# HEART RHYTHMS

## CHAPTER 1: SINUS RHYTHM

I diagnose the rare cardiac condition before I’ve even finished my first cup of coffee, which is frankly impressive considering the pounding headache threatening to crack my skull open from the inside. The patient’s symptoms read like a cardiology board exam question designed to trip up second-year residents—non-specific chest discomfort, mild dyspnea, unremarkable ECG, and normal cardiac enzymes. But there’s something about the pattern of pain radiation and the subtle ST-segment changes visible only when comparing sequential ECGs that triggers recognition in my brain.

“Prinzmetal angina,” I announce to the room of residents following me on rounds. “Variant angina caused by coronary artery spasm rather than fixed obstruction. That’s why her symptoms occur primarily at rest rather than during exertion, and why the nitroglycerin provided immediate relief despite minimal findings on initial workup.”

The residents stare at me with that particular mixture of awe and intimidation I’ve carefully cultivated over the past five years at Manhattan Memorial. Dr. Sharma, the senior resident who had presented the case with absolute confidence in her diagnosis of costochondritis, looks like she’s considering a career change to dermatology.

“But her cardiac enzymes were normal,” she protests weakly, flipping through the chart as if the numbers might have magically changed in the past five minutes.

“Initial troponins can be normal,” I explain, keeping my tone neutral despite the throbbing behind my eyes that makes me want to snap at her. “Order a coronary angiography with provocative testing for vasospasm, start her on a calcium channel blocker, and increase her nitrates. Document the diagnosis as Prinzmetal angina and flag the chart for my review before discharge.”

I move to the next patient room, aware of the residents scrambling to keep up both physically and intellectually. The satisfaction of the diagnostic catch momentarily overrides my hangover, though the fluorescent hospital lighting continues its assault on my retinas with sadistic enthusiasm. Last night’s bourbon was a mistake, but then again, so was agreeing to have dinner with my father. The two mistakes are, of course, causally related.

“Dr. Bennett,” calls a voice from behind me, and I turn to see Dr. Winters, the cardiothoracic department chair, approaching with the particular expression that means he wants something that will make my day worse. “A moment of your time?”

The residents scatter like startled pigeons, their self-preservation instincts correctly identifying an administrative conversation they want no part of. Cowards. Though I can’t blame them—I’d escape too if I weren’t the specific target of Winters’ attention.

“Of course,” I reply, my professional smile firmly in place despite the hangover and the certainty that whatever he wants will be both tedious and annoying. “How can I help?”

“The research committee meeting has been moved up to this afternoon,” he informs me, checking his watch as if his time is exponentially more valuable than mine, which, given our respective positions in the hospital hierarchy, is technically true. “Two o’clock in the Harrington Conference Room. They’re particularly interested in hearing about your proposed study on arrhythmia prediction algorithms.”

The study I haven’t actually started designing yet because I’ve been too busy covering extra shifts in the cardiac care unit while simultaneously preparing for my father’s visiting professorship next month. Perfect.

“I’ll be there,” I assure him, mentally rearranging my day to accommodate this new crisis. “The preliminary data is quite promising.”

This is a lie, but a small one in the grand scheme of medical politics. There is no preliminary data because there is no preliminary anything, but by two o’clock, there will be at least the outline of a study design compelling enough to satisfy the research committee’s curiosity without committing me to any specific methodology I might later regret.

“Excellent,” Winters says, already turning away, his attention span for non-department chair concerns exhausted. “Oh, and the new music therapy program starts today. Try to play nice with the new specialist. Apparently, she comes highly recommended by Mount Sinai.”

He disappears down the hallway before I can process this non sequitur about music therapy, which seems to have been tacked onto our conversation like a pharmaceutical rep’s promotional pen—unwanted but too insignificant to actively reject. I make a mental note to avoid whatever wing of the hospital has been designated for guitar strumming and tambourine shaking, then return my attention to rounds.

The next three patients present straightforward cases—medication adjustments for chronic heart failure, pre-op clearance for non-cardiac surgery, and follow-up on a recent pacemaker implantation. I move through their care with efficient precision, teaching the residents while simultaneously documenting in the electronic medical record, a form of multitasking that has become second nature after years of practice.

By the time rounds finish, my headache has receded to a dull pressure rather than acute stabbing, and I’ve almost convinced myself that I’ll survive the day without the embarrassment of vomiting in a supply closet. Almost.

“You look like hell,” observes Maya Rodriguez as she appears beside me at the nurses’ station, her emergency department scrubs rumpled in a way that suggests she’s been working for at least twelve hours. “Dinner with the great Dr. William Bennett didn’t go well, I take it?”

