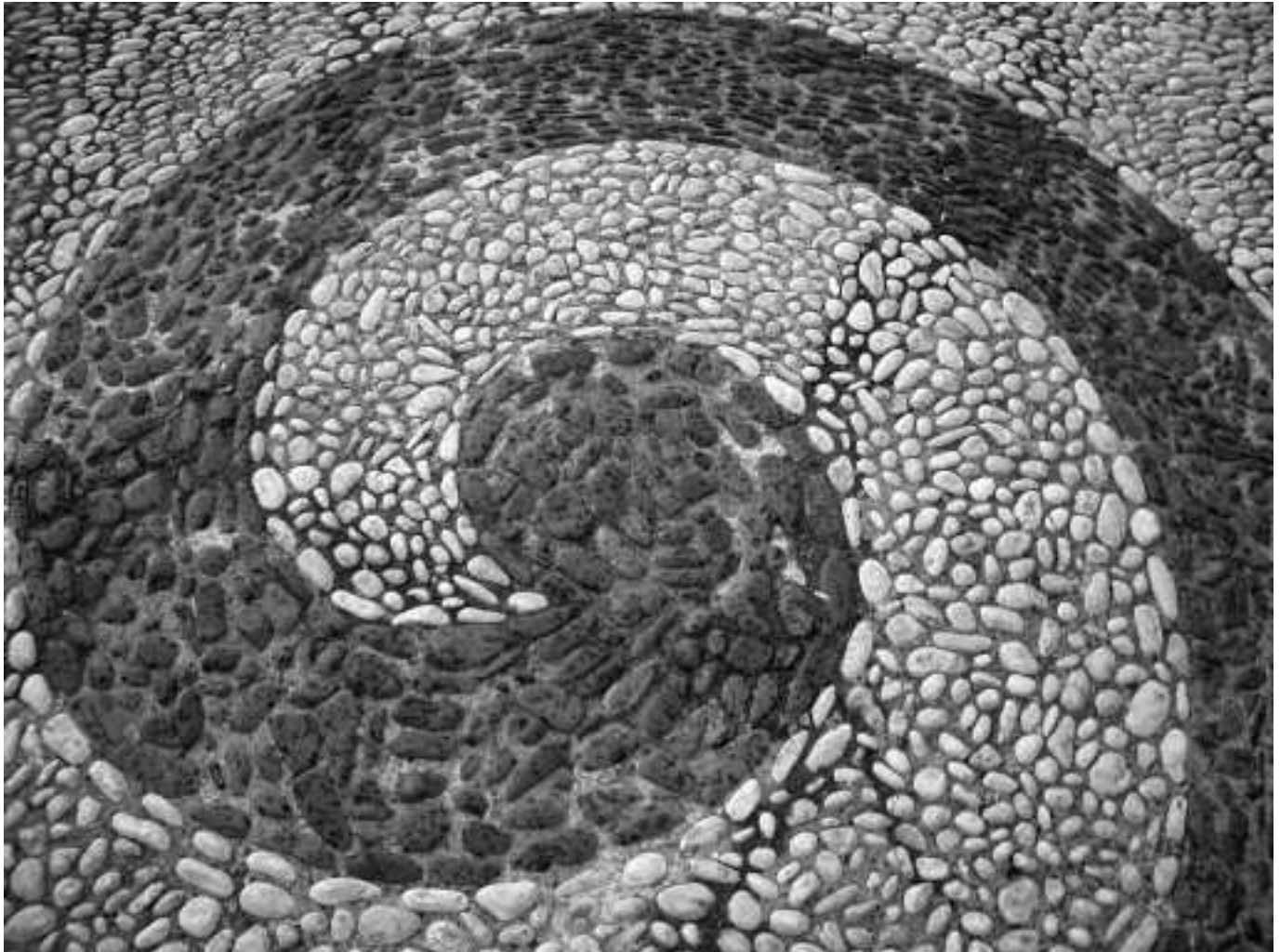


MEDICAL MUSE

*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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Submissions may be literary or visual, and may include letters to the editor. Participation from all members of the UNM Health Sciences Center community.

Electronic submissions may be sent via e-mail attachment to: medicalmuse@salud.unm.edu Please include name and contact information.

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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. We apologize if this has not been made clear in previous editions.

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

Making Time For Abuelita Maria

by Mark-Fischer, MS1

“Mi tia Dina sat me down and told me the news
Abuelita Maria passed away last night
Asleep in bed where she’d been
For three months slowly disappearing

The perennials were in bloom
Releasing perfume that filled
The front room as I remembered
Planting them years ago when
We landscaped abuelita’s yard
To increase property value

Her insurance cancelled
When Grandpa passed
Unable to work due to
Severe arthritis in her hips
From carrying ten children to term
Third mortgage providing food
Social Security managing
To keep the gas on

During winter she was alone weaving
Nothing able to mend her heart
Which cried tears for her familia
We visited regularly
But the house was too small
To accommodate any of our families

Abuelita refused to leave her home
Preferring to live with her parakeets
Than one of her children in some
Fancy house with thin plaster
Walls that would never last long enough
To absorb the love of seven generations
Or exude the warmth of la familia
The way her thick mud walls still spoke
Every night with their strong, soothing voice

