

MEDICAL MUSE

*A literary journal devoted to the inquiries, experiences, and meditations of the
University of New Mexico Health Sciences Center community*



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MEDICAL MUSE

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Please include name and contact information.

Reviewers for this issue:

Ann Morrison, M.D.
Erin Roth
Norman Taslitz

Advisor:

Norman Taslitz

Art Director/Designer:

Paul Akmajian
Assisted by:
Laura J. Hall

Thanks to Sandra Naranjo, Dept. of Internal Medicine

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We are pleased to bring you this edition of the Medical Muse. This semiannual arts journal is meant to provide a creative outlet for members of the greater Health Sciences Center community: patients, practitioners, students, residents, faculty, staff, and families. In this business of the scrutiny of bodies and minds, it can be all too easy to neglect an examination of our own lives. This journal is a forum for the expression of meditation, narrative, hurting and celebration – all the ways in which we make sense of what we see and do.

It is our hope that in these pages you will encounter a range of experience from the outrageous to the sublime. What we have in common binds and steadies us, yet there is much to be learned from the unfamiliar.

We see the purpose of the Muse as a way of encouraging members of the Health Sciences community to express their creativity, and we encourage all to submit. Occasionally, subject matter may be controversial. It is never our intent to offend, however we wish to explore the full-range of experiences reflected in our submissions.

Unfortunately, due to space constraints we cannot publish every work that is submitted in the print copy. We wish it to be known that our worst fear is that in selecting submissions we are discouraging the same creativity we wish to foster. We therefore sincerely thank all those who have submitted in the past and ask that you continue submitting. Without your creativity and courage to share the Muse would not exist.

- The Editorial Board

Contributors for this issue:

Terry K. Crowe, PhD, OTR/L	Margaret Menache
Katherine Fancher	David J. Mullen, MD
Katherine Flynn-O'Brien	Marjorie Power
Robert H. Glew, PhD	Ron Reed
Laura J. Hall	Anthony Smith, MD
Steve Thomas Kirk, MD	Ann Thibodeaux
Marsha Leaf, PA-S	Anne Woods
Gopi Mara-Koosham	



Laura J. Hall

Cover photograph by Margaret Menache

THE TIP

Blue's not the hue;
For, the Redwood has gained ground
Leaving the sky reticulate with autumn red.
While the weaklings vanish
In the venomous shade on the dark ground,
Children are born in to blood and death-
A periodic addition to the mound.
A technical error statistic.
Cowards have put cowards to work.
Cowards have put cowards to rule.
The man with the gun is ALWAYS at work.
The man with the gun is ALWAYS brave and ALWAYS right.
For the man with the gun is NO fool.
Aren't we connoisseurs yet-
To kill and live?
To be killed and live?
Has God taken a generation off
As we stomp on the gunman's trail?
Did we just hammer the last nail
In to our own coffin, to decay yet violently?
We are but failing peoples in a falling world
Circling about our end.
Paralyzed beasts that have forgotten
To look in to our absent hearts.
Winter shall come and bring back the blue.
Winter shall paint the redwood nude.
Don't you hear the march of time,
Loud and heavy,
That has uprooted many a Redwood?

- Gopi Mara-Koosham

The Soldier

by Anthony Smith, MD

I first met the man fairly late in the course of his disease. He had a case of advanced prostate cancer. On my first encounter with him, I was struck by several things. I noticed that he seemed to be an exceptionally kind man. I found out that he loved to fish. He particularly liked to fish for trout and in particular he liked to fish the small lake near his house which was nestled in the foothills of the spectacular mountain country in northern New Mexico. His life was pleasant and peaceful. We talked about his passion for knife collecting. He had a slightly rounded face that held a set of kind and friendly eyes. He smiled easily. But, I could also sense nervousness which was later confirmed during the many visits we had together when he would quietly ask me to refill his “anxiety pills.” I don’t know why but at the time I never questioned his need for them and never challenged him when he said he needed them to settle his nerves.

The one other thing that was clear was that he was going to fight his cancer. At the time he was in his late seventies or maybe even his early eighties and I remember thinking to myself, “Why does this man want to fight this thing so hard at his age?” By fight, I mean he was ready to try whatever standard or experimental treatment it would take to beat the cancer. There was no equivocation. There was no second guessing. He was insistent. This was something he was going to do. So we pulled out all the stops and began treatment. We tried many things and the years wore on but eventually the cancer began to win and there came a time when there was nothing left to do. The cancer had done its work and medical science had no more answers give.

The conversation took place at one of our last visits. I don’t know why the subject had never come up before but somehow we drifted into a discussion about war or the military and in the midst of it, I asked him whether he had ever spent any time in the service. The answer was short and to the point. He said quietly, “Oh yeah” but not much more. I figured there was a possibility he might have served during World War II so I asked.

“Were you in the service during the war?”

He responded quietly, “Oh yeah.”

It seemed like he didn’t want to go further but my curiosity got the better of me and so I forged ahead and asked, “What branch were you in?”

“The marines.” Once again there was silence. No elaboration.

I might have stopped there but I felt like I just couldn’t let it go. On a number of occasions during my career treating cancer patients, I have found that some patients late in



Jupiterimages

the course of their disease just need to talk and for some reason this seemed like one of those times. I like to understand my patients and sometimes during these sorts of conversations I have found that both the patient and I gain some new little insight about each other that brings us closer together. In fact, I have found that after one of those conversations, I often feel like I’ve been left with a crystallized picture of my patient’s life. I imagine that it must be similar to what it would feel like to find a nugget of gold in a river

or something like that. On the other hand, I suppose it might also have just been a selfish need to know but either way, I pushed ahead.

“Were you ever in any combat.”

“Oh yeah.”

“Where? Europe or the Pacific?”

“Pacific.”

“Were you ever in any of the big battles?”

“Oh yeah.”

Then came the question that tipped the conversation over the edge. “Which one?”

He started talking. The words began to flow easily. He began to rattle off the names and it became quickly apparent that he had fought in nearly every major battle in the Pacific. He had landed on the beachheads at Iwo Jima and Guadalcanal. There were many others. The list was long. I now understood the reason he had “nerves.”

We talked for a long time. During that conversation, he shared some things with me that in all my years taking care of him, I had never noticed. At one point, he said to me, “Doc, let me show you something.” He rolled up his sleeves. For the first time I saw that both of his forearms were crisscrossed by linear scars. The scars ran sideways from the wrist to the elbow on the fleshy part of the arm. They were small lines like you might see from superficial slices made by a knife but there were so many of them. Time had softened the scars and maybe that is why I hadn’t noticed them before.

“See these doc? I got these in hand to hand combat. Sometimes when we’d get in close, we’d wind up getting cut.”

I couldn’t imagine someone carrying on with that many knife wounds on their arms so I asked him, “Did you have to get out of the service because of those?”

“Oh no doc, that was something else. See one day I was standing on the front end of our destroyer and we took a torpedo in the middle of the boat. I was blown off the front end and wound up floating around in the Pacific for a few days until they found me. By that time, I had these sores all over my body so I spent about a year and a half in a hospital in New Zealand getting better.”

We talked about other things related to the war and

at times I noticed tears in his eyes. It was one of the most magical conversations I have ever had with a patient. For all those years, I had been caring for a true American war hero and had never known it until that moment. It was obvious to me now why he was out to “fight the cancer.” He had already fought a bigger battle. He had seen war and death and no longer had any fear of it. In the end he even told me so. This had been just one more battle to fight. This was his last great battle and I had been privileged to share it with him. What an honor.

