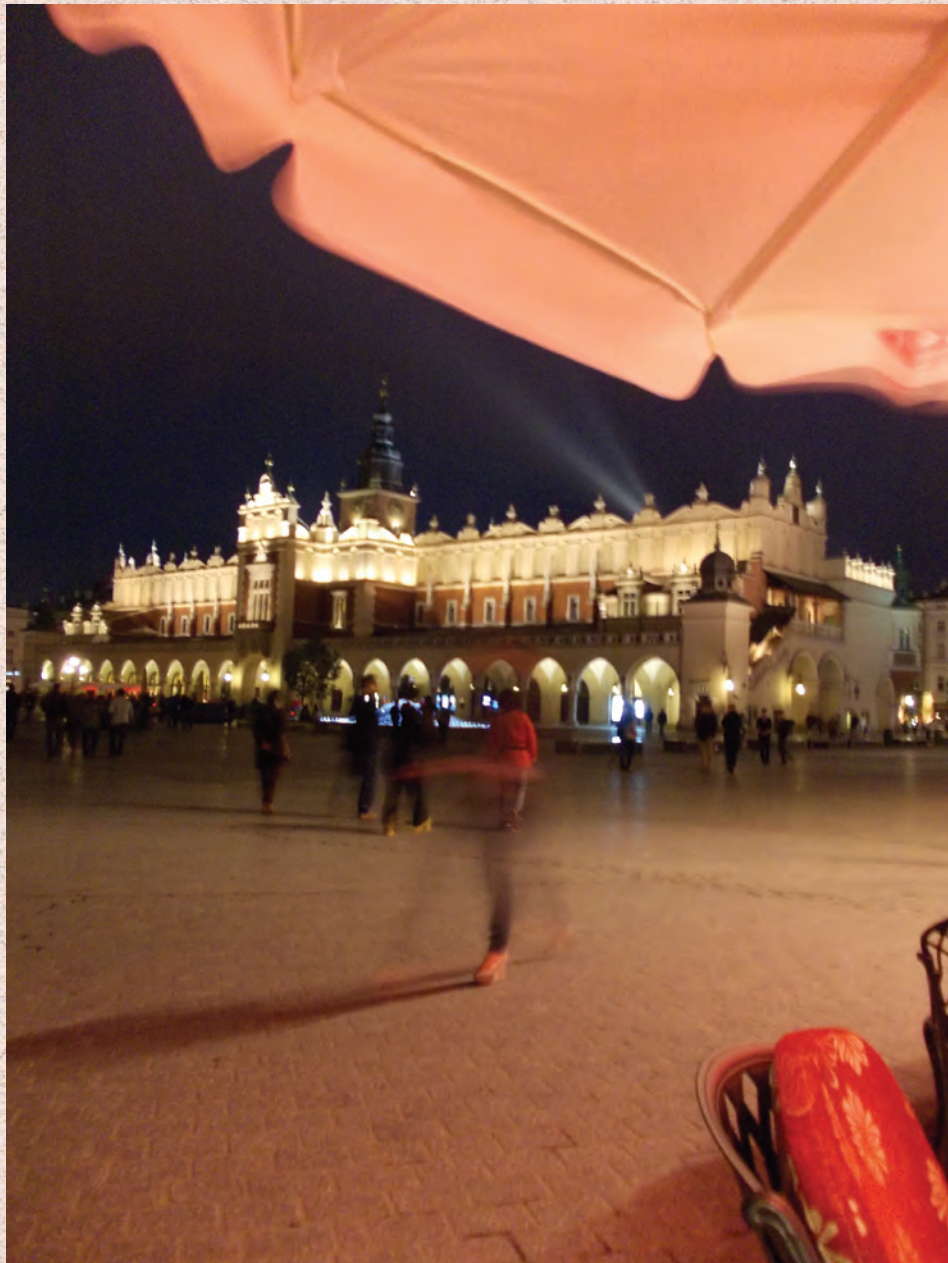


MEDICAL MUSE

*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.

Reviewers for this issue:

Cheri Koinis, PhD
Anastasia Anderson
Erin Roth
Norman Taslitz, PhD

Advisor:

Norman Taslitz, PhD

Art Director:

Paul Akmajian

Design/Layout:

Laura J. Hall

Thanks to Sandra Naranjo, Dept. of Internal Medicine

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

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

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

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

- The Editorial Board

Contributors for this issue:

Paul Akmajian	Noah Cooperstein	Paul Kaloostian	Sean Peterson
Lisa Antonio	Jeanne Favret	Sari Krosinsky	Stephanie Reich
Maureen Mahoney Barraclough	J. Rocky Funston	Victoria Lucero	Cody Saxton
Gonzalo Bearman, MD, MPH	Cindy Garcia	Umar Malik	Robert C. Schenck Jr.
David Bennahum, MD	Bethany Godwin	Ryan Mals	Katherine Schultz
James Besante	Laura J. Hall	Aroop Mangalik, MD	Howard F. Stein
Jonathan Bolton, MD	Annie Huerta, MOTS	Subramani Mani	Alan Vincioni
Mae Brown	Mary Ellen Ipiotis	Flannery Merideth	Kevin Patrick Vlahovich, MD
Melody Childs, RN, BSN, MS	Kathy L. Johnson	Alexander Miller	Dara Zafran

Cover photograph by Noah Cooperstein.



Kevin Vlahovich

Contained within this edition of the Medical Muse are writings of second-year medical students who participated in a narrative writing project as part of their Practical Immersion Experience (PIE).

During the summer between their first and second years of medical school, all UNM SOM students disperse for eight weeks to rural and underserved parts of New Mexico to live in those communities and to work with community-based primary care providers.

This is their first exposure to sustained clinical practice. Beginning in 2005, students have had the option to sign up for a special Narrative Strand of PIE, in which they write once per week about their field experiences, and e-mail their reflections to a mentor on campus who responds to their work.

Some of the works are poignant, some are funny. Collectively, they bring us into the minds and hearts of the beginning practitioner: moments of awe, crisis, humor, disillusion, and initiation.

Antes de la mañana... amor

Antes de la mañana,
en el silencio de la oscuridad,
pienso.

¿Qué es el amor?
Algo puro y oro,
fresco y blanco,
pasión y fuerza,
Amor.
A mi lado estás,
oigo tu aliento dulce
de tus labios,
temblo.

Antes de la mañana,
en el silencio de la oscuridad,
pienso.

¿Cómo podemos amar?
La raza de humanos,
Con nobles y bárbaros,
Todos juzgan de la misma cara.
La persona que soy,
Moldeada por una sociedad que odia
Una mujer que está libre.
De persona a persona,
Una distancia muy grande.

Antes de la mañana,
en el silencio de la oscuridad,
pienso.

¿Es amor poder?
Una mujer encima de un hombre,
un hombre encima de una mujer,
una pareja encima del mundo.
libertad en opresión.
Esto es poder.

Antes de la mañana,
en el silencio de la oscuridad,
pienso.

¿Quién puede amar?
Un hombre con un hombre,
mano en mano,
mujer con mujer,
tú y yo,
todo el mundo.

Antes de la mañana,
en el silencio de la oscuridad,
pienso.

¿Puedo amar?
Mi mano encima de tu corazón,
mientras te sueño,
oigo el batir,
estoy entumecido.
¿Es suficiente?
Una palabra de tus labios,
entonces un beso dulce,
relajación,
suspiro.
Sí, estoy contenta.
Sonrío y duermo.

Antes de la mañana,
en el silencio de la oscuridad,
duermo.

- Victoria Lucero



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Crying Wolf A very short story

by Howard F. Stein

Every time her anxious family brought Georgia to the hospital Emergency Department (ED), the admission clerk, nurses, and doctors would roll their eyes. They already knew this visit was medically worthless, that they would learn nothing new, and that the hospital in this quiet West Texas town would have to eat the cost once more. They called this stocky, demanding, 79 year-old family matriarch a “train wreck” who they couldn’t help any more than they already had – multiple times. Type II diabetes, edema of feet and legs, congestive heart failure, hiatal hernia, shortness of breath – these were her chronic ailments all under tenuous control. Still, she had survived these for years. In fact, she was doing better than the family who doted upon her and watched for every foul sign.

No one – least of all Georgia – could see her fear of losing control of her body, her independence, and her family place in holding them all together. No one could speak of her dread and their ambivalence, only of her chest pain and their effort to rid her of it at all costs. Peace at any price prevailed. To be angry was to be unChristian, so they not only could not express anger, they also could not even know they harbored it.

Georgia’s bad chest pain was the family cue to rush her to the hospital. Her fright was their fright – sometimes even greater alarm than hers. The ED physician would order tests, which came back each time with the same results. Georgia’s hiatal hernia was the culprit, and not life-

threatening. ED personnel called her manipulative, accused her of “crying wolf.” Like the family, they felt helpless, but repeated the same steps each time.

For years nothing changed – until Amy, a daughter living in Boston, flew in during one of her spells of chest pain. One morning Georgia even refused her cup of coffee. The vigilant daughter from Boston took notice: “She *always* has her cup of coffee early in the morning,” she said with alarm. Soon the family was on the road to the hospital again. When they arrived at the hospital, once more the ED staff sighed and rolled their eyes – and started care.

Out in the hall, Georgia’s children and grandchildren came as close as they could to quarreling. How dare Amy, who has not tended to her mother month after month like the rest of the family, just fly in and take over and tell people what to do? Who did she think she was? – they asked, while trying to be “nice.” This time was different, though. The tests came back positive for a myocardial infarction. Georgia’s life was now in real peril. She was admitted to the hospital.

The wolf had finally come to the door. “See, I *told* you I was sick,” Georgia rasped at both the ED physician and her own family. For a moment they stood facing her, dumbfounded and defeated. Georgia was back in charge again. Or her fear was. Like the potential energy in a wound spring, the spiral was set to widen. □

At the Foot of Mount Wachusett

A personal essay

By Kathy L. Johnson

I At the foot of Mount Wachusett is a lake called Wyman's Pond. I know about this place because I spent time there when I was a child. My family had a summer cottage overlooking this lake. I like the name Wyman's Pond. The word pond is friendly. When I hear this word I see pictures of peaceful waters, mirrored images, and I feel invited to drift in a small rowboat without ambition. My father and I knew Wyman's Pond in this way. The lake was our place to get away and spend time together as a family. We spent our summers discovering the lake and each other. At Wyman's Pond, I came to know my father shortly before he died.

My friends always wanted to know where my family eagerly disappeared to every weekend of the summer. I would tell them about our summer cottage at the lake. Even though it was only fifty miles away, no one had ever heard of it. In Massachusetts fifty miles was a very long way to go. My friends could not understand why I was so excited about spending my weekends with my parents. The ones who had met my father were constantly trying to decide if he was joking with them or not. He had a dry sense of humor that was not easily deciphered. He would intentionally call my current boyfriend the wrong name and remark, "Kathy talks about you all the time!" Not too many of my friends would accept my invitations to the camp, knowing my father would be around.

Every Thursday night our family and our lassie look-alike collie, named lady, would load into the station wagon. During the summer my father would take his vacation allowance on every Friday and Monday. This made it possible for us to have long weekends at the lake. Beginning in June, Wyman's Pond became our second home. The trip to the lake seemed to take forever. There were freeway exchanges and turnoffs. Traffic was always slow. Our car was overflowing with my brothers and sisters, all six of us, my parents, and the dog. In a crowded fashion we made the pilgrimage to our little retreat. The roads became more remote and less traveled at each junction. At last, we turn on to the final dirt road that encircled the lake and led to the front door of our cottage. Once on this road, my father would drop the tailgate of the station wagon and we would sit on it dangling our legs, occasionally tapping the oil-sprayed dirt as it passed

beneath us. All of us loved to be there. We would play all day and eat only when our stomachs insisted. Here we were free from the structure of our city life.

The cabin was covered in green clapboard. It had a steeply pitched roof sprinkled with pine needles. The cabin's name was carved in a board hung above the screened porch. It had been named "The OWL" after my father's grandfather, Otto W. Lanson. I usually slept on the porch under that sign. It was so easy to fall asleep to the sound of the water lapping against the lakeshore. I would lay there and dream of tomorrow's adventure on the lake with my father.

We had a small boat. It was called a Boston Whaler because of its squarish bow. It had three wooden benches and a small Johnson motor. My father would heap life jackets in the bow to make a comfortable place to rest, and I would be in charge of navigation. The motor could go incredibly slow. It would take us hours to circle the lake. During our journey, I would take particular delight in steering into the wakes of larger boats. The waves would splash up onto my father and make him jump! Meanwhile, I would try to look innocent and make apologies. He deserved these little jokes from me. I had learned the art of pranks from him. He was the master of shenanigans.

At the far end of the lake was a local sundry store. My father and I would go to this store almost daily. Shortly before he entered the store he would put his shoes on the opposite feet, turn his black-rimmed glasses upside down and ruffle his hair to look like Professor Irwin Corey. While speaking with the owner of the store, my father would do tricks with his lit cigarette, taking it entirely in his mouth and turning it around to puff smoke out of the filter end. The contest for all of us was to keep from laughing. Even the store owner, who knew my father well, would do his best to act as if everything was normal. My father played these kinds of jokes whenever he could. He and our neighbor, Charlie Page, would attend each other's campfires by the lakefront. After some complaining about smoke blowing into the cabins, they would discreetly drop firecrackers into the coals and quickly excuse themselves from the immediate area. These sorts of rituals went on all summer.

When the season came to an end, it was time to close the camp for winter. Usually on Labor Day we would make our final trip to pull the shutters in tight and take the boat out of the water. We always had a final boat ride to reminisce about our time together. Those rides were the most spectacular of the year. The lake was smooth as a mirror, and the flaming leaves of the shoreline trees colored its surface. I will always remember the incredible color that surrounded me. When it came time to take the boat out of the water, my younger brother and I were summoned to help. We were instructed to hold the bow of the boat perfectly still while my father lifted the engine off the back end of it. Then the water would unexpectedly move the boat, and my father would fall out the back end, motor in hand. My brother and I stood anxiously on the dock waiting for him to come up for air, alternately giggling and being concerned that he was all right. As he came out of the water, we clamored to explain the events that were out of our control.

When I was fourteen, we sold our summer camp to family friends when my father's job moved us to the southwest. I have missed it ever since. My father died a short time after we moved. That was twenty-five years ago. I could never have known that the lazy summers spent with my father would be the end of our time together. In looking back, my best memories of him were the times at Wyman's Pond. I recently attended a family reunion in Massachusetts, and I considered going to the camp for a visit. I wondered if the smell of the cabin or the taste of the wild blueberries near the shore would awaken memories I had long forgotten. My brothers and sisters warned me that the cabin and the lake had changed a great deal over the years. It was not the same as when my family had played there. I decided to leave my memories as they were. Even though I now live thousands of miles from Wyman's Pond, I often visit that lake of long ago and have a good laugh with my Dad. □



Alan Vincioni



Annie Huerta

The Pharmacy in the Fields: An Exploratory Paper about Identifying Healing Plants in Albuquerque

By Annie Huerta, MOTS

My favorite experience during the UNM course: Introduction to Traditional Mexican Medicine in Oaxaca, Mexico was the opportunity to take a walk with the botanist and curandero (traditional healer), Laurencio López Núñez. As we hiked up a mountainside in Cuajimoloyas, a village in the Sierra Norte Mountains, Laurencio named and explained the medicinal uses of well over 40 plants. If Doña Telesphora, a local curandera, was not waiting for us at the top of the hill, I am positive that there were countless other plants that Laurencio could tell us about. From a distance, the green mountainside looked exquisitely ordinary, but a closer look revealed hundreds of unique, individual plants, each with their own hidden, healing properties. I tried to write down every word Laurencio was saying and I also tried taking physical and mental pictures of each special plant, but there was no way I could retain all of the knowledge Laurencio was sharing with us. His is the kind of knowledge that only comes from spending your life's work studying and using these natural treasures on a daily basis.

