations presented in *Incidental Findings* as somehow closer to the truth of life: all writing is bound up with the art of self-presentation. Indeed, stories that hold an author's strengths and shortcomings up for public scrutiny, especially when they claim to be representative of the profession as a whole, are liable to be charged with many sins, the least of them aesthetic. They cannot afford to be as naked as they appear to be. It is a mode of writing that is hard to bring off. None less than George Eliot, in one of the greatest novels of the 19th century, warned of the dangers of attending too closely to the common suffering of others. The curious thing about

Middlemarch is that she does just that herself, amplifying the sounds that lie on the other side of silence. But rest easy, she adds, even the most receptive of us 'walk about well wadded in stupidity.'

Just how businesslike medicine has to be is told in *A Day in the Clinic*, which adopts the simple but effective expedient of using a clinic appointment register as a structuring device. If true doctoring means having a more comprehensive vision of patients' lives than the shorthand that ends up in their medical records then GPs are in the ideal position to provide it. That internists in public hospitals end up fulfilling this role in the urban US is a telling comment on the political priorities of American medicine. And one theme runs through this story: doctors have to learn to be subtly polyglot, even when they only speak a single natural language.

Iain Bamforth

### DANIELLE OFRI'S PUBLICATIONS:

*Singular Intimacies: Becoming a Doctor at Bellevue* (2003).

*Incidental Findings: Lessons from My Patients in the Art of Medicine* (2005)

See also her website at:  
[www.danielleofri.com](http://www.danielleofri.com)

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**8:30 AM:** Doing intakes — interviews with new patients at the Bellevue Hospital Medical Clinic. First one is Carola Castaña, a petite 35-year-old Brazilian who immigrated to the US 3 months ago. She folds her hands in her lap as I begin to take her history. She understands my questions better if I ask in Spanish rather than English, but her Portuguese replies are Greek to me, so she struggles to answer in English.

Her main complaint is that her joints hurt. Which ones? All of them.

How long? Since age 12.

Ever see a doctor? Once, as a child. They just told me that I had arthritis and gave me ibuprofen.

No X-rays or blood tests? No.

I start down the long line of questions, but we are stymied by language. I give up and reach for her hands. A principle of internal medicine holds that 'It's all in the history.' An astute clinician should be able to unearth any diagnosis just by asking the right questions. The physical exam is almost an afterthought, a mere confirmation of the already-ascertained diagnosis. But Ms Castaña silently and unwittingly puts this axiom to shame.

Her history has led me nowhere, but her hands subsume the work of logical reasoning. Her hands are severely ulnar-deviated: the fingers sail off course, angling out to the sides instead of straight forward. They point away from her body as though she is gesturing for the waters to part. The tips crane upward, forming a line of swan necks. The joints that connect her fingers to her hands are swollen like robin's eggs — bulbous, bony protrusions. This young emissary from Brazil has handed me the hands of rheumatoid arthritis, untreated for 23 years. These are hands that I have seen only in textbooks.

I explain what she has.

Is there is a cure? she asks.

Cure? I sigh. No.

But there are lots of treatments, I hasten to add. Lots of treatments — this time I say it with more energy in my voice. I wish

I possessed diversity in my Spanish so that I could reword my phrases for extra emphasis and depth. But I have only one way to say each thing. If only I'd spent more time in Mexico.

I arrange for X-rays and labs and I give Ms Castaña a prescription for hydroxychloroquine. Malaria medicines for arthritis — sounds crazy, but it works. I try to explain that in Spanish. At the last minute I remember to add a G6PD assay to the blood tests. Can't give hydroxychloroquine until you check the G6PD. Whew, almost missed that one. Good thing that some facts stick around from residency.

I instruct Ms Castaña not to take the medicine until I call her tomorrow with the G6PD results. I am glad that she has a phone; I don't take that for granted with my patients. In my head I plan to call the lab today at lunchtime to expedite tests and get the results by this afternoon and then call her before I leave work tonight. Wouldn't it be great if she could start her 23-year-delayed treatment today instead of tomorrow?