He came back the following week and gave me a scrimshaw knife which I still have to this day. Several weeks later he died in that final battle. □

The 4th Person I Saw Die

When Silence calls
And momentum stills
And we stop trying to cool
1000 square miles of steel
With the palm of our Osler
When the ICU digital aviary
Stops calling for attention
When people stop pounding
And let family pour in
With furrowed brow
And furtive looks
As though they stepped into a foreign church
When the gravity falls
That Great Quilt
Over the razor individual tip of Humanity’s 250 thousand years

The dirigible lifts
The lighter emotions free
This weighs heavy
This heavy moment in me

- Steve Thomas Kirk, MD

Oaxacan Adventure Learning about Traditional Medicine

by Terry K. Crowe, PhD, OTR/L
Professor, Department of Pediatrics, Division of Occupational Therapy

High in the Oaxacan mountains of the Sierra Norte is the village of San Antonio Cuajimuloyas. Even on a June day, the air is cool requiring a wrap to walk in the mountains. Cuajimuloyas means where the mole (the special Oaxacan sauce) froze in the pot and is symbolic of the weather in these mountains that are over 10,000 feet. The people are known as the “people of the clouds”. The village has approximately 1,000 residents with about 20 to 30% of the people working in the United States at any given time. Among the wooden or adobe structures, is a sprinkling of fancy, brick homes built with US dollars. Cuajimuloyas is part of a successful eight village cooperative that has connections going back to pre-Hispanic times. They have created several successful projects including an ecocultural tourism project in which a visitor can hike from village to village, stay in quaint, rustic lodges and sample the local cuisine.

We gathered in the dark, smoky kitchen of one of the local curanderas, a healer named Senora Telesphora, also known as Doña Lepa. Doña Lepa is a woman in her sixties who reminds you of “Mother Earth”. We are a group of 17: 12 interdisciplinary students from the University of New Mexico; our 2 local hosts (Yves Chavan and Claudia Schurr); our primary teacher, Laurencio Lopez Nuñez; the co-instructor, Laura Alonzo de Franklin; and me. I have accompanied undergraduate and graduate students to Oaxaca for the past 5 years to study traditional medicine. Dinner cooks on the adobe wooden stove as Doña Lepa shares with us her healing practice. She is small in stature but strong in spirit and clear in her purpose of life. She is mother of 9 children, 2 who work in the United States. She learned the art of healing from her grandmother who was also deeply connected to the earth and lived to be 110 years old. Doña Lepa believes God gave her the “don” or the gift of healing. She strongly believes that it is her responsibility to care for people both in the village and those who travel far to seek consultation and intervention.

Doña Lepa shares with us her healing gifts. She grows and gathers herbs and medicinal plants for special teas, suaves, baths and other preparations. Some plants are purchased from another woman who lives even higher in the mountains. Interventions are individualized depend-

ing upon each person’s unique physical and spiritual needs. Mexican healing practices today are rooted in the past influenced by the Toltec, Zapotec, Mixtec, Huastec, Maya and Spanish cultures. The significance of the balance of the 4 elements (fire, water, air and earth) is stressed along with treating the body and spirit as one inseparable entity. Doña Lepa tells us about her special way of performing a cleansing or “limpia” which incorporates the 4 elements of, earth and air (sweeping a special bouquet of herbal plants across the body to take away energy that does not belong to the person), water (spitting liquid on certain body parts to reawaken energy points) and fire (smoke from the burning of sacred copal in the 3 legged clay pot called a saumerio is blown as a blessing over the body). To be most effective, cleansings are done 3 times over 3 days. After the first cleansing, Doña Lepa often has dreams and can see what “really” is the person’s problem. Later in the course we all individually participate in a special limpia with Laurencio on the beach where waves are crashing and the sun is setting. In addition, the students participate in a temazcal, a traditional steam bath in an igloo-shaped adobe formation.

We all feel privileged to have conversations with healers like Doña Lepa over the 11 day course in the southern Mexican state of Oaxaca. Oaxaca is a state rich in tradition with a high percentage of indigenous people. The course has evolved over the past 5 years but the objectives remain the same. We want people to appreciate the ancient art of healing and in the process discover new information about themselves. Some students are from health professions including medicine, occupational therapy, nursing while others are from varied backgrounds including students studying Latin America, Spanish, and even Math. For health professionals we hope that they become more culturally sensitive/responsive and more open to different views of health, illness and healing as they work with people from cultures other than their own. The course is not meant to teach actual healing methods to incorporate into practice as we recognize this takes years of intensive study and mentorship. Occasionally a student seeks additional education in traditional healing. Andres, a student that took the course 2 years ago recently returned to live and work for several



Christine White, MOIS

Doña Lepa in her home in Cuajimoloyas.

months on the coffee plantation (El Mamey) where we end our course. He worked intensely with a gifted healer, Elizabeth Mattern Alcazar and became her assistant. He integrated himself into the family and village life. I have no doubt that this experience changed Andres's life and he will always return periodically visit El Mamey.

We all learn a lot about the medicinal use of common plants which are in our environment. Over the course, we study about plants growing in 4 different environments: around the capital city of Oaxaca, the high mountains of the Sierra Norte, the seacoast near the spectacular Lagoon Chacahua and the jungle where the shadow coffee grows. While there is an overlap between plants growing in the various environments, there are unique plants used medicinally in each ecosystem. By the end of the course, we have discussed numerous plants and their multiple medicinal uses. We spend one afternoon making hygiene and healing products from plants and all have samples to use at home.

Laurencio Lopez Nuñez who is both a biologist and a healer shares with us his vast knowledge about plants and supervises our preparation of the medicinal products.

I have no doubt that this experience changes everyone who participates in the course. While we all enter a new cultural arena of healing, we also learn about ourselves. When people are out of their comfort zones and routines, they are faced with new daily challenges, both positive and negative. Hopefully all participants come back to the United States with new knowledge and attitudes, fresh appreciation about their own strengths, alternative ways of thinking and a deep appreciation for the traditional Mexican healing practices. If you would like to learn more about this two credit course contact Dr. Terry Crowe (tcrowe@salud.unm.edu). Or if you wish to experience the real Oaxaca other times of the year, you can contact Yves and Claudia (info@tierraventura.com) or view their web page (www.tierraventura.com). □

Diabetes Mellitus: An Overwhelming Epidemic in Native Americans

by Marsha Leaf, PA-S

The myths associated with diabetes mellitus type 2 are far and many in my small Native American community of Tesuque with its population of about 300 residents. I have heard comments such as, “Don’t eat too much sugary desserts or soda, it will give you diabetes,” and “Diabetes is a disease that only affects the elderly people.” With that said, I never thought my son, Myron, would ever acquire or pass away from diabetes mellitus at the age of 27.

I still remember that day in March of 2007, when we first learned that he had diabetes; we were both astounded and angry. He was very much in denial with the diagnosis. I cried for him, but I also cried for me—because it is such a dreadful disease. This wasn’t supposed to happen to my son, who was in the prime of his life, and had so many things to live for and experience in this world. How could he possibly have diabetes? He wasn’t old! It didn’t happen to young people.

