

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.

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

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Cover photograph by Adam Kludt



Mara Nydes



David Chafey

The Subject

Just want to make some money
And not have to worry
About not having enough
And not getting by

I can't understand the consent
Don't care about the science
And I don't have a need to dissent
Or I be without my pence

I hope they can give me some healthcare
Since I can't afford it
But I understand it's a study
And they have no obligation
In our winners only nation
Where I have no station

- Mark Holdsworth, PharmD

Charon's Obol

Into my hands an assemblage of star dust has fallen
Which would you have to sit beside you, a business or calling?
Let it stand that I'm but a man,
And death, nothing less, is at hand
Look now, the ferryman of the river Styx
We mustn't tarry, this needs to be quick

"Life is short and art is long"
Leave the former, consent isn't wrong
Art or science, museum or machine?
You can't pick when, but you choose the scene
Fluorescent sheets as your wharf, aseptic bulbs light your way
Remove your mask; I must place a coin for his pay

I bid you farewell, back to elements you go
Your passenger is set Charon, you may begin to row

- Benjamin D. Ramos



Adam Kludt

My Love Lost

By Allen Dickstein

I was dying from a broken heart...this is what I came to understand about love lost. This extremely painful feeling affected my heart, my soul, my mind and my body. Sometimes I wish we had never met. I wish we had not attended the same health club and had not seen each other or noticed each other...but we did!

I knew he loved me but could not really love me because he did not love himself. He did not have any positive feelings about himself except that he was very handsome and everyone looked at him and everyone wanted him. But he loved me as I loved him.

It was the raging 80's...the AIDS epidemic! We had broken up, came back together and broken up.

It was the month of January in 1985 when I saw him on the New York subway. I looked away because seeing his face increased my agony and mental anguish and I could not deal with this. He walked over to me and quietly said "I have AIDS". I burst into tears not caring who saw me.

I said "we must be together" He wanted that too.

The first time we saw each other we sat at opposite ends of the sofa not daring to move closer. But slowly we did and our hearts poured out torrents of tears and feelings. We remained together what seemed like eternity.

When he got worse (and in the 80's AIDS was a death sentence), he sold his apartment and moved in with me. While this was agony, it was also joy in spite of what we

both endured. I took care of him night and day and even learned to cook Macrobiotic food which many believed would cure this horrendous disease.

People said to me "how can you care about him.... how can you be so loving and giving"? My response was simple....love is love and that's it no matter how much emotional pain I feel. I know it's real!

As the next two years progressed he of course became worse.

One day in the AIDS unit of the hospital he asked me what I felt about his dying. I did not know how I managed to be strong and as calm as possible. I told him that in spite of our highs and lows, he made it possible for me to know what it was like to be in love and that it was okay for him to let go and not to suffer any longer. He was happy and said that he hoped, in time, that I would meet someone else and again find love.

Two weeks later he died in my arms.

I knew I had to go forward....I knew it would not be emotionally healthy for me to build a shrine for him....I knew in time that I would meet someone else and fall in love....this I did. I made Gary happy.

My love lost was my love found! □

Adam

He was kicking yesterday.

My heart pounds and then sinks
as I search for his
through your taut skin and your panic
The air is humid with the weight of your fear
fanned by the pleading of your hands
fluttering desperately across your belly

He was kicking yesterday.

His name is Adam. He is your firstborn son and
the Biblical significance echoes in my head
An ultrasound probe travels a slow path across
your belly
Her knuckles white because she knows
and I know
and then we see his silent heart
and there is no way to protect you.

His name is Adam and carrying him
has been your favorite paradise.
Suddenly standing on the outside of Eden
you sit in stunned silence.
You ask if we are sure.

We are sure, but he was kicking yesterday
and you cannot comprehend his absence
and you cannot speak of funerals
so you tell me about the nursery
that you painstakingly made perfect.
Shades of blue, with seahorses on the walls
That will swim in the salt
of tears you haven't yet cried
because you are still asking if we are
absolutely sure.

His name is Adam
and as chemicals trickle into your veins
to force you to say goodbye
you relive all your imagined futures.
First birthdays and Halloween costumes

High School graduation
Vacations to oceans full of seahorses.
His name is Adam and someday
he was going to give you grandchildren.

But there will be no grandchildren
From this beautiful boy
Wisps of soft hair and cord
Wrapped twice around his neck.
His bride will marry another man
And never even imagine that she has lost him.

His name is Adam
and his perfect body was created
from the dust of ancient stars
and your own selfless cells.
His birth song is the keening of your grief
Erupting from the depths of your empty womb
and like clouds in a hurricane you collapse
and your husband sits mute

He was kicking yesterday but today
the seven precious pounds of him are heavy
in my arms.
I dip his hands in plaster
Press his perfect feet into ink
Instead of first steps you will have molds of tiny fists
and footprints on paper
and empty arms
and a nursery full of seahorses.

I cannot wait to leave and I never want to go
and in the elevator the tears come without warning.
I am sad but I am also furious
at the cord and the empty carseat
and the ache of his absence in your arms.
He was kicking yesterday
and today your stars have gone out
His name is Adam
and the world will never know the immensity
of our loss.

– Julia Toler



Ecuador

By Erik Hauswald

Two other students and I chose to do a three week clinical experience in Ecuador. It was a whirlwind tour of Ecuadorian healthcare in different settings. Briefly, we spent two days at one of the medical schools attending classes, three days in the ICU at a public hospital (Hospital Enrique Garcés) two days at an alternative medicine clinic, one week at a rural clinic, and three final days in the internal medicine wards at the same public hospital as before. We had arranged to do a medical Spanish course for an additional week but this fell through at the last minute.

As is any travel experience, the most interesting aspect to observe was (in this case medical) culture. The two days in the Universidad Tecnológica Equinoccial (UTE) gave us a view into their much different (from ours) education system. Ecuador follows the more common worldwide system of going into medicine directly after high school. Therefore the students were considerably younger than us. We attended classes with their 5th year students. Two of the major medical cultural aspects that stood out can reasonably be attributed to this system. One was the student's maturity and the high standards to which they were held. They had been in the medical program for four more years than us

and were clearly more adept at the case reviews covered in their small group. Their 5th year means they have had about as much experience in higher education as we have, yet they had more experience within the medical system and format. They were not allowed to use notes, and everyone had to participate. One other aspect of Ecuadorian healthcare that can be partly attributed to the educational system was a very clear difference between the doctor and the patient, even between the doctor and the rest of the hospital staff. This was one of the most striking differences between medicine in Ecuador and in the States. We are constantly being taught how to be more sensitive to our patients. The doctor in Ecuador is clearly the boss. Much of this of course can be attributed to other factors. However, one dynamic is that they separate themselves very early from the rest of the community to study medicine. Here in the States we enter medicine much later and often after a separate career. In college we study with a diverse group of colleagues. They do not and, even more than in the USA, the medical students come from families of high socioeconomic status. They often don't have any contact with the "common man".

In the three days of the ICU we worked with a very friendly, knowledgeable, and helpful physician named Dr. Luis Gonzales. We saw some interesting diseases and witnessed another striking difference between their system and ours. Ecuador is very diverse in terms of altitude and landscape. We saw one patient with myasthenia gravis who had come from the coast to Quito (at 9350 feet) and had an exacerbation. We saw a patient of African descent who similarly had a problem with the altitude due to his sickle cell anemia. Another patient had necrotizing fasciitis. Perhaps most interesting was a woman with liver failure who had previously been seeing a traditional healer. The patient had been sick for a long while and had gotten progressively worse under the care of a shaman. The treatment included many herbal drinks that the Ecuadorian physicians said often cause liver failure, along with more bizarre practices like biting the patient (she had multiple inflamed bite marks). We were able to see a lot because there was no privacy, none at all. The necrotizing fasciitis patient had a very large wound from his left foot all the way up to his groin. I witnessed a couple residents snapping pictures with their cell phones. At one point we had a lecture on ventilation with some 15 other students in the room of the myasthenia gravis patient.

The rural clinic was the best part of the whole trip. We were stationed in a town called Zumbahua which sits at 11,500 feet and has a population of roughly 12,000. The area is predominantly indigenous and many people speak only the native language, Kichwa. The clinic is actually run by an Italian NGO, though almost all the employees are Ecuadorians. The clinic had a small ER, 20 inpatient beds, a room for PT, and regular visit rooms. It was staffed by an OBGYN and a generalist. The generalist did a lot of everything, with essentially no experience in any of it. Physicians do no training after medical school unless they want to go back and do a specialty. It was scary. Not only was there a clear lack of knowledge, there was an even clearer lack of respect for the patient. Accusatory, yelling, almost zero patient education. Partly it was an issue of the indigenous community being viewed as unable to understand and unwilling to follow the doctors' orders, but much of it was a lack of interest in the patient on the doctors (and nurses I should say) part. Doctor is boss. Also no one washes their hands. Maybe if something very visible was there, perhaps. The experience was actually so uncomfortable that we spent most of our time escaping the hospital to go on house visits. They have two house visit programs; one for malnourished children and one for elderly patients who have a difficult time leaving their home. Each person enrolled in the programs would get a visit every 3 weeks. The visit included a

brief exam and either their meds, or some food supplements and a growth measurement. This was fantastic because we got to do much more, and see more of the culture. People still live in thatch roof houses, cook with an open fire inside, and have animals in their single room homes (including cute and apparently tasty guinea pigs).

The traditional medicine clinic in Otovalo can be described in no better word than interesting. The clinic is a mixture of both western medicine (they have an OBGYN) and traditional healers. One man specializes in herbs, and made sure to shoo us out of his room very effectively by releasing a bomb of spices so that after a few minutes only he could remain. Causing people to cry and coughing for five minutes would not seem to be a good strategy for convincing people to respect his practices. The traditional birthing mother rubbed eggs (and guinea pigs for the wealthier clients) over patients to diagnose all sorts of illness. The patients go, so the western docs have to at least recognize and know what the traditional practitioners are doing. At least no one got bit while we were there.

The internal medicine days showed us that privacy was clearly not a concept for the hospital. Each room had 8-10 beds. Rounds were done with about 40 people in the room. A nice example was a patient who had suffered a hemorrhagic stroke and kept yelling "empanadas", "empanaditas", and "ay yay yay". Empanadas are a common stuffed pastry for anyone unfamiliar with them. At one point during rounds a doctor suggested "Well someone buy her some already!", and they laughed. They ALL laughed.

The other interesting thing about the hospital was that it was public, and thus rather underfunded. Everyone in Ecuador gets free care, however the hospital often cannot afford all of the medicine people need so they send the families to go buy it in the pharmacy. Many patients cannot. The hospital while we were there was out of ketamine, and more surprisingly saline. They were cleaning wounds with deionized water, which is actually okay I guess.

Our experience was short but meaningful. We often looked up any medications or diseases we did not know much about, just as we would in the states. We also looked up Spanish words we did not know, and practiced patient interviews in Spanish. Fortunately I was already fairly fluent otherwise I would have been lost the whole time. I learned two words in Kichwa, and promptly forgot them. Fortunately I don't think I will need them here. Perhaps the most meaningful was observing practice habits that we did and did not want to do ourselves. What kind of doctors do we want to be? Certainly I will avoid biting anyone. I will try to stress patient education whenever possible. I will keep improving. □



morguefile.com image

Summer in Ecuador

By Emily Ball

This summer I spent three weeks completing a clinical rotation in Ecuador, and a few weeks afterwards to see the country. Our first few days were spent at the Universidad Tecnológica Equinoccial in Quito, the capital city. There we attended, among other things, a problem based learning session focused on diabetes much like the cases that we complete as part of our tutorial. Students in Ecuador begin to study medicine directly out of what is equivalent to our high school and continue for seven straight years followed by a mandatory year in a rural location or residency.

Another portion of our time was spent in the Hospital del Sur, which is a large public hospital in the South of the city that serves a population of low socioeconomic status patients. There we spent time shadowing both in the ICU and the inpatient Internal Medicine wards. We saw a spectrum of patients including a woman with HEELP syndrome, a young man with extensive cellulitis that had been debrided surgically, a girl being treated for a myasthenia gravis exacerbation, a woman with cerebral hemorrhage, another woman with advanced sequelae of hepatitis that came in after having been treated by a shaman and several patients with complications due to Diabetes.

For what we know about treatment plans at this point, it seemed like the doctors were doing more or less the same types of studies and using pharmaceutical regimens that are similar to what me might use. The differences in treatment that were most apparent were associated with

the low-resource setting in which we were observing. On many occasions the supplies necessary to treat patients simply were not available. Families of patients were sent to buy medications or supplies outside of the facility. If they were unable to afford them then the patients went without. While assisting with wound care one morning we were told that due to a hospital wide shortage of regular saline we were going to use water for cleaning bedsores and diabetic foot ulcers.

The most significant and eye-opening experience that I had was the week that we left Quito and went high into the mountains to a village named Zumbahua that is surrounded by dramatic scenery and steep hills that are covered with a patchwork of little farms. An Italian non-profit organization has built a hospital in Zumbahua that serves a catchment area that includes many other tiny villages and people often travel long distances to be seen.

In Zumbahua we spent our mornings visiting patients in their homes with several traditionally dressed community health workers. Our patients were either elderly or young children suffering from malnutrition. We would weigh and measure the children, listen to their hearts and lungs and leave some extra food with nearly every family. The high altitude contributes to an increased incidence of heart problems, and I heard several very prominent murmurs while visiting the thatch-roofed 'chozas' filled with chickens and guinea pigs where our patients lived.

In the afternoon we would return to the hospital. Due to the long distances many patients stay in the hospital for long periods of time accompanied by family members. One tiny little boy was there nearly the full week and we watched him slowly become more and more animated after having come down with pneumonia. His mother had a very thick accent, but was very friendly to us. (Most patients spoke Kichwa, an indigenous language, much better than Spanish) One day when I came in to see her and her little boy she looked completely changed from the day before, very pale and she was shivering. I followed her over to be seen in the small emergency department. She was attended to by the Ecuadorian OB/GYN on call, whom I found to be very harsh, and sent away with nothing. It was evident to me that she had a urinary tract infection and when I asked the doctor if she agreed I was told that she did and that she had already been given antibiotics the week prior. This case stands out in my memory because I was so shocked by the harsh treatment of the woman, both verbally and while receiving a gynecological exam. I held her hand while it was happening and I didn't know how this could possibly be acceptable. I would later see that a condescending and blameful tone was taken with many patients in the clinic. I found it very disheartening.

