



UCSD SCHOOL OF MEDICINE

VOLUME 17, 2012

# THE HUMAN CONDITION

*An Exploration of Art and Literature*

## LETTER FROM THE EDITOR

*The Human Condition* is entering its seventeenth year of publication. This issue continues the tradition of highlighting art, prose, poetry, and photography produced by those associated with UCSD School of Medicine: patients, faculty, staff, family, and medical students. UCSD has the good fortune of having members of its society that truly encompass the definition of a "well-rounded individual." Within this issue you will discover long-time patients that are remarkable poets; an esteemed surgeon that is as skilled with a paintbrush as with a scalpel; medical students and physicians that have extended their practice of healing from San Diego to the rest of the world; a renowned psychiatrist that truly embodies the term "healer." The works contained within show the depth of hidden skill contained within those of the UCSD community, as well as grant insight into the ambiguous entity known as the human spirit. Thank you for opening this magazine, and please enjoy all that you will find within.

Appreciatively,  
Ian Neel, MS IV



Cuong Nguyen, MS III

# THE HUMAN CONDITION

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VOLUME 17, 2012

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# DAY OF *Solidarity*

*Stories of compassionate care*  
UCSD MS IVs

In response to the tragic shooting of U.S. Representative Gabrielle Giffords on January 8, 2011, medical students around the nation elected to stand in solidarity, paying tribute to all compassionate caregivers like Dr. Randall Friese, and the University Medical Center team in Tucson who care for the wounded and dying. UCSD participated in this event by inviting seven fourth year medical students to share their own tales of compassionate care with first and second year medical students, in hopes of imparting some words of wisdom onto them as they prepare to move onto rotating in hospitals and engaging in patient care. What follows is a transcription of these medical students' stories from the 2012 Day of Solidarity.

## **Mackenzie Coffin**

**M**y story is one about the third year of medical school while on a pediatrics rotation. We had a two-month-old baby come in who was developing normally, but then all of a sudden stopped feeding, was no longer making eye contact, and started to lose the developmental milestones babies are expected to reach. This was at a Navy hospital and the only person with him was his mother. The mother's family was out of state, and the father was in Afghanistan. The father was returning from his tour of duty in August, however this was only March, and so the mother was in the hospital with her son—having to endure different tests, be seen by different specialists, determine if he had a mitochondrial or fatty acid oxidation disease—and she was alone. She was told not to stress out which, of course, made her stress out about not stressing out. She did a great job hiding her stress though, and I was impressed by how composed she was.

One day during pre-rounds, I was there with her and asked, "You're here by yourself. Is there anyone who comes during the day and supports you?" Suddenly, she broke down crying, and explained that she didn't have anyone nearby to be there with her. She did feel alone but had not wanted to mention it to the medical

team because she felt it was unimportant in light of the gravity of her child's illness. I proceeded to discuss the mother's difficult situation on rounds, explaining that she didn't have social support. As a medical student, I didn't know how to fix this child's metabolic disease, but I did know I could help the mom, by advocating for finding support for her. So I asked if there was any way we could try to get her husband to come home from Afghanistan, even for a short term, so that he could be here with his wife and child and help support them through this trying time. Over the course of that day the team contacted administrative staff in the hospital, and three days later the husband landed in San Diego and arrived at the hospital to be with his wife. It felt great to know that, while it didn't fix the child's problem, it at least provided the child's mother with some security, knowing she was not alone in dealing with her child's illness. This helped me remember that, as physicians, we cannot become sidetracked on a sole problem that we cannot fix; rather, we should search for other venues to address those problems that can be fixed.

***Suddenly, she broke down crying, and explained that she didn't have anyone nearby to be there with her.***

## Michael Charles

**T**he third and fourth years of medical school are years of great transition.

It is the point where we all take two years of hard studying and finally get to apply the gained knowledge to patient care. It is the year we truly start the steep learning curve of practicing medicine. It is a year that—while extremely enjoyable—can be frustrating and stressful. But sometimes lost amongst the rounding, the conferences, the journal articles, and the shelf exams is the greatest fundamental lesson of medicine: that much of our patient's healing begins well before any medication or procedure can be started and will continue when all of them have failed.

This lesson was made clear to me within my first week of third year. The second patient I ever cared for was an elderly man with severe end-stage liver disease. While my resident gave me this gentleman as he presented with all the typical stigmata of liver failure, he taught me a greater lesson. Despite all therapeutics, he was dying, and within a couple of days of meeting him I was to start the conversation of entering hospice. When I asked him what he knew about hospice, he stated that, "It's where people go to die!" While I clarified what hospice was, I also began to listen to how he felt. Most of my pre-rounding time the next several days were spent listening to him and letting him know we would take care of him, making him feel at ease as we hoped to place him at a hospice. On one of last mornings with this gentleman, he told me that he was ready to die and that I had been so great to him—me a student who had to read

*When I asked him what he knew about hospice, he stated that, 'It's where people go to die!'*

why he was taking lactulose or what does ocreotide do? This man never made it to hospice. He was sent to the ICU and passed away. I realized I might not have really known how to handle liver failure, or what the Child-Pugh score was—and to be honest I still don't—but at the very least I could care for the man and that alone helped him in his final days.

Another example of this lesson was while I was on pediatrics. I

had a teenager who had a problem that had every service perplexed. We later discovered she had what is called chronic recurrent multifocal osteomyelitis (CRMO) of the spine. She had a spinal fusion as well, and she also had Crohn's. I spent more than half of my inpatient rotation caring for her, reporting to her each morning to see how she was doing, relaying any new results and making sure all of her and her mother's questions were answered. Whether it was calming





**Often you heal the most the ones  
you can help the least.**

each of their concerns—until the gastroenterologists, orthopedists, and infectious disease doctors reached a consensus of diagnosis and treatment—or continuing to encourage ambulation and oral intake when she began to recover, I tried to do what I could for her and her mother. Here was a patient that had the best minds of Rady Children's Hospital puzzled and yet I knew I was helping by staying positive and reminding her that we will continue to take care of her. I know that scientifically, caring cannot cure in the sense of eradicating bacteria, but what it can do is heal a patient to where they feel whole and give them strength to heal physically.

Fourth year brought its own lessons. I was going to be an orthopaedic surgeon, a field not many people see as filled with humanism, and I was a "sub-I" so now I really had to know how to "take care of my patients." So I thought I was past having the time to have the experiences of third year—I mean I knew more now. I would not have to rely on just being nice to my patients. And yet this year was filled with moments where caring for the person had as much impact as treating

the disease. Whether it was a person with crippling arthritis, an injured weekend warrior, or a trauma patient, it was amazing how, by simply listening to the person and assuring them we could treat them or at least do all that, we would bring such relief to them. In some cases it was as if they already had begun to heal when they left the clinic. In order to do this properly I learned to practice the art of forgetting "the clinic clock" when it was evident a patient needed more care than the allotted appointment time allowed. I even witnessed an attending or two practice this as well. I also learned this includes even little actions like being that calming presence pre-operatively or post-operatively and letting the patient know everything went well.

You see, medical education is more than applying knowledge to a never-ending stream of patients, it's also learning to care for the whole patient. As some of my attendings demonstrated, as I progress in my own education I may learn almost all there is to know about how to treat a disease, but at my core I must continue to remember to care for the whole patient. Medicine will always have its limitations but our humanity will not. So what have all of these experiences taught me? It is that in terms of patients "Often you heal the most the ones you can help the least."

## Ian Neel

**T**he story I want to share is one that happened to me at the end of my medicine clerkship. Upon starting the last month I started taking care of a patient that had been followed by the team for a month prior to my arrival. She had been transferred to UCSD from Las Vegas after presenting with acute liver injury from a prolonged overuse of Tylenol for low back pain. She was transferred to us for transplant evaluation. Because of her precarious state and other factors she wound up not being a candidate for transplant, and thus her survival was left almost up to chance, because her severity of illness had literally a 50/50 chance of death. She fortunately survived the liver injury and her liver slowly began to recuperate.

About one week prior to my coming on service she suddenly became paralyzed. She couldn't move her arms, couldn't move her legs, and became extremely hoarse which led to examination revealing that one of her vocal cords was also paralyzed. The team thus began scratching their heads, contemplating what could be causing her sudden onset of paralysis, and this led to a month long work-up of numerous laboratory tests. Her liver was still recovering so she also had encephalopathy causing a delirium, which made conversations with her difficult, further complicating the diagnostic process. So she became one of those "medical mystery" cases that caused the team to say, "Oh, this would be good for the new third year medical student to take care of." I didn't know quite how to approach diagnosing and caring for her, but I did my best. As we proceeded to run labs, get results back, and exclude numerous different possible diagnoses, we eventually were able to find the cause. To jump to the end her diagnosis was critical illness myoneuropathy. The disease is just how the name sounds; it's a disease where, due to being critically ill, your muscles and nerves become inflamed and start to die. This was good news in that it's a disease you can recover from. You just have to go through a long process of physical therapy, and giving the nerves and muscles time for regrowth. That wound up being the majority of what I focused on with her for the last two weeks of my time on service, just going in daily, checking her strength, encouraging her to move things.

*...and thus her survival was left almost up to chance,...*

## Life and Death

What is it all about, being a doctor?  
It's working hard,  
Pushing yourself to do the best you can.  
It's caring about how you do it,  
It's learning new things nearly every day.  
It's sharing knowledge  
With teachers, colleagues, trainees, and staff.  
It's helping people,  
By giving them the best medical care possible.

It's also touching people,  
It's honoring the experiences we share,  
It's being there for the incredible times:  
Bringing life into the world,  
Healing and making a difference.

But there will be tragic moments –  
Moments of fear,  
Moments of loss,  
Moments of pain.