The next turn in our story is still one of disbelief, even today I still wonder about it. On February 11, 2008, my son collapsed, and died. Cause of death: diabetic ketoacidosis. How could that be? Diabetes took years and years to progress, and according to my readings, it had different complications before anyone died of this ugly disease.

It produced many questions, but none that can explain why he died within eleven months of his diagnosis. The day he passed, a part of me died with him. But I knew I had to stand up and keep going, especially for my three daughters. The only justification I could conceive of his untimely death was the realization that I might be able to make a difference in our community concerning the ravages left in the wake of diabetes.

If I have learned anything from the loss of my son, it was to grasp a hold on the fact that diabetes can affect both the young and the old. It can take years to manifest or it can attack quickly. It can linger and it can kill. I realized that if I could help educate another person about preventing diabetes, or help them realize that diabetes can be a manageable disease, then I have done something in my son’s honor. And this can only be done through health awareness.

The overwhelming facts about diabetes mellitus and the ravaging effects on the health status of Americans is at an all time high. According to the Centers for Disease Control (CDC), in 2005 it was estimated that 20.8 million people had diabetes, with 14.6 million people actually diagnosed and the remaining 6.2 million people undiagnosed.



*“Pueblo of Tesuque, Central Portion, Tesuque River vicinity, Tesuque, Santa Fe County, NM.”
Circa 1933, Washington, DC, Library of Congress Prints and Photographs Division, from Library of Congress Historical American Building Survey.*

Native Americans accounted for 118,000 of those who were diagnosed and undiagnosed. The prevalence of this disease among Native Americans in the southern part of the United States is at an alarming 26.7% (CDC, 2007). Within the Native American population, 95% of the people diagnosed with diabetes have type 2 diabetes compared to type 1 (Indian Health Service, 2007). And, according to the Indian Health Service website for diabetes, there was a 68% increase in the diagnosis of type 2 diabetes from 1994 to 2004 in our Native youth ages 15-19 years old.

While genetics may play a part in acquiring this disease, there are many environmental and socio-economic components that have led to this dramatic increase in rates. The National Institute of Health (2002) studies done on the Pima Indian Reservation is an alarming look at how high the prevalence and incident of diabetes mellitus is in just one Native American Community. And another disturbing trend has emerged, higher rates of diabetes are being reported for Native American pediatric patients.

With such devastating rates, it has become crucial to inform and educate the Native American communities of measures that can be taken to prevent or lessen the risk of acquiring this disease (Indian Health Service, 2007). Only through knowledge, prevention, and intervention can the cycle of this ravaging disease that is overtaking the health of American Indians be overcome.

Diabetes Mellitus is an acute and chronic disease process that is increasingly prevalent in Tesuque Pueblo, and is usually addressed only when it becomes a disease in progress. It has a high impact on the quality of life with respect to a community member's capability to hold a job, perform everyday life tasks, and perhaps even more so to his or her emotional well-being. The costs of job loss can be tremendous, usually resulting in the need for assistance, such as Medicaid, Medicare, food stamps or welfare. As I learned, the whole family is affected by this disease. Family members are often needed for transportation to the medical appointments, or in some cases, to dialysis. Oftentimes, it is the family member who must give the medications or insulin, translate into the Tewa language the details of the medical care for an elderly parent, or provide care for the many complications of this devastating disease.

Fear of the disease can hold back education, as community members are reluctant to discuss the problem until it actually becomes a final diagnosis (Indian Health Service, 2007). As the disease reaches out to younger and younger populations, it becomes critical to address this

problem earlier, to educate our community members about the symptoms, disease process, risk factors, complications, and most importantly, the preventive measures.

We must also begin to assess why these numbers are so high, especially among our Native populations, and to learn why they are still climbing. But of utmost importance: we must provide our communities, and especially our children, primary prevention, beginning with role modeling and information on healthy eating, exercise, and weight control. The education process must include a cultural component, relating to the traditional ways and beliefs of the community, and must be presented in a respectful, dignified, and sensitive manner to accommodate the unique needs of this community. Communities have the power to change the course of this disease process through preventive measures. By increasing the self-confidence of a community, it will be more apt to make positive lifestyle changes to reduce the incidence of diabetes.

Diabetes Mellitus is a disease process that can have devastating consequences on the lives of the people that acquire the disease and the family unit at a whole. Only through educational awareness about its potentially devastating consequences can we conquer this terrifying disease. My son was only one person, but one person can have a profound effect on the entire community. I hope that his death was not in vain, but instead to bring new hope to those he left behind. □

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When they ask you.

by Katherine Flynn-O'Brien

Alex has a heart the size of his chest. The last time I went down to Quito with Alex and mom to see Dr. Gaibor, the cardiologist, he said to me: "this kid is dying." As I tried to translate that information for mom in a slightly more appropriate manner, I had to smolder the emotions bubbling inside me. When I called Dr. Gaibor to discuss Alex's situation, he asked, "Is he still alive?" He explained that Alex will die if we don't do anything, but also that for Alex (who also has high pulmonary tension) the catheterism—the next step in our western medical trajectory—is highly risky and there is a good chance he can die during or shortly afterwards.

Last week Alex and mom had another appointment with Dr. Gaibor in Quito. I wasn't planning in going down. It was my last week in Zumbahua and they needed me there. I assured mom everything would be all right: "The social worker will meet you there. She is very sweet. She will take care of you." "But she isn't compañera Katy," she said as tears welled in her eyes. Blanca's mom explained that they were scared, scared to go without Katy because they don't know Quito. Her eyes revealed her fright, but their fright was more than a lack of orientation to Quito's chaotic layout and overwhelming streets. Was it that they might get

stepped on and overlooked in the bureaucratic processes of the hospital? Was it that they wouldn't understand the nurses and doctors (the language nor the medical terminology)? Was it the racism to which they might be subjected if I am not at their side?

The ambulance left the next morning at 4 am. I waited for its return that evening: anxious, worried, curious. Blanca's mom got out first. "We won't go down again without compañera Katy. It wasn't the same." My stomach did flips. Alex's mom got out second. "They want to do surgery," she said, "on Monday." And then, "What do I do?"

My mind, a cloudy confusion. My heart, an aching pump of emotions. My stomach, a nauseous tightness. Two separate issues were flying through me, causing this organic chaos. One: How can this be? What happened in Quito so that these moms do not want to—and will not—go down to Quito for medical care without me? Dependency. Lack of Sustainability. Injustice. None of it was acceptable. And how do I (we) remedy the situation? Was my presence wrong from the beginning? Two: What do I say to Alex's mom? She wants my advice...but on what? On how her child might better die? The catheterism is risky, and it isn't a treatment. It won't make him well. Rather, the catheterism will only maybe help us understand better Alex's pathology so that maybe we can treat him better. In my modern western-dominated paradigm, we should do everything possible (...most of the time). We should do the catheterism (...probably). In the indigenous culture however, it is better to die in the comfort of home with the family than in the unknown, unfriendly, sterilized Quito. I explained to mom the two issues and said it was best for her and her family to decide. I also explained the issues to Olga, a family relative and a well-educated, well respected community member.

As Alex's mom's head lay on my shoulder, her tears wetting my sweater...I couldn't get out of my head was the following: This woman already lost a child to cardiomegalia. She doesn't deserve to lose another one. □



Margaret Menache

Palsy

It came in screaming from my infant in the small exhausted hours of a broken sleep. We arose screaming as it screamed. The baby didn't sound right. Something wasn't right He would never be right. Again.

