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Requests for reprints of individual articles should be forwarded directly to the authors.

The Pharos of Alpha Omega Alpha Honor Medical Society (ISSN 0031-7179) is published quarterly by Alpha Omega Alpha Honor Medical Society, 525 Middlefield Road, Suite 130, Menlo Park, California 94025, and printed by The Ovid Bell Press, Inc., Fulton, Missouri 65251. Periodicals postage paid at the post office at Menlo Park, California, and at additional mailing offices. Copyright © 2015, by Alpha Omega Alpha Honor Medical Society. The contents of The Pharos can only be reproduced with the written permission of the editor. (ISSN 0031-7179)

Circulation information: The Pharos is sent to all dues-paying members of Alpha Omega Alpha at no additional cost. All correspondence relating to circulation should be directed to Ms. Debbie Lancaster, 525 Middlefield Road, Suite 130, Menlo Park, California 94025. E-mail: info@alphomegaalpha.org

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As president of the Association of American Medical Colleges (AAMC), I speak with physicians across the country about the rapid changes in the health care landscape. Unquestionably, today’s physicians face complex challenges: they are seeing more patients than ever, leading to shorter clinical visits and a decline in the personal relationships between doctors and patients. Rising costs have placed more pressure than ever on salary, reimbursement, and practice income. Private practitioners and academic physicians alike wonder what the consolidation of hospitals and health systems means for their futures. Physician scientists worry about stagnant NIH funding. Physicians also wonder how we can continue to make progress in our commitment to diversity in the medical profession in light of ongoing challenges to university admissions policies, including the return of Fisher v. University of Texas at Austin to the Supreme Court in the upcoming term.

Medical students see these changes to their profession and express concern about their own futures. They worry about the debt they acquired to attend medical school. They are anxious about competition for residency training slots, and worry about what they will do if they fail to secure a position in the Match. Some who aspire to careers as academic physicians express concern that this may no longer be a viable career option. Looking back over my experience of nearly four decades in our profession, I see today’s students voicing an unprecedented degree of uncertainty about their future career paths, uncertainty that reflects the rapidly changing world they see around them.

As a psychiatrist, I find myself wondering how these challenges affect our overall well-being. In my conversations with colleagues across the country, the issues of stress and burnout come up more and more frequently. A 2012 paper published in the Archives of Internal Medicine documents this distress.1 Surveying 7,000 physicians, Dr. Tait Shanafelt and colleagues found that nearly half—forty-six percent—reported at least one symptom of burnout, a significantly higher rate than in the general population. Burnout rates varied by discipline. Front-line clinicians showed the greatest vulnerability, with more than sixty percent of emergency medicine physicians reporting one or more signs of burnout. Even more alarming, more than forty percent of physicians screened positive for symptoms of depression, and seven percent reported having suicidal ideation in the last year. In a relevant study, a 2013 survey of 31,636 suicide victims, more than 200 of whom were physicians, found that a physician who commits suicide is much more likely to have an identified job problem than non-physician suicide victims.2 The authors, Dr. Katherine Gold and colleagues, posit that job unhappiness may be a factor in depression and suicide among physicians because of the extent to which their self-identities center on their professional roles.

Our identity as physicians and healers is one of the reasons that many physicians still see medicine as an exceptionally fulfilling and stimulating profession. But when professional challenges arise, they can cause genuine distress. These challenges frequently stem from all of the changes occurring in health care. An AAMC report documents the difficulty in keeping pace with change. This report made a number of observations about health care trends, including:

• “The future will see more health care demanded and provided than ever before. More physicians must be trained, and as quickly as possible.”
• “A clear trend of recent decades—and a virtually certain trend in the future—is the continuous rise in costs. All components of health care costs have risen. The cost of educating physicians has grown.”
• “The rise of specialization has resulted in the increasing trend toward team practice involving the contribution of a spectrum of specialists.”
• “Scientific advances have made vital the development of new skills to apply new knowledge.”

These are the same sentiments that I hear when I speak with physicians across the country. Yet while these observations could have been written yesterday, they actually are from Planning for Medical Progress through Education—more commonly known as the Coggeshall Report—published in 1965.3 In the half-century since its publication, the Coggeshall Report has been hugely influential in shaping American health care. It is important to note that while we face many of the same concerns we did fifty years ago, successive generations of physicians have made steady progress in improving our nation’s health. Every time our nation has faced a new health challenge, the medical community has stepped up. In 1965, the same year the Coggeshall Report was published, Congress established the Medicare and Medicaid programs under the Social Security Act. While some physician organizations were opposed to the establishment of Medicare and Medicaid at the time, over the last half-century physicians have embraced these changes, and they now have become a vital component of our social fabric. Our profession continues to evolve with our changing challenges.
Resilience and leadership for the challenges ahead

landscape, as doctors develop new payment and delivery models and explore innovative ways to respond to changes brought about by the Affordable Care Act.

Beyond the systemic challenges we face daily, the medical community also responds when faced with an urgent public health crisis. In the last year alone, hundreds of American and international physicians and scientists traveled to West Africa to address the Ebola outbreak, while physicians and researchers at Emory University, the University of Nebraska Medical Center, Bellevue Hospital Center, and the National Institutes of Health went to extraordinary lengths to care for patients here. In their response to the Ebola threat, physicians showed an essential quality seen in so many who choose careers in health care—a quality that makes it possible for us to work on problems that may require decades of persistent efforts to solve. That quality is resilience.

I see signs of resilience every time I visit medical schools and teaching hospitals and speak to leaders, faculty, staff, students, and residents. Academic medical centers are not retreating in the face of all the changes around them. As all these groups draw on their core resilience, they are seizing the opportunity to reinvent themselves and create a sustainable model for the future. Faculty teachers are creating positive environments for learners and patients. Faculty physicians, often assisted by learners, are improving clinical quality and safety. Researchers are finding ways to persevere in spite of historically low NIH grant funding rates. Beyond academic medicine, physician leaders are emerging with creative and assertive responses to the forces at work. Physicians are improving quality and safety in urban and rural clinics across the country. They are leveraging technology to do more with less and to communicate with patients outside of a traditional clinical setting. Across the country, the culture of medicine is evolving in response to the challenges we face.

Because of our shared resilience, medicine is thriving. So why, then, do we continue to see a high rate of burnout among an alarmingly high percentage of physicians? I believe it is because too many of us have become isolated, and we are not forming the support networks that are crucial to drawing on our inherent resilience. It is difficult for us to support our patients if we ourselves do not feel supported. Data from the AAMC Faculty Forward initiative show that two of the most significant drivers of physician faculty satisfaction, which is a likely surrogate for resilience, are connection to institutional mission and interaction with colleagues. When we lose these connections, we are at high risk for burnout and depression.

We all face disappointments and setbacks in our work—the ultimate failure being a poor clinical outcome, or even the death of a patient. In medicine, failure is part of daily life. Yet we maintain the strength to return to work with vigor by relying on support from our colleagues and a belief in our shared purpose. Our resilience allows us to face our daily challenges and accomplish more than we could imagine. It gives us a sense of mission, self-confidence, and a willingness to embrace change.

If our resilience is fostered by groups of physicians supporting one another, it is all the more important that our organizations, both professional associations and health systems, support that network of connections. This requires skilled and sensitive leaders who understand how to manage change in organizations. All too often, when organizations are searching for leadership, they bring in an outside “expert” who comes with a set of prescribed answers to all of their problems. But this type of leader will not be enough to face the challenges of twenty-first-century health care. To address our current challenges, we need “multipliers”—leaders who do not pretend to have all the answers, but who instead recognize, develop, and extend the talents of those around them. That is why programs like the Alpha Omega Alpha Fellow in Leadership Award (see pages 52–55) are vital, not only to identify and recognize the leaders that we already have, but also to support their development into the health care leaders we will need tomorrow—leaders who not only inspire hard work and motivation, but also extend our talents and bolster our resilience.

It is incredibly important that we continue to draw strength from one another as we face the challenges ahead. For decades, medicine has faced obstacles, but we have continued to improve our nation’s health through a shared commitment to provide our patients with the best medical care possible, discover cutting edge treatments and cures, and develop the physician leaders of tomorrow. We need to maintain our connection to our mission by strengthening and securing our support networks so that, when we come up against challenges, we do not face them in isolation, but rather feel part of a mutually supportive group of colleagues with a shared commitment to achieving our goals. The medical profession has always epitomized resilience, and we will continue to thrive if we affirm our shared mission, reach out empathically to one another, and rise together to meet the challenges ahead.

References

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The Pharos/Autumn 2015
Inclusion as a core competence of professionalism in the twenty-first century

Eve J. Higginbotham, SM, MD

The author (AΩA, Morehouse School of Medicine, 2008, Faculty) is the inaugural Vice Dean of Inclusion and Diversity at the Perelman School of Medicine of the University of Pennsylvania and a member of the Alpha Omega Alpha Board of Directors.

On July 6, 2005, the United Kingdom figuratively held its breath as it waited to hear whether London had won the bid for the 2012 Olympics. The country had lost three times before, and it was universally expected that its traditional rival France would be the victor. Crowds had already assembled at the Champs-Élysées in Paris, awaiting the announcement from distant Singapore. But the citizens of the world, in disbelief, instead heard celebratory voices from the streets of London. Not only had London edged out its traditional rival, but it had also squarely placed an innovative concept at the core of its bid: diversity and inclusion. The bid’s tag line, “Everyone’s London 2012,” and the inclusion of thirty East End young people in the country’s delegation to Singapore, strategically positioned London ahead of the traditional, homogenous delegation from France.

Tragically, the next day the focus on inclusion and diversity was in jeopardy, when an explosion on the London transportation system fatally wounded fifty-two people. The very initiative that had given London its competitive edge demonstrated its flip side within twenty-four hours.1

The United Kingdom’s London Olympics staff and volunteers created the most inclusive Olympic event in history. Their goal of positioning inclusion and diversity central to the games at a time when competing priorities were making it difficult to accomplish was viewed at times as unreachable. In his book, The Inclusion Imperative: How Real Inclusion Creates Better Business and Builds Better Societies,1 Stephen Frost, the designated lead for inclusion and diversity efforts at the 2012 Olympics, details how this was accomplished. Further, he provides a solid rationale for why these concepts should be at the core of every organization. The 2012 Olympics inspired a new generation of Olympic enthusiasts, while at the same time reducing legal risks associated with the games and contributing to a more cost-effective delivery of services. The value proposition for this model created benefits for the entire Olympics organization and community. These goals correspond to the interests of health care, given the complexities of the industry and the increasingly diverse communities that as providers we aim to serve.

In his recent editorial in The Pharos, Dr. Steve Wartman2 enumerates the significant trends affecting academic health centers that are creating a transformative tsunami of uncertainty and extraordinary changes in the health care landscape. This new era of leadership must embrace inclusion as a core competence in its effort to deliver high quality patient care, to remain competitive in research, and to optimize the education of the next generation of health care professionals.

Tomorrow’s demographics and today’s disparities

Significant changes in the demographics of the United States will continue to drive the transformation of medicine. By 2060, it is predicted that Hispanics and African Americans will make up forty-five percent of the population. Much of this change is driven by an increase in the number of immigrants to the United States, as many as 40 million since 1965, with more than fifty percent from Latin America.3 Not only will diversity increase, but the population will rise by as many as 100 million by 2050. Moreover, the proportion of those over the age

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Diversity and inclusion

While there has been focus on diversity—the differences among people in a group or community—for decades, there has not been as much attention paid to inclusion, which is the process of respectfully engaging all members of a community, organization, or nation. In The Inclusion Imperative, Frost notes three levels of diversity awareness:

- Diversity 1.0, programs that increase awareness about diversity.
- Diversity 2.0, efforts to highlight the benefits of diversity.
- Inclusion 3.0, when diversity is fully embedded in the organization’s fabric.

Diversity 1.0 and 2.0 are usually top-down approaches, but Inclusion 3.0 capitalizes on empowered individuals and is a bottom-up engagement with leadership support. In this phase of diversity/inclusion, more complex problems can be solved, employees are more productive, and the organization may see a result witness a more positive bottom line. Inclusive leadership fosters the ideals of authenticity, transparency, and respect. Rather than framing efforts to diversify as a zero-sum game in which one group loses based on the gains of another, the enterprise itself grows by “enlarging the pie.”

How does inclusion relate to the house of medicine?

In his preface to AΩA’s 2015 monograph, Medical Professionalism: Best Practices, Dr. Richard Byyny noted the intentions of the founders of AΩA in 1902, specifically the stated mission of the society: “The mission of AΩA is to encourage high ideals of thought and action in schools of medicine and to promote that which is the highest in professional practice.”

What better way to achieve the highest standards in professional practice than by including the perspectives of all who are able to contribute to the needs of society? Such a course is a natural extension of those principles, particularly given the complexity of addressing health disparities and the dimensions of human suffering that go far beyond the capacity of any one group of individuals to address. Weaving inclusive leadership into the core mission of modern health care organizations is an imperative that cannot be ignored.

Inclusive leadership in patient care

Today’s focus on value-based purchasing of health care and the shift towards accountability for the health of populations are compelling arguments for considering the centrality of inclusion. Given the ebb and flow of global immigration and the persistent disparities in health care, leadership must remain mindful of the important intersection of culture and health. A true patient-centered approach to care must incorporate engagement of the patient. Baroness notes engagement as one of the seven components of a patient-centered approach to care, the others being competence, reliability, dignity, agency, a dual focus on illness and disease, and concern for quality. Moreover, in addition to establishing trusting patient-physician relationships, physicians in this era of team-based care need to learn how to effectively work with teams of health care professionals whose members approach patient care from different perspectives. Of overarching importance, recognizing that one’s own unconscious bias may interfere with effective, high quality care is an important step in enhancing a physician’s quality of engagement with her patients.