It's also accepting that we are who we are,  
We can learn from our actions,  
We can teach others to avoid similar moments,  
We can whisper sorrows to those in distress,  
And shed tears to cleanse our souls.

It takes courage...  
To walk forward  
After times of unexpected grief.

We must trek softly in worn moccasins,  
That have walked many miles,  
That cling to our warm toes,  
That listen to the notes that sing in our hearts,  
That walk along hallowed grounds.

Being a doctor is living between life and death.  
It requires dignity, diligence and more.  
It can be tremendously difficult,  
Physically, intellectually, and emotionally.  
But...it is simply beautiful.

— Dolores H. Pretorius, MD

July 2009

“*You are there to help guide the patients on their journey through the hospital to demystify the process.*”

Slowly she began to recover, being able to move a finger, then able to gain some strength in her speech. I kept her updated daily through the duration of my time on service as to what tests we were running, what the results meant, and what the next step would be—although I wasn't sure how much she understood since half the time she thought she was floating in the air on a magic bus because of her encephalopathy. Nonetheless, I figured if I was in her situation, I'd want to know what was going on, and so I kept her informed. The day that really sticks in my mind with her is the day she finally demonstrated 3/5 strength. She lifted her forearm at the elbow and swung it to the side of the bed. When she did that, her hand happened to land on my arm. So I replied, “Wow, that's really

great!” and replaced her arm to its original position, encouraging her to try to move it again. She did the same motion and again put her hand on my arm. Eventually I was able to piece out that she was also trying to whisper “thank you.” She was thanking me for something that she did on her own. There was nothing I was doing to help her heal. All I was doing was showing up every day, keeping her informed, and being there for her in an attempt to make the hospital a less scary place. It really struck home that that's what being a physician is. Being a physician is not just about the medical knowledge we have, being able to recite all the different causes of MI, or being able to list long differential diagnoses off the top of your head. That's part of it, but what it truly means to be a physician is

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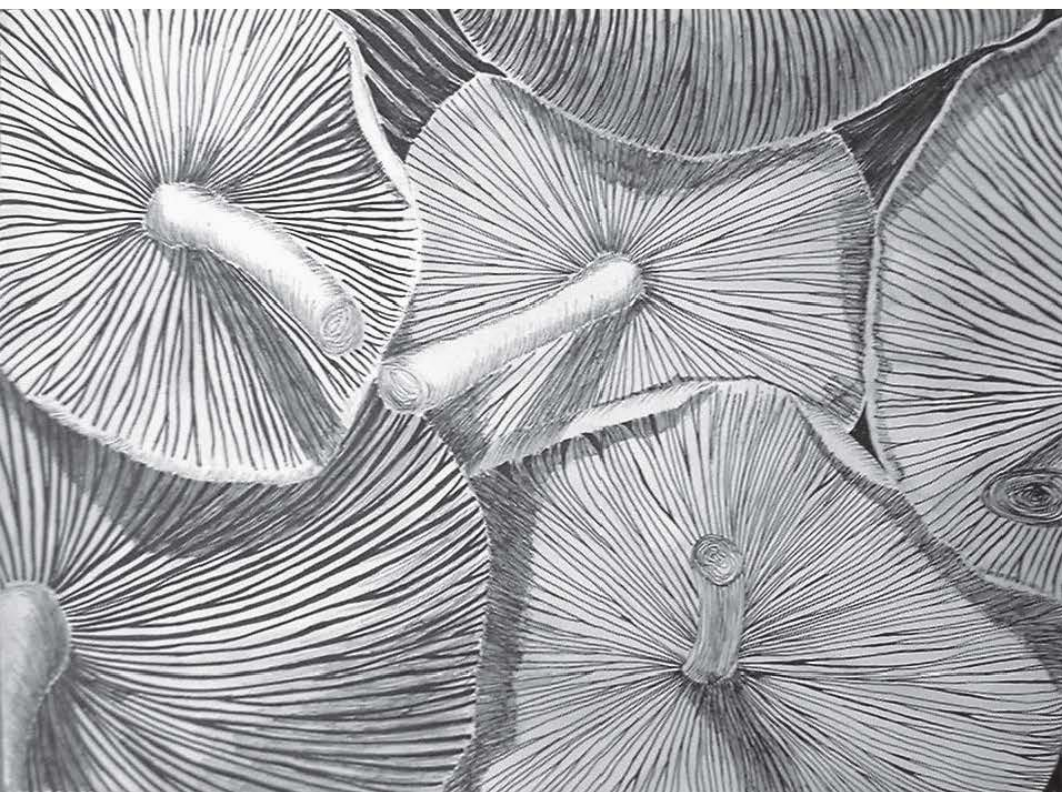
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— John Torous, MS IV

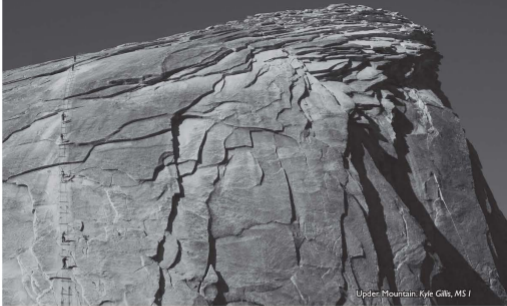
that you're there as an advocate for the patient. You are there to help guide the patients on their journey through the hospital to demystify the process. I carry that with me into every patient encounter I have, and I'll carry that with me to the day I die. I hope as you progress through your medical careers that you'll realize the truth of this as well.

### Christopher Birch

**W**hen I was thinking about something I can share, I realized it has not been just one formative patient experience for me, but rather a journey since starting medical school that came to a head this past couple months when I've been on interviews for residency. I'm applying for orthopedic surgery and one of the most common questions I was asked on interviews is, “What do you think makes a great orthopedic surgeon?” I still







Upper Mountain. Kyle Gills, MS I

don't ultimately know, because at the core they're getting at what a great physician is. In truth, empathy and compassion are higher on the list, while surgical skill and competencies are lower on the list. I have experienced that as early as first year of medical school. I had the fortune to be a student whose father was also a physician. Unfortunately, he passed away when I was in my first year of medical school, so I wasn't able to share in many tales of his clinical experiences with him. However, when I was at his funeral and during the days surrounding his funeral, I interacted with a lot of his patients, and heard from numerous ones "your dad was such a great doctor. He was so old school." I thought *that's weird*, I have never heard an 80-year-old woman say "old school" in my life. I didn't take much time then to explore what that meant, but fast forwarding to fourth year of med school, I was on an orthopedic spine surgery service. The day had been particularly long; we

had been in the operating room from about seven in the morning to about ten o'clock at night. The team began to get pretty tired, and when we finally got out of the OR we received a page for an ER consult with possible cauda equina syndrome. This was not something we could just wait and see in the morning when we were less tired. Cauda equina syndrome is a medical emergency, where you develop numbness in your legs, lack of movement in your legs, and this patient also hadn't had any bowel movements or urinated the entire day. Time was of the essence.

That moment was very instructional for me, because we were here with an attending physician who had been operating almost non-stop that day, and had a similar schedule during the past two days. However, the physician proceeded to walk into the room and sat with the patient for almost an hour and a half.

*...during the days surrounding his funeral, I interacted with a lot of his patients, and heard from numerous ones, 'Your dad was such a great doctor. He was so old school.'*

*“Ten minutes into the conversation, the patient broke down and began crying, telling me that his wife had recently died.”*



making calls to family members, performing a thorough exam, and even taking time to print out MRI images for the patient to teach her about the disease process occurring in her body. He went back and forth about the risks and benefits of the surgery after explaining all of these things to the patient, to ensure she was making a truly informed choice to have surgery or not. This blew me away: an hour ago, all we could think of was how we were hungry, thirsty, and exhausted, but none of that mattered when an emergency arose. I remember sitting in that room and remembering what my dad's patients said about being “old school.” I think a lot of what “being old school” entails is time—taking time to explain things to your patients, and taking time to just be there with and for your patients. We quickly learn as third year medical students that the surgical specialists are busy and notorious for not spending enough time with patients. Even on this rotation we were in a culture of “business,” but despite that culture this physician chose to take the time to demonstrate empathy and compassion to this patient with cauda equina syndrome. It made me realize that being a good physician is all about time.

### **Anthony Tadros**

**T**his was the beginning of fourth year, and I was on a cardiology service. We had a patient who had an unfortunate series of complications from his treatment course. He had a pseudoaneurysm, MRSA bacteremia, and a deep vein thrombosis—and he wasn't happy about it. He lashed out violently due to his displeasure, and notably had self-injurious behavior, hitting himself on the head repeatedly. This

was dangerous because his blood was thinned due to the treatment of the clot in his leg, and so we were very concerned about the guy. We diffused the situation, and attributed his agitation to being upset at the complications of his hospital course.

The last day before the patient left for a rehab facility I did something a little different than my normal morning exam. I sat with the patient a little while and listened. Ten minutes into the conversation, the patient broke down and began crying, telling me that his wife had recently died. He explained the reason he had been so upset during his hospital course wasn't so much about the complications, but actually that he felt abandoned by his children, who he felt were leaving him to die now that his wife was gone. That was my "a-ha" moment, that I should have spoken to him about his agitation sooner. I think the big lesson for you all is that when you go out into the wards you should seek out the difference between your interpretation of what is happening and the patients'. Often not doing so will omit things that are smouldering just beneath the surface.