**9:00 AM:** A 54-year-old Dominican woman. Sore throat, back pain. *No, señora, no necesita antibioticos por un virus.* Have you tried exercise for your back? Heating pads are helpful.

**9:20 AM:** A 37-year-old Bangladeshi man. New-onset diabetes, limited English. Will it be pills or insulin? It's my decision.

**9:40 AM:** A 41-year-old Mauritanian woman. Dizziness, can't sleep, neck hurts, back hurts, stomach hurts, chest pain. Hmm ... underlying depression? Drug use? Domestic violence? Political torture? The diagnostic possibilities are endless.

**10:00 AM:** A 72-year-old Puerto Rican man. Hypertension, ran out of meds last month. *Señor, you can't ever let your pills run out. Es muy importante.* You've got to take those pills every single day, not just

when you have a headache. Otherwise you could get a stroke or a heart attack. You can always come to the clinic for a refill — you don't even need an appointment.

**10:20 AM:** A 63-year-old Ecuadoran woman. Back pain, shoulder pain, foot pain, raising little grandchildren isn't easy at my age. *Señora, I know. Es muy difícil.* Is there anyone in the family who can help you? You might try getting shoes without heels. We do have psychologists who speak Spanish. And don't forget about the mammogram; you're way overdue.

Rushing through intakes tenses the muscles of my back, especially the spot just below my right scapula. These intakes are supposed to be screening visits, brief and to the point. The details of the history are supposed to wait until the next visit, but the details are everything and they spill out the minute the door closes behind us and we are alone in my small office. I roll my right shoulder backward to unkink the knot.

Next chart is Yang Qing Xing. I call out the name in the waiting room. No one answers to my probably mangled pronunciation. I seek out the Asians in the room and point to the printed name. They all shake their heads. But somehow, a Mr Yang is produced from the crowd. He is a tall, lanky man with a face wrinkled far beyond 41 years. He speaks no English but conveys with his hands that there is someone somewhere who can translate. He hands me a crumpled referral sheet and then I watch him limp awkwardly down the hall to find the communicator who can bridge his life to mine.

The referral is from endocrine clinic and the handwriting, thankfully, is decipherable. '41-year-old Chinese male with papillary carcinoma of the thyroid. Thyroid removed and radioactive iodine treatment given last year. Cancer cured. Needs general medical care'.

I guess it finally occurred to the endocrinologist that Mr Yang should have

an internist to worry about the rest of him now that his cancer is cured. Mr Yang is a young man — someone has to check his cholesterol and make sure he's up to date with his tetanus shots. While I wait for him to locate his interpreter, I check his labs in the computer. His TSH level last month was way off: his thyroxine dose needs to be lowered or even discontinued altogether.

Mr Yang returns with two young Chinese guys sporting baggy jeans, beepers, ice cream cones, and bottled spring water. Turns out that Mr Yang speaks only Fukienese, although he can understand a bit of Mandarin. One of the young men speaks Fukienese and Cantonese but little English. The other speaks good English and Mandarin, but no Fukienese. Needless to say, each question takes an endless time to traverse the space between us.

I explain that I will be Mr Yang's regular doctor, that I will take care of his whole body, not just his thyroid. Mr Yang conveys that his endocrinologist had told him to stop taking his thyroxine for 2 weeks (good, the endocrinologist saw that most recent TSH level in the computer). Ever since he stopped taking his pills, though, he's had trouble with his right leg. It just doesn't move well. He wants to restart his medicine.

I ask if he's ever had leg problems before, and he denies any. I ask the question again, not willing to trust just one cycle of translation. One of the young men says that he's translated for Mr Yang before, at another clinic appointment, and that Mr Yang didn't have a limp then.

'Common things happen commonly,' the saying in medicine goes. Or, 'When you hear hooves, think horses, not zebras.' I'm sure there is a simple explanation for his limp. What about an old sports injury? I ask. Or plain old arthritis. Maybe he tripped on the bus. Are his shoes too tight?