One of Laurencio's statements that I was able to capture that day was the idea that "the pharmacy is in the fields". Perhaps most conditions humans suffer from could be helped with the healing properties of a plant—pure and natural. After taking this walk with Laurencio, I wanted to see how easy it would be to find and identify the use of medicinal plants and herbs in Albuquerque, my hometown.

Nursery

Armed with two plant identification books, a notebook, and a pen, I went out to find healing plants. I chose a nursery to begin with because I was hoping that each pot would have a little, white card poking out of the soil with everything I ever needed to know. More importantly, nurseries are places where people can buy plants to grow in their own backyards, making them readily accessible to families and communities. Corrales Garden Nursery is an open area, directly off the side of the road with rows of colorful, flourishing flowers and plants.

One plant that I was able to identify without looking at my guidebook was a common, red geranium, or geranio. Laurencio taught us that geraniums are commonly used during limpieas (spiritual cleansing ceremonies) and that the red flowers can also be used to repel mosquitos. I was off to a good start.

Parks

The Veterans Park in Rio Rancho is a desert plant paradise. It is a calm place where people can quietly walk a path that leads up to the names of hundreds of veterans inscribed on marble walls.

I felt slightly guilty that I did not need to fumble through my books since most of the plants were identified for me. With each plant I came across, I would search for the name in my guidebooks and was surprised to find that so many of them had medicinal properties.



Annie Huerta

Within the park there is a gazebo completely covered in green and red grapes, which are healing plants in themselves. The mountain marigold has yellow daisy-like flowers and mild anti-inflammatory and analgesic properties that

can soothe a gastro-intestinal tract inflamed from emotional or physical stress (Krane, 2006). The plant can be made into a fresh plant tincture and shortly after 30 drops of the tincture is taken, it produces a calming effect, as well as a lightness of mind, and sometimes giddiness (Krane, 2006).

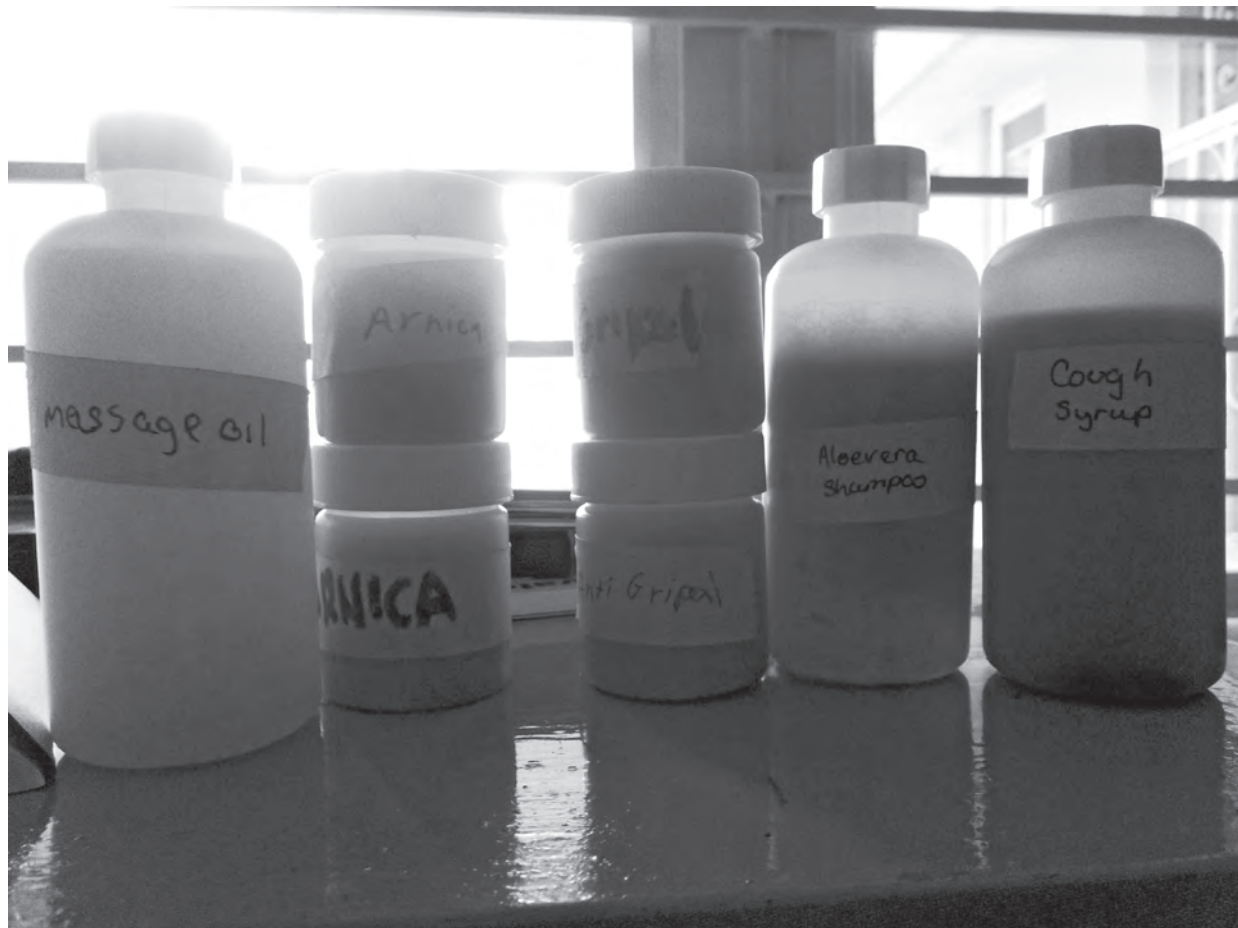
Laurencio told us that in order to identify plants, you must feel, smell, and taste them. At the park, I bent down to the plants and felt the leaves between my fingers. I bent forward and put my nose towards the flowers. I was tempted to bite into the leaf of the mountain marigold to try its calming effect, but I settled for a red grape under the gazebo as I wrote about my findings.

The Albuquerque BioPark is also an incredible plant sanctuary. Before this visit, I had only been here a handful of times and mostly as a chaperone for a large group of excited, school-aged children. This time, I walked alone, like an explorer in search of the finest, green gold.

The park has everything from the “Elizabeth Taylor” rose and pineapple mint leaves to plants that look like something out of a science fiction movie. After an hour of wandering through the gardens, I happened upon exactly what I was looking for, “el Jardín de la Curandera”. It is a short loop, but it is packed with medicinal herbs growing side by side: arnica for sore muscles; siempreviva for inflamed gums, yerba mansa for arthritis, and calendula for soothing pretty much anything that needs soothing. On the wall is a giant sculpture of a curandera being ushered into the room of a very sick man. I leaned in closely to smell the yerba buena, commonly known as spearmint, and I felt grateful to know there is a place in Albuquerque that reveres this traditional way of healing.

Festival

For the past eight years, the village of Los Ranchos in Albuquerque has put on a festival that celebrates the popular garden herb, lavender. Lavender, or alhucema, is used by Mexican-Americans as a tea for indigestion and new mothers are purified with the scent of burning lavender after childbirth (Davidow, 1999). For a price, festival goers can pick a bundle of lavender, which most people keep by their beds for sound sleep, or sprinkle the fragrant flowers into bathwater. Some people really get into the spirit by dressing their whole family up in violet hues. The festival is a great way to bring the community together to celebrate sustainable agriculture.



Annie Huerta

For free, you can go on a hike in the boulder-strewn foothills to find desert lavender that grows wild in New Mexico. Desert lavender can be used as a mild sedative during times of emotional stress and anxiety (Krane, 2006). Topical application of desert lavender as a salve or poultice can make an excellent dressing for an injury because of its antimicrobial and anti-inflammatory properties (Krane, 2006).

My Kitchen

Before I began my next excursion to find medicinal plants and herbs, I did not have to look any further than my own kitchen table. Aloe vera or *sábila*, is one of the most familiar of all herbal remedies. It is a native of Africa and legend has it that Cleopatra used to lather aloe vera gel on her skin to maintain her flawless complexion (Davidow, 1999). When the barbed, spear-shaped, thick, fleshy leaves are sliced open, a clear gel can be squeezed or scraped out and used for soothing wounds and burns and expedite healing by reducing the risk of infection (Davidow, 1999; Johnson, Foster, Low Dog, & Kiefer, 2012; Krane, 2006). Internally, aloe gel and aloe juice are taken for osteoarthritis, stomach ulcers, irritable bowel syndrome, and asthma (Davidow,

1999). Studies suggest that aloe juice may help lower blood sugar levels in people with type 2 diabetes (Johnson, Foster, Low Dog, & Kiefer, 2012). We scraped the inside of aloe vera spears in Oaxaca to make clarifying shampoo because the curanderas taught us that the top of our heads is where we absorb the most energy from the sun.

Every morning I sprinkle cinnamon into my oatmeal for its warm flavor. Cinnamon, or *canela*, has digestive, astringent, stimulant, antimicrobial, antifungal, and antiflatulent properties (Davidow, 1999). It is used in teas for upset stomach, fever, and as a treatment for colds, flu, chest infections, and coughs (Krane, 2006). The herb may also improve peripheral circulation and increase blood flow to the hands and feet. Similar to aloe vera, cinnamon has been shown to have an insulin-like effect in the blood and may help stabilize blood sugar levels in people with type 2 diabetes (Johnson, Foster, Low Dog, & Kiefer, 2012). In Mexico, the other students and I sipped cinnamon tea before and after sitting in the *temezcal* (traditional, aromatic sweat bath). We also put cinnamon into our homemade cough syrup that we made, along with berries from the *capulin* tree and *mezcal* from the mighty *maguey*.

Grocery Stores

Out on a hike, it was not easy rifling through the pages of my guidebook, trying to compare the picture on the page to the plant that was before me. Without noticing the slight variations in the shape of the leaf or flower, one could easily mistake a Mexican poppy for camphorweed. I decided to go to the local grocery store where most people have the easiest access to medicinal herbs.

Talin World Market is a mecca for produce and herbs from around the world. Right away I found a wall of bagged spices commonly used to flavor Mexican-American dishes. One herb that caught my eye was epazote because I ate fresh sprigs of this herb in my quesadilla at a little roadside restaurant in El Tule, Mexico. It grows wild in vacant lots and suburban drainage ditches. Medicinally, it is used to treat asthma and to combat intestinal parasites in humans and animals (Davidow, 1999; Krane, 2006). Interestingly, it is considered a cardiac stimulant, so it is not recommended for people with cardiovascular disease (Krane, 2006). I also find it interesting how such an abundant weed (that most people find to be a pest when it infiltrates their manicured lawns) has so many medicinal properties.

Similarly, the dandelion, or *diente de león*, is an edible weed. The leaves are rich in chlorophyll with Vitamins A and C, calcium, potassium, iron, and niacin. It is used as a *limpia* for the kidneys and liver and can be consumed as a tea or salad to reduce fever (Davidow, 1999). Mexican-Americans drink a tea of dandelion roots to “purify the blood”.

Pro’s Ranch Market on Atrisco is one-stop shopping at its finest. I bought a medium horchata and began my search in the produce section. My favorite food of all time is the avocado, or *aguacate*, especially sliced up and sprinkled with salt inside of a warm tortilla. Avocados were commonly used by the Aztecs as both food and medicine (Davidow, 1999). All parts of the avocado tree are used medicinally. The leaves, bark, pit, and peel may be used to treat anything from skin problems and muscle pains to chest congestion, wounds, and diarrhea (Davidow, 1999). Cactus paddles, or *nopales*, from the prickly pear, were piled high at Pro’s. Peeled and eaten as a salad or side dish, they are a natural diuretic with a good source of vitamins (Davidow, 1999).

Next to the glass case of *chicharrónes* the size of my torso, stands a giant wall of bagged herbs. I found the dried versions of the fresh plants that I saw earlier at the BioPark.

Penny Royal, or *poleo*, is good for a hangover and rosemary, or *romero*, is often burned in bundles to spiritually cleanse a room (Davidow, 1999).

Grocery stores have an abundance of fresh and dried herbs that are commonly used to flavor food, but can also be used as medicine. However, something to consider when buying pre-packaged herbs is under what conditions the herbs were grown. Was it near pollution? If they are picked wildly, there is no way to know how the plants were raised and picked (Davidow, 1999).

Drugstore

The neighborhood *tiendita*, B. Ruppe Drugs on 4th St., is the closest thing to being in the herbal section of a Oaxacan *mercado*. I walked in and the smell reminded me of the candles that burn in a Catholic church, very reminiscent of my childhood and my grandmother’s house. The store has several aisles and rows of shelves with large, clear, plastic bins filled with herbs and a handwritten index card identifying each one. Some of the names were recognizable from my course in Oaxaca: valerian, epazote, salvia, nopales, and copal. Others just read “Alcoholism” or “Cancer” to indicate the purpose of the herb. One sign made me smile, “*Damiana*: Sexual Rejuvenator”.

Against one wall are rows of little bags filled with a small amount of each herb. I bought *manzanilla*, *yerba buena*, and *eyebright*. The bags are \$2 each and have a handwritten label with a disclaimer on the back, “Warning: These products may be harmful if used incorrectly. Never use these products without consulting reliable usage information first”. The herbalist on site is Maclovia Sanchez de Zamora. She is an educator and mentor, specializing in herbs for the health of the community. She said that *eyebright* is the main herb for protecting and maintaining the health of the eye. Her instructions to me were to prepare it as a warm tea, dip cotton balls into the water and place them over my eyes twice a day for 10 minutes.

Other than herbs, the store also has religious artifacts, sage sticks, red beads for protection and books about *curanderismo* from Dr. Cheo Torres. They even provide a free, printed list called “Use of Herbs” with about 60 different herbs, their uses, and how to prepare the infusions or decoctions.

Using the herbs

Tonight I made a cup of chamomile tea that I purchased from B. Ruppe Drugs. I used one rounded teaspoon of the dried plant and I gently crushed the flowers with my fingertips to release their essence. I steeped the tea for about five minutes and watched as the water turned from clear to a soft yellow. My teacup was speckled with little pieces of flower and twig and I sipped the sweet tea until I was tired.

Chamomile, or manzanilla, are small daisy-like flowers. They are imported from Europe, but have become the most favored herb in Mexican-American remedies. After a rain, or when lightly bruised, the flowers give off the distinct scent of apple, hence the name manzanilla or "little apple". It is commonly used as a remedy for nervous tension, muscle cramps, skin conditions, and digestive upsets in babies, children, and adults (Johnson, Foster, Low Dog, & Kiefer, 2012). Used as a mouthwash, chamomile has been found to prevent mouth sores associated with chemotherapy and radiation (Johnson, Foster, Low Dog, & Kiefer, 2012). It is also a woman's herb, used to treat menstrual cramps. In rural Mexico, an infusion of manzanilla is sipped during labor and after delivery to ease the pain (Davidow, 1999).

Conclusion

Albuquerque is abundant in healing plants. If you know what you are looking for, you can find it.

One thing I learned from this experience is that New Mexicans are interested in the topic of healing plants. Just sitting here in this coffee shop writing this paper, I have been approached on three separate occasions by people wanting to know about my stack of books and my paper. One gentleman wants to start a club where people go on nature walks and help each other identify edible plants. In fact, he did start that club, 'Los Yerberos de Albuquerque'.