### Anshu Abhat

**I**walked into the first day of my fourth year internal medicine sub-internship thinking, *now I'm supposed to be more of a real doctor than I was in third year of medical school. Now I'm expected to know something.* I entered the room of my first patient and she looked sick. I grew a little

nervous and began researching more about her clinically. I learned she had anaplastic thyroid carcinoma, which is one of the most rare and aggressive forms of thyroid cancer. She had her thyroid removed, and resultantly injured her recurrent laryngeal nerve which made her hoarse. I knew she had a pleural effusion. I knew she was sick. It was tough for me, though, to come to grips with the knowledge that she was going to die soon. The patient proceeded to tell me, "Don't tell

me anything. I don't want to know anything about my condition or my medical care. Please convey everything to my sister." So I know that you're sick, I know that you're dying, but I can't tell you. I know that you're dying and you want someone else to take control over your life. I wanted her to take control, but I had to let that idea go. I found out that the patient was an incredible woman, who had put everyone in her life before herself. She had forgone getting married or having children and instead took care of all the other children in her family. She was always the strong one, and now she was asking for someone else to be strong for her.

**“Don't tell me anything. I don't want to know anything about my condition...”**

## Crazy Horse (Tashunka Witco)

In Lakota land lived a curly haired boy.  
He became a warrior and earned a warrior's name.  
As Crazy Horse he became a shirt wearer.  
Bravery as a fighting man earned him lasting fame.

First he led his braves at the Fetterman Fight  
Then stopped General Crook under Rosebud's burning sun.  
At Little Big Horn he finished George Custer  
Then we stabbed him in the back at Camp Robinson.

How can a man say goodbye to his way of life,  
Farewell to bow and to buffalo herd,  
Hello to cows and to plows and to hoeing weeds,  
All to make peace with men who don't keep their word?

Spirits spoke to him out of thunder and rain,  
Urged him on though he was reluctant to command.  
Was he betrayed by his spirits and visions  
Until he was dust again in Lakota land?

He was a man called to lead while his way of life  
Crumbled beneath the onslaught of white men,  
Men who would try to deny his ancestral ways,  
White men kept coming and he just couldn't win.

Heroes are often made by fights they can't win.

— Stephen Baird, MD

In the end the patient's sister had to make a decision of what's best for the patient. The sister was scared of taking the patient home where there were children that she didn't want to expose to a dying relative. Together though, we advocated for the patient.

The patient did pass a month later, but I think she passed with dignity

among those she loved. It was frustrating not being able to help her, but I think her healing was her passing on with her dignity intact. I guess that's something that I've realized over these four years of medical school—which I'm thankful will be done soon. Knowing your patient and what healing means to them can be very helpful.

## Pritha Workman

It's hard to come up with one specific example of how I've changed as my experience through medical school has been one of ups and downs wherein I feel I have personally changed a lot. However thinking of a formative example, I think back to about a year ago, my husband, a Marine, was deployed overseas. He's back now and safe, but that's not the point of this story. At the time he left I had an eleven month old child and was starting a surgery rotation, which is one of the more time intensive rotations in the third year of medical school. So you can start to see this perfect storm brewing. I don't know if you've spent a lot of time with an eleven month old, but they take a lot of time. Similarly, so does your surgery clerkship.

I was assigned to the transplant service. My normal day starts early, you round and see patients, then go to a surgery or two, followed by more care of patients in the hospital wards. Then I'd go home, make dinner for my son, take out trash, bathe him, and then somewhere at the end of the day I'd find some time to study.

One day proved to be different though. It was about seven thirty at night, and I was giving my son a bath, when I received a call from the transplant team that we had to go perform a procurement. I finished bathing him and handed my son to my sister in-law who was in town that month helping me, then quickly threw on scrubs and hurried to meet the team. We proceeded to drive to Montgomery Field which I was pretty excited about; getting to take a plane to the Central Valley to procure organs from a donor. We

# Friday Night

For dinner, the nurse hangs my bags:

clear TPN and milky-white lipids.

On the side: antibiotics, Miralax, lactulose, insulin, a snort of Advair, and a gallon of GoLYTELY, to wash it all down.

For spice, she cuffs my arm ...

then my other arm ...

my calf ...

and again, ripping now the Velcro off faster each time.

Then a second nurse tries.

Then a third.

"We can't measure your blood pressure," they say.

"It's too high."

"Hold still," they command. "And lie flat."

So, motionless, I ponder ... TPN, total parenteral nutrition, ...

Where does it come from? And what is it?

Animal? Vegetable? Or mineral?

Is it Kosher?

Vegan?

Or Vegetarian?

"It's Friday night," says my wife.

"Should be roast chicken."

— Steven L Shepherd, UCSD patient

*“I’m not sure if being a doctor’s making me a better mom,  
but I think being a mother is making me a better doctor.”*

landed and there was a black Escalade waiting for us that took us to the hospital. I knew nothing about the patient that we were procuring the organs from, which is appropriate given the ethics of procuring organs, but we were told what we needed to know: HIV negative, Hepatitis B and C negative, blood type, any other comorbidities, and cause of death. This particular patient was nineteen years old, and had been the victim of gang violence. He suffered a gunshot wound to the head, and—this term still doesn’t sit well with me—was considered an injury that was “incompatible with life.”

It was a disconcerting experience for me, because until this time I had always walked into an OR with the expectation that now we were about to do something to save a life, to help the patient in some way. The mood was so different on the procurement, because those expectations didn’t exist. Here we were going into an OR not to save a life, but to salvage organs from a life that had been lost. The act of procurement though is very elegant and beautiful. The heart and lungs go first, of course, because the heart has the shortest time span it can survive outside the body. You cross-clamp the great vessels and from that point you have four hours to remove the heart, have it whisked away, and delivered and placed inside the waiting recipient. So we’re on speaker with a team at Stanford waiting for this heart, coordinating our surgery with theirs, ensuring their patient was ready the moment we began the procurement. Then we proceeded in similar fashion removing the other organs: the lungs, the liver, the

kidneys. Now as you can imagine, you need to keep each organ intact inside the body as you remove the other organs. So when they remove the heart, they continue ventilating the lungs, to continue to provide them with oxygen. It was very disconcerting to see lungs inflating and deflating while the patient’s heart was gone. That unnatural feeling really stayed with me.

Toward the end of the case we had finished what we needed to do, and the scrub nurse said she would “close,” meaning sew the patient’s body back up. I told her “no, I will close.” I now see my patients—whether they are a nineteen-year-old gang member who died from gang violence, or an eighty-nine year old man—as my child. That day I was grieving. I was grieving for a mother who had lost her son. The patients to whom we delivered the organs at UCSD did well. It was really everything you want a transplant to be. After all was said and done my attending turned to me and said, “Aren’t you excited!? Wasn’t that amazing?” I replied “I—I’m not there yet.” Having seen the results of the transplant I was happy at the lives we saved, but that day, as someone’s mother, I had to mourn. I’m not sure if being a doctor’s making me a better mom, but I think being a mother is making me a better doctor.

# Death Packet

Brenda Nuyen, MSIII

**C**ode blue, the intercom serenely pronounced. Always said in such a matter-of-fact tone. It is an orderly packaging of un-orderly words, attempting to regain control of an uncontrollable situation. That day was my last one on this rotation, a beautiful altogether matter-of-fact Sunday. Who could have known that despite all, the day was heading towards uncontrollable.

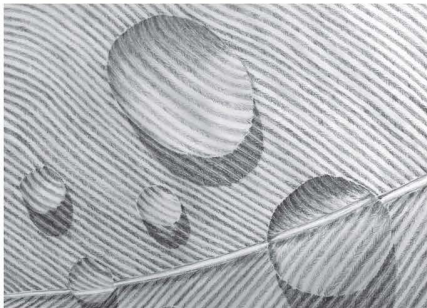
My intern and I were seeing another patient that morning when we heard the announcement. Per the usual, we perked up our ears; per the unusual, our eyes widened when we realized the patient could be ours. The intern ran out of the room to hear the intercom better, and heard some nurses mention the patient's name. From that moment of realization was a blur of actions. Ripping off my gloves. Sprinting down the hallway. Jamming the elevator button. A whole lot of movement, not a whole

lot of thought. I could not process the fact that this was *our* patient who basically had been announced on the brink of death. It was my first code, and I did not have the benefit of observing one with less emotional connection—there was no “easing into it”, if this situation could possibly even be “eased” into at all. Running down the hallway to where the patient was, I was amazed that the nurses and RT’s pointing us in the right direction were so calm, so controlled. They, unlike I, did not personally know the patient. They, unlike I, had seen this before. Security officers were standing outside the room with their arms crossed in front of them, just like they were presiding over some concert in the park and were keeping tabs on it. Keeping calm, keeping control.

The room was full with people and quiet concentration. If despairing anxiety was at all present, it was

well masked. An ER attending led the code with expertise, and the code team shocked, pushed meds, bagged. I got in line to do chest compressions, all the while frantically reviewing in my head what I had practiced on a dummy in the Price Center ballroom just months before. Before I knew it, I had to climb a step stool and fling my knee onto the hard surface where the patient lay, in order to get into position. What hit me first was that the human chest is not unlike the dummy chest. It was springy, and responded jauntily to each up and down, up and down. The body jerked with every compression, every shock, every attempt to intubate. Some blood trickled out of the patient’s mouth with each time the tube was jammed into it. All these signs of life – the flowing blood, the dancing movements of limbs and head – were so discordant with the realization that the patient was slipping away. Twenty-two minutes went by, and with the fourth shock, the ER attending announced asystole on the monitor. As I was wrapping my mind around that declaration, he—never wavering the tone of his voice throughout—asked for any objections. I felt the futility of the moment rise from the bottom of my stomach. I wanted to say something. I didn’t want to hear that it was the end. No one moved; no one spoke. The attending said, in the same tone in which you would order a coffee and pastry, *OK—time of death is 9:09 AM.*

I could barely hear someone murmur that the clock in the room was 5 minutes slow, and I hardly registered



that the attending corrected himself and announced 9:14 AM. The room still continued in calm motion, but now in the packing up of equipment, the grabbing of stethoscopes and white coats, the heading towards the exit. Except I just stood there awkwardly, thinking *what now?* My team huddled in the corner around me. I had never seen my attending and residents so crestfallen. In a way this dejection reassured me, that what I was feeling was normal, and that we were allowed even just a mere moment outside of the bubble of calm unfeeling precision that is the protocol of a code.