“Define ‘well,’” I reply, signing off on the last patient note before turning to face her. “If you mean ‘Did I endure three hours of subtle criticism disguised as paternal concern while he dissected every career choice I’ve made since medical school?’ then yes, it went exactly as expected.”

Maya winces sympathetically. As one of my few actual friends in this hospital full of colleagues and competitors, she’s heard enough about my father to understand the complex dynamics at play. “That bad?”

“He’s concerned that I haven’t published enough original research to secure the attending position,” I explain, the familiar frustration rising despite my attempt at professional detachment. “Apparently, my clinical work with actual patients counts for nothing if it doesn’t result in journal articles with my name prominently displayed.”

“Says the man who hasn’t touched a living patient in what, fifteen years?” Maya asks, her eyebrow raised in that particular expression that makes her such an effective emergency department chief. “Not since he ascended to the research heavens where mere mortals with stethoscopes dare not tread?”

Her characterization of my father’s career trajectory is not entirely inaccurate, which makes it both amusing and painful simultaneously. William Bennett, MD, PhD, FACC, abandoned clinical practice for research laboratories and academic publications long ago, a transition he considers evolution rather than retreat.

“He brought up Hopkins again,” I admit, lowering my voice though there’s no one nearby to overhear. “His colleague there is looking for a research fellow with clinical experience. Apparently, it would be ‘the perfect stepping stone’ to a prestigious academic position.”

Maya’s expression shifts from sympathy to indignation on my behalf. “You’re already at one of the top cardiology departments in the country. What exactly does he think you need a stepping stone to?”

“Something more impressive than merely saving lives, apparently,” I reply, the bitterness slipping through despite my attempt at humor. “Something worthy of the Bennett legacy.”

The Bennett legacy. The phrase alone is enough to trigger a tension headache distinct from my hangover. Three generations of cardiologists, each more decorated than the last, culminating in my father’s research empire at Columbia Presbyterian, where he conducts groundbreaking studies and trains future cardiac researchers with the benevolent condescension of a deity instructing mortals.

“Your father is brilliant,” Maya acknowledges, her tone suggesting this is not entirely a compliment. “But he’s also stuck in an outdated model of medical success that values publications over patient outcomes and academic prestige over clinical excellence.”

She’s right, of course, but the rational understanding does little to counteract thirty-five years of conditioning. The Bennett men are exceptional. Exceptional men publish. Exceptional men secure research grants. Exceptional men advance their field through innovation rather than merely practicing within established parameters.

“Anyway,” I say, deliberately changing the subject before I spiral into existential career doubt in the middle of the cardiac care unit, “how’s the emergency department? Still full of people who don’t understand that chest pain after eating an entire pizza isn’t a heart attack?”

Maya laughs, allowing the conversational pivot. “Yesterday I had a patient who was convinced he was having a cardiac event because his Apple Watch showed an irregular heart rhythm. Turned out he was just really bad at applying the sensors correctly. Spent twenty minutes showing him how to use the feature properly, which I’m pretty sure isn’t covered by insurance reimbursement.”

We chat for a few more minutes about the intersection of consumer technology and medical anxiety before Maya is called back to the emergency department for a new arrival. As she leaves, she turns back with a knowing look.

“By the way, your research committee meeting got moved up, right? Two o’clock?”

I narrow my eyes suspiciously. “How did you know that?”

“Because I’m also presenting,” she explains with a grin that suggests she’s enjoying my surprise. “Emergency department collaboration with the new music therapy program for anxiety reduction during high-stress procedures. Apparently, they’re very excited about our preliminary data.”

“You’re working with the music therapy program?” I ask, unable to keep the skepticism from my voice. Maya is one of the most evidence-based practitioners I know, her emergency medicine approach grounded firmly in research and protocol rather than alternative interventions or complementary approaches.

“Don’t look so horrified,” she laughs. “The music therapist is actually brilliant—has a research background and takes a very data-driven approach to intervention design. You might be surprised.”

Before I can respond with the appropriate level of doubt, her pager sounds again, and she hurries toward the elevator with a quick wave. I’m left contemplating this unexpected development—Maya Rodriguez, champion of emergency medicine protocols and evidence-based interventions, collaborating with a music therapist. The world has clearly gone mad, or perhaps my hangover is worse than I thought, causing auditory hallucinations.

I check my watch and calculate that I have approximately three hours to create a research proposal compelling enough to satisfy the committee while simultaneously vague enough to allow significant modification once I actually have time to design a proper study. First, however, I need more coffee and possibly some form of greasy food to absorb the remaining bourbon molecules currently wreaking havoc on my neurotransmitters.