She remained there through the decade
Which saw her grandchildren graduate college
Travel across the country for jobs, make lives
With people far removed from her
Gradually losing contact with their past

Until last December
When we returned for the Holidays
All her familia packing into her little casita
To hear the news that our abuelita
Had developed lymphatic cancer
And would not see another Christmas
Being the youngest daughter
Tia Dina was elected to move in
After the New Year we said our goodbyes
Boarded planes to places far away
And out of mind to wait for the call
That would inevitably bring us back

It came three weeks ago
And following our duty
We returned to our desert origin
To wait out the final days
Solemnly putting abuelita’s affairs in order
Praying rosaries, reading to her from
“Mi Abuela Fumaba Puros”
Her favorite collection of stories
About our familia

I kept her company mornings
Covering her with blankets
She crocheted while waiting for us
To visit day in and out
Watching Westerns, drinking
Thick teas made from herbs
She cultivated in the backyard

Abuelita Maria told me yesterday
To take the blue kerchief she stored
In her memory chest and keep it
The cloth Grandpa Joe
Used to wrap her wedding ring
She told me I should keep the tradition
Even if it was with La Blanquita
I thanked her for the gift and kissed her
As I left to find fresh spearmint leaves
For her to suck today
While I read her my poem



Anatomy of a Crime

by Greg Franchini, M.D.
Department of Psychiatry

As one gets older, there is a tendency to be forgiven for indiscretions committed at an earlier stage in life. This is perhaps best demonstrated in those classic prison films featuring the wise old prisoner who has spent his entire life behind bars after having been incarcerated as a young man for a murder (or other heinous crime) that he may or may not have committed. What is important is that, even if he was guilty, we are able to forgive and forget his past sins and appreciate the sage advice that he now provides younger, less experienced inmates. It is in this spirit that I share my story.

Ours was one of the first medical schools to adopt the “block” system of teaching the basic sciences. Rather than having a number of courses proceeding longitudinally throughout the year, we were taught in “blocks” that were each organized around an organ system of the body. During a “block,” which typically lasted four to eight weeks, all of our time, effort and attention were focused upon that particular body system. It seemed that those students who were most adept at purging their brains of as much “block-related” information as possible in the interval between the final “block exam” and the start of a new “block,” seemed to do best. Several members of our class had even developed some exceptional mind-cleansing techniques and were altruistic enough to readily share these with classmates at post-exam parties.

I had found the first year of medical school to be as difficult a time as I have ever spent, even to this day. So, having made it to the second year, I was definitely relieved and able to breathe easier. I was beginning to acknowledge the possibility that the school may not have made a huge mistake in accepting me, and even more importantly, I was starting to fantasize about actually becoming a physician. This new awareness served to re-awaken my spirit which then allowed me to look more critically upon the educational experience of medical school. While I continued to recognize “my place” and accept my relative helplessness as a medical student, I found myself thinking of ways in which I might

“tweak” the system so as to further enhance my self-respect and confidence. In a twisted sort of way I began to see this as a form of watered-down guerrilla struggle against an overly repressive regime.

As the second year progressed, I satisfied myself with making the usual trivial complaints about poor lectures, outdated handouts, and ambiguous exam questions. This innocuous activity coupled with subject matter that was appreciably more interesting than in year one, served to distract me from taking more serious action.

It was during the Cardiovascular-Pulmonary Pathology block that things would change. The actual opportunity presented itself with my receiving a particularly inedible portion of lunchtime food at the hospital cafeteria. Initial feelings of disappointment and disgust quickly gave way to those of anticipation and excitement as I realized the “gift” that I had been given. My plan

began to take shape almost as quickly as I could harvest my unpalatable, but still warm, specimen.

Our final exam of written and practical laboratory components was scheduled to take place within the week. That gave me enough time to inconspicuously use the school’s equipment to seal my newly acquired specimen in a clear plastic sheath just like those that would be used in the exam. I rationalized that since my plan wouldn’t injure, endanger or humiliate anyone (except maybe myself); I was ethically and morally exonerated. As I saw it, my actions might even serve to instill some much needed new life into my classmates whom I felt to be experiencing a mild, but unhealthy sense of stagnation brought on by the benign routine of the second year.

As the exam day arrived, instead of my usual anxiety, I experienced an odd sense of exhilaration—no doubt some sub-conscious connection to my “dark side.” My basic plan was to substitute the cafeteria specimen for one of the exhibits used in the practical exam. Since we would be moving on to the practical exam after completing the written test, timing would be critical. I needed to be one of the first students to arrive in the



practical exam room so as to make the switch early enough to affect most of the class. However, getting there too early would be risky as I would be too exposed to carry out my deed. There had to be enough activity to provide the needed cover and distraction for me to make the switch.

As I completed the first part of the exam and moved on to the practical component, I became overwhelmed with the thought of “What if I get caught?” While I wasn’t actually cheating, I would be “disrupting” the exam. I would also be removing (albeit temporarily) official school property from the exam site. Could they get me for theft? I was just about to chuck the whole idea when I came upon station # 4 of the exam. The gods must have been smiling upon me! The station # 4 exhibit turned out to be an exquisite slab of lung tissue containing some type of malignant mass. I couldn’t believe it! It was almost the exact same size, shape and color of my own specimen, and it was encased in the exact clear plastic material. Before I knew it, I had replaced the official exhibit with an unrecognizable fat-laden hunk of tissue that only I knew had been a pork chop in its previous life. With the bone removed and sealed in the official plastic covering, it took on a mysterious, almost alien-like appearance. It was difficult to withdraw my eyes from this new creation, but I finally placed a question mark down as my answer to station # 4 and moved along to complete the remainder of the exam. I couldn’t help but sneak a few quick glances back at the station and, as I finished up, lingered just long enough to catch a glimpse of several of my classmates struggling to identify the peculiar specimen I had produced.