Another day in the emergency department a woman came in with a very small child whose head was pulled back and whose eyes looked empty and clouded over.

The baby had very severe malnutrition and went on to die in the days following. Many people, although they farm very nutritious foods, are starving because they send their crops to Latacunga or Quito to be sold. It is a problem that plagues the area and for which many donations of food and vitamin supplements are brought from the medical school to help assuage.

For those children that are able to recover there is hope in the form of the orphanage in the village. An Italian woman started the home for children over twelve years ago. She cares for many children with disabilities, both mental and physical, as well as those who were unable to be cared for at home or no longer have parents. Some children come over from the hospital while recuperating from malnourishment or other illness. While we were there most of the children were away in a nearby village volunteering, but several of the youngest were there as well as the most severely handicapped. It was extremely touching to see the care that was provided by the Italian woman and her many local assistants. The children were very much loved.

We saw a great deal during our short time in Ecuador, but it was a learning experience in many ways. I have gained a deep appreciation both for what I have and for the services and care that we are able to offer patients here at UNM. I will never forget what I learned from being in Ecuador and will take better care of patients as a result. □



morguefile.com image

Today I Held a Heart

Today I held a heart in my hands.
It was smaller than I thought it would be,
though everyone said that our donor had a large one
comparatively.
I decide I do not want to compare his heart;
Because it is the best to me.
I cradle it tenderly,
thinking of who fell asleep to its rhythmic art
who leaned against his chest breathing in safety from his
heart.
I hold his heart safely,
and my heart beats,
beats hopefully, that,
In life, someone held his hand.

- Francesca Giovanna Garcia

A Farewell to the ER

I have lost my sense of time completely,
Challenged my notions of wrong and right.

Watched a mother worry over her child sweetly,
Held back tears as a patient went to the light.

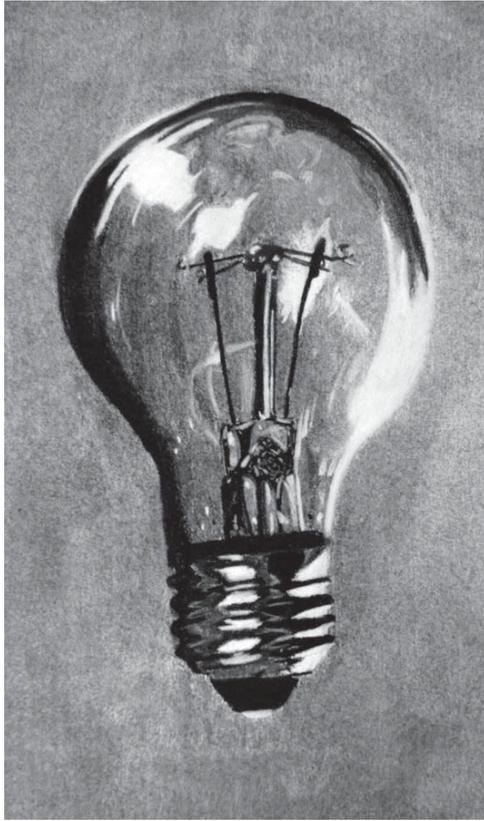
I have set up my sterile fields strictly,
Filled my nitrile gloves with sweat.

Forgotten my mnemonics quickly,
But remembered how to compress the chest.

I have laughed as nurses playfully teased,
Sutured many lacs intently.

Been fortunate to see pain eased,
And experienced emergency medicine completely.

- Mary E. Logue



Jessica McGraw

Your Dimming Mind

Oh, to remember a name.

With the firing of neurons of brain,
the letters they fumble,
your tongue, it will s t u m b l e,
the mind and the memory to blame.

But not just the names! It's other things too...
from finding the bathroom to tying a shoe.

As those memories resurface,
in your brain. run. short. circuits,
while others' minds runcirclesaroundyou.

But while you will survive,
for now in your own sense,
those around are the ones you can't convince.

While your minds gears are turning,
others' hearts, they are yearning,
for you to be the one that was you

- Jessica McGraw



Welcome

By Priya Shah

It was 4 AM when my phone rang next to me. Groggily, I answered, “Hello?” “You can come in now, she’s ready.”

My eyes snapped open as soon as the nurse hung up the phone. I grabbed my “new” UNM scrubs from my desk and headed to the restroom to change. I’m never up at 4 AM, but somehow my body knew to snap into shape quickly. It didn’t take long before I was standing in front of the mirror, dressed, teeth brushed, and hair curled up in a bun. I smiled as I stared at my reflection – the reality of what I was about to see finally seem to hit.

I headed out the door and made the short trek to the hospital. The air was crisp and cool; the smell of fresh rain filled the atmosphere. Zuni is so beautiful, even more so in the summer. I enjoy looking at the skies, which seem to tell a tale throughout the day. In the mornings, the clear, blue summer skies stretch out as far as the eye can see. As noon falls, the sun stands tall above us, playing a game of hide-and-seek with the clouds. As evening comes, the sun sets beautifully over the Zunis’ sacred mountain, painting a new hue of red and pink on the ancient rocks of the mountain. The stars decorate the sky as the dark gray clouds glow a little brighter in the moonlight and rain slowly begins to

fall. The land welcomes the gift happily, preparing for the birth of a new day. Walking to the hospital right now, the land around me was somewhere between that transition – of an old life welcoming a newer one.

I walk through the doors and am welcomed by the security guard, “Good morning! Headed to OB, I’m assuming?”

I smile and nod, amazed at how everyone in the hospital, from the cleaning crew to the doctors, had already welcomed me like one of their own. The people of the hospital functioned like a family, where all members were important and needed. I was so nervous to head out to Zuni, thinking that I would be “pimped” by the doctors and that the medical staff would be too busy to notice the shy first/second year standing in the corner. But, this first week has completely disproved that theory. Each morning I am greeted by everyone I pass with Good Morning’s and Good To See You’s. Simple phrases, but they make me feel important and a part of the team – it gives me the confidence to understand that, even as a medical student, I have the ability to affect the lives of patients simply by talking to them.

I walk into the OB waiting room, and it’s completely empty. I head back to where the delivery room is

and hear slight moans coming from the doorway. I knock and enter. The family turns and welcomes me with warm smiles. The room was filled with such a sense of hope – it was contagious. My heart raced as her contractions came; she was handling this like a champ! Her mom held her hand and whispered in Zuni to her, then she switched to English, “Just breathe, you can do this. You’re doing well.” A mom helping her daughter enter motherhood – a breath-taking site.

“I’m ready to push,” she said with such vigor.

The doctor pulled me to the side and handed me sterile gloves. “Here, wear these. Just in case.”

Just in case, what? She did know this was my first delivery...ever. Right? My hands, shaking, accepted the sterile envelope and put on the gloves. We prepared the mom for the delivery, the doctor talking her through the pushes. And just for reference, mothers in labor do not breathe like they show on TV shows; there is a much more efficient way of breathing, and screaming with all your might is not a part of that!

The mom fought through the pain and pushed as hard as she could. Before I knew it, a little head full of hair came into sight. She pushed, and pushed, and pushed and then, finally... the cries. The beautiful cries. His first breath in the world. His first call to his mother.

“It’s a boy!”

“We’ve waited so long, finally,” the mom smiled.

The Zuni people opt not to find out the gender of the baby for traditional reasons. So this truly came as a surprise to the family. After two girls, they were eagerly waiting for a boy to complete their family. And here he was. He was placed directly onto the mother’s chest – feeling her skin for the first time. The cord was clamped and the father did the honors. This all happened within a matter of seconds, but time passed so slowly. It was a beautiful sight, and I wanted to remember it all.

“Alright, you’re gonna deliver the placenta.”

Aaaand my moment of awe was broken. The doctor talked me through how to help the placenta come out as soon as we “saw the gush of blood.” She held my hand and helped me grasp onto the umbilical cord. As the flow of blood came, I slowly and gently pulled on the cord and helped the placenta out. As it plopped out, I saw the very first connection of our lives – our lifeline to the start of life. The very first bond we form with the selfless, strong, and courageous person who gave us life. I stepped back and looked at the mom. Her husband had wrapped his arm around her, as they both stared at their son. Tears rolled down from her eyes and onto her smile. An old life welcoming a newer one. □

The Hotel Room

The blank slate – relief -

Where nothing needs to be done

No dishes to wash

No plants to water

No floors to clean

No food to put away

No books to read

No papers to organize

The hotel room’s relief

Where no one knows

Where I am

Table tops are clean

Sheets are clean

Balance and symmetry are restored.

After three days, I tip the maid gratefully,

return home to have my own things

surround me, my own dust on my dresser,

my own dirt in the hallway, and

my own vases to fill.

– Jeanne Favret



Rachel Allen



Courtesy of UNM HSC Archives

“Mac”

By John C. Russell, MD

Everyone called him “Mac” – the doctors, the nurses, the techs and orderlies in the OR. And he called everyone “Kid”. He was the most positive influence any surgical resident could want, and he was fully committed to our training. As one of the senior attendings once told me, “If it wasn’t for Mac and the ward service patients, you guys would never learn how to operate”.

Mac’s greatest joy was taking a resident through an operative case. Any resident, any case. In fact, the only time I ever saw Mac discouraged was when he had to do a case himself. For him, helping a resident was fun – doing the case himself was not.

My first day of internship, I was assigned to help Mac with an inguinal hernia repair. I think I had seen one of these cases during medical school, but, in honesty, I’m not sure. Mac hands me the knife. He doesn’t know my name, but he says, “Here, Kid. This is where you make the incision.” Sure enough, he somehow gets me through my first OR case. I’m holding the knife and scissors, placing the sutures and tying the knots. It was only later, as a senior resident helping an intern through their first hernia repair, that I fully understood Mac’s rare gift.

Helping an intern do a hernia is a bit like driving with a baby in a child seat that has a toy steering wheel. The child believes he’s steering, but the loving parent knows better. The surgeon “helping” the hapless intern do their first hernia repair has to make tissue planes magically appear, direct the hands of the clueless, and give clear and succinct verbal and physical clues so that the sutures are

placed correctly. In those days, synthetic meshes were rarely used – this was the standard Bassini repair (“sew the conjoint tendon to Poupart’s ligament, Kid”).

As a surgical intern you fed off the confidence of the attending, and Mac had boundless confidence. No matter what we did, we believed that Mac could fix any mistake we might make (I’ve since learned that this, unfortunately, is not always true). Mac did “big surgeries” – he was the “Pancreas King” of our hospital, at a time when most surgeons shied well away from such procedures. Doing big cases meant having big complications, but, amazingly, Mac’s patients never seemed to complain. They seemed to innately understand that Mac was willing to take chances on their behalf, and that sometimes things just didn’t work out as planned.

We all wanted to do our first case of ANY procedure with Mac, because we knew he could get us through the case, and make us feel good about ourselves in the process. We knew that Mac had trained at Bellevue Hospital in New York, and thus, by definition, he had seen and done a lot of tough cases. As a Chief Surgical Resident, when you had a tough ward case, you discussed the case beforehand with Dr. B, but you did the case with Mac.

We loved Mac, and would do anything for him. He was the eternal optimist, and his optimism was infectious. If the door shut, the window was open. He inspired hope in his patients.

He inspired hope in us all. □

Passing Reflections

When September turned to autumn you suddenly slipped away and – though the piercing call brought shock – hindsight showed signs it was your season to depart:

Peeling house painted, fallen fence mended, relished time with relatives spent; broken body, worn, wanting rest. Heaven's hand finally sent.

I sleepwalk in fog from sneak-attack tears, no earthly Mom left to console me. Later,

I recognize you in wholly new forms, still ministering with reassuring comfort:

Brilliant bluebird on wing, rare rainbow in dark sky, ladybug landing close by on walls. All welcome guises - no need to ask why.

September's come twice since you went away, and I've tried setting grief's ruins aside. Your veiled visits may soothe my sore heart for a while, but the break in it can't be denied.

- Lynn Lessard



Adam Kludt



Courtesy of author

The Massive

By Robert C. Schenck, Jr.

The gnarled bark channeled the spring winds blowing down from the Canadian Rockies signaling the end of winter and the spark of buds. The weathered old timer had spent the past many decades surviving, but still growing, and had watched others fall with the harshest and hottest weather. At her feet lay the remains of three other trees that now formed an angled point for weary travelers and the occasional lost and bawling Hereford. This cottonwood was lucky, knowing that the water deep at her feet was still palpable, and that her thickened bark had tightly held, resisting the occasional back scratch of the wandering four-legged creature.

The wind reminded her of the beginning, whisked from one loamy bank to the next river in an unconventional start in the prairie just north of the Arkansas River. The spring rain had carried her miles down a normally dry gulch to a caliche bank that had no business growing a stand of cottonwoods. But she took. And in the first few years alone, her roots grew deep, finding a buried aquifer of life, and soon others joined in. But it was the gulch that changed and brought melting spring water to form a dif-

ferent path that kept her legs protected from the perennial erosion from her banked birthplace. She was the oldest of a dozen trees now an island strong enough to fight off any threat of a springtime, temporary threat. Water came from below and the she became massive. Wind, rain and snow were broken by her large armed protection.

Visitors were initially rare, but travelers were drawn to the area knowing water had to exist at her feet. With indifference she shared this life source with the weary and thirsty keeping most alive, and offering protection from the prairie expanse. The visits began with nomads who looked for protection, only if temporary, in their search for shelter on a harsh journey to put down permanent roots. But they all stopped at the base for shelter from blizzard, wind, and summer drought. She smiled upon the foster children. Many dug near her base where water seeped and collected; she heard the greedy gasps between drinks as she shared her source of wet.

