Corpus Callosum

Ebling Library's Journal of the Arts

Fall 2025

On the cover

Door County Winter

Michael Killips, BA
School of Medicine and Public Health
2024
Acrylic on canvas, 48” x 36”

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Fall 2025 Issue

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Dear Reader,

Welcome to the Fall 2025 issue of *Corpus Callosum*. Just as many things in life change and evolve, *Corpus Callosum* is no different; after five years of publication, we are debuting a new format, which allows us to showcase the amazing creative works in our health sciences community in a more dynamic, responsive, and engaging way.

This issue is packed with rich visual art, from moody monochromatic pieces to cheerful color compositions; thought-provoking written works considering many aspects of health and health care by those who practice and those who receive it; and an artist interview with wonderful advice for artists to be playful and to give themselves grace.

Enjoy!

In gratitude,

Lia Vellardita
Managing Editor, *Corpus Callosum*

Six Questions with Michael Killips

Michael Killips, retired from the role of Manager of Classroom and AV Services for the School of Medicine and Public Health, has several of his drawings and paintings published in *Corpus Callosum*, including *Tired Piano* (Fall 2020), *Pandemic Distractions* (Spring 2021), *Migraine* (Fall 2021), *Winter Field* (Fall 2022), *Evening Wine* (Spring 2024), *Lighthouse from Schooner* (Fall 2024), *Lake Superior Waves* (Spring 2025), and *Door County Winter* (Fall 2025).

Question 1: What drew you to drawing and painting and what is your background in it?

Killips: As a youngster I had a great interest in art but wasn't particularly good at any one discipline. I enjoyed the process of creating art but was often disappointed with the final outcomes. In high school I found success in other art forms such as performance and writing. I didn't tap into fine arts earnestly until taking a drawing class in college. I was surprised with how much I enjoyed drawing, how much effort I needed to put into the class to be successful as well as realizing I could draw at a high level.

My first two jobs out of college had significant artistic creative challenges which I loved. I worked at a radio station for a short period of time and then for the next twenty years I worked for the UW School of Nursing, managing the TV Studio. There I helped produce educational and broadcast quality programming. It was there that I honed my skills on composition, lighting and design. These skills, which I use every day, transferred nicely to fine arts. My work for the SMPH was less artistically challenging so I found an outlet in writing, inspired by a couple of other SMPH employees.

While planning for retirement I decided I would take drawing classes to further explore my fine arts interest. This decision included a promise to myself that I would approach this differently than I had approached fine arts in the past. Once I retired in 2018, I jumped in with both feet. I enrolled in art classes as soon as possible, committed to working on art every day, developed a routine that reinforced my commitment. I wasn't thinking about painting until one of my drawing instructors turned a drawing session into a plein air session. I hadn't painted since junior high school so I wasn't enthusiastic about the assignment. After a bit of reflection, I reframed my mindset, pushed past my fear of failure and painted with some unexpected success. I found painting expanded my opportunity to be creative and further express myself. Inspired, I signed up for several different painting classes which helped me determine that acrylic paint is my medium of choice. Eventually my commitment to creating art led me to converting a spare bedroom into an art studio. Having a dedicated space for art has been a game changer.

Question 2: What motivates you to create and what inspires your art?

Killips: Much of my art is inspired by nature. In nature I find peace so I can be introspective, open to expressing what I see and feel.

I've had the good fortune to have some great instructors and fellow classmates that motivate me to be a better artist. I learned a great lesson by watching a fellow classmate work very hard to create a wonderful art piece. What I understood after watching her was that if nothing else, I too can work really hard. That wasn't a guarantee that I would be successful but I certainly wasn't going to be a better artist if I didn't put some serious effort into my art. Over time that hard work has paid off. To be around talented classmates and having fellow artist friends has been inspirational for sure. The support and encouragement and the occasional blunt but truthful critique from my wife has been invaluable.

The wisdom and generosity of the many instructors I've had over the years has been critical in my development as an artist. These instructors have provided insightful critiques of my work and encouragement that has helped me grow as an artist. They've opened my eyes to a wider world of fine arts, much of which I can apply to my work. They also reminded me to be playful.

Question 3: Do you have any favorite artists or art that have influenced you and who/what are they?