Inclusive leadership in research

As Wartman noted, the lone investigator is no longer the dominant way research is conducted in academic medical centers, having been replaced by inter- and transdisciplinary teams to move the research agenda forward. An MIT monograph, The Third Revolution: The Convergence of the Life Sciences, Physical Sciences, and Engineering, highlights the benefits of merging scientific talent in the fields of molecular and cellular biology with that in genomics, engineering, and the physical sciences. As one example, interdisciplinary collaboration after the emergence of X-ray imaging in 1895 led to the advanced imaging methods that exist today. The pace of innovation can be hastened by overtly reducing barriers to effective teamwork across disciplines.

However, one of the barriers to progress in this new era of intensified collaboration is the lack of diversity that exists within the biomedical scientific workforce. Inequities in NIH funding patterns have been well documented. In their thoughtful commentary in 2011, the leadership of the National Institutes of Health highlights its interest in deepening NIH’s efforts to increase diversity among researchers in the United States. The authors note “residual cultural biases . . . have disproportionate adverse consequences on minority subgroups of our scientific community.”

Inclusive leadership in interprofessional education

There is no need to reiterate the rationale for interprofessional education. The business case for interprofessional
training has been noted by others. At the core of delivering an effective educational and training experience is instilling in future health care professionals the benefits of working with other professionals, the value that other professionals bring to the delivery of care, and the importance of respecting the unique contributions of distinct practice experiences.

How does one become a more inclusive leader?

Physicians need to consider inclusive leadership skills as core to medical professionalism in the twenty-first century. Morrow highlights three ways that we exhibit our leadership, emphasizing the importance of self-awareness, engaging effectively with others, and cultivating a culture in which everyone feels respected and connected. Recognition of our own biases and understanding how these innate preferences may influence our interactions and decisions moves us from a state of unconscious incompetence, or being “color blind,” to conscious competence, a first critical step. The next step is to consciously recognize and avoid that unconscious bias in dealing with others, resisting the snap judgment that is often based on that bias. When interacting with patients, for example, it is important to ensure that all patients are informed of the full slate of potential interventions based on evidence-based practice guidelines, instead of making assumptions based on preconceived ideas about what a given patient may (we think) prefer as an intervention. Even leading a meeting can be an opportunity to be inclusive by making sure that everyone has an opportunity to participate in the discussion and that no one dominates the process. Finally, as leaders, ensuring that the culture supports inclusive practices is important. Flexible hours and support for faculty or medical staff engaged in significant caregiving responsibilities are examples of policies that support the efforts of a segment of the professional staff, respecting the special circumstances they face. Engaging large segments of the organization in a whole-scale strategic planning process is another example of fostering inclusion. By fully embracing the importance of inclusive leadership, we can better leverage the full breadth of talent in our organizations. Such inclusivity will help us to deliver culturally appropriate patient care, to fully engage all members of the health care team, and to be more innovative in our research endeavors. As noted by Stephen Frost, “Diversity is a reality, inclusion is a choice.”

Choosing inclusion is the mark of leadership, deeply imbedded in the core values of professionalism.

References

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Can you please tell me whom to call, so I may donate my body?

Upturned hands can clutch no words,
Leave silence stuck to disbelief—
That even death is a question of storage.
Where to keep the last repository,
when memory is a soft rind that peels away to reveal:
All that we have fastidiously tucked into slivered paper,
thinned and pressed into photograph,
the netted and shimmering fish of our senses,
We must hastily overturn like a glass—
And reeling from life we are left to ask:
Who shall take us again?

Megana Dwarakanath
The first successful use of poison gas in modern warfare occurred here, just north of Ypres, Belgium, on April 22, 1915. The dirt lane marks the precise location of the French front line trench where French troops died en masse.

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An AΩA member goes to war—a century later, another reflects

Jeffrey Gusky, MD, and Debbie Lancaster
World War I began in July of 1914, when the Austro Hungarians declared war on Serbia. Although the United States government tried to stay out of the war, American news agencies reported on the conflict from the beginning, and the young men of the United States were eager to join by the time America entered the war on April 2, 1917.

One of the first to enlist—too eager to wait for the draft—was Bernard (Ben) Gallagher, MD (AΩA, University of Minnesota, 1915), who on August 10, 1917, left Minneapolis with many of his fellow interns at Minneapolis City Hospital to go to war to “make the world safe for democracy.” On reporting for duty in Washington, DC, he learned that he had just joined, not the United States Army, but the British Army Medical Corps!

Drawn from his diaries and edited by his son and grandson, both physicians, The Cellars of Marcelcave is an engaging first-person account of Ben Gallagher’s nineteen months at war in France and Germany.

The book follows Gallagher from his third year of medical school in 1915 through his surgical internship and enlistment. He and his fellow newly enlisted doctors board ship in New York for the nerve-wracking voyage to England, imagining lurking German submarines all the way. Gallagher is sent for training to Graylingwell War Hospital in Chichester, Sussex, where he slowly gains confidence and learns what kinds of care he can give the wounded in the trenches of the war. Of prime importance is tetanus antitoxin, which was first used in 1915. Gallagher learns that he must cherish his supply as if it were gold. The book details his deployment to France and the Front and surviving a gas attack, his division’s retreat from Amiens in March of 1918 after a major German offensive, and his capture by the Germans in the village of Marcelcave, where he was the only doctor left to care for the wounded who could not be evacuated. He is later sent to a prisoner of war camp in the Black Forest, eventually escapes, survives the “Spanish” flu, and returns home in February of 1919.

Two patients begin and end Gallagher’s narrative. The first, during Gallagher’s third year in medical school, is an eighteen-year-old boy admitted to the emergency room with a self-inflicted gunshot wound to the head. Gallagher is told to keep him breathing and still until he can be treated, but the boy insists on talking, dislodges the clot on his carotid artery, and dies in front of him. Gallagher is shaken:

Someone had walked out on him, someone had broken his heart, and he just couldn’t stand the pain anymore. So he put a rifle in his mouth, somehow stretched his arm down far enough to press the trigger, and ended his life. More ac-
curately, he caused the injury that eventually ended his life. But he wasn’t dead when he was entrusted to me. He was alive. Alive enough to talk to me. Hansen had just assured me there was nothing I could have done, but I didn’t know if I believed that. Maybe Hansen was just trying to make me feel better. Quieter, I should have kept him quieter, should have insisted he keep still. Maybe Giancomo could see I was just a medical student, not a “real” doctor. Maybe if I had conveyed more “authority,” he would have kept still, he would not have talked and coughed loose that clot. But I hadn’t conveyed that authority, hadn’t conveyed it one bit. I hadn’t kept him quiet. Not only that, I had also failed to place the tracheotomy. So I had made two mistakes, and now Mr. Giancomo was dead. I hadn’t carried the demeanor of a doctor and hadn’t performed like a doctor. And this young man, this handsome curly-haired young man, lay dead in front of me.94–5

Giancomo’s death continues to haunt Gallagher, but during his internship, his training in England, and work on the Front, he steadily gains the experience and self-confidence he needs to believe that he is a doctor.

The second patient central to Gallagher’s narrative is wounded British soldier George Cave, met in the cellar in Marcelcave after Gallagher decides to remain in the village to care for the casualties who cannot be evacuated in the division’s retreat from Amiens. George has had his hands and feet blown off and is riddled with shrapnel. Even worse, the local well has been destroyed so that it is impossible to keep the men clean, and Gallagher’s supply of tetanus antitoxin is gone.

On April 14, I was making my usual nighttime rounds with morphine. I knew one poor fellow who would need a strong dose of it, my friend George Cave, the man who joked about playing a piano with his blown off fingers.

Lice and scabies tortured him, but he could not scratch himself, for he had no fingers. He could not roll over when he had to relieve himself, so we were forever trying to clean him off. Through all of this, though, he never complained, and he continued to crack the occasional joke. Tonight, he looked grayer, sicker. . . .

“Here’s a little something to take the edge off, George.” I injected his thigh with the morphine.

“Thanks, awfully. You know, Dr. Gallagher, the oddest thing appened today when I was trying to eat some soup,” he said.

“What’s that, George?”

“Had a devil of a time getting my mouth open. Seems as stiff as a rusty ‘inge, it does,” he said.

Lockjaw, the beginnings of tetanus. The thought came so fast and loud, George might have heard me think it. He had been at the back of the cellar in Marcelcave, and had received no tetanus antitoxin. . . .

“Doctor Gallagher, am I going to die?” He asked it as a point of information, as you might ask whether it was raining outside, or whether dinner would be served on time.

“Of course, it’s impossible to say for sure, George, but I will say this, you are rather badly wounded.” For months now I had been talking to badly wounded men, dying men, and avoiding the statement, “You are going to die.” But most men could tell what I was thinking. And George Cave could tell what I was thinking.

“Could you write my Mum?” . . .

“I’ll write.” . . .

George started to get sleepy from the morphine. I came back an hour later and gave him a second shot. Three more times I came back that night, injecting him each time. The muscular contractures were creeping upon him now, twisting his body, turning his face into an awful leer, his breath-

Private George Cave. From The Cellars of Marcelcave: A Yank Doctor in the B.E.F.
ing labored, but the morphine at least kept him somewhat sleepy and unaware.

The next morning George Cave was buried by the roadside.\textsuperscript{202–203}

As the prisoners are marched off the next day, passing the grave site, Gallagher thinks about George Cave.

I knew George Cave. I knew a hundred George Caves, a thousand George Caves. But his name wasn’t always George Cave. Sometimes his name was Robson. Sometimes he wasn’t buried in this cemetery, he was in a convoy with Ted Sweetser, jumping off a sinking ship into the icy Atlantic, only to be covered with burning oil. Sometimes he wore a German uniform, and laid out in No Man’s Land with both legs shot, and put a bandage around a wounded Tommy’s jaw. I knew George Cave all right. He disintegrated in front of me during a barrage, fell next to me crossing a field, and died a dozen times in my Aid Post. I saw George Cave sprawled on a road, buried in a trench, and laid up on a parapet. I knew George Cave.\textsuperscript{\textit{p206}}

Before leaving for home, Gallagher writes to George’s family, meets them, and tells them about George’s final days. He reflects:

Death in the trenches, in No Man’s Land, in the field hospital, was expected. Men assumed they would die there, and they did. The real tragedy was at home. Mrs. Cave did not want a hero for a son, a medal for the mantelpiece, or a footnote in some history book. She sought no fame, no glory, no riches. A crusade meant little to her. New friendships meant little to her. The rise and fall of great empires meant little to her. She wanted to see her son, to hold him. But she could not, for George was dead, and buried on the road to Amiens.

Mrs. Cave would grow old, and die someday, as would I. But not so George Cave. George Cave would not grow old, would not bounce a grandchild on his knee and tell a tale of long ago, for George would be forever young. Nineteen years old forever. And I would never forget him.\textsuperscript{\textit{p263}}

Ben Gallagher returned to Minnesota, married and had a family, and established a successful practice in his home town of Waseca, where he died in 1962.

\textbf{A footnote}

As he was leaving Washington, DC, in 1917 for New York and then Europe, Ben Gallagher wrote to his cousin, a nun in a Chicago convent, to request prayer and to tell her a bit of news:

Oh, Marie, forgot to tell you. I made A.O.A. (Alpha Omega Alpha) when I graduated from Medical School. It’s a national honorary medical fraternity. Some people think it’s pretty important, but myself, I think it’s just a bunch of baloney.\textsuperscript{\textit{p21}}

Regardless of how he felt about \textit{AΩA}, doctors like Ben Gallagher exemplify the qualities that the society has stood for since its founding in 1902, epitomized in its motto: “Be Worthy to Serve the Suffering.”

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The Cellars of Marcelcave was brought to our attention by Dr. Jeffrey Gusky (ΩΩΑ, University of Washington, 1982). Dr. Gusky is an emergency room physician in Texas. Dr. Gusky’s photographs of The Hidden World of World War I were recently featured in National Geographic1 and the New York Times.2 Craig Allen writes in that article:

The last veterans of World War I died a few years ago. When we think of that war today, we imagine an age of Edwardian sensibilities, ragtime music and people with little connection to our modern world.

But as Jeffrey Gusky, an American emergency room physician, explorer and photographer discovered, the soldiers of that era were more like us than we may think. And they left behind many reminders of their existence, hidden away in places we never knew existed—the underground cities of World War I.

Ancient rock quarries that provided the stone that built the castles, fortresses and cathedrals of France lie beneath many of the trenches dug by the invading armies of Germany and its allies, who faced the French, the British and, later, the Americans. Engineers connected the trenches to these quarries—used by all sides—which became staging areas, hospitals, canteens and shelters from artillery bombardments. Some even have street signs and maps.2

We spoke with Dr. Gusky about Ben Gallagher, George Cave, his photography, and what he thinks about ΩΩΑ. A transcript of our interview follows.

Dr. Gusky: This morning I reread Dr. Gallagher’s narrative about George Cave and am looking at a photograph of Cave’s gravestone as we speak.

I first learned about Dr. Gallagher from my friend Iain McHenry, a World War I scholar and author, and one of the most respected battlefield guides on the Western Front. We visited George Cave’s grave several years ago.

Dr. Gallagher first met George Cave in a field hospital in a cellar in the French village of Marcelcave on the Somme during the retreat from the fierce fighting in 1918. Both of Cave’s hands and feet had been blown off and his torso was peppered with shrapnel, but George Cave still greeted Dr. Gallagher kindly with a smile. Dr. Gallagher and George Cave became friends, and through Dr. Gallagher’s eyes we can see George Cave’s indomitable spirit. Cave inspired Gallagher as our patients often inspire us. It’s astonishing how often we witness awe-inspiring courage, character, and selflessness in our patients and their families though they’re facing unfathomable loss. Where does this strength in the midst of adversity come from?

George Cave’s spirit somehow overcame his tragic circumstances. And there’s a transcendent hopefulness that infused the friendship between Cave and Dr. Gallagher till the end.

When the early signs of tetanus appeared, Cave joked with Dr. Gallagher about difficulty opening his mouth. But Dr. Gallagher knew exactly what was going on. And all he could do was to ease Cave’s death.