We headed upstairs to talk to the young granddaughter of the patient, who did not know what had happened. Neither did anyone else we passed in the hallways. Riding the elevator back up and walking through the floors, I saw everyone go about their business. Nurses were charting, patients were ambulating, visitors were carrying balloons and small children. It really was another day. I felt that I was walking in a glass box, that there were walls shielding me from the normalcy of this beautiful Sunday and shielding others from the tragedy we had just experienced downstairs. We were all occupying the same physical space of the hospital, just not the same emotive space.

*I could not process the fact that this was our patient who basically had been announced on the brink of death.*

My attending made the necessary phone calls, and the discussion with the family unfolded in a private room with a social worker. I watched as these people I had never met expressed emotions and thoughts that strangers rarely see or hear. The team sat in acceptance of the grieving process and the sobs and the silence. When we left the room, I was thinking that although I likely would never see them again, I was tied to this family in some way, a connection more profound than what I share with even some people I see day in and day out. This experience would be an indelible thumbprint in their lives, and even if not as deep and wide, in mine as well.

At the nursing station, my intern dug out a manila envelope. On the front was a big sticker, displaying tall composed capital letters—“DEATH PACKET.” In it was a stack of papers to fill out, with

Brenda Nuyen, MS III



“...I, for a life time, will be standing on the cusp of life and death, and will have to stare into both.”

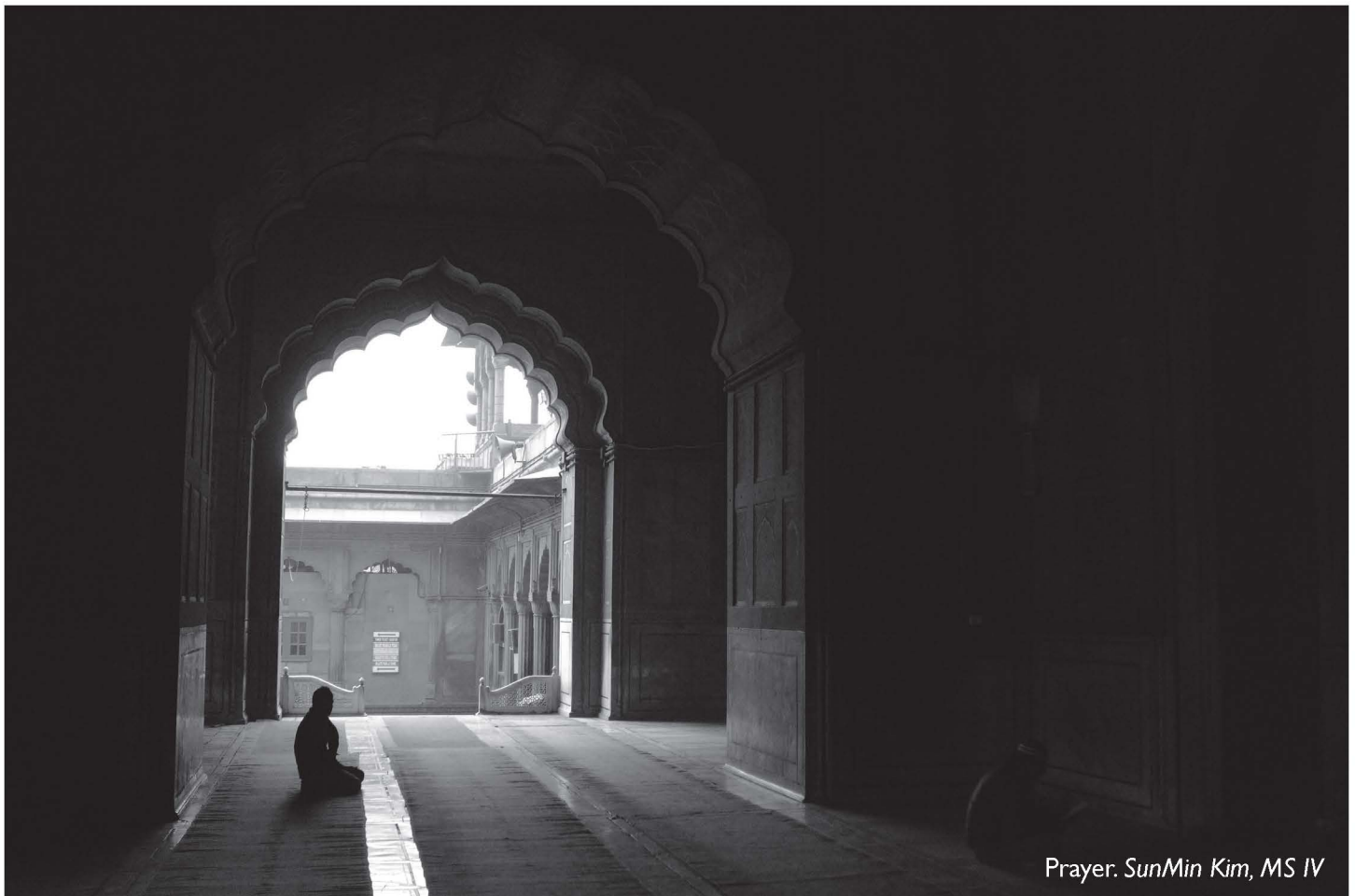
numerical steps and bullet points and signature lines and fine print. This clean orderliness reframed the sense of calm manufactured by the operation of the code. Here we were again, trying to regain control of something that fell out of our control. The rest of the day, the team continued to round on patients, put in orders, and type up our notes. But there was no way we could pretend it was just another day. Sitting amongst ourselves, we fought with our doubts settling in our minds and in our stomachs. We knew that there was absolutely no way that we could have predicted that what had happened would have

happened that morning in that way. We would reassure each other, but then soon enough we would be back revisiting those doubts.

When I left the hospital that day, this last day of the rotation, I walked to the parking structure, and instead of driving off to enjoy the gorgeous afternoon, I sat in my car and cried. I had to step outside of that bubble of unruffled precision and confront the un-calm and the un-control. I did appreciate the methodicalness—without it, how could the hospital continue to function? How could other lives be cared for and bettered and saved? But it was taking me

some time to process the event and come to terms with the fact that for the first time, I fully realized that I, for a lifetime, will be standing on the cusp of life and death, and will have to stare into both.

I continued to reflect on the events and emotions of that day, and for some time, the bruises on my knee that had climbed onto the CPR surface board reminded me that I had reached a milestone in my training. I am sure that with each future code I am a part of, I will be more able to envelop myself in the calm and control with which the neat lettering of DEATH PACKET was imbued, the precision that allows us to confront death time and time again. But I also hope to never lose that human edge of un-calm and un-control, that keeps us present and connected with life.



Prayer. SunMin Kim, MS IV



# Bad News

Sapna Iyer, MS IV

All I could think was that she must feel incredibly alone.

In truth, the room seemed too full of people. They were everywhere—sitting in chairs and corners, sprawled on scattered sheets strewn on the floor. Full of people and full of conversation—animated words bouncing across the walls, reaching out to meet us in the hallway before we even reached the door. Before we walked in, she had been gazing out the window, she alone silent in this chaos of words and faces. At our knock, her head nodded toward us, only briefly acknowledging our presence, but her eyes remained facing the window, her thoughts safe in the quiet, comfortable privacy of her mind.

The experience became sensory very quickly. The noise of conversation quickly faded, but silence never came: instead, the endless cranking and whirring of the room's air conditioning, which had been set to the highest level. The drop in temperature was immediate and alarming. The irony could have been comical—most in the room layered in sweaters and jackets and scarves; outside, a typically balmy San Diego afternoon. And she, in the room's center, only half-wearing her hospital gown, a towel against her forehead, and bucket of ice water dutifully nearby. Her body was running its own thermostat now.

I glanced at the progress note in my hand and reminded myself that she was only 43 years old. When she wrestled herself out of her thoughtful silence to finally

speak, it became clear how young she was. Remarkably present in the moment, she smiled often, laughed at our jokes, made jokes of her own.

We made small talk—the weather, the Padres' recent victory—but then, reluctantly, turned to business. The shift in tone was palpable, and we felt faces around us

tighten, family members lean towards us to hear our words. We inquired about her pain, nausea, and medications. She would need to leave the hospital briefly later that day for some radiation treatments, and the logistics of transportation were discussed. It could have been any other morning visit, any other check to see how her night had been. But eventually, inevitably, she asked the question we had been dreading: the MRI?

So much silence. An unending, infinite pause. My intern began to answer, and my resident filled in—in broken Spanish for the family—when necessary. Together they weaved a careful response, a delicate, artful dance.

**Metastasis.  
Leptomeninges.  
Brain involvement.**

Unspoken issues remained in the air—of prognosis and timelines and future steps. A few people in the room made motions to speak. But she was already back in her reverie—eyes to the window, distant from us all. It was clear that the best we could do would be to allow her her thoughts. And at least for now, those questions would wait.