Terrified, delirious at 3 AM.

First saw its picture: white, white, white, white, on a black scan of my son's brain. A vision of living death, hope burnt, smoking wreck in an x-ray heap on a cold table conference room surrounded by doctors with haunted eyes that know grief.

Chest bursting racking sobs, little Daniel please, please, please...don't leave.

The Palsy likes pictures. It has many pictures on many conference tables, X-rays of distorted brain now with wires and tubes, shunts and re-shunts put there by the surgeons as the damage grew and chambers of my child's brain were swollen like dark water balloons in a hell cartoon.

Your son won't die (but he might not live).

We feared the Palsy. But did not know how much yet. But we would learn how much, how to obey it, feel its steel grip on our son's flesh and bones. On ours. It came like an entropic iced wind and stayed like ancient rust and drug us down, a spirit weight dragging heavy to the ground.

He will never walk. He will never talk.

Daniel is pinned to a steel-trap chair that looks a cousin of the rack, black, heavy ponderous coal car, an evil black beetle. Palsy grips his skinny little limbs, splayed out, hands clawed up, he grunts arching back against nylon bands as the Palsy pushes, pushes, pushes, pushes till he looks to snap like a piano wire tight muscles humming.

He cries out and I want to cry. My little boy hurting.

Then his eyes grow wild as he belts out a guttural growling whoop out of his belly as he seizes and the broke palsied



Laura J. Hall

brain wires arc an electrical shit storm. He grinds his teeth, worn to nubs behind his cracked lips.

He takes a lot of medication. For a boy of six.

But, somehow, somehow, and even though, he is by the Palsy for life confined, and seizure racked in his body and his mind, will never talk, never walk, hardly eats and hardly sees.

But he still sees me. And he sees his sister, and his precious mommy.

And he lives on, despite the Palsy. It has never really defeated the little boy. He is an indomitable sun of young life.

Daniel's eyes and his smile tell us in infinite but insistent silent ways. That even though he will never be completely right that my little Daniel is

Alright.

He is.....Happy. Happier than you and Happier than I.

- David J. Mullen, MD

Encountering Mother Earth

An occupational therapy student's Mexican journey

by Anne Woods

In June of 2008 I had the opportunity to travel to Oaxaca, Mexico to take a class in traditional Mexican healing, or, *curanderismo*. As an occupational therapy graduate student at the University of New Mexico, the class was to broaden my horizons by learning about healthcare from a different cultural perspective. The course focused on exploring traditional medicines somewhat familiar to me, such as massage, sweat lodges, and healing plants. It would also explore those less familiar, spiritual cleansing (*limpia*), sadness as an illness, and *susto*, the idea that extreme fright can cause the spirit to leave the body resulting in symptoms described in the Western medical system as post traumatic stress disorder.

After mornings studying Spanish and afternoons learning about the remedies and philosophies of local healers, I was free to wander the colonial city of Oaxaca in the evenings. Dinner was *enchiladas* with mole, homemade corn tortillas, and hot chocolate mixed with cinnamon and chile. I was swept away with the colors, palm trees, cobblestone streets, and courtyards. I loved the feeling the courtyards gave of being both inside and outside at the same time, especially enchanting when I did my homework at the library, rain falling just a few feet from my desk. My wanderings took me into small museums and magnificent cathedrals. Cathedrals with breathtaking carvings, scrolling gold ornamentation, and high, domed tiled roofs. In the cathedrals I was struck by the fact that the focus was on the Virgin Mary, who took center stage on the main altar. In all the churches I had been to in the past, both the US and abroad, that was the position that Jesus held. But in Oaxaca it was Mary. She wore a crown on her head and a beautiful embroidered gown that spread out wide from its bottom edges, forming the shape of a triangle. Once I became aware of this version of Mary I saw her everywhere. She was in restaurants, in markets, and propped on the dashboards of taxis. On our last night in the city I sat in the Basilica de Nuestra Señora de la Soledad, gazing quietly at the radiating Virgin of Soledad, the patron saint of Oaxaca. Walking home that evening under my umbrella, I discovered an antique store down an alley behind a coffee shop. In it was a small frame made of rusty pressed tin, and under the glass an image much like the Virgin of Soledad I'd just spent time with.

But this Virgin wore a white dress, had dark skin, and appeared to be floating. *Virgen Santisima de Juquila* said the words under her image. I felt instantly drawn to her. But who was she?

The next morning our course took us high into the mountains and out along the sea. The further away from Oaxaca City we drove, the more I saw this word, Juquila. There were Restaurants Juquila, Juquila markets, and trucks with large letters on the front windows spelling "Regalo de Juquila" (Gift of Juquila). The final stage of our journey took us on a long winding dirt road past landslides, goats, and burros to a small coffee plantation deep in the jungle. It was there that we were to meet the final teacher for our class, Elizabeth, a powerful *curandera*. As I hauled my suitcase into the old house, past the hammocks on the porch and up the creaky wooden steps, I saw an altar with glowing red candles and palm leaves, and in its center, the Virgin of Juquila. I was struck once again by her image, the shape of her dress, the radiance of her crown. She seemed familiar to me.

That night our group gathered in a circle on the front porch. It had rained for six days straight at the coffee plantation and they had lost electricity. Such a rain was unusual for that time of year, the river was swollen and crashing with fresh clear water. Elizabeth told us it was new energy coming into the world, down from the mountain. The darkness of the porch was lit only by a single candle in the center of our circle, a few fireflies, and the two red candles glowing at the altar of Juquila. I knew by then that the Virgin was calling to me, asking for my attention. But the question remained. Who was she? Before I could even ask the question Elizabeth answered. "The Virgin of Juquila is Mother Earth".

That night I went to bed with a headache. Tossing and turning on a bed made of burlap I felt a woman come to me somewhere between wake and sleep. She was dark skinned and wore a white dress. She came up behind me and spread mud on the top of my head. When the mud dried it suddenly cracked in a flash of lightning. The woman told me to send the energy, which was causing pressure in my head, out through the cracks of the dried mud and down to the river. She told me to give it away to the river.



Anne Woods

As the energy rushed out from the top of my head my headache dissolved and I fell asleep.

At breakfast the next day, over fresh papaya and watermelon, I asked our tour guide Gordon to tell me more about Juquila. What he knew was that many people made long pilgrimages to see her, often on their knees, that the mud behind her shrine was used for healing, and that she had survived a fire.

Later research on the internet still revealed a story surrounded in myth and mystery. A carved wooden figure only two feet tall, the Virgin was brought to the small Mexican town of Amialtepec by a Dominican priest, Friar Juan Jordan, in the sixteenth century. When he left a few years later for another parish he gave the statue to his servant. Miracles were reported and after word had spread, a small shrine was built for her. In 1633 the entire town of

Amialtepec burned to the ground. Under the rubble, or on top of the ashes, depending on the storyteller, the Virgin was found completely unharmed. Though her gown of white and gold went unscathed, her face was scorched, its brown color inspiring the deep love and devotion of the local indigenous people. (Carrizosa, n.d.) While her shrine was being rebuilt she was placed temporarily in the cathedral in the town of Juquila. After she was moved into the newly rebuilt shrine in Amialtepec she mysteriously disappeared, reappearing back in the altar in the cathedral in Juquila. After doing this several times the people surrendered and she became known as the Virgin of Juquila. (Alice & Anderson, 2004)

I recognized by then that her familiarity came from the images of the Hindu goddesses I'd discovered through my yoga practice. With the Virgin of Juquila's hands in prayer position and holding a flower much like the lotus of India, her golden crown radiated like the crown chakra of an enlightened being. She was the Catholic manifestation of what I'd already discovered through Hinduism. She was Shakti, divine feminine energy. In the book *Kundalini Vidya*, Shivarпита Harrigan writes, "Shakti is the divine power that permeates everything, that is, in fact, everything in the phenomenal world, no matter how subtle. Because of this generative quality, Shakti is referred to as the divine mother" (Harrigan, 2005). This divine mother was that divine mother, one and the same.

