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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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.

The Muse exists to encourage members of the Health Sciences community to express their creativity. 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 doing so.

Without your creativity and courage to share, the Muse would not exist.

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Laura Hall and I would like to thank everyone for the opportunity to present this current edition of the Medical Muse. Our many thanks for the contributions from the UNM Medical Family and the great work from our dedicated reviewers: Jill Bolton, Patricia Finn, Gale Hannigan, and Liz Lawerence. Again, please send us your interest in reviewing future submissions as it is a great way to become better, make the muse better, and if you are a writer, artist, photographer, painter, it allows you as the reviewer to see different styles to help you hone your own.

It is bittersweet to mention my upcoming retirement from the University of New Mexico as I have been honored to serve here for over two decades and Trish and my family have loved living in New Mexico since 2000 when I moved to be head team physician for the UNM Lobos. I became Department Chair in 2005 and after 17 years in this position I want the Department and University to enjoy new leadership. I am so grateful for what we have accomplished here and am excited for the future of UNM and Orthopedics in particular.

As I look on the growth and beauty of the Medical Muse I must send my thanks to Laura Hall. It was on my 50th birthday that I began a journey of writing for arts and humanities. I am grateful for the many people who supported me in writing for fun and like many I started with biographical stories and am grateful to Jill Bolton, Laura Hall, Norm Taslitz, and my wife Patricia Whelan Schenck who read and remarkably, enjoyed my stories. I am grateful to the Southwest Writers group as I submitted stories to their annual contests and won recognition with “The Magic Christian,” “Roaring Fork,” “Billy Graham and the Ice Cream Man,” and “The Ghost of Chris LeDoux.” Laura and Norm enjoyed and promoted the stories, and after publishing them in the Medical Muse I found...
a nice readership. My many thanks for academics and UNM as the opportunity to add another facet of writing. I still write scientifically and in particular knee dislocations but have moved to an equally fulfilling work. With that work, I was honored with being named Editor of the Medical Muse once Norm retired and have enjoyed my partnership with Laura Hall in producing a beautifully conceived art source for the medical community at UNM. After our publication for Covid Muse, I was asked to be Deputy Editor of Arts and Humanities for the Journal of Bone and Joint Surgery and I tease that I published on knee dislocations but in Orthopaedics I am now asked to edit poetry, which truly is now a dream job.

Interestingly, there is a bit of controversy of using retirement rather than resignation and one friend counselled me to say “resign” rather than “retire.” I chose retire as we are moving to different opportunities looking for new ways to give back, be a good human being, and as always an academic. So even though I am retiring from UNM, I will continue to work, give back, write, and create. As Arthur Brooks wrote in “From Strength to Strength” my focus will be on the second curve of work intelligence (crystalline rather than fluid) where I work more on using wisdom and giving back to society rather than doing knee ligament surgery. I think great advice from Arthur Brooks are in his last chapter where he focuses the reader on living by the following seven words:

Use Things
Love People
Worship the Divine

My plan is to step down from the chair position officially on 6/30/2023 and I will retire from UNM but will continue to be an academic, give back and continue to be a good human being. It seems just like yesterday when Trish and I interviewed here on July 5th of 2000. The night before we had flown down from Denver watching the many 4th of July fireworks displays on the front range and cities all the way to Albuquerque. It was symbolic of how excited we were to join our new colleagues, raise our family here in New Mexico and be part of the UNM Family. As I have said, although I didn’t train here, I wish I had, as my heart will always be with this program and University.

Dear Readers,

Thank you.

- Bob Schenck, Editor-in-Chief

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The Sound of Rain

Growing up in the desert I remember rain being sudden and severe like clapping hands.

Raindrops smacked the surface of earth sending clouds of dust into air with the impact. Tiny dark brown craters punched into the ground.

But today the rain is light and persistent and has lasted for days. Earth has become something more liquid.

Consumed by wet, open mouths, raindrops fall into puddles of mud, the sound of positives and negatives joining, of bonds forming, of many becoming one.

That need of living things to hold their shapes gives way. To moisture. Appendages soften. Cells become plump and luscious as they touch the sky.

Bodies here are accustomed to harshness and uncertainty. Rough edges are smoothed by rain. Touching things embrace, wrap themselves around each other rather than snap or snag or scrape. And what more from life do we need than to reach out and be received and receive in return?

- Nora Murray
Sitting in class, all I feel is my heart beating strong and hard in my chest, like the rhythmic pounding of an old wooden door in an ancient house. The reverberations are urgent, insistent, painfully loud. They do not stop, and I cannot get away from them. My throat tightens, my breath catches and suspends. It feels like a mere trace of oxygen reaches my organs, and I am barely surviving. I might die if I stay here one more minute.

But I do not get up. I stay seated. And I try to focus instead on my professor’s words. She discusses stroke recovery and an occupational therapist’s role with executive function and hemispatial neglect.

This is one of countless times since I started grad school for occupational therapy that I ponder the question, “Why am I doing this to myself?” In the thick of the daily grind, it is easy to forget why I am here. More often than I want to admit, I feel burdened, immensely uncertain and terrified.

It took me a long time to realize I have anxiety. I grew up surrounded by it. My mom, my dad, my grandma, my sister. You would think I would have made the connection sooner, but I did not see myself in my family members. Anxiety had become so omnipresent, I had no idea it wasn’t everyone’s daily experience.

Over many years of reflection and support, I have come to understand that anxiety is part of who I am. Being in grad school for occupational therapy has helped me a lot with this.

Occupational therapy is not easy to describe or understand and many people really don’t know what it is. In order to understand it, you have to understand “occupation.”
By occupation, I do not necessarily mean your job, though your job technically is an occupation. Your occupations are ALL the things you do that get you through your day, that make your life worth living, that make you happy and healthy and grateful.

Have you ever felt your heart lift out of your chest and float into the New Mexico sky out of pure joy during a beautiful hike in the East Mountains? Or when you take your first sip of tea or coffee in the morning? Have you ever felt such immense relief to take a hot shower after a long day, that you feel your body melt and become one with the water? What about when you eat a ripe peach or the perfect batch of red or green chile?

Occupations give our lives meaning. Occupational therapists help people who experience injury, disability, health conditions and developmental challenges participate in their valued occupations. Occupational therapists take a holistic, client-centered approach and can target just about anything that might inhibit someone’s participation, including physical, psychosocial, sensory, behavioral, cognitive or environmental challenges. At the heart of it, we offer the spark of possibility.

In a lot of ways, possibility is what occupational therapy is offering me. In school, I have learned about things like orthopedic injury, neurological impairments, and spinal cord injury. But more than anything, I am being given the opportunity to connect with others, to help people in my community, and to learn about myself.