It turned out that the most difficult part of the entire adventure was to resist the urge to share with my classmates what I had done or to offer explanations for the mysterious specimen on station # 4. I did take some personal satisfaction in hearing it mentioned a number of times at the “mind cleansing” party on Friday night after the exam.

Imagine my surprise and subsequent dread when the head of the block greeted our class at 8:00 a.m. the following Monday morning. He somberly reported that there had been “a serious breach of security” in which someone had “stolen” a specimen from the exam and replaced it with another comprised of “tissue of unknown origin.” We were then informed that an investigation was already underway, and, if it was determined that the “unknown tissue” was taken from one of the cadavers, the perpetrator risked expulsion. He then

advised the person responsible for this “immature and unprofessional act” to turn himself in immediately or risk even more serious consequences (*Even more serious consequences?*).

I sat there stunned, trying not to look as guilty and vulnerable as I felt. What had started out as a stupid, harmless prank now had the potential to end my medical career before it even began. No mention was made of the fact that the original specimen had been returned unharmed and undamaged to the departmental offices over the weekend. This led me to believe that no attempt would be made to treat this merely as a prank, nor would any leniency be shown should the perpetrator turn himself in. Acknowledgment of guilt was now totally out of the question.

After spending that day in anguish and a night without sleep, an idea came to me early the next morning while in the shower. If I could get to school before anyone else arrived, there might be something I could do. Any action seemed better than continuing to obsess about my eventual and inevitable demise.

Later that morning as students began to file in for class, someone noticed large block printing on the board that declared: **PRACTICAL EXAM STATION # 4: IDENTIFY THE SPECIMEN. ANSWER: “PORK, THE OTHER WHITE MEAT.”**

Case closed.

Living in a Storm

When the lightening flashes

And for one jillionth of a second

Everything is perfectly clear

I always close my eyes.

Who can stand to see everything?

– Rebecca Mayo

Kayella

I didn't really expect her to fall asleep,
to tuck her head
onto my one time bony shoulder,
grown soft in added weight
and added years,
and just
fall
asleep.
I didn't know how she'd respond,
or why I asked to hold her in the first place.

You see, I'm afraid of babies,
watched my two nieces grow up without cards on birthdays,
begrudged Christmas presents,
no phone calls or letters.
I'm a lousy uncle, and now my two nieces
18 years old and 13, I think,
know not to expect too much from me.

I took the baby from her mother,
who I'd last seen at the "Hole" a year before, and held her.
She fell right asleep.
Even the mother was surprised, then turned to talk to friends
as I sang softly to myself and the sleeping baby in my arms.
My mind stopped racing,
stopped needing to talk to people,
and stopped being critical of the constant noise.
Suddenly, I was at peace.
A friend remarked, "You want one of those, don't you?"
And I, without hesitation, said, "Yes. I do. I do."

Call me selfish,
foolish,
or even silly but I'd never felt so peaceful,
never felt so much myself
as when I was holding a baby
in my arms,
singing it to sleep.

June 4, 2002

– Don McIver

Volleyball (for Breece Deboutez)

In a dream,
a white volleyball is flying over the net,
and my niece,
knees slightly bent,
arms curled so that the smooth white flesh of her inner arm
waits for gravity to pull the ball down to her waiting hands.
Her left hand cups her right hand.
She watches the ball drop,
follows the ball as it hits the base of her palm.
“Set,” she yells out,
and sends it up into position,
hands opening up to the sky.

In reality, she’s arcing up and away from the car,
body twisting and turning in the air.
Just west of Nevada, Missouri,
the Mitsubishi my niece is traveling in crosses over a median
and strikes a Dodge.
She’s holding out her arms,
a follow through on a perfectly executed set,
pushing the sky away from her,
looking at the starlight through her fingers,
as she comes back to Earth.
What kind of prayer did she offer in the last few seconds
before the impact with the black, unknowing, unyielding highway 54
crushed her 5th vertebrae?

One month after the accident, my niece came to me in a dream at 5 AM.
She is paralyzed, as my mother says, “from below the nipple.”
My niece cannot control her bowels,
can use a toothbrush but not squeeze the toothpaste,
can lift her hands but not open or close them,
can hold a pencil but not use it,
can lift a phone receiver but not dial it,
can hold a remote control but not change the channel,
can keep her hands above a keyboard but not use the mouse,
can backhand a volleyball but not bump, set, or serve it.
My niece,
a sophomore on the Varsity volleyball team,
can’t play volleyball.
In a dream a white volleyball is flying over the net,
and my niece,
knees bent as she sits in the wheelchair,
arms curled so that the smooth white flesh of her inner arm
waits for gravity to pull the ball down to her waiting hands.
Her left hand cupped into its permanent shape.
She watches the ball drop,
follows the ball as it hits the base of her palm,
ricochets up into the air, “Set.”
Hands open to the sky, but never moving.