Laurencio A. Lopez Nunez, the curandero who guided us for the majority of our class, explained to us that in pre-Hispanic Mexico the native people worshipped Mother Earth. The *temezcal*, similar to a Native American sweat lodge, was seen as the womb of Mother Earth, a place local indigenous people ritually entered for healing, purification, and rebirth. During the Spanish conquest images of the Virgin Mary were placed in the sacred places of Aztec female deities. It was through this imposition that the two assimilated, and why the Virgin Mary receives such great devotion from the Oaxacan people. The triangular shape of the Virgin's dress reflects the shape of a mountain and, especially, her role as Pachamama, the Earth Mother. (Damian, 1995).

There was something else that I saw in the triangular shape of her dress. Shakti is illustrated geometrically as a triangle. In the sacred geometrical design called *sri yantra*, similar to a Buddhist mandala, which maps the human journey from physical manifestation to spiritual enlightenment, this triangle represents the first manifestation of

the One, or God, which is illustrated as a dot in its center. (Harrigan, 2005)

In talking with the healer Elizabeth later that day she told me that the Virgin of Juquila is *una puerta*, a door through which to access the divine. This was a concept with which I was already familiar. For years I'd been noticing the common patterns in spiritual paths. I could no longer see Christianity in opposition to Hinduism or Buddhism, but rather the connection between all things. Halos, hand gestures, silence, light. With prayers, scriptures, symbols, and an enlightened master to help illuminate the path. My observations were later confirmed when I read in the *Kundalini Vidya*, "When the varieties of mystical/religious/spiritual experience and methods of individual people and religions are categorized and meta-analyzed, outstanding patterns and themes emerge. This is because the human subtle body functions the same in a Buddhist as it does in a Hindu, Christian, Hopi, or Jew, or an atheist or agnostic, for that matter." And, "While religious instruction to the many caters to cultural preference and style, allowing seekers to begin on familiar ground, the teachings of the realized ones are of the same voice, and they are universally relevant." (Harrigan, 2005)

This reflects what a yoga teacher once told me, that the many Hindu gods and goddesses are simply different aspects of the one Supreme Being. That these gods and goddesses offer a human like form that we can relate to, call to. That God/The One/The Universe/The Supreme Being is so vast, infinite, and all permeating that the individual gods and goddesses help us to focus. And that we are most drawn to the one that best reflects us. "By whatever title, gender, race, or dress all are Kundalini Shakti. The name and form are of little consequence except to attract and focus the seeker more easily." (Harrigan, 2005) The Virgin of Juquila who survived a fire, *una puerta*. yes, of course.

As an occupational therapy graduate student, I wondered how all this seemingly magical discovery could possibly work its way into my future practice of helping clients to participate fully in the tasks and activities that are most meaningful to them. In our course in Oaxaca we learned that the role of a curandera is not to cure illness, but to restore balance, the balance between the mind, body, and spirit. This too is the role of Shakti, who moves through the body, clearing her pathway through the mind, body, and spirit in her unyielding determination to unite with the divine. And too, this same restoration of balance is

the goal of occupational therapy. In fact, it is the only discipline within the Western medical system that includes the spirit in its practice model. One esteemed model, the Canadian Model of Occupational Performance, in illustrating the relationship between person, occupation, and environment, holds in its center a triangle, which represents person, the small circle at its core, spirituality.

I remember a book I once read called "Waking". In it, Matthew Sanford, a person with paraplegia resulting from a car accident, wrote "The physical therapists guided me to believe that the only meaningful connection to my paralyzed body was through a regenerating spinal cord". Discovering yoga thirteen years after the accident led to a profound experience of the energetic connection throughout his entire body, even those parts he could not physically move. Sanford writes "The integration of my mind and body has meant realizing a deeper connection with the more vulnerable, feminine aspect of my consciousness. The caring, more nourishing part of me that was pushed aside when I was guided to willfully overcome my disability." (Sanford, 2006)

When speaking of Shakti, the divine inner presence, Shivarapati Harrigan writes, "It gives us awareness and talent and drive. It is the essential source of desire, and it is our spiritual director. With our free will, we choose what we do with that holy, gnawing, burning fire within, and it is that pivotal ongoing choice that makes our life sacred or profane or unremarkable". (Harrigan, 2005). As an occupational therapist I will hold this awareness for my clients in the dance with what is scientifically sound. The gift of Juquila. □

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Margaret Menache

LIE

We lie in the slipping sands
 Out of Love's grasp,
Sealed- with our tied hands-
 To each other.
The open sky has closed in,
 Smothering,
 As we lie waiting
 Inside the eroded bubble.
We sleep in our intersecting vacuums
 Like two lines parallel,
A trouble next to another trouble;
 Two uneasy twigs
In an uneasy bundle of two.
 Lying next to each other,
 May be we are a bold line
Bold, three-fourths through.
 Our meandering minds
 That go blind beyond
Our own thinning bubbles.
 Parallel to eyes
Yet our hearts so anti-parallel.

- Gopi Mara-Koosham



Margaret Menache

Stories

I have heard them thousands of times.
Seen them in my dreams a thousand times more.
Over and over is the telling.
The patients tell me.
The resident physicians tell me.

But when they tell me,
I still grit my teeth and the nails bite my palms.
The light seems a dim thing in the rooms, and
dark rolls in on the words a rancid fog.

I stare into the hells of the cheap and filthy
where suffering bites like the screw worm
twisting into naked flesh.

Aching brutalities of little bodies bruised, beaten,
groped, violated in nights without dawn
in the smell of stale beer, and the acrid breath

of men whose only claim to fatherhood is semen
carelessly tossed up in drunken couplings:
rapes in the spit and blood of violence
and the shit of contempt;

of mothers sneering vicious
grasping for pleasures in the bleeding
shards of an angry mirror and pissed
to venom by the insolent and demanding cry....

of a newborn.

And I feel rage.
And I feel stripped and naked.
And I feel alone and separate from faith, from hope.
And I feel, I feel,

afraid:

of meeting behind some blank inner door, humanity
shorn
the screw, the bloody worm and author
of the stories.

Weeping, I cling to myself and the children
by the salt and gossamer bands
of the tears behind my doctor eyes.

- David J. Mullen, MD

Apnea

A flame wavers.
My infant son
blushes blue then white.
Blood surfaces,
but under ice.

After this first frost
his heartbeat becomes
not felt but seen. A deep
amber beam pulses
like a light marking a
dangerous intersection.