Killips: One of my favorite artists is Edward Hopper. His paintings *Nighthawks, Gas and Ryder's House* in particular all have touches of isolation and loneliness that I connect with. As an introvert, Hopper's works resonate those feelings for me through his design and application of paint. As a youngster, I was influenced by the music of Hank Williams. His ability to tell a vivid story through his music, lyrics and woeful singing touched my soul and since then I've wanted to create art that does the same thing. In part because of him, I taught myself how to play guitar but only through drawing and painting have I been able to create art at a much deeper level.

Question 4: How do you balance your art with the rest of responsibilities in your life and does art help you in those other arenas of your life?

Killips: As I was preparing for retirement, I decided that I would reserve every morning to either create art or do things that are art related. Now when I wake up in the morning I put on my "Art Clothes," have breakfast and head to the studio. It's a great way to start the day!

For the past couple of years I have had to deal with some serious health issues in the family so I've learned to pivot when necessary and fortunately most days start in the studio. Creating art has been helpful for me to find a quiet place to recharge and recenter myself. I also think that some of my recent paintings have more intensity as I've channeled that stressful energy into my art work.

Question 5: What is next for your art (anything you are working on now or planning to)?

Killips: I have some rather ambitious projects planned for the foreseeable future. I have a challenging charcoal drawing I'd like to finish that I started a while ago. I plan to revisit several subjects that I think I can improve upon with new paintings. I have a couple large landscape paintings in the queue, one being 40"x16" and one that I'm considering that might be 72"x48". Finally, I'm designing a three-painting series with different, complementary canvas sizes.

With all that going on, I signed up for a class which begins soon. One of my goals in that class is to do some experimenting with colors and paint application tools. I want to use color in less obvious ways than how I use color now, for example paint an apple using blue instead of red. I also want to try using different sponges to apply paint and create more abstract works. I look forward to all those challenges.

Question 6: Do you have any advice for anyone curious or interested in getting into art who hasn't before?

Killips: My advice to anyone curious about getting into art is: Do It! I recommend taking classes to jump start your quest and see what might be of interest. Classes are available locally through MSCR for example, which has a variety of classes for those just starting out. Take the time to figure out your expectations, how much time and energy you can devote to creating art. Give yourself some grace as you navigate your art journey. When things don't go according to plan, understand that every experience can be a learning experience and not everything you create will turn out as expected. That's Okay!

Corvid Curiosity

Kallie Harrier, OD
School of Medicine and Public Health, Ophthalmology and Visual Sciences
2023
Photograph, 44” x 22”

Early Morning Flower Visits

Qiuwen Quan
School of Medicine and Public Health
2021
Photograph

Five minutes to midazolam

Madison Harris, BA, BS
School of Medicine and Public Health
2025
Short story

I thought my brother died in my arms.

His lips were blue, his body shaking all over, and he wasn't breathing. The brightness of his red hair and glasses only made the stillness more terrifying.

It began in slow motion- his arm stiffening, slumping over the side of the chair. My mother and I thought he was taking a nap at first, but naps don't have that much twitching.

I bolted from across the room, catching him before his head hit the floor. I held him tight, easing him from the chair to the ground, turning him onto his side so he didn't choke on his own tongue. My hands fumbled for my phone, starting a timer as I ordered my mother to call 911 and grab his emergency medication.

Midazolam. The seizure medication.

It was only to be given if he seized for more than five minutes. So, we waited.

Do you know how long four minutes, and fifty-nine seconds is? I'm not sure I do anymore. Time dissolved into something unreal. We sat in the living room, begging the ambulance to come faster, pleading with my brother to stop- though he had no control. The fire alarm went off, dinner burning in the oven. The smell filled the room. *Ironic*, I remember thinking. *Are we smelling the phantosmia with him?*

We smoothed his hair, wiped the sweat from his forehead, and held on to one another- helpless, waiting for the sirens to save us.
Then, at four minutes and forty-seven seconds, the shaking stopped.

In neurology clinic years later, an epileptologist prescribed a mother a familiar drug. “Midazolam,” he said. “Give it if the seizure last more than five minutes.”
From my chair in the corner, I wondered-
how long is five minutes to them?

Gizmo: a Gremlin in NYC

Rachel Mosher
Waisman Center
2024
Oil on canvas, 20” x 16”

Learning to Carry the Load

Toby Campbell, MD, MSCI
School of Medicine and Public Health, Department of Medicine
2025
Essay

If you can think of one hundred ways for a person to die, then I have seen at least as many reactions from patients who learn they are dying. As an oncologist, I have the responsibility of identifying and delivering the worst possible news to people, and I have been witness to an awesome range of reactions, from whispered regret to outrage. It is my job to prepare myself with the most accurate information and then lead all of us through this life-altering conversation, making certain that all voices are heard.