One of many things I am learning is how to become better friends with my anxiety. Even though I’ve become more aware of my anxiety over the years, I have not liked that part of myself. I often want it to just go away and never come back. But the reality is, the act of rejecting my anxiety makes it 10 times worse. I’m realizing that what I want, what I need, is to treat myself the way I would want to treat my future clients. I have realized that not only do I want to do occupational therapy, but who I want to be is an occupational therapist. A core part of the profession is the type of care we provide and the therapeutic relationships we intentionally build with clients. Occupational therapists prioritize compassion, empathy, validation, radical nonjudgment, curiosity, patience, flexibility and trust. We help our clients work on their challenges and limitations, but also emphasize strengths and successes. How can I expect to treat others like this if I don’t treat myself this way?

And so, every day, every moment, I am practicing, knowing that I will never be perfect. I am practicing curiosity with my anxiety. I am practicing validating and even loving my anxiety, rather than judging and disapproving. Through loving, accepting and caring for myself, maybe I can learn to love, accept and care for others. Or maybe, it is the other way around. ♦
How do I explain what I witness every day? 
A glimmer of hope in a patient’s eyes after hours of dismay.
How do I put into words the beauty that I see
When most what’s in the hospital is suffering, not glee?
A moment of courage with a simple crayon;
A burst of endurance with a duet;
A peaceful journey with a beautiful minuet.
Peddlers of hope, that’s what we are
Trying to ease those mental scars.
It’s not just poetry, yoga, massage, or dance,
We are the gift-givers of respite in overabundance!
Where the patients and families become the star
With a private concert on cello, harp, flute, and guitar.
We give of ourselves freely and see in their face,
Through the waiting and suffering, artistry and grace.
Approaching without judgement, easing their pain.
On this mission POSSIBLE, our Arts-in-Medicine campaign

- Melissa Sandoval
To My Grave by Tobias Godwin
Needles in South Dakota by Allen B. Adolphe
Needles in South Dakota by Allen B. Adolphe

Sunlight in the Forest by Allen B. Adolphe

Rushing River by Allen B. Adolphe
Swimming Upstream in our Health Care Ecosystem
An Essay
By R. Philip Eaton, MD

As you and I contemplate the new reality of the Covid Pandemic of 2020s as patients and physicians, I can’t help but consider today in context of my family recollections of the past 100 years. I became a physician in 1961, while my father, born in 1902, started surgical practice in 1929. We are talking about ~100 years of change in health care from the joint perspective of patient, health professional, and government.

This centennial perspective in our country blossomed after the Civil War generating massive health need at every crossroads. Motivated families and communities volunteered to seek care for the sick, the poor and the mentally disabled by building hospitals as a civic duty.¹ From 1865 to 1925, the country industrialized, science and technology expanded, and the hospitals nurtured a strong linkage with pharmacology and professionalization of patient care. The possibility of actually saving lives and curing disease based upon science was uncovering the ecosystem of health care. My father walked to school as a teenager passed swaddled corpses of the pre-immunization era of the Flu Pandemic of 1918, and wore a mask then as we have been doing 100 years later. However, as hospitals and technology advanced, he experienced advancing from performing his own drop-ether anesthesia for tonsillectomy on kitchen tables, to surgical vessel replacement for ruptured aorta in the modern hospitals of the mid 1940s.

By the 1950s ventilators, antibiotics, chemotherapies, and cardio-vascular medications brought intensive-care units and improved health care outcomes to hospitals. This was facilitated by federal funding based upon
the Hill-Burton Act of 1946 stimulated by the healthcare awaking of World War II veteran’s health. My father had been drafted into the Army specifically to advance understanding of blood transfusion resuscitation on the battlefield, a precursor to cardiac surgery.

Another response to World War II was health care insurance, transforming the economics from essentially a local store to a legal social requirement. The linkage between science, patient, health professional, government, and economics was growing in impact just as I was entering the profession.

Entering the 1960s there was no way to measure blood sugar at the bedside. Thus, as an intern we would treat diabetic patients with the dosage of insulin that produced the least hypoglycemic symptoms. The only bedside glucose measurement required urine in a test-tube over a Bunsen burner. However, in my first year as a resident, I was to work in the first week of the first cardiac Intensive Care Unit of Barnes Hospital, Washington University, St Louis. For the first time, it was possible to use electric shock to correct cardiac rhythm in a critical patient. In addition, I experienced saving diabetic patients with a new antibiotic for resistant staphylococcus sepsis, who would have died the year before.

I also was able to save patients with renal failure with intraperitoneal dialysis at bedside who would have otherwise died. At the same time, I was also using the same iron lung management of polio patients that I had watched my father use when I was a teenager. Polio vaccine was yet to wipe out this disease.

The patient’s experience was also dramatically changing as I moved from medical student, to intern, to resident, to fellow, to faculty member in 1969. The class of 1964 had just graduated at the University Of New Mexico School of Medicine, and I was to be its first Endocrinologist. As a boy walking to school, my image of infectious disease was the signs on the windows of homes saying “Scarlet Fever.” I also was isolated in a hospital with pneumonia with four other children in individual cribs. We were all receiving penicillin, a new antibiotic, and I was one of the few that survived.

In prior decades I would probably have remained at home and received a house call by a doctor, or I might have been sent to a special hospital for rheumatic fever patients. In those years there were also specialized hospitals for polio patients, tuberculosis patients (sanitariums), and mentally ill patients (insane asylums). With these and
other advances in the management of many non-surgical diseases, both necessity of specialized hospitals and the use of house alls for patient care of chronic disease was to become a thing of the past.

The 1970s, 1980s, and 1990s replaced the local pharmacist, doctor and hospital ecosystem with health-care professionals merged into organizational groups and sub-specialties, clustered within hospital organizations. Advances in communication, imaging, pharmaceuticals, robotic surgery, electronic medical records, and human genomics, was creating opportunity for improving every aspect of care. I was at the right time and place to advance insulin delivery and prevention of heart attack. There was the continuing historic presumption that ecosystem changes would improve the health of our nation.²

Now the 21st century has seen the curtain to rise upon science based treatment utilizing targeted pathophysiology. Ultra-high-speed computers with cloud storage are exploring Artificial Intelligence and gene-based intervention as replacements for many aspects of health-care. The two most lethal chronic diseases of atherosclerosis and cancer are being addressed utilizing statistic-based significant clinical outcomes. The focus has become both a public and private health care ecosystem for the benefit of humanity as never before thought possible.

However, we have now experienced the Covid-19 pandemic, a virtual reproduction of my father’s 1918 pandemic. Nature continues to be a challenge, in spite of 100 years of advances.