Mr Yang shakes his head as each of my questions is processed for him. No, he insists. It all started 2 weeks ago when the doctor told me to stop taking my

thyroxine pills. Just let me start the medicine again, he says, and I will be okay.

I scour my brain: can leg weakness be some bizarre rebound effect of stopping thyroxine? No, that's crazy. The half-life of thyroxine is several weeks; his body probably hasn't even noticed that he's stopped taking the pills.

Somehow, via the circuitous linguistic orbit, the following line from Mr Yang emerges: 'I feel like Christopher Reeve — my head is fine but I can't move my body.'

I give up with the questions, realising that I am not getting anywhere with the history and that time is running quickly. The pile of intake charts is growing and if I don't get a move on it, I will have to work right through lunch. Again.

I skip right to the physical exam.

Mr Yang places one foot on the step of the exam table but wavers as he tries to pull himself up. The two young men spring to his side and steady him. Their squat muscular arms guide him up to the table and help him swivel his skinny body around into a sitting position. While I listen to Mr Yang's lungs I recall a patient I saw on my very first day as an attending in the clinic. She'd been sent over from Employee Health because her blood sugar was 130; the referral said 'Rule out diabetes'. I took a complete history, asking about all aspects of her health. Like every other patient I'd seen that morning, she also complained of back pain. I'd actually palpated her spinal column and even documented in the chart the absence of point tenderness — more than I usually did for back pain. But this was just run-of-the-mill back pain. Try some ibuprofen, I said.

Three days later she was paralysed. Needed emergency surgery for acute spinal-cord compression — a lymphoma tumour at T7. Surgery, radiation, weeks of rehab. Now she has only a limp, thank God, and manages to walk with a cane.

With her limp in my peripheral vision, I do more than the usual neuro exam on Mr Yang. Using my rubber hammer I bang not

only his knees but also his elbows and ankles. I run through the 12 cranial nerves. I verify sensation of light touch, pain, and vibration — it all seems normal. I even check rectal tone to test the spinal nerves. But when I check flexion and extension of his muscles, his right leg really is weaker than his left.

I can't decide what to do. Do I send him home and see if it gets better in a few days, like most every other ache and pain that I see in the clinic? Or do I need to do a stat X-ray right now? Is there something that I'm missing in his history? I leave the room to get a quick curbside consult with a colleague in the bowling alley — the long hallway behind all the exam rooms. I tell her my story about the lady with a spinal-cord tumour. She doesn't think it sounds like the same thing. But if it'll make you more comfortable, she says, get an X-ray of the spinal column today and then have him come back in 2 days. See if it's gotten better or worse.

My stomach nags at me. Am I about to miss something big, or am I making a big deal over nothing? Gotta decide quickly — the clerk has just tossed four more charts in the intake bin. The decision is mine, and mine alone. Two vastly different paths could branch out from my decision: I could reassure Mr Yang that it's nothing and send him home, or I could start calling X-ray and CT and orthopedics and cajole stat evaluations from them, thereby falling even further behind in my work, and make Mr Yang and his two interpreters, who probably have other places to go, spend hours schlepping around the hospital to do all these tests.

My choice will send him marching down one path or the other. A wince in my right shoulder reminds me of that aching muscle. There's no one hovering above me to whom I can punt the responsibility. There is advice from colleagues, but then I am left with the independence or loneliness, depending on how one looks at it, of my own decision. I can't afford to guess wrong. If only I could speak directly with Mr Yang to pick up the subtleties of

his descriptions and match his body language to his history.

Or, my colleague adds, you could call neuro to come see him; they usually come reasonably quickly. But don't bother trying to call endocrine; they won't call you back until a week from Tuesday.

I call the neurology consult, who says he can swing by in 45 minutes. I am impressed and thankful. I park the polyglot trio in the room next door and set about catching up on the stack of charts that is now spilling out of the intake bin.

My next patient is an elderly Egyptian woman from Alexandria. She screws up her mouth. 'I here since eight thirty! Is it because I am new patient? Because my English is no good?'