My experience in Mexico gave me a much-needed reconnection with nature. The curanderas reminded us of the importance in taking off our shoes and walking in the grass or letting the rain hit our skin during a storm. We must put a priority on cultivating healthy, abundant plants that are healing to our bodies. One suggestion is to create more places like the Veterans Memorial Park that not only preserves the plants, but also educates visitors on the names of the plants. We should go a step further and include the medicinal uses of plants in order to promote the idea of the pharmacy in the fields.

The Introduction to Traditional Mexican Medicine course taught in Oaxaca, Mexico was created by Dr. Terry Crowe, a professor in the UNM Occupational Therapy Graduate Program. It is currently being offered Summer 2013. □

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Kevin Vlahovich



J. Rocky Funston

Keep an Open Space in the Day

For the emergency patient
For the unexpected request
For the joy of watching rain
For the smell of wet twine

For the fish tank that leaks
For the egg crate that falls
For the phone call from England
For the voice of a friend

For the dance in the kitchen
For the view of our garden
For the hand on my knee
For the hugs when we sleep.

- Jeanne Favret

Never Thought *this* Day Would Come So Soon

By Lisa Antonio, PIE Narrative Strand

When we entered the room, she was slouched in the chair, head forward, palms intertwined, her braided auburn hair draping off her right shoulder. As she looked up at us, peering through her dark-rimmed glasses, one could immediately see the misery masked behind her half-smile. The exhaustion, fatigue, frustration, and pain of the past three months all exposing themselves through her dark brown eyes, shouting at us as if to remind us not to overlook them.

Once we began, she explained the past three months journey up until this point: Lower right back pain that soon radiated to the front, crossing her entire abdomen. She thought constipation was the culprit, so began incorporating more fiber in her diet while decreasing her intake of greasy and gassy foods. Someone told her the problem could be gluten, so she took out breads, pastas, and cereals too.

“I’m basically a vegetarian now, and still nothing has helped. And what surprised me was that I didn’t lose that much weight either.”

“Do you have a family history of kidney stones?” asked Dr. X as he typed all her history into the computer.

“I don’t think so, but I had ulcers when I was young. They told me my stomach would never heal right, so could that be the problem?”

“Well, maybe. It could be your gall bladder as well.”

“Yeah, it could be. I know my grandfather had problems with his.”

“Let us run some tests and schedule a CT scan of your belly, and we’ll see what they tell us. That information should give us a better picture in what we are dealing with. I have my money on the gallstones though.”

A few questions and an abdominal exam later, the soon-to-be thirty year old carried the CT scan request out of the same room she would be returning to the next day; a supposed day of celebration for her, as it marked her thirtieth trip around the sun. She was not scheduled to come in until the following week, but the results demanded immediate attention.

She thought the CT scan would bring back answers, and finally she would know what was causing this unending pain. Dr. X and I thought the scan would bring back an image of gallstones or kidney stones; something tangible that was causing her pain would show up, and we were just waiting for the confirmation. The one result we all did not even bother to consider was what the scan brought back. It is the result that does not bring relief, but more anguish. It is the one that brings grief, not joy. It is the result that changes lives forever, and sadly, may even end them. The C-Word... cancer.

The CT scan did not show gallstones or kidney stones, but rather tumors; multiple masses in the young woman’s abdomen. They were the culprits. They were the bad guys who were slowly damaging her body from the inside out.

“It can’t be. No. No. NO! You don’t know...this is what all my aunts and all the women on my mom’s side had. They all died! No. That’s not it. It can’t be. NO!”

I felt helpless in the chair next to her, only able to offer her my hand on her shoulder and some Kleenex. Here I was, a stranger, a girl six years younger than her, bringing the bad news with the doctor. I wanted to hug her, hold her in my arms and tell her, ‘I know it’s not fair. It shouldn’t happen to you. You don’t deserve this, especially not on your birthday.’ She reminded me of my childhood friend Sam, and I think that is what made this more personal than it should have been. I still kept my professional boundary, only rubbing her back as I held the Kleenex box, all the while thinking, ‘This could be Sam. I could be telling Sam she has cancer and that most likely, this is what is going to end her life. How could I ever tell my best childhood friend that she is going to die?’

As medical students, we rarely think of the day that will come when we have to be the bearer of bad news. For the first two years at least, we are focused on studying and passing our exams. This time is so stressful and important we don’t have time or energy to dwell on anything else. What is the mechanism of hydrochlorothiazide? Is this a systolic or diastolic murmur? Can a patient take Ibuprofen and Warfarin at the same time? What replication error and in which

DNA phase does Klinefelter's Syndrome arise? These are the things saturating and occupying our minds. After all, these years will determine our specialties, our lives, our futures.

While we study, and study, and study some more, we often forget that what we are learning is tangible, real, organic, and it is only when we encounter patients that we are reminded of this. We need to remember that it is people who we are treating, not only the illness, disease, or syndrome. Yes, we need to maintain professionalism and not be too emotionally invested, but we need to have empathy and compassion. Imagine this patient being your grandmother, mother, sister, wife, girlfriend, or friend. Too often, we hear that doctors become jaded, distant, and cold during their careers. I hope this does not happen to me but it very well could. So, I am grateful for these experiences, as tough as they are, because they remind me I am only human too. Just because I am a doctor does not mean I cannot have compassion and sincerity. It means my life is just as fragile as everyone else's life, and that one day, rather than being the bearer of bad news, I could very well be the receiver of it. □



Dara Zafran

El Guapo

El Guapo with a shopping cart,
His home on wheels has broke apart,
Life spread across the boulevard,
A nuisance now for passing cars.
But no one stops to help him up,
Because no one ever gives a fuck,
About El Guapo and his shopping cart,
Whose broken life has broke apart.

- Kevin Patrick Vlahovich, MD

Lord Nelson

It's said Lord Nelson, when he lost his arm,
Still felt it by his side,
And took this as his sacred proof,
That life continues when you die.
And God, I've heard, can heal the blind,
And makes crippled men walk,
But when I ask Him to regrow my hair,
He doesn't want to talk.

- Kevin Patrick Vlahovich, MD

Catching a Baby

Week 2

by Ryan Mals, PIE Narrative Strand

It was Wednesday at 4:45 PM—almost time to escape my dingy blue scrubs, grab some pizza, and head back to the Super 8 Motel. After nearly nine hours of work on the hospital’s Labor and Delivery floor, I felt satisfied with a day well-spent. Swiping my ID card to enter the Men’s changing room, I heard the echo of someone shouting my voice: “Ryan! Time to catch some babies!” Was she serious? Though my preceptor had delivered countless babies at St. Vincent’s, it never crossed my mind that I might have the opportunity to deliver one myself. Maybe because I was afraid of breaking some hospital protocol or law, but probably because I tried to block the thought out of my mind ... as an only child without a uterus, I felt like the least-prepared person for the job.

The patient was a nineteen-year-old Hispanic girl named DG. FOB (father of baby) was nowhere in sight. Soon-to-be-grandma tried comforting her as contractions intensified, but since the epidural team didn’t arrive in time, labor proved too mighty a foe. My preceptor, Phifer (Lisa) attempted to discuss pain management. . . She was quickly interrupted by DG, whose began screaming profanities so violently we expected her ribcage to pop the breast implants she received three months prior. Needless to say, Grandma left the room.

Nursing staff slowly trickled in as Lisa counseled DG, and showed me how to don sterile gear. We sat down at the edge of the bed on rolling stools; though she maintained a calm confidence, I felt horribly out of place and could feel my loose scrub top making contact with beads of sweat. Keep in mind: my last experience with childbirth was at age 5, in the Boston Museum of Science—I stumbled into a theater showing a newborn drenched in amniotic fluid, then proceeded to forcefully vomit on my best friend’s father.

Seconds seemed to inch by as hours. As she pushed down on DG’s suprapubic region, her opposing index and middle fingers entered the vagina. Finally, Lisa gave me a decisive nod and started shouting instructions at Mom. I imagined how strangely similar her attitude was to a drill sergeant, yet everyone in the room including Lisa-recognized the privilege and honor of attending this mother’s child birth.

With the “Night at the Roxbury” head motion, Lisa indicated for me to get involved. I placed my hands over hers, and as she slowly withdrew from DG, I began to feel distinct, increasing warmth—both physical and emotional.

I am the furthest possible thing from religious, but the moment I realized I would deliver a baby on my own was truly transcendent. Just as our diabetic patients experiencing hypoglycemic shock, the world seemed to blur around me for a moment—this time, however, I had no urge to vomit. (Though, as I encountered the next day, women who do not empty their bowels before labor are highly likely to push two things out ...)

Slowly, DG Jr. inched his head out, as his mom continued to shout more four-letter words than a game of Boggle. Quietly Lisa whispered directions to me about hand placement and guiding the infant’s head. A few minutes passed, and by that time DG Jr.’s whole neck had been introduced to the outside world—in what seemed like a millisecond, his whole body burst out with a strong contraction and one well-timed “Push!” My muscles went on autopilot to execute the moves I had seen Lisa perform many times—safely inching out the umbilical cord, applying suprapubic pressure to push out blood, and retrieving the intact placental bag. Meanwhile my mind felt blank, as if I didn’t know how to interpret the stimuli I was receiving.

As Grandma rushed in, the room dynamic changed dramatically; though DG was rightfully wiped out from giving birth without an epidural, she apologized to the nurses for profanity, embraced her mom, and happily received a showering of congratulations and wide smiles.

While the physical experience of delivering DG Jr. was life-changing in itself, I feel like the most important take-home from this experience was seeing just how much of a positive impact physicians can make in the lives of others. After a year of boring didactic training and rote memorization of clinically irrelevant information, seeing the room light up while a woman became a Mom gave a purpose to the med school classroom/library trudge. While humans have been having babies since, well, the beginning of humans, Dr. Phifer’s role in giving DG the most comfortable

environment possible was very inspiring. While I don't anticipate a future for myself in OB/GYN, this experience underscored the responsibility of the ideal physician- selflessness, and derivation of satisfaction vicariously from the patient's experience.

A final thought- For this entry, I had planned to write about a different experience in addition, but ended up not having enough time. Needless to say it was equally eye-opening, and unique. The attending OBI an older Southern male from Vanderbilt, who performed the C-section, perfectly described my thoughts while watching for the first time: "It's a cross between gutting a deer, and seeing God." □



Stephanie Reich

Mirror Lake

Sitting on a rock beside the lake
I looked into the water
It was still like a mirror
Didn't see the mountains rising up vertically
On all four sides
Neither the ferns, pines nor the maples
Not the pale blue sky with patchy clouds and
streaks of orange
Then I saw your face
Fuzzy first, like in a fog, misty
It became clearer, like a new painting
A soft face with eyes closed
Like a child sleeping

I then started telling my story
Little tales □ bits and pieces
Your large eyes opened up
Your ears cocked up
Everyday a story □ sometimes long
Mostly short, at times very short
Of my childhood
Of my growing up
My loves lost and forgotten
And suddenly remembered
Like a key lost and found
You listened intently
Like my infant son
When I told the same story
Of a hare and tortoise
Every day, for many days
And one day, suddenly he gave a bored look
He had grown up!

Today, I don't see your face
There is only a mask
I try to tell a story
No words come out
I make strange sounds
Like I was a mute all my life
I look up
There is a mask hanging from a tree near me

- Subramani Mani



Colima Man (Emphysema) 100-300 BCE, Cody Saxton

Thrive

by Gonzalo Bearman MD, MPH

Five AM and the alarm sounds aggressively. The neon glow of the clock gently illuminates the room giving it a warm glow. Jude searches for the snooze bar, hitting it firmly with the hope of gaining a few minutes of coveted sleep. With his wet nose pressed to her face, Rupert, a furry and overly excitable bijonfrise, nudges her repeatedly. Additional rest seems remote.

Jude watches the soapy water pool at her feet in the shower. The simple action of applying shampoo to her hair is oddly challenging as the warm water fails to revive her. Jude's mind drifts. It seems like not long ago she was in Colorado, having moved there with a group of friends after graduating from college. The menial jobs in ski resorts, the late nights out, the constant string of roommates always seemed transitory, so it was no surprise when she returned home to seek a nursing degree.

As the shampoo slowly rinses from her hair, her thoughts flow. Nursing was not only a steady job but an ideal, an opportunity to alleviate pain and suffering, to experience the human condition and to feel valuable. "Isn't this what I always wanted?" The answer seems less decisive. The side effects of innumerable twelve hour shifts with barely a lunch break, an understaffed ward, and a unit manager who is perpetually disconnected from the staff are eroding her alacrity.

The walk from the parking deck to the ward seems interminable particularly in the dark, misty winter morning. Arriving partly winded and with a damp chill, a sinking feeling sets in after an initial glimpse of the activity on the unit: patient transportation delivering a new admission, hospital security officers at the end of the hall attempting to calm down an unruly patient, and an urgent electrocardiogram for a patient with chest pain.

"Jude, you are in charge today" greets Emma, the nurse manager. "Sorry about the short notice, but Dana called in sick. I know that I can count on you".

"Sure," she responds with a tone of voice that wavers between acceptance and annoyance, afraid to delve further into the issue as the manager, albeit friendly, has a reputation for intensity and overreaction.

The patient mix varies little and Jude's challenge is to distribute the patient load evenly. With the ongoing staff turnover, she is pressed to match the patient with the caregiver. Seemingly, every other month a new nurse is hired, typically fresh out of nursing school. Rumors have surfaced in the break room that 'so and so' is looking for a new job, or that 'so and so' is taking Xanax to push through the day. Driven by an innate sense of conflict averseness, Jude delegates the patient assignments efficiently while avoiding eye contact.

The patient care mobile phone rings. "Yeah, I need my nurse" a woman's voice impatiently demands.

"Just a moment," Jude says, "I'm in the medication room getting pain meds for another patient."

Tonya is a young mother of two, from the city's underbelly, diagnosed with HIV and with a poor record of medication adherence. After nearly 17 days on the unit she has managed to alienate nearly all the nursing staff with her incessant demands, periodic refusal of medications and harsh tone. A mood of rebellion and denial exudes from her room.

There is silence for a moment followed by "my IV has been beeping and ain't no one doing anything. I called and no one cares".

"I am sorry, Tonya, I will be there as soon as possible" she responds fearing that her tone of voice may sound aggressive.

Jude diligently punches in the codes for access to the medication cart, but midway through the routine task her attention is broken. "Jude to the nurses' station" she hears through the glass door of the medication room. "Unbelievable," she whispers, "not a moment to focus."

She recalls how not long ago, there was much fanfare with the opening of a new acute care hospital. A state of the art building brings highly advanced patient care. Looking at the glossy floor she feels eerily disconnected as the bed expansion has merely resulted in increased patient volume. In an



Alan Vinci

environment plagued by understaffing and rapid patient turnover, Jude feels paradoxically more distant than ever from the patients.

After orienting the new nursing students, several of whom seem overenthusiastic, Jude takes the plunge into the recessed corner room passing the medical team as they emerge from the back, the typical banter between team members is absent as they stride down the hall, eyes transfixed on the medical records glowing from their tablet PCs. Unlike the halls with the bright light and predictable prints of French impressionist masters on the wall, Tonya's room contradicts this perfection. Despite the expansive hospital room with modern décor and large windows, the lights are off and random belongings clutter the room. The television gives the place an eerie glow and gently illuminates a thin, frail figure sitting in bed.

"You here to yell at me too?" says Tonya " 'cause Dr. Stewart and his team just left, and they makin' it sound like it's my fault and all that I am so sick. "

"No, you rang out for me about the IV pole beeping".

