Be Worthy to Serve the Suffering
Alpha Omega Alpha Honor Medical Society
Founded by William W. Root in 1902

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“Be Worthy to Serve the Suffering”
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With a distinguished history of 116 years of service to medicine and society, Alpha Omega Alpha (ΛΩΑ) is the nation’s interdisciplinary honor medical society, recognizing, advocating for, and inspiring physicians in the care of patients and the promotion of health. Members may be elected throughout their career. They epitomize academic and clinical excellence, professionalism, leadership, education, scholarship, service, and “being worthy to serve the suffering.” ΛΩΑ is dedicated to improving care for all by recognizing high educational achievement; honoring gifted teaching; encouraging the development of leaders in academia and the community; supporting the ideals of humanism; and promoting service to others.

As the honor medical society, ΛΩΑ’s members promote scholarship and research in medical schools; embody a high standard of character and medical excellence; and are servant leaders in medical science, patient care, and community health. ΛΩΑ physicians exhibit the qualities of excellent doctors through their knowledge, skills, attitude, compassion, empathy, altruism, and teaching.

The function and influence of a society depends on the wisdom with which its members are elected. Membership in ΛΩΑ may be attained as a medical student, resident, fellow, faculty member, alumni, clinician, or distinguished leader in medicine. The criteria for nomination include, but is not limited to, scholastic achievement, demonstrated professionalism, leadership capabilities, adherence to ethical standards, fairness in dealing with colleagues, achievement in medicine and/or research, and a record of service to school and community.

Physicians or scientists who have attained distinction in any endeavor related to medicine, and who are not eligible for election by other means, may be elected as honorary members.

For medical students, the Dean of the School of Medicine or his/her designee identifies a pool of candidates who approximate in number the upper quartile of the class expected to graduate, and who have excelled in the criteria for nomination to ΛΩΑ membership—scholastic achievement, professionalism, leadership, community service, and research. Scholastic achievement refers to the qualities of becoming, and being, an excellent doctor—knowledge, skills, trustworthiness, demeanor, care of the patient, proficiency of the doctor-patient relationship, decision-making, compassion, empathy, altruism, values of the profession, teamwork, life-long learning, and servant leadership. Each of ΛΩΑ’s 132 Chapters in medical schools across the country, in Puerto Rico, and Lebanon develop the metrics and rubric to weight the criteria as best fits its medical school, keeping in mind the Association of American Medical Colleges (AAMC) Liaison Committee on Medical Education (LCME) approved curriculum and evaluation, and then select 16 percent of its graduating class, 25 residents/fellows, three to five faculty, and three to five alumni as new members of ΛΩΑ.

All members of each medical school’s Chapter are eligible to vote for nominees at a meeting of members convened for that purpose. Selection as a nominee shall require a majority vote of those in attendance. Once nominated, election to membership in ΛΩΑ occurs when the nominee registers with the ΛΩΑ National Office and submits a dues payment for the first year.

ΛΩΑ is committed to improving diversity in the medical profession based on evidence that inclusion of talented individuals from different backgrounds benefits patient care, population health, education, and scientific discovery. ΛΩΑ is dedicated to overcoming bias—implicit/unconscious and conscious bias—as well as discrimination at all levels throughout the organization. It values a diverse, fair, and equitable work and learning environment for all, and supports the medical profession in its work to achieve a welcoming, diverse, inclusive environment in teaching, learning, caring for patients, and collaboration.
AΩA advocates for diversity in all of its forms—identity, cultural, geographic, experiential, sexual orientation, ancestry, ethnicity, gender, age, economic and social status, physical abilities, and religious beliefs.

AΩA works with its members, Chapters, medical schools, residency programs, and health organizations to improve diversity within the organization and throughout the medical profession. No candidate for membership shall be denied election because of age, race, color, ethnicity, national origin, sex, pregnancy status, gender, identity or expression, sexual orientation, language, physical or mental disability, marital, civil union or domestic partnership status, veteran status, socioeconomic status, or religious or political beliefs.

Fostering excellence

Since AΩA was established in 1902, more than 185,000 members have been elected. Today, there are more than 120,000 living members with 4,000 new members elected each year. AΩA is primarily supported through member dues and contributions.

AΩA publishes a one-of-a-kind, interdisciplinary, peer-reviewed medical humanities journal called The Pharos. Published since 1938, it was named for one of the seven wonders of the ancient world, the Pharos lighthouse of Alexandria. The Pharos is a quarterly journal that publishes scholarly essays covering a diversity of nontechnical medical subjects, including medical history, ethics, medical-related literature, and other topics. Peer-reviewed by an Editorial Board composed of medical experts and prolific physicians, authors, and educators, The Pharos has been described as a unique journal:

In an age of rapidly evolving technology and forced efficiency, The Pharos continues to emphasize the artistic, the literary, and the place of music, language, and culture in medicine. Although themes may shift—now touching upon the economics or the ethics of times—humanism is the enduring content of our AΩA journal.

—Faith T. Fitzgerald, MD, (AΩA, University of California, San Francisco, 1969) The Pharos Editorial Board Member, and AΩA Distinguished Teacher

Consistent with the AΩA mission, 12 national fellowships, grants, and awards that support leadership, professionalism, teaching, research, scholarship, and community service for medical students, faculty, medical schools, and medical communities have been developed. In 2017, AΩA provided nearly $2 million to students, residents, faculty, physicians, and medical professionals at medical schools having an active Chapter.

The Carolyn L. Kuckein Student Research Fellowship supports and promotes basic and clinical research in medical fields, social sciences, or health services conducted by medical students with mentors. This is a peer-reviewed grant program that in 2018 awarded research fellowships of $6,000 to each of 69 medical school students.

Each year, in collaboration with the Association of American Medical Colleges, AΩA selects four outstanding teachers—two basic science and two clinical—and recognizes them as the best medical school teachers in the country. There have been 101 AΩA Distinguished Teachers since the award’s inception in 1992. These Distinguished Teachers are selected by former award honorees, and receive $10,000 each, with an additional $2,500 provided to the recipient’s school, and $1,000 to the AΩA Chapter at the recipient’s school.

Each year, AΩA provides each Chapter the opportunity for a Visiting Professorship. Chapters may select an acclaimed teacher or speaker to serve as a Visiting Professor for the school, students, and community. AΩA provides a modest honorarium for the speaker and reimburses all travel costs. In the last academic year, AΩA supported 65 Visiting Professors.

Leadership

Leadership in medicine, medical education, and health care is more complex in the 21st century than ever before. It is a core value of AΩA, and is a tenet of the organization’s mission, as well as criteria for membership.