Dr. Gallagher was inducted into ΩΩΑ a hundred years ago. But his experience of becoming a doctor was so much like our own. He was molded by the same pressure cooker that molded all of us to shape the character, leadership, and judgment that make a doctor a doctor. He went from medical student to intern to resident. He dealt with the same chaos of being a newbie, he learned to bear the same life and death responsibilities, and engaged in the same struggle to save lives.

When Gallagher was a third-year medical student, one of the first patients he was given charge of was an eighteen-year-old boy who had shot himself in the head after his girlfriend left him. One minute the boy was talking and alert. The next minute, he coughed, dislodged a clot from an arterial bleeder, and hemorrhaged to death before Gallagher’s eyes. The memory of the boy’s death and the self-questioning about what he could have done differently never left him.

Dr. Gallagher was a deeply caring human being and surgeon. The fact that he was an early member of Alpha Omega Alpha gives weight to our tradition. A century ago, he lived the ΩΩΑ credo, “Be Worthy to Serve the Suffering,” not knowing that his example would set a standard for serving others that would last a hundred years.

The Pharos: What made you want to become a doctor?
Dr. Gusky: When I was six years old, I remember the experience of going to my pediatrician and being drawn to what he did. I had a sense, even then, that this is what I wanted to do. And it has never left me.

My pediatrician, Dr. Bud Tanis, was a deeply compassionate human being. He had this ebullient smile and a way of making children feel safe in his presence. He clearly made a...
difference in people’s lives that even a six year old could appreciate. I felt drawn to these characteristics.

Once I began medical training, Dr. Tanis’ capacity for caring remained an important influence. I’m sure that many of us are drawn to the practice of medicine for similar reasons. Medicine is and always will be a calling.

Dr. Gallagher’s practice of medicine while a German prisoner of war touches a place so deep inside me, it almost brings tears. In the past six months I’ve been working on several photographic projects near places where Dr. Gallagher was held prisoner. But the meaning of his story to my life goes far beyond that. Dr. Gallagher’s example touches the core of what a career in medicine has meant to me. To know that he was an early member of ΑΩΑ who volunteered to serve on the Western Front, putting his own life at risk and never knowing what tomorrow would bring is profoundly moving. He saved lives and gave comfort. What an amazing role model he is for us all.

*The Pharos*: How did you feel when you got into ΑΩΑ?

We see in the book that Dr. Gallagher didn’t think it was such a big deal, but clearly he epitomized everything that ΑΩΑ stands for.

Dr. Gusky: I was thrilled. At that time I was dating a brilliant female medical student who was inducted into ΑΩΑ in our junior year. She bested me, since my induction didn’t take place until the fall of our senior year. I smile when thinking back to those times and that relationship. I’m honored to be a member of ΑΩΑ.

I’m often asked in interviews about the intersection between my career in medicine and my career as an artist and explorer. Dr. Gallagher’s story sheds light on this intersection. We all have a chance to make a difference in a way that goes beyond our routine practice of medicine. To me this is what ΑΩΑ is about: striving to leave a legacy and give something back that goes beyond our day-to-day lives. For me, ΑΩΑ is less about class ranking and more about striving to lead, unselfishness, and working hard, hard, hard to leave a legacy.

This is a special interview for me. I’ve done quite a few
interviews since July of last year when the news of the Hidden World of World War I broke in National Geographic, but with this interview, there are no talking points, it’s from the heart, and touches on our responsibility to make a difference, and to live on the front lines of life. To touch people.

"The Pharos: It’s clear in Dr. Gallagher’s book, that sometimes all you could do for somebody was just touch him.

Dr. Gusky: When you think about the role of the physician in modern society, there’s hardly another profession where human touch is so important. With a gentle touch we convey heartfelt concern. In a split second, we form a bond that makes the doctor-patient encounter deeply human and real... there is a sacred quality to this part of what we do as physicians.

Dr. Gallagher practiced medicine with almost nothing but his reassuring touch. Bandages, medications, and even water were in short supply. But he gave his patients something of great value. He gave his patients comfort, and inspired a relentless will to survive. He made their world, as prisoners, a less chaotic, less toxic and more hopeful place.

"The Pharos: So is that what you’re trying to do with your photography?

Dr. Gusky: Yes. This is exactly what I’m striving to do. At its core, my photography is about hope. Photography can break through the thick walls around our emotions. It can engage conscience and inspire hope.

The people on both sides of World War I were like us in many ways. We can see it in Dr. Gallagher’s story. They were modern people. They had electricity, telecommunications, trains, and subways. Like us, they lived in modern cities and experienced the same problems of dehumanization, anonymity, and numbness from being immersed in environments of
inhuman scale.

Just before World War I, no one on either side foresaw what was about to happen. Citizens were unaware of the modern high-tech weapons that were quietly being developed at the same time as all the technological marvels of the modern city. People had no idea that there was a dark side of modern progress that was as terrible as the miracles of modern progress were good. There was a fatalism about progress that blindered people to its dangers.

On both sides of the conflict people marched enthusiastically into a meatgrinder. They thought they would be home by Christmas. But by Christmas, a million were dead and there was no end in sight. They were stuck in a 450-mile trench war that devoured on average 6,000 soldiers’ lives a day for four and a half years. World War I was the first modern mass destruction and the world’s first confrontation with the dark side of modern progress.

The Pharos: Dr. Gallagher writes about the disconnect in behavior between men during battle, where they will kill without thought or conscience, and men dealing with prisoners of war, in which they feel an almost paternal need to care for their prisoners.

Dr. Gusky: World War I was the first time the new technologies of mass media were used to manipulate millions to go to war against people who, only months before, had been neighbors. Each side used media as a weapon to transfigure neighbors into demons. But in field hospitals, the enemy was not an abstraction. The enemy was a human being with a face and a name.

With all its wonders, modern life can profoundly diminish conscience. World War I began with massive self-destructive mania on both sides of the conflict, in which blind faith in modern progress overwhelmed conscience and blindered people to extreme danger . . . danger that was right in front of them but that they couldn’t see or even imagine.

Look at Germany. It was the most technologically advanced nation in Western Europe before World War I. Who could have predicted that a genocidal monster would seduce the German people to turn their backs on conscience and the rule of law, and murder millions of innocent people in the name of a utopian fantasy about racial purity in World War II?

After doing a major project on the Holocaust and this project on World War I, I’ve come to believe that civil society is more fragile than we think. History can turn on a dime, even in advanced Western countries. Civility that takes generations and even centuries to build can disintegrate before our eyes.

In 1919, at the end of the war, leaders sat around a table at Versailles and redrew the map of the world. Several years later, they created the Kellogg-Briand Pact, a treaty signed by all the leading nations of the world that outlawed war. Since that treaty, we’ve experienced the bloodiest century in human history.

My mission as a doctor, artist and explorer is to help people liberate themselves from the shadow of World War I by seeing through the illusions about the perfectibility of human nature that blind us to danger.

Only the individual consciences of ordinary people can protect us from the dark side of human nature, while allowing the noble aspects of human nature to flourish. But it requires effort, commitment, and clarity about human nature. The unspoken bonds between people that keep our society civilized, decent and free don’t survive on autopilot.

Doctors must always be at the vanguard of this struggle. Doctors must act. Doctors must lead. Doctors must inspire others to cherish a human scale in modern life that preserves conscience, decency, and sobriety about human nature.

The Pharos: When did you become interested in photography?

Dr. Gusky: In 1995 I went on a trip to Poland in the dead of winter. I was at a concentration camp called Plazów, which is the actual place where the story of Schindler’s List took place. I found a part of the camp that was all but unknown, even to locals, where people where tortured and then murdered. This very sad place was where my abilities as a photographer first surfaced. To this day, when I create a photograph, what’s guiding me is that intuitive sensibility first awakened on a cold December day at Plazów.

The Pharos: Do you photograph people?

Dr. Gusky: Almost never. I know where my strengths are in photography and photographing people is not it.

I tend to photograph haunted places, if you will, places where there is something in the air, something unexplained, some residue from the past that you can feel.

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Each day through the end of the World War I Centenary in 2019, a new photograph from Dr. Gusky’s Hidden World of WWI will be published on Instagram: https://instagram.com/hiddenwwi/ and Facebook: https://www.facebook.com/HiddenWWI. More of Dr. Gusky’s photographs of the Hidden World of World War I can be seen at his web site: http://jeffgusky.com and on Lensculture: https://www.lensculture.com/most_viewed?modal=true&amp;modal_type=project&amp;modal_project_id=60393.

Information about Iain McHenry’s battlefield tours may be found here: http://www.trenchmaptours.com.

References

Contact Dr. Gusky by e-mail at: jeffgusky@gmail.com.
Iron domed observation post atop Fort Douaumont, the largest of the French Army forts encircling Verdun.
A German communications trench leading directly to the front line in the Bois d’Allly, a portion of the Apremont Forest near St. Mihiel, France. This was the front page photograph of the *New York Times* Travel section on Sunday, December 28, 2014.

“U.S. Forever” carved by an American soldier on the wall of this farmhouse cellar staircase. The farmhouse was destroyed, but the cellar is intact.
German soldiers’ mess located in an extensive tunnel system at the former village of Vauquois, a strategically important vantage point located on a butte overlooking French supply lines to Verdun. The village was destroyed by the opposing armies, but the German and French tunnels remain. The site is open to the public on a limited basis.

In this rural ossuary, the remains of more than 7,000 American, German, French, Italian, and Czech soldiers lie in state.
Inscriptions and works of art by hundreds of American WWI soldiers from New England, part of the famed Yankee Division, now exist in total darkness beneath a rural farm field in Picardy, France.

This drawing, found in another underground city inhabited by American soldiers, now exists in complete darkness. Hundreds of American soldiers lived here during 1918.
A mountainside WWI German bunker on the Hartmannswillerkopf battlefield.

A nurse drawn by an American soldier.
A large carving by Mechanic A. Ardine from South Brewer, Maine, near Bangor.

American soldier Dr. Leo Gagnon left his mark on the wall.
No Words

When I do not have the words
Speak to me,
Tell me who you are.
If you cannot hear my voice
Listen to my eyes,
Wait for the whisper of our hearts.
When my mouth forms no words
Still, I can hear.
When my ears receive no sound,
I can see.
And when my eyes refract no light
Remember, I am a person.

Brittney S. Jones

Ms. Jones is a member of the Class of 2015 at Howard University College of Medicine. Her poem won honorable mention in the 2015 Pharos Poetry Competition. Ms. Jones’ e-mail address is brittneyjone015@gmail.com.
Illustration by Laura Aitken.
Lord, rest my weary soul from the wraiths who come through these double doors.

Give me peace with the crack of bones, one-two-three as the heart slides in its place to this rhythm pressed by gloved hands.

Give me strength for the young man pulled from a car whose thick palm I pinch between thumb and forefinger—can you feel this? Can you feel this?

I ask again and again, though I know the answer; his hand is unmoved, his legs are still.

The ones who come without family—spare me them and their pale feet protruding from a white sheet as their bodies move through the humming CT machine.

But the families, too—the mothers sleeping next to their sons, young men with tumors that spread fingers around spinal cords; the girl who stares with wide eyes at purple blood oozing from her father’s ear.

And after this godless night, when some of them expire to the wrong side of the glass doors and are laid naked on their stainless steel beds, let the sun stay mute behind the morning clouds, and let me walk home still in their grace.

Alyse Marie Carlson

Ms. Carlson is a member of the Class of 2016 at University of Iowa Roy J. and Lucille A. Carver College of Medicine. Her poem won second prize in the 2015 Pharos Poetry Competition. Ms. Carlson’s e-mail address is: alyse-carlson@uiowa.edu. Illustration by Erica Aitken.
Caring for the invisible and the forgotten

Richard C. Christensen, MD, MA

The author (ΩA, Wright State University, 1990) is professor in the Division of Public Psychiatry at the University of Florida College of Medicine in Gainesville.

Illness isolates; the isolated become invisible; the invisible become forgotten.
—Elisabeth Tova Bailey\textsuperscript{3,12}

I was recently asked to speak to the class of graduating medical students on the topic of humanistic care in medicine. Always after receiving those sorts of invitations I start fretting about what I can possibly say that will be meaningful, memorable, and maybe even a bit profound. On my morning runs, at night lying awake, and on my drives to and from the clinic, I propose, formulate, and discard potential topics based on what I think would be of interest to the group in attendance. This time I had the good sense to ask one of the student organizers what she thought would be of value to upper level medical students who were just a few months shy of starting their residency training. “Just talk,” she suggested, “about your own work in medicine and what we might learn about patient care.” Following her advice, I began to think in a more deliberate way about my patients, and their struggles, and what they have taught me over the past several decades. I focused upon trying to describe what I have learned as a physician about patient care from persons whose illnesses have frequently driven them into the shadows of our society and, oftentimes, outside the web of human relationships.

For twenty-five years I have been providing care to patients whose illnesses contribute to the most devastating form of suffering: human and social isolation. Through my work as an academic community psychiatrist I have been given the somewhat unique opportunity, and privilege, to dedicate my full professional energies to caring for mentally ill persons experiencing homelessness. My patients are those who, for the most part, have received the bulk of their healthcare through safety net clinics, emergency departments, public crisis units, jails, and prisons. They have been treated by a myriad of different unfamiliar providers, most commonly under rushed and less-than-caring circumstances. Over the years I have come to fully appreciate that they shoulder burdens most of us cannot begin to fathom. And they have taught me everything about the grinding pain that arises from human isolation and aloneness.