August 1, 2004

– Don McIver

Exiting Ethics

by Mark Unverzagt, M.D.

One of the most rewarding aspects in patient care is the privilege to hear stories. These stories can often inform us about our own lives as well as developments in society around us. So listen as I tell you of my experience.

In the late 1990's, there was a graduate student who took a year off from training in order to spend time with his young family. He worked a series of part time jobs to pay the bills. They lived in a slow rural setting and enjoyed the respite that the year off was giving them.

During this time, his wife became pregnant with their second child. Their first child, a daughter, was born healthy. However, a prenatal ultrasound showed a potential problem with their daughter's kidneys. Remember that this occurs in the early days of the widespread application of ultrasound to routine healthy pregnancies. There was still much that was not known. And medicine being what it is, any abnormality is considered a problem until proven otherwise. In this case, all the subsequent testing turned out to be normal. But it came at the expense of pain and discomfort to their newborn daughter, a prolonged stay in the hospital and the

worry of her parents and extended family. For any of you that have been through anything like this, you know that no matter the outcome, these events in your life are not insignificant. So with the second pregnancy, they wanted to take a different approach—which they did. Along with their obstetrician, they agreed to try and avoid any unnecessary testing unless there was a clear medical indication.

The clear crisp days of autumn with the changing leaves turned to winter with occasional snowfall which turned to a vibrant spring full of daffodils, tulips and blooming dogwood trees. Life, and the seasons that

usher it along, was taking its course. And by this time the second pregnancy was blooming too. But around the 38th week, there were some subtle changes that might indicate a problem. They could also be a variant of normal. Clearly there was no emergency. But was there an important message here?

Despite some trepidation that there could be another false positive this time around, an ultrasound was ordered and performed. There was indeed a problem. A maternal-

fetal medicine and genetics consult were obtained.

Myriad specialists became involved. Things quickly became even more intense. Two days later, labor was induced. And after three days of a pitocin drip, a baby boy was born. Less than 72 hours after the birth, this baby boy died. There were no mistakes in this case. All the appropriate medical care was provided. As tragic as it was, it was simply one of the cruelties of Mother Nature. Everyone involved in this case grieved. But life moved on. On some level the death took its toll on the marriage, and the parents divorced several years later. But before their divorce, the family had two additional children, and all



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three children are healthy and thriving today.

The family involved in this story is mine. I was a 25-year-old medical school graduate taking a year off before starting residency. I didn't have health insurance because I was unable to get it. We were approached about finances while we were in the hospital. Our financial information was taken, and we later made a payment plan and paid our bill in full. But at no time during this story was I told that unless I could pay at least 50% of the anticipated cost of my care I might have to reschedule either the ultrasound or the consultation. This is the current policy of this medical center

for non-emergent care for self-pay patients or for patients who don't have their co-pay. At the earliest sign of the problems in the pregnancy in my story, there was no emergency. No one could have known the extent of the problem until the ultrasound was performed. Early intervention was the key in my case from preventing an awful situation from becoming a full-blown tragedy. It might have saved another life. At the very least, it saved a lot of money. Since we knew the diagnosis going in, we had some time to plan for the care of our son. We elected comfort care, not the ICU, since the outcome was certain. Having this time was a godsend. We could plan to deliver higher quality care appropriate for the circumstances without using more costly resources inappropriately.

Confronting someone up front with the dollar amount of his or her pain is an enormous barrier that I think few of us have experienced. But now we can no longer avoid the issue. Clerks are scripted to tell patients "Co-pays and/or down payments are expected to be paid at the time of service. If you cannot make this payment, you may be rescheduled." This seems innocuous enough, and there is an option to have a nurse triage you. But how many times have we seen a triage note describe one thing, and it turns out to be something completely different that we would have never known if we hadn't had an actual face-to-face encounter? The truth is, we cannot know unless we are there to ask. I know that there will be people who will read this and angrily denounce my analogy saying that such a thing would never happen here. But those of us on the front lines know that it happens all the time. It's one thing to discriminate based on sound medical judgment. It's another to do so primarily for financial reasons. We take an oath that in effect pledges us not to.

I do not believe that providing healthcare requires you to do something for nothing. I am a very strong believer in personal responsibility. And I don't like it when people take advantage of me. But our current policy is prejudicial. It assumes that people can't or won't pay. A senior leader in our institution recently told a large group of physicians and administrators that the institution has no obligation to help self-pay patients unless they are in our emergency room. I heard another say that healthcare is a commodity much like car maintenance or buying bread at the store. It should be paid for at the time of purchase. It seems easier these days to blame the people like I was—a person without health insurance—for our institutional debts. We seem to have shifted from placing responsibility on our elected leaders

for a failing national system of healthcare to placing responsibility on individuals in our community who don't have insurance or public assistance.

I think we can do a better job balancing our fiscal and ethical responsibilities. What if we told patients, "Your health is important to us. Unfortunately, we cannot offer you these services for free. So we will require you to meet with a financial counselor to help you pay for the cost of your care after your doctor determines what is medically necessary. There may be assistance programs that you can apply for. But today, your health is the most important thing." This is the approach we took when I ran a clinic in one of the poorest counties in the state. I had patients driving from other counties and across the Arizona border to receive care at my clinic. Some of them had insurance, but most did not. There was no county indigent program. We had very few people that abused this system. Patients knew first and foremost that we cared about them. They also knew that they had a responsibility to keep the clinic afloat. There was a genuine partnership between the community and the health center. And every year we turned a profit and expanded our operations until we were the largest non-governmental employer in the county.