"Yeah, that was an hour ago!" she tensely responds. "Where you been? I unplugged the machine myself, damn" she angrily says, flicking on the light in the room, revealing her

protruding collar bones and sunken eyes. The direct gaze is piercing, making Jude uncomfortable and tightly pulling at her guilt strings. Although not the first time assigned to Tonya, these recurrent bursts of hostility still impact her with the same weight.

"I am sorry, I've been tending to tasks non-stop" knowing full well that the answer rings unconvincing. "Are you okay? Is there anything else that I can get you?"

"How about some new doctors. These ones seem to know it all!"

The patient care mobile phone rings again. Jude silences it, sparing herself the obligation of responding for a brief moment.

"They don't understand. They think that I just do this to myself as if I am some sort of troublemaker" bursts Tonya, with tears welling in her large eyes. "Like it's my fault that I got infected. It wasn't me who was shooting dope. My boyfriend ain't ever told me that he got AIDS."

Jude approaches the bed and reaches down to mute the television on the remote control, she adjusts the bedside recliner and sits on the arm in silence.

'Now he's gone and what am I supposed to do? My mother got mental illness and my Dad's an alcoholic. He be askin' me for rent money and be commentin' how I look thin and all. If he finds out that I got that 'disease' then he will kick me out of the house. How am I supposed to take all those AIDS pills with him snooping around?"

"Do you have other family to turn to?" Jude asks.

"I got a grandma about an hour away, in the country. She don't know my status, she don't even know I'm here. I am afraid that if my people find out, they gonna take my kids away from me. How am I going to make it? I had plans for my life once." In the span of 20 minutes details of a hard life on drugs, unplanned pregnancies, missing father figures and broken dreams are revealed. Jude utters nearly no words during this encounter, she sits on the arm of the chair, gently leaning in the direction of Tonya, overcome by the recounting of events. Silence ensues. With their gazes fixed on the misty morning as it envelops the bedside window, both are in thought. Although worlds apart, they are connected by very disparate yet strained realities, each similarly longing for purpose and seeking to survive.

The electronic ring of the mobile phone summons Jude back to the relentless grind. Blood draws, medications, change of dressings, patient baths, a dispute with bed management, a shortness of breath emergency and an unruly demented patient who insists on stealing the food off of the trays of other patients. Through the thick of it, Jude witnesses an elderly woman, a visitor with a stooped gait and tired eyes stop at the nurses' station and inquire about the room in the back corner.

Twelve hours nearly elapse and the shift comes to an end. Jude hurriedly begins the final rounds on her patients, saving the corner room for last. The room remains dimly lit and the silhouette of the stooped, elderly woman is closely seated at the bedside, next to Tonya, their thin hands lovingly intertwined.

"Jude," Tonya says as Jude enters the room, "Thank you.... for listening."

Before Jude can respond, the patient care mobile phone breaks out in its high pitched ring. She pauses, letting it ring repeatedly, then answers "One moment please." They make eye contact, having reached a new level of connectedness. A voice sounds in her ear but the words go unnoticed, her mind is elsewhere and her comprehension is acutely

altered. The "thank you" resonates beyond words. It is an affirmation of the human ability to cope, persevere, and adapt within the confines of a pressured and seemingly disconnected and dispiriting existence, it evaporates frustration and rekindles the desire to press on, survive, and thrive.

Silently Jude turns and walks to the door, pressing the phone against her ear as she slips past a moving gurney, "This is Jude" she resumes, "how can I help you?" □

"La Cabeza Fea"

Little Christina was born 4 months to the date
Growing so quickly, unwrapping her fate.
Eating so well, moving with such strength
Pooping with a force that it tests a parent's faith.

Parents are worried about their sweet Christina
"Doctor porque ella tiene la cabeza fea?"
Her head shape abnormal, very long and narrow
"Senora vamos a ayuda con todo."

We make the incision, an S-shaped curve
Dissect off the tissues from the soft spot, a swerve.
Drill down the skull on either side of the vein
Remove this fused bone, allow the skull to grow plain.

3 months later, the molding helmet removed
A normal young child, a head so smooth.
"Gracias doctor, somos muy contenta"
"De Nada senorita, este es mi vida."

- Paul Kaloostian

Valero

Late night strange places
Well lit
With no place to sleep.

Fluorescent island's highway side
Luminous havens of smokes and petrol
Look to offer sanctuary from the night.

As if, somehow, the chemical buzz
Of excited noble gas was warmth.

But these lights,
Artificial in every sense,
Produce no heat.

- Noah Cooperstein

A Physician's Prayer

If I should die before I wake,
I pray pathologists will take,
My body for an autopsy,
And tell my family what killed me.

- Kevin Patrick Vlahovich, MD



Bethany Godwin



Stephanie Reich

In Twelve Years

by Alexander Miller

In the twelve years since I first knew I wanted to be a doctor, my understanding of what the job entails has been augmented and overhauled countless times. As no surprise, this trend has accelerated since I began medical school two months ago. Each new clinical environment, each preceptor, and nearly every patient encounter shifts my expectations and ambitions in some way. But one of my first experiences providing care attuned me to an aspect of the profession that seems as fundamental today as it did then. This was in high school, when as a freshly minted EMT I treated a good friend after he sustained a serious injury while sledding one night. Though I did everything I could with the resources I had available, he died.

For some time afterward, I thought about that night all the time, turning it over in my mind, imagining all the ways in which things might have gone differently. I was preoccupied with why it had happened, or, more closely: why it had had to happen. At some point, I realized that I should stop asking this question, that there was no way to answer it adequately.

Where much of my clinical experience has shown me the collaborative nature of modern medicine – how and when control and responsibility are shared, how and when they're delegated – Eli's death illustrated how, sometimes, we don't seem to have any control at all. Plenty of times, terrible

things happen to good people, and plenty of times, as a health care provider, you witness those things without being able to meaningfully affect or comprehend them.

As much as we learn, over time, about risk factors, or genetic predisposition, or the molecular basis of aging and bodily breakdown, death and disease are never going to be fully fathomable. For every case that can be completely documented and understood in a clinical sense, there are ten situations in medicine that defy deeper scrutiny. I expect that there will always be patients whose suffering and death seem senseless to me, and that my job will always involve coping with these empty moments as I help others to cope. For me, this is one of medicine's most bewitching attributes: working on a frontier of human knowledge and experience means you have to make your way through the unknown from time to time.

One of Eli's favorite books at the time he died was *The Plague*, by Camus. It's one of my favorite books, too. As it portrays a doctor's simplicity of purpose when confronted by the impossible irrationality of mass death, the novel suggests that embracing the inscrutability of life is an important part of making it worth living. I feel similarly about medicine. If health were a deterministic formula rather than the capricious phenomenon it is, I wouldn't be making a career in its stewardship. □

Hidden

by Sean Peterson, PIE Narrative Strand

Every week continues to bring dozens of very diverse experiences, each of them priceless and educational, but they come at so fast a rate that I feel like a kid in an amusement park, whisked from one fascinating (and sometimes a bit scary) ride to the next.

On Tuesday I encountered something I didn't expect to for years. One of the first patients to come in had a mysterious cough, which my preceptor, Dr. S, chose to treat with an albuterol nebulizer. I disagreed with that choice based on the history and the fact that when I took the peak flows with her assistant, he was above the normal expected values. The nebulizer treatment ended up irritating his throat and his breathing and cough got worse. I was surprised that not only had I disagreed with the chosen treatment, but I had been right where my preceptor may have made a small error. I certainly didn't feel confident enough to voice that opinion in the moment (and as it happened I wouldn't have had that chance anyway), and for all I know that was the best way to handle the situation anyway, to take the chance that he might get worse. I don't feel judgmental in any way, I'm rather just surprised that I feel competent enough to have thought to myself that I might make a different choice from the expert, and that perhaps it would have been the correct one.

Although I am occasionally frustrated by the times when despite my persistence in asking, "Are you sure there's nothing else you want to speak about with the doctor?" it never fails that at least a couple of significant topics come up that I couldn't elicit. I completely understand, though: they really did come to see Dr. S, and she knows her patients very well, so of course they would want to share the complete story with only her.

Nevertheless, there has been nothing like these weeks to really boost my clinical persona and presence in the room with a patient. I love it when I think to ask relevant questions that Dr. S then asks the patient when she is doing her own history. It was fantastic on Thursday to have found a heart murmur I wasn't expecting to hear (although the patient immediately asked if I could hear his aortic stenosis, so I guess he knew about it from long ago), to actually have seen a clear case of otitis media when I've had such trouble with the otoscope in the past, and give the little bits of

medical advice I feel confident in telling patients myself. I even felt proud of myself simply putting on a band-aid on a patient with an abscess. Isn't it always different and better when the doctor puts the bandage on? I've always thought so.

And then again, there's the patient who has a cough and I don't even think to check his lungs; the paper I forget to put the patient's name and date on; the patient who seems really anxious to have me leave. All in all I'm really enjoying this stage of my education - though I may be the pesky medical student who seems to just be delaying the "real" visit with the doctor, at the same time I am also the medical student who does not yet need to make the critical decisions or do the patient counseling. It's kind of nice to collect all the data, give the diagnosis my best shot, but then let her take over and make the official decision. I guess I only have a little bit longer to hide before I'll be in the limelight myself with patients and nurses and whoever else looking to me to make the big decision about what to do. □



Laura J. Hall

Nightmare

Doctors said they would stop,
these witches and demons.

They told mom,

“Nothing to worry about she’s still so young.”

So young,

I know Mom worried it was the divorce.

But oh no,

it was long before that,

long before my memory even had a name.

As long as I can remember,

I’ve had these things.

These witches and demons,

plagues of the night,

filling my sleep like bees in a hive.

I wake up

a zombie.

Really, I’ve had no sleep;

just these dreams

of witches and demons and things.

Twenty years,

I am used to these things;

as is my mom

nothing new about waking up to blood curdling
screams.

But you,

my new bedmate,

are not yet used to these things.

I know,

I scare you with my screams.

Don’t worry I say.

After all,

they’re only witches,

demons,

and things.

- Victoria Lucero

Not Today

by Mae Brown

It's 4:30 am. The year is 1985. The earliest slivers of light shine through the sun porch windows as the sun rises like any other day. My patient would have probably been sleeping soundly in her bed at the convent on any other day, but not today. She would have woken up, showered and donned her traditional wool habit in preparation for her day, but not today. The sun porch in which her bed lies was converted to a 7-bed medical intensive care unit (ICU) several years prior in this Catholic hospital. Thankfully, they left the 15 foot-tall windows in to let in the light. Once upon a time the windows opened but they don't allow that anymore, not today.

Today she lies unconscious, her frail body stiffened with abnormal posturing, her eyes open and her gaze askance. Today she looks grotesque with her swollen head and wild grey hair. Her mouth is distorted from her breathing tube and saliva runs freely into the pillow case cover. The ICU is a stuffy place, and cramped. Only curtains separate the six beds. The air smells putrid, a mixture of solid air freshener, feces and infected urine. The nursing desk was in the middle of the room and even though the other nurses were talking softly, it could be heard all over the room. The hiss of ventilators and monitor alarms added to the cacophony of noise. Near her bed there is a familiar metallic odor that all multiple trauma patients have; the smell of blood. It is time for the morning bath, and I dread it because just turning her elicits a cascade of responses and none of them are good. Her face contorts even more and her wrists bend as if to break. Her skin becomes slick with perspiration and her heart races madly. My heart races madly too; I'm frightened. I'm a new nurse, and very new to the ICU. The senior nurses don't seem to be bothered; two of them play cards at the desk. I am offered help with the bath and I agree to call when I need help. I pull the curtain around and begin.

I breathed in over the sudsy warm water in the bath basin and relaxed a little as I began her bath. By shift change the Sister was washed, powdered, and combed. I tied her long grey hair with the cloth ties we used to secure endotracheal tubes. I wanted her as presentable as possible as her biological sister was coming today. I knew if the way she looked frightened me, then it would surely be frightening to her sister.

I was not aware that there was an ethics committee established in our hospital. The concept of moral distress was in its infancy. The neurosurgeon responsible for my patient's care wrote in her progress note, "Due to legal implications in this case, this patient is denied the right to die with dignity." The Quinlan case and resulting Supreme Court decision had established do not resuscitate laws in 1976 but in my hospital they were used very seldom. In this circumstance, our legal department advised against withdrawal of life support due to potentially interfering with a vehicular homicide charge against the driver (The Sister had been a passenger on a bus that was struck by a drunk driver).

It is very emotionally difficult to care for a brain dead patient and most of the nursing staff refused to do anything they didn't have to. Suctioning, turning, bathing, were viewed as futile by most of the nursing staff. She was cleaned only when she became odorous. Some nurses refused to take her as a patient at all. I suspect that many found it eerie as I did. Still, I cleaned and cared for her, mostly without asking for help, because I didn't want to hear them say "Why are you doing this?" It all seemed so tragic and undignified. As a nurse I was taught to be matter-of-fact. Nothing in my training had prepared me for this. My patient had a severe form of whiplash, similar to shaken baby syndrome. The inner lining of both vertebral arteries were torn from the shearing force, and within hours both vessels became completely occluded. A cerebral angiogram showed no posterior circulation to her brain. After several days of absent reflexes, fixed dilated pupils, and no response to any stimuli, the hospital's legal department finally allowed withdrawal of care for brain death. By the time the decision was made to remove the breathing tube and withdraw care, everyone, including her biological sister, was relieved. □



Kevin Vlahovich

Week Four

by Katherine Schultz, PIE Narrative Strand

We hear a lot about how this process dehumanizes us, about how the grueling hours, the hard cases, and the difficult situations cause us to become closed off, separated from our empathy and our emotions. It is the doctor's defense mechanism. I am sure the process takes time, because no one just wakes up one morning having lost their empathy, but it is hard to see now how I can lose my compassion.

Working with people and for people is a large reason many of us have gone into medicine, and finally being in a clinic is a fresh reminder of that. What's more, talking to these patients is really eye opening. It can be simple to view a person as a set of symptoms and diseases, to forget to look at them and see something more than a pulse and temperature. If you talk to them, however, and listen, really listen, I think that difficulty vanishes.

Every person is a wealth of knowledge and experiences you have never had, and more than anyone, he will know if something is wrong with his body because he is with it all the time. More importantly, he will tell you, though it may not be verbally, if something is wrong: if he is depressed, angry, anxious, frightened, or tired. He will tell you that his spouse of sixty years just died last May, or that his best friend from high school just developed cancer; he will tell you about his child getting married and the birth of his first

grandchild. He will, if he trusts you, open his heart to you because he needs that comfort and that interaction, because he is sick, and sickness is not always of the body; it can also be of the mind, and you may be the only person who can help him with his sickness.

So yes, it is easy to become overwhelmed and overworked, so much so that your head feels as if it might explode, and you may not want to take the time to talk to someone, to empathize with him. But if you do, if you take just a moment to really be in that room with him, you might impact his whole world, and that is what makes the stress worth it. I am lucky that, so far, I have had a patient every now and again to remind me of this, to make me sit down and take a deep breath.