See how silently he spins
beyond the reach of
smoldering windows. In winter
I would glide like this on the
frozen pond my parents had made for me.
Feet numb, lips gray, I'd loop intently
on bent ankles around the ash tree. But even
in loneliness I was accompanied by the
raw breath of blades.

I am taught to loudly call his name and
snap a finger against his sole.
Day in, day out, I lift us from the
frigid drifts where
breathing stops.

- Katherine Fancher

The Cane

by Anthony Smith

It had been a long hard day and I had many things on my mind. There were a lot of problems. They were all very important. They all needed an answer right now. I'd had a few arguments with some people that day. There were problems that I was sure only the good Lord could solve but I was certainly going to try anyway. So, I was full of worries and more than a little irritated. I picked up the phone but I had no idea that the world and all its problems would be put in perspective for me in the next short conversation I was about to have with my wife. I had decided to call Sheila to check in and let her know that I was on my way home. I tried the home phone but she wasn't there. Now that was annoying. It seemed like nothing was going right. I tried her cell phone. There were two rings and she answered. I said hello and asked how things were going for her. I was sure that she could hear the edge in my voice. I was really looking for a sympathetic ear. Instead she answered in an excited voice, "I have had such a great day! You just wouldn't believe what happened!"

She began with a story. She had been on the phone earlier in the day to locate a single railroad tie to put in front of the gate in the back yard so our two border collies, Jasmine and Blue, could not escape underneath. The first place she called directed her to another lumberyard because they only sold ties in a bundle of six. The second lumberyard sold them individually so Sheila headed out to buy one railroad tie. Some fifteen years earlier, Sheila was involved in a very serious accident where the horse of her dreams tripped and rolled over her head leaving her in a coma. She spent years in rehabilitation. Our marriage remained intact but we had to make adjustments in our lives because she was left with many problems. Her balance was one of those problems. Since the accident, Sheila has walked with a wider based and somewhat shuffling gait. When she walks, she looks unsteady on her feet. Anyone watching her walk knows that she has suffered through some sort of a great trauma. Sheila must walk with a cane if she wants to remain upright. She has a lot of difficulty trying to negotiate uneven surfaces. Early after her accident Sheila had trouble with just about any uneven surface or hill. Anything in front of her path had to be moved.... sticks, the hose, or even tiny stones. On several occasions we had to take her back into the emergency room to have

fall related wounds stitched up. The cuts usually wound up above the right eyebrow. One day she had a fall where she broke all of her front teeth out and had to have plastic surgery to repair damage to her upper lip. The brain injury slowed her reflexes so when she would fall, she was unable to get her hands up fast enough to protect her face or break the fall. So she would wind up with an injury and a trip to the emergency room.

While her balance has improved dramatically over the years, she is still a significant fall risk. Today, she still needs the cane and a relatively even surface to be able to walk successfully without a fall. Getting around for her is still not an easy task. Just watching her day to day struggle to carry on and move about has been an inspiration to me and many other people. When an area is uneven, Sheila will carefully inch her way around the obstacle looking for handholds and showing great patience in the process. In spite of her difficulties, Sheila has become a happy up-beat sort of person who spends her time helping others as the parish nurse for our church. People almost never forget her name once they meet her as she leaves such a powerful impression on them. On this particular day Sheila had gotten out of the car at the lumberyard but was unable to find her cane.

We have been through quite a few canes over the years. The most recent cane had just been purchased from a medical supply store after a cane she really liked accidentally got left on the top of the car roof and had fallen off on the highway. Now she had accidentally left the new one at home. At the lumberyard, Sheila got out of the car and unfortunately, the ground was a dirt surface that was uneven. She was trying her best to walk without the cane and was struggling patiently with the terrain when a man who worked at the lumberyard walked up. The man had seen her predicament from the window of his woodworking shop. Sheila explained to the man about her injury and how she needed her cane but had forgotten it. She noticed this stranger had a limp from a long-standing injury. He told her about his injury and told her that he too had to walk with a cane. In fact, he told her that as a woodworker, he had just made a cane for himself. The man asked if she wanted to see it and she said yes. So, he offered her his arm and helped her walk across the parking lot to the shop where he showed her his new cane. According to Sheila this cane

was particularly beautiful and hand carved so she was even more surprised when he offered it to her as a gift. As Sheila explained to me, this particular cane was “just perfect!” The stranger had even sawed a piece off the cane so that it would be the perfect height for her. This single event had become the source of my wife’s happiness. It was the essence of her “great day!” A complete stranger had given her a cane and in that gift had eased her burden and lightened her load. I doubt if this man in the lumberyard even realized what kind of impact he had on Sheila’s day or mine.

Sheila didn’t know it, but I just about cried on the phone. My wife’s day had been made wonderful because of the gift of a cane. I am convinced that God has put

angels here on earth for each of us and they come in many forms. But, those angels have a way of showing us the truth and letting us see little glimpses of what heaven is like. I know that Sheila is my angel. I have learned many things about life from her since her accident that I don’t think I would have ever learned otherwise. I have learned things about kindness, God, patience, love and so many others too numerous to mention. On this particular day, I learned that I worry too much about things that don’t really matter. I learned that maybe life is much simpler than it seems and that happiness is relative and not all that hard to find. It can flow from a simple act of kindness. In fact, it can be as simple as the gift of a cane. □



Margaret Menache

Revised Journal

by Ann Thibodeaux

Isn't this supposed to be more dramatic, more heart wrenching? – my thoughts as I am witnessing the death of my brother – sitting on the floor in front of me with glazed bluish eyes no longer capable of sight, trying to speak, telling me that he is dying – not afraid – just matter of factly saying “Andee, I am dying” and looking to me to help him through this final step.

His death is not unexpected; in August, 1992 he was told by his doctor he could not survive longer than 18 months. We agreed that we would make good memories during this time and I promised to take care of him until the end. And I did.

Later that year he was admitted to ICU with pneumonia following a doctor's appointment and subsequent UH ER visit. His blood pressure was undetectable so he was taken back to be resuscitated – a great opportunity for learners – his blood pressure was eventually stabilized but most of his ribs were broken in the process. He was told the chest pain was caused by pneumonia – he believed this – he had chest pain for months after the pneumonia resolved and never had a clue. At this point I started keeping close track of his half vast medical care.

The next few years were interesting with many other illnesses and treatments, the most memorable of which was his diagnosis of and treatment for asthma when in fact he had cardiomyopathy which was discovered by a medical student and subsequently treated with good results.

Fourteen years later and hundreds of clinic visits and hospitalizations later, he is down to 114 pounds and unable to swallow. GI team says, ‘sorry, you don't have cancer but we don't know what it is so we will refer you to Mayo and maybe the docs there can figure it out’. Shortly thereafter, another visit to the ER and four days lying on a gurney in a glassed-in cubicle in the ER pending admission “when a bed is available upstairs”. What is that thing on the wall, a large jar filled with something brownish and foamy? It has been there since his arrival four days ago and is beginning to smell awful. What is wrong with his arms, both having IVs and both very painful, red, and swollen? He came to the ER because of uncontrollable hiccups – no one here is attempting to help him – he is unable to sleep and now he is dehydrated. He remains uncomplaining and sweet, ER staff's dream patient. He names the medicine

team from upstairs The Keystone Kops. When the swollen arms become hot to the touch, I demand that the infiltrated IV(s) be removed and a male nurse comes in to check and says that everything is fine and that my brother needs to “suck it up”. Now I am livid and barge into the administrator's office to ask that something be done for my brother. He has been in the ER for four days and nothing has been done to help him. Do they understand the term “moribund”? The ER director comes in and tells me to understand that they are short staffed and are taking care of patients as they can and if I make waves, it will only serve to “piss off the ER staff and your brother won't be cared for appropriately”. I then ask that my brother be transferred to another facility. By the time I return to his cubicle ten minutes later, a nurse is busily removing the IV from each arm and getting things together in anticipating of his transfer – upstairs. One of many bottles of medicine is on the table, she picks it up, opens it and spills the contents on the floor, gathering up the pills and putting them back in the bottle. The floor is filthy – and filthier yet are the corners of the room that have not been scrubbed for a LONG time – I ask her to give the bottle of meds to me and I will take them to the pharmacy for disposal – she cannot do that as he has not been admitted yet and he must be admitted with all the medications he has been taking on his own the past four days as the ER nurses were not responsible for meds other than what were prescribed while a guest in the ER.