My inner-city clinic welcomes those who spend most of their days in solitary wanderings through our city streets, oftentimes wholly preoccupied with bizarre ruminations or engaged in conversations that only they can hear. Even though we have a medical street outreach team that tries to engage individuals experiencing chronic homelessness, most remain unseen and unnoticed, invisible to the many who pass by on their morning treks to work or on their way to grab a quick sandwich at the noon hour. For the vast majority of my patients, the clinic appointment is the one opportunity they have to be heard, to receive attention, and to know that their lives matter and have meaning. In those
Caring for the invisible and the forgotten

... clinic encounters, or during the fleet ing stop-and-greet meetings on the street, discussions about medications, treatment plans, and lab results are put on hold. Because the most common shared experience for most of my patients is one shaped by human loneliness and deprivation, my initial treatment intervention is nothing more than undivided attention and empathic listening. I fully believe my most important role as a physician is to show up and, by my presence say, very clearly, “I see you. I hear you.” It is always the first step to coaxing persons out of the shadows and back into the human community where many have come to believe they are unwanted and unwelcome. In fact, some have come to the conclusion they do not exist at all.3

A few months ago I was called to the front of the clinic to see a young woman who had wandered in from the streets where she had been living for several years. She was disheveled, malodorous, and seemingly oblivious to the efforts of our staff to gather the usual intake information. She was not one of our regular patients and no one in our clinic had ever seen her before this unexpected appearance. When I introduced myself and asked how I should address her, she reluctantly and guardedly gave her name: “Dead Girl.”

I invited her back to my office and sat with her. She began a long, detailed account of her nihilistic belief that her internal organs had rotted away and she had died many years ago following the suicide of her boyfriend. She had lived mostly on the streets over the years, but had become a “ghost” who was invisible to others. “No one can see my face,” she explained, “since I’m dead.”

As I often do during that tenuous slow dance of building trust, I worked hard to speak little and to listen much. I later learned that her name was Robin and she had experienced at a young age the sorts of horrifying trauma that can wound persons beyond repair. As a child she saw herself as being invisible to the family who was supposed to care for her and, later, to the agencies that were supposed to protect her. Now, many years later, her illness made her invisible to those who walked by her every day. Instead of interpreting the chronic social ostracism as human rejection, she had developed the delusional belief that she was no longer a living being who could be seen. Obviously, it was much more acceptable for her to believe that she was invisible rather than ignored and forgotten.

Then there is Willie, a middle-aged gentleman who suffers from the ravages of rheumatoid arthritis and schizophrenia, who we seek out every couple of days through our medical street outreach team. Gaunt and drawn from years of being battered on the beach by the sun and wind, he hides beneath layers of blankets and tarps. Several trash bags filled with his personal belongings surround his living space and stand like sentinels that silently warn others away. Each time we make contact with Willie it takes many minutes before he peeks out from beneath what he perceives to be his cloak of invisibility. He almost always acts surprised that we have been able to find him because he fully believes that he is unseen underneath his makeshift cover. And in many ways he is “invisible” since he is surrounded each day by a crowded beach teeming with swimmers and surfers, bikers and walkers, who seemingly are incapable of “seeing” the mentally ill person who is sharing their public space. The contact with our medical outreach team appears to be the only tether to the human community Willie has remaining to remind him he is not invisible and he is not forgotten.

The fundamental acts of relationship and human connection in medicine can be healing and restorative, as underscored by the physician Richard Gunderman, MD, when he eloquently describes what patients most need from the doctors who care for them:

They need us to be genuinely curious about them and take a sincere interest in their lives, not just with a view to arriving at a diagnosis or prescribing a therapy, but simply to share their experience. Everyone will get sick. Everyone will die, even the doctor. Medicine may turn the tide for a time, offering a reprieve of months, years, or even decades of life. But the end is always the same, and every human being, even a doctor, needs someone with whom to share it. There are times when our patients need us to be human beings first and experts second.3

My patients who struggle with chronic homelessness have been exemplary teachers when it comes to understanding the therapeutic value in medicine of an empathic presence, other-directed attention, and human recognition in the slow work of healing. They have taught me that physicians must always be willing to recognize those patients who, because of the depth of their illness and suffering, are isolated and alone, unseen and forgotten, whether they are living on the streets of our cities, occupying an ICU bed within a teaching hospital, or sitting alone on the edge of a bed in a skilled nursing facility. And, as physicians, I would hope the initial impulse and response that begins the process of healing will always be, “I see you. I hear you. You are not invisible.”

References


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Everyone has a name story, and in caring for patients I’ve found that simply asking “How did you get your name?” or “Who are you named after?” has been a wonderful way to get to know them better. I encourage the medical students and residents to ask their patients how they got their names (even if the name isn’t so unusual). It really is a wonderful way to get closer.

Alan Blum, MD

Dr. Blum is Professor and Gerald Leon Wallace, MD, Endowed Chair in Medicine at the University of Alabama and Director of the University of Alabama Center for the Study of Tobacco and Society. His address is: 850 5th Avenue East, Tuscaloosa, Alabama 35401. E-mail: ablum@cchs.ua.edu.

Elroyce.
My father name’ me after
Elroy Hirsch of the L.A. Rams.
Never seen my father since I was two,
and he ain’t never tried to contact me.
Only thing he gave me was my name.
Leadership in medicine, medical education, and health care is more complex in the twenty-first century than ever before. Escalating costs, unequal access, less than ideal outcomes, and political challenges facing health care legislation have contributed to an unprecedented level of uncertainty in the delivery of health care and medical education. The medical profession and the country are in need of leadership that is inspiring, insightful, engaging, and humble—leadership that both understands and represents the needs of patients, physicians, and medical educators and trainees. Because of their unique knowledge of the practice of medicine and understanding of medicine's core professional values, physicians are ideally suited to serve as leaders in this period of change. The integral parts of the professional life of a physician are the values affirmed in the Medical Professionalism Charter that emphasizes the principles of patient welfare, patient autonomy, and social justice (http://annals.org/article.aspx?articleid=474090).

The ΑΩΑ Fellow in Leadership Award recognizes and supports the further development of outstanding leaders exemplifying the qualities of leading from within, ΑΩΑ's professional values, and the concepts of servant leadership.

The five essential components of the ΑΩΑ Fellow in Leadership Award are: 1) self-examination, the “inward journey,” leading from within; 2) a structured curriculum focused on topics related to leadership, including an understanding of the relationship between leadership and management; 3) mentors and mentoring; 4) experiential learning to broaden the perspective and understanding of leadership as it relates to medicine and health care; and 5) team-based learning and developing communities of practice.

We are pleased to announce the 2015 ΑΩΑ Fellows in Leadership, each of whom received a $25,000 award to be used for further development as future leaders:

- Cynthia Arndell, MD, RN, FACP—Associate Professor in Internal Medicine at the University of New Mexico Health Sciences Center in Albuquerque, New Mexico.
- Ronald Robinson, MD, MPH—Medical Director of Surgical Services at Centura Health, Avista Adventist Hospital in Louisville, Colorado.
- Elizabeth J. Warner, MD, FACP—Medical Director of Continuous Improvement Support at Bronson Healthcare Group in Kalamazoo, Michigan.

Fellows and members of the ΑΩΑ Board of Directors Committee on Leadership met at ΑΩΑ’s national office in Menlo Park, California, for a four-day meeting that included a two-day orientation session during which fellows and committee members learned about the background, development, goals, and principles of the award; discussed fellows’ goals for the fellowship; worked on refining the fellows’ projects; and got to know each other. The final two days included the course, The Science and Practice of Leading Yourself, led by ΑΩΑ Board of Directors member Dr. Wiley Souba of the Geisel School of Medicine at Dartmouth.

Attending the meeting were:

- 2015 Fellow in Leadership Cynthia Arndell, MD, RN, FACP
- ΑΩΑ Executive Director Richard L. Byyny, MD, FACP
- ΑΩΑ Leadership Committee Chair Eve J. Higginbotham, SM, MD
- ΑΩΑ Leadership Committee Member Page Morahan, PhD
- ΑΩΑ Board of Directors President Douglas Paauw, MD, MACP
- ΑΩΑ Leadership Committee Member Alan Robinson, MD
- 2015 Fellow in Leadership Ronald Robinson, MD, MPH
- ΑΩΑ Leadership Committee Member Wiley “Chip” Souba, MD, DSc, MBA
- ΑΩΑ Leadership Committee Member John Tooker, MD, MBA, MACP
- 2015 Fellow in Leadership Elizabeth Warner, MD, FACP
- ΑΩΑ Leadership Committee Member Donald E. Wilson, MD, MACP
Cynthia Arndell, MD, RN, FACP
Associate Professor, Internal Medicine, University of New Mexico Health Sciences Center
Albuquerque, New Mexico
(AΩA, University of New Mexico, 1994)

As an Associate Professor at the University of New Mexico Health Sciences Center (HSC), Dr. Cynthia Arndell has been able to fulfill her passion for making a difference in the lives of marginalized individuals and communities. Through extensively researching best practice models and networking across disciplines, she has taken the lead role in the development and integration of the medical curriculum that addresses social accountability. Her successes include the following required educational activities:

1. The first two-week course, Health Equity: Introduction to Population Health, which introduces all incoming medical and physician assistant students to social determinants of health.

2. The first-year medical and physician assistant student interviews with homeless populations.

3. Third-year medical student post-discharge home visits with pharmacy students, which address the challenges of transitions of care in patients experiencing low health literacy and scarcity of resources.

4. The fourth-year medical student Comprehensive Ambulatory Care rotation, which advances student skills in interprofessional collaboration to address the needs of vulnerable populations.

Additionally, in collaboration with faculty across disciplines and community partners, she developed and implemented the senior medical and pharmacy student Street Outreach and Respite four-week elective. Dr. Arndell serves as the faculty mentor for overseeing all medical student-led volunteer outreach clinics for the homeless and was the champion in developing the Interprofessional Student Clinic for Albuquerque Homeless Men’s Shelter.

Dr. Arndell’s curricular innovations have gained national and international recognition, resulting in numerous prestigious awards and guest speaker invitations. Her experience in interprofessional education curriculum development has led institutional leadership to appoint her as the University of New Mexico School of Medicine Interprofessional Coordinator. She has subsequently taken a lead role in securing the support of HSC deans across disciplines to agree upon the implementation of an interprofessional longitudinal community-engaged curriculum for all HSC students.

**Integrating Interprofessional Education (IPE) into an Academic Health Sciences Institution—What are the key challenges we face in faculty engagement?**—As a native New Mexican living and working as a health professional in a state that ranks forty-eighth in the nation for poverty, I have witnessed firsthand the impact of social determinants on population health; i.e., how the array of social, economic, political, and built environments shape individual and societal health, resulting in gross inequities between and within populations. As a nurse, physician, and community volunteer, I have served our state’s communities for over thirty-five years. And I find myself struggling more and more with the inability of our fragmented health care systems to meet the needs of our populations, particularly those who are the sickest and most marginalized. As a faculty member at University of New Mexico Health Sciences Center, I have had the privilege of developing, implementing, and teaching the medical school curriculum that addresses the social determinants of health. A coordinated team of multiple disciplines is necessary to improve the health outcomes of individuals and their communities. As a result, I have collaborated with professions both within and outside of our health sciences institution to begin developing interprofessional educational opportunities for our students. Although the University of New Mexico Health Sciences Center has given top priority to the integration of interprofessional education, our institution faces similar challenges to other academic centers in securing faculty buy-in and interest.

In recognition of the crucial role faculty engagement plays in successful interprofessional education implementation, my scholarly project will focus on the development of a cross-disciplinary strategic plan for grounding institutional faculty development and commitment.

I am confident that this fellowship will serve to advance my work in continuing to align the education of our future health care workforce with our societal contract to improve the health of all.
Ronald Robinson, MD, MPH
Medical Director of Surgical Services, Centura Health, Avista Adventist Hospital
Louisville, Colorado, (AΩA, University of Texas Medical School at Houston, 1993)

Dr. Ronald Robinson currently serves as managing partner of High Plains Anesthesia Consultants, and as medical director of surgical services at Avista Adventist Hospital, a Denver-area community hospital. He received his MD and MPH from the University of Texas Medical School at Houston in 1993, and completed his anesthesiology residency at UT Houston in 1997. He has practiced anesthesiology continuously since graduation in underserved rural and community hospital settings.

In addition to private practice, Dr. Robinson has served as a flight surgeon for both NASA’s Johnson Space Center and the Texas Air National Guard. He has educated medical students and residents as clinical faculty at the University of Texas at Houston, and Lake Erie College of Osteopathic Medicine at Bradenton. He has participated actively in research, and is published in the fields of physics, aviation medicine, and pain medicine. Dr. Robinson has also owned and operated multiple small businesses involving aviation, finance, and real estate.

Concurrent with his clinical practice, Dr. Robinson is pursuing an MBA through the University of North Carolina’s Kenan-Flagler Business School. In addition to his experience in business and medicine, Dr. Robinson recently completed a certificate program with the Greenleaf Center for Servant Leadership.

**Charting the course for servant leaders in community practice**—My project will target one of the thorniest issues in modern medical care: the rapidly increasing cost of invasive procedures, which is largely unaccompanied by an improvement in outcomes. The focus of the project will be reducing variability in clinical practice and optimizing resource utilization in laparoscopic hysterectomies performed at Avista Adventist Hospital.

Women’s services are a critical component of the care that is delivered at our institution, and we provide a wide spectrum of services from obstetrics to advanced urogynecology. Analysis of the service line, however, reveals extensive variability in clinical practice and resource utilization in laparoscopic hysterectomies performed at our institution relative to comparable institutions, resulting in underperformance of the service line as a whole. The goal of this project is to reduce variability, implement best practices, and improve the performance of the service line to a level exceeding that of our competitor institutions.

This project provides the opportunity to apply traditional management techniques, such as revenue cycle analysis and supply chain optimization, within a collaborative servant-leadership framework. Success in this project requires developing a team of physicians, nurses, and administrators that can meld the various stakeholders’ viewpoints, and deconflict competing priorities, to increase the performance of the service line while maintaining a community of care centered on the fundamentals of physician and patient autonomy and state-of-the-art clinical practice.

Successful completion of this project will demonstrate the cooperation that is possible between managers and clinicians under a servant-leader model. Application of the servant-leader model in this context will demonstrate that high quality care can be provided in a cost-constrained environment, utilizing modern medical and management practices, without increasing governmental regulation. The project will provide valuable experience in team-based learning for all participants, and it will facilitate similar projects in other service lines at Avista. It is my hope that success in this project will chart the course for other institutions that wish to follow suit.

