Ascona Prize Essay Submission: Doña Paulina

By Peter Cooch

Having started medical school less than five months ago, it feels premature for me to speak of a truly personal student-patient interaction. Yet from the moment I saw this prompt, I felt compelled to write about Doña Paulina. More than anything, I am writing to catalogue my experiences for my own reflection and future recollection.

These events occurred prior to my entrance into medical school, during the ten months I spent volunteering at a clinic in Guatemala. For the second half of that time, I worked as an aide for an elderly Mayan woman suffering from a considerable ulcer. My friendship with this octogenarian hermit, with whom I share almost no language or cultural background, is the oddest relationship I have experienced with another human being. Yet, perhaps for that same reason, it has been among the most meaningful.

How did I come to meet Doña Paulina? In most ways, it was by chance. I had first come to Guatemala to work as a whitewater rafting guide. During my travels, I visited Santa Cruz la Laguna, an indigenous Mayan community in the highlands. The 6,000 inhabitants of the municipality were scattered across a half-dozen villages along the shore of a volcanic lake. There, I encountered a small clinic run by two married physicians, an American and Guatemalan. They had worked, unpaid, for the past six years to provide free primary healthcare. I realized I wanted to spend much more time in Guatemala, and I felt a unique connection with the clinic. After shadowing the staff for several days, I asked if I could stay as a full-time volunteer for the next seven months.

My medical experience was limited to several years working as an Emergency Medical Technician. In my early days in Santa Cruz I found a niche by training local volunteers as first responders for obstetric emergencies. However, most of my time went into absorbing and integrating myself into the daily flow at the clinic.

The success of the doctors’ model was built around mobile outreach clinics, usually two per week. For each clinic, we’d pack up medications and equipment and travel to several nearby villages, seeing from thirty to ninety patients in a day. It was during one such outreach clinic that we first heard of Doña Paulina.

We were in Tzununá, a community of several thousand Mayans that we usually visited on Thursdays. That afternoon, a visitor at the outreach clinic asked if we could come see an ancianita (little old lady) in dire health. The man making the inquiry had stopped by her home
to inquire about harvesting *jocotes*, a small pitted fruit. He had found her bedridden and delirious, with a gangrenous miasma overpowering her hut.

After seeing our last patient, one of the physicians and our nurse practitioner Guadalupe set off hiking to investigate. They encountered a heartbreaking situation.

Although we’d never heard of her before, Doña Paulina was perhaps the oldest living person in Tzununá. In Spanish, “Doña” is a title conferring respect, a step above “Señora.” She believed she’d been alive for 85 years—placing her decades past the typical life expectancy in the area. Having long outlived her husband and children, she was left with absolutely no one to care for her.

However, this remarkable spirit now seemed close to fading away. A nearly circumferential ulcer had eaten away most of her left calf. It had eroded down to the fascia and swollen her foot like an inflated rubber glove. At that moment, she hovered on the verge of sepsis. Her body was scalding to the touch, reduced to a sack of flesh and bones weighing less than 25 kilos.

She wasn’t diabetic, nor did her other leg have varicosities. Although I asked on many occasions, I was never able to determine the origin of the ulcer. We imagined a small cut, bite or burn had become infected and continued to grow, while she remained unable to seek (or unaware of) options for outside care.

In the U.S., such an ulcer would warrant hospitalization, IV antibiotics, and whirlpool wound-care treatment. In Tzununá, all of those were out of the question. Over her 85 years, Doña Paulina had likely never left her village. The department hospital in Sololá, several hours away, is cramped and understaffed. Among Mayans, it is still considered an option of last resort. We considered the shock of pulling her from her home and placing her in an utterly alien institution, with no guarantee of receiving superior care. We decided we’d be doing more harm than we could hope to cure.

With limited resources and hundreds of other patients, many young and very curable, our physicians were reluctant to go to drastic measures on her behalf. Daily home visits to bring her infection and dehydration under control were the most we could offer. After that, someone might make intermittent trips to change her dressings and bring food and potable water. None of the staff who’d visited her believed she would live for many more weeks.

I had been treating a gentleman with a similarly sized (although far more superficial) venous stasis ulcer for several months. As the most expendable member of the clinic staff, and eager to undertake any medical assignment, I was chosen to be her caregiver and “wound technician”.
Despite my enthusiasm and recent experiences, my first few trips still shook me to my core. Doña Paulina’s home lay at the end of a muddy, garbage-strewn pathway deep in the forest above the village. She lived in a wattle and daub hut that measured perhaps three meters per side, with about one-and-a-half meters of headroom. There was no electricity, water or plumbing.