It made me realize that the kind old woman, childless, who was smiling and patting my hand was also terribly sad for having just lost her husband, and, more than a blood pressure check, she just needed someone to acknowledge her grief. Even though we are forewarned about losing our compassion and our empathy, even though we may think it will never happen to us, the fact of the matter is, we can only avoid it if we actively seek otherwise; maintaining our empathy is not the feat of a moment, but the continued safeguarding of a lifetime. This is what I learned this week. □



Alan Vincioli



Mary Ellen Ipiotis



Cindy Garcia

On the White Coat Ceremony Greetings to the Class of 2016, the 49th Class to Enter UNM's School of Medicine

by Jonathan Bolton

You are about to go through the White Coat Ceremony. Anthropologists call it a rite of passage. You will have gone through other rites of passage in your life: confirmation or Ba Mitzvah, Quinceañera, high school graduation, 21st Birthday, perhaps a wedding. Rites of passage demarcate and keep separate different phases of a life. This ceremony marks a break in time, a break in your life course. It marks the end of one phase in your life and the beginning of another phase. Who you are, your self-identity, your social status is changed in some ways by this ceremony.

Yesterday, you were college students, perhaps nurses or EMTs, maybe research assistants or researchers. *Yesterday*, you could sleep in and you had summers off.

Today, you are publically recognized as medical students. Your family and friends are here to witness it. Your parents are so proud. From now on you will know and be known to have been admitted into medical school.

Through this ceremony today you are publically making a statement about accepting the responsibilities that go with first being a medical student, and then with being a physician.

You are not asked to take the Hippocratic Oath. Despite what you might have heard, the Hippocratic Oath has a confusing history. It is not clear that it was among the original Hippocratic writings.

The Hippocratic Oath asked a number of things of the initiate that sadly seem to have gone out of favor. For example, one part of the Hippocratic Oath asked the initiate to agree to give his teacher money when he needed it, to teach the children of his teacher 'without fee or indenture', and to support the teacher in his old age. Oh well... It lost its popularity in the late 19th century. In 1928 only a quarter of medical schools administered the oath.

Instead of the Hippocratic Oath, you are asked to commit yourself to the Physician's Oath, or the Oath of Geneva. This oath emerged from the discovery of that physicians had participated in the Nazi atrocities. It was adopted by the World Medical Association in 1948 and is now widely used as part of the initiation into medicine.

Tomorrow, and especially on Monday, after you have taken this oath, you will be different. What is on the other side of this ceremony? You will start your training. I think the mysteries of the Anatomy lab awaits you.

Over the next four years, you'll see and hear things that are not allowed to other people. Your training will be physically and emotionally hard at times. Your training will change you. There may be times when you are not happy about some of the changes you notice in yourselves and your colleagues. However, your training will not change the fundamental goodness that your family and others sees in you. But the world will become even more interesting, even more enchanted as you start to see the world through a clinical lens.



Cindy Garcia

Medical school has one more R than primary school; it's the biggie.

Reading

You're going to do more reading than most of you will have ever done. Medical books are not known for being slim.

You're going to learn to read EKGs, MRIs, CTs, lab results, ultrasounds.

The most amazing thing you will learn to read is the human body: you'll learn names for parts of the body that you didn't know had names. You will learn to see, hear and feel signs of the body's illness—directly, with your own eyes, ears and fingers.

'Riting

You're going to learn how to write history and physicals (my first one took me literally 24 hours—something I can now do in a few minutes.

You'll learn how to write a case study. You'll learn how to write a prescription. Some of you will learn how to write a grant proposal or a research protocol.

'Rithmetic

You're going to learn how to calculate medication doses, BMIs, fluid replacement, electrolyte repletion. You'll learn about pharmacokinetics and biostatistics.

Responsibility

The fourth R, Responsibility, is the biggie.

Responsibility fundamentally means caring—caring for and caring about. You are about to move from being an amateur carer to being a professional carer. If you are parents you are already well used to caring, but this will be different. You will be caring for people who are not part of you, who may not seem to know what to do with your caring, and who you may meet for brief moments. Before medical school you didn't have to care; by entering medical school you are now expected to care.

We hope that our selection process has kept out those who really don't care about the things doctors are supposed to care about. We hope we have done this job well because, and this might surprise you, we don't have a way of making you care if you don't. We can't argue you or

‘teach you’ into caring, really caring. We can make it so that you learn to act as if you care, but we can’t do more than that. Caring has to come from within you. Aristotle wrote that the more you try to care the more you will care.

We can model for you how to care for people, what to care about, and we pledge to do that. That said, you will meet doctors who seem to care more about money, status, the good life than about quality of care, empathic support, and helping people to decide what they want. This means you will have to choose your role models well. And in case you didn’t know it already, House is not a good role model.

Back to today. The Geneva Oath you are going to take today and the UNM School of Medicine Code of Conduct that you have already signed describes some of the people you will be expected to be responsible to. We ask you to demonstrate in your day-to-day interactions the virtues of altruism, accountability, excellence, duty, honesty and respect for others. In short, we ask you to care.

The primary person you will be expected to care about is your patient. I think we do a pretty good job showing you how to care for patients; perhaps not so well at showing you how to care about them. You are also agreeing to be responsible to, to care for and care about your teachers, your colleagues, your team-mates in other professions, your profession, your institution and your community.

Hopefully, you won’t feel alone in being responsible, in caring. We are all in this together. We can help each other.

It is good to have you with us, and we look forward to having you as colleagues a few years from now.

Congratulations and welcome. □



Stephanie Reich



Laura J. Hall

Decrescendo

by James Besante, PIE Narrative Strand

I met Silvia the day she died. I knew she was going to die and so did everyone else, but Silvia didn't know she was dying.

At 5:30 pm after a long day in clinic I was asked to accompany my attending physician to visit his old friend in a long term care facility near our office. I accepted the offer and on the way I learned Silvia's story. She was an accomplished musician, teacher and host of a local classical radio show. Several years earlier she was diagnosed with cancer, which she fought valiantly into multiple remissions. With no living family, Silvia's friends had assumed care for her after a recent transition to hospice.

When I walked into Silvia's room I was greeted by two of her friends seated at the foot of her bed. My presence was announced and I tried to make eye contact with Silvia as she looked past me.

My attending began his physical exam. As he removed his stethoscope from Silvia's chest he paused. A few minutes passed and then he turned to address the room. He said, "There is another pneumonia." He then turned back to his semiconscious patient to deliver his diagnosis. "Silvia, your pneumonia is back... Should we treat it?"

The battles with her illness had taken their toll on Silvia's body, which now lay emaciated and diminished, but her fighting spirit remained unscathed. She responded with a resounding "Of course!" The room shuttered. My attending

looked at Silvia and said, "I think this may be the end of the road and I would prefer not to pump you full of antibiotics." After a long and difficult conversation, the room was full of smiles as Silvia announced, "Folks I think I'm going to check out of this place." The room laughed with her. Silvia passed away two hours later surrounded by her friends who played one last violin concerto.

When I think of medicine, I think of healing the sick and prolonging life. Silvia taught me that physicians preserve not only life, but also dignity. □

Tremors

An eye surgeon's hands begin to shake.
No longer able to operate,
he sees office patients each day -
his work is useful.

Her head vibrating, a woman feeds pigeons
on the courthouse steps.
Lawyers rush past her, then briefly slow down -
her work is useful.

A man can't balance
on the high girders anymore.
Legs trembling, he drives a forklift -
his work is useful.

A woman writes lines of prose and poetry.
Each morning, quaking, once more
trying to convince herself, she opens her journal -
her work is useful.

- Jeanne Favret

Finally Real

by Umar Malik, PIE Narrative Strand

Mrs. T grabbed me in the hallway as I walked out of a patient visit. “Excuse me, are you the new doctor here?” I shook my head, “I’m a medical student working with Dr. S.” “Oh, yeah! He’s the one I need to see. Can you tell him I need to talk to him after he’s done with this patient?” “Sure,” I responded, “did you already sign in for your appointment?” “Oh no,” she quick replied, “I don’t have an appointment scheduled to see him until later this month, I just really need to talk to him.” I nodded my head and agreed to let him know once he was done seeing his patient.

As I walked back to the room where I had just seen my last patient, the nurse handed me a note from Mrs. T’s previous provider. It stated the need to get Mrs. T off of pain pills immediately. She had recently been caught filling prescriptions at multiple locations in Grants, Albuquerque, and other areas. The last sentence of the note particularly caught my attention; “Patient is opioid dependent and must be tapered off of opioids in the near future. Requesting transfer of care to oversee this process.”

Dr. S walked out of his last encounter just then and I handed him the note. “Mrs. T is here to see you, she doesn’t have an appointment, but she says that it is really important.” Without any hesitation, he walked out to the waiting room and called her in. We sat down in the exam room, or as Dr. S calls it, the “living room” due to the many Native blankets and pottery he has placed around the room. He placed the note I had handed him face down on the desk and looked straight at Mrs. T without reading it. “So, tell me what’s going on,” he said.

I had already played out the visit in my mind. She was going to come in here and try to get another prescription that she could go fill somewhere else. New patient, new provider, history of opioid dependence; it all made sense. I figured Dr. S thought the same. Mrs. T slowly began explaining why she needed pain pills to help control the pain in her ankles for the past 9 years. As she spoke, my mind jumped back to a patient who had spoken to our med school class during first year. She had the same story, and I remembered her explanation of how easy it was to get new prescriptions from new providers. “This is the same exact thing,” I thought to myself.

Yet throughout the visit, Dr. S had not interrupted her once. He just nodded his head and listened to her story. I don’t think I’ve ever met a physician who would spend time with a random walk-in on a day when he had several scheduled appointments to still see. That alone, was a reflection of his integrity and compassion as a healer. He sat and listened to Mrs. T until she was done. Then, he asked her if she had ever thought about coming off of the pain pills. I knew the answer, “of course not, she came in here practically begging for more pills.” Mrs. T looked down, and after several minutes replied, “yeah, I don’t want to be on these pills anymore. I just can’t do it. My kids are growing up and I need to be there for them. I can’t handle it anymore. I want to get off them, I really do.”

I was stunned. There was a quintessential silence in the room. It was clear and vivid and yet, it was as loud as silence can be. Because as I looked up at her, I saw years of pain and days of struggle pour out of her eyes in the form of tears. Those tears spoke louder than any words could have described. Each one dripping away the feelings she had kept hidden for far too long. How could I have been so naïve in categorizing Mrs. T as any other opioid dependent patient I might see? How could I have judged her as an addict and underestimated the true feelings she carried in her heart? In that moment, she was my silent professor, and she taught me a lesson of understanding I will never forget. She wasn’t an addict. She was a mother, a wife, and a daughter. She was more than a patient in our clinic. In that room, perhaps for the first time in her life, she was treated as a human being. She was real.

Yes... she was finally real. □

It is All Marx's Fault

by Aroop Mangalik, MD

He has been blamed for so many things, events and ideas why not a few more. At 193 he has broad shoulders and can take it. He has been blamed for changing the life and style of the mill owners in Manchester. The fellows were forced to increase the pay of the workers in their mills! It cut into their ability to have lavish balls and take trips to Paris.

But what he did to the Tsar's is really shameful. Here was a family going for generations just living their life. St. Petersburg was cold, they just warmed up their life with some good food, a few parties with vodka and caviar, and they needed a place to live so they had to have a palace. It is Marx we have to blame for all those wonderful things being brought to an end.

It goes back further. The Pharaohs loved beauty and they wanted to be comfortable and safe and well placed when they moved on to the other world. To do that, they needed big structure, jewelry, food and above all companions. So they did what they needed to do. They had their soldiers fight a few wars and collect a few hundred thousand slaves. The slaves needed to be kept busy, what better job than to make them dig some stones a few hundred miles away. Shape the rocks into blocks of a few tons. Move them to the Nile Valley and pile them into a structure a few hundred feet high and a few hundred feet at the base. So some of the slaves died of starvation or injuries but a structure was built that thousands of years later thousands come to see and admire. It was then ready to take them to the other world. Nice chambers with thrones and jewelry and the best wines and food were readied for the journey. And of course, they had to have their family and servants and slaves there to keep them company and take care of them in the afterworld. They all were happy to be with their master and king and god in this world and to go to the afterworld with him.

Nobody had a problem. That is the way it was. Then came Marx and started telling everyone how unfair it was, how the slaves should have been taken care of, how instead of building pyramids they should have grown food for the people. He just ruined it for those who enjoyed the beauty, admired the skill of the engineers and were in awe of the power and ambition of the great Pharaohs. Yes, he ruined

it for all of us by making us think of those slaves and taking away our joy or at least putting a damper on it.

Whether it be the wall in Northern China, the Cathedrals and temples and mosques or the Taj Mahal, he made us think differently about them.

The powerful men in Europe needed more money to enjoy life. He had made them poor by making them pay higher wages to the mill workers. So they needed to find other ways. There were all these people in Africa, and Asia and South America who were just sitting around doing nothing. These men of power and ambition and desire found a simple solution. They took over the land and people of Africa and Asia and did something with it. They built nice houses and palaces, collected art and jewelry, paid musicians and singers to entertain them and we now had a thriving culture in Europe. Intellectuals, progressives, thinkers and scientists had a good life too. No matter the progressives did not want the women to vote or the poor to have a fair deal. No matter the scientists put in a lot of effort to build a war machinery. Yes, it was a good set up. Then came Marx He wanted everyone to have a house, everyone to eat enough, everyone to have a fair share. He ruined a system that had been going for a long time.

Some of his followers wanted to push the Europeans out of Asia and Africa. Some of them asked the peasants to kill the Tsars and the lords who had been taking care of the poor for centuries. He ruined a time tested system.

What did it do? It just upset the successors of those who were hurt. As expected, they reacted with more force on the poor and on the people of Asia and Africa. Some in Africa and Asia joined the Europeans. So we have more power for a few and less food, less comfort for more and more people.

Yes, it was all Marx's fault. □

My Privilege

by Melody Childs, RN, BSN, MS

Coffee dripped into the glass pot. The aroma was better than the taste. I looked across the table at Lynn, who was giving me the report. She asked, “You have Mrs. Martinez?”

When I nodded yes, she warned, “She’s emotionally draining.”

“Why?”

Lynn shrugged. “She wants to die she just lies in bed with her hands folded, waiting.”

“Is she that close?”

“Not from what I can gather. As soon as her chest tube is removed, she’ll go home to hospice.”

Entering Ms. Martinez’s room a short time later, I introduced myself to a middle-aged woman lying on her back, one hand tucked beneath her back, one hand tucked beneath her limp blond hair. She stared dully at the ceiling. The window blinds were closed, even though her room had an impressive view of the mountains.

“Would you like to see what it’s like outside?” I asked.

She shook her head.

“If I can get you anything, let me know.”

Ms. Martinez turned her face away.

“No, nothing” she said. Her voice was soft, with a faint Appalachian accent. She looked like a woman who’d struggled her whole life to eke out a living and wasn’t sure why she’d bothered.

When I checked on her an hour later, I tried to spark a conversation. But she shifted in bed and turned away from my voice.

As I left the room, I felt my energy fading. Lynn was right; she was emotionally draining.

I reviewed her chart for some insight. It revealed the cold facts: “49 years old, female, high school education, convenience store clerk, divorced twice, recently remarried, three children, positive smoking history, 35 years. Thoracotomy performed with diffuse adenocarcinoma, wrapped around pericardium. Inoperable.

Just then, one of the surgical residents came down the hallway. I asked him if Mrs. Martinez was likely to die soon.

He looked puzzled. “Soon? Well, her prognosis is poor. She has maybe three to six months with radiation.”

“Donna, I Love You”

When I brought in the lunch tray, her husband sat by the bed.

Rubbing her forearm with his fingertips, he said in a soothing tone, “I want you to eat everything. You have to get your strength up and come home.”

With his help, I got her up and into the chair. He brushed her hair back while I took her vital signs. Then he began feeding her with one hand and stroking her arm with the other. She leaned back in the high-backed chair and I heard him say, “Donna, I love you.”

“Me, too,” she said. Glancing up from my chart, I thought I saw the hint of a blush in her cheeks.