I don't understand why we aren't having more institutional discussions about the larger national health care crisis that is in large part responsible for our dilemma. Why aren't we, as a research institution, researching ways to provide high-quality, low-cost care to the uninsured? Instead we seem to be handed only one solution that lays much of the blame at the feet of the poor. We are encouraged to create a two-tiered system of care. This sets a dangerous precedent for the institution. And I don't know how to role model this for our students.

I am troubled enough by this that after working here for eight years, it has become a significant part of my decision to leave the institution. It's a tough call. But as a rank and file faculty member without any particular authority or influence, I don't feel empowered to change this situation or even to offer up any solutions that can be taken seriously. And I am tired of wrestling with my conscience. I want to wake up each day being able to act upon it. This story is an attempt to do just that. My hope is, without diminishing the importance of the financial problems we face, to generate wider discussion and more creative solutions for our uninsured patients. I intend to do what I can in the remaining few months that I have here. But then it will be up to you to help people that, as my story illustrates, are not too different from me. □

The Challenge of Health Care in America and New Mexico: An Opportunity for Those With Helping Hands

by R. Philip Eaton MD, Executive Vice President, UNM Health Sciences Center

When the Muse's editors invited me to write an essay about the challenges of health care, I initially thought I would write about our recently adopted clinical enterprise strategic plan. However, I have decided that connecting the dots of some of the experiences in my life would provide a personal perspective that might frame the discussion in a different way, and permit me to connect more personally with the readers of this publication. Four of my experiences seem particularly relevant to the topic, although their connections might not be immediately apparent.

The first experience was the frustration that my physician father experienced fifty years ago dealing with administrative barriers while caring for the sick within his practice in an urban environment in the Midwest. His response was to become a medical missionary under the auspices of the Presbyterian Church, and to travel to what was then Persia with my mother. There, for a decade and a half, they were able to provide care to the sick with no administrative barriers and no billing or collecting. The satisfaction they derived with their helping hands was enormous, and the impact upon my life continues to this day.

The second experience was the personal frustration that I experienced in the early 2000's, when behavioral health delivery across the state of New Mexico was beset by mass closure of mental health hospitals and clinics and by a loss of trained providers across the state. These closures and departures resulted from financial cutbacks in Medicaid dollars from the federal government and from decisions by our state government about how the remaining dollars would be spent. A notable exception to the closures was the continuing care delivered at a financial loss by the University of New Mexico through the Department of Psychiatry and the Children's Psychiatric Hospital and the University Psychiatric Center. I was frustrated because I saw patients who

needed care, and health care professionals who wanted to provide care, but a financial situation that compromised the delivery of health care; I was further frustrated because I saw many exceptional psychiatrists, psychologists and other behavioral health professionals leave the state because of the significant funding cutbacks.

The third experience was the excitement of accepting a leadership role as Vice President of the UNM

Health Sciences Center in 1999. I was both humbled and enthusiastic about having the opportunity to guide the development of a long-range vision for the HSC, while at the same time being accountable for its operations and adding value to the tremendous work of the faculty and staff engaged in education, research and patient care. In the seven years that I have led the institution, I have seen our delivery of health care to the children and adults of our state increase by thousands of individuals and millions of dollars each year. We have extended access both to those traditionally underserved because of financial limitations, as well as to the "new-underserved" who have been

unaware of the cutting-edge primary and specialty care available at the HSC and how to access that care.

The fourth and final experience has emerged gradually over the past 37 years during the time I have been a faculty member at UNM. I have come to appreciate more than ever the very direct connection between the people we elect to public office and the issues we deal with on an ongoing basis at the HSC. A decision in Washington to reduce Medicaid funding, for example, sends shock waves throughout our organization; it is usually too late at that point to influence a different outcome. It is vitally important that as an academic medical center we engage with our public officials at the local, state and national levels, and it is equally important that as citizens we remember that our votes determine the people and policies that will guide the



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direction of health care in this state and this country.

Connecting the four dots may provide some understanding of my perspective about finding solutions to the challenges of health care within our state. First, to me, the essence of health care is understanding and feeling the core value of caring, and seeking to share with those who are in need. I know that great satisfaction is derived by health professionals in the process of providing exemplary health care. Administrative barriers should not get in the way of these outcomes as they did for my father before he began his missionary work.

When I connect the first dot of health care without administrative barriers to the second dot of the collapse of mental health care in the state, I can see the disastrous consequences that can occur if the medical industry is not financially sustainable: Health care professionals are limited in what they can do, with many being forced to pursue their careers elsewhere, and patients do not receive the care they need. We must make sure that all of health care in New Mexico does not repeat the unfortunate experience that befell behavioral health care in our state several years ago.

Linking to the third dot, as Vice President I have seen our mission expand dramatically to include increasing numbers of indigent and uninsured patients as well as increasing numbers of the new-underserved patients, those with insurance who seek the cutting-edge primary care and specialty care available at UNM. Even though we have increased our uncompensated care by millions of dollars each year, the multiple revenue sources from enormous faculty and staff effort, combined with state and federal public support, have not been sufficient to cover the costs of that care and invest for the future.