The medical profession and the country are in need of leadership that represents and personifies what is best for patients, and is inspiring, insightful, engaging, and humble, leadership that both understands and represents the needs of patients, physicians, medical educators, trainees, communities, and society.

Leadership is an integral part of the professional life of a physician. Physicians are effective servant leaders in medicine, medical education, and health care because of their professional knowledge, skills, and experiences. To best utilize these professional attributes, qualities, and experiences, physicians should aspire to become servant leaders who lead based on caring, service, and professional values.

Each year, AΩA selects and supports three mid-career physicians as Fellows in Leadership to further develop outstanding leaders in medicine. Each Fellow is provided $25,000 to participate in leadership development, and to complete an institutional leadership project, with the
in institution providing 25 percent protected time for them to work on the fellowship and project. The ΑΩΑ Fellow in Leadership emphasizes servant leadership, ethics- and values-based leadership, and the inward journey which teaches that effective leadership results from knowing oneself and aspiring to lead others.

Fundamental leadership principles are critical to building a better future by recognizing that the work of leadership involves an inward journey of self-discovery and self-development; establishing clarity around a set of core values that guides the organization as it pursues its goals; communicating a clear sense of purpose and vision that inspires widespread commitment to a shared sense of destiny; building a culture of excellence and accountability throughout the entire organization; and creating a culture that emphasizes leadership as an organizational capacity. Leadership and learning are inextricably linked.1

Experiential learning in leadership with role models, mentors, and coaches, and development of a leadership community of practice are core to the Fellowship.

**Professionalism**

Professionalism in medicine has been a core value for ΑΩΑ since the society’s founding. ΑΩΑ is committed to serving as a leader and catalyst to improve professionalism in medicine.

Medical professionalism stands on the foundation of trust to create an interlocking structure among physicians, patients, and society that determines medicine’s values and responsibilities in the care of the patient and improving public health. A combination of leadership and professionalism can have a synergistic and positive impact on ΑΩΑ members and the medical profession.

ΑΩΑ is focused on learning about, and teaching, best practices in medical professionalism. With grant support from the Josiah Macy Jr. Foundation, ΑΩΑ has published two monographs—*Medical Professionalism Best Practices*, in 2015, and *Medical Professionalism Best Practices: Professionalism in the Modern Era*, in 2017—both of which are distributed widely to all interested parties without charge.

In addition, ΑΩΑ promotes the Edward D. Harris Professionalism Award, which recognizes and honors outstanding faculty and programs that have demonstrated the best practices in medical professionalism education. Up to three awards of $10,000 are provided annually.

**Recognizing and assisting medical students, residents, clinical faculty, and administrators**

Medical Student Service Leadership Project grants fund medical student leaders, faculty mentors, Chapters, and medical schools that establish innovative, unique community projects incorporating experiential leadership for the students. Selected projects are funded for three years.

ΑΩΑ also funds peer-reviewed postgraduate (resident/fellow) research/scholarly projects that fulfill Accreditation Council for Graduate Medical Education scholarly activity requirements for residency training programs.

In recognition of their indispensable services, and excellent teaching and mentoring, ΑΩΑ provides awards to clinical faculty in community practices who volunteer to teach students and residents. ΑΩΑ also provides Administrative Recognition Awards for services provided by administrative personnel who work tirelessly in support of students, local Chapters, and Councilors.

To support and promote writing and scholarly publications as a professional responsibility, ΑΩΑ supports several writing awards including the Helen H. Glaser Student Essay Award, *The Pharos* Poetry Award, and the Robert H. Moser Essay Award. Each year, three student essay and three student poetry award winners are published in *The Pharos*, as is the Moser essay, which must be written by a physician.

**The organization**

ΑΩΑ is governed by a board of directors with elected officers who each serve limited terms. The ΑΩΑ Board of Directors consists of nine at-large members, who are distinguished ΑΩΑ members; three Councilor members; three medical student/resident members; one organizational representative; and one membership initiative representative. The direction of the society is vested in its elected officers: President, President-elect, Immediate Past President, Secretary/Treasurer. The national office is directed by an Executive Director, who is chosen by, and reports to, the Board. He/she is responsible for implementation of all activities of the society, including the day-to-day operations of the office, and is Editor of *The Pharos*. The national office consists of six employees, including the Chief of Staff and Managing Editor of *The Pharos*, the Director of Member and Chapter Services; the Programs Manager, the Controller, and the Executive Assistant/Office Manager.
Chapters

Upon receiving their Liaison Committee on Medical Education accreditation, medical schools may apply to AΩA to establish a Chapter. Each Chapter has a Councilor who must be a member of the medical school’s faculty and an active member of AΩA. On the recommendation of the Chapter’s members, Councilors are appointed by the Dean of Medicine and are responsible for the operation and well-being of the Chapter. Each Chapter has elected medical student officers—President, Vice-President, and Secretary-Treasurer—who are members of AΩA. All AΩA members, including medical students, residents, faculty, and alumni, are eligible to participate in Chapter functions, activities, and elections.

The Chapter officers along with the Councilor provide leadership and work to generate social, educational, and service projects. Each Chapter must submit an annual report to the AΩA national office detailing their activities, programs, and support of the AΩA mission.

A history of leadership

AΩA was established before the Flexner Report and prior to the establishment of the AAMC LCME. At the time, most medical schools were proprietary and independent for-profit institutions. Medical education was essentially an apprenticeship program.

AΩA was established in response to the need for recognition of academic achievement and professionalism in medical education and the medical profession. It contributed by developing and promoting values that were implemented, recognized and upheld through Chapters in medical schools. In the early 1900s, there were only a few internships. Some new doctors underwent a year of postgraduate experience, but most began medical practice upon graduation.

After the Flexner Report, as medicine and medical education advanced and became more scientifically- and scholarly-based, medical education responded and internships became a requirement for medical licensure. Medical school accreditation was required to recognize and confer a medical doctor degree.

As medicine and clinical practice advanced, the requirements to become a physician also progressed. Medical schools also evolved and began teaching a new language of science and medicine, knowledge, skills and attitude. Medical students grew from novice to competent to expert with the qualifications to receive the medical doctor degree. However, clinical experience and increasing experiential learning from accrued clinical responsibility was required to be prepared to practice medicine. With these increased educational opportunities came additional experiential learning in the form of a post-doctoral year of internship.

Advances in medicine continued and medical specialization evolved, which required even more education and empirical learning. Specialty residencies and post-residency fellowships were established.

Throughout this evolution AΩA has been at the forefront of confirming and affirming the core values of medical professionalism, by supporting and promoting physicians who exemplify leadership, are role models and mentors, who generate new ideas, teach others, serve as innovators, provide excellent care for patients and their communities, and are worthy to serve the suffering.