The hospital cafeteria is experiencing its mid-morning lull, the breakfast crowd gone and the lunch rush not yet begun. I select a coffee large enough to qualify as a personal swimming pool and an egg sandwich that looks only mildly questionable, then find an empty table in the corner where I can work undisturbed. Opening my laptop, I begin outlining a study on predictive algorithms for arrhythmia detection, drawing on recent literature and adding just enough innovative methodology to seem original without requiring resources I don’t actually have access to.

I’m deeply focused on creating a budget spreadsheet populated entirely with educated guesses when my phone vibrates with an incoming call. The screen displays “Dad,” and I experience the familiar mixture of obligation and dread that characterizes most of our interactions. For a brief, rebellious moment, I consider letting it go to voicemail, but thirty-five years of conditioning override the impulse, and I answer before the third ring.

“Hello, Dad,” I greet him, keeping my tone neutral despite the lingering effects of both the bourbon and the dinner conversation.

“Elijah,” he responds, using my full name as he always does, despite the fact that no one else has called me anything but Eli since elementary school. “I’m calling to follow up on our discussion last night. Have you given any thought to the Hopkins opportunity?”

No “How are you?” or “How’s your day going?” Just straight to the career advancement agenda, as if our dinner conversation had merely paused rather than concluded eight hours ago. Classic William Bennett efficiency.

“I’ve been a bit busy with patient care this morning,” I reply, unable to keep a hint of edge from my voice. “Diagnosed a case of Prinzmetal angina that had been missed on initial workup.”

There’s a slight pause, and I can almost hear him deciding whether this clinical accomplishment merits acknowledgment before he returns to the more important topic of my career trajectory.

“Interesting case,” he allows briefly. “Regarding Hopkins, Richard would need to know by the end of the month if you’re interested in the position. The timing would work well with your contract renewal at Manhattan Memorial.”

The implication is clear—I should consider leaving my current position for this “opportunity” his colleague has magnanimously offered, despite the fact that it would effectively be a step backward in terms of clinical responsibility and autonomy. But it would have the Bennett stamp of approval, which apparently outweighs such trivial considerations as professional satisfaction or personal preference.

“I have the research committee meeting this afternoon,” I tell him, offering this information as both explanation and deflection. “I’m presenting my proposal on arrhythmia prediction algorithms.”

Another pause, this one calculating rather than dismissive. “That could be promising,” he acknowledges, academic interest momentarily overriding his Hopkins agenda. “What methodology are you proposing for the machine learning component?”

I outline the approach I’ve been developing on my laptop, watching as my made-up study gradually becomes more real through the simple act of describing it to someone else, especially someone with my father’s expertise in cardiac research methodology. Despite our complicated relationship, his technical feedback is invariably insightful, and I find myself taking notes as he suggests refinements to the study design.

“Send me the proposal after you’ve presented it,” he instructs as our conversation winds down. “I’d be interested to see how the committee responds. And Elijah—” he pauses, his tone shifting slightly, “—think about Hopkins. It could be the right strategic move at this point in your career.”

The call ends, and I stare at my phone for a moment, experiencing the familiar emotional whiplash that characterizes interactions with my father. The brief connection over research methodology, the momentary sense of shared intellectual passion, followed immediately by the return to his agenda for my career path. It’s a pattern so consistent I could graph it with mathematical precision, plotting the brief peaks of genuine connection against the longer troughs of expectation and evaluation.

I return to my research proposal with renewed focus, incorporating some of my father’s methodological suggestions while stubbornly rejecting others on principle. By the time I’ve finished my enormous coffee and questionable sandwich, I have a study design that looks impressively comprehensive on slides while remaining conveniently nonspecific about certain logistical details that I haven’t actually figured out yet.

With the research committee crisis temporarily managed, I return to the cardiac care unit for afternoon patient rounds, reviewing new admissions and checking on the morning’s cases. The Prinzmetal angina patient’s angiography results have returned, confirming my diagnosis with the particular satisfaction that comes from being right when others were wrong—a petty but genuine pleasure in the often humbling practice of medicine.

I’m updating her treatment plan when my pager alerts me to a code blue in the cardiac catheterization lab. I sprint down the hallway, adrenaline instantly clearing the last remnants of my hangover as I mentally review the ACLS protocols for cardiac arrest during catheterization procedures. Pushing through the doors to the cath lab, I find organized chaos—nurses preparing the defibrillator, a resident performing chest compressions, and Dr. Patel, the interventional cardiologist, attempting to complete the stent placement despite the patient’s arrest.

“What happened?” I demand, quickly assessing the monitors and the patient’s status.