I see this as one of the most exciting moments in the history of Health Care from a scientific and technological perspective. However, I find at my core an old-time hand-holding Doctor, who really values caring for another person face-to-face and holding their hand. The 100 year old perspective of “families and communities seeking the care of the poor, the sick, and the mentally disabled as a civic duty” remains the foundation of our health-care ecosystem, and a value worth preserving. We are still swimming upstream. ♦

¹ “From Homes for the Ill to Institutions of Science Technology: The Evolution of American Hospitals”. May 14th, 2020 Biomereux, Inc.
² Benjamin Franklin, Theodore Roosevelt, Barack Obama
Hierarchy

For Reneé Ornelas

From our perch inside
the house we watch
sparrows, finches, the odd
blue jay storm the locust
tree, thin leaves and end-
branches tumble as birds
rush the feeder to be first.

Pigeons on the ground
gobble falling grain like
manna from heaven
until, impatient, they rise
scattering the small birds
‘til, they, too, are scared
away by the angry pecking
of my seed-provider friend’s
nails on the windowpane.

Pigeons, she says, don’t
know their place. That’s
why no one likes them.

- Sylvia Ramos Cruz
Grandma’s Thread

Yesterday I ripped my favorite skirt.
The pocket is hanging by a thread ...

So today I’m going to Grandma’s.
Grandma fixes things.

“I’m here!” I sing.
I skip into her sewing room.

She opens her arms.
I leap into her lap.
We lean close and laugh.

Her sewing room is messy.
Scraps cover the table,
Buttons blanket the floor.

I love Grandma’s sewing room!
It’s where she makes and mends.

Grandma uses needles and thread -
Lot of thread.
It’s silky, smooth, and strong.

Grandma looks at the pocket.
She feels the fabric.
She chooses the thread.

She sends the skirt through the machine.
Slow and steady ...

A new seam!
We hum along.

“Can I help?”

I match the material.
Grandma pushes the pedal ...
The seam is lopsided and loose.
But Grandma declares,

“You’re the BEST seamstress ever!
Let’s celebrate.”

We go to the kitchen for cookies and milk.

Grandma’s cookies are sugary, soft, and sweet.
I decorate and draw:
  A letter
  A heart
  A stream

Grandma watches.
Her smile spreads to her eyes.
She does not hurry me.

We add sprinkles and stars,
And clean up together.

“They’re the BEST cookies ever!” Grandma praises.
“Let’s have an adventure.”

We go fishing.

I roll up my pants.
Dip my feet in the shallow stream.
The mud feels like butter between my toes.

I help Grandma unpack the tackle:
Rod, line, hook
Float, bait, sink
We toss our lines,
The fish dart.
We wait,
They come back.

We watch,
They tug the lines.

We don’t catch any fish,
But being with Grandma tugs strings in
my heart.

“You’re the BEST company ever!” she says.
“Let’s go home for more fun.”

We make art.
I draw animals with chalk:
   A monkey
   A hippo
   A flamingo
Grandma adds animal homes.
I scribble grass to roam.

We are proud.

“This the BEST zoo ever!” Grandma announces.
“Let’s take a break.”

The sun is sinking.
We go outside.

We glide on Grandma’s favorite swing.
She squeezes my hand.

Little lights appear . . .
Blink!  Blink!  Blink!

Fireflies!
We watch them glitter and glow.
They look like shooting stars.

“This is the BEST day ever!” Grandma
concludes.
“Let’s finish your skirt.”

Grandma shows me a trick.
I match the material.
Grandma pushes the pedal.

This time, the seam is straight and snug!
I try on the skirt.
I twirl around.
I look down . . .

Thread holds the pocket together,
Like Grandma and me!

We’re sewn together, too.
Stitched with threads of love.

- Lisa Michelle Acuff
Blossoming Pneumonia by Mariam Salas
A friend gave me some double-layered cotton masks she made. I went online, found a pattern, sent to others, so they, too, can pull out Singers and sew. A flurry of emails and texts flew in.

From Southeast Albuquerque:
- I wore folded paper towels with stapled rubber bands to the grocery store today.
- A friend just brought me a cloth mask she made.

From Jersey City:
- My wife’s family in hard-hit Philippines is making masks, sent pattern to us.
- Now my (neonatologist) wife, our (college-student-stranded-at-home) daughter, (makeshift seamstress) Aunt Alice, and I (emergency room doc) can walk around outside for a few moments, wave at Lady Liberty across the bay, before returning home to hunker down.

From Puerto Rico:
- Acá estamos encerrados. Shut in. Even have night curfew. Got a few máscaritas when this began. Ahora, none can be found. Mi nieto sent me videos showing how to make them. Am not going out, so am OK, for now. May need some later. I think this will be a long haul. Cuidate, prima. Take care, cousin.”

From Chicago:
- A while back I got a few surgical masks from the office to use when cleaning house and yard. Now, they’re mandatory outside, so we’re disinfecting them. My niece está cosiendo más.”

From New York City:
- A friend 18 floors up at the edge of Central Park writes, “Women in my building are sewing some. So is my niece in Brooklyn, who has doctor friends sharing quarters in L.A., away from families to keep them safe. All have exhausted fabric and elastic.”

(Mask-maker friend in Albuquerque says suppliers are stretched thin. Seems the not-too-skinny elastic band is now dearer than toilet paper.)

Mi amiga in the Manhattan aerie ends, “Wouldn’t you know, all the sewers are women.”

I think of mi abuela, Mama Mela, bent over her Singer in Isabela, Puerto Rico—feet pumping treadle, speeding, braking, turning corners just in time, orando once again the bolt of cloth and spools of thread Papa Mingo brought from town will stretch, cover their ever-growing brood of almost twelve. Somehow, she always made it do.

And I think of the woman’s hands in a video I just saw @ dingdongdonghi fashioning a no-need-to-sew mask from a bandana and a pair of rubber bands.

I text my friend in the sky, “Not surprised. Women have always had a plan for this, that, and the other thing.” ♦
Hello. You’re not my doctor he says.
Yes. I am his doctor.
Calm. I explain this.
No. You’re not. We’ve never met. I want the other doctor.
Gentle. We have met, but there are a lot of us, it’s okay if you don’t remember.
Angry. I have never met you. I want my real doctor. The man.
Breathe. I’m one of his colleagues.
Scorn. Whatever. I don’t feel good.
Curious. How do you mean?
Rage. What do you mean, I just told you, I don’t fucking feel good.
Loud. Just say okay and do your fucking job.
Exhale. Okay. I invite him into the examination chair to look in his ear.
Scrape. I wrestle with the old drawers in the exam room.
Clunk. They do not open and do not close but are full of the instruments that I need.
Sizzle. Do you have to be so fucking loud?
Shake. I’m sorry sir, I’ll try to be quieter.
The broken drawers snap.
The drawers aren’t fucking broken, you don’t have to lie, just say okay.
Breathe.
Clench. Okay.
Exhale. I warn him that I’m going to lean his chair back.
Sigh. We go slow. I adjust his head rest.