A life-long responsibility

AΩA is the national honor medical society for medical students, physicians in post-graduate training, medical school faculty, practicing clinicians, and scientists. It promotes scholarship and research in medical schools, encourages a high standard of character and conduct among medical students and physicians, and recognizes meaningful contributions in medical science, practice, and related fields.

AΩA membership is the best recognized medical school award for achievement in medicine. As most members are elected in medical school and before medical specialization, the membership is interdisciplinary and represents all fields of medicine. It represents more than 116 years of hard work, perseverance, and high ideals.

AΩA expects members to commit to a life-long responsibility of high quality clinical care, academic achievement, exceptional leadership, noteworthy professionalism, and remarkable service. Members serve as role models, mentors, coaches, and leaders throughout their communities of practice and in society.

AΩA is committed to working with medical schools, AΩA Chapters, and the medical profession as a whole to achieve an inclusive environment embracing diverse colleagues in teaching, learning, scientific discovery, and caring for patients.

“Be worthy to serve the suffering” is our commitment to our profession and the patients we serve.

Reference

Gender and professionalism: Does it matter?

Eve J. Higginbotham, SM, MD

Dr. Higginbotham (AOA, Morehouse School of Medicine, 2008, Faculty) is Vice Dean for Inclusion and Diversity, Professor of Ophthalmology, and Senior Fellow at the Leonard Davis Institute at the University of Pennsylvania in Philadelphia. She is the current President of the Alpha Omega Alpha Honor Medical Society Board of Directors.

For years, September has been celebrated as Women in Medicine Month, thereby noting the accomplishments of women and celebrating the legacy of women who have contributed to the science, art, and delivery of patient care. This year’s celebration is particularly notable as an important new milestone is being celebrated—the significant number of women among current medical school matriculants.

In 2017, for the first time, women were 50.7 percent of the 21,338 matriculants (49.8 percent in 2016.) This proportion is representative of the general population of which women compose 50.8 percent based on the 2010 census. It has only taken 250 years to reach this milestone!

The changing context of our nation—and by natural extension our environment as medical professionals—must be considered in our ongoing and future practice of professionalism as providers, researchers, and educators. Inclusion is a core competence of professionalism that we must seek to optimize, in addition to the other core competencies of altruism, humility, and integrity.
Does gender matter in the context of medical professionalism?

Given the magnitude of this topic and its importance, it is helpful to consider the choice of terms in the title, and a useful roadmap. Gender relates to how individuals are perceived in society, rather than solely their biological assignment at birth. It also recognizes the influence of environment, culture, and societal expectations.6

If gender does matter, how do we get there? How do medical professionals become more mindful of the influence that gender has in our professional lives?

There is value in building an inclusive environment that engages diverse perspectives in medicine. And, there is clear evidence that suggests we currently are neither adequately nor effectively accomplishing this goal. Intentionality to achieve this goal is important, and evidence-based solutions do exist.

The ultimate value of considering this context enhances the culture, allowing professionalism to flourish successfully for everyone.

The value proposition at the intersection of gender and professionalism

The social contract between medicine and society has been at the center of many discussions as medicine has evolved from a model of individual physicians practicing in local communities to one of employed physicians delivering care in large health care systems, impacting populations. At the core of this transformation is the recognition that the values of the caring physician who touches individual patients must be preserved at the organizational level if medical professionalism is to remain true to its core tenets of delivering professionalism and healing.

Cruess et al., noted that, "Professionalism is the basis of a professional’s social contract with society. Society uses the concept of the profession to assist in the organization of the delivery of essential services that are required. In medicine, it is the services of the healer that are to be organized."7 Thus, balancing the business needs of a large system with these core values becomes the daily challenge of governing boards and executive leadership as well as providers, researchers, and staff.

Corporate America has long recognized the benefits of advancing the equality of women in leadership positions. In 2015, the McKinsey Global Institute projected that if the gap between women and men in the work force were closed by 2025, $12 trillion could be added to the global economy.8 Translating this projection to academic medicine, particularly as medicine moves from volume as its currency of reimbursement to value, the benefits of gender diversity are evident.

Reimbursement should be based on outcomes rather than the number of patients seen. One key metric is the 30-day readmission rate, which is rewarded with additional revenue if specific targets are achieved. A recent study examined mortality and readmission rates of patients treated by male physicians versus those treated by female physicians. It found that lower 30-day mortality rates were associated with the care provided by the women physicians compared to the male physicians.9 This is one example of how women physicians can demonstrate their value to the bottom line as well as their value to patient care.

Another key metric is patient satisfaction. Mast and colleagues noted that the differences associated with physician nonverbal behavior are affected by gender. In their study, patients expressed greater satisfaction with female physicians who exhibited female mannerisms such as leaning toward the patient, and using a softer voice. On the other hand, some patients preferred male physicians who spoke louder and were more distant from the patient.10 Moreover, Lagro-Janssen observed female physicians to be more patient-oriented compared to male physicians.11 A meta-analysis by Roter, Hall, and Aoki of the effects of gender on communication with patients confirmed that female physicians engage in more patient-centered communication in primary care settings compared to male physicians.12

The importance of delivering patient-centered care has been emphasized by the National Academy of Medicine, noting "engaging patients and families (as a strategy)...to improve health outcomes and efficient use of care."13

The value of gender diversity has also been underscored among scientists. Campbell and coworkers reported the benefits of gender-diverse working groups, demonstrating the evidence of such groups publishing in higher impact journals compared to homogenous groups.14

Differences in the approach to care by women and men, both measurable and immeasurable, can, over time, enhance the care of patients, contribute to the renewal of medicine’s social contract with society, and stimulate innovative research.

Women in leadership

There are few women at the highest levels of leadership in academic medicine or hospital leadership. Despite decades of at least 20 percent woman matriculants entering schools of medicine, only 16 percent of the deans of schools of medicine in 2015 were women, and only 20
percent of professors of medicine are women, an important pipeline to decanal positions.

Disparities have been reported in the promotion rates of women, compared to those of men, when determining promotions to associate professor and professor. This makes it difficult to assess the depth of female talent that never ascends to higher ranks, given the less than predicted numbers of women who are promoted. In 1980, 24.9 percent of medical school graduates were women. Given this data, we would expect that at least 25 percent of deans should have been women by 2018. However, at the current rate it will take 40 years or more before there will be full parity of women and men as deans.

Women compose only 18 percent of hospital CEOs, and in at least one state, women compose only 26 percent of boards and 18 percent of executive management teams in health care systems. Thus, there is a paucity of women who can serve as candidates or role models for key positions of leadership in health care systems that drive the culture.