“Ventricular fibrillation during stent deployment,” Patel explains tersely, his focus on the catheter he’s manipulating with remarkable steadiness despite the crisis unfolding around him. “Likely reperfusion arrhythmia. I’ve almost got the stent in place—if we can maintain circulation for another thirty seconds, we might save both the patient and the coronary artery.”

I take charge of the resuscitation efforts, directing medication administration and preparing for defibrillation while Patel completes the stent deployment with impressive speed. The moment he withdraws the catheter, I call for defibrillation, and the characteristic thump of electrical current delivering its potentially life-saving jolt resonates through the room.

For two eternal seconds, nothing happens. Then the monitor shows a return of organized electrical activity, followed by the even more crucial return of a pulse. The room collectively exhales as the patient stabilizes, the crisis resolving as quickly as it developed.

“Nice work,” Patel acknowledges, his typical competitive edge temporarily softened by our shared success in saving the patient. “Couldn’t have timed it better if we’d rehearsed it.”

I nod, the post-code adrenaline already beginning to fade as we transfer the patient to the recovery area with enhanced monitoring. These moments—the perfect synchronization of technical skill and medical knowledge, the narrow margin between life and death navigated successfully through training and teamwork—these are what I love about cardiology despite the politics and the pressure. The heart’s elegant simplicity and profound complexity, its resilience and its vulnerability, its mechanical precision and its mysterious variations—all of it fascinates me in ways I’ve never been able to adequately explain, even to myself.

By the time I’ve completed the code documentation and checked on the patient’s post-procedure status, it’s nearly two o’clock. I gather my laptop and research presentation materials, then head to the Harrington Conference Room for the research committee meeting, my mind still partially occupied with the code blue case and the particular arrhythmia pattern that preceded the arrest.

The conference room is already half full when I arrive, committee members engaged in the particular form of pre-meeting small talk that characterizes academic medicine—subtle boasting disguised as casual updates, strategic name-dropping, and careful positioning for influence all wrapped in seemingly innocuous conversation. I greet several colleagues with professional cordiality while setting up my presentation, noting that Maya has not yet arrived.

Dr. Winters calls the meeting to order precisely at two o’clock, reviewing the agenda with administrative efficiency. I’m scheduled to present second, after Dr. Goldstein from neurology discusses his stroke recovery research. I use Goldstein’s presentation time to make final adjustments to my slides, only half listening to his methodology explanation until a phrase catches my attention.

“…in collaboration with the music therapy program, we’ve observed statistically significant improvements in fine motor recovery when rhythmic auditory stimulation is incorporated into standard physical therapy protocols,” Goldstein is saying, displaying a graph that indeed shows impressive differences between the control and intervention groups.

I look up from my laptop, suddenly more interested. Goldstein is one of the most methodologically rigorous researchers in the hospital, his studies impeccably designed and conservatively interpreted. If he’s reporting statistically significant results from a music therapy intervention, there must be something substantive behind it.

Before I can consider this further, the conference room door opens, and Maya enters, accompanied by a woman I don’t recognize. The stranger is approximately my age, with dark curly hair pulled back in a professional style that nonetheless fails to fully contain its natural volume. She carries a tablet and a folder of materials rather than a musical instrument, which somehow surprises me despite being the obviously appropriate choice for a research meeting.

“Sorry we’re late,” Maya apologizes to the room. “We were dealing with a patient situation in the ED.”

Winters nods acknowledgment, and Goldstein continues his presentation, but I find my attention divided between his stroke recovery data and the newcomer, who must be the music therapist Maya mentioned earlier. She listens to Goldstein with focused attention, occasionally making notes on her tablet with quick, precise movements. There’s nothing particularly ethereal or artistic about her demeanor—she has the alert, analytical expression of a clinician evaluating research methodology rather than the dreamy affect I’ve unconsciously associated with music therapy.

When Goldstein finishes, I’m called to present my arrhythmia prediction study. I move through the slides with practiced confidence, explaining the potential clinical applications and innovative methodology with enough technical detail to establish credibility while avoiding specifics that might generate uncomfortable questions about implementation timelines. The committee members nod along, occasionally asking clarifying questions that I field with strategic precision—answering directly when I have the information, and redirecting with thoughtful consideration of alternatives when I don’t.

It’s going well until the music therapist raises her hand during the discussion of patient selection criteria. Winters acknowledges her with a nod, and she leans forward slightly, her expression professionally curious rather than challenging.

“Dr. Bennett, have you considered including psychological stress measures in your baseline patient assessments?” she asks, her voice carrying the particular clarity of someone trained in vocal projection. “Recent studies from the European Heart Journal suggest that autonomic nervous system activation patterns during psychological stress may have predictive value for certain arrhythmia types, particularly in patients with preserved ejection fraction but abnormal heart rate variability.”