Sniffle. He begins to cry.
Shame. I’m sorry ma’am. I’m having a rough time, coming down from alcohol and meth.
Damp. My parents died and my brother sold the house.
Anguish. I don’t have any money. I don’t have a home.
Soft. I clean out his ear. The infection is much better.
Tender. He can’t stay here any longer. He knows.
Dry. That other doctor bought me a Coke the last time. The man. I love Coke.
Grace. Thank you for doing your job and taking care of my ear.
Maybe it was the gratitude. Maybe I don’t want to be outdone.
Maybe it is pity. Or compassion.
Maybe it’s trying to prove that lady doctors are just as cool as man doctors.
Breathe. The hallway is quiet.
Click. I buy him a Coke from the vending machine.
Bounce. It slips from my hand and hits the ground.
Fizz. It might explode, I warn him when I return. He’s familiar.
Release. He takes the drink and returns to the wild.
Exhale.

– Antoinette Esce, MD
Child Free Life!
By Monica Moya Balasch, MS

When my husband and I decided to tell our friends and family that we were expecting, people were stunned. Everyone was seriously surprised; my mom thought I was joking. It’s true, we didn’t tell anyone we were trying to conceive. I really don’t want to put the image in people’s head that we are having unprotected sex, which is the first thing I think about when a heterosexual couple will proudly announce that they were “trying” to start a family. I never know what I’m supposed to say, good luck? Break a leg? Are you stretching so you don’t injure yourself?

The real reason people were in utter shock was because for many years my favorite chant was “Child Free Life! Child Free Life! Child Free Life!” I’d whisper it to myself when a toddler would be throwing a temper tantrum in the produce section. One time I was holding a friend’s baby, more out of obligation than wanting to, and the thing puked on my brand-new cardigan. The mom wiped his mouth and continued with her conversation. I wasn’t offered anything to clean up with nor did she give me money for the dry-cleaning bill. I remember singing the familiar chorus in my head “Child Free Life!”

I don’t recall when I first decided I would not produce offspring. Perhaps it was after I got a raging headache after I babysat Benny and Luke, the three-year-old twins who lived a block away from me. Their idea of fun one evening was to hit me on the head with their new foam bats. But I suspect the idea was starting to form in my head the moment my younger brother was born. David came into the world when I was six years old. As the oldest daughter in a Latina household, I was about to be offered free child rearing practice.

In a similar manner as prisoners in gulags are presented with the opportunity to work for free for hours and without pay. Lucky us.

I was a free and mostly reliable babysitter from the moment my brother was born. My younger cousins were also tacked on to me when they were born. That’s what you get for being a woman, I mean responsible. Sure, I dropped my brother a couple of times on his head, but he still somehow met all developmental milestones and is seemingly normal over twenty years later. By the time I started high school, I started to question the expected life course for the average woman in my family. It was implied that I would meet a man in college, marry this man after graduation and then comes Monica with a baby carriage.

I started voicing my desire to remain childless around the time my babysitting business was ramping up as a side business in college. I didn’t want to deal with the crying, the snot, the dirty diapers, the temper tantrums. My mom would reassure me that “it’s different when it’s your kid,” but I suspected my own offspring would still exhaust me without the added benefit of someone paying me to watch them. There would be no leaving them behind and going home, as presumably your kids live with you.

When I first met Chris, he just seemed like a father figure. Responsible, even-tempered, and fun-loving. Kids, dogs, and cats would all flock to him as if he was some sort of interspecies Pied Piper. From the beginning I was clear with him, he must love dogs, I was planning on going to medical school, I didn’t want to get married and under no circumstance did I want kids. I felt like I was doing this man a disservice by not procreating with him, he had the best dad jokes already!
However, he swore he was fine not having kids and I even overheard him a couple of times sing my theme song of “Child Free Life!”

Without using words, but rather through his actions, Chris slowly made me love him more and more every day. I don’t remember whose idea it was but one Saturday we found ourselves at a local jewelry store picking out wedding rings. Over a year later we were a happily married couple with plans to travel to Europe during my next break in medical school, but then COVID-19 started wreaking havoc. Suddenly the world shut down, medical school went remote, and Tiger King was all the rage on Netflix. At first the pandemic was fun, mostly because that pesky virus was a distant concern and Chris was forced to work from home. We were spending more time together and loving it. Then I started volunteering at homeless shelters as they tried to control outbreaks in a place where the concept of social distancing was a non-existent possibility. As the pandemic raged on, three of my family members died from COVID complications within a week of each other. Two of them were doctors and the third was my great uncle, the father of a pulmonologist who had recently contracted COVID. Ironically, I had recently reconnected with “Tío Luis” over social media, and we were making plans to visit him in Colombia.

Somewhere between reading the obituaries of my loved ones because we could not hold funerals, the driveway hangouts with my parents, and with my partner drying my tears that my priorities changed. I realized that in the bigger scheme of things, my neurosciences quiz score didn’t matter. It was insignificant that my cardigan got baby spit-up on it all those years ago. I was already dealing with bodily fluids and crying while in the hospital, why not at home. Sleepless nights were already the norm for me thanks to my anxiety and copious amount of coffee I drank during the day.

It was while the death count was increasing in hospitals and nursing homes that I broached the subject with Chris. What if we had a kid. This conversation took place before any COVID vaccine was approved, when there was no end in sight to this pandemic. Surely, he would question my sanity and decision-making capacity. But like most things I propose, he just replied with “if you want, love.” The same answer I get when I suggest getting Chinese take-out or going camping for the weekend.

Without much fanfare, I had my IUD removed and for the first time in my life I started having unprotected sex. When I saw those two red lines on the pregnancy test that meant an embryo was slowly forming in my uterus, I immediately told Chris. He was ecstatic and at the same time a little peeved that I told him without much flourish on a regular Tuesday.