Connecting all four dots brings me face-to-face with the message for leadership: Find a way to make our institution financially sustainable without compromising our mission or ignoring our core values. The message is simple, but the execution of the message is not simple. As we launch the strategic clinical enterprise initiative, we will seek even more resourceful and effective approaches to maintain our values and our solvency. There is no one to blame, no mission to be compromised, and no core value to be ignored. We must depend upon our academic inventiveness and creativity to find opportunities to extend our hands to those in need by means of a financially sustainable business model, and we must be mindful of the significant influence of the voting public on the government's decisions that affect health care in New Mexico on a daily basis. □

Why only love can save me

I wasn't no apple
of my mother's eye
at most crabapple

Her plaintive fussing (therefore?)
reminiscent of a child
cawing constantly
at me with barren swoops
born of bed-ridden mother of her own
I'm just told

Snipping squint-eyed
at me with anxious abandonment
assigned by her alcoholic father
to whom she could say nothing
he being a doctor

When I think of her
she was like some girl-friend
whose life was receding
from you even before...
well, in this case before my mother
had me
and you feel your need
to curve back
to her well after her death
to protect
her and you find
yourself circumscribing
this emptiness the doctors call
an ulcer

– Arun Ahuja

A letter to my first patient

I just wanted to say thanks for all that you've taught me.
This experience of strolling through
the evidence of your life has shown me more
than I ever dreamed about the human body.

Not unlike my first love,
I feel as though I will remember you forever.
First, there were your arms that taught me strength.
Next, you showed me your hands,
and taught me about gestures.
I can never forget your cheeks,
which divulged the secrets of your smile.

I am grateful for your seemingly tireless patience
with my never-ending stream of questions.
Through your generosity, I have had the privilege
of viewing a phase of the cycle of life
that will allow me to place
all others in perspective.

Reflection on the evidence of your life made me think of a quote attributed to Buddha:

*I am of the nature to grow old. There is no way to escape growing old.
I am of the nature to have ill-health. There is no way to escape having
ill-health.
I am of the nature to die. There is no way to escape death.
All that is dear to me, and everyone I love is of the nature to change.
There is no way to escape being separated from them.*

*My actions are my only true belongings.
I cannot escape the consequences of my actions.
My actions are the ground on which I stand.*

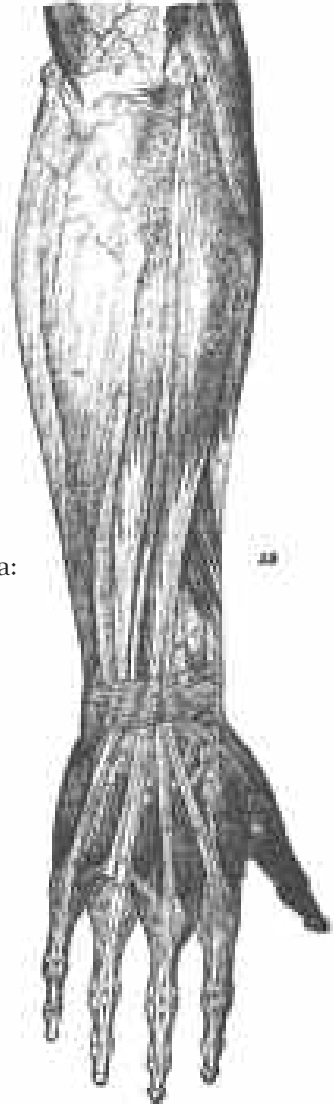
Your actions are your legacy.
and although I have not discovered
the depths of your likes and loves,
your personality and habits,

I think I can safely say
that I have seen and discovered—
an open and generous heart.

Thanks, and farewell.
Love,
Beth

November 2002, On the occasion of the memorial service for the families of cadaver donors.

– Beth Saltzman



If I die,
If I am ever blown from the sky.

Let this tome be my one
True Testament to all
Things that I have seen
And to all things I felt.

I bless the day I was
Born to feel your breath
On my chin.

I am helpless
Like a leaf that floats
To points unknown
Without the feel of
your eyelash on my cheek.

14February05

– John Brandt

A poem of love
Each day
Cannot but waft
All clouds away

A kiss, a hug
A glass of wine
Can on occasion
Slow the march of time

The many forms that
Love can take
From loving poem
To birthday cake

As now in silence
I can hear
A quiet whisper,
She is near!

**On hearing on NPR on Valentine's Day that the
journalist Robert St. John wrote a poem for his wife
each day for 52 years.**

– David M. Bennahum, MD



Brian Buggie, MSI

Diabetic for Three Days

by Paul Romo, MSII

The Land of Enchantment is also the land of ethnic groups at highest risk for developing diabetes, particularly among our Native American and Hispanic citizens. There are 120,000 New Mexicans who suffer from this disease. This is almost equivalent to the entire population of Santa Fe, and rapidly increasing. As a medical school student, I realize that I will be faced with the challenges of helping diabetic patients manage their disease to delay or avoid complications. In order to gain more empathy and understanding of what it is like to have insulin-dependant diabetes, I agreed to live as diabetic for three days.