N=1. *Maryam Soltani, MS II*



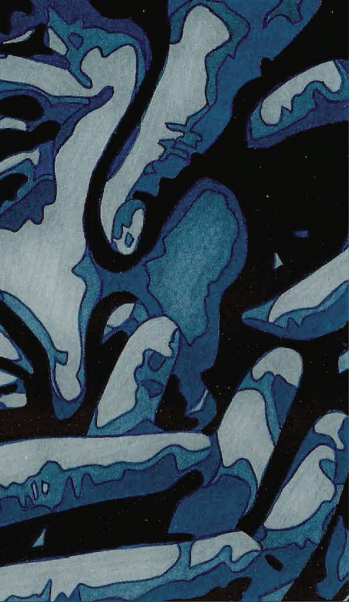


Above, top to bottom: Hmong Youth. Kyle Gillis, MS I  
Pascual Hunter Dutton, MS IV  
Cuong Nguyen, MS III

Right, top to bottom: Workers in Fes Madrasa.  
Sam Sepehr Keyhani, MS II  
Bonigen, Switzerland. Kyle Gillis, MS I  
On a Leash. SunMin Kim, MS IV  
Across: Racetrack Playa. William Auyeung, MS IV

Clockwise from top left:  
Karyotype. Vanda Farahmand, MS IV  
Oppression. Maryam Saltani, MS II  
Nice Purple. Kyle Gillis, MS I  
Spectators. SunMin Kim, MS IV  
Manzanita. Ashlin Mountjoy, MS II  
Street Performers in Old Quebec.  
Sam Sepehr Keyhani, MS II  
Introspection. Eric Sorensen, MS I  
Village Kids. SunMin Kim, MS IV







Clockwise from top:  
Pineapple Man, *SunMin Kim, MS IV*  
Guitar, *Tony Neel*  
Farmer from Garmeh Oasis, Iran.  
*Sam Sepehr Keyhani, MS II*



# Words from the Heart

## A Hospice Experience

Jennifer Greenhall, MS IV

Opening my eyes, I stare at the white, mottled ceiling. Am I still alive? As I glance around, I recognize my husband's dresser and the quilt my grandmother gave me...ah, my room...home. A wave of relief washes over me just as a pinch in my side reminds me that I'm so far gone I can't eat anymore. Crap.

Let's see, what do I have going for me? I feel air moving in and out of my mouth and my pulse echoing in my ears. I guess I'm breathing...my heart's beating. With effort, I move my foot and raise my hand to rub an itch on my face. Very well, but the rest of my body has become a prison. How long have I been like this? The days run together. I wish I were still a girl playing at school, or better yet, a young mother pushing Tommy on the swing. He loved to swing...

The light has dimmed. How long was I asleep? I turn my eyes to a voice, my mother's voice...my mother's face...but she died years ago. Am I dead? Where am I? I spy the quilt again and relax a little, but who is this woman impersonating my mother? I try to ask her who she is, but no words pass my lips. No matter how hard I think them, they just don't come out any more. She's talking

but I can't understand her. The sounds merge together into nonsense. Concentrate. Did she say Lily? She can't be my sister, Lily. Lily's young and beautiful with long brown hair. Whenever she tosses it, the young men take notice...



Slot Utah. Kyle Gillis, MS I

lips haven't carried anything but a moan across them in weeks, but it seems my heart must have forced the words out. I try to continue but I'm back to being mute. Tommy kisses my hand as a tear rolls down his cheek. "I'll always love you, Mom."

Cold. Pain. Someone is jostling me. What's happening? Cool wetness is smeared across my back. Cleaned. I'm being cleaned. My mother... is she my mother? She seems to say that Tommy will be here soon... Tommy, my Tommy...A smile spreads across my lips. Soon...I cling to that as my eyes shut again.

Light lips on my cheek wake me. I focus my eyes, and there he is, my boy, my baby, the light of my life...Tommy, oh Tommy...He holds my hand, and I squeeze his with all the strength that I have. He smooths the hair back from my face. He's talking but my foolish mind can't comprehend what he's saying. Oh, he's so beautiful, so sweet, so precious. "Tommy, I love you," I say. My





*Alone in the Mist. Katherine J. Blair, MS II*

## The Lewy-Body Brain

Your frail and rigid body lay beneath  
The sheets that day when I, a wide-eyed student,  
Came to see a man of God  
Fight valiantly your fear of death.

He knelt beside your bed, so calm,  
His face near yours, a whisper sweet,  
A kindly word to penetrate  
The prison wall that was your  
Mask-like face.

You stared at me as holy words  
Like living water flowed through agéd ears  
And stirred familiar memories  
In your Lewy-body brain  
Of peace and grace and sacred times  
When God was near, his presence felt,  
Within the chambers of a younger heart.

How many nights had I stayed up  
In terror that I too would share your sorry fate?  
That tremor, pain, and stumbling gait  
Would lead me down the path you trod,  
Towards a heartless prison,  
That I never could escape?

How strange to see my darkest nightmare,  
Harshly on display before me now,  
With you, dear Mary, fate's cruel victim,  
Helpless, hopeless, seeking peace,  
Preparing sadly for your final day.

Fortune, fickle, now has turned  
And shown me that my fears were vain.  
And yet, I realize as I meet your darkened gaze,  
Behind your stoic, masked face,  
Beyond the madness of your battered brain,  
Deep within the farthest, hidden crevice of your soul,  
That horrid fear that haunted me, a memory now,  
In you burns hotly, still the same.

The man of God speaks words divine  
And kisses you upon the cheek.  
A life of love, like yours, he says,  
Is noble, valiant, praiseworthy.

The sacred silence graces eyes with tears.  
Can holy words reach past your broken brain  
To quench the fire of fear that hotly burns  
So deep within the human soul?

Rest in peace.

— Jacob D. Durrant, MS III

# Kia Ora, Report from New Zealand

*My First Day in the A&E Department*

Martin Kabongo, MD/PhD

It must have been around four o'clock in the morning. I was having my restless night with fretful nightmares that occur when I am on call. Then I heard the dreaded croaking sounds of the "hot potato." That's what they call the mobile phone a.k.a. pager. I jumped out of bed.

"Hello," I grumbled.

"Doctor Maaarrteecenn."

"Yes," I replied.

"This is Foote Ward, nurse so and so." I did not quite catch her name. "You need to come now. Nurses can't stop the bleeding..." Click! The phone died on the other end.

I jumped out of bed and slipped into my ever present good luck teal scrubs in seconds. Those scrubs have accompanied me everywhere I have been. I don't remember from which hospital I stole them. I can't remember how many times they have been washed. I am not even sure if these scrubs are still a teal color anymore. At the same time, my heart was pounding. The pulse must have been more than twice my age if I had checked it. A sign of fitness? No! Because in my head I kept asking myself, "Should I still be doing this 'shit' at this age anyway? Oh! Damn, when was the last time I got certified for ACLS? Remember ABC...."

I have subconsciously grabbed the key to the PRIME. That's the name of the "primary in emergency" car that one inherits unenthusiastically the evening of call in the A&E. That stands for the Accident and Emergency



“Did I say salvage  
another soul? Why?  
Is it really what our  
role is?”

Department. A&E is attached to the 8 bed hospital (Foote Ward) of the community health clinic. The sky blue Toyota Corolla has all that is needed—from emergency drugs in a neon yellow bag to a green monstrous oxygen tank. It comes complete with a blue emergency police beacon. The beacon comes with a siren that I could have turned on as I dashed in the misty fog to salvage another human soul. Actually I did not have to use the police strobe light since I was the only car roaring on a slippery semicountry road back to Foote Ward. Did I say salvage another soul? Why? Is it really what our role is? Or is there another way of making a living?

As I lumbered in the room, all the walls were painted crimson red. “*What happened?*” I sheepishly asked like an idiot. I looked on the cot, I saw a squirming and screaming victim. The nurse’s nice white uniform was painted with red blotches as well. She reproachingly looked at me as if to say what took you so long?

An 18-year-old fellow was smoking a bong. God knows what was in it. Then he “*went crazy,*” his large-bosomed girl friend told me between the sobs. She looked pathetic as black eyeliners were smudging her red face. Apparently in his trance and hallucination, the bong-smoker threw himself into a glass window. He sheared a full thickness skin off the right side of

## Unfailing Love

“*What a man desires is unfailing love...*” Proverbs 19:22

And what is love?...

- ... To bring him a shell from the ocean or a rock from the mountain where you were without him
- ... To give your last penny to buy her the orange she wished for so much
- ... To eat this extra bite I want to share with you even when you are full
- ... To come home after 16 hours of work and wash the dishes you didn’t eat from without resentment
- ... To wake up at dawn to pray for your children
- ... To kiss the dirty face of your dog
- ... To hold his tremulous hand even though you might faint from the smell of his past
- ... To choose to trust even when you know you all she says is a lie
- ... To hold her cigarette even though you don’t smoke
- ... To forgive before the apology
- ... To close your eyes when the beauty walks by so you can remain faithful to the one who was as beautiful to you when you first met her
- ... To fit your whole heart in one look in the eyes
- ... To swallow your pride and embrace when you feel like running
- ... To take a breath when you feel like dying
- ... To remain silent when the words burst at the gates of your lips
- ... To pick up your cross and walk the narrow path
- ... To accept God’s unfailing love and to allow it to flow through you

— Emanuela Christati, MS III

his face, thus lacerating his right temporal artery. By the time he was brought into A&E he had lost more than one liter of blood from the squirming artery. The local St. John ambulance crew could neither contain the combating bong-smoker nor control his bleeding.