I knocked and entered. Sunspots pulsed on my retina as my vision adjusted to the dark. The only illumination came from slivers of sunlight between the bamboo stays. But any visual sensory deprivation was countered by the overwhelming olfactory stimuli. I had never smelled anything similar before (although knowing that most healthcare providers have, I will refrain from description). In the corner, I could detect a dark shape wrapped in a pile of blankets.

The inside of her dwelling seemed like the set from a movie. Other than some pots and utensils, plastic buckets and the corrugated tin roof, there were almost no industrially-fabricated objects—in a country inundated with cheap plastics. The bedding and baskets were hand woven, the walls bound with twine and the stool and bed frame appeared simple carpentry. The floor was earth and ceiling was glazed with creosote from indoor cookfires. Bundles of herbs hung from the ceiling, and a rosary between two candle stubs clearly served as a shrine.

I knelt at the side of a makeshift pallet containing a child-sized woman. Her white hair was pulled into a braid in back; the loose wisps in front had been stained yellow from smoke. She seemed to speak absolutely no Spanish. I introduced myself and explained my new role, but her murmured response was indistinguishable. Although I was accompanied by an interpreter, I could tell our communication has hampered by a gulf more profound than language. Her eyes, deeply sunken in parchment flesh, flickered with pain and sorrow that was utterly foreign to me. I hesitated a moment, uncertain how to proceed. Then I donned rubber gloves and lifted her bandaged leg off the edge of the bed over to a drape I’d spread over the dirt floor.

Changing her dressings eventually became a familiar routine, but that was not the case on the first day. I’d start by unpeeling the saturated layers of cling-gauze. Next I’d tease away the non-stick pads, revealing the wound itself. At first, I was struck by the resemblance to a panorama from the American southwest. Canyons and mesas, fissures and reefs scored her flesh in angry reds, green patinas, and yellow seeps. Using a syringe, I’d work through half a liter of saline to irrigate the deep fissures. I’d then apply a coat of silver sulfadiazine antibiotic ointment. I’d finish by pressing 5 or 6 large non-stick pads over the surface, and securing them with roller-gauze. Initially, the whole process would take me almost an hour.

After finishing the dressings, the two of us would be exhausted. I had been hunched over, working by headlamp, eyes stinging with sweat, meticulously trying to avoid cross-
contaminating my supplies. She had held herself upright during the entire changing, eyes rolled, murmuring padre and dios.

Afterward, I would mix a thick brew of powdered milk and give her a multivitamin and some acetaminophen. Before swallowing each pill, she crossed herself. She would then slowly drain the mug, swing her bandaged leg into the bed and lower down to the pillow. When I stood to leave, she would ask me when we’d be back. “Two days”, I’d repeat, and motion with my hands. She would nod, murmur her thanks, and appear to drift off to sleep.

Over the next two months, I made trips every other day to Doña Paulina’s home. To get to Tzununá was a fifteen-minute motorboat ride or a one-hour hike along the shore. Our routine progressed. I enjoyed the long walks, and became speedier and more proficient with the dressings. She made requests for sundry items, like candles or matches.

The initial antibiotics and cleanings had had a dramatic effect. The exudate had grown clearer, the smell diminished, and her discomfort was clearly less. The margins were pinkish-white and slowly growing. When I showed up, I was just as likely to see her up and tending a smoldering cookfire as in bed. It was remarkable how seeing Doña Paulina upright changed my perception of her home’s size. She stood not much higher than a meter, making her home’s dimensions seem comparatively spacious. With her inquisitive eyes, wrinkled skin and walking staff, she often reminded me of Yoda from Star Wars.

Just as gratifyingly, our patchwork system of communication had improved significantly. Every few weeks I’d come with an interpreter to clear up any recent miscommunications. Nonetheless, we had been finding remarkable overlap between the handful of Spanish words she revealed and the Kaq’chikel I was practicing. We had a formal greeting every time I arrived and could make small talk about the weather. I could ask her about her pain, explain medication schedules, and ask what she needed. To be sure, when she started to chatter, I found the words as indistinguishable as ever. Yet the tones were unmistakable: bantering, reproach, curiosity.