Diabetic for Three Days is an experience introduced for the first time to second-year medical students during the Clinical Skills portion of the Renal/Endocrinology Block. It is designed to enable students to voluntarily step into the life of an insulin-dependent diabetic for a 72-hour period. In order to learn this new routine, M.L. Johnston and Linda Reineke, Certified Diabetic Educators (CDEs) in the Patient Education Department of the hospital, trained me in the rituals that I would use to manage my diabetes. First, they gave me a glucometer, which is a pocket-sized device that would allow me to check my blood sugar. I was taught to prick my finger with a needle called a lancet which briefly stung and itched like an ant bite. I then had to place a drop of blood onto a reagent strip known as a chem-strip. The chem-strip was then placed into the glucometer and after several seconds, displayed a digital readout of my blood sugar. I was instructed to check and record my blood glucose levels four times daily, once when I woke up and two hours after each meal.

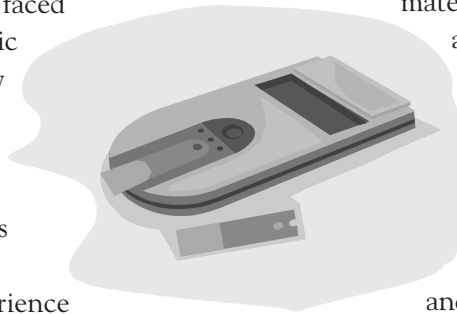
Next, I was given a set of syringes and ampoules of *Lantus* and *Novolog* insulin, which were actually saline. I felt anxiety as the CDEs demonstrated how to draw the correct amount of insulin into the syringe and how to remove air bubbles. I was taught how to cleanse the skin on my abdomen with alcohol swabs and then give myself a subcutaneous injection. I was hesitant to inject myself and only tried it after the CDEs injected themselves to show me that it did not hurt. I had to inject ten units of *Lantus* at night before bed and five units of *Novolog* immediately after each meal.

The dietary modifications required me to limit my

carbohydrate intake to 60 grams per meal and eat up to five servings of vegetables daily. I had to use an information chart provided by the CDEs to determine serving sizes and grams of carbohydrate in combination with the Nutritional Facts chart on the side of the package of everything I planned to eat. The chart was used to estimate approximate portions of food in order to adhere to the dietary restrictions. In addition to this list of demands, I also had to exercise for a minimum of 30 minutes at least three times a week.

Immersing myself into the life of an insulin-requiring diabetic interrupted my daily routine in many uncomfortable and inconvenient ways. During my first day as a diabetic, I woke up to a beautiful morning, poured a large, delicious bowl of Rice Crispies and added a spoonful of sugar on top. I was ready to taste the crunchy, baked carbohydrates in the cool milk when I remembered that I was a diabetic. I had to rearrange my morning and check my blood sugar first. Frustrated, I pricked my finger with the lancet and put the drop of blood onto the glucometer strip. After eating what I determined a serving size of cereal 60 grams would be, I measured out five units of short acting insulin (saline) and injected it subcutaneously into my abdomen. On my way to school, I had to return to my house because I forgot to bring my glucometer, syringes, and insulin for my lunchtime meal. Having diabetes already began to feel burdensome.

After a day of lectures and labs at medical school, I came home anticipating a delicious dinner. Much to my dismay, the meal prepared was not in accordance with my diabetic diet. But it smelled so good! I had to remove the potatoes and flour tortilla from my burrito and I could only have a very small serving of beans. All of these dietary changes made me aware of how many carbohydrates, candy, and sodas I consumed throughout my day. In addition to dietary modifications, I had to learn a new type of dining etiquette. After I injected five unit of *Novolog* at the table, my girlfriend expressed disdainfully "Gross! Please don't do that right after I eat." I felt like an outcast at my own table. I didn't realize how being a diabetic affected those around me. Not only was it difficult to inject myself in the abdomen after every meal and at bedtime, it was not a pretty sight.



Day two and three passed with equal discomfort. I was supposed to check my blood sugar two hours after every meal, but I found myself forgetting to do this a couple of times. I also had trouble getting into the habit of using the charts and tables to calculate carbohydrate grams and calories. It was overwhelming and time-consuming to completely adhere to the necessary regimen. I resisted almost every part of the self-management tasks (carbohydrate counting, injections, glucose monitoring, etc.), except exercise because it was already part of my routine. I just couldn't get used to this new lifestyle and I was resentful of the fact I couldn't drink a soda or snack on my favorite candy.

When the experience came to end, I had a profound realization; being an insulin dependant diabetic is more serious and challenging than I imagined. I experienced the challenges of living as a diabetic for only three days, yet I could not grasp the difficulty of having to go through that regimen of injections, needle sticks, and carbohydrate counting day after day for years, with the shadow of complications such as vision loss or cardiac problems looming over me. It intimidated me to think of the thousands of needle sticks and injections needed to prevent the possible diabetic end-stage diseases. The thought that 90% of the population has the type of diabetes that may be prevented was also a disturbing realization for me.