Disparities in the objective assessment of talent is evident in many training programs. Dayal (AΩA, Rutgers New Jersey Medical School, 1998) and coworkers evaluated the attainment of milestones by male and female emergency medicine residents from eight community and academic training programs. Although there was no difference between male and female residents at the beginning of residency, at subsequent milestone assessments men were more likely to score higher than women. Interestingly, there was no difference between the assessment of these residents by male and female faculty evaluators.

There have been many theories and observations offered to explain the disparities between men and women in academia and health care. Differences in accessing mentors, motherhood, maternity leave, and caregiving responsibilities have been advanced as important contributors. Unconscious bias has also been discussed in the literature, and is now being actively addressed in schools of medicine and medical centers. Enhancing self-awareness of all medical professionals regarding unconscious bias requires intentional attention, particularly for the processes related to search, evaluation, promotion, and publication. The acquisition of research awards should also undergo greater discernment as it is another area where gender disparity has been observed.

To reduce or eliminate bias, decisions need to be made with a clear head and free of idiosyncratic influences. Making important decisions when one is hungry, angry, late, or tired (HALT) eliminates the important step of reflective thinking that can reduce bias.

When gender intersects with ethnicity, there can be an intensified effect which was noted by Ginther and coworkers who reported that Asian and Black doctors were less likely to receive National Institutes of Health funding. Generally, women submitted fewer applications, and investigators who were new submitted only one application during the observation period of the study. Although these observations are credible data points, it is important to delve more deeply into the root causes of these findings.

The concept of culture has been openly discussed in organizational developmental literature for more than 50 years. Culture, defined as “collective values, beliefs and principles of organizational members,” may be described as supportive, non-supportive, or toxic depending on the topic and the circumstances. A recent report from the National Academy of Sciences (NAS) places culture and climate as central to the discussion of sexual harassment. “Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine,” reports on a frequency of episodes of sexual harassment among medical students and graduate students that exceeds 40 percent. National advocacy efforts associated with the #MeToo movement places an important emphasis on this topic.

The NAS Sexual Harassment Committee, an ad hoc committee under the oversight of the Committee on Women in Science, Engineering, and Medicine, identifies three types of harassment:

1. Gender harassment, including verbal and nonverbal behaviors that contribute to a hostile environment;
2. Unwanted actual sexual advances; and

As one who has experienced instances of a toxic environment in the workplace, and personally counseled women, and men, who have been subjected to academic bullying, the reality of these observations is undeniable. When compared to men, more women consider leaving an institution rather than confront unprofessional disruptive behavior. And, as a result of internal and external social, cultural, and environmental stressors, women physicians have been reported to be at greater risk for burnout than men.

**A culture that enhances professionalism**

Assuming that one is convinced that there is value in advancing efforts to reduce the gender gap in medicine and
science, and there exists an array of challenges that impact men and women differently in the workplace, some may consider these challenges impossible to solve. Borrowing from corporate America, the Korn Ferry Institute gathered the observations from 57 women CEOs who offered recommendations regarding organizations, peers, and women in the workplace.

The women CEOs said that at the organizational level, there must be a clear recognition of the role of unconscious bias in key processes such as recruitment, promotion opportunities, and annual evaluations. These institutional processes reinforce the status quo. One of the women CEOs explained, “Survival of the fittest is not a meritocracy: it inherently favors the dominant group.”

Additional recommendations from the women CEOs include the recognition of nontraditional models of leadership; the identification of future leaders early in their careers; reframing the role of leaders as agents of cultural transformation; and encouraging women to assume roles that require profit-and-loss accountability. These are important recommendations for women and men alike.

Faculty development programs have proven to be effective in retaining faculty. Mentorship is critically important in the development of new leaders, as is sponsorship, which can provide key opportunities for greater exposure institutionally, and within professional organizations.

Women and others who may be involved in caregiving may require access to bridge funding to facilitate re-entry into a briefly disrupted career. These individuals may want to consider seeking sponsors and mentors, searching for early roles with measurable results, and finding networking opportunities.

Networking with others within an institution, and externally, is important in building careers. Warner, et al., measured the quality of the network of male and female faculty, and noted that men had more robust networks compared to women as noted by the number of first-, last-, and middle-author publications and h-index. All are important metrics associated with promotion.

Above all, it is important to know one’s passion, understand personal strengths, and acknowledge weaknesses.

**Enhancing the environment for all**

Inclusion and diversity is a larger issue than any one individual or a single gender. It should be considered a focus for all who care about sustaining, and enhancing, medical professionalism. It is important to clearly define the qualities of professionalism that all will share, respect, and collectively strive to achieve. Without this process of consensus-building, there is a risk that ambiguity will cast professionalism as a punitive instrument.

Borrowing from the words of Scribonius in 47 AD, professionalism is a commitment to “compassion, benevolence, and clemency in the relief of human suffering.” There is no better way to accomplish this goal than by ensuring the full engagement of all leaders, providers, scientists, and staff who bring a diversity of perspectives and talent to the workplace.

Now is the time to ensure that everyone is on board, ready, and inspired to help solve the complex problems that plague modern society and the medical profession. Only by engaging in reflective thinking, taking into account our ever-changing landscape, will our shared goals be achieved, and in the words of the Alpha Omega Alpha Honor Medical Society, “Be Worthy to Serve the Suffering.”

**References**

8. McKinsey Global Institute. The power of parity: How advancing women’s equality can add $12 trillion to global


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The Hippocratic Oath for humanitarian aid workers
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With refugees fleeing war-torn Syria, famine-plagued East Africa, and ethnically oppressed Myanmar, current migrations surpass anything seen since the end of World War II. Meanwhile, the humanitarian aid community faces the crisis with its own epidemic of trauma and burn-out. The George Washington University Global
Mental Health Program takes a unique approach to this problem by offering mental health support and education to humanitarian aid workers. In journeys to Iraq, Japan, China, Haiti, and Greece, the program’s academic and community clinicians offer direct care to refugees along with psychological first aid, mindfulness, and crisis intervention to aid workers. Little can be achieved if colleagues on the front lines are not supported.

Post-traumatic symptoms affect humanitarian aid workers in the same manner as refugees. Meta-analyses show a clear increase in trauma rates, burn-out, depression, and anxiety among aid workers—even after the end of their tours. Effects on volunteers can be greater than on professional rescue personnel, with post-traumatic stress disorder (PTSD) rates ranging from 24 percent to 46 percent among those working with natural disasters or airline crashes. This is a confirmation of the very human response to crisis.