The question is unexpectedly specific and scientifically relevant, citing literature I’m familiar with but hadn’t considered including in this particular study design. I experience a moment of genuine surprise, followed by the immediate instinct to defend my methodology against this unexpected scrutiny from someone outside my specialty.

“That’s an interesting consideration,” I reply, my tone professionally neutral despite my internal recalibration of who exactly I’m dealing with. “The European studies you’re referencing used a relatively homogeneous patient population and specialized autonomic testing equipment that might be difficult to standardize across our more diverse clinical setting. But it’s certainly worth exploring as a potential substudy if the initial results show promise.”

She nods thoughtfully, neither intimidated by my response nor antagonistic in her follow-up. “The equipment limitations are valid, though I wonder if there might be value in even a simplified assessment protocol. My lab has been developing a standardized measurement approach using commercially available heart rate variability monitors combined with controlled psychological stress induction. We’re seeing promising correlation with arrhythmia susceptibility in our preliminary data.”

Her lab? Preliminary data? This is not fitting my mental model of a music therapist at all. I find myself genuinely curious despite my initial skepticism.

“I’d be interested in seeing that data,” I respond, surprising myself with the sincerity of the statement. “Perhaps there’s potential for collaboration if the measurement approach could be integrated without compromising the core study design.”

A slight smile appears at the corner of her mouth, as if she’s achieved exactly the opening she was looking for. “I’ll send you our protocol and preliminary findings,” she offers. “There may be more overlap in our research interests than initially apparent.”

The interaction concludes as Winters moves the meeting forward, but I find my attention periodically returning to the music therapist during the remaining presentations. She contributes several more comments throughout the meeting, each demonstrating a solid understanding of research methodology and relevant literature across multiple specialties. By the time Maya and she are called to present their emergency department collaboration, I’m genuinely curious about their project rather than merely professionally polite.

They make an effective presentation team, Maya covering the emergency medicine applications while the music therapist—whose name I learn is Dr. Sophie Winters—explains the intervention design and outcome measures with scientific precision. Their preliminary data, while limited in sample size, shows promising results for anxiety reduction during certain emergency procedures, with corresponding decreases in medication requirements and improved patient satisfaction scores.

“We’re particularly interested in the potential applications for patients with underlying cardiac conditions,” Dr. Winters explains, displaying a slide that breaks down their results by patient demographic categories. “For patients with histories of arrhythmia or heart failure, procedural anxiety can trigger sympathetic nervous system responses that complicate both the procedure itself and the recovery period. Our targeted music therapy protocols show the most significant effect sizes in exactly this population.”

She glances in my direction as she says this, the implication clear—there’s potential relevance to my own research interests. It’s a subtle but effective move to establish a connection between our work, professionally appropriate while suggesting possible collaboration. I find myself reluctantly impressed by both her research and her strategic communication.

When the meeting concludes, I gather my materials while observing Dr. Winters from my peripheral vision. She’s engaged in conversation with several committee members, responding to their questions with articulate precision while maintaining an approachable demeanor. There’s nothing of the stereotypical alternative medicine practitioner about her—no crystal pendants or discussions of energy fields, just evidence-based explanations and methodological details delivered with scientific confidence.

I’m about to leave when Maya intercepts me, her expression suggesting she’s fully aware of my recalibrated assessment of her collaboration partner.

“So,” she says with poorly concealed amusement, “still think music therapy is just guitar strumming and tambourine shaking?”

“I’m reserving judgment until I see more comprehensive data,” I reply, maintaining professional skepticism despite my genuine interest. “The preliminary results are intriguing, but the sample size is limited and the effect mechanism remains unclear.”

Maya laughs outright. “That’s Eli-speak for ‘I was wrong but can’t admit it directly,’” she translates. “Just wait until you see her full research portfolio. Sophie completed a dual doctorate in music therapy and neuroscience at NYU before her clinical fellowship at Mount Sinai. She’s published in Neurology, the Journal of Affective Disorders, and yes, even your precious Circulation.”

This information is both surprising and somewhat challenging to my preconceptions, which makes me instinctively defensive despite my intellectual interest. “Publishing doesn’t automatically validate clinical applications,” I point out. “Plenty of well-designed studies show statistical significance without meaningful clinical impact.”

“True,” Maya acknowledges, “which is why you should talk to her about the clinical outcomes they’ve documented at Mount Sinai. Reduced length of stay, decreased pain medication requirements, improved functional recovery metrics—all with proper control groups and methodology that would satisfy even your exacting standards.”