Prior to this experience, it was so easy for me to say, "Why don't these patients just follow the treatment regimen? Don't they realize they could go blind, need dialysis, or even require amputation of a foot or a leg?" Now, I admit, I know how easy it is to be less than 100% faithful to such a rigorous lifestyle change. Eating and what it symbolizes is central to our American lifestyles. When I was told I could not eat how I wanted to or drink a soda for that matter, I resisted it because I felt like I lost control over what was my right. Losing the ability to eat and drink what I desired created feelings so strong that they eclipsed what I knew to be the potential dangers of diabetes. Given the rigorous demands of this disease, it became more apparent to me why a patient may not be able to comply with the regimen needed to manage their diabetes, despite being aware of the spectre of health complications that may ensue. Now, when I'm in the clinic working with patients affected by this epidemic, I will strive to be patient, empathetic, and understanding, because it is easier to tell someone how to self-manage diabetes than to actually do it. □

Acknowledgements – Thanks and appreciation to George Comerci Jr., MD, FACP, M.L. Johnston, MS, RD, CDE and Linda Reineke, RD, LD, CDE for organizing this experience for the class of 2007.

DAD

Why did you slap me around like that?
I loved you
followed you around
watched you
I watched you fix plumbing & wiring
unclog sinks and toilets
and rebuild the window fan
with the washing machine motor - it was loud!
I learned how to use tools watching you
You taught me how to do dishes too
Squeaky clean a *useful* discipline.

Why did I sit naked in a tree, Dad?
waiting for aliens to take me away.
Why was it, Dad
that I sat on my attic room window ledge
wondering how long it would take
to hit the ground
and how to fall?
Best to fall on my head
smash the brain feel no pain.

Why did you slap me like that, Dad?
back and forth back and forth
my head swinging like the pendulum
in a grand fatherclock – no –
more like the ticking of a bomb
Why did I knock you down, Dad?
Why did you stop my foot
inches from your face –
when all I wanted to do
was smash your head open and
smear your brains on the kitchen floor?
You smiled then never hit me again.

You're dead now
cigarette tar in your lungs
cancer ate one lung, then the other
and pancreas spleen stomach
and you were dead
4 1/2 months ahead of schedule
(doctors don't know shit)
and 25 years too soon.

Dad, I'm sorry you died that way
alone, out of work, in pain
You didn't deserve that.

Look at me when I'm talking to you!
you fucking bastard
I loved you.

– Terry Mulcahy

On Healing.....

God walks into the room in a long white coat
to the corner where sits a ghost wearing too many clothes.

She peers sideways through half-closed eyes,
“I haven’t slept for weeks,” she explains.

Hands shaking her coffee in the morning she averts his gaze.
He studies her chart. Same as before.
“Are you in pain?” he inquires.
“Yes.”
“Where does it hurt?”
“Everywhere.”

Hanging by a thread on the wall his degree of knowledge
attests to nights not sleeping — studying and working and missing opportunities lost.

Dark circles in a sullen face,
Desperate expressions haunt the man whose religion knows no cure.
Science..... Medicine.....

“Are you eating?” he asks.
“I can’t.”

No touch. No warmth. Alone and lonely.
Wanting to die. Wanting to be dead.
He sees she is fading.

Tears swell up in too old eyes with heaves of labored breath.
“I... I need something else,” whispers trembling lips.

He sees she is fading, fading fast.
A soul trapped by prison flesh hears freedom calling
like water falling down to a pool at the bottom
where all souls go to be together as one.

Hiding behind an empty face,
the heart in his throat swallows words he cannot say
as he offers the only comfort his science will allow

Another prescription.....

– Loisia L. Watson

Morning Cope

Falling into the rhythm of his commitments
he feels less jerked around as in
bouncing off those views through his feelings

But that explosive bark
of neighborhood dog on his walk out
wipes his heart out again and
he his back to thinking:

I am a sensitive
What's wrong with that, even as
a man? I need
a place where I don't get triggered,
a monastery...

only he is psychically so wary,
psychosomatically so allergic
to religiosity
or at least its overt expression, there's something deeper
there is culture,
as in waking up to very Indian sounds
of relatives now estranged
then splitting out to morning bark
of dog, he is convinced
it assaults him because
if dogs can detect cancer, can they not
also detect genes as in
race other than owner's?

– Arun Ahuja

Upon The Death Of A Solitary T-Cell

Vision like an over-exposed X-ray
Scent of sweet oranges
Tasting copper on buds
Clouds overcast pupils
Mountains rise from
Flat plains of flesh

I can hear hair breaking
Burning tears trying to peer
Through dark thunderheads

Bob Mould passes time
Mumbling wisdom in San Francisco
Actually it's apricots I smell
Disinfected tile

I contemplate

.....breathing

– Mark-Fischer MS1

Rebecca Purvis





Yucca Lodge Motel, Bowie, AZ

Paul Akmajian

Transforming

Assume a posture of readiness to
Elevate what you know
Beyond the ordinary, past ease of memory
To the disturbed thoughts
Reserved for changing

Yes, you were young once
And ignorant too
Now your shining eyes
Depict a knowing,
The yearning for which propelled you here
To this place
And time enough to learn again
To move purposefully beyond
That ordinariness expected

Emergent and impulsive curiosity
Born of the uniqueness
That also brought you here
To see what only you can observe
And know that which is in your
Destiny to discover

Then finally
Becomes your readiness
To share what you know, what you are
And wait for the young and ignorant
To then come forward
And show you

– P.H.DeVoe



Brian Buggie, MSI