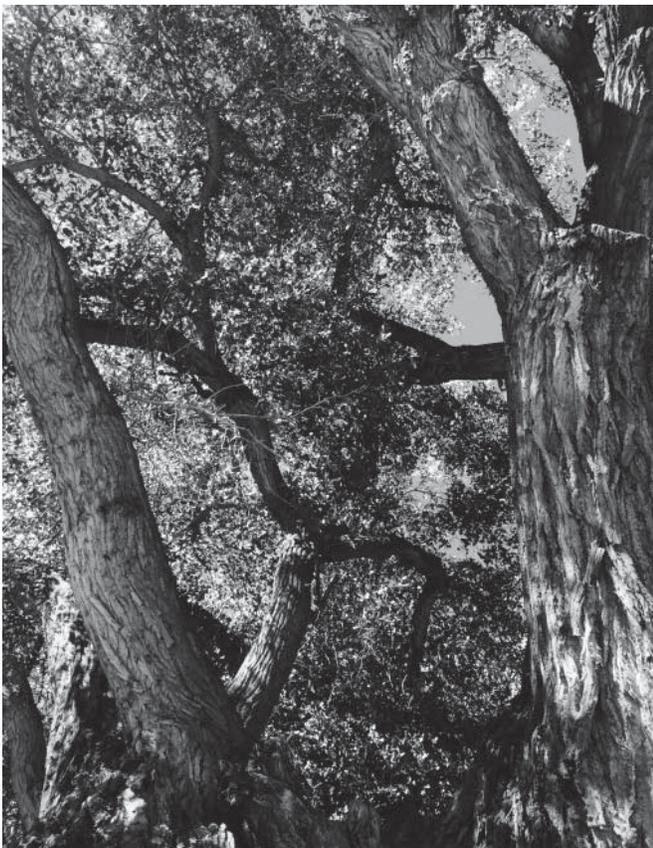
Many also came to steal parts from the massive. Creeping tiny friends traveled for days to reach and eat portions of the copse, the teeth of the many-legged creatures

a microscopic match to the edges of the leafy meal of the Fremont. Chunks of bark were torn free for nourishment as the people saw that the pulp protected against weakness; she witnessed and felt the skin being crushed, moistened and applied to injury, to calm and heal. They came to the coppice and took the living twigs and she saw her parts bent and woven, then carried away under the arms of nomads. Feeling these lost parts, slowly dying, moving away in contorted shapes as a tiny death of the whole. But she survived and progressed, drinking and breathing nourishment deep from the earth and sky. The distant sounds of beating wood and covered skins were heard, pieces of the grove in the distance. She grew and shared with the world.

As years passed the trees multiplied and the water remained plentiful. The trees grew tall, but she was the tallest, viewing the horizon, further than any other, giving the lost and weary rejoice as the earth curved away into the distance. She became a symbol of power and life and towered over her small world. Visitors stared in amazement at her massive arms in their wide, stretching reach. Her need for water increased and she was always first to reach deep into the earth. Others grew, but more slowly, and offspring took hold only for short periods. Despite the cycles of drought the group remained alive, but was limited to a patch of massiveness with grass between their bases. She knew only so many would live.

Both good and bad paid their respects to the Fremont. Outlaws came through, she could only tell slight differences in speech and felt their distrust, each keeping their distances leaning against the fallen trees with their individual fires. Nomads huddled together, sharing one fire, appearing weaker; but she felt their goodness. Occasionally there was death from freezing snow and taut hided covered bones nourished the copse despite the tragedy of death. But occasionally the anger of the bad would spill into her world and a rope was thrown over a towering branch and the victims twitched in the dry wind. She really wanted no part in any punishment, but acknowledged when asked. Her battle scars slowly healed with growth, absorbing an arrowhead, bullet, or even rope burn. She lived and grew while others were left nourished, wounded or died at her feet.

The wind was especially calming as she made sounds throughout the day and night, even with the slightest breeze. In summer the bristling leaves created a slight plant chatter that was calming to the trees and the occasional visitor. The equinox marked the release of her seed, the white cotton achene that blew across the prairie creating a warming blanket of summer snow. As summer grew, the sound and rustling sight of leaves looking from the ground up, made the sunlight change and sparkle in rhythm with the light musical scrapes of green veined sound. Her leaves were rough with teeth-like edges that created the rustling



Courtesy of author

sounds, and they moved to break the light as if chewing the wind, sun and blue sky. In the fall, the leaves changed their sound as they turned a golden yellow brown, changing in pitch as they slowly lost their grip and fell to make one final noise captured by the feet of the trees and fallen branches. She heard their gasps as they melted into the earth with the moisture of rain and snow. Soon the sound came from within as the intertwined branches scraped the bristled whitened bark that made eerie squeaks during the frozen winter. The blankets of white snow matched the quiet of the grove gently foretelling the upcoming spring melt. In good years the water flowed and reached the boscage surrounding their feet, and she always felt water deep in the earth.

The Fremont continued to live and outlast the others, growing wider and wider but she stopped seeing farther. Her bark was gnarled from lost limbs, she was able to breathe and drink deeply, but she could grow no taller. Decades became a century and she started to feel the dry-

ness of the earth where it once felt moist. Portions of her reach stopped growing as the earth became dry and she was forced to depend on the darkened water filled skies, losing independence, and becoming like the smaller gorse of cottonwoods of years past. She began to live on less and felt parts that couldn't heal where they once quickly sealed. Broken limbs and stolen bark remained open scars with dried exposed tissue more, like firewood than the bouncing, flexible trunk. She worried the end was coming. The winds blew but her strength and hold were unmatched to the pulling wind, and she resisted the turning of the earth. But still she had fewer leaves each spring and her cotton harvest grew smaller each summer. Gratefully, there was no pain, there was no suffering, only slight sadness and a slow change to darkness. Her limbs were barren and smooth until her skeleton collapsed. The wind blew from the north. □

Bonanza Reruns

Together, all 4 men ride
across the green hill and burst
through the flame-burning map
into our living rooms.

Little Joe rides his pinto, still offering to help.
Hoss tips his round, felt hat, still gentle and considerate.
Adam wears all black, still mysterious and away.
Ben wears his tan, leather vest, still the leader and Pa.

Wealthy, single men -
available to all the TV watching women
for an hour each week;
we dream one of the Cartwrights could be ours.

We've hit the Bonanza of dreams -
Can build a warm fire in a stone fireplace,
see shimmering water and green pastures,
and we get to live on the Ponderosa.

- Jeanne Favret



Adam Kludt

Rashid's Story

By Katherine Gavin

Crickets chirp from across the room. It's the unfortunate infamy that is my cell phone alarm clock. Rise and shine is so much easier said than done. I peel myself out of a warm and comfortable king bed that I'm sharing with Sarah, a friend of a friend. We are at Newport Beach Resort in Miami, Florida to attend the wedding of our mutual friend, Christina. A beautiful ceremony transpired into a glorious reception and an all day pool party. I meagerly attempt to wash the resulting hangover down the shower drain. Not to disturb my slumbering roommates, I keep the light off and peel back the window curtain to reveal a dreary Florida morning with thunder and pouring rain. I can't help but think that Puerto Rico will be warm and sunny and hope that my flight to paradise isn't delayed. I quietly pack up my things, skimp on the makeup, admire last night's hair leftovers, and barely muster the energy to brush my teeth. I whisper goodbye to my new friends, and head to the lobby to check out.

The usually bustling lobby is pleasantly quiet with only a few early risers like myself. I even notice the whistling sound of the glamorous ceiling fans as they move the cool air throughout the room. There is no wait to check out, so

I quickly sign my bill and chug some complimentary thirst-quenching lemon water before heading out to catch a cab.

The sound of pouring rain as it hits the cement and roof over the driveway permeates my ears as I step outside. A very nice valet guy quickly comes to my aid and calls for a cab. He makes lovely but awkward small talk, even asking me my ethnicity; yes, he asked me this – the white girl from Minnesota. I can't help but notice, almost simultaneously, that there is an older gentleman taking cover with his king charles spaniel and a family trying to cram way too many over-stuffed suitcases into a minivan. I conclude that though cavalier, the spaniels are still ugly, and traveling light is an accomplished art at its finest.

I watch cab after cab drive by and not pull in. The valet assures me that one will definitely be coming. I think to myself, 'Doesn't he get it? It's 7 am, I have a hangover, and am in desperate need of some strong coffee!' Just then, around the corner, I see a minivan cab slow and pull up into the driveway. Finally!

My first impression is a typical cab with your typical cab driver. Tidy, but with seats full of stains and questionable smells, being driven by some immigrant with a thick

accent and the most benign facial expression on his face the entire trip.

The man that steps out of the drivers seat initially meets my very stereotypical and naïve assumptions: 50s, Indian-Asian, thinning hair, petite frame.

The ride begins nice and quiet. I stare out of the window as drops of water hit and run down the glass, blurring my perception of the outside world. Much to my initial dismay, the cabby starts to talk. I don't recall how exactly the conversation started other than him politely asking my destination and going from there. I notice immediately that he has a Pakistani accent with rather high-pitched inflections throughout his speech. He has a sort of permanent, subtle smile and I can easily understand his English. Something about his demeanor is calming and welcoming.

He introduces himself as Rashid. Our conversation gets started with the usual, "Where to?" "Miami International Airport." I reply. In my mind, the hard part is over. I can now enjoy my ride, staring out the window into the dreary Miami morning. I can daydream about strong, rich coffee soon to hit my tongue once I'm through security and the warm Puerto Rico sand and water soon to kiss my skin.

Rashid - probing questions in hand, quickly interrupts my thoughts. "What brings you to Miami? Where are you from? Where are you flying to?" I politely answer his questions, one after another, each time hoping that it will be the last. I'm normally not so anti-social, but this post-wedding celebration hangover hit me hard. To fulfill my end of the awkward small talk, I ask one gentle question, "Where are you from?"

That is where my half of the conversation ended. Rashid's story-telling mouth took off like the airplane I was en route to board. He tells me he is from Pakistan but has been in Miami for many years. I'm quickly told I am not one of his usual clients, for which he has a handful who request him regularly. Retired Jewish men seem to be his forte. Smiling, he tells me that most of them never married, but bought their some-day wives graves next to them. Knowing the premium of a burial plot, Rashid asked if he could have one. He was told the people in the Jewish community would be upset if they had a terrorist buried in their cemetery. He says that he gives his Jewish patrons enough grief; they didn't want him continuing to bother them after they were dead.

While I'm not sure what to think or how to respond, the smile across his face and the most unforgettable high-pitched, air-punching, contagious laugh fills the cab and it is at that moment that I am hooked.

Between the look on his face and his Jewish humor, I couldn't help but want to hear more. Now that I know

Rashid, I realize I really had no other option.

The next thing he tells me is that, believe it or not, he has seen a black rose before. Surprised, I ask, "Really? Is that even possible?" He goes on, informing me that the black rose he knows of is another favorite patron of his, a beautiful African American woman named Rose. With laughter filling his voice, he says, "Why yes, then a black rose is possible. Believe It!" He goes on to share that she is one of the nicest women he has ever met and he looks forward to her rides. She shares in his sense of humor and even lets him joke about how he tells other riders he calls her "Black Rose."

I can't help but giggle about how ridiculous his sense of humor is. His limited understanding of the English language has left him clueless to the fact that his jokes are borderline (understated) culturally insensitive. In a way, his innocence is touching. At the very least, he has gotten my attention.

After a short pause in the conversation, he reaches into his pocket and pulls out his wallet. He opens his wallet and passes it back (yes, he passed me his wallet) with it open to two pictures. Each picture is of a beautiful young woman: dark skin, dark hair, entrancing eyes, and soft smiles. "My daughters." He shares.

The oldest, Mishthann (means 'sweet' in Hindi), is a nurse. He is eager to point out to me, after already knowing very well that I am a physician, that she is very smart. She chose not to be a physician because she isn't dumb - It's way too much work. She married a great man. His now son-in-law had to meet the approval of Rashid's wife before even being allowed to meet Rashid. He is quick to point out that she has the ultimate say on who her daughters end up with. Rashid finds humor in pointing out he did a background check and was happy to report the man isn't a liar. His youngest is at Tulane, studying math. She is anxious to date. It's at this point that the smile drops from his face and he looks in the mirror back at me, finger waving in the air, to inform me that his daughters aren't allowed to date until they are done with school and have an education and career to be able to support themselves. No exceptions. His piercing look back at me has me beginning to regret thinking I could still fall in love and get married in residency. It is as if I could disappoint him as well. Now, it's official. I'm deeply committed to this conversation.

We drive on. The final picture is of he and his wife on their wedding day. They had an arranged marriage. He shares how much he loves his wife and how thankful he is that she brought such beautiful and amazing children into his life. It's obvious that he absolutely loves to share the story about his family. I can tell he has recited the lines and

shown the pictures many times before. Each time, he clearly loves them more and more.

Rashid wasn't the first in his family to come to the US. In fact, it was his sister who was in the US and was able to help secure him a green card. Thirty years ago, Rashid's feet hit western soil. At the age of 27, he was a single man coming to a place he had heard such wonderful things about. All of his wishes had been granted.

That was, until he realized he came with only \$30 in his pocket and spoke no English. In fact, Rashid had never driven a car, so he walked everywhere. Miles upon miles, day after day. He wandered, soaking it all in, getting used to the culture and the 'regular' scene of things. He attempted to learn English at any opportunity.

At one point, he heard Wendy's might be hiring. He was supposed to go with his friend who would translate for him but his friend never showed up. Rashid walked in there alone, saying two of the meager handful of words he knew in English, "Me work." After an awkward exchange with one of the managers, they politely gave him an application. To him, it was gibberish. He had no idea how to speak English, let alone write or read it. He glanced around the Wendy's and noticed a group of teenage girls hanging out. Next, he whipped out the only other English words he knew "Pardon me. Excuse me." He repeated over and over. Then again, he said "Me Work." And handed them his application. He was desperate for help, so the teenage girls helped him fill out his job application. He turned in his application as soon as it was completed and was told to come back the next day to talk to the boss.

He was told to come back the next day for fifteen days in a row. He came back every single day, and his persistence paid off. He eventually got the job. It was his first job working the line at Wendy's where he dedicated himself to learning the English language. There was a large black woman who worked the cashier who taught him English. Perhaps this can explain some of his affinity for Black Rose.

Once his English skills improved, he heard about an opportunity for more money as a pizza delivery guy. The unfortunate part for him was that he didn't know his way around the city. Again, using his surroundings for help, he befriended a handicapped homeless man. Shortly after their introduction - as in, his first night of work was the same night they met - the man rode shotgun and directed Rashid in the right direction. The man got dinner while Rashid got his pizzas delivered on time, resulting in happy customers and better tips.

His job in the pizza business helped him study the ins and outs of the city and provided an opportunity for him to apply for his taxi license. He failed his first attempt

at the taxi driver test. On his very first ride after having passed his test the second time around, a rider asked to be taken to the Miami Pier but provided a nickname that Rashid had never heard. Out of desperation to not foil his first ever rider, he pretended he needed gas and used the opportunity to ask another Pakistani man for directions without the rider knowing. Proudful, he ends the story mentioning he still received a decent tip.