Respiratory Distress

An hour later, as I was doing some charting at the nurses’ station, a nursing assistant rushed toward me. “Melody, could you check on Mrs. Martinez? She’s having trouble breathing.”

I found my patient taking rapid shallow breaths. Her husband was gone. After we got her back to bed, I called respiratory therapy for help and increased the oxygen flow rate via nasal cannula to four liters/minute.

I put a pulse oximeter probe on her index finger, the monitor flashed 82 percent. By the time the respiratory therapist

arrived, the Spo2 was dropping and Mrs. Martinez's nail beds had turned violet.

"Your hands are so cold; I'll put the sensor on your ear," the therapist explained to her, "We'll use this mask to help you get more oxygen." Even with the flowmeter cranked up to 10 liters/minute, Mrs. Martinez continued to gasp for air.

I nudged the therapist and pointed to my patient's red do-not-resuscitate bracelet. We nodded to one another, and she gathered up her case and left.

The pulse oximeter now read 70 percent. I disconnected the probe and shut off the machine.

Mrs. Martinez's eyes darted back and forth. With a frightened expression, she grabbed my hand.

"Oh God, I wet the bed."

It's odd how one statement can predict the future. This woman I barely knew was going to die. She was going to die with me alone, in this cool, dark, room. There was going to be no reprieve, no backup.

I kissed her on the cheek and told her not to worry about the bed.

"I'm so cold," she said, her teeth clattering.

I wrapped her up in her robe and the only extra blanket I could find. The linen closet seemed a continent away and I knew I couldn't leave her.

Her arms were flailing and her pursed lips opened and closed with little puffs. Then she reached up and touched my face gently. "I'm not going to make it, Melody, am I?" I didn't realize she'd even remembered by name.

I couldn't lie to her. My answer was in my silence.

I knelt on the bed and put my arms around her. "I'll be here, Donna," I promised. "I'll keep you warm." I wanted to do a body fusion, to somehow let my 98.6 degrees penetrate her frigid skin.

Her respirations had become even more loud and labored. I felt her nails digging into my back. I knew she was slowly suffocating, and I hated the idea that she was fighting for air. I thought about those CPR films and how long it takes someone to expire.



Jeanne Favret

"Donna, squeeze me. I'm here," I whispered. "I've got you." But, I was thinking, God, let her die quickly. Don't let her suffer.

I felt her arms loosen, but I still held her close. Now all I could hear was my own breathing. Her face was still and gray, and her pupils were so large that her brown eyes appeared black.

I tucked the blankets in and felt for a pulse, although I knew I wouldn't find it. I called the resident to pronounce death.

Camaraderie Among Nurses

Nurses from both the day and evening shifts consoled me and offered to help with my other patients. I was grateful for that camaraderie among nurses.

As I completed my charting, one nurse, Karen, asked me what had happened. I told her the whole saga, sparing no detail.

“You know, Karen,” I said, “I guess I’ve been lucky up until now. I’ve had patients die in their sleep or found them dead a short time after repositioning them. This was the first time I’ve witnessed a difficult death. She struggled. All I could do was hug her and tell her that I was there. I don’t think I did much.”

Karen reached over, squeezed my arm, and handed me a tissue. “What counts is that you were there for her. Her husband couldn’t be, but you were. My mother died with no one to hold her. You were privileged.”

“Privileged?”

“Yes,” she said, “Like when you’re present for a birth, you’re privileged to be part of someone’s death. To be there for the transition.”

I mulled over her words as I finished charting. I’d gone into nursing for many reasons, but being part of someone’s death hadn’t been one of them. On this day, that changed.

Witnessing the death of Donna Martinez hadn’t been easy, but it was something I’d never forget. It was the most intimate experience I’d ever had.

It had been a privilege. □

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Teotihuacan Warrior 400-650 BCE, Cody Saxton

Variability of Practice, or “How could the Blind Lady See Blood in Her Stool?!”

Week 3

by Ryan Mals, PIE Narrative Strand

Yet another week in paradise, it seems. After hitting the three-week mark, I figure it is appropriate to reflect on my time in Santa Fe from a “bigger-picture” perspective. Since my days as an undergraduate, I have cultivated a deep love of psychiatry, and were I to choose my specialty tomorrow, I would undoubtedly pick that field. Nonetheless, seeing such a different perspective on primary care as is the case in Santa Fe has forced me to rethink my options and reevaluate the possibility of entering a primary care field. In this entry, I would like to discuss some of the lifestyle choices and “day-to-day” aspects of working in family medicine, with respect to both the attendings and Santa Fe-based UNM FP residents. I will admit I titled this entry so as not to forget a patient quote from this week, which is now infamous among the UNM residents.

My second week in Santa Fe, La Familia Medical Center (preceptor’s home base) began a clinic-wide transition to EMR. Though the change will surely confer an improved workflow and better care in the future, the first two weeks transformed the Provider Dictation room into Hell on Earth. To offset the system’s learning curve, doctors were only scheduled for half their regular patient load. This seems like a great administrative accommodation until you realize:

- Providers there are not salaried, and pay is low to begin with (it is a sliding-scale model).
- Most physicians are under 35 and still have insurmountable loans to chip away at.
- The clinic’s internet connection empirically does not have enough available bandwidth to maintain the EMR’s server-side infrastructure.
- “Physicians are not allowed to prescribe benzodiazepine to each other.” (- a disappointed resident..)

As a child of the Information age, my first steps were towards the computer; at the age of ten I built a working Windows 95 PC out of recycled hardware and scrap parts in wood shop. Naturally, it was easier for me to grasp the layout of their EMR system, and I could use it functionally during patient interactions. While most providers faced a

steep learning curve I did not understand, I realized a bigger issue at play. Despite having gone through at least twelve years of higher education, the daily lives of these La Familia doctors were essentially dictated by their boss in a separate Administration building. Our typical portrayal of the modern doctor (perhaps biased among med students) exemplifies self-reliance and the ability to thrive independently. After witnessing the devastating effects of implementing an EMR at La Familia, I no longer believe this to be true. Most physicians were forced to take on extra hours and would often remain 4-5 hours late to see more patients during the day. Having a physician for a father, I would like to think my perspective on a physician’s day-to-day life is somewhat realistic; the effects of La Familia’s EMR implementation lead me to a more cynical outlook.

That being said, just as each clinic or hospital location operates differently, medical specialties vary in day-to-day lifestyle and quality of life. Too often, I believe, this crucial detail is overlooked by eager, idealistic med students ... Thus they opt for “glamorous” specialties like general surgery, without considering its staggeringly low satisfaction rates (available on Medscape) and poor compensation. Though I am currently just a second-year, I am trying to expose myself to the lifestyle of various specialties as well as the content and scope. There’s little time before choosing a residency, but I hope with this approach I may have a better chance at discovering the field that matches me best.

Three weeks in, I must admit that Family medicine has almost won me over as much as psychiatry. I honestly love the wide variety of patients, continuity between hospital and clinic, and satisfaction conferred by patients’ improvement—not to mention the fun things like basic surgical procedures and deliveries. Not to mention, the family docs I’ve seen do a little bit of psychiatry with all their patients (hence the title, a woman who profusely complained about “seeing” blood in her stool until a resident pointed out she was completely vision-impaired).

Though I expected primary care physicians to be less satisfied overall with their jobs (as is reflected by the same

Medscape surveys cited above), the ones at this Santa Fe site are extremely enthusiastic, dedicated, and exude a deep commitment to both their patients and the field at large. Spending time in a location such as this has been truly inspiring for that reason. Thus, quite a double-edged sword: I've discovered something I do really enjoy day-to-day, but it will make it harder come the Match when I can't definitively choose psychiatry ... □

Through the Nose

Young Hispanic woman presents to the clinic
Eighteen months of headache and eye pain so quick.
Sent to the scanner, the problem is found
Such a demon in the brain with area to grow so proud.

Call it a planum meningioma, small yet fierce
Causing her symptoms, shedding her tears.
"I just cannot live knowing I have this tumor,
Doc take it out, I want to be free forever."

"Lisa, I will gladly, remove this strong beast
Need to discuss a method to approach the feast.
I recommend going through the nose
Sounds so scary, but direct access, no tolls."

Pin her head, navigate through the brain
Place the camera straight into the nare, insane!
Remove the tissues, forge straight ahead
Tumor is right there, stealthily move without lead.

Tumor is all out, the patient is well
All through the nose, a procedure so swell!
"Doctor, thank you, for removing my tumor
All though the nose, an amazing skill, no rumor."

- Paul Kaloostian

Phoenix

I was minding my own business
Soaring above the clouds
Singing love songs
Doing cartwheels
Letting my hair blow wild

Enemy fighters attacked me from behind!
They swarmed in and surrounded me
Bullets flew every which way
I couldn't deflect them all
One ripped right through my heart

The enemy saw I was wounded
Saw the sky right through my chest
The blood in trails, marking my path
An easy target, they buzzed around me
Teasing, tormenting

They took out my wings,
Couldn't stand to see me soar
First the right, I spun wildly
Then the left, I plunged toward hell
They weren't satisfied until I was a smoking ruin.

Long before the smoke cleared
I rose up from the ashes
New determination, better armor
My enemies will never have me
And they don't know what they're missing.

- Mae Brown



Jeanne Favret

Graduation Address to the Physician Assistant Class of 2012

by David A. Bennahum, M.D.

First let me thank Cheri Koinis, Kathy Johnson and the other members of the faculty, the staff and the students and your families for inviting me to help celebrate your graduation and for the welcome from you that I have experienced over the past year. On Tuesday it was exciting to hear the high quality of the research theses that members of your class presented and that I believe reflected so very well on each of you.

Most especially I would like to thank Dr. Norman Taslitz for inviting me to speak to you at this special moment in your careers. One must always be careful to avoid him as his welcoming smile and casual invitations, such as “Oh David are you free on August 11th”, lead inevitably to unexpected consequences! In truth it is a great honor to be asked to think and speak about the meaning of what you as individuals or as a group have and can accomplish. And what you have each accomplished in coming to this day is extraordinary not just for yourselves, your families and your friends, but also for the thousands of men, women and children that you will help and care for in the years to come. So the question arises how can you best achieve the goal of being

the best that you can be? In trying to answer that question I thought that I would concentrate on the concept of Clinical Judgment and the Ethics of Medicine.

You are entering the profession of medicine at a critical moment in American Health Care. Will we as a people and we as a profession, come together to accept our mutual responsibility for Distributive Justice? Although the final outcome remains somewhat tenuous and there will be many problems to resolve, the outlines seem to be clear that after a century of national equivocation, we as a nation seem to have finally begun to piece together a system of universal health care, the last nation in the developed world to do so. We should not forget that Chancellor Otto Bismark of Prussia, no liberal he, introduced worker insurance in 1885, New Zealand had universal health insurance by 1900, Great Britain a modest plan by 1905 and full National Health Service after 1945. Even Taiwan and Switzerland, after great hesitation, introduced universal care in the past 15 years, and that some 27 nations have longer life expectancy, lower infant and maternal mortality, less adult morbidity and lower adult mortality rates and all at less cost than does the

United States. Yes, foolishness, ignorance and self-interest may yet abort our national accomplishment, but I prefer to be an optimist, because there is no other way to bring down the cost of health care and to make it just and fair than to initiate a universal plan. I will not burden you with my personal views on for profit health care other than to say that profit and competition have never been an engine of efficiency in the care of the sick or the prevention of illness.

But, in order to provide for the needs of the people of the United States and of New Mexico, we must have primary care providers and we surely cannot find sufficient numbers in the ranks of the graduates of our 150 plus schools of medicine or the immigrant physicians that we welcome to America. Less than 5% of our current physician graduates choose to train in primary care. It must therefore be to you, our Physician Assistants and to our Nurse Practitioners that we must turn to meet the need. I would hazard to predict that in the next two decades many of you, our present and future graduates will become the front line providers of health care. At the moment you too are burdened with debt and those most eager to employ you will be specialist physicians who profit from the present system and are eager to enhance and use your skills, but hopefully in the future there will be new opportunities to be fairly recompensed in the primary care of patients.

So what might that mean for each of you? In large hospitals and clinics there will still be supervising physicians on site to turn to for guidance. In smaller, especially rural and inner city clinics the physician may be very far away. Computer and video technology can help, but even when consultation is available, what must be the critical qualities necessary to your wise decisions? Certainly competence and knowledge of medical science is important, but can familiarity with Biomedical Ethics enhance your practice of medicine?

Edmund Pellegrino, who founded the Center for Bioethics at Georgetown University has said that Medicine is a moral enterprise and has written of two essentials necessary to the Good Physician: Competence and Compassion. One without the other ignores the necessity of both knowing and caring in the care of patients in the healing professions. For Hippocrates and the Hippocratic physicians, the Iatros, of the Greek world 2500 years ago it was a commitment to the individual patient rather than to the group. Public health was not as yet part of their charge. But it was a commitment couched in ideal terms that claimed for the Iatros purity and holiness in contradistinction to others who

claimed superior knowledge or skills. In a sense their claim to ethical purity was a marketing tool; but setting an ideal for any reason can enhance the outcome. The Hippocratic Oath, the contract between the Iatros, the Master, and his apprentice recognized that the Gods are our witnesses and that we must be guided by the following principles so let me take a moment to read it and then discuss its meaning as a first step to an Ethic for Medicine.

Hippocratic Oath: Classical Version

I swear by Apollo Physician and Asclepius and Hygieia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

[The god Apollo consorted with the lovely maiden Coronis who gave birth to the demi-god Asclepius who was taught the secrets of medicine by the centaur Chiron. Asclepius healed the sick and raised the dead which offended the Gods so Zeus sent an arrow, a toxicity from his bow, his toxon and killed Asclepius; but he and his five children Hygia, Panacea, Machon and Podilarius who were soldiers and physicians in the Iliad at Troy and Telesphorus, god of the handicapped.]

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot. (Edelstein, 1943).

We thus find the following ideas:

1. Parity with the Ten Commandments and God as our witness.
2. The idea that our Parents remain witnesses to our choices.
3. Loyalty to one's parents and teachers.
4. Confidentiality: the ability to keep private what one sees and hears.
5. Competence: to refrain from actions for which one was not trained.
6. Justice as fairness: to not distinguish between patients whether male or female, free or slave.
7. Justice as Duty: not to take sexual advantage of patients.
8. Professional Duty: to teach what we have learned to our sons and to our pupils a term that is gender free.
9. Difficult ethical questions: ideas which we might or might not agree with, such abortion and euthanasia. The latter I must leave for another discussion, but notice that the statements stimulate the ethical questions.

The Hippocratic aphorisms collected in the Hippocratic Corpus also remind us of certain foundational principles that contribute to Clinical Judgment and we can see the connection between clinical experience, ethics and Clinical Judgment:

First do no Harm.
An error of Commission is more serious than an error of Omission. (The modern version would be that when you don't know what you are doing, stop and think about it.)

Life is short, art is long, opportunity fleeting, experience delusive, judgment difficult.

The Hippocratic physician also saw the causes of disease as natural not supernatural. Perhaps in that intuition is the birth of evidence-based medicine. In effect the application of reason and logic, Logos, to the study of nature. That is Science. Not our Cartesian Science based on hypotheses and experiment and guided by mathematics, but still a rational attempt to explain nature and illness.

Lastly, but most important, the recognition that a professional's reputation is precious. In the final analysis will you each be the good clinician for your patients? Will you be honored and respected, even loved for all time for your care of your patients?

To be the good clinician requires, as Doctor Pellegrino suggested both competence and compassion. But how are you to achieve that?