Before I can formulate a suitably noncommittal response, Dr. Winters approaches, having concluded her conversations with the committee members. Up close, I notice details I missed during the meeting—the intelligent intensity in her dark eyes, the slight calluses on her fingertips that suggest regular instrument playing despite her professional presentation, the confident posture of someone comfortable in academic medical settings.

“Dr. Bennett,” she greets me with professional courtesy. “I wanted to follow up on the potential connection between our research interests. If you’re open to it, I’d like to share our autonomic testing protocol and discuss how it might complement your arrhythmia prediction work.”

Her direct approach is refreshingly free of the political maneuvering that characterizes many research collaborations at Manhattan Memorial, where territorial concerns often outweigh scientific synergy. I find myself responding to this straightforwardness despite my lingering skepticism about her field.

“I’d be interested in reviewing your protocol,” I acknowledge, maintaining professional distance while opening the door to potential collaboration. “My primary concern would be integration complexity and the risk of confounding variables in the prediction algorithm.”

She nods, understanding the technical concern immediately. “Valid points. The protocol is designed to be minimally invasive to existing clinical workflows, and we’ve developed statistical methods to isolate the autonomic variables from other potential confounders. I can send you our validation studies along with the protocol itself.”

“I’ll look forward to reviewing them,” I reply, surprised by my own genuine interest. “Your question during my presentation suggested familiarity with the arrhythmia literature beyond what I would have expected.”

The moment the words leave my mouth, I realize they could be interpreted as condescending despite my neutral tone. Maya shoots me a warning look that confirms the potential offense, but Dr. Winters merely raises an eyebrow slightly, seeming more amused than insulted.

“I find cardiac electrophysiology fascinating,” she responds with professional poise that neither acknowledges nor challenges the potential slight. “The heart’s electrical system has remarkable parallels to certain aspects of neural processing in music cognition—complex rhythmic patterns, sensitivity to timing intervals, predictable variations within established sequences. My postdoctoral research examined those parallels in some detail.”

Her response is both intellectually substantive and subtly assertive, establishing her expertise without directly confronting my unconscious bias. I find myself simultaneously impressed by her knowledge and uncomfortable with my own assumptions—an unusual combination that leaves me momentarily without a practiced response.

“I wasn’t aware of that research area,” I admit, defaulting to honesty in the absence of a more strategic reply. “It sounds like there might be more relevant overlap than I initially considered.”

“Most people underestimate the scientific foundations of music therapy,” she acknowledges without apparent resentment. “It’s an understandable misconception given how the field is sometimes represented in popular media. I prefer to let the data speak for itself.”

Her diplomatic handling of my implicit skepticism further challenges my preconceptions, leaving me with the uncomfortable realization that I may have misjudged both her and her field based on superficial assumptions rather than scientific evidence—a cardinal sin in my own approach to medicine.

“A sound principle in any scientific field,” I agree, finding solid ground in this shared value despite our different specialties. “I look forward to reviewing your data.”

She smiles briefly, professional but genuine. “I’ll email everything this afternoon. And Dr. Bennett—” she pauses, her expression shifting to something more direct, “—I understand skepticism. I encounter it regularly and respect its place in scientific discourse. I don’t expect automatic acceptance, just open-minded evaluation of the evidence.”

With that remarkably straightforward statement, she excuses herself to speak with another committee member, leaving me with the distinct impression that I’ve just encountered someone who will complicate my neatly organized professional world in ways I can’t yet fully anticipate.

“She’s something, isn’t she?” Maya comments beside me, not bothering to hide her amusement at my obvious recalibration. “Not quite what you were expecting from the ‘music lady,’ I’m guessing.”

“She seems scientifically rigorous,” I acknowledge, deliberately understating my impression to avoid giving Maya the satisfaction of witnessing my complete reversal. “Though I’ll reserve judgment until I’ve reviewed her research in detail.”

Maya laughs, seeing through my professional detachment with the ease of long friendship. “Of course you will. Heaven forbid Eli Bennett admit he might have been wrong about something on first impression. I expect a full report after you’ve analyzed her data with your characteristic thoroughness.”

I’m saved from responding by my pager alerting me to a patient situation in the cardiac care unit. “Duty calls,” I tell Maya, gathering my materials with perhaps more haste than the situation strictly requires. “We’ll continue this discussion later.”

“We absolutely will,” she agrees with the particular smile that suggests she finds my discomfort entertaining. “I can’t wait to hear your scientifically rigorous assessment of Dr. Sophie Winters and her research.”