So for nearly three years, Rashid worked every waking moment at three jobs. Part of his duty as the oldest male child was to help support his family back home. He sent \$300 every month back to Pakistan.

That's not to say Rashid never had a good time. In fact, a friend took him to the disco. He freely admits he had never had a drop of alcohol but that night he drank a Heineken. Per his admission and accompanied by his signature Pakistani giggle, he "acted and danced like a monkey." He proudly tells me he met a girl that night named Brenda and she told him he danced like a peacock. This story ends when he tells me his jealous friend guilted him into buying a tank of gas on the drive home that night.

He managed to save \$10,000. Then, the time came for him to go home to Pakistan for his arranged marriage.

He was unable to secure vacation days from work for his time away, so he was laid off from his jobs. He was terrified of telling his future bride and her family such bad news. He laughs and says, "They never even asked what I did for work. I'm not sure how they could forget to ask such an important question, but thank God they did!"

He did not meet his wife until the day of his wedding. He simply states, "I didn't marry already in love, my marriage created love."

As we approach the airport, he is forced to briefly summarize his great American life. He brought his wife back with him to Miami where they had their two children. He worked tirelessly for more than twenty years as a taxi driver. During that time, he bought and paid for a house, a car for each daughter, and their entire college tuition. He emphasizes he made sure to instill the importance of saving money in his daughters. He is working to pay off the last \$3000 of a car loan, his only debt.

We roll up to the terminal. The smell of exhaust, the sound of rolling luggage on cement, and a sea of brake lights reminds me that my ride is over. I hesitate to get out of my seat. Forty-five minutes ago I couldn't wait to get the ride started just so it could be over, and now I'm sad it has come to an end. Throughout all of this, Rashid is busy at work getting my luggage out of the back of the cab. I'm having difficulty grasping the complexity of emotions that hit me in that one moment.

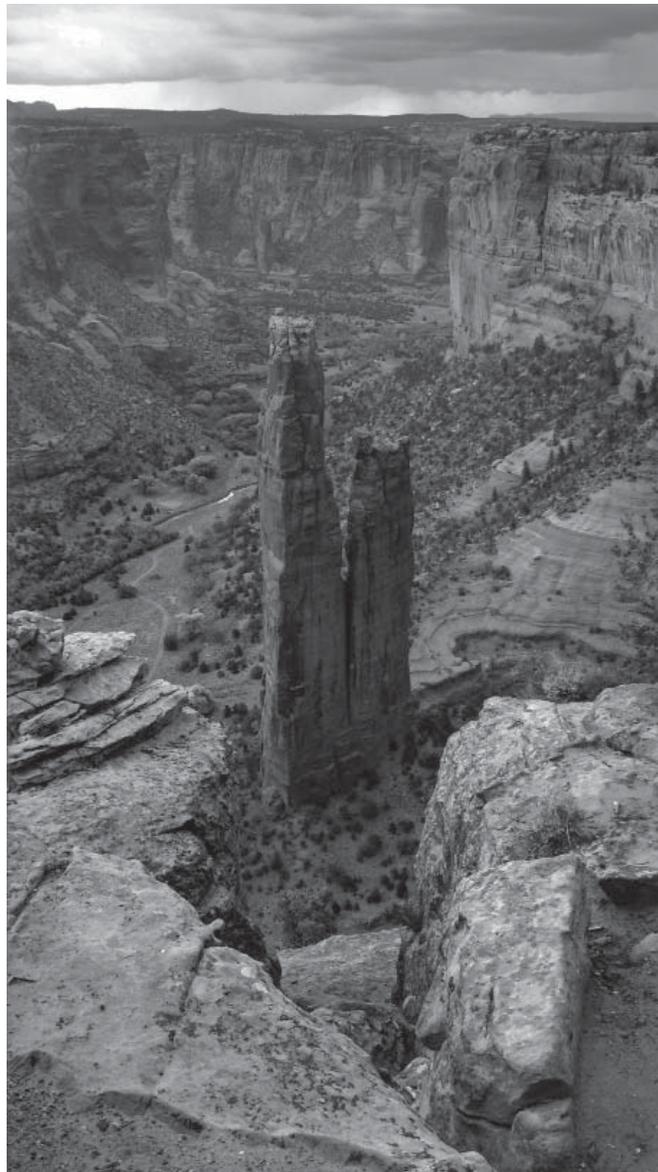
I look into my wallet and see a wad of my “vacation 20s.” I’m quickly reminded of the \$30 it took Rashid to make a life for himself and his family. He came to America with the expectation to succeed by his family in Pakistan. The life he has now is worth so much more than the cash. His persistence, motivation, humor, humility, and smile created, for him, his American dream.

With no other words to say but “Thank you,” I attempt to hand him a generous tip. He declined. He wanted me to pay off my student loans.

In America, we are blessed with millions of Rashids. We wouldn’t know it unless we allowed ourselves a moment to listen. Rashid is my reminder to keep my eyes

open, to avoid assumption and judgment. We are all just trying to make it, regardless of where we come from. I was born into my wonderful American life and I inevitably take it for granted. However, at some point, someone from each of our families was a Rashid.

It doesn’t take long for me to realize: I am a 29-year-old single female physician, training to be an orthopedic surgeon, daughter of a plumber and a teacher, sitting on a plane to continue my vacation in Puerto Rico. However, I am not the same person I was when I woke up this morning and stared out into the rain. I have Rashid to thank for this. □



David Chafey

Rebecca's Story

The following is the prologue for the "The Daily Practice of Compassion: A History of the University of New Mexico School of Medicine, Its People and Its Mission, 1964-2014" written by Dora L. Wang, MD, Shannan Carter, JD, and the University of New Mexico School of Medicine.

The morning of her surgery, Rebecca Salazar awakened at 5 a.m. in her home outside Ohkay Owingeh Pueblo. It would be a two-hour drive, past rolling tumbleweeds and snow-capped distant mountains, to the University of New Mexico Health Sciences Center in Albuquerque.

Since Rebecca's stroke, she hadn't walked or used her right hand. Just a year earlier, she worked at the State Capitol in Santa Fe, was an avid moviegoer and follower of politics, at her peak, at age 50. Stepping outside her workplace for a breath of winter air, in an instant, she fell to the ground. For hours, she lay in the snow, helpless to move or to call out, gazing at windows and at her co-workers in warm light. She was rescued at nightfall, before frostbite took her life.

Her doctor diagnosed a stroke, but he couldn't explain why a person as healthy as Rebecca would bleed in her brain. He referred her to UNM, where New Mexicans go for specialized medical care.

A Tesla 3 MRI scan, available only at UNM in the state, revealed several previous strokes so small Rebecca hadn't noticed. It was all due to a cavernous hemangioma, a rare collection of abnormal blood vessels in her brain. It was a fate written in her genes.

Rebecca was a proud descendant of the nation's first European settlers, a claim that few outside New Mexico can make. In the late 1500's, her ancestors arrived from Spain into New Mexico, years before Pilgrims landed at Plymouth Rock. A genetic mutation occurred early during their lives in the new world. For the next centuries, cavernous hemangiomas befell members of this population. This was a story made clear through research done by professors and scholars at the UNM School of Medicine, one of many examples of the school and its hospitals serving the particular needs of New Mexicans.

Rebecca's husband, Earl, tended steadfast to her for the past year.

Earl's ancestors had lived in New Mexico for even longer than Rebecca's. His were the original people of this land, who arrived in ancient times, and eventually migrated

to Ohkay Owingeh Pueblo in approximately 1200 A.D., where they still live. Blue-eyed, with sandy blond hair, Earl himself, and his marriage to Rebecca, exemplified New Mexico's mixing of cultures. In the living room of Earl's childhood adobe home, were native katchina dolls, Catholic icons of Christ, along with a souvenir statue of Hawaiian hula dancers. On traditional feast days, his mother served native posole, along with potato salad, jello with cottage cheese, and red chile enchiladas.

For the past year, Earl brought Rebecca from Ohkay Owingeh to UNM for appointments with the neurosurgeon who diagnosed the cavernous hemangioma, the neurologist who treated her seizures, the psychiatrist who saw her through her post-stroke depression, along with pain specialists, physical therapists and speech therapists.

Because of Earl's six terms as Governor of the pueblo, Rebecca was often called Ohkay Owingeh's first lady. In 1998, the couple hosted the Vice President and other dignitaries from the Kingdom of Spain, to commemorate the 400th year anniversary of contact between the native peoples, and Europeans.

Two years after her stroke, when Rebecca was finally strong enough, neurosurgeon Christopher Taylor, M.D., was ready to operate. He would fix the cavernous hemangioma, and prevent further strokes.

Rebecca and Earl climbed into their grey pick-up truck outside their home. They lived along a stretch of the Rio Grande where Spanish conquistador Juan de Onate y Salazar garrisoned in 1598, an event that lingers in the memory of local residents today. That same year, Onate constructed San Juan Bautista Church, now North America's oldest church, where Earl stood for each of his inaugurations, with Rebecca beside him.

On the road to UNM, Rebecca and Earl drove past San Juan Pueblo, the first European capitol in North America, founded in 1598. They bypassed Santa Fe, founded in 1608 as La Villa Real de la Santa Fé de San Francisco de Asís. They passed turn-offs to the prehistoric cave dwellings of Bandelier, and to the nuclear facilities of Los Alamos National Laboratories, where the atomic bombs of Trinity, Hiroshima and Nagasaki were made.



"Rebecca and Earl Salazar stand in San Juan Bautista Church at Ohkay Owingeh, New Mexico. Founded in 1598, it is North America's oldest church. Governor Earl Salazar follows the ancient tradition of holding the Sacred Canes of the Governor, on the occasion of one of his six inaugurations. In his hand, are canes gifted by: Ohkay Owingeh ancestors, the Spanish Government in 1720, the Mexican Government in 1821, and United States President Abraham Lincoln in 1864. The canes represent Ohkay Owingeh's authority and independence. Since Europeans settled North America in the 1500's, each colonizing nation has gifted canes to each of New Mexico's nineteen pueblos, acknowledging their sovereignty. (Photo courtesy of Rebecca and Earl Salazar).

At last they arrived at the University of New Mexico Health Sciences Center, the specialty medical center and regional trauma center for all of New Mexico, parts of Arizona, Colorado, Texas and Oklahoma, the Navajo Nation, two Apache reservations, and the 19 Pueblos—a lifeline of the southwestern United States.

Earl steered Rebecca's wheelchair through the sliding glass doors of the UNM Hospital building. At the front desk, information was posted in English, Spanish, Navajo and Vietnamese. Maps and signs pointed to services from the Newborn Clinic to the Geriatric Clinic, and for all challenges of health through the cycle of life. Serving as safety nets were the Emergency Room, Trauma/Surgical and Burn Intensive Care Unit, and Transplant Services.

In the Chapel/Meditation Center, quiet light through colored glass provided comfort during life's largest transitions, which are often marked by illness and injury, and occur in hospitals.

In the corridor before the operating rooms, nurses and technicians stood in turquoise scrubs and caps. UNM provides the health care infrastructure for New Mexico, and educates the state's physicians and allied health care manpower.

On the operating table, Rebecca was surrounded by machines. Taylor, a UNM Professor of Neurosurgery, in gloves and a sterile gown, worked quickly. Beside him, a resident in neurosurgery, a medical student, nurses and technicians, observed and assisted.

Technology enabled Rebecca's brain MRI to appear on a screen, as a map to guide the surgeon's scalpel. Through fragile brain tissue, the blood vessels finally appeared, like a tiny rose. The professor cauterized the cavernous hemangioma, and he closed.

Rebecca awakened in the recovery room. For the past months, she had been nervous about losing her speech, a risk of the surgery.

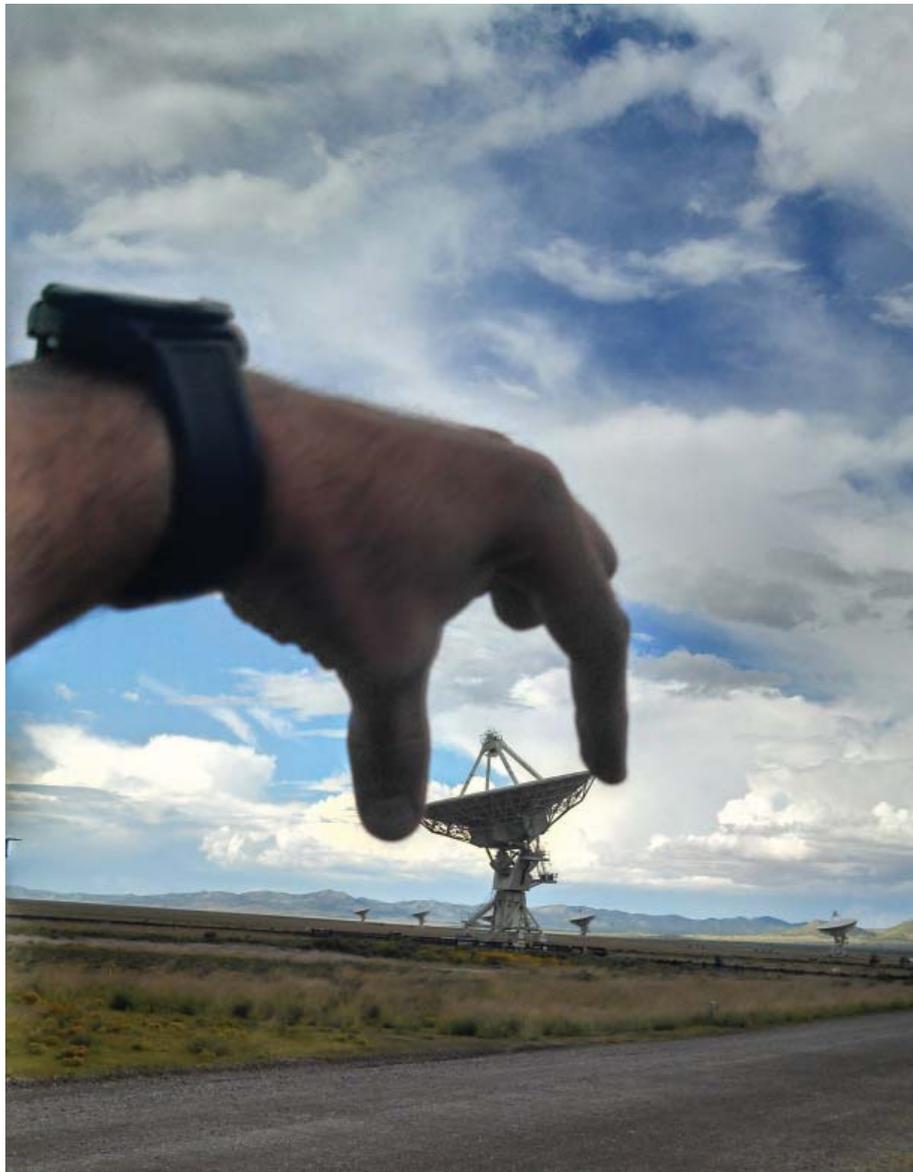
The world gradually came into view. She heard a woman's voice, a nurse, telling her that the surgery was successful. She would be just fine.