Sir William Osler at the turn of the 19th century spoke of Equanimity, being calm in the raging storm, as most important.

William Peabody suggested that:

The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy, and understanding must be lavishly dispensed, dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for for the patient (Nuland, 1988).

My father-in-law, Professor Maurice Chazin on his 75th birthday when asked by his grandchildren what was the secret of life answered, "Luck, but you have to be able to recognize it."

Caring for patients is hard work, endlessly stimulating, too often sad but also positive and joyful. You will each make mistakes. We all have; but I believe that the best clinicians are optimists who find meaning in their work and bring hope and knowledge to their patients. As you weave together the strands of knowledge, experience, empathy, compassion and intuition you too can discover that most important gift, Clinical Judgment. In closing let me wish you all the

best of luck, and that you recognize it when it comes, as you take up your wondrous new profession. □

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Jeanne Favret

Everything going so well for me

by Flannery Merideth, PIE Narrative Strand

Everything had been going so well for me. A new mother came in to the medical center that morning in labor. Her baby's heart rate was dropping so an emergency Cesarean section was planned. I rushed with the patient to the OR and scrubbed in. That's when I made mistake number one. I touched my sterile gown with my non-sterile, albeit clean, hands. The nurse was not pleased. She had to grab another gown. "Doctor," she said, "I thought this was supposed to be an emergency." She rolled her eyes in my direction. Yikes. Then I had trouble getting my gloves on. It's hard to squeeze gloved hands into another pair of tight gloves! I fiddled with it for what seemed like an eternity, the whole time feeling like a complete idiot.

I eventually took my place at the table next to the doc and made myself useful, holding tissues out of the way of her hands and the baby's head. I always thought of babies as being fragile, delicate little beings. But man, that doctor stuck her hand right in the uterus, grabbed that little baby by the head and just pulled. And when that didn't work, she used a little baby vacuum that attaches to the skull and applies gentle sucking pressure to draw the babe forth. Unfortunately, the little darling was writhing about so that an additional incision had to be made through the rectus abdominus. Finally she was freed! Umbilical cord was clamped and cut and she was handed off to the pediatrician for APGAR scoring. The placenta was removed and we discovered a knot in the umbilical cord. This was probably the source of the baby's low heart rate. Every time she moved, the knot was pulled tighter, cutting off her oxygen supply.

Then it was time to stitch things back up. I was given some scissors, instructed on the proper way to hold them, and began cutting sutures at the doctor's request. She was showing me how to make a surgeon's knot and telling me about how to check for hemostasis before cutting the suture. I continued to hold tissues back with a bladder blade and occasionally blotted blood with gauze. Suddenly my left hand began to feel very fatigued and tingly. I looked down and saw my gloves were gathered at the wrist, cutting off blood flow to my hand. I guess that was the straw that broke the camel's back, because when I looked back up at the operating table, I started to get that feeling. You know the one. That "oh crap I'm about to lose consciousness" kind of feeling where you get woozy and dizzy and the room suddenly feels like an oven. "I don't feel so good," I said. "Ok," the doctor told me. "Step back from the table and lie down on the floor. Don't get up, stay down until we are finished." I lay down on the floor and managed to avoid syncope. And that's the story of how I came to lie on a bloody operating room floor as a second year medical student.

Of course, it could be worse. One of my roommates scarred her preceptor's face when she tried to freeze a skin tag off of his forehead with liquid nitrogen. 1 second on, 1 second off for 10 seconds, not 10 seconds of continual application. Now he's got a nice big scar right smack on his forehead! It was a learning experience for both of them. There are many, many opportunities for learning in medical school... □

The First Cut is the Deepest

Week 4

by Ryan Mals, PIE Narrative Strand

One of my favorite aspects of the La Familia clinic, is its track record in maintaining an excellent standard of care for a medically underserved, socially marginalized population. With a sliding-scale payment model similar to Albuquerque's Casa de Salud, the organization singlehandedly serves a population of over 10,000-most of whom are uninsured, and/or undocumented, and/or "Limited English Proficiency" (LEP). Having coordinated and worked last year at a student-run shelter clinic for homeless male patients, I have developed a greater understanding of and empathy for these populations. Among low-income Santa Feans, and no-income Burqueños, there are countless horror stories of patients receiving poor treatment, or no treatment, by virtue of their background. While the gradual shrinking of the American middle class has exacerbated this unremitting social injustice, our clinic patients this week seemed disproportionately skewed towards the low end of the sliding scale. Furthermore, the overwhelmingly depressing nature of our patients' complaints got me thinking: How do primary care physicians protect their own mental health while taking on the burden of their patients' problems? Rather than describe various acronym-heavy coping strategies developed in academic medicine, I figured this entry might be a good outlet to describe an emotional case-if for nothing else, to remind me of the importance of connecting with the patient, should I become more cynical.

Monday morning, I had the opportunity to interview a patient who had recently undergone neurosurgery for placement of a Deep Brain Stimulator. Though scientists continually find new uses for this device, its original-and most popular use was as a treatment for Parkinsonian dyskinesia.

Our patient, "ES," was a middle-aged LEP Hispanic female on welfare. Two years ago, after receiving her Parkinson's diagnosis, her husband-the father of their three teenage boys-announced he had been unfaithful and vanished from the scene. As a newly single mother, she struggled to support her children as they progressed through high school, though their chances of graduating seemed slim with a permanent record full of detentions and failing grades. As they neared the end of their high school career, her textbook-level Parkinson's symptoms quickly reared their ugly heads: pill-rolling tremor, tardive dyskinesia ... needless to say she became unable to perform routine daily activities.

So, in an effort to be more present with her children, and maintain her own health, she had applied for government disability-but was denied twice, (I later discovered the average number of applications to disability before acceptance is 4; that number does not account for those who were never accepted.)

Frustrated by the public system, and encumbered by her inability to speak English, she succumbed to the whims of her doctors at "a prominent academic teaching hospital in New Mexico," where she felt she had served as a medical "guinea pig." In this capacity, she underwent neurosurgery for symptomatic treatment.

After her DBS implantation/activation procedure, her surgeon informed her that he had "dropped" or "left" something inside her skull, but "didn't know what could happen. For several days, ES tried to contact the surgeon's office by phone, but her calls went unrequited.

Almost immediately after the procedure, the symptoms on the right side of her body were gone. Our physical exam revealed almost no tremor or dyskinesia on that side-a remarkable improvement for anyone living with Parkinson's. While attempting to encourage her with this, she broke down into tears.

Though her condition was depressing and frustrating in and of itself, she found herself trapped in a horrible, unfortunate situation. To make matters worse, she was oblivious to her own health and medical management. After allowing ourselves extra time listening to her vent a miasma of frustration, anger and sadness, she seemed relieved, happier, and healthier-though no medicine was performed.

We then found out that her surgeon did not take the time to find a translator when debriefing ES' procedure. He had not in fact "left" something in her skull, but his Spanish speaking was not proficient enough to convey that the "left" side of her skull may not respond as favorably due to the nature of the procedure-par for the course, and something that can be treated during follow-up appointments.

Understandably, ES refused to return to that surgeon, but her options were limited based on her lack of insurance,

and inability to speak English. To help ease her anxiety, we talked at length about her medical conditions and sent her home with patient information handouts; we will see her at a follow-up next week to determine an appropriate next step.

To me, this patient exemplifies common struggles in low-income, medically underserved populations. First of all, she received substandard care as a result of not understanding her own conditions and subjecting herself to the wills of her physicians. Second, she had an extremely limited number of options for providers, further contributing to her frustration. Third, her inability to speak English had led past providers to dismiss or devalue her concerns. Fourth, the turmoil of her personal and home life brought forth unique insults to her mental health, none of which were ever addressed by a medical professional (until she came to La

Familia). The doctors I have worked with at La Familia are without a doubt the most caring, dedicated, and empathic physicians I have encountered; they are passionate about serving their specific population, and work tirelessly to prevent these medical tragedies. Nevertheless, they face depressing cases such as ES' on a daily basis while maintaining composure and refusing to let the negativity "get to them."

I am unsure if a "perfect coping mechanism" exists. It seems, however, that finding a specific niche-and population-I am passionate about serving may be a step in the right direction. I cannot forget the importance of the patient's "whole picture"; an all-too-prevalent pitfall made worse by the growing role of EMR. □

People of (Southeast) Walmart

It's Walmart and I'm at 2 am
Drinking a toxic cocktail of
Necessity and fluorescent light.

I wander the melons
And see no one.
God damn, if this
Place doesn't lack
Even the romance
Of Patterson.

And I dissolve in the dregs
And wonder if I should
Get on some Xanax Or Zoloft
Or whatever the fuck it is,
You people take....

And then I realize.
This place doesn't.
Even. Sell. Beer.

Christ.

- Noah Cooperstein



Paul Akmajian

The Auction House

by Robert Schenck

I thought it was normal to walk through people's homes with an eye to value as mothers wept at the loss of their sentimental treasures. "It's in the contract," my father would explain as he instructed the defeated to leave everything behind. "We have to sell everything for the bank," and adding with confident innocence, "Remember, it is not my doing." We auctioned the lives of families, and my father was known for his ability to get the most on any auction day. And yet he had a hidden talent. My father had an uncanny sense in determining what was valuable, and he kept that talent and the object a secret, except to his only co-worker. I had worked by his side for many years and could tell by his silence when he found some rare, unappreciated object. He would remind me after each sale, once the houses were emptied, and the cash box was locked, "Someday this business will be yours." I think he was really warning me to toughen up and silently acknowledging something we both knew to be true. He didn't look at me as a daughter, but as an employee.

We would arrive the day before every auction, and my father would limp through homes inspecting every item and would categorize them according to their place in the sale with the most valuable going last, keeping the next day's bidders interested. As we wound through the house, he would quiz me on an item, and I would be impressed with the accuracy

that he would get with the crack of his gavel the following day in the unlucky front yard. Yet he was most interested in the item of unrecognized value. Those items were given a special tag that I would carefully tie marking it for my father during the following day's auction. Every house had at least one, and it was usually old, dust covered, and quite often small. But once tagged, my father never lost track of it. That was where he made his profit as he sold it as his own. The foreclosed family rarely recognized the object's value, and he would appear charitable by giving the family a worthless, sentimental, or badly needed object. Our focus was the money, and the bank cared less about one or two items as they did about liquidation. Tears meant nothing to the banker or my father.

It was spring when we came to a farmhouse that was at the top of a rocky hill, land that was never intended for farming. We pulled onto the long mudden driveway with memories of winter in the thawed ruts of earth that served as our guide to the front yard of the house. It was this kind of day when my father's pelvis had been snapped beneath the unforgiving flank of our last mare. We almost lost our home as the injury put him in bed for months, mending but dreading creditor's letters and knocks at the door by a bill collector. But as he healed and limped, the bank offered him a side job to cover his payment and my father's true

talent was discovered. "This will only be temporary," he said, driving away from our first auction. But other banks asked for his help, and slowly we stopped working the farm and began working for the banks to help them reclaim their collateral. By the following winter, my father was walking with a cane, and I was no longer his farmhand, but his unpaid associate in the auction business.

As we parked the truck on the rocky hillside, my father wondered out loud, "How could someone be so foolish as to think this rock covered farm could succeed?" Then answering his own thought, he painfully exhaled with harsh satisfaction as the truck bounced over one last rut, "You reap what you sow." He balanced himself on my shoulder as we walked up to the graying, two story house, which had been bent from years of ground moisture and perpetual wind. My father rapped on the single pane glass that rattled as if it would break, and we were welcomed in. Bored, listening to the somber instructions, I gazed out the kitchen window and saw a small boy flying a stick tied newspaper kite. It spun and dipped as the boy let out his ball of pieced together string, knotted much like the ragged yellow tail of the kite. The boy was my age and worked the string with a motion of carefree expertise that could only come from childhood practice and protection. I realized the wind never stopped on this creditor's paradise, and his parents hadn't told him what was happening the following day. The house was warm, and I could still smell breakfast in the tiny, spotless kitchen, with the soon to be sold dishes drying on the undersized dime store rack.

We spent the next hour inspecting the remains of the failed farm as the children were slowly gathered, and the mother sobbed quietly in the sitting room. I watched and followed outside as she was led to their truck, patched together with different colored fenders and shaped tires. I wondered how the bank had let that slip from their claim and suspected some deal had been made with my father. I heard his muffled voice through the window, "Come on back inside, now!" as I lingered on the porch watching as the children smiled to me, and I waved back in a good bye as they huddled, sharing a thin wool blanket in the bed of the pickup. I could see their mother's head rocking on their father's shoulder as the truck bounced in and out of the frozen ruts, disguising her sobs. I smiled as the boy my age waved a final goodbye and then lifting his arm several times, as if he had almost forgotten, he pointed to the sky. I stopped, amazed by what I thought was pure magic. The kite was still flying, as if it had a life of its own. I finally realized the string was anchored to a splintered board at the other end of the porch.

It was late in the afternoon when we finished our work, and standing together outside, my father finally noticed the fluttering kite still bobbing near the rose colored clouds. "Go back in the house and get some scissors," he shouted as he winced, unsuccessfully kicking at the cheap string, while the house was fighting to hold on to its last possession. He waved off the kite as if a nuisance and limped towards our muddied truck, my father defeated again by physical labor. Dreading my task, I walked back into the lonely dark house and found a pair of rusty scissors. While turning to leave, I saw Dad's prized item and softly smiled as I cut that string, and watched his most important tag flutter to the kitchen floor. Rattling the front door shut, I hesitated as I neared the tense kite string with scissors at my side, looking for the strength to disobey. As I climbed into the truck, my father reached over and patted my shoulder, "No one would understand an auction with a kite," he whispered, as I wiped my tears, bouncing towards home. □



Stephanie Reich



Kevin Vlahovich



Kevin Vlahovich

We Actually Did These Things

by Aroop Mangalik

During my last trip to India, I spent about a week with a young doctor. He had recently graduated from Meerut Medical College. He, as a final year student, had visited Albuquerque and spent time at the UNM Cancer Center.

We were traveling by car through some of the smaller towns of North India and we had several conversations about “medicine then and now.”

Memories of what had been the norm in the fifties came to me and I described them to Ashutosh. He was fascinated by what I had seen and done and he urged me to write them down. We talked about treatment of hypertension. There were very few drugs that could control high blood pressure. President Roosevelt had uncontrolled hypertension and died of a stroke in 1945, just before the end of World War II. Thus making Harry Truman the man who had to decide whether the atomic bomb should be dropped on Hiroshima and Nagasaki.

During my first year of residency, a new set of drugs were introduced. These were ganglion blocking agents. The idea being they would reduce sympathetic tone. Unfortunately, they blocked the autonomic nerves unselectively. The BP was well controlled in the sitting or lying position, but the patient got a sudden drop in BP on standing and severe abdominal distention from parasympathetic blockade. The drugs did not last long.

Diuretics were limited to mercurials. They worked fairly well but required acidification of the body for them to be effective. So we had to give what was called an “esidrone course.” The patient received a number of doses of ammonium chloride through the morning then the mercurial esidrone was given intramuscularly and they diuresed. All done as an inpatient.

Later, there was alpramethyldopa that was introduced for hypertension and furesamide for diuresis, both of which changed the management significantly.

Tuberculosis was a big problem in those days. Streptomycin and dihydrostreptomycin were introduced in the late forties. Unfortunately, one caused cochlear damage and the other caused vestibular damage.