No, I promise her. You know how things are in the clinic. I catch her eye and hope she smiles back sympathetically. But we'll take care of your diabetes, don't you worry. Her face relaxes a little bit. When's the last time you've had a mammogram, Mrs Jamila? Never? Well, it's time.

**11:00 AM:** A 59-year-old Puerto Rican man with emphysema. Had another attack last week. *Señor, necesite dejar de fumar!* You can't smoke if you have emphysema. And you have to get your flu shot every year, *por favor*. No, the vaccine won't make you sick, I promise. I get the shot every year and I never get sick. *Nunca!*

**11:15 AM:** A 33-year-old white man with schizophrenia. Used to be a computer programmer before he had his first psychotic break. Now he's in a halfway house and able to take care of the basics in his life on his current medications. Needs a physical exam to get his benefits. Are you in touch with your family at all? No? Is there anyone at all you can turn to?

**11:30 AM:** The neuro consult knocks on my door. He has just finished examining Mr Yang.

'Good call,' he says with admiration. 'You just picked up a brain tumour.'

Brain tumour? The pinch under my scapula suddenly ratchets like a drill deep into my back. The consult leads me back to Mr Yang. He demonstrates the subtle hyperreflexia of the right leg, the pronator drift of his right arm. Mr Yang's face is carved with wrinkles, maybe from years of labouring in the sun. I can't read the expression among the deeply etched corrugations. How much, I wonder, has been translated back to him through the serpentine linguistic channels? Still dazed, I fill out the hospital admission forms, and the neuro guy whisks Mr Yang off for an emergency CT scan before I can gather my thoughts. I wish I knew how to say 'Good luck' in Fukienese. Or 'I'm so sorry.'

**11:45 AM:** A 61-year-old black male. Arthritis in the knees. Exercise the muscles. Take the ibuprofen with food, otherwise your stomach will hurt.

**12:00 noon:** A 32-year-old Dominican woman. Heartburn. Deaf patient. Sign language interpreter is stuck in pediatrics. That's okay, we'll just print on paper. Luckily she can read English. TAKE THIS PILL TWICE A DAY, I write in block letters, careful to keep it legible. IT WILL MAKE YOUR STOMACH FEEL BETTER.

**12:30:** All the intakes are done. Finally. Grab my cheese sandwich and start preparing for the afternoon. There's a third-year medical student coming to my clinic this afternoon. Our topic today is evidence-based medicine. I rifle through my files, hunting for an article that demonstrates those academic principles while still being relevant to clinical practice.

**1:00 PM:** Explaining evidence-based medicine to the third-year medical student. She sits stiffly on the chair with her white jacket buttoned up and her *Washington Manual of Medical Therapeutics* sliding over the edge of her pocket. She nods mechanically at each

thing I say, even when I ask if she has any questions. Did I look this nervous when I was a third-year?

I leaf through the paper on coronary disease with her, pointing out the differences between primary versus secondary prevention of heart attacks and how not to be fooled by the relative risk reductions quoted in the study. You have to go by the absolute risk reduction. She is still nodding mechanically. I pause from my explanations. Have you ever even seen a patient with a heart attack? I ask. She shakes her head no. I flip the paper over and start drawing a simple diagram of the heart with its coronary arteries. Got to start with the basics.

**2:00 PM:** A 64-year-old Puerto Rican woman with hypertension who hasn't had a pelvic exam in decades. Eljida Rivera hates the GYN clinic. I don't blame her; I spent time in that clinic as a medical student and it reminded me of cattle being herded through a factory. But she will allow the Pap smear in the medicine clinic. I am honoured that a patient would trust me with this most intimate of examinations.

I lug the exam table from the wall to free up the leg rests. It heaves forward in fits and starts, and I feel that spot under my right scapula strain. I jam a tongue depressor in the arm of the lamp so it won't float up to the ceiling. I lay out my equipment on a clean paper towel spread on top of the industrial garbage pail. I print her information on all three lab forms, and I stamp labels for the specimens. I hold the speculum steady with my left hand while my nondominant right hand is forced to take the samples, spread them on the slide, spray the fixative. My kingdom for a nurse. But my Spanish is adequate to explain most of what I'm doing. Glad I spent that extra week in Peru working on the imperative.