Elizabeth J. Warner, MD, FACP
Medical Director, Continuous Improvement Support, Bronson Healthcare Group
Kalamazoo, Michigan, (AΩA, Michigan State University College of Human Medicine, 1998)

Born and raised in Cedar Rapids, Iowa, Dr. Warner’s higher education began in the University of Minnesota, Minneapolis, where she graduated summa cum laude with a Bachelor of Arts in International Relations, and a minor in French in 1994. She was inducted into Phi Beta Kappa for her efforts. Dr. Warner received her Doctorate of Medicine from Michigan State University, College of Human Medicine in 1998, where she was
honored with election to AΩA, and completed her Internal Medicine residency at the Kalamazoo Center for Medical Studies. Upon completion of her internal medicine residency in 2001, she developed as a primary care internist, where she practiced with passion and purpose for the health of her patients. This passion guided her to a leadership role as Primary Care Medical Director from 2012 to 2014. She currently serves as Medical Director of Continuous Improvement Support, Bronson Healthcare Group, Kalamazoo, Michigan.

Her formal and informal training are ongoing. Active in the Michigan Chapter of the ACP, she received LEAD certification from ACP (2010), and Fellowship status with ACP (2009). She is actively pursuing her Certified Physician Executive certification with educational guidance from the American Association of Physician Leaders, of which she is a member. She received Lean Certification with the University of Michigan (February 2014) and continues to develop this practice.

Her strengths include public speaking on a wide range of topics from obesity, leadership and teamwork skills, and motivational interviewing, to rediscovering a personal sense of purpose in medicine. She speaks about balance, spirituality, and resilience, even as she strives and struggles to achieve them for herself. As an involved community member, parent and human being, she is inspired to practice the principles of lean thinking, including respect for people, continuous improvement, and leading with humility, throughout all aspects of her life.

**Transformational Lean Management System**—As Medical Director of Continuous Improvement Support at Bronson Healthcare Group, I serve as physician champion, advancing the work of lean tools and principle-based organizational excellence. This work is anchored in the principles of respect for people and continuous improvement, with the explicit intent of improving the value and sustainability of the care we deliver to the patient. Bronson's definition of lean is taken from the work of Jeffery Liker (Developing Lean Leaders at All Levels: A Practical Guide. Winnipeg, Manitoba: Lean Leadership Institute Publications, 2014) and is as follows: a strategy for operational excellence based on clearly defined values to engage people in continuously improving safety, morale, quality, cost, and productivity. With the uncertainties and external pressures in the American health care system, and changing reimbursement models, we need clarity of vision and constancy of purpose to develop reliable structures and nimble pathways to identify problems. Health care systems need to problem solve them as close to the work as possible, and to anchor these behaviors in the principles that drive operational excellence.

Our organization has doubled in size over the past five years, and we are experiencing the “growing pains” of mergers and acquisitions. This is challenging us to consistently deliver on the value proposition of high quality patient experiences and lowest cost. I hypothesize that lean problem solving discipline and scientific thinking will help us experiment our way to an improved patient care, and sustainable systems for caregivers. Our lean work to date has yielded some great pockets of success, and now we need to develop aligned systems to build upon this work. We have identified critical ideal state components of our organization’s future, including:

- Building integrated and engaged health care teams across the continuum of care.
- Consistently showing respect by developing our people.
- Celebrating finding problems and applying disciplined rigor with simple tools to close these gaps.
- Cultivating leaders who embrace personal growth and learn to manage by process rather than managing by objective.

I propose to develop and deploy a principle-based management system founded in lean thinking and grounded by the pillars of continuous improvement and respect for people. This includes a leadership system built to inspire and provide clarity to the frontline worker, as well as help leaders practice leading with humility; a delivery system intended to align the work in service to the patient, and to learn from the frontline workers; and an improvement system built to deliberately empower and develop our people to deliver and improve patient care. Conceptually developed from the work of Bronson Healthcare Group, and further informed by the trailblazing work of Virginia Mason, ThedaCare, and others, I will partner with colleagues throughout my organization to understand, develop, and practice a new way of seeing, doing, and improving the work of patient care. The leadership, delivery, and improvement systems will reinforce behaviors that will get us closer to the ideal state components listed above.

Robert B. Taylor

Reviewed by Jack Coulehan, MD
(ΔΩ, University of Pittsburgh, 1969)

If I have seen further, it is by standing on the shoulders of giants.” This statement is usually referenced to a letter Isaac Newton wrote to his fellow scientist (and rival) Robert Hooke in 1676. Although the sentiment did not originate with Newton, its attribution to him is compelling because of the seeming paradox: one of the greatest scientists of all time expresses a sense of profound humility. This seems strange to us because humility is not a highly regarded virtue in today’s science. And certainly not a big feature of contemporary medicine. Thus, Robert B. Taylor’s new book, On the Shoulders of Giants: What Today’s Clinicians Can Learn from Yesterday’s Wisdom, is timely and refreshing.

Taylor presents the reader with quotations (or “pearls,” if you will) from the works of numerous historical physicians, philosophers, sociologists, and others regarding various topics related to medicine: professionalism, doctoring, health, illness, diagnosis, therapy, and so forth. In each case the author gives us a short reflection that suggests lessons clinicians of today can learn from the wisdom of these “giants.” Most of these reflections are illustrated with appropriate images, usually the giant himself—or, in a very few cases, herself. Taylor’s pearls are drawn from the works of eminent physicians like Hippocrates, Maimonides, William Heberden, Rudolph Virchow, Elizabeth Blackwell, William Osler, Sigmund Freud, Harvey Cushing, Joseph Lister, Wilder Penfield, Lewis Thomas, Michael DeBakey, and Ed Pellegrino; as well as notable non-physician writers ranging from ancient philosophers such as Aristotle and Seneca, to contemporary medical sociologist Paul Starr.

The reader will find great richness in these texts and commentaries. For example, the second half of the final sentence of Dr. Francis Peabody’s famous 1927 JAMA article is widely quoted in medical education, “the secret of the care of the patient is in caring for the patient.” This is a meaningful and memorable play on words, but rather nonspecific advice. However, Dr. Taylor shows that the educational impact can be much greater by citing the whole final paragraph:

The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy, and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.668

This more complete text links care to empathic understanding and the physician-patient bond to professional satisfaction. A far wiser pearl!

Another welcome insight comes from Dr. Arthur Hertzler’s memoir, The Horse and Buggy Doctor (1938). Hertzler was a general practitioner and surgeon in a small Kansas town during the early twentieth century. On the importance of medical history-taking, he wrote:

The securing of an adequate one is a work of art. It requires a knowledge of disease and of human nature. It is hard work and is time consuming
but it is necessary because in many cases it is the most important factor in the whole procedure.\textsuperscript{122}

The concept of the history as a doctor’s work of art reminds us that oftentimes it is the physician and not the patient who is a “poor historian.” Likewise, in these days of controversy over apologies to patients for medical errors, it is refreshing to read Sir Joseph Lister’s forthright statement: “Next to the promulgation of the truth, the best thing I can conceive that a man can do is the public recantation of an error.”\textsuperscript{198}

However, a few of the sayings are curiously dated, if not intrinsically overblown. For example, Susruta, one of the first systematizers of Ayurvedic medicine (about 600 BCE), wrote that the patient “should put his own life into [the physician’s] hands without the least apprehension of danger; hence a physician should protect his patient as his own begotten child.”\textsuperscript{28} This very strong version of paternalism has no place in contemporary medicine, and its advice to dismiss “the least apprehension of danger” strikes a false note in this time of excessive testing, inappropriate surgery, and abuse by insurance providers. Taylor’s commentary dwells on the physician’s duty to protect the patient from such practices. Perfectly true. Unfortunately, though, in many cases physicians themselves perpetrate these harms. Educated caution, not mindless embrace, seems a better injunction.

In another example, Taylor quotes Plato’s vision of the ideal society where:

No physician, insofar as he is a physician, considers his own good in what he prescribes, but the good of his patient: for the true physician is also a ruler, having the human body as his subject, and is not a mere moneymaker.\textsuperscript{6}

The reminder here, well-articulated in Taylor’s comments, is that even in ancient Athens the lure of self-interest and personal gain could compromise professional ethics. He cites a number of recent examples of conflict of interest in medicine and even outright criminal activity, the most dramatic of which is the 

\textdolar{}4.8 billion of fraudulent billing by 1,400 physicians discovered by the Medicare Fraud Strike Force.

Finally, a quotation from Paul Starr’s \textit{The Social Transformation of American Medicine} raises the question of reason versus “power” in medical practice. Starr wrote:

The dream of reason did not take power into account. The dream was that reason, in the form of the arts and sciences, would liberate humanity from scarcity and the caprices of nature, ignorance and superstition, tyranny, and not the least of all, the diseases of the body and the spirit.\textsuperscript{20}

However, stipulating a dichotomy between reason and power can be very misleading since it is, in fact, the power of reason that drives science. Moreover, medical power derives not only from science, but also from cultural beliefs, institutional influence, patient expectations, and the physician’s own charisma. Pharmaceutical companies, for example, exhibit massive influence on medical practice. Thus, when Dr. Taylor writes that the Affordable Care Act (ACA) of 2010 “represents the greatest transformation of the profession and exercise of raw power in the history of American medicine,”\textsuperscript{21} I’m skeptical. What about Medicare? What about rapid technological change? What about our subservience to the pharmaceutical industry? Frankly, I don’t think an attempt to make American health care more equitable and accountable deserves the appellation “raw power,” unless your definition of raw power includes the democratic process.

\textit{On the Shoulders of Giants} is a richly wise and provocative resource that will appeal to students, physicians, and anyone interested in the relevance of medical history and tradition to today’s practice. I found it fascinating to revisit the words of many old friends and, especially, to learn new insights from thinkers I had never before encountered. In medicine it’s true that learning is a lifelong process.

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\textbf{America’s Bitter Pill: Money, Politics, Backroom Deals, and the Fight to Fix Our Broken Healthcare System}

Steven Brill
New York, Random House, 2015, 528 pages

Reviewed by Nick Estes, JD

Steven Brill is the author of the terrific exposé in \textit{Time Magazine} about the high cost of American health care. Brill is a wonderful reporter and storyteller, and believe it or not, this book is a page turner, especially for those of us who have followed the saga of
ObamaCare at a distance. This is the inside story of its adoption and implementation, and it's fascinating and appalling at the same time.

Two central facts jump out at me in reading about the drama of getting health care reform adopted in America: the unbelievable political power of the health care industry and the fact that sixty votes are required to pass anything in the United States Senate. What challenges!

Health care is the largest business in the United States, weighing in at over $3 trillion per year. That will buy you a lot of lobbyists, and health care has far more than any other industry. Their tracks are all over Obamacare, and this compelling book recounts how they got there.

Imagine: in the face of universal concern about health care costs, Obamacare preserves the prohibition on Medicare negotiating volume discounts with the all-powerful drug companies. Imagine: Obamacare establishes a comparative effectiveness review mechanism, but forbids Medicare from relying on its findings when determining what procedures and drugs it will cover. These are typical of the Faustian bargains felt necessary to get this bill passed.

The Senate’s filibuster rule amplified the power of the industry by making its support so essential. Democrats comfortably controlled both the House of Representatives and the Senate (60-40 in the latter case). But they had to get every one of those Senate votes. So special inducements like the “Cornhusker Kickback” (so blatant it was ultimately eliminated) were necessary even to keep the Democrats on board.

The sixty-vote rule almost killed Obamacare completely after Ted Kennedy died and was replaced by Republican Scott Brown. The Senate had passed a bill but it wasn’t liberal enough for the House. After Kennedy’s death it wasn’t clear how the Senate could pass a bill splitting the difference. Ultimately the Senate compromises had to be put into a separate bill that focused on the financial provisions, so that the Senate could pass it under the “reconciliation” rules that permit closing debate on budget bills with a simple majority vote.

One result was that inadvertent language was left in the final bill that seemed to restrict federal subsidies to buy private insurance on the new “exchanges.” This gave Republican opponents an opening for the lawsuit ultimately rejected by the Supreme Court that would have gutted an important aspect of Obamacare. (The court ruled in June that the subsidies imperiled by the lawsuit were valid.) It wouldn’t have happened if the Senate could have passed a cleaned-up bill by a simple majority vote.

Then we’ve got the saga of the disastrous implementation. Once again, Brill tells a fascinating but appalling story. The inability of different parts of the government to communicate with each other was incredible to me. Brill makes a convincing case that neither Obama nor Health and Human Services Secretary Sibelius had any idea prior to the rollout that the experts in charge knew the website needed much more testing and was likely to be a spectacular failure.

Think of that. It’s as if FDR and George Marshall had been so removed from the D-Day planning that they wouldn’t have known if most of the generals had been privately grumbling that the invasion was almost certain to fail. Good leaders figure out ways to make sure they know what’s really happening on the ground.

On the other hand, the tale of the fixing the website is fascinating and uplifting. Experts, mostly but not all from the private sector, jumped into the mess and worked virtually around the clock for two months, many of them for no pay, to get the website repaired. Americans can certainly rise to the occasion.

As Brill recounts, the Obamacare negotiators abandoned any serious effort to deal with the ridiculously high cost of American health care (so well documented in his Time article). So in the final section of the book, Brill proposes his own solution. He dismisses as politically hopeless the “single-payer” solution adopted in every other advanced country, where the single-payer (usually the government) uses its regulatory and bargaining power to control health care costs directly.

Instead, he suggests we encourage a couple of large health care providers in each “market” to start their own insurance companies so that the people providing the care work for the same entities that pay for it (like at Kaiser Permanente in California). He argues that this would at least eliminate the costs of providers arguing with insurers, which are certainly substantial. He recognizes that providers who work for entities that also are insurers have major incentives to minimize expensive care, but he proposes that quality-control regulations be beefed up to deal with that obvious problem.

I agree with the Dr. John Geyman’s assessment in How Obamacare is Unsustainable that this approach is unlikely to have much cost impact, since it leaves private companies with even less competition and with every incentive to make money running the show. I agree with Brill that it will probably be a long time before we take the sensible step of expanding Medicare to cover everyone.