It must be an awful experience, being the unfortunate subject of this "it's not curable" conversation. Sometimes I see rationalization ("at least I…") and sometimes resignation ("everyone has to die someday…") and commonly rejection ("there must be something you can do"). Whatever the verbal response, there is always an emotional response--often the strongest emotion of that patient's entire life ("Who the fuck are you to tell me that?").

Quite naturally, a patient's first reaction is to ask about treatment options: "What are we going to do?" The patient is usually hoping, often desperately, to discover that I have a way out of this situation, in spite of what I just said. Our patients may even implore us to "give me some hope"--"hope" usually means "treatment"--even before they have a firm grasp on the goals for treatment. The concept of life-prolonging or palliative therapy may be so clear and familiar to oncologists, yet it is easily misunderstood by a patient desperate for a clear path to a long future. The temptation, of course, is to accept their suggestion and follow them into the routine dialogue about the standard of care, chemotherapy, or the current clinical trial, but this often obscures the prognostic implications. The rotten "this is incurable" bit gets washed away like so much water under the bridge. I think allowing the conversation to proceed in this order is a big part of the reason patients and caregivers routinely misunderstand their prognosis and the goals of therapy[1]. So I have learned to slow down and to ask permission to wait for a moment before we talk about treatment. "We will definitely talk about treatment," I tell them, "but before we do, can I check in on you? How are doing with this news?"

I have come to believe that my responsibility to my patient in this daily (for me) and once-in-a-lifetime (for them) conversation requires me to carefully transfer a piece of completely unwelcome knowledge about disease and mortality. Only then can we honestly consider, and plan for, their future. In this moment we create, we have to spend some time processing, and beginning to cope, with the news. We have to jump into the river together. My goal is for them to fully understand what I am telling them. They may not be able to take it in unless I create and hold an emotional space for the patient and family to process, to grieve, or weep, or thrash.

When you have this conversation as frequently as I do, you see all these reactions in their most raw and honest and fresh form. I see the moment someone truly registers the mortal implications of what I am telling them. I see them break, as I gently apply the pressure, like a pretzel popping in my hands. If I press steadily, and slowly, with just enough force, the pretzel pops into pieces but doesn't crumble. If I do my job well, my patients can still see me as a caring, even loving, presence rather than an aggressor. With my patient Jake, I found it difficult to tell in the moment if I had succeeded. But ultimately, he demonstrated his understanding, incorporated his impending mortality, and proceeded to live in the face of it.

When I told Jake, a 65-year-old veteran with rough hands and relapsed mesothelioma, he sat, still and silent. For a long time, the only sound was his sandpaper hands rubbing slowly together as he shook his head. Then, hands now rubbing and then tapping his thighs, he began to nod. His wife, Carol, sat by his side but never touched him and never spoke. It occurred to me they had coped with difficult things before and she knew what he needed from her. Neither of them cried. The tension was so thick I may have held my breath as I took Carol's cue and held the silence.

Jake took in a huge breath and let out a long sigh. Then he abruptly stood and offered me his outstretched hand for a shake.

"Well, Doc, I'd better be going."

Shocked, I said with a little chuckle, "What? Jake, this is a different reaction than I was expecting." He just looked at me, so I added, "How are you doing with this?"

"Oh, okay, I guess. I need to get out of here. I need to buy a Corvette. I'm going to get a brand new one. Red. It is the one thing I always wanted to do, own a Corvette. I want to thank you for helping me realize it's time to buy a new car." Carol, with a half-smile, shook her head, gazing at her lap.

Over the next couple years as we treated his mesothelioma, Jake proved to be a man of few words. He lived his remaining time with conviction and a clear sense of purpose and he often thanked me for being honest. "I appreciate that I could drive my corvette a lot longer than I ever imagined."

I carry these conversations with me, and the older I get, the more stories I have to carry. Now, in my twentieth year as an attending oncologist, I am feeling the accumulated weight of tragedy and my strategies to lighten my load seem limited to playing basketball and family time and eating out. It all makes me wonder: is my part in this work a privilege? An opportunity? A burden?