During the Global Mental Health Program’s 2016 visit to the refugee camps in Greece, and its accompanying workshop on resilience, there was strong interest in the professional requirements of current humanitarian aid work. Among the 45 Greek representatives of 19 non-profits that attended, there was a simultaneous commitment to humanitarian ideals and Hippocratic scholarship that addressed both the risks and rewards of their work. Because of the Program’s own interest in the Hippocratic writings and their place in the region’s history, program members joined this group of Greek professionals in a modern-day reenvisioning of the Hippocratic Oath. A structured discussion reviewed the Oath and its potential application to the work with refugees, and updated it for issues that could not have been anticipated by the Ancients. Later, a coding team categorized the discussion and molded it into a combined expression of Hippocratic and humanitarian ideals.

The Global Mental Health Program believes that the Hippocratic Oath offers an established and recognizable standard for humanitarian aid efforts. Still heard at commencement exercises in the United States, Greece, and elsewhere, the Oath offers grounding in a tradition that has frequently been updated for contemporary practice. Scholars updating the Oath address many of the modern challenges arising in medicine (e.g., multidisciplinary teams, organizational accountability, social justice), but have not tied core principles to the normal stress responses and vicarious trauma of humanitarian aid work.

In its original version, the Oath underscored the importance of the patient-physician relationship, education, appropriate treatment, confidentiality, and honor. Classic admonitions to enter patients’ homes only to benefit the sick, avoid exploitation, and know one’s limits formed the basis for a series of permissions and prohibitions that created an ethic of “competence, caring, and commitment.”
is an ethic that resonates for humanitarian work, but does not yet encompass global crises.

Where critics of the Oath have seen this absence of responsibility to the broader community, to multidisciplinary teamwork, and patient safety, others recognize a “proto-professionalism” and a shaping of medical expertise. Workshop participants were no different, recognizing classical efforts at professional grounding and survival. Similarly, modern revisions retain commitments to patients, education, and non-exploitation while removing appeals to the Greek pantheon (“I swear by Apollo...”), or the prohibition of surgery (“I will not cut for the stone”). It was not hard for international colleagues to find the kindling of humanitarian principles in both old and new versions of the Oath.

Workshop participants found that the original invocation of the gods and the punishment of fate were part of a broader social commitment. The prospect of divine retribution for breaking the professional covenant was a clear appeal to communitarian principles. This extension of responsibility can also be found in other parts of the writings. The Hippocratic Aphorisms, for example, provide exhortations to care for those around patients as well as for the patient’s affairs.

Beginning the discussion with foundational principles, participants drew on both the Hippocratic corpus and their resilience training to set a new tone. Treating people with dignity and respect, especially for their culture and religion, moved the guild-protective and dyadic Hippocratic ethic into a modern context of human rights and social tolerance. The discussion responded unexpectedly to criticisms of the classic writings.

Eager to underscore their shared humanity, aid workers noted their efforts to ease the culture clash as Muslim refugees entered a Christian region and as people of color entered a homogeneous white community. Same-faith and same-race advisors were valued partners on the beaches and in the camps. Conference participants did not complain of the poverty on the Greek islands where fishing nets were torn by abandoned life-jackets, and roads were ravaged by non-governmental organization trucks. In the midst of an economic crisis themselves, Greeks requested medical aid for their own communities, an appeal that created a shared bond.

Most aid workers poignantly described their own migratory narratives dating back generations—their families had been part of the ruthless “exchange of populations” following World War I, or the brutal fall of Smyrna. Others had married immigrants from distant parts of the world.

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The Hippocratic Oath for Humanitarian Aid Workers

**Section I**

- I will treat all people as dignified human beings rather than hopeless victims, because what I offer is for the sake of humanity.
- I will give precedence to people who require more urgent care, while attending to the needs of all, leaving no one behind.
- I will welcome refugees to my community with open arms, allowing them to acclimate to their new environment at their own pace.
- I will stand up for the rights of vulnerable people, honoring their independence and autonomy, and respecting their privacy.
- I will treat refugees with compassion and empathy, understanding the suffering they have experienced.
- I will advocate for fair treatment whenever I can, aiming to rectify the injustices I may witness.
- I will be hopeful for positive change and a brighter future, offering hope to grieving refugees who have lost so much.
- I will not disclose the secrets confided to me, unless fear of imminent danger requires me to do so.
- I will serve to the best of my ability, striving to offer individualized emotional assistance.

**Section II**

- I will work with others as part of a team, recognizing the importance of self-care for my fellow aid workers and for me.
- I will treat my fellow humanitarian workers with respect and humility.
- I will seek counsel from more well-informed colleagues, not hesitating to seek assistance, guidance, and advice.
- I will not deliver false hope, admitting the limits of my knowledge and disclosing information as accurately as possible.
- I will extend the depth of my knowledge, educating myself on how to work more effectively in a crisis.
- I will learn to handle stress the best way I can, so that I am more prepared to ease suffering and recognize my own.
- I make these promises solemnly, freely, and upon my honor.
Their shared narrative gave them special incentive to look, listen, and learn, witnessing and professing what they saw so that history could record its judgment. This was an unspoken hope for rectifying injustice, and an aspect of witnessing and public advocacy that advanced the writings of the Hippocratics while retaining their core.

Aid workers recognized the capacity for harm if they were resentful or cross-culturally inept. The theme of a common humanity gave “voice to the voiceless:” this was one aid worker’s articulation of the vulnerability of refugees and aid workers alike.

Turning from general principles to the virtues and rules of self-care, participants recognized that they could not be effective without taking care of their team. Checking on their colleagues’ break and sleep schedules, connecting with family by Skype, and using self-reflection and meditation to maintain their equilibrium became critical strategies for nurturing resilience. Most had seen death on the beaches, but did not want to give up on hope. Instilling hope, a particular focus of resilience training, was a critical goal for refugees and aid workers, even when the goal was incremental and hope was fleeting.

Virtues like empathy and transparency echoed the Hippocratic texts, especially because information was at a premium in the camps, and updates about borders and visas was hard to come by. Participants were deeply sensitive to the temptation to provide false hope and partial information.

As the program’s coding team fit these statements into an oath-taker’s framework, they began with the discussion’s foundational ethics: the language of respect, human rights and social justice, and fair treatment and positive change. The language of striving underscored the impossibility of being everything to everyone. Acknowledging common suffering and grief confirmed shared virtues of compassion, empathy, and hope for a better future.

Like the original Oath there are two sections to this effort, with the second section turning mainstream principles toward the common functioning of humanitarian teams—applying the respect and humility of the general principles toward individuals and their colleagues. Self-care, consultation, and education are the focus now, just as in resilience training. The new Oath moves steadily toward the essence of resilience work—recognizing one’s own suffering in order to ease the suffering of others. Closing with language of the Declaration of Geneva the new Oath concludes, “I make these promises solemnly, freely, and upon my honor.”