It was clear this mission might end up much more than palliative care. Unfortunately, my seven months were nearly over. I needed to replenish my finances, and had the option of returning to the states to work for the winter. I spent my final few weeks in Guatemala transitioning her care to the clinic staff.

Back in the U.S., I spent the next five months fundraising, working, and making plans for my return. I devised a plan to drive my old pickup truck from Montana to Guatemala to convert to an ambulance. There, I would donate it to three villages served by the clinic, whose inhabitants had no access to emergency care. I left in early May from Montana, the truck loaded with
donated medical gear. Over the next three weeks I drove almost 7000 kilometers across the US and Mexico. The trip was full of adventures including minor engine problems, contentious border crossings, and numerous taxes and fines. In the end the ’94 Toyota completed the journey without a hitch, breaking 300,000km along the way.

At the clinic I heard good news about many of the old patients, including Doña Paulina. During my absence, a fourth-year medical student and his wife had volunteered at the clinic. Rather than powdered milk and eggs, he and his wife had brought her home-cooked meals. Under his care, Doña Paulina’s ulcer had made incredible progress.

The first day I returned, I was greeted by the sight of Doña Paulina standing outside of her house, shooing around a gaggle of chicks with a broom. She was even more talkative, if possible, from the last time I’d ever seen her. She could name off her favorite dishes in Spanish, such as beef stew, chicken and fish, and was not shy about doing so. The ulcer had healed from the size of five or six hand-prints to a narrow band on the inside of her leg. The rest had smoothed to mottled pink scar tissue. The improvement was astonishing.

Yet for all the steps forward, there had been a few backward. In the three weeks since the last volunteer’s departure, no one had come to visit her. Her wound, although much smaller, was encrusted with a thick coating of ash, as well as magenta-colored flakes I’d never seen before. She proudly showed me her leg, but whether to appreciate the diminished ulcer or the homemade poultice I was unsure. What did grab my attention was the oozing pus around the margins. I was taken aback yet again when a deep, hacking cough interrupted her speech.

That morning’s wound cleaning was painstaking for me and excruciating for her. I picked and irrigated at the crust of dirt over the wound, trying not to damage the tissue below. Doña Paulina clucked and gesticulated in agitation. After an almost an hour the wound was superficially cleaned of dirt, but clearly macerated.

As I packed up to leave, I realized that I’d forgotten the packet of eggs, beans, tortillas and chicken I’d made for her back at home. When it became clear I had brought nothing to eat, she howled the word for “food” in Spanish: “Comida!” Although demanding, the cry was also plaintive and anguished. I cursed myself and tried soothe my distress my giving her a few dollars. Her progress, and our relationship, no longer seemed on such solid footing.

Back at the clinic, I tried to clear my head. I had just over two months back in Santa Cruz before I began medical school in the states. I promised myself that I’d do whatever it took to heal the ulcer before I left. Eighty percent of progress had already been made—it was just up to me to finish the job.
Yet my good intentions weren’t sufficient to achieve results. The rainy season was just beginning. It would prove to be one of the worse the Guatemala had ever faced. Once the rain began, it continued incessantly. The dampness baked in a suffocating haze at midday and sank into an icy chill at night. As rainwater coursed down the hillside around Doña Paulina’s house, her earthen floor churned into a muddy mess. A week after I arrived, tropical storm Agatha saturated Guatemala for nearly a week. Flooding and landslides paralyzed the nation, killing hundreds. The villages to either side of Doña Paulina were repeatedly evacuated, at times by the military.

Around Lake Atitlán, latrines washed out, crops rotted, springs became fouled, and families relocated to crowded shelters. The clinic staff worked overtime to counter the rising burden of disease. We doubled the number of weekly outreach clinics from two to four, keeping our doors open until well after dark.

Despite the chaos, I remained steadfast in my visits. I’d wake up at dawn to jog the two-hour round trip to her place before we opened the clinic in the morning. The path was now streaked with gutted ravines and steep landslides that added new treachery to the journey.

A regimen of antibiotics cleared up the pus and reddening, but did little to help the cough. Meanwhile, Doña Paulina became more and more resistant to receiving care. I didn’t take long to realize she seemed to tolerate our bandages for no longer than 48 hours. If my visits passed that threshold, she would remove the gauze bandages and smear the ulcer with ashes. According to her, the wound appeared dryer, and thereby healthier, when it was rubbed with cinders.