The moment prognostic awareness dawns on someone is a scary and tenuous point, in both the conversation and our relationship. I expect strong emotions so much that their absence is how I realize I haven't yet done my job. Because breaking people is, in a way, my job. I know from experience they will pick up the pieces and reform, both in the moment and over the duration, into something new and different--usually something stronger, but not always. Sometimes I fail to navigate this moment just right for a particular person. If so, I usually discover I've broken not only the patient but our relationship—but I only learn this later, when the patient asks me never to return or goes to see a different doctor for follow-up.

With Rhonda, I think I went too far on the first visit. While I treated her with chemotherapy and she lived nearly two years, I was never able to regain the trust to broach the subject of mortality again. Even when she was approaching the very end of her life and I tried, in vain, to discuss the help a hospice agency could provide, I managed only to push Rhonda and her family away.

Rhonda was a 58-year-old elementary school cafeteria worker with purple hair and a love for dancing. When I told her, she stared at me, then looked at her family: she had brought at least ten family members to the visit today, including a 2-year-old grandchild who was currently scooting around the hallway outside the room in a toy car. The family's eyes were darting between each other and back to me, silently registering the information.

"You all are going to be okay," Rhonda pronounced.

And with that, like a wave they all rose and surrounded her. Her sisters were at each shoulder, leaning down to hold her. A daughter was on her knees in front of her, crawling up into her lap, sobbing and wailing uncontrollably. Others were in the chairs next to her. With no room to reach her, a daughter fell to her knees on the floor in front of me, arms wrapped tight around my legs and her head in my lap. She was shaking her head between my legs as she screamed over and over "No, Jesus. No, Jesus. NO JESUS NO JESUS NO JESUS."

Typically, my emotional and physical needs in these crucible moments are minimal. But right then, in this compromised position with an unknown woman's head in my lap, I had a moment of terror all my own: what if someone walked in here right now?

Rhonda saved the day. "Tamara, you get up," she said. "Tamara: get off the doctor. Come over here and give me a hug." Rhonda looked at me as if to say, What can you do?

Rhonda, her eyes shiny but not flowing, looked like a person who wanted to break down, to embrace her sadness, but who worried about the effect it would have on this roomful of crushed souls. In future visits, Rhonda would bring a sister and a daughter, her strongest protectors. They would remind me as soon as I entered the room that they were there to "talk only about good news." Even after all chemotherapy was exhausted and I was seeing her at home on video visits, we never captured another moment of intimate conversation. Her *family was shocked when she died. "I'm sure you're an excellent oncologist with the technical stuff," they scolded me, "but you really need to work on your bedside manner."*

Even as I do my very best, I have cases like Rhonda's that gouge into the core of my identity as a physician and send me reeling. I felt doubt about my oncologic and communication skills, drank too much, and wondered if continuing as a clinician was pointless. I could recognize the symptoms of fatigue and burnout. Since the pandemic, and some chronic knee pain, has limited my basketball playing, I decided to try another method.

I have been writing for 25 years informally as a mechanism to process and explore events that happen in my life. I decided to partner with a local author, editor, and writing instructor (MW[2]) to create a narrative workshop for myself, trainees, and colleagues as a tool for coping with being an oncologist. We worked collaboratively to develop a curriculum and agreed to include four core components to our workshop: writing, sharing with peers, editing, and a public reading[3].

The process of writing is often as significant as the finished work. Only as I wrote this essay did I realize my patients and I are in a similar fragile condition. They are dealing with the acute shock of facing mortality; I am carrying the accumulated burden of stories of loss. I sometimes feel dejected, even hopeless, in the face of my five new patient visits every week. Yet our patients expect us to be tireless crusaders, invulnerable to the slings and arrows of fortune. And I want to be, if not tireless, at least able to maintain my energy and enthusiasm for the day-to-day practice of oncology. So, like my patients, I have to create space to process and to grieve.

For me, writing and sharing stories with my colleagues is the safe space we create together in order for us to do what we must: allow ourselves to break. We write from prompts and learn writing techniques to help us explore and express ourselves. We edit to refine and retell the story to others but also to discover the elements in the story that are central to us. Finally, we read aloud one of our pieces publicly which, while anxiety provoking for all, feels like a critical step, for me, to ultimately letting a story go. By doing all of it *together*, we give our stories away and lighten the load. We have the opportunity to learn from one another, support one another, and re-form into something stronger and more resilient.

Sharing my written work publicly, as in this essay, is another step in admitting my own vulnerability. The partnership with a writing professional elevates the quality of the writing and of our experience. It also fosters our ties to the local community. For example, our public reading is at a locally owned bookstore where many graduates of the course buy their books.