Turning Hippocratic ideals to modern use was a deeply meaningful experience for Greek aid workers collaborating to underscore self-care and resilience. Self-care was readily acknowledged as the origin of a cascade of caring that could apply to both refugees and to professional ideals.

To do so in one of the cradles of modern medicine was profound for us as well.

Acknowledgments
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References

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Medals4Mettle (M4M), a 501(c)(3) public charity founded in 2005, collects ribbons and medals earned by athletes who complete endurance events (marathons, half-marathons, triathlons, and half-triathlons), and awards them to children and adults suffering with illness. The University of Louisville School of Medicine (ULSOM) medical students presented the concept for M4M to the school’s faculty in 2008, and formed the first chapter of M4M at a medical school.

M4M’s mission provides medal donors a simple, meaningful, and effective opportunity to communicate compassion to fellow human beings and their families. M4M has awarded more than 55,000 medals—primarily to children—in more than 80 hospitals around the world through an expanding volunteer network of 70 chapters. ULSOM student leaders and faculty have sustained and grown M4M every year since 2008.

Athletes donate their medals to pay-it-forward in recognition, support, and celebration of another human’s mettle for enduring a much more difficult race. Anonymously donated medals are awarded to recipients by chapter coordinators and volunteers.

The ULSOM template provides the opportunity for students to identify a pediatric patient well before the awards ceremony is appealing because the lesson of empathy is more likely to take hold. The awarded medal is only a symbol, not the main purpose, and adds the opportunity for enduring humanistic behavior in the student’s development as a physician.

The ULSOM medical students and faculty embraced the concept as an opportunity for the students to understand and empathize with all the encumbrances of disease. It is also an opportunity for students to learn that disease and illness have a name and a family.
University of Louisville School of Medicine student Amber Todd with her “buddy.”
Students run a distance event that helps them understand that the struggle required to complete the race is much less than the struggle their patients and families face every day.

The program brings students together to share a fellowship with their classmates and share the experience of personally awarding their medals to their patients.

The program also provides an opportunity for faculty to teach how being a physician is a noble humane mission, and that physicians must commit to providing the best possible care for their patients.

The novel ULSOM M4M program has demonstrated positive outcomes to enhance the medical student-patient bond. It is sustained by the students, supported by faculty, and researched with scientifically peer-reviewed outcomes.

Enhancing the medical student-patient bond

After signing up for the April Kentucky Derby Marathon or Half-Marathon, medical students at ULSOM are matched with their “running buddies,” many of whom are patients at the University of Louisville Pediatric Cancer and Blood Disorders Clinic. The patient coordinators and nurses display M4M flyers in the clinic and discuss the program with patients. Once a patient decides to participate, they fill out a Health Insurance Portability and Accountability Act (HIPAA) compliance form. Because patients undergoing treatment may not have appointments during the months of recruitment, outreach is also done via phone.

Student coordinators preserve continuity by randomly assigning patients to students, and reassigning previous patient participants with their established student-partner.

Throughout the months of training for the marathon, students meet with their patients and families, often connecting via e-mail or phone. Students are encouraged to learn more about their patient-partners and their illnesses, how the family and patient are coping with the diagnosis, and to foster a relationship that is mutually beneficial for...
The University of Louisville School of Medicine
Medals4Mettle Template

**Step One**
(2-4 months before Award Ceremony)

<table>
<thead>
<tr>
<th>Students</th>
<th>Patient Coordinator/ Nurses</th>
<th>Patients/Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sign up and pay fee for endurance event (approximately $75)</td>
<td>• Distribute M4M flyers to patients and families</td>
<td>• Sign HIPAA form and contact information form if they wish to participate</td>
</tr>
<tr>
<td>• Students are matched with “running buddies” - selected pediatric patients from Hematology/Oncology/Chronic disease etc.</td>
<td>• Discuss HIPAA compliance forms</td>
<td></td>
</tr>
<tr>
<td>• Student Coordinators assign patients randomly or to previous students for continuity</td>
<td>• Recruit patients by phone who visit clinic less frequently</td>
<td></td>
</tr>
</tbody>
</table>

**Step Two**

<table>
<thead>
<tr>
<th>Students</th>
<th>Patient Coordinator/ Nurses</th>
<th>Patients/Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Train and complete event</td>
<td>• Facilitate communication between patient, family and student</td>
<td>• Can attend endurance event and even cross finish line with student</td>
</tr>
<tr>
<td>• Connect with patient and family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Learn about child, child’s illness, how child and family are dealing with illness, foster relationship with child and family</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Step Three**

<table>
<thead>
<tr>
<th>Students</th>
<th>Award Ceremony University</th>
<th>Patients/Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Award medals to patients with families present</td>
<td>• Provide facility for ceremony</td>
<td>• Attend ceremony</td>
</tr>
</tbody>
</table>

Optional:

- $200 for M4M shirts designed by students
- $250 for ceremony refreshments
- Anonymous donors and other sources provide funds
Figure 1. Comparison of scaled responses from students and patients or parents.

<table>
<thead>
<tr>
<th></th>
<th>Students</th>
<th>Patients or parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would recommend this program to other UofL medical students/to other patients and families:</td>
<td><img src="students_bar_chart.png" alt="Bar Chart" /></td>
<td><img src="parents_bar_chart.png" alt="Bar Chart" /></td>
</tr>
<tr>
<td>Participating in M4M was a good use of my time:</td>
<td><img src="students_bar_chart.png" alt="Bar Chart" /></td>
<td><img src="parents_bar_chart.png" alt="Bar Chart" /></td>
</tr>
<tr>
<td>M4M added ‘Value’ to completing the running race/ M4M increased my optimism</td>
<td><img src="students_bar_chart.png" alt="Bar Chart" /></td>
<td><img src="parents_bar_chart.png" alt="Bar Chart" /></td>
</tr>
<tr>
<td>I could imagine I was running for my patient partner and not just myself/I could imagine I was running with my student partner:</td>
<td><img src="students_bar_chart.png" alt="Bar Chart" /></td>
<td><img src="parents_bar_chart.png" alt="Bar Chart" /></td>
</tr>
<tr>
<td>M4M helped me relate to patients on a personal level/ M4M helped me relate to my healthcare team:</td>
<td><img src="students_bar_chart.png" alt="Bar Chart" /></td>
<td><img src="parents_bar_chart.png" alt="Bar Chart" /></td>
</tr>
<tr>
<td>M4M improved my personal communication skills/improved my communication skills with the health care team:</td>
<td><img src="students_bar_chart.png" alt="Bar Chart" /></td>
<td><img src="parents_bar_chart.png" alt="Bar Chart" /></td>
</tr>
</tbody>
</table>

all involved. Patients who are physically capable are encouraged to attend the race and cheer for their partner, and cross the finish line with them.