The book might have been better to recognize that, in the meantime, perhaps there is a good old American solution to handling high costs: encourage more competition in the provision of medicine. For example, we might reduce the barriers that limit how many foreign-trained physicians may practice here. We might publicly finance medical education and expand residency programs. We could allow Medicare to bargain with the drug companies and allow medicine to be freely imported from Canada and elsewhere.

One reason health care in America is so expensive is because there are many anti-competitive arrangements that keep prices higher than they might be. Maybe we will ultimately deal with this in a very American way if people...
like Stephen Brill keep writing good books and articles telling us all what’s going on.

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How Obamacare Is Unsustainable: Why We Need a Single-Payer Solution for All Americans

John Geyman, MD
Friday Harbor, Washington, Copernicus Health Care, 2015, 328 pages

Reviewed by Nick Estes, JD

It’s been five years since passage of the Affordable Care Act and over 30 million people have obtained health insurance coverage—most for the first time. The national uninsured rate has declined from a peak of eighteen percent to eleven percent. Low-income individuals have benefited from the expansion of Medicaid (in about half the states) and from the premium subsidies for private coverage purchased on the new health insurance exchanges. Obamacare brought major reforms to our health insurance system: carriers can’t deny people because of pre-existing conditions, annual and lifetime caps on benefits are not allowed, and young adults can stay on their parents’ policies until age twenty-six. The ACA, together with a reviving economy, even seems to have bent the cost curve down somewhat.

So what’s not to like?

Plenty, according to Dr. John Geyman in How Obamacare Is Unsustainable: Why We Need a Single-Payer Solution for All Americans. Dr. Geyman makes a compelling and well-written case that America could do much better for its citizens.

First, 30 million people are still uninsured under the ACA. This would be unimaginable in other advanced countries. And there is little hope that many more of these individuals will become insured. Many of them are low-income individuals who are just above the income cut-off for Medicaid, but feel they can’t afford the coverage offered on the exchanges—even with a federal subsidy—and are willing to take their chances with a tax penalty—or with a sudden serious illness.

Moreover, even for those with insurance, Dr. Geyman emphasizes that an “epidemic of underinsurance” has developed. Many employer-sponsored health plans (some adopted to meet ACA requirements), as well as individual plans, including many purchased on the new state exchanges, have higher and higher deductibles and co-pays. For example, most people are buying “silver” plans on their exchange, which only cover seventy percent of the enrollee’s medical bills. Many are buying “bronce” plans, which cover sixty percent. Obviously, a family could easily be financially devastated by having to pay thirty or forty percent of the cost of treatment for a really serious illness.

Moreover, health care remains twice as expensive per capita in the United States as the average of other advanced countries, while health outcomes are not any better, and are frequently worse. Obamacare is only expected to cause marginal improvement in that unconscionable statistic.

According to the Dr. Geyman, the basic problem with the ACA is that it is built on our current system of private health insurance, which costs a fortune in administration and profits, while adding essentially nothing of value to American health care. The incredible political power of the health care industry, and especially the health insurance industry, forced the politicians, from President Obama on down, to exclude any consideration of a “single-payer” system like Medicare, in which citizens pay taxes rather than insurance premiums, and a government agency, rather than private companies, pay the health care providers.

I was startled to learn from Dr. Geyman that the excess administrative costs attributable to our system of private health insurance (both at the insurance carriers and at hospitals and physician offices) currently are almost $600 billion per year—over three percent of our nation’s gross domestic product. That’s almost twenty percent of our total health care costs. The administrative costs of Medicare, by contrast, are about three percent.

For all this money, there is no evidence that the health insurance companies provide any useful service that couldn’t be provided just as well by a government agency like the Centers for Medicare and Medicaid Services at much lower cost.

There are two functions of health insurance. First, the insurance function. Someone must collect funds on a regular basis from a large pool, and then use those funds to cover at least some of the health care costs of individuals when they occur, recognizing that some people every year will need far more health care than others. A government agency can provide this risk-smoothing function as well as hundreds of private companies, as Medicare does now for our highest-risk population. Second, there is the administrative function: managing the collection of premiums and the payment of health care costs to the providers, minus co-pays and deductibles. To keep payment costs down, the insurance companies bargain with providers and limit access in various ways, so they can guarantee providers
certain volumes of business in exchange for lower rates.

The core problem with this system is that it takes huge costs to administer a system that requires each company and provider to determine which costs are covered—and that will depend on the patient’s particular plan, on which entity provided the service, what type of service was provided, and under what circumstances. In the meantime, the company has every incentive to find ways to maximize the costs borne by the provider and the patient, and minimize what it must pay. These limitations on coverage cause people to skip preventive, non-emergency care, and wait until they are really sick and have to go to the emergency room at great expense.

Dr. Geyman argues very persuasively that it is high time we recognized that provision of medical care is not primarily a “business” best left to the private market, because everyone deserves good care regardless of their income level. Most advanced countries combine a system of mostly private providers with a form of universal national health insurance ultimately supported by income and payroll taxes. Canada is an example. (The United Kingdom is unusual in providing most care through a national health service that actually employs the physicians.)

This book is a very informative, clearly written, comprehensive indictment of our present health care system, five years into Obamacare. Personally, however, I doubt that the system is as “unsustainable” as Dr. Geyman thinks. American politics is remarkably adept at resisting changes that threaten the incomes of powerful interests. Thirty years ago, when health care spending was less than ten percent of GDP, everyone would have said that a spending level that consumed eighteen percent of our GDP surely would never be allowed. Today we think that surely Americans will wake up and adopt national health insurance as health care spending approaches and then exceeds twenty percent of our income. I’m not holding my breath.

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In his latest book, Offit argues against religious practices that ignore medical facts as primary treatment of serious disease. Bad Faith presents gripping anecdotes of women and children who have died because they did not receive vaccinations against serious illness or obtain medical care for life-threatening infections or injury. The author’s passion burns on every page. The book centers on faith healing and vaccination refusal. It describes parents who, under religious influence, watch their children die or suffer irreversible damage rather than take them to a physician. Court intervention is insufficient because the children often are too far gone when authorities learn of their illness.

It seems almost churlish to criticize a book written by a famous, heroic author seeking to address this deplorable treatment of children. However, this book suffers from some flaws that detract from the strength of the author’s arguments.

The first is its overbroad proposed solution. This is to abolish religious exemptions from child neglect and child abuse legislation. It is appropriate to consider denial of care for serious illnesses, including vaccination, as abuse. Criminalization may not be as appropriate for lesser parental failures, though. I, like many parents, have agonized over when to take a febrile child to a pediatrician. However, a delay by a poorly educated fundamentalist would be more likely to attract the attention of a prosecutor than would a similar delay by educated professionals.

A second weakness in Offit’s presentation is his condemnation of orontal suction during circumcision and laws prohibiting pregnancy termination when a woman’s health is at stake. The former is a practice of especially strict groups of Orthodox Jews, while the latter legislation was enacted in Ireland under Catholic influence. These practices may be valid health concerns, but
are not directly germane to the book’s basic issue, which is that some religious groups withhold medical care from children. Offit’s advocacy is not served by opposing people such as Catholics and Orthodox Jews, who mostly support provision of medical care to children.

Most important, though, is that Offit’s understanding of religion is incomplete. He views religion instrumentally: it is good to the extent it promotes secular well-being. To be truly religious “is to be humane.” Offit, who says he is nonreligious but ethnically Jewish, describes an Orthodox Jewish doctor as being faced with two “conflicting ideologies”: his religion and “scientific and medical training.” Neither medical training nor science itself is an ideology, however. Secular choices themselves may also reflect conflicts with the value of health, such as taking the risk inherent in cosmetic procedures. The ideological consideration is deciding when religion should take priority over health, and vice versa. Physicians certainly should be committed to furthering health, but their patients often can appropriately prioritize other values.

Religious people do not regard their faith and practices primarily as a way to improve their material circumstances, though. Religion involves belief in an order outside of nature. Religious doctrine may hold that there are rewards for compliance with this order, and punishment for noncompliance. Some religions emphasize the fate of the personality after death, while others seek primarily to organize society in accordance with a divine blueprint. To these ends, religions espouse three major concepts that are in conflict with material goals. These are martyrdom, renunciation of physical goods, and prophetic outlook. Most major religions regard death as preferable to abandonment of the faith under compulsion. Most also require some degree of physical renunciation, such as sexual restraint or dietary restrictions. Finally, religious adherents may bear witness to the perceived failings of society, its leaders, and its institutions. From Samuel’s criticism of King Saul’s misrule to Martin Luther King’s condemnation of American segregation, this prophetic outlook has been integral to the Judeo-Christian tradition. Criticism may come from different perspectives; the critical perspectives of religious adherents are radically different. A prophetic outlook is not necessarily correct. It can be bizarre, as with the faith healers Offit describes; or even vile, like that of Fred Phelps. Which of these, if any, reflect true religion is uncertain, but certainly all are truly religion.

Offit gives insufficient credit to major religions’ support for medical care. His portrayals of Judaism and Catholicism do not explicitly acknowledge that both traditions normatively regard medical care as the preferred treatment for physical illness. Not only Jews and Catholics, but members of most religions, may pray for recovery while simultaneously pursuing medical treatment. Although Catholic doctrine accepts intercession of saints, this is considered a last resort. And Western Jews not only have relied on medicine, but have disproportionately become physicians, while most sizeable modern Jewish communities have built hospitals. Conflating ancient Israelite with modern Jewish practice, Offit cites Biblical passages that attribute illness to divine visitation. Offit also misunderstands the Israeli practice of “ritual child murder;” even in ancient times child sacrifice was considered abhorrent.

Offit also offers an incomplete, instrumental view of law. He seems to construe the significance of Supreme Court cases as being the way the dispute at hand is resolved. The justices, however, are more concerned with the general legal rules that will serve as precedents for future cases in many courts, applied to a wide range of facts. Bad Faith ignores these legal rules. So Offit sees Church of Lukumi Babalu Aye v. City of Hialeah (1993) as being about animal sacrifice, rather than as about the power of government to enact laws that target specific religions using a secular pretext. He sees Burwell v. Hobby Lobby (2014) as addressing post-coital contraception, rather than the question of what rights individuals must give up when they operate their businesses as a corporation. The Court strives to make the rules come out right rather than to make the resolution of the facts come out right. Most of us probably would prefer to be judged under reasonably fair and predictable rules rather than take our chances that we will appear before a judge whose social and political opinions agree with our needs.

Bad Faith makes a strong case for government action against reliance on faith healing in children instead of medicine. The book would be even more persuasive if it exhibited a better understanding of religion and law.

Reference

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Letters to the editor

Re “The academic medical center in a disrupted world”

Training physicians at academic medical centers to be politically adept technocrats, data miners, and team players in the “disrupted world” Steven Wartman describes in his recent editorial (Spring 2015, pp. 2–9) gives short shrift to what many of us heard when called to the guild of the Aesculapian helix. As he has written so eloquently about over the years, medical training involves imbuing doctors with wisdom concerning the nature of suffering and its amelioration. However, in this present editorial, taken up with the fiscal and sociopolitical crises we face at academic medical centers, and even in his otherwise excellent work as a medical ethicist, he barely hints at something critically important to reafﬁrm any time we speak of the basis of the social contract we honor as a healing guild: the teaching of the philosophical basis for, and the psychological aspects of, what physicians do, and helping create the good people to do it.

Our academic medical centers (AMCs) must not only produce efﬁcient, articulate health care delivery specialists, ﬁne scientists, researchers, and delegators of power: they are also providing role models with strength of character, maturity, and moral compass for their communities, but, even more critically, in the process of providing health care one patient at a time. In our rush to master the technical, economic, and political challenges of the day, the complexities of the caring role of the physician might have been under-emphasized in our training at the AMC, and are even less likely to ﬁgure subsequently in CME opportunities through our practice careers. And even when referred to, in lecture or at bedside, it can fail to approach the emotional truth of what goes on when the act of healing hurts and/or exalts both patient and physician. Business and cost-centers notwithstanding, how are we preparing ourselves each day for the deeper soul work of health care? Do we doctors lack only for compensatory strategies that enhance our intellectual command of our specialties, our efforts as part of the health care team, our transparency in declaring conﬂicts of ﬁnancial interest? Perhaps so, and as suggested by some, do we need only to improve our capacity at understanding patient informed consent and risk management, and develop skills for communicating pertinent facts?1–3

Most physicians, when pressed, would agree that we lack something else, and I believe it is one of the critical reasons for our loss of respect as a guild of healers. Without its being recognized and confronted, again and again, I fear we will continue to fall in society’s estimation of our worth. By emphasizing our work as an industry, as producers of a product called health, we ignore the affective aspects of how both patients and we arrive at consensus about the world and their medical care. The question thus raised is not how do we make these messy aspects of thinking go away, but rather how do we physicians learn to shepherd and moderate the relational process of reaching common ground on the value of facts and feelings, as it plays out in clinical practice?

We must continually remind ourselves that, even in the midst of such crises as Dr. Wartman describes, AMCs must also produce psychologically and philosophically-aware physicians, able to identify and address ontological, epistemological, affective, and psychological aspects of the alliance of patient and physician. This is just as important as restructuring the institution financially and creating efﬁcient ways of delivering team-based health care. There are critical experiences in the healing alliance that patients, and doctors, need and expect to be shepherded and nurtured, whether or not those needs and expectations can be articulated. Patient empowerment, the accessibility of data and opinions that we all share in the new internet age, the postmodern respectful approach to culturally bound values, do not take away from their inclusion—in some measure dependent on our characterologically-constrained openness to appreciate such things—and so understand what we can know, and how we know it; and as well, how to take a moral measure of everyone’s approach to the issues at hand. But most of all, in the crucible of the health care encounter, fraught with fear, suffering, and the potential for healing, it is the physician’s task to nurture the needs of all involved to love and be loved, to respect and be respected, to value and be valued, in the professional manner that our guild has evolved in its work for humanity.