Several weeks later I bought a small newborn onesie with the words “Hola Abuelitos!” I invited my parents over for dinner and gave it to them as a present. When my mom saw the small piece of clothing with the words that was greeting the new grandparents, she laughed then said it wasn’t funny. There was silence, they slowly realized I wasn’t playing a prank. My dad immediately hugged and thanked Chris, for convincing me to get pregnant. Because there was no way the woman who once repeatedly professed wanting a child free life would change her mind on her own about wanting to have kids while in medical school and in the middle of a pandemic. ♦
Falling Down
By Tara L Neubrand, MD, FAAP

Two hours before I met her, she was flying. As her legs pumped back and forth on the hot, rubber swings, her blood pumped, fervent and full of oxygen. Four sites bound by life’s breath and cycling through the body like the seasons. Blood flowed, emphatically soaking tissues and capillary beds, violaceous and sustaining while she climbed up a slide, slipping down the hard plastic in bare feet, and smiling, before we met.

Thirty minutes ago, she stopped flying, not landing, but crashing. When blood stops flowing, it becomes bruised, sticky. It does not puddle or pool when it leaves the body. It sculpts itself into a new form. Solid and three dimensional, it is scooped, not mopped into cardinal colored biohazard bags and later incinerated, flames consuming plastic the color of life.

One hour after I met her, her mother collapsed, fell to the floor of the trauma bay while surrounded by 18 strangers in full PPE. In N95’s, thick yellow gowns, blue rubber gloves, and full face shields, her mother could not see the eyes of the people who told her they had been unable to re-start her child’s heart. Maybe the shields are a good thing, protecting both of us. No one wants to remember the eye color of the person who breaks the world. When her mother fell down, the team walked carefully around her, gently tucking warm blankets around cold fingers and tiny toes. The tubes and lines had to stay though. The coroner said so. The detective sat outside of the room and prevented the mother from touching her daughter while she lay, prone and silent, on the hard floor at her child’s feet.

Two hours after I met her, the emergency department was full of new patients, and the ambulances kept coming. Her last day was our Tuesday, and there was work to do. “Jack of all trades, master of none” goes the description of our specialty. True, unless the description is of squeezing blood from stone, finding resources and resilience where there is none. Of that, we are masters. We squeeze until the rock shatters and the shards slice into our hands, and we all start to bleed. ♦
Mother’s Love by Gary Smith
They call psychiatry rotation “psy-cat-ion,” a clever play on words implying that psychiatry rotation is a vacation compared to other rotations. And sure, the hours are shorter without overnights for medical students. If you’re motivated and uninterested, you can typically leave around noon.

That wasn’t me though; I quickly became invested in every patient I saw.

I must admit, the week-long rotation at the Veterans Affairs Medical Center got off to a bumpy start. A patient called me “a pretty nurse,” even after I introduced myself as a medical student on his psychiatry team. I got too many compliments on my yellow dress from patients, got mistaken by a patient with dementia as his wife, and was told to smile (despite wearing an N95 mask). But it was the VA. What did I expect, other than pleasant older men with a side of slight misogyny? I quickly fell in love with work and patient population.

My first patient, Mr. H, had schizophrenia and PTSD. I was immediately interested in him from a medical standpoint. Although he had been well-treated by the time I joined his care team, he was still experiencing some delusions or auditory command hallucinations, thinking that the TV newscasters could communicate with him.

In fact, he tried to show me that when he moved across the room, they’d continue looking at him while talking. When they didn’t, he simply said, “I guess they aren’t doing it right now.” This was my first experience with psychiatric diagnoses that I’ve only read about in textbooks.

Things quickly became darker as the week progressed. My patient’s roommate hanged himself. I was spared the reality of what had happened, but it didn’t prevent the imagined scene from haunting me.

This was my first patient death, and the circumstances weren’t what I imagined. When you go into medicine, you know that you’ll lose patients. You imagine it’ll be secondary to cancer, an MI or old age if you’re lucky.

I had never considered that it might be due to self-inflicted death. Although mental illness is a chronic disease, no different from hypertension or diabetes, it feels different in the moment. It brings up conflicting feelings of sadness (Why didn’t they ask me for help?), guilt (What could I have done differently?) and anger (They didn’t have to do this).
My immediate reaction to this tragedy was selfish and raw. My thoughts ran from “I can’t do psychiatry. This is too hard,” to quickly trying to compartmentalize the death so I could function throughout the day - as we’re too often taught to do in medicine.

Luckily, awareness and caring are built into psychiatry as a profession. Upon recognizing my feelings and processing the situation, I broke down. Although I didn’t know the patient well, it hit me hard. I cried - and I cried some more. Even now, the thought of a hanging or noose makes me stomach turn and I feel physically sick.

More, I wondered: how would this death affect my own patient, who had seen the body and was admitted for suicidal ideation himself? Would it trigger another tragedy?

Luckily, the answer was no. He experienced some grief and anger toward his roommate but was discharged soon afterwards, stating that he had no suicidal ideation and felt safe to return home. He completed his safety plan, and as I transcribed his answers into the patient chart, I found that I made a bigger impact on his care than I realized when I saw my own name as someone he could rely on to help him. I hope he was telling us the truth and continues to be safe at home.

But the theme of suicide would not end there. My next patient, Mr. W, had been admitted due to opiate withdrawal and COVID infection. He was transferred to Ward 7 secondary to suicidal ideation and assigned to me.

He had a host of untreated medical issues, including PTSD, substance use disorder, chronic pain, and depression. I spoke with him for hours every day, discussing his life and feelings. Over the week, I heard about his wartime experiences in the military doing unspeakable things for his country, his childhood abuse at the hands of his father, and his struggle with addiction and the loss of his family’s support along the way.

He told me that he had nothing left to live for and that the overdose meant to take his life just hadn’t worked as planned. He wasn’t sure he’d ever be able to find someone who understand him, even if he did stop using illicit drugs. He was lonely and self-medicating with opiates, not only for physical pain, but his emotional pain. I was struck with the information he entrusted me with. At one point he told me I knew more about him than anyone else in his life.

The difficult thing about psychiatry is that the medication and therapy take weeks and months to show a sizable effect. When a patient is grappling with depression and suicidal thoughts, how do you bridge those weeks that could save their life? And who takes care of the people taking care of these patients?

I only had one week with Mr. W before I had to move onto my next rotation at the Office of the Medical Investigator, where I would perform countless autopsies, many of them resulting from self-inflicted death.

Still, I found it extremely difficult to leave his care team and continue to wonder how he’s doing. Have the medications started to improve his target symptoms? Was he accepted to an inpatient treatment facility? What will his life be like in five years? Has he decided to leave Ward 7 and start using opiates again? Would I see him one day on my autopsy table at OMI?

It was only one week, but I can confidently say that he will stay with me for the rest of my life. During our goodbye on Friday evening, he said, “You know, without you, I wouldn’t be here,” I responded as usual, that I was glad he was here, but that he should recognize his hard work in being here, fighting the cravings, physical pain, and emotional distress. But then he repeated it: “No, without you, I wouldn’t be here.”