Here was Earl, his warm hand upon hers.

She looked at him and said, "Hello." □



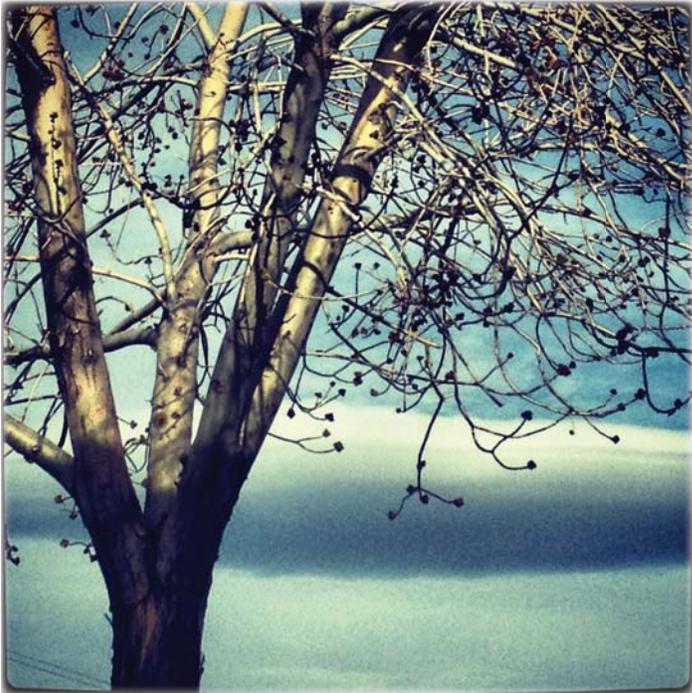
Adam Kludt



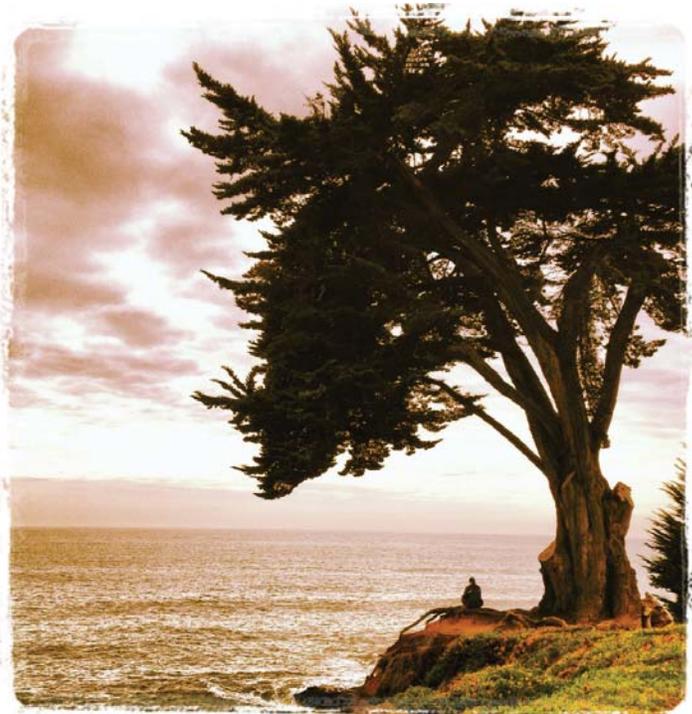
David Chafey



Rachel Allen



Annie Hooten



Annie Hooten



Adam Kludt



Adam Kludt



Kate Morris



Kate Morris



Sarah Sanders

Suboxone

A thick leafy tree
holds ten thousand green shields
against the heat
just to sit in the cool shade beneath
is all they ever wanted
a place to rest and sigh
long and drawn-out
like a ripple gliding across a lake
it seems so easy to find
but for some
it is not easy

a bit of stardust piled here
some over there
a touch of magic and enzymes
and that double-stranded staircase of life
so sweetly begins
but why me here and them there
my roll of the dice
let me dream safely through the night
not peer at double-hung windows
shut tight in the dark
too heavy for five year old limbs to lift
no escape
when the demons came and entered their
beds at night
at seven
they weren't tall
cupboards held the clear bottles of liquor
too high to reach
they couldn't break them
on the cold linoleum floor
so the bottles broke them
their faces stung and bled red
though less than their hearts
I try to imagine what it was like
staring at all those other kids
reading stories
coloring
eating sandwiches and candy
while you taste dirt
it is what you are

you taste what you're told
so they come to me
anxiety whining like turbines
holding urine cups filled with heroin
oxy
cigarettes
vodka and violence
risky sex and loneliness
benzos and despair
they all test positive for pain
they beg me for sublingual refuge
a place to stand and feel craving
lie still beneath their heels
if only for a while
I control the printer
it hums as it works
spitting scripts
and I feel hollow
but for the sadness

people torn long ago
just trying to mend
life boiled their pride
like so much else
now only a vapor
their stories are hurricanes
from within the eye
I see chaos
suffering
heroism and awe
shoot past in the wind
their eyes speak words through the roar
don't judge me

they have been strong beyond it's own imagination
but now
they just want calm
and that shade

- Chris Camarata, MD



morguefile.com image

China

by Elaine Fan

I am Elaine Fan, currently a second year medical student at UNM. Dr. Norman Taslitz announced about a program named the Practical Immersion Experience Overseas (PIE Overseas) in our class, and I decided to take this opportunity to learn about other countries' healthcare system. I initially picked the UK, Australia, and China as my candidates, and Dr. Taslitz encouraged me to visit China because UK and Australia's healthcare model is somewhat similar to ours here in the US. By the way, I grew up in mainland China and moved to the states during high school, so I am fluent in spoken Chinese. However, I barely know anything about its healthcare system. So here I am, excited, and ready to tell you about my medical trip to Mainland China this summer 2014.

I am very grateful that I was able to visit two Chinese hospitals during the trip- one in a large city named Wuhan, and another that is a county hospital in Anhui Province which is relatively rural comparing to the prior. Visiting both hospitals has indeed given me a better understanding toward the Chinese medical practice.

First, please allow me to give a general introduction of the medical training system in China. As for medical school, it is college-level where the entering degree require-

ment is high school diploma. It is composed of five years of training including four years of basic sciences and one year of clinical rotation in the hospital. According to a couple of residents I spoke to, med school graduates usually need one to two years of residence training before they can prescribe medicine independently. All Chinese med students will attain a Bachelor's degree after graduation. However, more young graduates nowadays decide to get a Master's or Doctorate's Degree after the medical school education for a better job pay and other benefits.

When talking about China, I cannot skip mentioning its large population. According to the Population Reference Bureau, China has a population of 1.37 billion people in 2010. Inevitably, Chinese people are dealing with limited resources, not only in food, water, space, but also in economy, industry, and healthcare. Interestingly, I had several experiences in resource scarcity in China this summer. Let me tell you about the elevator story now. Different from the UNM Hospital, both of the Chinese hospitals I visited are very large, which consists of 3-5 buildings with the main buildings having over twenty floors. Patients, families, and healthcare workers have to take the elevator to their beds or offices unless they want to climb up the stairs. Every day not

so excitingly, I had to wait for twenty to thirty minutes before I can get into an elevator- and of course, each time the elevator is overfilled with people- no personal space at all.

Because there are so many patients in China, making outpatient doctor's appointments won't really work. So before they show up at doctor's office, patients have to get registered into the hospital's computer system at the registration office which usually takes hours. One thing worth mentioning is that at the doctor's office, there are always some patients who get "special treatment" and can cut in line because they have some personal connections to the physician themselves or from their families and friends.

The physician I worked with in the county hospital is a senior neurologist with a cerebrovascular subspecialty. He works in both inpatient and outpatient settings. Since he is the director of the Department of Neurology, he is busy with patients all the time. In his outpatient clinics, he typically sees 40-50 patients per day. Since most of his patients have complaints of headaches with a potential cause of stroke, he usually works his patient up for underlying cardiovascular diseases, and orders CT scan, MRI, and other imaging techniques. The physician told me that in his hospital, MRI costs less than \$70 and CT costs about \$40. When he works inpatient, the senior neurologist usually has the morning round in the morning and office visits from other patients in the afternoon. As for the morning round, he usually comes with his residents to examine patients with complications. His floor has over 60 beds with three patients per room.

In the city hospital, the physician I worked with is a well-known hepatobiliary and pancreatic surgeon. Because he has great surgical skills and a lot of clinical experiences, most patients travel from other parts in China to consult him. He has a doctorate degree in medicine, and had previous medical trainings in Hong Kong, France, and Japan. Since he can speak English, he helped me a lot in understanding and learning Chinese medical terminologies (oh, trust me, medical Chinese is a whole other world). His floor has a capacity of 35 beds- but in real time, there are 60 beds with many being placed in the hallway. He works 7 days per week and over 10 hours per day. I can't imagine how he gets through the intense work load every day! As he told me, he is on call 24/7, and there always are VIPs (usually those are government employees with power and wealth) call him for emergency surgeries. For him, it is not uncommon to be called by the hospital to operate on people past midnight.

As for the medical insurance payment, both physicians told me that every Chinese citizen has a government issued medical care. Local hospital covers about 80% of

medical fees, and national hospital covers about half of the cost.

Comparing these two hospitals, city physicians tend to have higher education background than those in a lower-level hospital. Both hospitals are overfilled with patients regardless of their size. As Chinese physicians, they are very experienced because they work with many patients daily. From what I have observed, Chinese traditional medicine and western medicine are commonly prescribed together. Similar to the US, physicians are encouraged to diagnose patients through their medical history first, and confirm their diagnoses through labs and imaging. Due to the drop-in and "unexpected" VIP patients, Chinese physicians have a huge workload. From what I have seen, Chinese physicians in general have a good relationship with their patients.

Despite having stomach flu and other interesting experiences which I don't have time to mention here, I am glad that I went on this medical trip to broaden my views and increase my awareness of global healthcare. Now I understand why Chinese physicians have a much shorter medical training than us here, because one of their goals is to quickly produce as many physicians as possible to meet their medical demand from the large population. But for us, I appreciate the fact that we are going through long periods of training to enrich our medical skills in order to provide the best care we can. There is no right or wrong about the healthcare system as long as it is accomplishing its goals accordingly to meet the country's unique needs. □



Laura Hall



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Basal Cell Carcinoma

by Sasha Sokolowski

I just recently got diagnosed with pigmented nodular basal cell carcinoma. Although this is a cancer that is most common in the middle-aged and elderly, it does not discriminate. It does not discriminate with races either. The type I have is actually most common in hispanics and african americans, only 6% of caucasian people get this type of skin cancer. BCC is most often associated with ultraviolet radiation, either from the sun or artificial sources like tanning beds. Unfortunately, I was exposed to both. I grew up in Florida and New Mexico, the top two states with the highest rates of skin cancer.

I still remember feeling guilty every time I went to a tanning salon, I would even keep it a secret from my mom, but I still went. I knew the consequences but I also wanted to have that beautiful bronze skin that so many of us see as “healthy.” But apparently, I thought I was invincible. It wouldn’t happen to me. Until it did. My vanity took over my common sense.

In my defense, I did always try to wear sunscreen on my face, but it usually came in the form of a moisturizer

that had SPF in it. The directions said to reapply every couple of hours, I never followed those directions unfortunately. As I got older, I did get wiser. My SPF number increased and I did follow directions better.

But most sun damage occurs early on and most of the damage is already done. My mom had melanoma as did my late grandfather. Skin cancer was a frequent topic in my family. I started going to the dermatologist at a young age due to my skin being covered in moles as well as my family history. This sparked my interest of the medical field. I knew that I wanted to go in to the medical field at a very early age, I also knew I was interested in dermatology and plastic surgery since I saw the significance that these providers played in my mom’s life as well as many other people that I knew .

It is quite ironic that I will now be relying on dermatology and plastic surgery to help heal and cure me. Another piece of irony in this story is when I discovered my infamous mole. It was actually right after we finished our dermatology block in school. I made an appointment with

dermatology, it was a seven month wait. I had no options of other clinics to go to since I was being guided by the health plan that I belonged to at the time and I was only covered at one facility. So, I waited the seven months and then missed that appointment due to my hectic life as a PA student. I rescheduled and waited another six months, and what do you know? I missed that appointment too because I was on rotations.

In the mean time, my mole had actually fallen off but then it grew back again, which I thought was very odd and very different than any mole I had in the past. Luckily, I was able to obtain health insurance when the Affordable Care Act finally kicked in. Once the craziness of rotations died down and I was able to make an appointment based on my schedule, I was able to get in to dermatology. At this point, I was there for a much overdue full skin check and a biopsy of this little mole that my dermatologist said was benign but she would remove it for me because of my family history as well for cosmetic purposes.

When I got her voicemail about my results, I knew right away what she was going to say. She was not supposed to call me with results unless there was an issue and she assured me that she did not expect any result except for something benign.

I am not sure who was more surprised, the dermatologist of myself. All I could think about was a patient that

I had during my dermatology rotation that was similar in age to myself and very similar skin color. She had a BCC on her cheek that was so locally invasive once they opened her up, they removed so much more than anticipated. But, I also remembered how well they performed the surgery and what she looked like afterwards, you almost couldn't even see a scar. That part gave me comfort as well as the fact that she is doing ok today and is just very vigilant about her skin. All of this has been a huge wake up call.