**3:00 PM:** The neuro consult drops by. Not one, but four! Four big goobers in Mr Yang's brain, he says. They'll give steroids and radiation to shrink the swelling. That

will improve his symptoms, but the neurosurgeons won't operate if there are already four intracranial masses. Six months to a year, they say ...

I close my eyes for a moment and I see Mr Yang's wrinkled face with the expression that I can't read and can't match with his words. And what did he make of my facial expressions that he couldn't match with my words? I am suddenly overwhelmed by the fear and loneliness that I imagine he will feel, upstairs in a hospital bed, maybe for weeks, unable to communicate with anyone except when the Fukienese interpreter is available.

**4:30 PM:** I check Ms Castaña's labs. No G6PD results to be found. I call the lab and they tell me there was no order for one. But I know I checked it off on the requisition slip. No dice, they say, we don't have a requisition for it. Damn! I don't want to make Ms Castaña come back again for another blood draw. Twenty-three years of inappropriate treatment is long enough. I want to show her that we'll do it right this time. That we'll take care of her at Bellevue. That she'll get care as good and as prompt as she would at any private practice.

I wish I could do something for Mr Yang. Something that could change his prognosis. But he has been whisked away from me. Whisked away on a stretcher by the neuro consult, whisked away by the language barrier that reduces the doctor-patient relationship to its most crassly bare bones, whisked away by his disease that we had assumed was cured. Harrison's says that papillary cancer of the thyroid, the type that Mr Yang has, rarely metastasises; that follicular cancer is the one to worry about. I remember memorising that one for the boards. Another patient unwittingly disproving the rules. The least I can do is expedite Ms Castaña's treatment. I just need that damn G6PD.

Residency was only a few years ago; I still know the back channels. I call Central

Accession and track down the sample number. I dial hematology and ask if there is any blood left over from her CBC to send to the special hematology lab for a G6PD. The tech is cranky: 'There are a thousand samples; call back in an hour.'

**6:00 PM:** Finally home. Got to leave for Spanish class in a half hour. Spanish is my lingua franca in this clinic. I telephone hematology while I stuff *Gramática Española Avanzada* in my bag. The evening-shift tech is much more pleasant. She's able to locate the specimen. And there's enough left over! Just bring over a lab slip, she says kindly, and I'll pop it right in the machine. But I'm home already, I can't bring over a lab slip.

Evening clinic. Who's doing evening clinic tonight? Elaine's got Tuesday nights. Maybe she can walk the lab slip over to the lab.

I call the clinic and talk to the clerk at the front desk, who puts me on hold. I pour a bowl of raisin bran while I'm waiting, trying to keep my crunch away from the phone. Still on hold, I finish my cereal. Where the heck is she? I wash the bowl, keeping the phone cramped between my ear and my neck. That spot behind my right shoulder is acting up. Still on hold. I've got to leave for class, where is she? Finally she returns, informing me that she was finally able to locate the chart in the chart room.

I slap my hand on my forehead, too dumbfounded and annoyed to speak. We don't need the chart to get a lab slip, I want to scream. How could you waste so much precious time? But it's not worthwhile to yell at the clerks. It never accomplishes anything and they'll never do you any favours ever again. Gritting my teeth to modulate my voice, I ask her to please connect me to Dr. Feingold's office.

**6:15 PM:** I give Elaine the patient's name, the medical record number, the sample number, the name of the tech who approved the add-on test, and which test

to order. She fills out the form then transfers me back to the clerk so I can tell the clerk what to do, but there's no answer. And no answer. And no answer.