“*Please get me an Allis clamp!*” I calmly yelled as the geysers were pumping. “*What’s that?*” I was not sure if it was an answer or a question to a question. I contained my shaking hands and calmly asked again for a hemostat. The nurse

handed me a needle driver. At that point I was wondering whose heart was going to give up: mine or that of the bloody grotesque Frankenstein-like man on the table. Give me 3-0 nylon. Please compresses. Give me this. Give me that. Orders rained. The poor nurses were scrambling. But nothing was coming. Geysers were still gyrating like a symphony of dancing fountains in front of Chrysler Building and Detroit County Building one summer evening. The bong-smoker was cussing. There is nothing more desperately sobering than when all

## With All of My Cardiac Myocytes

You send me an SMS and my SNS starts to fly  
When you are around me, you deflate my alveoli

Beauty is in your genes, constitutively expressed  
Even in your scrubs and mask, I'm totally impressed

You give me tachyarrhythmias when you try to call  
It's not safe to think of you without taking propranolol

As you are you don't need botox, silicon or surgery  
You are perfect to every integrin and cyclic A M P

Your smile is by far my favorite phenotypic trait  
But also your ASIS and immaculate gait

If you were a cardiac interval, you would be a QT  
You're more valuable than a surgeon's salary

When you feel depressed and want to sit and cry  
I'll lift you up inside like the levator ani

I'll treat you out to dinner and treat you when you have the flu  
I'm a practicing specialist and it's in pleasing you

I wish we were paired chromosomes, with ties no one could sever  
Then we could be in metaphase, from now until forever.

— Brian Champagne, MS I

smiled. He was still alive.

The pumping vessels could neither be isolated nor clamped since they were sheared so close to the skull. I neither had the proper clamps nor appropriate materials. My figure of eight sutures that I had blindly jabbed in the poor boy's face did not hold off the bleeding. After half an hour of futile efforts, I stepped back. Rivulets of red blood were meandering on his face, some coming out of the gauze, filling his right ear canal. His eyeballs were scrutinizing my every move.

At that point, either the young man was going to slip into a hallucinatory coma or I was going to have an acute coronary syndrome, and he and I would be spared of the agony. Finally I yelled, "Do you have elastic bandages?" We wrapped the head with white linen and transformed him into a Muslim woman wearing a hijab. Or did we change Frankenstein into a partial mummy? In my panic, I had forgotten the basics. Pressure will always do it.

We called St. John again. We shipped the young man to Greymouth, the base hospital a 100 km away. As they sped with the sirens on, I sat down and asked myself where in my three year training in Detroit did I learn to do vascular surgery? Should every county and hamlet emergency room have a vascular surgeon or plastic surgery? Is it asking for trouble for family physicians to go everywhere there is need? If family medicine finds its high in meeting an undifferentiated, unsolicited patient, and find solace in being comfortable with the unexpected, I sure did not feel comfortable with this unexpected patient. That is stress.

eyeballs are watching and fixated on your person. Thank goodness that none could decipher how much I was desperately blushing.

Finally, the nurse handed me a zero Vicryl with large bore needle, like the one we use in OB. I did not care. As I jabbed the needle in the face, the bong-smoker jumped off the table. He cussed, "*You motherfu... American! You're hurting me!*" The walls were painted red again. My

teal scrubs changed into another color that I can't describe. I had forgotten to use local anesthetic. I was sweating. My heart rate must have been three times my age by now. But, I was glad the young man was still alive. The resilience of a young body can be impressive. Maybe that is the reason we send them to wars. After two liters of blood loss, and while nurses were struggling to start an IV line, the young man was still cussing. I

***At that point, either the young man was going to slip into a hallucinatory coma or I was going to have an acute coronary syndrome,...***



## A Corridor Encounter

Another busy morning:

The teams are rounding, some patients crying, the nurses chatting.

I'm making my way through the bustle, reviewing the chart in this hustle.

No time for distractions! We're dealing with sick-people transactions!

Seems like a luxury to pursue simple human interaction!

With the corner of my eye I catch a glimpse of your hair in the distance.

I turn and see your silhouette at the other end of the hallway in that very instant.

So many people between you and me...

Your team surrounds you, could you possibly see?

But I ignore them in a blink...

Your eyes are all I seek.

And then you look at me,

My whole heart smiles and you see it.

Your face now glowing too,

And this one smile, as I pass you by, holds all the words I cannot find.

— Emanuela Christati, MS III

## FACULTY HIGHLIGHT:

*An Interview with*

# DANIEL SEWELL, MD

*Leader of UCSD's Senior Behavioral Health Unit*

By John Torous, MS IV



One of UCSD's most outstanding physicians, Dr. Daniel D. Sewell is a geriatric psychiatrist loved by patients, staff, colleagues, and trainees. As Medical Director of the Senior Behavioral Unit, he helped to create and now continues to lead one of the most advanced, multidisciplinary, and clinically sophisticated inpatient acute geriatric psychiatry services in the world. Dr. Sewell's passion for healing, dedication to caring, and commitment to education make him a wonderful role model for medical students seeking to combine the spirit of service with medical excellence. Despite his busy schedule, Dr. Sewell created time for me to come to Hillcrest and hear his story. Between his wonderful library of eclectic novels and scholarly tomes, unique art, and a cozy carpet, I felt like we were meeting in a pleasant library rather than a plain medical office. As Dr. Sewell began to share his life story with me, I quickly found myself enchanted on a journey across the world of such a remarkable doctor, teacher, and friend.

### **How do you think students and trainees arrive at a career in geriatrics?**

That is a wonderful question. Because of the escalating concern regarding the mismatch between the rapidly growing number of older individuals in our world and clinicians, including physicians, who have the knowledge and skills to provide them with optimal medical care, research has been done to elucidate what are the key factors that influence someone to choose a career in a geriatrics related field. My personal background reflects some of the key factors that have been identified in this research. For example, I was very lucky that when I was younger, I had wonderful relationships with my grandparents. I learned from my grandparents that being with older people is both fun and rewarding. All but one of my grandparents lived to be what we now call an "old, old" person. My paternal grandmother lived to be ninety-eight years old and lived in her own home until age ninety-seven. These experiences helped protect me from the negative stereotypes of what it is like to be older. There are so many myths out there of what it is like to be old. Sometimes those of us in healthcare professions are actually the greatest perpetrators of these myths due

to sampling error in that our work selectively connects us with older people who are ill. But if we look at the research data, or perhaps reflect upon older people whom we knew when you were younger, we will discover that older people are actually more satisfied with their quality of life than any other age group.

### **How did you begin your journey towards a career in geriatric psychiatry?**

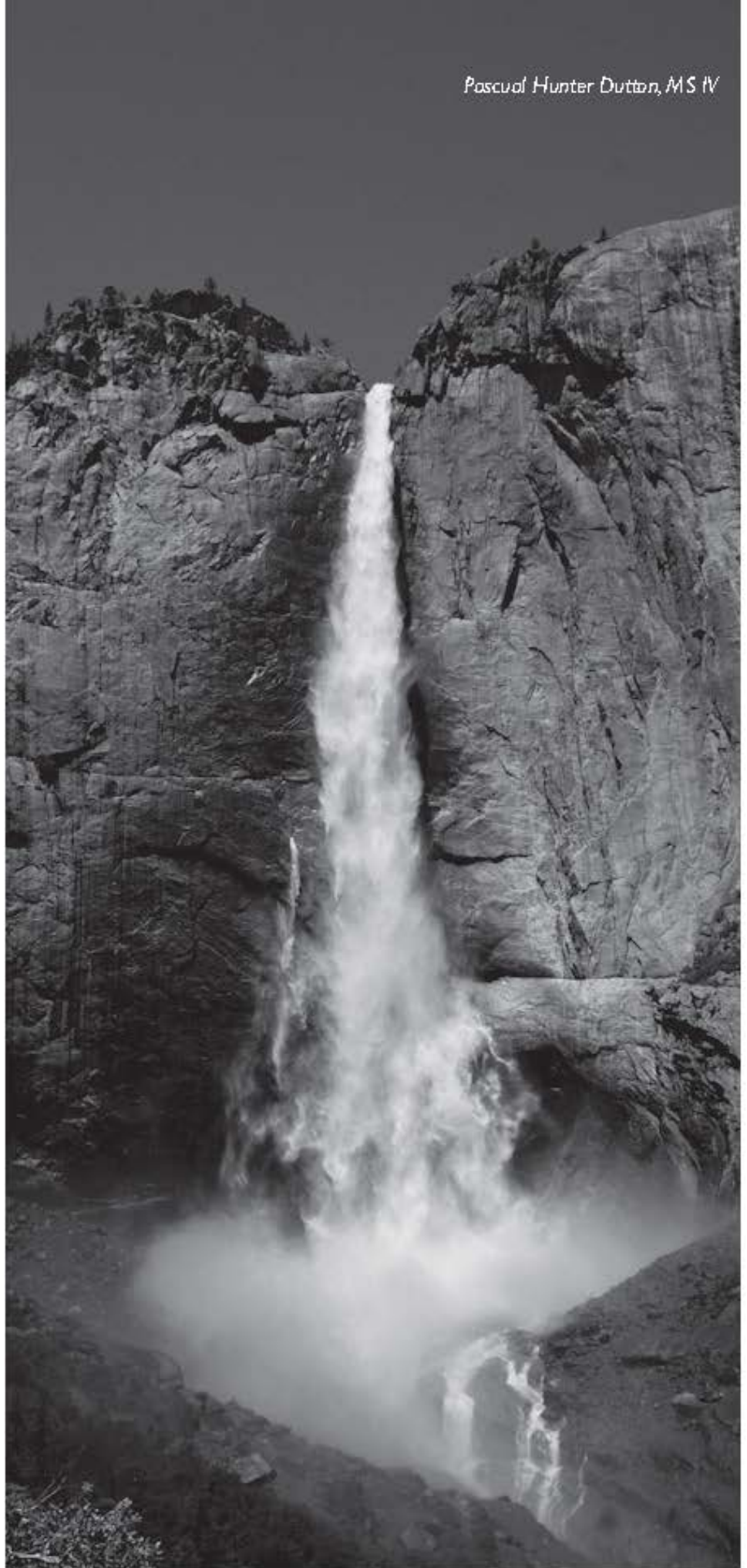
In addition to my experiences with my grandparents, while in college I spent several summers working as a nursing assistant in a skilled nursing facility in my hometown. Still, when I enrolled in medical school I thought I wanted to be a pediatrician, in part, due to the relationship I had with one of my dad's best friends who was a pediatrician. That changed during my third year of medical school. Pediatrics was enjoyable but not as much as the excitement and rewards I found in other fields. There were so many choices! Using my "left brain" I created a table and ranked each of the factors I sought in a career such as the quantity and quality of patient interactions, intellectual challenge, lifestyle, etc. While using my "right brain," I closed my eyes and reflected on how comfortable, competent

*...older people  
are actually more  
satisfied with their  
quality of life than  
any other age group.*

and energized I had felt during each of my rotations during my third year of medical school. Thankfully, both sides of my brain produced the same answer: psychiatry.