I am determined to not let this diagnosis define me but I will use it as a stepping stone to help me become a better provider. Although unfortunate and scary, I am determined to turn this situation into a positive one. If I can reach out to a few people to show that skin cancer really does happen to young people, to not go to that tanning bed, to never leave your house without SPF, I will feel like I helped a little and this may all be worth it. Interestingly enough, a couple of weeks after my diagnosis, the Surgeon General of the US came out with a public message that skin cancer is now an epidemic in our country.

Hopefully this national awareness on skin cancer will spread and everyone will start taking more precautions to protect themselves from the sun. It doesn't matter if you are in the sun for 365 minutes on one single day or for one minute each day, 365 days a year, it all adds up to the same amount of sun damage. Prevention is key! □



Adam Kludt



Adam Klucht

The Hardest Thing

Caring for you when you had
cancer was the hardest
thing I've ever had to do.

Each day I saw you get weaker
as I guided you down that cold
Cedar-Sinai corridor to get a new
dose of body-wracking radiation.

We marked your last treatment
with lunch at Wolfgang's
but you paid the price later –
bedridden with implacable pain.

Feebly, I'd hide my fears while
trying to Reiki away the brutal
burn that singed your insides.

Later, after you cried aloud for
hours and then slept from sheer
exhaustion, I let myself sob while
sweeping up patches of fallen hair.

– Lynn Lessard

A Heart Like No Other

by Nguyen Park

I had the privilege of being the last to hear my grandmother's heart beat. When you pronounce someone in a hospital, there are usually heart monitors and other machines to confirm their passing. A host of other medical professionals are usually standing by, and a curious stillness after the cacophony of chest compressions and beeping machines enters the room. It is like a held breath, just long enough for the exact hour and minute to be noted, and then everything begins again, the clock restarted, time marching onward. Gloves snap, charts close, trays rattle, and all the people melt away, on to the next pressing task.

In hospitals, signs of holidays are everywhere to keep patients oriented to time and place, and to cheer up staff and visitors. Valentine's Day is no different, red and pink hearts decorating hallways and doors. Perhaps because my work was in cardiology, Valentine's Day always carries a different meaning for me, all the emphasis on hearts reminding me of the steady beats I listen to every day.

The night my grandmother passed away, the rhythmic rise and fall of soft, sad voices in prayer filled the spaces between each beat and breath. I knelt beside her bed, my fingers on her pulse, feeling the erratic beats slow. Without a monitor, I had to trust my trembling hands to lay my stethoscope on her chest.

Absence of sound is a funny thing. You have to listen longer, to the in-between spaces that stretch out, a ribbon of silence, and it is you that pulls away, weighing the likelihood of sound against your willingness to listen further. I bend my neck, a prayer, the blessing of this moment heavy on my head.

In that moment, I am a child again, kneeling at my grandmother's bedside, hesitantly echoing her words, the air in the darkened room heavy and still, time marked not by the ticking of a clock, but by decades of Hail Marys. In those hours at her feet, the sounds of my mother's country molded my tongue, and I say the Sign of the Cross in Vietnamese, joining my family in benediction and intercession. I look at my watch, unable to see the numbers through my tears.

My grandmother was born in the Year of the Snake. Like clocks, a calendar in those days wasn't important, the tasks of the day tied to the setting of the sun and the turning of the seasons from wet to dry, harvest to sowing, and so we don't know her exact birth date. It seems wrong somehow, that instead of honoring the date she came into this

world, we observe the date of her death. She was not sad, but ready, longing to be in Heaven with her angels, two little boys who died in childhood, in the days before vaccines or antibiotics. I learned about the power of grief from her, as she told me stories about her clever little boys, rheumy eyes still wet with memories from decades long before, when she was a young mother losing her sons.

I grew up under those watchful eyes, her hands always slightly gnarled, but soft and smooth, as if the years of running rosary beads between her fingers had transferred the smoothness to them. My earliest memories are of being with her, eating crusty French bread dipped in Borden's condensed milk, or walking around our apartment complex through early morning dew. She never really seemed to age, until after I moved out into my own home, married with children of my own, carrying my stethoscope like a talisman as I made my way through the world.

In the year before she died, my grandmother was hospitalized where I frequently did rounds. In that hospital bed, surrounded by those beeping machines, she was so much smaller than I remembered, and so much less herself. The nurses and physicians would comment on what a sweet patient she was, and how attentive my family was, as she was never left alone. Though she received excellent care from the staff, I am grateful that she did not die in that hospital bed. Instead she died at home in her own bed, surrounded by family. The oxygen saturation of her last breath was not measured, her arms lay untouched by IVs or needles, my stethoscope the only foreign thing in her room. Hers was the most peaceful death I have ever witnessed.

There were no machines, no trays, no gloves, just the soft touch of loving hands folded in prayer. I do not know the hour or the minute of her passing, and it is not noted in anyone's chart. I know it was the year of the Dog, and that my grandmother finally went home to be with her angels. □

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Service Learning In Guatemala A PT Student's Perspective

by Rachel Johansen

In my experience, traveling has always been an amazing opportunity to discover beauty in the people you meet, the places you see, and the food you eat. As physical therapists, we meet people from all over the world and with many varying perspectives and attitudes. I knew traveling to Guatemala would expand my perspective and allow me to treat present and future patients with an open heart and mind. Our trip, however, differed from many in that we would be serving people daily in either a wheel chair clinic or in a hospital. Philanthropy has been a large part of all of our lives and hopefully will continue to be as we develop more skills that can help the underserved in our own city and all over the world.

Ten of us (8 students and two physical therapists, Dr. Burke Gurney, and Tom Debevec) set out for Antigua, Guatemala to begin our adventure. We stayed with local families in Antigua. Four of us stayed with a woman named Theresa. The houses in Antigua may look plain from the

street but inside the walls lies a beautiful courtyard surrounded by all of the rooms. Theresa is a mother of three and is very proud of her kind husband and educated children. Traditionally, Guatemalan women might have more than 8 children and their role is strictly to take care of the house and family. Theresa consciously broke away from the tradition only having three children that she had enough money to take care of and became involved in hosting students from all over the world. She made me realize Guatemalans are brave and motivated, and always looking for new possibilities.

We continued to see this attitude during our work at the wheel chair factory run by Hope Haven. Our job involved evaluating patients, many who never had a proper wheelchair and then fitting them to a wheelchair, making proper adjustments. We evaluated children with cerebral palsy, phocomelia, spinal cord injuries, and muscular dystrophies. Most of the employees worked on making parts

for the wheelchairs from their own wheelchairs. I quickly became friends with Gustavo. He had an amazing ability to anticipate when I was about to use the wrong tool and quickly came to my rescue. The employees taught us so much about how they expected their chairs to feel and to move and the best ways to adjust them for our patients. My favorite patient to work with was Juan Jose, a two-year-old boy with phocomelia. He only had one fully functioning limb, his right arm, but he would not sit still throughout the entire evaluation! His parents talked about how necessary the wheelchair would be in his life. They had already begun talking to him about attending high school and he could already count in English! We fit him into a wheelchair that would allow him to use his right arm to propel the chair. He sat in the chair somewhat apprehensively at first but after the first two pushes, he was hooked. He didn't want to get out of the chair even for more adjustments. Locomotion is such an important part of development and I am excited Juan Jose now has the opportunity to move himself. His charm and intelligence, along with a good wheelchair are going to get him anywhere he desires.

Our next service project took place in la Hospital de Santo Hermano Pedro. We separated into two teams and took turns working in the adult and pediatric section. In the adult section we saw patients with various issues including brain injury and orthopedic fractures. Many of the patients demonstrated that same motivation and drive that I kept seeing amongst the Guatemalans. Alma, who suffered from cerebellar ataxia, begged for longer physical therapy sessions even when she was extremely fatigued. Gladys fractured her hip 16 months ago and had not walked since the injury. The neck of the femur did not heal properly so now she has a major leg length discrepancy of nearly 4 inches. Dr. Gurney decided this was not acceptable and made her a 4-inch lift out of foam that we just strapped on her shoe with tape. By the end of the week, Gladys was independent with a walker and walking over 50 feet without any breaks. I can't imagine how Gladys felt but the look in her eyes was full of determination and gratitude.

Outside of our volunteer time, we took 4-hour Spanish classes every day. I thought physical therapy school would be the most mentally challenging experience of my life but four hours of Spanish class every day was pretty tough. My teacher, Billy, was patient and when he saw I was frustrated, he would take me on tours of Antigua. He was so proud of his city and knew all of the history from the time of the Mayans, to the conquistadors, and finally the very recent end of the civil war. I soon began to realize that the history of Guatemala explains the characteristics of most Guatemalans I have met: pride, motivation, and patience.

Somehow we were able to fit in a fair amount of tourism on top of our fairly busy schedule. On our third day, we climbed Volcan Pacaya, and roasted marshmallows on the top. The volcano exploded two days later. It made me think of a quote I found at our favorite restaurant, Por Que No?: "If you aren't living on the edge, you are taking up too much room." We visited Lago Atitlan, a beautiful lake surrounded by volcanoes. That's where we found a live crab underneath one of our beds on the second floor of our hotel room. We visited lively markets, coffee farms, music museums, and ate some delicious and not so delicious Guatemalan food. Claire and I continued our trip after the group left. We took an overnight bus, an adventure in itself, to Tikal. Tikal is home to some of the most impressive Mayan ruins known to man. The Tikal ruins reminded me that some things in life are so much greater than the individual. Then I realized the entire experience was so much bigger than anything we could have done by ourselves. We put ourselves outside our comfort zone and we learned more than I could have hoped for. I can only hope that we take our lessons from Guatemala everywhere we go in the future, especially in our physical therapy practice. □



Laura Hall



UNM SOM Founding Dean Reginald Heber Fitz, 1965. Courtesy of the Fitz family and UNM HSC Archives.

Appendicitis and the UNM School of Medicine

by John C. Russell, MD, FACS

With the 50th Anniversary of the UNM School of Medicine fast approaching it is worth noting the historical link between “appendicitis” and the founding of our medical school, a link I became aware of shortly after my first meeting in the Dean’s Large Conference Room in January, 2004.

Appendicitis has been called “The Quintessential American Surgical Disease” because America is where early appendectomy first became the “standard of care.”¹ Until the late 1800’s the usual treatment for acute appendicitis in America and Europe was “watchful” waiting, hoping for either spontaneous resolution of symptoms, or the development of a superficial appendiceal abscess that could be readily drained (so-called “laudable pus” – “laudable,” because when such pus became clinically evident and then drained, the patients usually recovered, rather than died of generalized peritonitis. McBurney, Senn and Deaver were among the “Radical American Surgeons” of the late 1880’s and 1890’s that pioneered early surgical intervention for acute appendicitis (before the occurrence of appendiceal perforation or abscess formation), and their names have since been memorialized in instruments and incisions used daily by

general surgeons throughout the world.² However, the real American hero was a pathologist and clinician, a man who published and spoke widely, who held influential positions and had powerful friends in American medicine at the turn of the twentieth century, and who started a Medical Dynasty that inevitably led to UNM.

The Shattuck Professor of Pathological Anatomy (and then the Hersey Professor of the Theory and Practice of Physic) at Harvard Medical School, this individual has rightly been called the “Father of Appendicitis” for his contributions to our understanding of appendicitis.^{3,4} He was the first to recognize its varied clinical presentations and pathologic findings, and he proselytized for early surgical intervention. His seminal work was “Perforating Inflammation of the Vermiform Appendix: With Special Reference to Its Early Diagnosis and Treatment”, a study of 257 autopsies of patients with perforated appendicitis (and a correlation of his findings with 209 patients with a clinical history consistent with appendicitis).⁵

Building his autopsy and clinical findings on a firm foundation of prior medical literature, he argued conclusively that “typhlitis”, “perityphlitis”, “paratyphlitis”

and a variety of other pathologies previously described by pathologists, were just different manifestations and stages of a single disease – acute appendicitis. He logically concluded that this disease could be accurately identified by a careful patient history and physical examination, and its progression to perforated appendicitis, peritonitis and death could be aborted by early surgical intervention – appendectomy. A pathologist telling physicians and surgeons what to do – imagine that!

As described by Carmichael, our hero was the “right man in the right place at the right time.”³ He was a meticulous observer, an eloquent writer and, reportedly a forceful speaker. He presented his findings at the pre-eminent medical meeting of his time (the inaugural meeting of the Association of American Physicians in June, 1886)) and published these findings shortly thereafter in as many as three journals.³ Through his close friend, William Osler, the pre-eminent physician of his time, and author of the leading medical textbook, “The Principles and Practice of Medicine”, his message was amplified and spread to physicians (and surgeons) throughout America, at a time when the thought leaders of American surgeon were ready to pick up the gauntlet thrown down by our hero.⁶ He was lauded by physicians and surgeons throughout the world for the many lives saved by the early appendectomies he proposed. Within 20 years of his proposal and the widespread adoption by early appendectomy by surgeons in America, and then elsewhere, the mortality of appendicitis dropped from more than 30% to under 10%, at a time when antibiotics had not yet been discovered, and general anesthesia was still in its early days.⁷

In addition to his contributions to our pathologic understanding of appendicitis, he made a similar contribution to the understanding of pancreatitis through a publication in 1889.⁶ He also started an American “Medical Dynasty”.

His son was a captain in World War I. His son’s marriage in 1919 was hosted in England by Sir William Osler, by then the Regent Professor of Medicine at Oxford (his father had died in 1913). His son thereafter became a leader in Internal Medicine. A Professor of Medicine and Assistant Dean at Harvard Medical School he also served as Chairman of the American Board of Internal Medicine (1944 – 1946), and as President of the American College of Physicians (1949 – 1950).⁸

His grandson (and namesake) was also inspired towards a career in medicine and medical leadership. He also graduated from Harvard Medical School and became a Professor of Medicine and Assistant Dean at the University of Colorado.⁹ In the 1950’s several hospitals in Albuquerque

(including Bernalillo Hospital Indian Medical Center, the Albuquerque VA Medical Center and the Lovelace Clinic) began a residency program in Surgery, under the academic sponsorship of the University of Colorado. It is likely that through this connection his grandson became aware of the opportunity for the development of a medical school in our region.