As an unanticipated side benefit, I think the writing class helps me be a better clinician: in learning more about story development, I find myself interviewing my patients with more attention to details about character and setting and story.

Each of these components of our process is important. Each contributes meaningfully to the end result of a more resilient community of clinicians.

Judy, a 74-year-old retired executive making a second career as an organic farmer, simply looked at me. She looked at me for a long time. Then her brow furrowed and head started shaking, a slight rhythmic oscillation, more like a tremor than a gesture.

Her husband reached out to take her hand and she looked at him, eyes wide and blank. And then back to me, her expression lost, eyes imploring.

"I don't understand," she said.

"Shocking, I know," I replied.

"I've lived a good life. I've always eaten all the right things." She had a yellow legal pad in front of her with what appeared to be pages of questions she'd been prepared to ask me, with spaces for writing my answers. She flipped through the pages, front to back and back again, looking for something to ask me. From what I could see as she flipped, I guessed her prepared questions were no longer relevant: How long might I expect the recovery to be after surgery? Do you have a wig salon? How soon after we finish treatment can we travel internationally?

She scratched her pencil on the paper as if taking notes but, from my vantage point, I could see it was just wordless jottings.

Here, in the sterile quiet of my office, it feels clear that what I do is, of course, both a privilege and a burden. Oncologists and palliative care clinicians are at high risk for burning out, doing this day in and day out, and I certainly feel the despair at times. It is through writing that I have come to an understanding that I have a choice to make: I can *decide* to consider this part of my job not the "dirty work" but a chance to have once-in-a-lifetime conversations every day. My patients are fully aware and engaged when they choose to grant me access to their secret desires and sacred family spaces. We unite to plot against our common enemy and we celebrate victories, large and small, along the way.

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2. Madison Writers Studio Homepage. (Accessed 3/17/2022, at https://madisonwriters.com/our-team/michelle-wildgen.)
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Madrid Man and Door

Jay Gullixson
School of Medicine and Public Health
2024
Photograph

Sick Days

A.C. Mapes
School of Medicine and Public Health
2023
Poem

She was trying to help, but
I didn't want to hear it,
her telling me exactly
what I would have told her—
what I did tell her—
when it was her illness that flared:

It's okay to rest.
It's okay to say no and to
cancel and to sleep ten hours
when you need to.
It's okay to take a sick day.
It's okay to take more than one.

*

"It'll be easier once your immune system
destroys the tissue completely,"
my doctor assured me.
But total destruction
would mean
total dependence.

Luckily, I was too tired to care;
my brain
too foggy to worry
about drug shortages,
natural disasters,
or good manufacturing practices.

If I were stranded on a desert island,
what would I take?
Levothyroxine. The two bottles required

to craft my dose, and
Brazil nuts to pop once a day
like vitamins in case they helped.

If I didn't get rescued
before my 90-day supply ran out
I'd go from fine
to forgetting words
to losing hair
to ashy white legs despite the tropical humidity.

I'd go from alert to fuzzy,
content to depressed
no matter how sunny the island.
I would no longer feel fine;
I would no longer feel much,
my brain
dazed
and slow
to process.

*

Last time, it wasn't my body
making me ill,
it was my insurance company.
A change in formulary.
A decision by a man—I imagined—in a tie
looking at financial reports not lab results.

Last time, my heart raced.
I buzzed with anxiety.
I couldn't sleep.
My skin was warm to the touch,
my speech on hyperdrive without
a drop of caffeine.

This time, the etiology of my illness is
pharmacological—a new generic,
fluorescent green from artificial dyes.
Stinky and strong. Too strong.
I'm even sicker—the adverse effect a

Grade 2, but no one's tracking that anymore.

*

The sick days add up and I dread them.
I worry every time I wake up tired
or feel anxious
or can't come up with a word in conversation.
I'm normally sharp. I'm normally funny
but this is too far from fun to laugh about.

Whether I feel well and function,
whether I get to live in the world or on my couch
is up to Big Pharma, lobbyists,
insurance bros, investors, politicians,
and what generic is available when
I call for a refill.

So I listen to my friend's words.
I call in sick and stay home and
wonder how many signs I missed.
Hyper could be fun before the crash,
hypo too ambiguous to recognize
until the symptoms added up to Aha!

I take another sick day
I hope doesn't turn into a sick week,
a sick month, a sick life.
I try to tamp down my anger at the betrayal
that yet again, my illness was manufactured
by a system far sicker than mine.