The cost to the students for participating in the program is the race registration fee of $75. There are no costs to the patients or their families. Program expenses include student designed M4M shirts ($200), refreshments at the ceremony ($250), and informational flyers and posters ($75).

**Program evaluation**

Medical students, patients, and family members who participated in the ULSOM chapter of M4M between 2008 and 2014 were invited to participate in a study. A total of 126 students and 63 patients were invited to complete the surveys including students and patients who had participated for several years in a row. Only one survey per participant could be completed regardless of the number of years they participated in the program.

Surveys consisted of six Likert scaled questions anchored with five response points ranging from “Strongly Disagree” to “Strongly Agree,” and three open ended questions. The six Likert scale questions were designed to provide quantitative data for description and comparison, and the three qualitative questions were designed to capture specific language. The questions were reciprocal to support comparison of student and patient data.

Student and patient participants were invited to respond to the survey during the 2014 M4M ceremony held at ULSOM. Students and previous years’ participants who were unable to attend the ceremony were emailed the survey, informed of the procedure, and given one month to complete the survey online.

For the quantitative analysis, comparisons between students and patients on the Likert scale items were analyzed using the Mann-Whitney U test. Means and standard deviations were depicted in graphic form. All p-values were two-tailed. Statistical significance was set by convention at \( p < 0.05 \). SPSS Version 22.0 was used for the analysis.²

Qualitative analysis was completed using Pundit’s variation of Glaser and Straus constant comparison,³ which is useful with broad topic qualitative data sets. Three reviewers coded open-ended data independently, and then came to consensus on the final codes assigned. The frequency of each code by comment, and by respondent group (students or patients) was calculated using Excel.

Data was collected from 62 out of 126 medical students.
The Mann-Whitney U statistic showed no significant differences between groups for any of the scaled questions. All mean scores were greater than 4.0, with the exception of the student response to the question regarding the program improving communication skills. Specifically, mean scores for student responses were 4.84, 4.70, 4.72, 4.59, 4.28, and 3.94. For patient responses, mean scores were 4.81, 4.76, 4.67, 4.35, 4.48, and 4.05.

Table 1 depicts the percentage of responses analyzed by code, question, and group. Four predominant codes showed more consistency among and between groups, and across questions, than other codes.

Results

The results suggest that M4M is a successful program that encourages humanism in medical students while connecting them with patients battling severe illnesses through a unique and beneficial experience. While the study’s results revealed myriad qualitative differences explaining why there was initial involvement in the program, there were striking quantitative similarities in both student and patient scaled responses.

All study participants agreed, or strongly agreed, to recommend this program to others, and felt that it was a good use of their time. In addition, the majority of respondents agreed, or strongly agreed, that M4M helped students relate to their patients on a personal level, and helped the patient relate to their health care team.

Several qualitative patterns emerged from the survey that were reflected in both patient and student responses. Four categorical themes were consistent across responses to all questions for both groups—a child/patient benefit in participating in the program; the program allowing for one to connect with others; the desire to participate in the program again; and that it was a wonderful program overall. One parent commented, “Sarah loved meeting her runner and spending time with her. I feel like we really connected. It meant so much to us that a young student took time from her busy schedule to run this race and donate her medal to Sarah.”

Another parent remarked, “It is amazing to see what it means to your child and your student as they get to know each other. The inspiration and the bond created are incredible.”

Students were equally as excited about participating in the program with one commenting, “I had no idea how fulfilling it would be to get to know the kids, and experiencing the real sense of solidarity that seems to be absent in my clinical rotations. It’s a wonderful use of your time in medical school and offers a chance to connect to a patient and to better explore the humanistic aspect of the medical field.”

Students appreciated the experience of forging a special relationship with a patient outside of the hospital or clinic. They acknowledged it as an opportunity to discover humanism in a creative manner, and expressed the desire to continue participation in the program.

The patient, family, and medical student connected on a level not often experienced by students in their typical medical school curriculum. Through participation in M4M, a paradigm of interaction can be integrated into the clinical setting so that students develop a heightened sense of caring and compassion that will manifest in their subsequent patient encounters.

The only area of dissatisfaction with the program voiced by student participants was the desire to be paired with their running buddies (patients) at an earlier time. This would allow the pair to create a longer-lasting, more meaningful relationship prior to the race and ceremony.

The major limitations of this study were that it was conducted at a single institution, and that it followed a single M4M event. The population was too small to conduct a pilot study of the survey, so the validity was based off of expert review, which was another limitation.

It is possible there was some response bias among participants, however not all responses were positive. There was an area of dissatisfaction indicating that respondents felt free to offer their opinion.

A post-hoc power analysis indicated the sample size of 62 medical students and 21 patients would achieve 80 percent power to detect a significant difference between groups given a moderate to large effect size of 0.65, and a significance level of 0.05 using a two-sided Mann-Whitney U test. If smaller effect sizes between groups exist, statistical significance may not have been detected due to the small sample.

Sharing the program with other schools

Participating in the M4M program is a positive experience for all parties involved. Replication of the program requires a few simple components:

1. Funding for the race entry fee, race shirts, and ceremony—approximately $1,500 for 20 student runners;
2. A community-based half or full marathon racing event;
**Table 1. Percentage* of comment type (code) by question and group.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Student</th>
<th>Patient/ Parent</th>
<th>Student</th>
<th>Patient/ Parent</th>
<th>Student</th>
<th>Patient/ Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal benefit (e.g. get back into running, healthy)</td>
<td>38%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>7%</td>
<td>0%</td>
</tr>
<tr>
<td>Opportunity to give back (service)</td>
<td>13%</td>
<td>4%</td>
<td>0%</td>
<td>0%</td>
<td>9%</td>
<td>0%</td>
</tr>
<tr>
<td>Motivating and inspiring</td>
<td>11%</td>
<td>0%</td>
<td>3%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Child/patient benefit</td>
<td>22%</td>
<td>36%</td>
<td>1%</td>
<td>5%</td>
<td>11%</td>
<td>10%</td>
</tr>
<tr>
<td>Connect with others</td>
<td>7%</td>
<td>0%</td>
<td>13%</td>
<td>19%</td>
<td>11%</td>
<td>20%</td>
</tr>
<tr>
<td>Wanted to participate again</td>
<td>4%</td>
<td>9%</td>
<td>9%</td>
<td>29%</td>
<td>2%</td>
<td>20%</td>
</tr>
<tr>
<td>Adds value to running</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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*Percentage of all replies per open-ended question by group. **Bold** indicates a predominant code across question and groups.
3. A venue to host the post-race celebration/medal gifting;
4. Faculty time to provide mentorship;
5. Students to participate in the program; and
6. Patients to participate in the program.