Medical education may have emphasized behavioral science and a scholarly understanding of how health care functions in society, but for many of us it may have neglected the tools required to bring these to bear in one’s work with patients, or importantly, on ourselves. It is critical to realize that book-learned comprehension, or even mentored clinical encounters, can still leave one without the psychological tools with which to practice, and live with, empathic clinical medicine, through our professional and personal lives. It’s my observation that for most physicians there is a vacuum where there might otherwise be opportunities that allow us to “check in” and work on our capacity for psychological
This is not solely about what is commonly called health management, nor is it simply a matter of dexterously inserting a bit of our personal magic into the rushed clinic visit. To make this work, we need to take the task of constructive empathy more deeply than simply interacting compassionately at the delivery end of the health care industry. Good doctors listen to patients, acknowledge the power of the patient’s narrative, and realize the consequences of the biopsychosocial aspects of medical care. But even when this is done well, we can still be left with a gaping chasm dividing us from our patients on critical issues. Do our duties end at acknowledging such disagreements, and documenting them for defensive purposes?

Current medical knowledge and practice are indeed modeled on the biomedical sciences and the technology derived from them. In the main, physicians’ anxieties about competency and expertise arise from our capacity to practice medicine measured by these yardsticks. And many ethicists’ concerns with interactions with patients are aimed at getting everyone to an agreed recognition of what “rational,” “scientifically valid” problem-solving brings to health care decision-making. However, in the tradition of David Hume, and supported by the work of social psychologists such as Jonathan Haidt, and Daniel Kahnemann, the bases for our capacity to understand ourselves and others are strongly influenced by how we use reason posthoc to justify our intuitions in establishing the value and ethical probity of actions and thoughts.4-6 Much of what we intuit as being true about the world and ourselves is embedded in the stories we tell others and ourselves, rather than in reasons derived from the slower, more cognitively complex process of logical reasoning. And in spite of what we champions of the Age of Reason might think, this is not all bad.4-6 There are fascinating implications here on how we think, feel, and decide, which can and should be applied to medical practice. The role of the doctor is more psychologically complex than we appreciate.7-11 This is at least partly because the affective gestalt of the relationship is owned and expressed by both the patient and the doctor, in different and more intimate, personal ways than are facts. And, despite protestations of denial, both parties to the deed are letting feelings and affect permeate their process of arriving at decisions about risk with which they are comfortable.9

In this light, the proper approach to establishing meaning and value in all interactions with patients, whether it is about risk/benefit decisions, or sharing impending death, or in any ethically challenging health care interaction, is via an understanding of the conflicts and commitments, beliefs and expectations, fears and hopes operative in the psyches of all stakeholders. Importantly, relational work goes both ways. The test of our competence would be to bring such insights back to the relationship, and reframe the process for the patient and loved ones as it may be informed by such dynamics. In order to do so, the physician will likely also need to similarly try to understand what is driving her in the relationship with this particular patient, and how such issues of projection, transference, countertransference, trust, and emotional connectedness prioritize and value what is at stake. Does your academic medical center model this approach to medicine, and train its students, faculty, and community of physicians for this work? You get CMEs for working on this? And if these competencies are not in our skill set, can we still practice good medicine? What have we allowed our profession to become, if such goals are not among our key priorities?

Our confidence as physicians relies on the ability to master the mechanics and information flow of our specialty, what Wartman describes as “professional intelligence.” And his six steps required of academic medical centers are needed. In the same breath, however, we need to reaffirm what health care ultimately is about, person by person. We physicians, curious amalgams of scientists, scholars, researchers, administrators and healers, should be aware of how we respond both intellectually and emotionally to the uniqueness of each of our physician-patient relationships, and be willing to explore ways in which the psychological and interpersonal dynamics influence the ethical, medically-correct choices we pursue in them. The mission of the AMC—to educate, research, and treat—must incorporate ways to emphasize and provide focus on these additional goals. The success of our institutions, the assembled multi/interdisciplinary teams, our patients, the community we serve, as well as the physicians leading our efforts, depend on it.

Acknowledgment


References


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Letters

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Re “The tragedy of the electronic health record”

Dr. Byyny’s editorial (Summer 2015, pp. 2–5) should be read by every physician, hospital administrator, dean, medical student, government official, and patient. It is a perfect complement to Drs. Ober and Applegate’s brilliant essay, and it is the best summary of the subject of the electronic medical record that I have read. I disagree only with his last sentence: he’s too optimistic.

The issue arrived a day after I requested at our Family Medicine faculty meeting that our department discuss the negative impact the EHR has had on resident education, patient care, and staff morale. My note in advance of the faculty meeting is below.

Subject: Engaging residents in periodic discussions on the role of the electronic medical record

Returning this week from the Sixth International Conference on Graphic Medicine (which explores illustrated illness narratives, visual forms of patient education such as comic books, and reflective drawing and writing as an educational component of the medical school curriculum)—with the theme of “Spaces of Care” and at which I gave a talk entitled, “Drawing Patients Closer: Freeing the patient from the electronic medical record, the ultimate confined space”—I was confronted by a virtual stack of more than 60 clinic charts to sign in my Inbox.

Several of the notes were exceptionally well-written and well-reasoned, but the majority reminded me of the observation in the attached article from The Pharos by the chair of the American Board of Internal Medicine: “One really doesn’t ‘write a note’ any more; rather one charts on each of the patient’s problems, one by one.” This creates a string of verbiage that “outwardly appears to be the patient’s progress note.” But . . . “It’s not really a note, it’s a series of problems (each accompanied by a brief assessment and plan) held together with electronic Steri-Strips.”

Following on the heels of nurses’ retreat from the patient’s bedside to the charting station, residents are now spending far more time in front of the computer screen than with the patient—as much as 90% of a resident’s shift at the hospital.

Accepting that the electronic record (and typing on the laptop in the exam room) as the new normals in medical care is one thing. But when the time spent on the computer winds up replacing time spent with the patient—creating an “iPatient” with which all too many emerging physicians seem to feel more comfortable, as Dr. Jeffrey Chi wrote last December in a commentary in JAMA—then there is all the more reason for us to require readability, understandability, and reflection of continuity of care as standard criteria for electronic progress notes.

Let’s take the lead on this (and take back our patients) by making the EHR adapt to family medicine rather than by being EHR lem-

mings. At the very least, I think that in the next week or two (once the responses to our EHR satisfaction survey have been submitted), the residents should receive the attached articles, and we should have periodic forums to discuss the EHR, not just from the standpoints of our practice’s report card on Meaningful Use, potential data collection for research, or the quirks of the latest EHR “enhancements,” but rather on the ways that the EHR affects our care of patients and our relationships with them.

Congratulations on a job well done.

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I read with interest Drs. Ober and Applegate’s article (Winter 2015, pp. 8–14) concerning electronic medical records. I have a completely different take. I actually enjoy using these software products, and find them a marked improvement over paper charting. I considered writing a letter expressing my opinion but never got around to...
it. However, after receiving my Pharos summer issue containing an editorial by Dr. Bynu, in addition to two letters to the editor disparaging EMRs, I felt I had to respond. I find clinical data much more organized, easily available, and easily read in electronic medical records. Data entry (charting) is much easier once one gets the hang of it.

I am not exactly sure why such negativity. Let me share my experience. When electronic medical records came to my office and hospital I heard several physicians say that they were going to learn just the minimum to get along. It was just too difficult to learn all the little nuances of the software programs. This seemed like a good idea initially, until I gave it some more thought. If I just learned the minimum then I might be unaware of a more efficient and accurate way to document clinical data. So I did the opposite. For thirty days I did not watch TV or read a newspaper or magazine. I spent every evening studying the EMR binder and practicing the software on the tutorials. It was fun, and I knew every nuance of the software when I was done. I still struggled for a few months when the EMR went live, but soon I loved the electronic medical record, and found I spent less time entering information. The piano is a beautiful musical instrument, but only if one knows how to play it. I hope I am not the only AΩA member who enjoys the EMR.

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I enjoyed reading your editorial, “The Tragedy of the Electronic Health Record,” as well as the Letters to the Editor in this summer’s Pharos.

Jim McGuinness’s cover illustration, I believe, clearly suggests that a patient, who can only look at the back of the physician (and the computer monitor), is noting time pass without personal and meaningful interaction with that physician.

As I looked at the cropped illustration heading your editorial on page 2, I was struck by the image depicting “wondering where the time is going,” as it relates to the overall inefficiency of our EHRs and specifically to your Dr. Healy’s point regarding the hidden costs involved. Each of the several administrative and clinical operations meetings that I have attended this week have referred to:

1. Additional resources necessary to develop “work-arounds” for either design flaws or illogically constructed algorithms, which then require additional resources to deal with the unintended consequences of those “work-arounds.”

2. Additional time and personnel needed to extract and reassemble useful operational data out of currently collected EHR “data.” Simple extraction to usable spreadsheets or statistical software seems to be restricted and designed to require additional vendor funding in order to perform what would appear to be standard analyses for any hospital in this day and age.

3. Lack of clinical logic to develop useful methods of linking important clinical information to order appropriateness for testing, medications, and bedside care. This in part relates to the array of quality metrics for which patient benefit has been overshadowed by “best practice advisories” or other time-consuming hard-stops, which could have been addressed during up-front EHR systems construction. Order sets designed to “not miss anything” now result in overuse of testing, and medication class duplication.

4. Physician and nurse time needed to perform tasks previously performed either by the physician personally or by other healthcare professionals in a much more time efficient manner. I agree with Dr. Block’s observation regarding the value of a trained transcriptionist over a voice “recognition” computer program. I used to be able to round on postoperative cardiac surgical patients, including review of vital signs, laboratory data (two large sheets of paper record), and radiographic images, patient and nurse interview and patient examination, progress note entry, order entry and nurse clarification/debrief in five to seven minutes/patient. Now each step is prolonged by a series of mouse clicks, and screen searching, during which time we are turned toward the computer and away from the patient; progress note entry which could either utilize a series of drop downs necessitating additional mouse clicks, or meaningless cut-and-paste “information” (where inefficiency is compounded by my personal inability to type without errors), and correcting voice recognition transcription errors; and order entry, again slowed by my lack of typing skills, and which now requires ten to fifteen minutes/patient.

Referring to Jim McGuinness’s illustration on page 43, I am clearly the square peg where the round hole of the EHR is involved.

Thank you for your comments and for Jim McGuinness’s insightful illustrations.

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Thanks for writing such a clear review of the state of EHRs. Your piece is well-written and compelling. It is heartening that we seem to have passed the tipping point and many commentators and leaders now see the shortcomings of existing EHRs.

In my own practice we’ve had an EHR (McKesson) since 2002. I wrote a commentary in 2008 about our experience,¹ and have testified twice to...
It’s hard to be a real doctor now

I and most other physicians went into the medical profession for similar reasons: we liked biology, we liked human beings, we wanted to reduce human suffering; and, we knew physicians held some degree of respect in society. Early in our lives we chose to commit to the required science courses in college, prepare ourselves for the rigors and also the intellectual and personal joys of medical school and residency, and then enter practice. Practice offered relationships that were exciting and fulfilling. We exchanged cases and ideas with our colleagues and developed collegialities within our community, our hospitals, and with our patients. We knew our patients, listened to their fears with them and their families. We treated our patients as human beings and made medical decisions based on the best available evidence, clinical experience, and how the patients perceived their disease(s) and prognosis. They trusted us. We were “real” doctors.

The joy in the practice of medicine has declined. The reasons for this are multifactorial, including the need to see more patients in less time in order to sustain enough revenue to pay costs; the diminution of humanism driven in part by the need to type electronic medical records rather than sit and listen to patients. The joy is also being influenced by the burdens of insurance preauthorizations and denials by payer employees with little or no medical training or licensure, or accountability to my patients. These insurance employees deny the “medical necessity” of my knowledge, based on forty years of clinical-academic education, of what I think is best for my patient. Denials are now the routine, not the exception. Denials create a greater degree of stress and hopeless fear for my patients; they don’t deserve more uncertainty on top of what their basic disease has already given them. Additionally, the financial cost to my practice, by adding more medical assistants hired solely to “fight” the insurers is not reimbursable.

These additional costs have driven many physicians out of business or into early retirement, or forced their employment by hospitals. Hospital administrators then become the deciders of what physicians can or cannot do. Even after I write appeals of the denials defending the necessity of the medical management plan and then have the phone calls—“the peer-to-peer” with some “medical doctor” employed by insurance companies who have little knowledge of the disease(s) I treat—can I obtain approval for the pharmacological treatment or radiological tests I have ordered. Insurers are now the “doctors” and doctors are now the commodity. Humanism in medicine across the board is vanishing.

What are the consequences of these firewalls? Time will define the costs, higher or lower, for these insurance denials and the distancing of real doctors mediated by the demand to type the EMR. Even if costs savings can be directly linked to denials, will the change in a profession transformed into a commodity be worth it? The costs in terms of decrease in my own passion for medicine or respect by my patients for the practice of medicine are already being felt. I am honored to do what I do, but cannot do it in the way I was trained.

Are there solutions? I hope so, but only when society in its broad terms allows doctors to be doctors. Patients have to have the confidence that their physicians are their advocates. While overall medical costs must be a concern for all of us, the burden of disallowing physician’s good management of their patients is costly as well. That cost may not be obtainable. The training of insurance companies “phantom doctors” is not what medical school is about. Unaccountability of insurers is unacceptable. Every individual physician, professional society, academic center, industry executive, and government agency that respects what real practicing physicians deal with day in and day out must work to allow the return of sound and necessary medical

Reference


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Letters
decisions made by well-trained doctors, done by well-trained, real doctors.

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Re “The $6 million physician: A history of robotics making surgeons better, stronger, faster”

The title of Dr. Marc Polacco’s recent article on robotic surgery (Spring 2015, pp. 11–15) is presumably a reference to the old television show “The Six Million Dollar Man,” in which every week bionic man Steve Austin saved the day with his robotic skills—but the title held an uncanny irony for me.