Weeks later he is discharged after surgery and a jejunal tube placement for liquid nutrition. After he recovers to a small degree, we travel to Mayo Clinic where stents are placed in his esophagus as UNM is not able to do this procedure. He is hoping to be able to eat and drink again, but is able to do neither. A strong, persistent cough begins a few weeks later and he is told that he coughs so hard that his ribs are cracking but nothing can be done for the cough as it is related to the stents. A biopsy is taken at Mayo in May, 2007 which shows that he does indeed have esophageal cancer. He is referred back to the cancer center at UNM where a treatment plan is supposedly in place, but it will be several weeks before treatment is actually begun. The chemo causes many horrible side effects and one night at home he begins spewing black material from his nose and mouth and is taken on life support to a private hospital

where he is intubated and is in ICU for a week and miraculously survives. Could it possibly be that the cough has traumatized his body and the black stuff is old blood? No, that is not possible he is told. One more chemo treatment after discharge with a subsequent admission to UH Cancer floor. On the fifth day I am with him during morning rounds when I am called out into the hallway where patients, visitors, (adults and children of all ages) and staff are going back and forth and I expect to be told something trivial, but no, I am given the news by the attending physician that my brother is terminally ill and will be referred to hospice for his last few weeks of life. I am told this very matter of factly along with everyone else within hearing range and I think, "is this how it is supposed to happen??" - delicate, life changing news in front of the whole world?" I leave in tears and unbeknownst to me, the team goes in to see him - he has only days, and perhaps a few weeks if he is lucky, he is told. Could they not have told him with a family member present? His understanding of hospice is a nursing home where patients are placed to die. No one explained hospice to him. I was so shocked when I went in an hour later and found him in a terrified state and I explained what little I knew about the whole situation. The next day his oncologist visited him and told him to get his affairs in order and two days later he was discharged home to me.

His few weeks turned into eight months, time which was spent with antibiotics via PICC line, injections, blood transfusions, innumerable doctors' visits, a myriad of testing, and hospice nurses three times a week keeping track of him. There were also many happy times. He was able to enjoy Halloween and celebrate the holidays as well as his 54th birthday in February. As we knew this was certainly the last one, each event was relished.

I dreaded the moment when he would draw his final breath and my hope was that he would not be alone. I dreaded his reaction to the realization that he was, in his words, "buying the farm". I often wondered how long it would take - would he be afraid and how I would be able to help him? - The hospice nurses had left a large box called the "E kit" (euthanasia kit?) with all different medicines for use when the time came so he would be unaware of what was happening to him; fortunately, this was not needed. We became accustomed to having the lights on all night as he needed pain meds often, the noise of the oxygen concentrator never stopped, the cough and nausea never ceased, and sleep was sporadic for both of us. I learned the true meaning of sleep deprivation.

Early one morning in May, following an evening with profuse cold sweats and vomiting, my brother stopped fighting. What a blessed relief it was for him. I talked to him, held his hand, watched and listened to his final breaths and saw all the frown lines disappear and his body relax and peace came over him. I try to forget the horrible noises coming from his body as I remember the blissful look on his face. I lit some candles and wondered what I should do next. Call hospice? - Yes,- the nurse was there within an hour and listened for heart tones and told me yes, he was indeed gone, asked for all his meds and some dish detergent and requested that I call a funeral home. All I remember is the nurse diligently putting dish detergent in his medicine bottles and putting everything in the trash, then helping the man from the funeral home place his body on a gurney. I had forgotten how heavy bodies are and how they are truly treated as dead and no longer capable of feeling. The funeral home employee told me that I needed to go to the office as soon as it opened to make arrangements (write a check, as nothing could be done without this check). According to my brother's wishes his remains would be cremated. Two days later I got a phone call telling me to pick up the cremains by mid afternoon, a plastic sack placed in a cardboard box with a receipt on the outside and a note stating the death certificate would be forthcoming.

This is a very small part of the story of the final years in the life of my baby brother. My main regret is that I did not fight for better medical care for him. It may not have extended his life but perhaps what was left could have been a little more pain free and maybe with a glimmer of hope. I would also have been more picky about the mortuary as this is very important for the family following the death of a loved one. "If anyone wants to see the remains, that will be an additional \$90". No, thank you anyway but who asked to see the remains? Not me.

When I worked in direct patient care many years ago, the main goal was to do the best for each patient and the family and do this with loving compassion. "In Pursuit of Excellence" was the battle cry in medical care 30 years ago.

What happened? □



Jupiterimages

A “Last Lecture”

Program for the School of Medicine

by Robert H. Glew, PhD

In 2007 a truly remarkable lecture was delivered at Carnegie-Mellon University in Pittsburgh by Randy Pausch, a 46-year-old professor of Computer Science with a diagnosis of terminal pancreatic cancer. Four hundred students and colleagues crammed into the auditorium to listen to what was called “The Last Lecture”. The theme of Professor Pausch’s uplifting and inspirational lecture was achieving your childhood dreams. During his lecture Pausch reminisced about his academic career in teaching and research and reflected on values that were important to him as a father, husband and citizen of his community.

The lecture had such a profound effect on the audience that within hours a videotape of Pausch’s presentation was circulating on the internet to millions of people in countries around the globe. A book of the same title occupied the number-one position for weeks on the New York Times Best Sellers list.

Europeans have had a long-standing tradition of offering senior faculty on the threshold of retirement the opportunity to address not only the academic community but the wider community as well with the “*afscheldscollege*” (retirement lecture) or as the Dutch call it, the “honour lecture”. Faculty use the Last Lecture to reflect, reminisce, philosophize, synthesize and sometimes just to gripe. At York University in Canada, the valedictory lecture is named “The Perception Lecture.”

The retirement lecture can take many different forms. Commonly a retiree chooses to use the occasion to reminisce and give her personal reflections about change of one sort or another: the undergraduate curriculum and teaching methods (e.g., problem-based learning, teaching clinical skills to medical students); or collegiality and community spirit. Others stick to their particular discipline and devote their valedictory lecture to fundamental ideas developed during the course of their scholarly life, such as “Shakespeare and Renaissance Literature”, “Confessions of an Anthropologist” or “The Warburg Effect and Me”. Some have used their Last Lecture to argue a political point. For example, a Dutch professor whose expertise is in designing public housing entitled his lecture “The Minefield between Delft and The Hague”. In contrast, there have been in-

stances where a retiring faculty has used his “Last Lecture” to diss the institution he is leaving. There is also the recent example of a retirement speech in the Netherlands that was censored by the university administration on the grounds that it dealt with religion and ethnicity and would create an immediate security risk.