### **Who were the early mentors in your career?**

I completed my residency in psychiatry here at UC San Diego. I came to UC San Diego because even twenty-five years ago both the medical school overall, and the department of psychiatry, in particular, had established reputations for excellence in clinical care and research. I had decided to pursue a career in academia and knew that the UC San Diego Department of Psychiatry would provide me with ample opportunities for wonderful mentoring. I must tell you that my experiences at UC San Diego as a resident surpassed even my most hopeful expectations. When I was finishing my residency here, several of my mentors, including Joel Dimsdale, MD, and Sidney Zisook, MD, suggested to me that a fellowship would be a smart way to advance my academic aspirations. Both Drs. Dimsdale and Zisook suggested that I consider a geriatric psychiatry fellowship and connected me with Jacquelyn Harris, MD. Those of you who may have known Jackie will not be at all surprised to learn that she charmed me and we just clicked. Near the end of our very first meeting she stood up and said, "I've got to



introduce you to Dilip.” This was a reference to Dilip Jeste, MD, whose current accomplishments include being the president-elect of the American Psychiatric Association and the Director of the UC San Diego Stein Institute for Research on Aging. Both Drs. Jeste and Harris were truly amazing mentors. To this day I strive to carry on their commitment to mentoring through role modeling the best clinical and patient skills with a true passion for teaching and research. Once I began working in geriatric psychiatry, I loved it. I was fascinated with my patients. I enjoyed their stories and learning about the history of the world through their life experiences. I have come to develop a deep appreciation for all that they went through and I find great inspiration in overcoming the challenges in my own life by remembering the challenges that many of my patients have faced so successfully in their lives. I consider the time that I spend with my patients to be

both an honor and a gift.

### **How did you come to help found the UCSD Senior Behavioral Health Program?**

I was originally interested in research focusing on non-psychiatric medications with dopamine blocking properties such as metoclopramide and compazine. These medications can cause side effects such as tardive dyskinesia. As a young faculty member at UC San Diego, I was awarded a “RAG” grant from the VA which is often a stepping stone to another grant, a VA Merit Award. However, when I did not receive this second grant, I began to focus more on my clinical, administrative, and teaching roles. My intent was to earn my keep and also continue doing research on the side. Balancing so many roles, however, was so stressful that I actually had a psychosomatic illness

## **The Wealth of Myself**

I have undergone a loss—  
A loss in what I used to do,  
In what I once materially had.

I thought these things would  
Not change—They were mine.  
And then life happened, and  
They were not.

For a long while  
I felt worthless,  
Or, of less worth.  
And most certainly deprived.

Today I began to reconsider  
My situation  
(The difference from then to  
Now is tremendous and indisputable)  
Yes, I started to fully realize  
The wealth of my soul.  
Realizing I am worth  
More than words can say,  
And I’m rich beyond compare.

What a bad habit it is  
To react to what is not- badly thinking of  
What I do not do,  
And what I have not got

For doing this misses  
All that is wonderful  
About me, and about my life.

As I live I give  
And love and feel—  
And I connect with the world.

There is a spark of joy  
In me, from me  
Or, rather, a raging fire.

This fire fires and inspires  
Those whom I touch.  
And what better thing to  
Do is there than this?

As for what I have or have not,  
Richard Wagner said:  
“Joy is not in things, it’s in us.”

So I look inside,  
And I find a wealth  
Of joy and more  
In myself.

— Sandra Frank  
Traumatic Brain Injury Survivor  
8/12/11



and broke out in hives. Recognizing such stress, I took a leave of absence from academia for two years and worked at the Mission Valley VA OPC and with a local psychiatric care provider organization. Then one day the phone rang. Lewis Judd, MD, the chair of the psychiatry department, called with a unique opportunity. The UC San Diego Thornton Hospital had just opened but was empty. There was an opportunity to help create a brand new geriatric psychiatry unit from the ground up while filling empty beds at Thornton Hospital and helping the hospital become better known to the greater San

*“I consider the time that I spend with my patients to be both an honor and a gift.”*

Diego community. I think Dr. Judd picked me because of my geriatrics background but also because he believed that I could balance well the roles of administrator, clinician, and teacher.

### **What was it like to build the Senior Behavioral Health Program from the ground up?**

My vision for our program was to be the very best geriatric psychiatry

program in the state, country, and perhaps even world. I had big goals. With a team including John Daly, MD; Keiko Gladajo, MD, PhD; Harold Guy, MD; Gretchen Merkle, RN; Judith Pfeifer, PhD, RN; and many others, we did our homework to discover how to make a cutting edge geriatric psychiatry inpatient unit. We studied everything from architecture to flooring to psychopharmacology. We looked for where we could innovate and then did. For example, with help from Sonia Ancoli-Israel, PhD, we had therapeutic lighting installed at a time when such a concept was unprecedented. We handpicked artwork for each patient room to counter age-istic beliefs and to reflect the true vitality of our elderly patients. We examined everything from the ideal shower spout design to the optimal colors for furniture. We also sought to ally ourselves with so many of the wonderful resources in our community. For example, we partnered with the Alzheimer's Association's 'Memories in the Making' art program to provide our patients with art therapy experiences while on the unit. Such a partnership with an acute inpatient psychiatric unit was unheard of when we first began it. More recently, with the leadership of our occupational therapist, Elisabeth Refn, OTC, we have launched a horticultural therapy program which has already proven to be a tremendous success.

### **How has the Senior Behavioral Health Program become so successful?**

We knew we were doing well



Self Portrait. Sam Sepehr, MS II

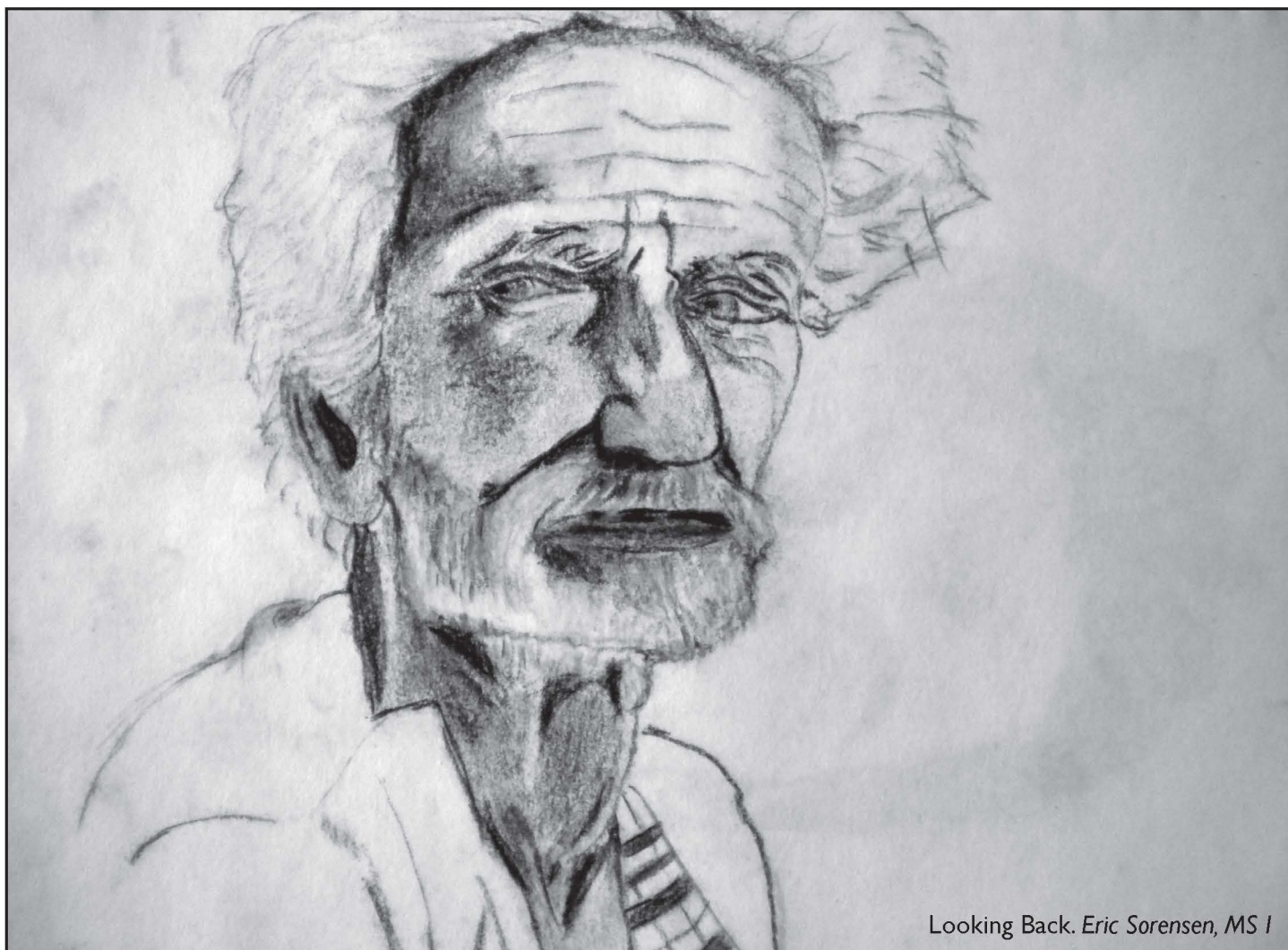
because patients were getting better. Word of mouth started to spread and soon we had so many referrals. We now have had patients fly in from Canada and Mexico. We also now train students in geriatric psychiatry from around the world. Every year for the past several years we have hosted students from Dokkyo University in Japan who come to our unit to learn. But our success stems directly from the talent and dedication of the staff. We offer the best quality care and this was captured in print by one of our former patients, the well-known author William Murray. In the July 2003 issue of *San Diego Magazine* article entitled “Close Call: A Memoir of Madness,” Murray writes:

The UCSD Medical Center has the only psychiatric unit devoted exclusively to older patients suffering from some form of mental illness. Within an hour of being admitted, I received a complete medical examination and was interviewed in depth for more than two hours by Dr. Sewell, who had come back to the hospital from his home to do so. He is a small, trim, middle-aged man with a kindly but no-nonsense air about him and dark penetrating eyes that seemed to bore into my innermost thoughts. What had happened

to me, he wanted to know. For the first time since my return to the United States, someone expressed an interest in what I had gone through in Italy and wanted to hear a full account of it. Alice and I were asked to respond in detail to the dozens of questions he asked regarding my breakdown and subsequent events. A study was immediately undertaken of the medications I had been receiving at Ramsey, and these were quickly and drastically adjusted to reflect Dr. Sewell’s diagnosis of my condition.

The Senior Behavioral Health Program has also become successful because we have such unique and fantastic partnerships. We have a wonderful partnership with geriatric medicine that allows us to offer a level of care beyond almost any other psychiatry unit. We are proud

*...a kindly but no-nonsense air about him and dark penetrating eyes that seemed to bore into my innermost thoughts.*



Looking Back. Eric Sorensen, MS I

of the way we integrate the disciplines of geriatric psychiatric and geriatric medicine. We also have such great nursing leadership, nursing staff members and other member of our team, like our occupational therapist and our social worker, who understand all our patients' needs from IVs to various forms of therapy. It is rare to find nurses who have kept both their psychiatric and medical nursing skills so sharp and who also savor the opportunity to work with older patients. We have become a magnet for like-minded people who share our commitment to providing the best care to the older members of our community.

### **Do you recall any other patients who also achieved such amazing success through the Senior Behavioral Health Program?**

I had one patient who came to our program after failing treatment for her depression at so many other hospitals including UCLA and Loma Linda. Her depression had progressed to a point where she had developed somatic delusions including the delusion of no longer being able to walk. Her husband, who was around 85 years-old at the time, was desperate as he watched her legs atrophy from disuse. He found our program through the internet and, after careful evaluation of his wife, my colleague, E. Clark Allen, MD, and I decided on a course of electroconvulsive therapy. After 4 sessions she transformed into the "den mother" and "social butterfly" of our unit. It was amazing how she recovered from her depression. I have known this couple for eight years now and every time they come back for follow up therapy her husband seeks me out and gives me a hug. "Thank you for giving me my wife back" are words he has repeatedly expressed to me.

### **What do you love most about geriatric psychiatry?**

I love geriatric psychiatry because my work as a geriatric psychiatrist requires me to use my mind and talents to their fullest. Geriatric psychiatry is exciting because it is the best of all worlds, combining both medicine and psychiatry. Here I can put to use all aspects of my training when helping patients. From interviewing skills to understanding liver function, family dynamics to brain chemistry, I am a doctor who has to keep everything in mind. Seeing a patient get their life back is so rewarding. I have so much energy each day because I love what I do. I love helping people enjoy their lives to their fullest.

## **Notes**

the humming birds are humming  
and the mocking birds are mocking.  
the little rabbits are running for their lives  
while the fat old dogs laugh.

— Paul Quinton, PhD

### **Why do you think the UC San Diego Psychiatry has always been such a highly ranked program and department?**

I think that initially our reputation was built on our amazing success in both bench and clinical research and because we have such an internationally renowned research faculty here at UC San Diego. More recently, however, I think that our clinicians have caught up with the reputation of our researchers and I think that both have contributed to how well we have done in various polls including the *US News and World Report* rankings. In the recent *San Diego Magazine's* Top Doc poll, 16 of the 29 Top Docs in psychiatry/geropsychiatry are current (8) or former (2) faculty at UC San Diego or are graduates (12) of the UC San Diego Psychiatry Residency Program. I have counted some of these physicians as both former residents and either current or former faculty members (6). This really puts us on the map.

*"I love helping people enjoy their lives to their fullest."*



### **What does the future hold for geriatric psychiatry?**

Psychiatry, and especially geriatric psychiatry, is such a wide open frontier. The brain is still shrouded in mystery. It is exciting to be here on the frontline with so much yet to be learned and applied to the care of patients. It seems like almost every day new discoveries are being announced. At UC San Diego we are fortunate to be closely affiliated with and/or supported by to the Hartford Foundation (we are one of two national Hartford Centers of Excellence in Geriatric Psychiatry), the Stein Institute for Research on Aging, UC San Diego Alzheimer's Disease Research Center, the UC San Diego Academic Geriatric Resource Center, the George G. Glenner Alzheimer's Family Centers, Inc., the San Diego/Imperial Chapter of the Alzheimer's Association, the National Alliance for the Mentally Ill, the Southern Caregiver Resource Center and Silverado. These organizations are helping us to care for older individuals with serious mental illnesses including dementia and to learn more about dementia and other later-life psychiatric disorders. The future really is wide open.

### **What role will the geriatric fields play in the future?**

I think geriatric medicine and geriatric psychiatry will become more and more important as the "tsunami of elderly patients" that I have heard Ruth Covell, MD, speak of so many times is even now beginning to lap at our shore. January 1, 2011, was a very important date because it was the day that the very first baby boomer turned 65 years of age. The need could not be greater than it is now. What gets me up in the morning includes my goal of influencing at least five or six trainees a year to pursue a career in a geriatric discipline. There is just such a tremendous need. We have to provide the highest quality care to the elderly because, first and foremost, this is what they deserve and, secondly, because if we fail at this then our whole society loses. When we do not offer the highest quality care, the

*I want everyone to know the truth about what it is like to be older. It is a time of increased creativity, rewards, and enjoyment.*

I'm 57 years old and have cystic fibrosis—for which I've been seen at the UCSD Cystic Fibrosis Center for over 30 years. CF is often thought of as a lung disease, and it is. But it affects other organ systems as well, including the GI tract. In the midst of a recent "routine" pulmonary exacerbation for which I was receiving IV antibiotics at home, I developed a bowel obstruction that led via the ER to a nearly three-week stay in Thornton Hospital. I wrote these two poems (pp.12 & 37) while an in-patient there on the second floor.

## Jinxed

"At least," said my doctor,

speaking of declining lung function,

repeated hospitalizations,

and the last difficult 18 months,

"you haven't had a bowel obstruction."

So I had one.

— Steven L. Shepherd, UCSD patient

cost to society goes up and we all end up paying for extended hospitalizations, unnecessary medications and other treatments, and preventable and, sadly, often iatrogenic, complications and injuries. This means less money for things like our roads, for the arts, and for our universities. We all stand to gain from providing the best quality geriatric care. This is a challenge we need to face now. The 2008 Institute of Medicine Report entitled "Retooling for an Ageing America: Building the Health Care Workforce" stated "The nation faces an impending health care crisis as the number of older patients with more complex health needs increasingly outpaces the number of health care providers with the knowledge and skills to adequately care for them."

**What finals points would you like everyone to remember about geriatric psychiatry?**

I want everyone to know the truth about what it is like to be older. It is a time of increased creativity, rewards,

**"I want to reduce and, hopefully someday, eliminate ageism. Older people can learn, grow, and change."**

and enjoyment. I want to reduce and, hopefully someday, eliminate ageism. Older people can learn, grow, and change. Many older people are currently contributing a lot to our world. Some older people have a lot to contribute to our world but need to be given the opportunity. Most older people report very high levels of life satisfaction. And yes, older people even continue to enjoy physical intimacy. In fact, they do so on a fairly regular basis. Also, I want everyone to realize that geriatric care is very specialized and unique. For example, if you have an ill child, nowadays everyone knows that you want to take that child to a pediatrician instead of a generalist. Just about everyone understand that a five year old is very different than a forty year old. I hope that very soon it will also be widely understood that if you have an ill eighty year old you will want to take them to geriatric specialist because an eighty year old is very different than a forty year old in the same way that a five year old is very different than a forty year old.



Z. Maryam Soltani, MS II



**The Human Condition staff.** From left: Sepehr Keyhani, Ian Neel, Lakshmi Ganesan, John Torous, Anna Grove, Csilla Felsen, SunMin Kim, and Jessica Lin. Not pictured: Stephanie Feldstein, Rohan Verma, Rohit Majumdar, Michael Caton, Brian Nuyen, and Maryam Soltani.



Front Cover: The Daily Commute. *SunMin Kim, MS IV*

## THE HUMAN CONDITION

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### Editorial Staff

<i>Editor-in-Chief</i>	Ian Neel MS IV
<i>Layout</i>	Csilla Felsen MSTP SunMin Kim MS IV
<i>Prose</i>	Stephanie Feldstein MS II
<i>Poetry</i>	Anna Grove MS IV
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<i>Art</i>	Lakshmi Ganesan MS IV

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