In 1961, our hero’s grandson and namesake, was named the “Founding Dean” of the University of New Mexico, School of Medicine, a position he held until 1969. Thereafter, he worked at the Commonwealth Fund in New York City before retiring. The grandson died last spring in Woodstock, Vermont, at the age of 92. At the request of Dean Roth, on February 11, 2014, the Regents of the University of New Mexico renamed the Basic Medical Science Building as Reginald Heber Fitz Hall, in recognition of his seminal role in the creation of our School of Medicine.¹⁰

So, if Reginald Heber Fitz, the grandson, the Founding Dean of UNM, can be called the “Father of the UNM School of Medicine”, then Reginald Heber Fitz, the grandfather, the “Father of Appendicitis”, can rightly be called the “Great Grandfather of the UNM School of Medicine”! □

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Adam Kludt

More Lessons Learned

by Viki McCoskey

In times like these

In times like those

What will be will be

And so it goes

And it always goes on and on

On and on it goes

The soothing lyrics of Jack Johnson's Times Like These drifted through my head as I walked out of the UNM Clinical Neuroscience Center into the midday heat of April. Lots of thoughts were rushing through my head but they kept returning to some patients only live for 8 years after diagnosis.

In September of the previous year I had been diagnosed w/ transverse myelitis. In that time frame I had had 4 MRIs, 2 of my C-spine, 1 of my T-spine, and one of my head. I had also undergone a lumbar puncture with a subsequent spinal headache and blood patch, as well as multiple blood draws. The most concerning of all these were the longitudinal lesions extending from C3-6 and the strange values reported on my serum testing for Neuromyelitis Optica (NMO) from Tricore. The positive value for NMO was 6 and the negative was 4 and my number kept coming up as 5 and was interpreted as "indeterminate". By February, my neurologist at Presbyterian decided a further evaluation by a specialist at UNM neurology was warranted. So phone calls were made, prior authorizations were obtained, and my appointment was set for April. In the meantime, I had my family and (funny enough) the neurology block to focus my attention on.

As the days and weeks went by, my concern over the referral lessened. I reasoned that my neurologist was "just being cautious" and I expected to sit down at my appointment and have a laugh that I was there and be sent home with reassurances that all I had was transverse myelitis from a viral infection. So after two months of waiting, the day of my appointment felt like a relief. I was in my final week of continuity clinic and we didn't have class that morning so I dressed for clinic and headed to the neurosciences office. My husband called, worried because his busy work schedule was not going to allow him to come to my appointment with me, but I assured him that this appointment was only to make sure my neurologist covered all his bases and that it was not an appointment I really needed.

I was quickly checked in, taken back to a room, and waited only a few minutes before Dr. Edmonds, who I had met a few weeks previously when she gave a lecture to our class, walked in with a warm smile and got down to business. She told me about her patients with NMO and the variety of symptoms they experience. Two of those patients had recently passed away and there were some that only lived for about 8 years after their diagnosis. I remember thinking to myself man, I'm glad I don't have that disease, it sounds awful. And then she said "...based on what I have here, I think you will develop the disease." Time felt like it slowed. I wanted to stand up and say Wait, what? This isn't how this is supposed to go! I'm fine! Dr. Edmonds continued to qualify this by stating that my neurologist had not sent her my MRI discs, only a copy of the report and what she really needed to be sure, was to see the images herself.

She informed me that without the images, she was not going to start me on any medications that would help to slow down the disease progression because they are chemo drugs and nasty to take. She asked if I had a child and if I planned to have more. I told her that I had a son that was almost two and that currently we did not plan on having anymore, especially while I was in school. I figured she was asking in case I had to start using these drugs. That was not the case. I was told that the odd thing about NMO is that unlike MS, pregnancy makes it worse. That's about where my brain shut off.

We're taught these things in Foundation of Clinical Practice, how patients hear the worst news and then tune everything out. It's true. The rest of the appointment went by in a daze for me. I told Dr. Edmonds I would go to Presbyterian myself and get the CD for all my MRIs and bring it back within an hour for her to review. She thanked me, asked if I had any questions and I numbly shook my head no. A part of me wanted to laugh that this neuro saga of mine was continuing as Jack Johnson's lyrics began playing through my head, but the majority of me was in shock. My husband and I had decided that another child wasn't in our plans, but hearing that I couldn't have another made my heart ache.

I was halfway to my car when I finally took my phone out of my purse to call my husband. I relayed the news without much emotion until I voiced that we would definitely not be having anymore children, and I lost it. He had to come pick me up.

I brought my CD and dropped it off to Dr. Edmond's nurse. I heard back from her quickly that the images were too bad for her to make out so I was scheduled for another MRI of my C-spine along with a Visual Evoked Potential and a follow-up appointment in July. My husband made sure he was available to come with me to my next appointment. I already knew my latest C-spine MRI was negative, but I wouldn't allow myself to relax prematurely this time. I nervously tapped my feet while we waited and this time Dr. Edmond's smile looked a little bigger. The lesions were gone, my labs had some borderline levels but nothing definitive so at this point, I was given a clean bill of health.

I was so shocked I was speechless. I went from thinking I was going to, at some point, develop a progressive neurodegenerative disease that could only be kept at bay with chemo drugs, to being told that all along it really was just a virus. Relief washed over my husband and I both. I felt a weight lift from my shoulders and my heart. Thank you God I thought over and over. This nightmare of the past 10 months, was finally, finally over.

*But somehow I know it won't be the same
Somehow I know it will never be the same.*

The last lines of Times Like These were very applicable to how I felt leaving the neuroscience building after my last appointment. There was a lesson in all this for me. Were all those MRIs and tests necessary? What did it accomplish besides an additional burden of stress on me and my family. We have been cautioned against over testing in every block. In each tutorial, when asked what labs or imaging we would get, we always had to justify why and how we thought it would help. The problem with this warning is that we live in a litigious society. If we miss something, it's not an honest mistake, it's malpractice.

So what are we to do? Walk a fine line between going overboard and getting just enough? Where does that line lay and who draws it? A preceptor once told me we are not paid for our unerring ability to diagnose patients, we are paid for our consultation and advice based on the knowledge we have. I want to be sure my patients are getting the most out of what they pay for and this calls for critical thinking and judgment and continual learning. In my last article I started by saying we are a sum of our experiences. Would I work up a patient with my symptoms any differently than my neurologist did. Probably not. But my experience would tell me to know the positive predictive value of the test I was thinking about ordering, because once a patient has been

told about a potential serious illness, there is no way to ease their mind while they wait. "First do no harm" applies to more than just physical well-being.

And what will be will be

And so it goes. □



Lynn Lessard

Milagros

by Jennifer K. Phillips MD

It is all I can do to hold her down. She is writhing in pain. “We need to get an IV in you. We need to get you some pain medicine.” ‘Try to be still’, I silently pray. She is 26 years old. This is her sixth pregnancy. All of her children live with other relatives. She is really so pretty, aside from her teeth, which are yellow and some rotted. They call it “meth mouth” and she uses methamphetamines sometimes, but that is really not her thing. She goes to a methadone clinic daily to get her dose of opiate medicine and she is really doing well. She has been clean and only on Methadone. She used to use 3 g of heroin a day for years. Her veins are a mess. She has marks up and down her arms. She has hepatitis C too. Everyone does who uses IV heroin in New Mexico. Everyone. 99%.

I don’t really know her story and all I care about tonight is that she doesn’t die. She is crashing. She doesn’t know where she is. She has a high temperature. She has been in the hospital for two days after being sent from jail after a roll over crash. She has been cleared by trauma surgery but she is not clear any more. Her problem is just now blossoming like a forgotten seed. We call trauma team to her bedside. “Please come help us, she’s sick.”

She was the unrestrained passenger ejected from the vehicle. Her boyfriend was high and driving. There was a warrant for her arrest for drug charges and instead of being taken to the hospital she was initially taken to jail. Thank God someone there realized she needed medical care. She had a gaping arm wound that hadn’t been sutured or cleaned. She is 28 weeks pregnant too and needed to have the baby monitored. People don’t always see her- they just see the tattoos, the track marks, and the chaos. She doesn’t expect any better.

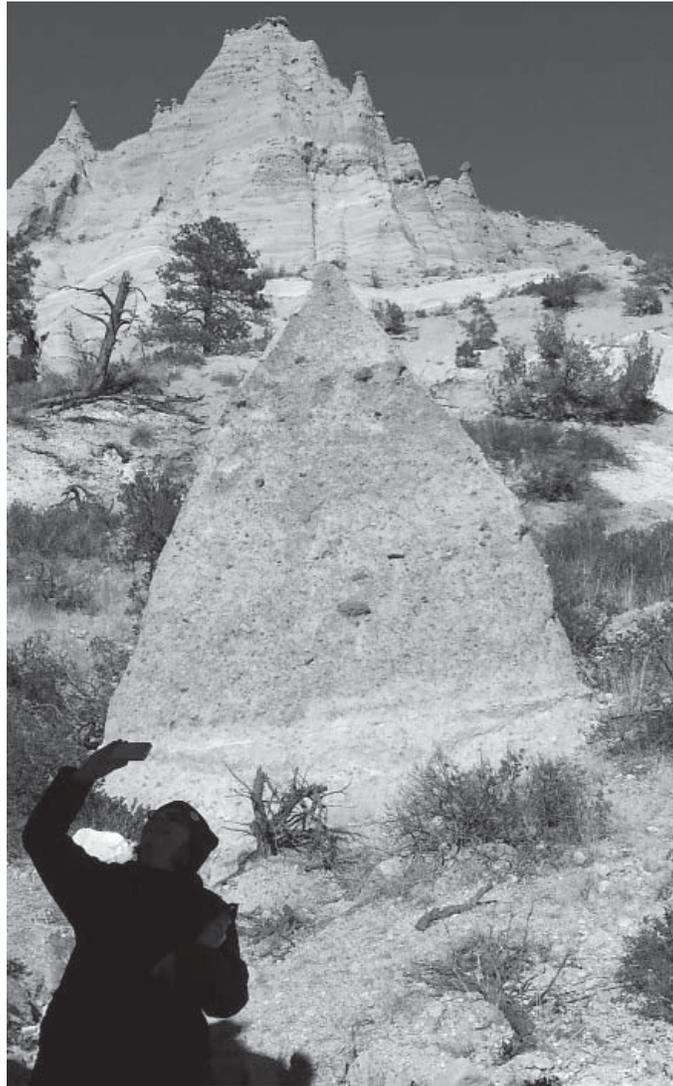
She is used to being treated this way. She is used to no respect and no one caring. She has been a drug addict for so long and she doesn’t expect much. As a little girl, she was raped by her step-father repeatedly. No one believed her. The people who believed her told her it was her fault. She started taking pain pills in middle school. She started smoking cigarettes and pot before that. She has always used drugs to numb the pain of things that happened in her childhood. Her drug use has put her in situations that are dangerous again and again. She is used to it.



morguefile.com image

Tonight she is really sick. This might be the last time she gets into trouble. She might die. She has an infection deep in her skin and blood and bones. The infection has been brewing from her arm wound that was deep and untended. She is septic. She gets an IV and a tube down her throat and goes to the intensive care unit (ICU). She is intubated for weeks in the ICU and on antibiotics. Miraculously, she gets better.

Weeks later I see her in clinic for a prenatal visit. I don’t even recognize her until she leaves. She is now 38 weeks pregnant and her baby’s heartbeat is strong and good. She is all smiles and so excited for her little one. We make jokes and laugh. She asks if I will try to come to the birth. I say that I will. She is resilient. She is moving forward. She is better today than yesterday and she does not give up. I am so glad to have seen her again. I do make it to her birth and it is beautiful and a miracle as all birth is. She plans to have a better life. I pray that she does. □



Lynn Lessard

Medicine – Contrasting Cultures

by Ramnarine Boodoo

On March 23rd, 2010, the following press release was issued by the White House –

Statement by the President on the Reauthorization of the Indian Health Care Improvement Act

“Earlier today, I signed into law the Patient Protection and Affordable Care Act, the health insurance reform bill passed by Congress. In addition to reducing our deficit, making health care affordable for tens of millions of Americans, and enacting some of the toughest insurance reforms in history, this bill also permanently reauthorizes the Indian Health Care Improvement Act, which was first approved by Congress in 1976. As a Senator, I co-sponsored this Act back in 2007 because I

believe it is unacceptable that Native American communities still face gaping health care disparities. Our responsibility to provide health services to American Indians and Alaska Natives derives from the nation-to-nation relationship between the federal and tribal governments. And today, with this bill, we have taken a critical step in fulfilling that responsibility by modernizing the Indian health care system and improving access to health care for American Indians and Alaska Natives.”

I moved to Albuquerque roughly three months ago, with one of my major aims being to work with Native American people. I have not been disappointed. Treating Native American people in a Western health care system has been challenging and gratifying, allowing me to develop skills

of interaction that seem to harken back to another, more profound, time in the practice of Medicine. I had the luxury of looking up and discussing ways of interacting with Native Americans, allowing me to approach patients in a more culturally sensitive manner. This seems to have worked well, even in cases where I was forewarned that the patients and families may be difficult. Principles such as speaking in a calm and respectful manner and allowing patients time to express their concerns are universal. Other techniques such as describing procedure risks in terms of having happened to other patients and not as direct risks to the patient (Cleft Palate J. 1988 Oct;25(4):395-402. The craniofacial team and the Navajo patient. Smoot EC et al.) are more specific.

Prior to the conquest of the western hemisphere by Europeans, Native Americans had unique cultures, civilizations and ways of relating to their environment. They also had unique ways of healing. Unfortunately, "American Indians experienced massive losses of lives, land, and culture from European contact and colonization resulting in a long legacy of chronic trauma and unresolved grief across generations. This phenomenon, labeled historical unresolved grief, contributes to the current social pathology of high rates of suicide, homicide, domestic violence, child abuse, alcoholism and other social problems among American Indians." (Am Indian Alsk Native Ment Health Res. 1998;8(2):56-78. The American Indian Holocaust: healing historical unresolved grief. Brave Heart MYI, DeBruyn LM.)

Despite this, Native American healing practices survive to this day. All Native American cultures are unique, though many share similarities. In my readings so far, a common thread that seems to run through all these is the view that medicine is intrinsically and inseparably related to promoting balance with forces in one's environment. Another thread is healing of a person holistically, not just the affected organ or system. It seems that in order to bring about change via this model, a practitioner must get to know an individual, cultivate a relationship, and via intuition and spiritual insight, prescribe various interventions be they ceremonial, herbal and so on. Community involvement is another principle that seems to run through various tribal healing models.