I don’t know if Carnegie-Mellon University has a standing policy of inviting retiring faculty to deliver a Retirement Lecture and pass on something meaningful to the university community; perhaps Carnegie-Mellon University does provide for the retirement lecture, but perhaps, like UNM School of Medicine, it does not. It strikes me as ironic that at some institutions of higher education, a tenured professor might have to be given a terminal diagnosis before he or she is invited to deliver their “Last Lecture”.

It is unlikely that all retiring faculty in any given year would choose to deliver a retirement lecture. A professor at the University of Massachusetts who was about to retire declined the offer to speak, saying that meditating on his career in public would be too much akin to reading aloud from his own obituary and that he didn’t want to put himself in the position of “moralizing or ladling out morsels of senescent wisdom.” Nevertheless, we suspect that of the dozen or so faculty who retire each at the University of New Mexico School of Medicine, at least one and probably more would jump at the chance to present their own “Last Lecture”.

The downside of inviting every retiring faculty member to present or disseminate a Last Lecture either as a public lecture or by some other vehicle is that individuals may feel pressured into participating out of concern that to decline to do so would embarrass them. I can imagine an instance where a faculty member close to retirement would worry that their best scholarly days are long past and that to deliver a public valedictory would present them in an unfavorable light. These considerations lead me to suggest that the better route would be not to have public Last Lectures but, instead, to invite retiring faculty to publish their reflections as text on the School of Medicine website. Perhaps if one of the several Last Lectures appearing on the school’s website were to engender great enthusiasm, the author of that piece would be invited by the Dean of the School of

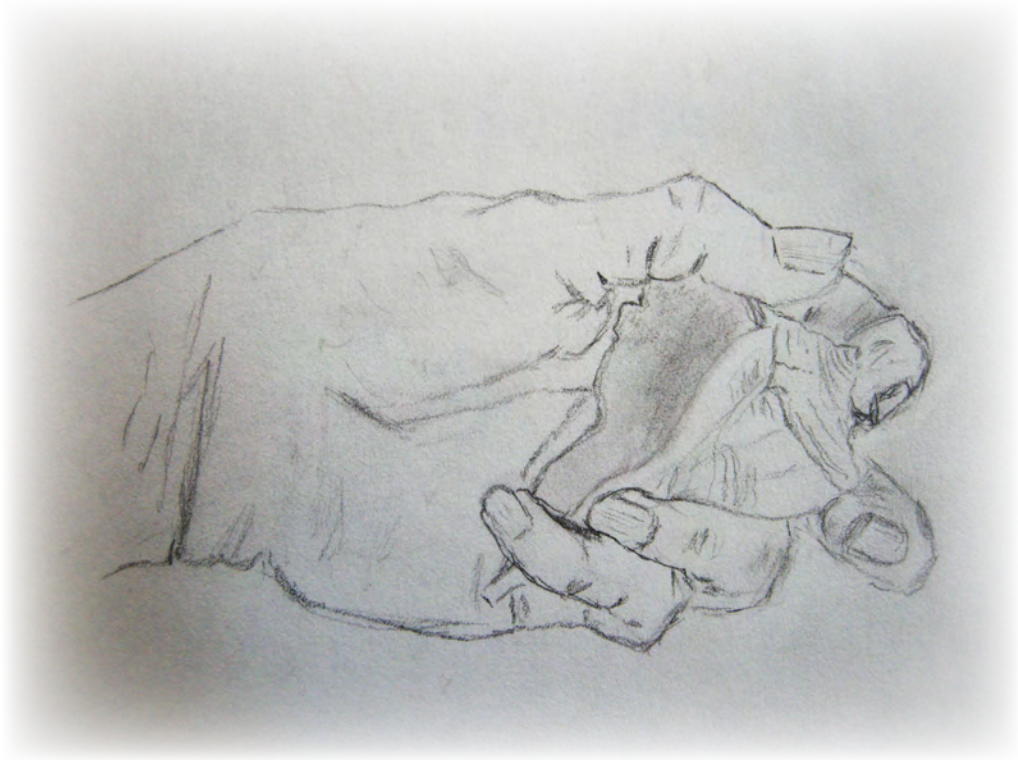
Medicine or Vice-president of the Health Sciences Center to deliver his or her lecture in person to the university community.

The School of Medicine administration should establish an annual Last Lecture series and encourage soon-to-be-retired faculty members to seize the opportunity to share with the faculty, students and staff their reflections and meditations on their years of teaching, research and service at the institution. It would also be useful to record these valedictory lectures in printed form. Space limitations

and the issue of cost would make it impractical to print every Last Lecture in a given year in the *Medical Muse*. However, I can imagine the editorial board of *Medical Muse* inviting one or two faculty members per year to publish their Last Lecture in one of the journal's annual issues. This medical school should go one step beyond Carnegie-Mellon University and not wait for a terminal illness before inviting a faculty member to deliver his or her Last Lecture. Why not institutionalize the Last Lecture in one form or another for the next crop of retirees at the School of Medicine? □



Margaret Menache



Margaret Menache

Conference Room 2

Long tables arranged to form a square.
Forty chairs at the ready, others that wait.
Alone painting: yellow-orange blossoms
floating in a peacock green haze.
Perhaps it was a gift.

I might as well choose a seat, try the coffee.

White walls, white ceiling.
Slatted white blinds.
A lone vehicle outside, also white,
the word security neatly lettered
across its trunk.

Fortunately I have brought my knitting.

If my husband didn't have our car
I could drive away. I could call a friend
if I had one in town. I'm miles from home
in the fog at the top of a hill.
In a hospital, on a Saturday.

A year ago, I had a room upstairs.

My clipping reads, *For those celebrating life
after cancer...physician-led talks...
alternative therapies...music, art...
followed by a meditative walk
through a healing garden.*

- Marjorie Power

SEASONS OF WINTER

for Bryce

Just you and me and the hospital bed
and a tangle of tubes and wires:
intricate strings to bond you to this room, this space, this life –
the steady pulse of the breathing machine
the color-coded threads tirelessly crawling across the monitor screen
tracing the tides of your turning fortune
and the amber dance of the CRT, leaping and looping its
tight little pirouettes of
mysterious information, the fluid grammar of the interior –
and the soothing sounds, the beeps and blips and hums that punctuate
our one-sided conversation

I talk philosophy with you, my captive audience, take silence
for assent when I ask you if you'd like me to recite some of my poetry,
to chant for you, to play a lame tune on the recorder –
Knowing you will remember none of it when you awake to new life.

Do you dream, in the throes of your fevered winter?
Is your mindfulness at home, or fishing in the solar streams of the imagination?

Now, weeks have passed, the cat's cradle of connections have been put away
and I understand from the other end of the continent
you're beginning to stir and bubble
words that bounced imperviously before now insinuate themselves
into the folds of your skin,
seeking entry, seeking response

your eyes are like permeated seagulls, floating in a skyless dawn
I hear the rustle of the sheets as your muscles twist and stretch
through the phone I hear your gigantic breathing
and know your brain is readying you for the first small step
on the path of once-forgotten, fresh new tomorrows.

– Ron Reed



Laura J. Hall