I tried to assure that 48 hours never elapsed between visits, but the threshold dropped to 36. I dabbled in pleading, reason, and bribery. I printed out color photos of her ulcer taken seven months earlier to emphasize the progress we’d made. I tried to make the food I brought contingent on her bandages being in place. If I found the wound smeared with ashes, I would furrow my brow, wag my finger and place the food back in my backpack. But each time, after explaining the need for patience and consistency, I would relent. She must have known all along that I was only bluffing. I did, however, frequently withhold the petty sums of spending cash I often had often passed her before. But rather than softening her resolve, it only seemed to chill our relations.

I was becoming embroiled in an exploration of that ugliest of words, compliance. Although Doña Paulina still reluctantly allowed me to clean the wound, she would flat-out refuse care from the rest of the clinic staff. She made her displeasure clear every time I treated her, and
removed the bandages after I left. Despite the remarkable improvements we’d managed in under a year, she had completely discredited our attempts her mind.

A visiting friend of mine noticed that the perfectionist care she took in daubing the wound with ash might be indicative of her fierce independence and self-reliance. He suggested that if we taught her to apply her own bandages, she might take ownership of the process. I was immediately optimistic, and she appeared willing to try. Yet our shared handiwork would be removed just as certainly by my next visit.

Why was she upset? I couldn’t make sense of her complaints or reasoning. Her leg hurt badly. The pain must have been unbearable, even with mild painkillers. But surely she could appreciate the progress we’d been making? She would repeat that the dressings made the pain worse. After she would pluck and tug and the cling gauze, I guessed we might have been applying it too tightly. We switched to taping the non-stick pads on, but that make no difference. She wanted to let the wound air out, a concept with a certain intrinsic appeal. But living in such a septic environment, there seemed no way to let her do that without dirtying the wound.

What else could we be missing? Was their another factor I was overlooking? Did her personal treatment have any validity? At the clinic we took great pains to remain culturally sensitive. We conducted most of our consultations with an interpreter, as very few of our patients spoke Spanish. Our local staff was just as adept at navigating cultural as linguistic obstacles. Likewise, our beloved nurse practitioner Guadalupe, who had the highest level of medical training available to a nurse in Guatemala, was a Mayan woman who spoke three indigenous dialects. Although we were far from perfect, the clinic had overcome initial mistrust to become accepted by the community.

I was asked by others, as I sometimes wondered myself, why I kept pressing the issue against such resistance. Doña Paulina had made it clear that she didn’t want our assistance. If she had her full decision-making capacity, what business did I have still visiting her?

It was hard for me to conceive that I was truly unwanted. Despite her protests, I thought I’d honestly convinced her to receive each treatment willingly. My threats to withhold food had probably bordered on coercion. But I had never been able to carry through on those, and I believed she knew it. I couldn’t bear to write off the hundreds of hours myself and others had spent caring for her as a lost cause. I felt a sense of duty to the previous volunteer who had made so much progress. Most of all, I believed I was looking out for her well-being. In the end, all of these justifications boiled down to a certainty that I knew what was best for her.
Not many others bought into my convoluted ethical justification. In the time I took me to care for Doña Paulina, one of our physicians or nurses might finish four consultations. Most of the patients seen at the clinic had acute but easily-treatable tropical maladies, such as ascaris, impetigo, or bacterial diarrhea. Prevention and treating acute illness was a much more efficient use of the clinic’s meager resources than the quagmire I’d entered. After my departure, I knew that it was unlikely anyone would carry on with her treatment. Yet that knowledge only added to the pressure I felt to do the most I could.

In my consternation, I hadn’t paid much attention to Doña Paulina’s frequent scratching at her back and arms. When I got around to looking at her shoulders, I realized she was covered in scabs. When I asked her, she pantomimed bugs crawling over her when she tried to sleep.

Although it didn’t match up exactly with what I’d seen, my initial suspicion was scabies. Known as the “seven-year itch”, scabies is caused by a burrowing mite and is pervasive in the developing world. The mites that cause it can be spread by physical contact, infest fabric, mattresses and skin alike, resist most cleaning, and quickly proliferate. There’s no half-hearted way to eliminate them.

One culprit was obvious. Doña Paulina’s mattress was an ancient, thinly-stuffed burlap pallet which had once nearly been her deathbed. Her fast-growing brood of chickens roosted there whenever given the chance. Although we’d brought her new blankets over the years, these too were long overdue for a washing.