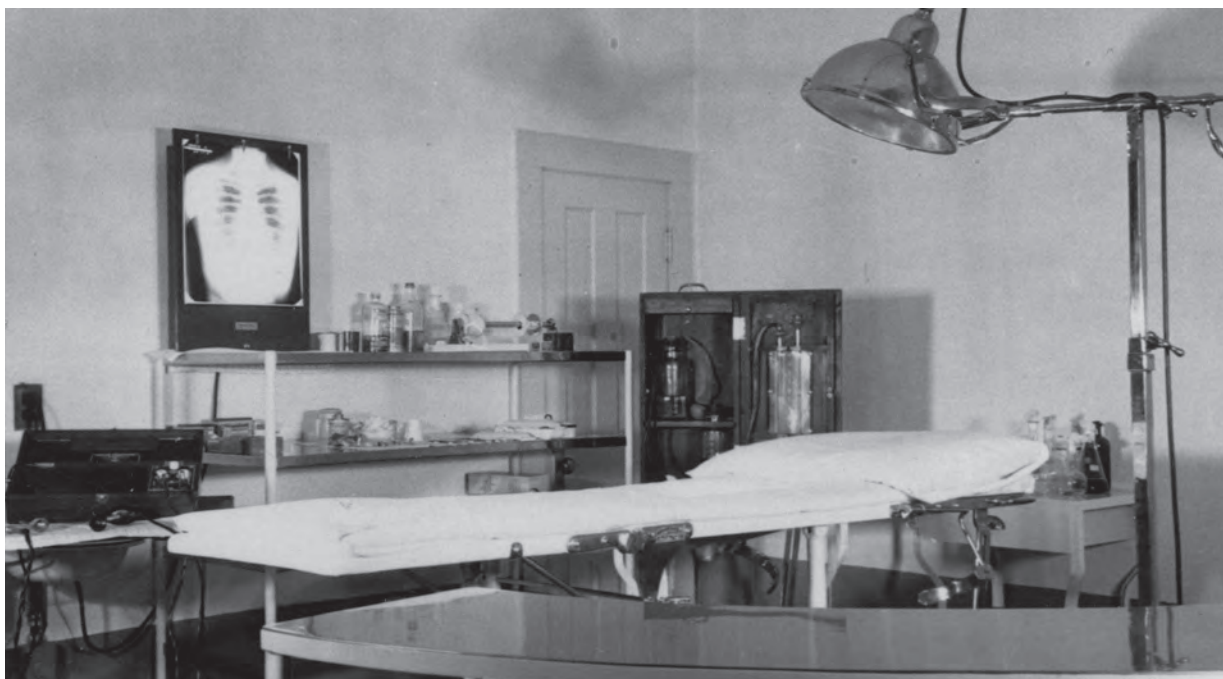
During my summer vacation before I started my clinical years, I spent some time staying with the family of one of Papa’s friends’ who was in charge of a tuberculosis sanatorium in the hills. It was a beautiful place with lots of hiking in beautiful country. I also saw my first surgery there. One of the theories about tuberculosis was that the bacterium grew more easily in the areas of the lung that had more oxygen. Based on this someone came up with the idea of collapsing the lung to reduce its oxygen content. There were three methods of doing this and I saw one of them as a student and performed two of them as a house officer.

I was allowed to watch a thoracoplasty - a procedure in which the posterior half six to eight ribs were removed and the lung was permanently collapsed. The procedure was done under local anesthesia! After the ribs were exposed, each was stripped of its periosteum (hopefully without penetrating the parietal pleura). Each rib was cut with a plier like tool and the lung allowed to collapse. The patient was awake, sitting up resting his elbows on a table. It was brutal, especially to a 19 year old who had only seen cadavers. I do not know if the results of the procedure were over evaluated. I do know that randomized clinical trials were not very common in those days. One of my classmates in Medical College had had that procedure - remarkably it produced very little deformity and with normal clothing one could not tell.

The other procedures were reversible and were carried out even into the late fifties. As a house officer, I performed pneumoperitonium and “artificial pneumothorax”. The idea was the same, you injected air into the peritoneal space or the pleural space to cause both or one lung to collapse. I have no idea how well they worked and certainly did not question the procedure’s efficacy or risks.

Radiology was another field which did amazing things - what is now considered unacceptable or worse.

One was the procedures called pelvimetry. They sequentially x-rayed the baby as it descended down the birth canal. They noted its progress and its relationship to the pelvic bones and used the information to decide about cesarean section or other interventions. We heard about this from one of our professors. He had gone to Sweden on a government sponsored tour to learn about the “latest and best”



Operating Room at Valmora Sanatorium, Watrus, NM. 1940s. Carl H. Gellenthien Collection of the Valmora Industrial Sanatorium Records, New Mexico Health Historical Collection, Health Sciences Library and Informatics Center, University of New Mexico.

the “West” had to offer. He came back all full of praise of the advances they had made and used this as an example of Western progress. What a contrast to now when any x-ray exposure to a pregnant woman has to be discussed to determine risk/benefit ratios.

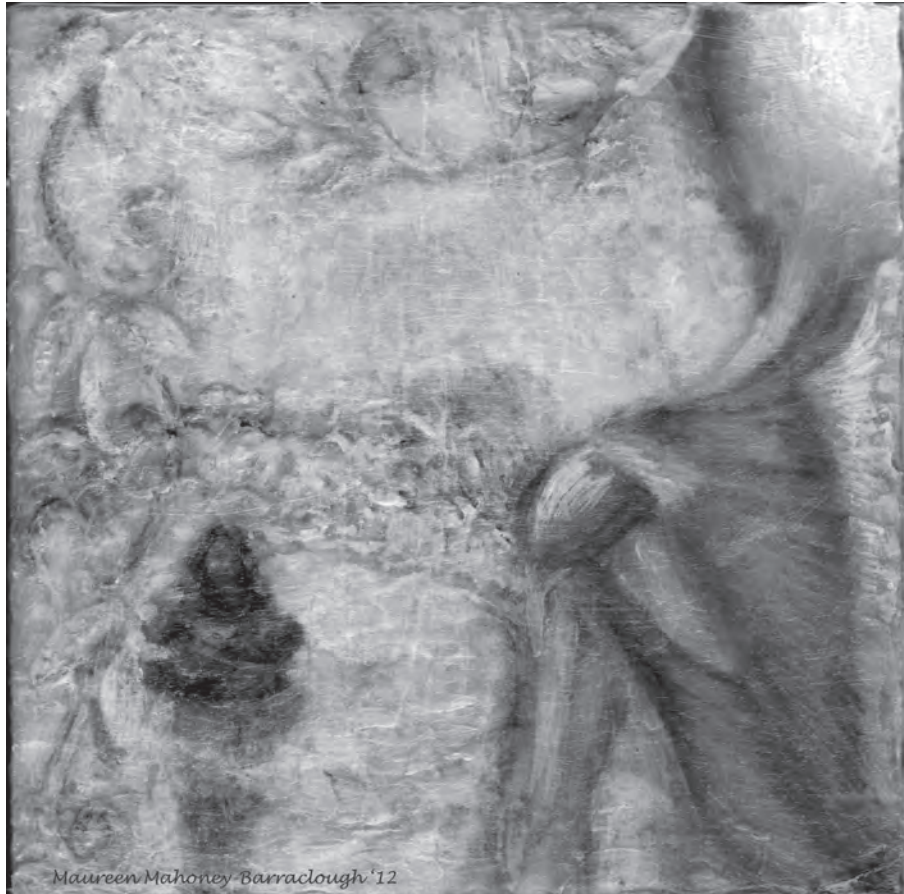
Another radiology procedure was the pneumo-encephalogram. This was actually done at our hospital. A spinal tap was performed, cerebro-spinal fluid was drained and air was injected to the spinal space. The patient was sitting and asked to tilt the head back to allow the air to go into the ventricles of the brain, then asked to tilt the head forward to go to the CSF space above the brain. Through this maneuver, they could image the brain. This was forty years before MRIs and maybe it was important to image the brain. I did not know enough to judge if useful information was obtained but I saw the patients after the procedure and they were quite sick.

The worst example of coercion, lack of autonomy I saw was on a man with a carcinoma of the penis. The patient was told he would have a simple penilectomy and he agreed. He was given a spinal anesthesia and prepped. Just as they were starting the procedure the senior resident said that he had never done a radical penilectomy - removal of the entire penis and testes. They would create an opening for the urethra in the perineum. So, they told the patient they had changed

their plan. The poor man pleaded not to do that procedure which, amongst other things, would require him to urinate like a woman. This would be a major public demonstration of his “lack of masculinity.” No heed was paid and they proceeded with their radical surgery.

What I have described are some of what I remember. Examples of early “advances” which Professor Daniel Callahan calls the rough edges of progress. Some examples of putting into practice, some theories without testing them. But then the example that demonstrates the differential of power between the rich, powerful doctor and the poor patient who had no recourse but yield to his fate.

What will the future say about what we do today? Some of our brutal treatments with minimal benefit, the patients we subject to pain because we cannot accept failure - only time will tell. □



Maureen Mahoney Barraclough

The Locked Ward

33

The gummed street seems so
inviting. Welcome, too, the tire grinding
skull into asphalt, meat into treads.

The light turns. I step
into the street, agree to exist
another day, another hour.

9

From the back seat, I told my new mom
she's like Mary Poppins. "You think
I'm magical?" she said. "No," I said,
"You're practically perfect in every way."

I had yet to lose faith in perfection. I had yet to learn
growing up means your mistakes get bigger, too.

I return to you in the lobby after we promise
not to leave until I see a doctor, after I checked the box
that said I might hurt myself. I fidget with the locker key
dangling from a pink child's flip-flop between turns
of iPad Scrabble. After we've said goodbye
and you've gone, the tech buttons on
a new plastic bracelet, symbolizing my move
from the Front to the Locked Ward.
He tells me I can toss the first band or keep it
for a souvenir. It's nice to know I'm not
the only one who'll keep both.

16, 18

When mom came into the kitchen,
I was on the floor, a crescent curved
'round the gleaming star reflected

off a knife. The running tap almost hid
her gasp. When the yelling started,
it accused me of faking
to get out of washing the dishes
still heaped in the sink.

Easier I guess, than dealing with a not quite suicidal
teenager. I think I'd do better, while I remember
two years later bringing Aidan to the hospital.

Skittish and weary under the fluorescents after
his lamp lit confession, after being passengers so
he'd have a reason not to drive into the black river,
we talked him through 'til a doctor could see him,
talked each other through 'til he
was committed, 'til the first bus
of morning came to take us home.

Then I remember I never came to see him
the month he was in the hospital, never apologized
for avoiding him when we found each other
in the street another month after he got out,
had stuttering sex on my single futon.

Mom was a champ, compared to me.

Only nine patients
on the Locked Ward.
Could've been 60,
a nurse tells me.
I'd count my lucky
stars if I could see
any through the
opaque windows.

I do everything they say:
shower
brush my teeth
tell the doctor and nurses all they ask
even pick my things off the floor
and make the bed like I never do at home

I want to get out the day
I know I'll be safe.

13

I lay behind low shrubs behind
the lawn crying into the dust,
escaping an hour from
parents, neighborhood kids
before dad found me.
It made him angry, those times
I couldn't explain my tears.

33

I ask you to tell Stacy and folks
at work. When you ask if I
want you to tell my parents,
I say No. I say I don't want
to deal with another of dad's
anti-psychiatric medicine rants.
It's the only reason I can guess.

The Locked Ward is a time warp to summer camp:
coloring
beading
board games
tiny cartons of milk
and industrial meatloaf

on plastic trays.
Only took three days
for someone to work out
vegetarians eat things
other than pizza
and salad.

Nobody better start pulling legs off spiders
or they're gettin' punched. But I don't joke aloud.

16, 6-27, 33

In the school psychologist's office after
some student found me crying in fetal
against my locker, I couldn't tell her
what was wrong with me. I didn't know.

Neither did she or any of the other therapists.
Not the school therapists.

Not the councilor who helped me get on testosterone.
Not the creep who said my birth mother's death made me
transgender.

Not the guy mom sent me to when I didn't kill myself.

Not the roommates I hid from.
Not the friends I pretended strength to, nor the ones who
witnessed.

Not the lovers I consumed like I could fuck depression
away.

Not the loves I believed would cure me, too polite to turn
me from their doors.

Even my psychiatrist couldn't find
the right cocktail for months, but
I'd never told her how I'd locked
nearly everyone out. How could she
have known the people
would do as much as the drugs?
I hadn't known what I was avoiding
'til I'd forced it on myself.

33

These are the patients in my hospital:
2 attempted suicides
2 bipolar disorders

1 depressive with hallucinations
1 mother
3 college students
1 working man
1 homeless veteran
1 involuntary
13 voluntary

1 man who most days lies in bed

1 woman who is reputed to thread insults like Christmas
baubles but to me says only Your hair is pretty
1 boy who paces the hallways, shuffles in circles as if dan-
gling by his nose from the magnetic pull of the hemisphere
ceiling mirror that shows most of the wing - which I know
because I copied him

1 man in search of Alpha Centauri's twin stars

1 roommate who spends half her last 20 hours telling me
everything a patient needs to know to survive the Locked
Ward—who to fear, how to talk to the doctors, telling the
truth always because those women would see every lie, how
the comb will rip my hair

1 who sees the Locked Ward more as prison than camp—the
courtyard where we take our daily laps in the sun, my pink
(not prison orange) flip-flops firing synapses to memories I
don't share

13 waiting for the doctor's pardon

13 who think I look too normal to be here
me

I'm lucky they let me in this company.

28

I believed love would cure me. It didn't.
It merely keeps me alive when I've rusted through every
other chain.

33

I see you every day I'm on the Locked Ward.
The third night, when I'm only waiting
to see the doctor to get home, we finish
a 300-piece jigsaw puzzle in 40 minutes,
amazing all who see. The space between us
is home, even here, until visiting hours end.

Next morning, the nurse shows me a photograph
someone took while I waited to be taken
to the Locked Ward, my expression almost dead,
captured in melting wax, without the assistance
of slit wrist, overdose or leap from tall building.

I don't need a mirror to know my face
is resurrected. I look anyway.

I'm not watching TV, I'm looking through
the window, through a courtyard just large enough
to pace, to the blue square of sun-stroked sky. I believe
I've just about done earning my crazy credentials.

But we don't use that word here.

- Sari Krosinsky



Kevin Vlahovich

Ami says

Ami says,

“Always be patient in the end”.

In this towering metropolis of life and death, we stand along the edge.

As the flag-bearers, the minutemen, the thin line at the end.

We are the front line, the telegram, and the anchors of the wind.

We are reflections in the water, when the flow begins to live.

We are the pipeline, the life-line, the skyline of bliss,

We are the hope inside of those who have never felt a wish.

As architects and artists, we are healers from within.

And we have everything to lose, if there's nothing left to give

So we do it for the smiles, for the people that we lift,

For the good days, the bad days, for what it represents,

We are the visionaries, the frontiers, the new lands ahead,

We are the dreamers, the renaissance, the leaders that are left,

And in those moments when it's hopeless and we're standing near the bed,

As we hold our patient's hands, and they take that last breath,

“Always be patient in the end,”

Ami says.

- Umar Malik

Sueño

Me sueño de usted;
muchas noches.
Espero que no los terminen.
Encuentro alegría,
cuando no lo tengo en el día.
Quiero dormir.

Me sueño de usted;
en maneras malas y buenas.
Sueños cortas y largas.
Siempre te encuentro allá.
Siempre estas esperando para mi.
Quiero dormir.

Me sueño de usted;
¡Dios, por favor guárdame aquí!
No quiero volver,
a un mundo que no tiene usted.
Guárdame aquí,
quiero continuar dormir.

- Victoria Lucero