I exit the conference room with as much dignity as possible, my mind already shifting to the patient situation while a small but persistent part of my consciousness continues processing the unexpected encounter with the music therapist. By the time I reach the cardiac care unit, I’ve mentally filed Dr. Winters and her research under “Requires further investigation”—a category reserved for phenomena that don’t fit neatly into my existing understanding but present sufficient evidence to warrant serious consideration rather than immediate dismissal.

The patient situation turns out to be relatively straightforward—a post-procedure arrhythmia that responds to standard interventions—but it leads to a cascade of other cases requiring attention, and I spend the remainder of the afternoon immersed in clinical work. It’s nearly seven o’clock when I finally return to my office to complete documentation and prepare for the next day’s cases.

My email inbox contains the expected accumulation of administrative notices, consultation requests, and journal table of contents alerts. Among them is a message from Sophie.Winters@manhattanmemorial.org with the subject line “Autonomic Testing Protocol and Arrhythmia Prediction Applications.” It was sent at 3:17 PM, less than an hour after our conversation, with multiple PDF attachments and a concise message:

*Dr. Bennett,*

*As discussed, attached please find our autonomic testing protocol, validation studies, and preliminary data on correlations with arrhythmia susceptibility. I’ve also included two published papers that may be relevant to your prediction algorithm development.*

*I’m available to discuss integration possibilities at your convenience. My schedule is relatively flexible on Tuesdays and Thursdays.*

*Regards,* *Sophie Winters, PhD, MT-BC* *Director, Integrative Music Therapy Program* *Manhattan Memorial Hospital*

The email is professionally direct without being either obsequious or presumptuous—a refreshing change from the politically calculated communications that characterize much of academic medicine. I download the attachments, intending to skim them briefly before heading home, but find myself increasingly absorbed in the methodology and results as I read.

Her research is impressively rigorous, with careful attention to potential confounding variables and appropriate statistical analysis of the results. The autonomic testing protocol is elegantly designed to capture relevant data with minimal disruption to standard clinical procedures, and the correlation with arrhythmia susceptibility is stronger than I would have predicted based on previous literature in the field.

I’m particularly struck by a case series included in the preliminary data—patients with preserved ejection fraction but abnormal heart rate variability who experienced arrhythmias during psychological stress testing. The pattern of autonomic activation preceding the arrhythmias shows distinctive features that could potentially enhance predictive accuracy if incorporated into the algorithm I’m developing.

Before I realize it, I’ve spent over an hour reviewing her research, making notes on potential applications and integration points with my own work. The scientific merit is undeniable, regardless of my preconceptions about music therapy as a field. Dr. Winters clearly approaches her work with the same empirical rigor I demand in my own research, and the potential synergy between our projects is more substantial than I initially recognized.

I draft a reply to her email, then pause before sending it, aware that my response has shifted from professional courtesy to genuine intellectual engagement. After a moment’s consideration, I decide that scientific integrity requires acknowledging the merit of her work regardless of my initial skepticism, and I complete the message:

*Dr. Winters,*

*Thank you for sharing your research. The autonomic testing protocol is impressively designed, and the correlation data with arrhythmia susceptibility is stronger than existing literature would have suggested. I’m particularly interested in the case series demonstrating distinctive autonomic activation patterns preceding arrhythmia events in patients with preserved ejection fraction.*

*There may indeed be valuable integration points with the prediction algorithm I’m developing. I would be interested in discussing potential collaboration further. My schedule permits a meeting next Tuesday afternoon if that would be convenient for you.*

*Regards,* *Eli Bennett, MD* *Cardiology Department* *Manhattan Memorial Hospital*

I send the email, then gather my things to finally head home after a day that has included a hangover, a diagnostic triumph, a code blue, a research presentation, and an unexpected intellectual challenge from a specialist in a field I had previously dismissed without proper evaluation. As I walk through the parking garage to my car, I find myself still thinking about the autonomic activation patterns in Dr. Winters’ research and their potential implications for arrhythmia prediction.

It’s only when I’m halfway home that I realize I’ve spent more time thinking about her research than processing my father’s call about the Hopkins position—a rare deviation from my usual thought patterns that suggests either professional evolution or complete mental exhaustion. Given the day I’ve had, I’m inclined to attribute it to the latter, though a small voice in the back of my mind suggests there might be something more interesting happening than simple fatigue.

My apartment welcomes me with the particular emptiness of a space that serves primarily as a sleeping location rather than a true home. I drop my bag by the door, loosening my tie as I head directly to the kitchen where I pour a glass of whiskey—considerably smaller than last night’s pour, given the consequences I dealt with all day. The first sip burns pleasantly, and I carry the glass to my piano, running my fingers lightly over the keys without pressing them enough to produce sound.