I regularly lecture to medical students and residents about the high costs of medical care in the United States. Among the many causes of these high costs is a lack of cost containment leading to unnecessarily high charges and profits in some areas of medical care. One of several examples of these excess charges is from the bill a patient received for his robotic surgery. The physician billed $10,000 for his services, in addition to facility and hospital and operating room charges. This physician typically schedules twelve of these surgeries per week. Simple math shows this to produce bills of $120,000 per week, and if he works a typical physician year, occasionally adds extra surgeries, and also performs some outpatient procedures and clinic visits, this physician likely bills about six million dollars for his services per year. Even with high overhead costs and poor collection/reimbursement rates this physician might still be collecting an annual salary of 1.5 million dollars.

According to Medical Group Management Association (MGMA) data, the mean salary for a primary care physician, likely working the same hours as this surgeon, currently is $181,000 to $196,000 per year. The average MGMA reported salary for specialist physicians ranges from $178,000 to $640,000, depending on specialty, which averages to a reasonable 1.5 to 2 times that of a primary care physician. On the other hand, salaries that range up to eight times that of a primary care physician are among the contributing reasons to high medical care costs, along with the often excess charges for imaging, medications, and other health services. Granted, there are many other contributing factors to high medical costs, such as excess administrative burden, large numbers of unnecessary or ineffective tests and treatments, costs attributable to defensive medicine and malpractice, high costs near the end of life, and costly new technology that provides minimal improvement over older and less costly tests and treatments. However, since it has been reported that sixty-two percent of all personal bankruptcies in this country are attributed to high health care costs, any excessively high charges really cannot be justified.

I applaud Dr. Polacco’s article. To his credit, he included a very nice discussion of the cost/benefit issues in robotic surgery, though he did not specifically address surgeon charges. It is ironic, however, that his title might just as well refer to the very high annual charges some robotic surgeons might be billing, as to the Steve Austin-like robotic skills those surgeons now have with the robotic tools at their disposal. The type of six million dollar physician that I have presented here is definitely not a savior given the unsustainable high medical care costs that exist in this country.

References

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A Forensic Pathologist’s Villanelle

I only get them once they’re dead
Unveiled on sleek sterilized steel
A whole life story to be read

Start with a Y, end by opening the head
My scalpel, no longer does he feel
I only get them once they’re dead

I examine his fatal wound caused by lead
I discover his final meal
A whole life story to be read

When I’m done, my gloves are red
I write my report of his end ordeal
I only get them once they’re dead

My report done, the answers lie ahead
His last moments I reveal
A whole life story to be read

I tell the families what needs to be said
But his wounds won’t scar or heal
I only get them once they’re dead
A whole life story to be read

Catherine Perez

Ms. Perez is a member of the Class of 2018 at University of Illinois at Chicago. Her poem won honorable mention in the 2015 Pharos Poetry Competition. Ms. Perez’s e-mail address is cperez45@uic.edu.

Illustration by Laura Aitken.
Beginning in 2002, Alpha Omega Alpha’s board of directors has offered every chapter and association the opportunity to host a visiting professor. Sixty-five chapters took advantage of this opportunity during the 2014/2015 academic year to invite eminent persons in American medicine to share their varied perspectives on medicine and its practice.

Following are the participating chapters and their visitors.

ALABAMA
University of Alabama School of Medicine
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Diana W. Bianchi, MD
Executive Director, Mother Infant Research Institute, Vice Chair for Research and Academic Affairs, Natalie V. Zucker Professor of Pediatrics, Tufts University School of Medicine
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DISTRICT OF COLUMBIA
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Dean for the National School of Tropical Medicine, Baylor College of Medicine

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Senior Vice-President, Surgical Accreditation, ACGME
Florida State University College of Medicine
Robert Phillips, Jr., MD, MSPH
Vice President for Research and Policy, American Board of Family Medicine
University of Miami Leonard M. Miller School of Medicine
Maryellen E. Gusic, MD (AΩΑ, Pennsylvania State University, 2009, Faculty)
Chief Medical Officer, Association of American Medical Colleges
USF Health Morsani College of Medicine
Captain Eric A. Elster, MD (AΩΑ, University of South Florida, 2014, Alumnus)
Professor and Chairman Norman M. Rich Department of Surgery, Uniformed Services University of the Health Sciences

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Emory University School of Medicine
David Hackam, MD, PhD (AΩΑ, University of Western Ontario, 1992)
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Medical College of Georgia at Georgia Regents University
LaMar McGinnis, MD, FACS
2010 President of the American College of Surgeons

ILLINOIS
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The Pharos/Autumn 2015
2015 Visiting Professorships

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Luigi Mastroianni, Jr. Professor of Obstetrics and Gynecology, University of Pennsylvania
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Boston University School of Medicine
James O’Connell, MD
President, Boston Health Care for the Homeless Program
Tufts University School of Medicine
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Vice Dean for Academic Affairs Emerita, Medical College of Georgia of Georgia Regents University; 2012 Abraham Flexner Distinguished Service to Medical Education Award
University of Michigan Medical School
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President, University of Michigan
MINNESOTA
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Samuel Finlayson, MD, MPH
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MISSOURI
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Former Deputy Surgeon General of the United States
Rutgers Robert Wood Johnson Medical School
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Edmund N. and Carroll M. Carpenter Professorship in Psychiatry, Harvard Medical School
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Professor and Vice Chair of Radiology, Indiana University School of Medicine; member at large of the AΩA Board of Directors; author
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WASHINGTON
University of Washington School of Medicine
Ruth-Marie Fincher, MD, MACP (AΩA, Medical College of Georgia, 1976, Faculty)
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Professor Emeritus, Department of Molecular Biology, Princeton University; Dean Emeritus, Yale University School of Medicine

The Pharos/Autumn 2015
2015 Volunteer Clinical Faculty Awards

The Alpha Omega Alpha Volunteer Clinical Faculty Award is presented annually by local chapters or associations to recognize community physicians who have contributed with distinction to the education and training of medical students. AΩA provides a permanent plaque for each chapter’s dean’s office; a plate with the name of the year’s honoree may be added each year that the award is given. Honorees receive a framed certificate and engraved key ring. The recipients of this award in the 2014/2015 academic year are listed below.

DISTRICT OF COLUMBIA
George Washington University School of Medicine and Health Sciences
Richard Kaufman, MD

GEORGIA
Medical College of Georgia at Georgia Regents University
George L. Rainsford, MD
Morehouse School of Medicine
James Franklin Densler, MD, FACS, FAAP

HAWAII
University of Hawaii, John A. Burns School of Medicine
Jason Isa, MD

ILLINOIS
Chicago Medical School at Rosalind Franklin University of Medicine & Science
Phillip H. Zaret, MD
University of Chicago Division of the Biological Sciences The Pritzker School of Medicine
Michael Ujiki, MD

INDIANA
Indiana University School of Medicine
Rajalakshmy Sundararajan, MD

IOWA
University of Iowa Roy J. and Lucille A. Carver College of Medicine
Matthew Fox, MD

KANSAS
University of Kansas School of Medicine
Tyler G. Hughes, MD

KENTUCKY
University of Louisville School of Medicine
Glenn R. Womack, MD

LOUISIANA
Louisiana State University School of Medicine in New Orleans
Jennifer Baur, MD

MARYLAND
Johns Hopkins University School of Medicine
Jason Goldstein, MD
Uniformed Services University of the Health Sciences F. Edward Hebert School of Medicine
Craig Shepps, MD
University of Maryland School of Medicine
Eugene Newmier, DO

MASSACHUSETTS
Boston University School of Medicine
David DiChiara, MD
University of Massachusetts Medical School
Eric Matthews, DO

MICHIGAN
University of Michigan Medical School
Welton Craig Washington, MD

NEBRASKA
University of Nebraska College of Medicine
Karen Higgins, MD

NEW JERSEY
Rutgers New Jersey Medical School
John A. Conti, MD
Rutgers Robert Wood Johnson Medical School
Jill Gora, MD

NEW YORK
Icahn School of Medicine at Mount Sinai
Frank Centanni, MD
New York Medical College
Sanatkumar Dagli, MD
New York University School of Medicine
Michael Brabeck, MD
State University of New York Downstate Medical Center College of Medicine
Kaiser Islam, MD
State University of New York Upstate Medical University
Ryan D’Amico, DPM
Thomas Helm, MD
University of Rochester School of Medicine and Dentistry
Edward Lewis, MD
Weill Cornell Medical College
Timothy Dutta, MD

NORTH DAKOTA
University of North Dakota School of Medicine and Health Sciences
Eduardo Meza, MD

OHIO
Ohio State University College of Medicine
John Robinson, MD
2015 Administrative Recognition Awards

This award recognizes the AΩA chapter administrators who are so important to the functioning of the chapter or association. The nomination is made by the councilor or other officer of the chapter. A gift check is awarded to the individual, as well as a framed certificate of appreciation.

The following awards were made in 2014/2015:

**MASSACHUSETTS**
Tufts University School of Medicine
Mary Broderick

**MISSISSIPPI**
University of Mississippi School of Medicine
Virginia Covington

**NEW YORK**
State University of New York Upstate Medical University
Patricia Gooden

**TENNESSEE**
East Tennessee State University James H. Quillen College of Medicine
Sue Russell

Virginia Covington  Patricia Gooden  Sue Russell
Alpha Omega Alpha is establishing a writing prize to honor one of the great leaders in American medicine, the late Robert H. Moser, MD (AΩA, Georgetown University, 1969). The Moser Award: Casting Light on the Many Paths of Medicine, will be awarded for essays celebrating the lives of physicians like Dr. Moser who have enriched the world through their careers within, related to, and outside of medicine.

Bob Moser’s career in medicine was varied and colorful. From organizing and working in one of the first MASH units during the Korean War, to becoming a pioneering flight controller for NASA during the Project Mercury and Project Apollo space programs, to serving as Chief of Medicine at Walter Reed and Tripler Army Medical Centers in Hawaii, to treating patients at the Kalaupapa Leper Colony in Molokai, to editor of JAMA, to executive president of the American College of Physicians (during which period he was invited to the People’s Republic of China to observe medical practice there in one of the earlier signs of détente), to Pharos editorial board member, Bob was a man for all seasons and a distinguished leader in medicine.

We invite you to join us in supporting this award to highlight other physicians whose lives have enriched medicine.

To join your fellow distinguished physicians in supporting this award, please send your check to:

The Moser Award
Alpha Omega Alpha
525 Middlefield Road, Suite 130
Menlo Park, CA 94025

Contributors

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2015 Postgraduate Awards

In 2011, the board of directors of Alpha Omega Alpha established the Postgraduate Award. Its purpose is to encourage and support AΩA residents or fellows from programs or institutions with an active AΩA chapter or association to pursue a project in the spirit of the AΩA mission statement that could fulfill the ACGME requirements for scholarly activity. Project applications are accepted in the categories of:

1. Research: Support for clinical investigation, basic laboratory research, epidemiology, or social science/health services research.

2. Service: Local or international service work, focusing on underprivileged or immigrant populations or those in the developing world, as well as patient and population education projects.

3. Teaching and education: Research, development, or implementation of education academic curricula, with the focus on postgraduate education.

4. Leadership: Leadership development.

5. Humanism and professionalism: Projects designed to encourage understanding, development, and retention of traits of humanism and professionalism among physicians, directed to physicians in postgraduate training.

Four applicants received $2000 awards to support their work. The recipients of the 2015 awards are:

Susan Marshall, MD
New York University School of Medicine
Project category: Research
Phase II Study of MR-US Fusion Biopsy-Guided Focal Cryoablation of the Prostate in Men with Clinically Localized Low-Immediate Risk Prostate Cancer
Samir Taneja, MD, mentor

Laura Mazer, MD
Stanford University School of Medicine
Project category: Teaching and education
A competency-based curriculum for the surgical sub-internship
James Lau, MD, mentor

Johnny Nguyen, MD
USF Health Morsani College of Medicine
Project category: Research
Understanding the Relationship between Genetic Basis and Immunomodulation in Myelodysplastic Syndromes and Related Myeloid Neoplasms: Focusing on p53, EZH2 and Some Dendritic Cell Markers
Ling Zhang, MD, mentor

Vivian Shi, MD
University of California, Davis, School of Medicine
Project category: Teaching and education
Incorporation of teledermatology in Nepal for international medical outreach
Raja K. Sivamani, MD, mentor
Sestina for a Father

I don’t know much about it anyway, the self-professed king who handed over his part of the Three Kingdoms to an idiot son, the tyrant who slew his warhorse to feed his dying troops, the general whose main battalion burned, decades flying into the air like water. Yet I never saw your eyes water when the farm boys, charging, yelled away, their scrawny arms the force behind the main assault, their fire-lit arrows sent over to pierce the laughter of the gloating king, whose victory horse must now sit quiet in the stall, idle as an idiot.

I do not want to be the idiot, father. I do not want to be the one to watch you water plants in little clay pots, you who rode your horse giddy towards mountains. You say this illness is nothing, just some pain to get over. You watch melodramas from the couch, hunched in your domain. All onscreen believe that whoever could get a certain man on their side would unite the Kingdoms. Idiots. Though what tragic joy lay in that wise man’s eyes, when all was over, to say he could have done nothing more, nothing to water down the terror of a child-king who shrank from war, if his father’s away and dead. Wisdom and goodness ruined by a boy who played horse.

Even if I screamed my voice hoarse, father, I could not say it—these mangled manes, these stories broken down into madness. Away from you, I know nothing, least of all a charging river, one that nursed idiots and heroes. I know nothing of waters old and depthless. I clap my hands when the show is over.

When all this is done, when all this is over, I will buy you some land and a horse to lead around fields and drink from cool well water. I will watch you there, free from harm by the main house I cannot go back to. I will be that idiot and I know it, at that shrouded bank when you ride away, laughing. And perhaps it’s easier that way, to be that idiot not knowing when things are over, than to stand on that main bank without so much as a horse to ride into the water.

Ting Gou

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