Fifteen minutes I keep dialing. No answer. Where is the clerk? Where is anybody? I don't know the direct number to Elaine's office and can only phone the front desk. Over and over I call, hunting in my fridge for a snack to bring to the 3-hour class. At least there's a redial button on my phone. I finally dial the page operator and have Elaine paged overhead. No answer. No one ever hears those overhead pages anyway; it's a total waste of time.

It's 6:30, and I've got to get going. I can't miss Spanish class; tonight we're doing the preterit and the imperfect. I need those tenses. I start randomly calling every desk in the clinic, hoping someone will pick up. After ten calls and many pleas, someone has a heart and connects me to Elaine's office. I am panting with relief.

'Oh,' says Elaine, 'the clerk walked the lab slip over to the outpatient lab but it was closed.'

Of course the second-floor outpatient lab was closed, I want to scream. It's after 5 PM You have to take it to the fourth-floor central lab! I slam a Granny Smith apple in my bag. Doesn't anyone know the system around here?

Please, Elaine, could you please drop it off on your way out? Would you mind, please? She hesitates. It's been a long day. 'Could I bring it to the lab tomorrow morning on my way in?' she asks.

Nothing personal, but I hate to trust anyone to remember anything. Please, please could you bring it over tonight? It's only two floors up. And there's never any wait for the elevators at this time of day.

Mr Yang is probably sitting all by himself in his hospital bed. The nurse's evaluation is brief because she can't explain about the daily routine of the ward or ask him if he has any dietary preferences for his meal tray. The interpreters have probably gone home for

the day. All the nurse can do is take his blood pressure and pulse. I want it to be right for Ms Castaña. I want to be able to call her tomorrow with the results like I'd promised. Just because we're a city clinic doesn't mean we can't give our patients medical care like they get in private practice. I want to live up to my word.

**6:45 PM:** Forty-five minutes working on this stupid lab slip. I could've gone back to Bellevue myself and walked it over. Elaine finally agrees. I dash off to Spanish class on my bike.

**10:30 PM:** Home. Head still swimming with the preterit tense, I call the lab and track down the heme lady. She's pleasant and helpful. The lab slip was received! Thank you, Elaine, thank you. The tech carried the sample herself to the special hematology section. The G6PD will be done first thing in the morning. Of course I would have liked to have it done tonight, but I'm happy that it will get done at all without making Ms. Castaña come back for another blood draw. Thank you, oh anonymous technician, for getting it done. I hope.

**11:30 PM:** Bed. A few pages of a novel before collapsing under the covers, as the images and people of today swirl in my head, pounding my consciousness. In less than 24 hours, my life has swooped into the lives of people of different sizes, shapes, colours, nationalities, and religions. We're more alike than we are different, but the sheer randomness and devastating consequences of illness terrify me. Why them and not me?

My gastrocnemius and soleus muscles effortlessly allow me to bicycle to my Spanish class, while Mr Yang limps from his tumour. My joints glide smoothly while Carola Castaña's chafe bone against bone. I live in a culture in which medicine is so easily obtainable, yet Carola's arthritis has gone untreated for so many years.

It pains me that there is nothing I can do for Mr Yang. And that I lack the language

skills to offer even the slightest balm of comforting words. Perhaps that is what is driving my obsession with Carola Castaña's arthritis treatment. It is obvious that a 1-day delay, after 23 years of inadequate treatment, is meaningless. Yet it has consumed my energy. I have spotted one tiny brick in the chaotic rubble that I can attempt to right.

The harrowing state of humanity can be chilling, and if I meditate too long upon it, the ache under my right shoulder bores its way through to my insides. I grab a heating pad, cram it under my shoulder, and crank it to the highest setting. The heat seeps in slowly and I can feel my brain gradually easing its frenetic grip on awakesness.

Yes, the world is random and cruel. And yes, there is not much an individual can do to alter that.

But maybe re-righting one brick will provide a scrap of order to the chaos, a sliver of support for a future column. Maybe Carola will finally get her medications. Maybe that is cause enough for joy.

Tomorrow: Another day at the clinic.

My eyelids give up fighting and finally sink closed.

#### Danielle Ofri

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