The piano was my one non-negotiable purchase when I finally moved out of hospital housing into this apartment three years ago. I rarely play it—sometimes going weeks without touching the keys—but I need it to be here, available, even if mostly silent. It’s a Yamaha baby grand that occupies too much space in my living room and required hiring specialized movers to navigate the narrow hallway of my pre-war building, but its presence provides a particular comfort I can’t rationally explain even to myself.

Tonight, after the unexpected encounter with Dr. Winters and her research connecting music and cardiac function, I feel an unusual impulse to actually play rather than merely touch the keys in passing. I sit on the bench, set my whiskey on a coaster atop the piano, and begin a simple Bach prelude that my fingers remember despite years of irregular practice.

The notes flow more easily than I expect, muscle memory compensating for lack of recent practice. The precise mathematical patterns of Bach have always appealed to me—the logical progressions, the predictable variations, the elegant resolution of tension through established rules of harmony. It’s music that makes sense, that follows discernible patterns while still creating emotional resonance.

As I play, I find my thoughts drifting between the arrhythmia prediction algorithm, Dr. Winters’ autonomic testing protocol, and the distinctive patterns of cardiac electrical activity during stress responses. There’s a connection there, something about rhythmic patterns and predictable variations within established sequences—the very words Dr. Winters used to describe the parallels between cardiac electrophysiology and music cognition.

I transition from Bach to Chopin almost without conscious decision, my fingers finding the opening notes of a nocturne I haven’t played in years. The shift from mathematical precision to emotional expressiveness changes something in my mental state, allowing connections to form between concepts that had seemed separate—the heart’s electrical patterns, music’s cognitive processing, autonomic nervous system activation, and emotional response.

By the time I finish playing, I’ve formulated the outline of a potential collaboration that integrates Dr. Winters’ autonomic testing protocol with my arrhythmia prediction algorithm in ways that might significantly enhance predictive accuracy while expanding the clinical applications beyond what either of us could achieve independently. It’s scientifically intriguing and potentially valuable for patient care, regardless of my initial skepticism about music therapy as a field.

I return to my whiskey, sipping it slowly as I consider this unexpected development. My father would undoubtedly disapprove of collaboration with a music therapist, viewing it as a distraction from the serious research required for career advancement in cardiology. The thought brings a slight smile to my lips—a small, private rebellion against the Bennett legacy that nonetheless has genuine scientific merit.

Tomorrow I’ll review Dr. Winters’ research more thoroughly and refine the collaboration concept before our meeting next week. For tonight, I allow myself the unusual luxury of feeling intellectually stimulated by something unexpected, something that challenges my preconceptions while offering new possibilities for my work. It’s a sensation I haven’t experienced in longer than I care to admit—this particular combination of scientific curiosity and intellectual challenge that reminds me why I chose medicine in the first place, before career advancement and family expectations complicated the pure pursuit of knowledge and patient care.

As I prepare for bed, my phone chimes with an email notification. Despite the late hour, I check it, half expecting another message from my father about the Hopkins position. Instead, I find a reply from Dr. Winters:

*Dr. Bennett,*

*I appreciate your thoughtful review of our research. Tuesday afternoon works well for me—shall we say 3:00 in the research conference room? I’ll bring additional data on the preserved ejection fraction cases that might be particularly relevant to your algorithm development.*

*I look forward to exploring potential collaboration. In my experience, the most interesting scientific developments often occur at the intersection of seemingly disparate fields.*

*Regards,* *Sophie*

Her last sentence resonates with my earlier thoughts about connections between concepts that had seemed separate, and I find myself looking forward to Tuesday’s meeting with unexpected anticipation. It’s been some time since a professional interaction has generated genuine intellectual curiosity rather than merely strategic consideration or political calculation.

I set my alarm, place my phone on the nightstand, and lie down, my mind still processing the day’s events as I drift toward sleep. Just before consciousness fades, a final thought surfaces—I never did eat anything after that questionable egg sandwich at breakfast. The realization is accompanied by a sudden awareness of hunger, but exhaustion outweighs appetite, and I make a mental note to remember breakfast tomorrow as sleep finally claims me.

My last conscious thought is of cardiac rhythms and musical patterns, autonomic activation and predictive algorithms—connections forming between separate domains of knowledge in ways that might lead somewhere interesting if I’m willing to follow where they lead, even if the path diverges from the carefully planned career trajectory the Bennett legacy has established for me. It’s a thought both unsettling and oddly liberating as I surrender to sleep at the end of a day that has challenged more than one of my certainties about both medicine and myself.