That’s when I realized he didn’t mean here in Ward 7. He meant here, alive.
She smelt of strawberries. Sweet. Innocent. Delicate. Her scent overpowered the smell of disinfectant lingering in the OBGYN clinic.

She peered over at me from behind thick, black bangs. Timid, she was, wringing her hands in her lap. She sat on the edge of her seat.

“What brings you in today?” I asked. The usual leading question.

“I don’t know”, said she, softly. Her eyes shifted from me to the floor.

Long pause.

“Oh, well why don’t I start with questions on my end, and you can choose whether or not to answer them?”

She nodded in agreement.

I asked her about high school, about hobbies, about friends. She fed me little pieces of information. And then, I asked about relationships, reminding her about confidentiality. I started slow.

“Do you like males, females, both?” My hands were folded on top of my crossed legs. I was calm. No judgement.

She answered, males.

“How many partners have you had in your lifetime?”

She answered, four, peering over at me, waiting for my reaction. I nodded, unphased. I probed her with more questions. With every answer, she sat deeper into the chair.

And then suddenly, a big sigh. “Oh, what the hell!” she exclaimed. Words started pouring out of her mouth like water out of a jet stream hose.


I soaked it all in. A vessel for her thoughts. My face calm, nodding in understanding of her concerns. When she paused for a breath of air, I met her eyes and leaned towards her. I congratulated her on disclosing her concerns. She was very brave.

She chuckled, tossing her hair behind her shoulder. “Me? Brave!” She sat up straighter.

I spoke of having control of her own body, of finding boys who respect her values, of practicing safe sex. She nodded to every sentence she heard, devouring the information she had never had the privilege of hearing before.

I told her about everything that we could do for her today. And I let her decide. She was, after all, in control of her own body. She wanted a Nexplanon, pregnancy test, and testing for sexually transmitted diseases. We did exactly that.

At the end of the appointment, I walked her to the waiting room where her foster mom sat reading.

As they prepared to leave, she turned to me, and hugged me. Thank you, she whispered. She smelt of strawberries. Sweet. Strong. Confident. ♦
As I knelt next to the bed, I could feel my toes cramping and a subtle ache in my knee where it contacted the linoleum. After sitting multiple hours in the waiting room of the emergency department in extreme pain, my patient had finally received a bed located directly under the bright fluorescent lights in a busy hallway.

Curtains had been hung from the ceiling tiles, granting little privacy while he lay curled in a ball, clutching his abdomen. Almost like muscle memory, I had introduced myself and then immediately apologized for the uncomfortable state of our healthcare system. He expressed his frustrations that he had not been adequately cared for and begged for fentanyl to control his pain. His chart was full of previous visits for intoxication and injuries from fights, leaving his care team with preconceived notions about his reason for visit.

When a patient appears to be drug seeking, it flips a switch in our brains. We tend to stop thinking about the possible medical conditions and feel a distrust towards the patient. I listened closely to the story of his symptoms, keeping his history in mind, and then went back to my workstation to place orders for an abdominal pain workup and present to my attending. After hearing the whole story, I told the attending that we should give the patient a stronger pain medication but to keep in mind he may be drug seeking. My attending looked up from his computer directly at me and said “if someone is in pain, we treat the pain.”

New Mexico has always had limited healthcare resources for patients, as one of the bottom five states in the country when it comes to hospital beds per capita. But, when the Covid-19 pandemic began, the system was stressed passed its breaking point and never recovered. We are now left in a system where medicine is being performed in waiting rooms and patients get their care from an overstretched clinical team. The system can leave many providers overwhelmed, frustrated and almost apathetic. Add in our own conscious and unconscious biases and it quickly becomes a nearly impossible system for many patients to navigate. Regardless of these barriers, we need to remember why we are here. When my patient’s labs came back, a formal diagnosis of pancreatitis was clearly supported. His pain was very real.

While it is going to take change from every level of healthcare to improve the current state of our system, we as healthcare workers can still do our best to reframe even the most difficult situations for our patients. If we are kneeling next to a chair in the waiting room asking a patient about their skin rash, we can acknowledge that while our system is stretched thin, we are going to do everything in our power to make them feel better and safe.

For our patients assigned to a hallway bed we can ask them if they need any food, water or blankets while they wait for lab results from a backed-up laboratory. And for our patients with social factors that have led them to a life of poverty and substance use, we can suspend judgement to trust that they are in need just as everyone else. Because, if our patients are willing to look past the ways our healthcare system has neglected them and believe that we are working in their best interest, then we can do the same for them, regardless of their history. And we do this by remembering if a patient is in pain, we treat that pain.
In the words of the recently deceased Zen Master Thich Nhat Hanh, a cloud can never die. This was one of his favorite phrases to try to explain how we are all a continuum of each other, we “inter-are” and how we live on even after not being physically present. He used to recommend that if you were in love with a cloud, to not be sad when the cloud disappears. He used to say that if you were attentive enough, you could see your cloud becoming the rain and then becoming the flower, and even your tea. Physical death does not mean becoming extinct and this was one of the biggest misunderstandings of life.

When I started this journey, I was not even sure if I was going to enjoy the practice of oncology since from the outside it could be seen as bleak: the constant delivery of bad news, conversations about death, and the overwhelming amount of suffering. Oncology from the outside may seem depressing and dismal but there is nothing further away from the truth.

Through this journey, I’ve met the most remarkable people. Patients, family members, nurses, MAs, CNAs, social workers, and other providers. And through all of them, the meaning of the oncologic practice has become obvious.

Oncology is not only about treating cancer and relieving physical suffering through medications. It is the deep listening and compassion that knows no other and were the barrier of me, you, he/she and they fall away. It is the practice of relieving suffering but that does not mean only treating the pain, nausea, or the anxiety.

Through all of you, compassion and alleviation of suffering flow. This is what our work is, the work of a “bodhisattva” which according to Buddhism is when you decide to come back to this life over and over again to help others.
Through this journey, not only you reach patients but certainly, they will reach you. All of them, though some in a more obvious way. I vividly remember one of my patients when I was a first-year fellow, his initials were JY. Let’s call him Joe.

Joe was a gentleman in his mid-70s, single with no kids, who was admitted for back pain and a recent inability to walk from metastatic prostate cancer. He was with us for several weeks receiving radiation on a date close to mid-November of 2020. He was grateful to all and was always in a terrific mood. Is it not admirable that a patient with that advanced disease remains positive? A lot of it stemmed from him being grateful and just reminiscing about his own life. I came to see him a few times by myself and we always ended up talking about life or what he used to do and love. He was a carpenter, who loved old cars and his dream was to take a road trip by himself on what I think was the pacific coast highway in one of his old cars. Before leaving service I sat down to just spend my last moments of inpatient service with him.