In the city of Sololá an hour away, I purchased a plush replacement mattress and some cheap American clothes from a thrift store. I visited her the next morning with an interpreter. She crossed herself before taking the ivermectin I’d brought her. I then asked her change out of her elaborate, hand-sewn traje into the second-hand outfit I’d brought.

A few minutes later she emerged from her front door with a sheepish smile, clad in a baggy black t-shirt and a cotton skirt. The incongruity of the scene made me think of John Travolta and Samuel Jackson in Pulp Fiction, dressed in shorts and t-shirts “like a couple of college kids”. She started to giggle, our interpreter couldn’t hold back her own laughter, and before long the three of us were howling in mirth. To this day, this remains my absolute favorite memory of Doña Paulina.

After we had wiped the tears from our eyes, I set about stuffing her blankets and clothing into bags. But when I pulled aside her pallet, I found a writhing ants’ nest, swarming with eggs, larvae, and pincered workers. My amusement evaporated in shock and guilt. I was horrified at the conditions she had been enduring, and was humbled by my incorrect assumptions. Over the
months I’d visited, I’d never taken the time to ask more in-depth questions, or even look through her bedding.

We washed and swept out the nest, and I departed for a nearby town with her bags of clothes. They spent the day going through multiple rounds of bleach and boiling water. Coming back that evening, we rolled out the clean mattress on wooden pallets, made the bed with fresh blankets, and presented her with a packet of washed trajes. I have never slept as well as I did that night, knowing that Doña Paulina was snuggling into clean sheets for the first time in years.

A few weeks later I went to visit Doña Paulina with a translator and our clinic’s attending physician. My concern over her unremitting cough and ulcer had been growing.

With some prodding from our attending and insightful questioning by our interpreter, the truth came pouring out. Doña Paulina gleefully launched into her confession. She admitted to buying plugs of tobacco with the money I’d been given her. I was completely taken aback—I’d never encountered any evidence, and the habit is almost unheard of among Mayans. We told her that tobacco was causing her cough. She countered that it was the only thing that helped. In fact, she claimed the cough had only worsened because we hadn’t given her enough money to replenish her cache.

She continued by stating that her own treatments were only thing that had ever healed the ulcer. In fact, the past year’s progress had been thanks to her own special medicine. She produced a small bag of magenta granules, the same flakes I’d seen in the ulcer a few months earlier. Our interpreter recognized the substance as a potent agricultural insecticide. Suddenly, tears welled in her eyes and she turned and addressed me. “Pedro, why have you abandoned me?” translated our interpreter. Abandoned! It was less than a day after I’d spent an hour carefully washing her swollen feet and massaging them with lotion.

After an unsuccessful attempt to confiscate the flakes, we departed. Our doctor had found the exchange quite humorous, but I felt at a complete loss. I had only a few weeks remaining of my time in Guatemala. There was no way the ulcer would be healed by the time I left—it looked worse than it had two months before. Establishing a continuity of care for Doña Paulina was my next best hope. Yet that appeared just as unlikely. We had known each other for almost a year, had probably spent 100 hours in each other’s company, and yet I was scarcely welcome. How could I transfer care of such a recalcitrant charge?

I did what I could. I kept up my visits, although I suspected the bandages were removed as soon as I left. When I realized her edematous feet no longer fit into her plastic slippers, I bought her a pair of rubber clogs, a child-sized version of my own giant pair. That earned a laugh and perhaps restored some good will between us. The clinic recruited another volunteer to spend a
few months in Santa Cruz and potentially carry on my visits. A pair of European expats who owned a small hotel a fifteen-minute walk from Paulina’s agreed to bring her leftovers from their kitchen from time to time.

Once again, I departed with very little sense of closure. That was five months ago. The clinic informed me that after I left, Doña Paulina began refusing treatment altogether. She hasn’t been visited since then, and no one can tell me how she is doing.

I will not return to Guatemala for another five months. I keep imagining that I will hike in to find her herding chickens outside her home, or stoking her little cookfire. Perhaps, I think, the transition from rainy to dry season will make the same dramatic difference as it did during my first absence. Or maybe, as improbable as it seems, there is a gem of truth in her home remedies. Sometimes she strikes me as so resilient I can’t imagine her departing this earth. Other times her vulnerability seemed so complete that I marveled she didn’t wisp away before my eyes.