In my experience so far, I have seen the stark contrast between traditional Native American healing as described above and Western Medicine. The former seems to have a synthesizing approach, the latter an analytic; the former, a broad view of the human being with the affected organ being seen in the context of a wider, biological, psychological and social context; the latter, a narrower view of treating an organ in relative isolation, neglecting the association of biological problems with psychological and

social functioning. Although in current Western medical training there is some focus on cultural sensitivity and the importance of spending time with patients, I have seen time and again, the systemic lack of accommodation for these principles e.g. the "fifteen-minute med check" and reimbursement priority given to medication management over psychotherapy in psychiatry. The imposition of treatment protocols on patients without proper tailoring of interventions to the individual is another concern. As clinicians, we have limited time to treat patients of mainstream culture, how then are we supposed to develop cultural competency for Native peoples whose traditional beliefs about healing incorporate a practitioner cultivating a relationship with the patient?

Perhaps Western Medicine can learn from the Traditional approach, allocating more time and resources to allow us to form a relationship with our patients, understand the issues really troubling to them and thus formulate more effective and less expensive treatment interventions. If the powers that be can find a way to manage this, we will be much closer to realizing the goal of honoring our duty to Native Americans as described by the President, and we will also realize a larger goal of the practice of Medicine – the alleviation of suffering. □



Adam Kludt

Breakfast at 7 a.m.

by Nancy Kerr, MD, DTM&H, MPH

Breakfast at 7 a.m., hospital cafeteria. We were all assembled, the new class of interns, a gaggle of sorts, on June 24, 1975. Four young pediatricians-to-be, 4 OB/Gyns, 6 internists, 4 surgeons, 6 internists, 6 family practitioners, 3 psychiatrists and radiologists and maybe even a pathologist. Fresh from medical school graduations, with no more than a month's break, we embarked upon a year's journey. For me, it was to stretch to four years, for most others, just three, excluding the surgeons. Our average age was 26 years. We assembled from the West Coast, East coast, Midwest and down home New Mexico.

This journey was to turn us into "real doctors." We would shed our short white jackets, don long white coats, just as a juvenile gulls and herons develop new plumage when reaching sexual maturity. We would insist upon being addressed as "Dr. Smith" and "Dr. Jones" rather than Betty or Bob, as appropriate to acknowledge our sudden state of learnedness. We would be able to write our own prescriptions and sign our own medical orders. We would do surgery, not just hold retractors. Outwardly everyone tried to present themselves as being secure, mature, enthusiastic and well prepared. To the attending faculty physicians, I now realize we looked very young and very green. How many voyages start adequately prepared and provisioned? I did not even have the foresight of John Wesley Powell who wrote of his venture "into the unknown" as he entered the grand canyon of the Colorado River with his wooden boats. I could not possibly have foreseen all that would happen, and all the changes I would go through during the next four years. No one told us to look to either side of us, to see someone who might not make it through the next few years. Bit, many of the group did not make it very far at all.

I don't remember worrying whether I was ready for major league play. I did worry about how my medical school training would compare with everyone else's. No one wants to look stupid, and many physicians are known for their delight in the one-upmanship game. I had attended the Medical College of Pennsylvania, previously the Women's Medical College of Pennsylvania. Many of us there suffered an unjustified inferiority complex as females, just because we had encountered such difficulties in getting into medical school. But I had my diploma and my uniform; I was ready to go.

The breakfast speakers included the dean of the medical school and some others dignitaries. They welcomed us to New Mexico and hoped we would want to stay here and practice the rest of our lives. They were here to help us, just let them know. We should not drink too much or do drugs. Those were the last things on my mind. I had needed to borrow money from my sister just to travel to New Mexico from Philadelphia, and was staying at the home of the father of one of my classmates from medical school, as I was flat out broke, and the first paycheck would not arrive until August 1. I had shipped thirteen boxes of books via the postal service to the home of one of the senior residents, for \$70. Then I had moved across country looking like the Beverly Hillbillies truck with my furniture lashed on top of my little Toyota Corolla wagon. I visited family and friends en route, mooching off them in my poverty, not knowing I would repress those memories. I was into survival mode.

Breakfast culture shock. Yes, this is a definite culinary and sociological entity. I had experienced it before. For example, pickled vegetables, miso soup, raw egg cracked over hot rice, plus green tea equals absolute sudden immersion into Japanese culture. Here we were served a set meal of omelet with little pieces of hot green peppers—green chile! Then, the corn bread also had little pieces of very hot green peppers—more green chile. I was used to my 25 cent bagel, cream cheese and coffee breakfast in Philly. Egad, Toto, we're not in Kansas anymore! And indeed, we were not in medical school anymore either.

Why New Mexico? There are many choices I have made in my life, and this is one that I typically look back upon as extremely fortuitous. It was as much a combination of subliminal factors, bizarre coincidences, and pure luck as any rational thought process on my part. I learned to love green chile... □



Kate Morris



Rachel Allen

Becoming Me, M.D.

Accepted

I'm in
They want me
They said I'm worthy to join their ranks, to become a doctor
In my interview, Dr Bull In A China Shop said she
had my back
I wouldn't want to cross her either
She convinces them and I'm in

But maybe someone made a mistake?
All around me greatness, brilliance
I'm no longer the smartest or the most accomplished
I fight to be part of this new world
Where acceptance is measured by
Who can find the latest article, the best reference book
Who stays up the latest, studies the most, get the best grades

Becoming a healer is art like a Jackson Pollock painting
The individual lines of paint come together to make
a masterpiece
The "I's" become "We"

We teach each other
We struggle
We drink from the fire hose of knowledge
We break and pick each other up

I'm not sure all this sacrifice is for me, but the thought
doesn't last long only because
I need those brain cells to memorize bones, neural
pathways, pharmaceuticals
No time for contemplation without feeling guilty for
not constantly studying

Just when I think I can't keep up the pace, they pile on
more and I see that I can
At least enough to pass, which in this world is acceptance
and proves my worth

Failure

To fail is to be a dark, deep, *black hole*
Feared, misunderstood, and undesirable

We don't fail...
Except that I did

They tell you failure is a possibility and to come to them
if you do
I never thought it would be me

Until it was me

My test results read, "FAIL"
But I interpret them failure, as in *I am a failure*
An "F" sewn on my chest

My world shatters like glass broken in a hurricane,
no protection from the howling,
dark, twisted winds
Shards of glass never to be put back together again, never
the same, never whole

How could they possibly help me now?

"Honor roll", "valedictorian", "magna cum laude", "first
place", "best at"
These were all words I was used to

Shit, I'm that person they talked
About
The one we all laughed about and thought was Big Foot

This can't be happening, I pinch myself

Yup, it's happening

How do I recover, fix, change this
Stop this unfamiliar
Gnawing, half-wanting-to-wretch feeling of dread
Deep inside my gut

Go away

Reward

"I'm in the ICU," I text
He writes back, "sweet"
Sweet, as in that's cool

First day in the pediatric intensive care unit
Craniosynostosis, unknown infection, renal transplant
Smiling faces with twisted tubes, parents wringing hands,
blood soaked sheets
In the glass prison cells that keep them alive

Comfort mother as her child is whisked away by the
bristly neurosurgeon
Explain to the intubated teenager who wakes unexpectedly,
"I know it's scary, but don't panic, the ventilator is helping"

Learning is shoved quickly in my mouth not thinking
about taste or texture
Flood gates open, with each bite my emotions spill until
there is nothing left
While drowning I see the gentle poison gifts we
give keeping them
Smiling, alive, moving toward a future
The child becomes a diagnosis and my flood gate closes

"Prescribe more water for the renal transplant," I say
I can breathe again
Anticipation and excitement for another day

Inspiration

One-day old tiny human newness with a tracheal esophageal
fistula enters our OR
Scrubbed, gowned and sweating we begin
Dr Older and Wiser uses her low, relaxing voice to cut
the tension
His "First Assist", she describes what they see and,
teaching me the procedure, she guides him
Dr Young and Cocky cuts, grabs, sews
It's as if he's the gymnast and she's the coach
She says and he does, but not in a way that takes from his
identity or skill
The miracle happens in front of my eyes
Their dance has created a life-sustaining passageway
Wounds sutured, we remove the gowns stained with nerves,
tension, life-saving skill, confidence, teamwork, and I notice
awe on mine

As I watch Dr Young and Cocky talk with tiny human
newness's parents, relief spreads across the mom's face
She cries
She grabs Dr Young and Cocky's hands reverently like I've
seen devout Catholics touch the Pope
In her eyes I see him walking on water

As I stand next to this god the power she pours into him
spills out onto me too
The feeling lifts me up and I forget about all my sacrifice,
tiredness, debt
A fleeting moment to feel god-like

Icing on the Cake

Three diamonds in a ring brilliantly sparkling in the
loving sunlight
Past, present, future
Butterflies leave their cocoon gliding joyfully on the dance
floor of my heart
My transformation into wife begins.

- Kathleen Rooney-Otero

Hospital in the Tropics

A visit to Hospital Dr. Alfonso Moncada Guillen in the mountains of Nicaragua

by Matthew Rethorn and Julia Youngs



Courtesy of authors

Ocotal, Nicaragua - Three hours north of Managua nestled in the Segovia Mountains is the town of Ocotal. Revolutionary figure Augusto Cesar Sandino, who grew up in the Segovias, defines as much of Ocotal's local history as it does for Nicaragua's modern history. His nationalist ideals inspired revolutionaries in the 1970s and 80s, known as the National Liberation Sandinista Front (FSLN), to take up arms and overthrow the Somoza dictatorship. Under the leadership of Daniel Ortega, the revolutionaries democratically ruled the country for a decade until they lost at the ballot box in 1989. However, President Ortega was given a second chance when he won reelection in 2006.

It is clear immediately upon arrival that Ocotal remains a Sandinista stronghold, and supports the politicized image of Nicaragua's homegrown hero, Sandino. Whether in street art and political slogans, or on lampposts and houses, the signature black and red stripes of the FSLN logo are easily spotted throughout the town. Interestingly, one of the places where it is most recognizable is on the steps leading up to the hospital overlooking the city, where the vertical face of each step is painted black and red.

As the capital of the state of Nueva Segovia, Ocotal has served as the main regional hospital since 1937, when it was originally inaugurated as Hospital Somoza. After a

series of name changes, the hospital was renamed over two decades ago after a prominent physician originally from Ocotal, Dr. Alfonso Moncada Guillen.

As the largest regional medical facility, the hospital serves a wide variety of patients. In the second half of 2013, there was a dramatic surge in patients when a deadly outbreak of dengue ripped through the mountain region. Last year alone the hospital saw over 400 dengue patients, easily overwhelming its limited resources. The hospital's capacity of 99 beds stood no chance of accommodating all the patients. In fact, some patients were forced to share a bed. To make matters worse, many of the attending doctors and nurses contracted the disease, and soon patient and doctor were lying next to one another. In addition to staff shortages, the hospital lacked adequate food supplies to sustain the inflated population. Forced to house patients wherever there was space, many departments of the hospital relocated to makeshift workspaces outside or in corridors. Thanks to the community resolve, the hospital managed to remain efficient in the face of such strain.

Together as a whole, the hospital and the town collaborated to fight the disease. The town responded by donating food, clothes and additional beds. In order to eradicate dengue they used a tripartite strategy of extermination, prevention, and education. They fumigated the city to destroy adult mosquitos, inserted a chemical neutralizer in the water to prohibit larva growth, launched a cleaning crusade to remove freestanding dirty water, and disseminated public health information. The community's swift and effective response succeeded and in 2013 there was only one dengue related death. By the turn of the New Year, only one patient remained in the critical unit for dengue.

While the stressed caused by the dengue outbreak was extreme, the hospital is used to stretching its limited resources to meet public demand. Ocotal's hospital is the oldest still in use in Nicaragua, and this fact is evident in the building's appearance. Beneath peeling paint and dingy yellow light, patients stand waiting to be seen by one of the five doctors on shift. However, while small in number, the



Courtesy of authors

Nicaraguan and Cuban-trained doctors exude a sense of confidence, expertise and dedication.

Although they differ slightly in structure, in practice the Cuban and Nicaraguan models of medical education prove highly complementary. Every year one hundred Nicaraguan students are trained in Havana, Cuba in a six-year medical program at Escuela Latinoamericana de Medicina specializing in tropical diseases and disease prevention. The Nicaraguan doctors who receive training within Nicaragua also undergo a six-year program that is focused more on general practitioner training. Together these two models bring a variety of philosophies and experiences to the table. Like in Cuba, healthcare is free in Nicaragua.

The hospital in Ocotal hospital serves approximately one hundred forty people a day. We were fortunate to speak to two of its most valuable employees: Dochyta Facon, nurse and patient rights advocate, and Doctora Corrales, an Ocotal native who was selected to train in Cuba and returned to practice in her hometown. Like many of the staff, these two women carry onerous schedules, often times putting in upwards of 60 hours a week in the hospital. Despite the stress, Dochyta insisted on high-quality patient care remarking, “The patient for us comes first.” This is evident as their caring smiles and unwavering resolve put patients at ease.

Recently the World Bank gave a loan to the hospital that made not only the patients but also the staff more at ease. They were eager to show off their new x-ray machine complete with digitalized images. As the hospital is used to antiquated medical equipment and makeshift wheelchairs, the staff could not help to grin replete with pride.

Given the hospital’s high traffic rate and long life span, Daniel Ortega recently bought land for the construction of a new hospital. As for what is going to happen to the old hospital, no one knows. In the meantime, the hospital is desperate for the adequate equipment, particularly monitors for EKGs and material for osteosynthesis. If interested in donating, please contact rwaltersunm@gmail.com. □



Adam Kludt

Too Many Passwords

So many passwords to remember
Add a number, change a letter,
Start out with the same word,
ABCs and 123s and !@#s mean
Yes, this is who I am.

Ways to purchase things like
Flight tickets to Iceland to see Volcanoes
or buy Life on Fire, the DVD from PBS.
Make hotel room reservations in France or Italy,
or buy a cookbook from Jacque Pepin or Lidia.

Link me to a Cloud.
Buy Santa Fe opera tickets,
poetry books by William Stafford,
new comfortable shoes or a flannel shirt.
Buy music - pick a new identifier.

All my passwords could be my social security number,
A string of numbers I memorized at age 16,
assigned only to me. Why can't I just be me
with no passwords?
You know who I am. Yes, this is really me.

- Jeanne Favret