His stories were amazing, had lost his father when he was still a toddler and as the older brother, he took early the position of the man of the house. He had another dream too which was to narrate his life and make it into a book and he was working on it with a freelancer at the time of his admission. He then told me how for most of his life he had been a carpenter and had made a big piece for a rooftop restaurant here in Albuquerque and told me to have a look at it one day. He even gave me his professional card and told me after leaving to message him and think of him as my “Crazy Old Uncle Joe”. I feel he was feeling somewhat lonely there.

I never messaged him, I was caught up in the busyness of the clinic and forgot. Also in medicine for some reason, they try to teach you to be distant and to not give your personal phone or accept big gifts or hang out with patients. They teach it in absolutes. They should teach it in relative terms.

A few weeks later I came back to the inpatient service only to find out that he had died two weeks after our last conversation. I immediately regretted not reaching out. Connection is the most meaningful and fulfilling aspect of being human. This is what we should nourish.

One and half years later, while celebrating the birthday of one of my close friends here in Albuquerque, we ended up in a restaurant that had a massive wooden piece as a bar and roof. I googled him and his obituary. His work was mentioned there and indeed the bar was his work. He had come to me this time. Our patients remain with us even after they are long gone. We are their continuation, and if you are attentive enough you can see this too. You can meet them everywhere while gazing at the sky or drinking a cup of coffee, walking, or treating another patient. This is the meaning of interbeing.

Every time you treat one patient you are treating them all, including yourself. Behind our illusion of separation, we are one and the same. So let us remember the patients that we have had the privilege to care for because in reality they are not gone and they continue with us.

A cloud can never die. ♦
Kindness On The Covid Ward
By Sarah Malone

I write as a Covid survivor, with deep gratitude to those who cared for me before, during and after my hospitalization in January 2021, before vaccines were readily available. I am also a retired clinical social worker, so write from a place of experience as a healthcare provider.

As a patient suffering from a potentially lethal disease, I experienced kindness at every turn of my hospitalization experience, starting with my call to the hospital for directions and continuing after my hospital discharge.

Once my telemedicine provider instructed me to go immediately to the hospital, I was determined to drive myself as I did not want to expose my husband to the virus. I believed I could gather all my strength and presence of mind to get to the hospital safely. The young orderly who took my call was very patient and gave me step-by-step instructions on how to find the hospital, where to park, and how to find the emergency room dedicated to Covid-19 patients. Thanks to the guidance of the young orderly, I succeeded.

Upon arrival, every individual I met, from the folks at the check-in desk to those who measured my blood oxygen levels and got me into a wheelchair, was patient, thoughtful, and communicative. I felt a tremendous sense of relief and trust that I was in good hands. Such care and consideration continued throughout my stay of several hours in the emergency room - where both ER nurses and a physician took pains to get me into a bed, take the necessary ex-rays to diagnose double covid pneumonia and recommend admission. They began an appropriate Covid treatment immediately, while I was still in the emergency room. No one appeared to be in a hurry; they all appeared...
to be totally attentive to my care and comfort.

During my three-day hospitalization, such consideration continued. Later I wrote the hospital CEO to praise not only the excellent clinical expertise of the hospital staff, but above all, their kindness.

As a patient of a certain age, I am loathe to cause any undue hardship or difficulty to anyone, especially someone caring for me. I strive to be a “good,” low maintenance patient! The hospital staff must have picked up on this tendency as I was continually encouraged to express my questions or concerns. None were considered illegitimate or superfluous. As a Covid patient, I experienced brain fog and bouts of anxiety; nonetheless, every staff person I interacted with showed me both patience and respect, coaxing out of me whatever my fears might be - or in some cases, intuiting what those concerns were without my having to put them into words!

Following discharge, I was referred to the post-Covid clinic where my progress continued to be monitored and supported. Again, the staff at the clinic, from nurses to the doctors, continually asked probing questions and listened carefully to my answers. Above all, they reassured me of my progress and acknowledged my hard work in recovery.

As a retired social worker, I well remember the times when my caseload was high, making it doubly challenging to remain open and engaged with each new client during the work day. Yet, it is that ability which makes all the difference in the patient feeling heard, and supported in their own recovery. In the end of the day, it is, perhaps, the ability to connect with each patient individually what keeps a caretaking profession fresh and meaningful to each provider, from clinical staff to orderlies!

In writing about his experience as a physician in Kenya in the early 1990s, Tom Gates wrote: “The famous turn-of-the-

century physician, Sir William Osler once said that the highest attribute that any physician could aspire to is “equanimity,” the capacity to detach one’s self from the patients’ pain and suffering in such a way that one’s scientific training can best be utilized to help the patient. Equanimity was indeed absolutely necessary, simply in order to keep functioning. But equanimity is not the same as not caring. It’s not turning to the next bed and carrying on as though nothing has happened, but rather learning to carry on with a broken heart. It is not aspiring to a heart of stone, but learning that the heart of flesh which God has given us comes with a price.”

As I learn more about the tremendous stress experienced by health care providers in hospital settings, especially on Covid-19 wards, I am filled with gratitude for the ability of my own attending staff to give me unfailing clinical care, coupled with emotional support, wrapped in kindness. It made all the difference in the world, not only to my hospital experience, but to my recovery.

was working in the bee yard on Wednesday, January 6, 2021 when the text message comes. It is a plea from my goddaughter, Maribel, in Santa Fe, to watch her then 8-month-old baby, Carlos, over the next two days as his regular babysitter is ill.

I ponder the request; weigh it; breathe it; fear it.

“What's the matter with the babysitter? I ask.

“A cold. She called the doctor.”

My goddaughter, a single mother, can’t afford to miss work. Yet, for me to go to Santa Fe and watch the baby at all, especially under these circumstances, is a risk, and I know it. Haven’t I held firm in my resolve to stay out of Covid’s way for all these months?

I call the babysitter. “Yes, just a cold,” she assures me. “My doctor told me so.”

It’s 9:30 Friday morning and I am holding the baby down for his nose swab, and then take him back to the apartment for a slow day, with fever, naps, soiled diapers, and rocking. Lots of rocking, holding, comforting. “Yesterday he was fine,” I reassure myself. “Maybe the fever that started overnight is a cold, or teething, or….”

The Covid diagnosis comes at dinner time. My goddaughter and I both know we are doomed. I call my husband, Jim, and ask him to prepare our bedroom for my quarantine as has been our plan should one of us fall sick. “Get me the oximeter,” I remind him.