Our worlds were so different it seemed improbable we had ever found common ground at all. I had been twenty-four, while Doña Paulina was old enough to no longer know her age. I had traveled from thousands of kilometers away, while she had never journeyed farther from her birthplace than she could walk. I’ve spent two decades in school; she spent two decades waiting out civil war. I saw medicine as infallible, while he had been alive sixty years before I was even born, likely without ever seeing a doctor. While I enjoyed perfect health, she had endured years of agony. She scrabbled for every meal, while I often considered food an afterthought. While I plugged in my laptop and turned on the lights, she lay in the dark from sunset to sunrise.

Although I felt frustration, it must have been dwarfed by her experiences. The troubles of a provider and a patient occupy entirely different planes of existence. She had a debilitating injury. She couldn’t know what caused it, whether it would ever go away, or if it might kill her. For a year, she had let strangers come into her home. We had told her what to do. I had scolded, bribed, and questioned her. Each time, she’d been subjected to invasive procedures, via pills, injections, or tubes placed into her veins.

When I’d begun to visit her, there were very few expectations on me. No one thought she would live much longer. I was merely providing palliative comfort for a dying patient. Medically, of course, treating such a sizeable and infected wound was no small task. Several physicians had told me it rivaled some of the worst they’d ever encountered. I was fortunate to have already had the opportunity to expose myself to a similar situation treating a patient’s venous stasis ulcer. In the end, all credit for the healing process goes to her resilience. Her body had
overcome poor circulation, malnutrition, and microbes to knit the flesh back together. And there’s no way the unpleasantness of tending a wound could compare to the unpleasantness of having it.

Despite these gulfs, a connection had indeed existed between us. We’d shared laughter at the incongruity of those cotton clothes, or holding my massive shoes next to her miniscule pair. There had been effort on both our parts to communicate. As I practiced Kaq’chikel, she attempted Spanish, and we had comfortably conversed in this middle ground. When she thanked us for food and gifts, I was sure her gratitude was always sincere. And she most likely had tolerated my presence and interventions far beyond her own intuition or comfort.

It is hard to avoid feeling a sense of guilt and failure regarding entire affair. Yet I hope my experiences will allow me to better navigate conflict-fraught aspects of patient care in the future. Thanks to my experiences with Doña Paulina, I have been able to put considerable thought into working across cultural barriers and trying to build relationships with reluctant patients.

The concept of compliance is a rife with paternalism and inequality. Yet as much as clinicians try to rebrand the phrase, the problem it represents—a breakdown in the patient/physician relationship—are all too common. The potential for such conflicts increases significantly when medicine serves as the tenuous link between parties of remarkably different cultures or backgrounds.

It is not necessary to travel abroad in order to experience such divides. While practicing almost anywhere in the US, most clinicians will interact with patients from different cultural or socioeconomic backgrounds. The book The Spirit Catches You and You Fall Down, by Anne Fadiman, chronicles the history of a Hmong girl with epilepsy and the inability of her Californian doctors and Laotian parents to see eye-to-eye. The story is described as one of the most contentious and tragic in the hospital’s history. It is a perfect example of how easily medicine can break down at cultural interfaces, and how destructive the results can be.

It is true that I knew almost nothing of Doña Paulina’s world view. Mayan culture is rich is superstition, mythology, animism, spirituality, and magic. Curses, witchcraft, deities, ancestors, the calendar and heavenly bodies all hold enormous portent. Our nurse practitioner, for example, still believes that a menstruating woman give it the evil eye to infants, although she has practiced western medicine for decades. I wish I had spent more time inquiring about her beliefs of the cause and cure for her wound, or explored her worries and concerns.

As the patient-caregiver paradigm so often invites, our contact was founded on dependency and inequality. At times our interactions have brought out my most judgmental, ethnocentric,
and patronizing characteristics. Yet she has had a deep transformative effect on me. I’ve felt humility, frustration, elation, and sorrow in her presence. I have enormous respect and affection for her. I am sure, through my retelling, this account oscillates between comical and tragic elements. Yet for me, the proceedings resonate with a sense of dignity. I hope I was able to extend some comfort into the years of a formidable individual. I wish that I had been able to do more. I’m determined not to rewrite any aspect our interaction to my benefit, but to honestly learn and gain from the experience. Above all, I am grateful to have been able to play a role in her life.