My own positive test results arrive on Tuesday. I grow progressively worse. Fever; exhaustion; no appetite; upset stomach; dizziness; cough; shortness of breath - extreme shortness of breath. On the floor, at one point after a near faint, I realize: “This is on me! I can’t ask Jim to help me! I can’t expose him!”

By Wednesday morning I have a second video visit with a nurse practitioner. She asks me to show her the oximeter reading. 84%

“You need to go to the UNMH Emergency Room NOW,” she orders.

I call my husband in the next room. “I don’t want to go to the hospital,” I wail. “Why not?”

Covid-19
A Love Story

By Sarah Malone

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My own positive test results arrive on Tuesday. I grow progressively worse. Fever; exhaustion; no appetite; upset stomach; dizziness; cough; shortness of breath - extreme shortness of breath. On the floor, at one point after a near faint, I realize: “This is on me! I can’t ask Jim to help me! I can’t expose him!”

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I call my husband in the next room. “I don’t want to go to the hospital,” I wail. “Why not?”
“It’s crawling with Covid!”
“But Sarah, you have Covid!” Oh, right. I remember.

Under the best of circumstances, I am extremely directionally challenged.
“Can I get lost in a paper bag.” I like to tell people to get a laugh. I call UNMH and learn they have a separate ER just for Covid patients! I’m in a brain fog, but talk with a young man who gives me step by step directions on how to get to the hospital; where to park; which staircase to take; what door to open; how to find the Covid ER. I carefully write down his instructions and slog through the packing of a bag, not knowing what the future holds. Garnering all my concentration and strength, I drive myself slowly to the hospital, wearing an N-95 mask and face shield. I refuse Jim’s offer to drive me, again out of fear that I’ll expose him.

As I arrive at the ER, the care begins immediately. As I said, this is a love story!

Every nurse, every technician, every orderly treats me with kindness and concern. I am given a wheelchair where I bend over in an effort not to get sick, but throw up anyway. “We need to get her into a bed!” someone says, and they do!

Exhaustion overcomes me. The ER doc orders x-rays. “Double Covid pneumonia,” he reports, and offers to call my husband. “We’d like to admit you, just to keep you under watch for a few days...due to your oxygen levels and...your age,” a young nurse adds. She tells me of her own bout with Covid last year. Her tale reassures me. This is beatable, I think. She starts an IV with an anti-inflammatory drug, and warns me about what side effects to expect. “We call it the crotch burner!” she confides with a grin. “Oh great,” I think, “As if I didn’t have enough problems!” I manage a weak smile in return.

An orderly wheels me to my room, the same young man who had given me such painstaking directions on how to find the hospital! It feels like I am floating on a cloud.

I collapse into a bed on the Covid floor and am given oxygen, which surely is sweeter than any drug I could imagine. A feeling of absolute relief washes over me. Someone else is going to take care of me! It’s no longer all on me.

The coming days are quiet, as I am alone in my room; no visitors are allowed. Only members of my medical team enter, each and every one donning elaborate PPE coverings, but never forgetting to give me a personal welcome, check-in, and support. There is Gaby, who reassures me one night when I am overcome with anxiety; Jesús who makes sure the feed to my IV line is untangled; Hannah who delighst in the Covid journal I’ve been keeping for months, complete with the updated numbers for each day in New Mexico, the country and the world. There is a circle around the date of my own diagnosis. The overriding feeling this staff evokes is of kindness. Yes, they are experts at what they do, teaching me how to interpret oxygen levels on the monitor by my bedside and giving me tips on how to keep it in the safe range; encouraging me to rest. “I can tell you are someone who takes good care of others,” says Gaby. “Right now, focus on taking care of yourself!” Above all, I have never felt so enveloped by an equal measure of kindness and expertise, gradually turning around the assault on my body by the virus that has taken the lives of so many. A body divided against itself cannot stand.

At some point along the way I begin to talk to Covid. I plan any move outside of my bed, as each takes huge effort and concentration. “Covid,” I say aloud, “Would you please just cut me some slack?”

Then, one night, I find myself alone in the silence of the room, except for the constant hum of an oversized air purification system. In the silence, I close my eyes and remain present with the beating of my heart, my belabored breath, the beeping of the monitors. Suddenly I feel myself drawn...
downward into a sort of dark spiral tunnel. Round and round I go, having no idea how deep it is, whether I will reach bottom, or whether there is any other way out but back up the way I came.

From the beginning of the pandemic, I wondered if there might be some broader purpose for a worldwide pandemic. Might it be part of a larger plan? So, I decide to put the question to Covid.

“What is it,” I ask, “That you’re trying to teach us!” By us, I mean all of mankind. “Covid, what are you trying to teach us?”

The answer comes swiftly and clearly. “You need to love one another more.” “That’s it?” I ask.

“That’s it!” is the swift reply.

As I make my way back up the darkened tunnel, I feel a great peacefulness envelop me. I am crystal clear that all I need do is tell others what I just learned, and all will be well. People will wear masks to protect one another; they will get vaccinated; they will maintain appropriate distance; they will care about others as much, or even more, than they care about themselves. They will feel gratitude toward the medical staff who treat those with Covid, at risk to themselves and their families. Take it a step further and maybe whole armies will lay down their weapons, treating one another and the earth with the kindness that should be our birthright.

In a few days I am given word of my release. My nurse asks me to choose a favorite song, and without much reflection I name Amazing Grace, for that is what has carried me through thus far. As I am wheeled out of my room, Amazing Grace resounds throughout the long Covid ward hallway, and the entire staff comes out to cheer me home.

I wish I could say that the sharing of this story made the difference I imagined it would in the stillness of that night on the Covid ward. It’s not a story that many want to hear. In one month alone I attended two funerals of people dear to me who died from Covid-19. One was a close relative whose denial of Covid and refusal to get vaccinated took his life. Yet, not even his long suffering and death appear to have swayed the feelings of the Covid-deniers among his family and friends — the needle doesn’t appear to have moved at all.

I go back to my room in the Covid ward frequently in my mind’s eye. I remember the staff and their care and attention. I fear for their safety now, as new, more contagious, variants are coming down the pike, ones that may get around the vaccines that kept them safe when I was hospitalized back in January.

I go back down the tunnel to see if, by chance, Covid’s message for mankind has changed. But it remains the same.

“Covid,” I ask. “What are you trying to teach us?”

“Love one another better,” is the swift reply.

“That’s it!” I ask, incredulously.

“That’s it!”

Who knew? Covid-19 is a love story, for those of us who choose to hear it. ♦