At ULSOM pediatric patients with hematologic or oncologic illnesses are included, but other institutions could include patients with other chronic illnesses, or even the adult population.

Conclusion

M4M is a replicable model for other graduate health care professional schools to use and adapt as a tool for teaching humanistic behavior in a unique and effective way. “To celebrate and reward the collective courage of all human beings” has been the mission of M4M over the past 11 years, and the innovations of the M4M program at ULSOM provide a novel technique to teach humanistic behavior to medical students.5

M4M is an activity led and embraced by the students who manage it as a team. It has been scientifically verified for its value to all involved, and proudly represents the medical profession. The humanistic behavior that participating students develop with their patients facilitates their transformation into a physician.

Acknowledgments

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References:


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Editor's note: The Pharos is introducing a new section, “Reflections,” that focuses on physician experiences related to AOA’s mission of leadership, professionalism, teaching, and service. Each vignette will be a brief (no more than 1,000 words) evocative description, account, or episode with a major point of learning, insight, experience, and/or reflection. Vignettes will be focused on leadership, teaching, education, learning, medical excellence, humanistic qualities in the individual physician, professionalism, and/or ethics. It is our hope that readers will find this new section to be insightful, educational, and entertaining, and that they will consider submitting their own reflection for possible inclusion.

God shot me with an arrow
Richard L. Byyny, MD, FACP (AOA, University of Southern California, 1964)

Dr. Byyny is the Executive Director of Alpha Omega Alpha Honor Medical Society, and Editor of The Pharos. He is an internal medicine physician.

I was caring for patients and teaching residents and medical students at the University of Colorado Hospital General Internal Medicine practice in the 1970s. I was evaluating a 48-year-old Latino man who I had been seeing for more than two years. He initially presented with cough, fever, weight loss, night sweats, and production of yellow blood streaked sputum. A chest X-ray revealed a right upper lobe infiltrate with central cavitation. His sputum stains revealed acid fast bacilli and the diagnosis of pulmonary tuberculosis. He was started on isoniazid, pza, and rifampin observed therapy by his wife. He improved rapidly.

Twice he returned with a recurrence of his night sweats, weight loss, and fatigue, and his chest X-ray revealed an increase in the right upper lobe lesion. Sputum smears for acid fast bacilli were negative, but his culture grew mycobacteria tuberculosis. He told me he had stopped taking his medications, though he had no side effects. With medication, he rapidly improved and was better for almost a year.

He returned a third time with the same symptoms, and another X-ray revealed the same right upper lobe lesion.

I sat down with him, a resident, and a student, and asked him if he was taking his medications reliably. He answered “No.” I asked why, and he replied that he wasn’t sure, and had no side effects from the medications that were being offered by his wife on schedule.

I asked what he knew about tuberculosis. He answered that he knew it was an infection in the lung due to a bacteria, which caused his symptoms. I asked him if he thought the medication was effective and helping to treat the infection. He answered, “Yes, it seems to work each time I take the medications.” I then asked him why he wasn’t taking the medication if he thought it was helpful in treating his tuberculosis. He asked me to put his X-ray up on the view box. He got up and walked to the X-ray and pointed at the lesion and said, “See that spot? That’s where God shot me with an arrow. You can easily see where it went through.”

I asked him why God shot him with an arrow, and he replied, “I really didn’t know, but it was punishment for something I did that God was unhappy with. I can’t be cured by Western medicine until the spiritual cause is healed.”

He was from the San Luis Valley in Southern Colorado and was explaining a spiritual cause for not being curable. I asked him if he believed in curanderismo, and if he knew of a curandero or curandera.

Curanderismo is a traditional Mexican-American healing system from the integration of Catholicism and indigenous holistic healing. It treats and cares for people through religious, spiritual, health-related means and rituals. It is a type of holistic folk medicine. Followers define disease as having both biologic and spiritual causes that can often be resolved only through respect and acceptance by the healers.

The patient told me he knew a curandero. I asked if he believed that having a curandero would help cure him, and he answered, “Yes.”

We organized a consultation with the curandero who developed a plan for healing that involved spiritual rituals with the patient and his family. My student, resident,
one of our nurses, and I were invited to participate in the ritual event. The curandero used small brooms with herbs to sweep away the curse, and acknowledged the patient’s punishment to resolve his guilt and violating God’s will.

The ceremony lasted two hours. The experience used the tools of the curandero to heal the patient, and his belief system. The patient agreed, now that God had forgiven him for his transgressions, that he would take his medications knowing that he would now be cured both medically and spiritually.

Dr. Sydney Margolin, a professor of psychiatry and a learned colleague, had taught me that “the reality and life of patients and their problems are richer, more interesting, and more complex than can be encompassed or defined by any theoretical framework,” or by scientific method alone. He taught me to have an intense curiosity about unusual people, unique human problems, and cultural differences in the roots of healing processes. He explained that the historical relationship of physicians with priests and shamans of other cultures, including the curandero, have a place in medicine and cannot be ignored.

Inquiry and understanding of a patient’s issues, awareness of our own professional and personal biases and limitations, and a willingness to better understand culturally different populations and patients can help us to curar.

As a team caring for this patient we treated his mind, beliefs, illness, and body as a whole. We understood that our patient’s perceived supernatural disorder was interfering with curing him of an infectious disease. Through understanding and respecting our patient’s beliefs—and with the help, support—and rituals of the patient and his curandero, we were successful in the treatment and caring of our patient and his family.

A quandary resolved
Jack Coulehan, MD (AΩA, University of Pittsburgh, 1969)

Dr. Coulehan is a member of The Pharos Editorial Board, and one of its Book Review Editors. He is also Emeritus Director of the Center for Medical Humanities, Compassionate Care, and Bioethics at Stony Brook University in New York.

My friend, Peter Martin, and I were members of the University Hospital ethics consultation service. As an attorney and philosopher, Peter would complain that most of our consults weren’t about ethics at all, but usually had to do with poor communication. He said that by talking with the parties involved and conducting family meetings, ethics consultants were often able to resolve the issues, and facilitate patient care. Peter appreciated these good outcomes, but still argued that they didn’t specifically entail ethics. I took the position that poor communication resulted in bad clinical care, which was itself unethical.

I received a consult from urology regarding Mr. Williams, a patient who kept pulling out his percutaneous endoscopic gastrostomy (PEG) tube. He was an elderly man who suffered from Alzheimer’s and swallowing dysfunction as a result of a previous stroke. He had been admitted for urosepsis, which had resolved with antibiotics. However, he remained delirious for unclear reasons.

He had pulled out his PEG tube several times. To prevent further problems, he was put in arm restraints, which only increased his agitation. His inarticulate cries could be heard down the hall. Mr. Williams’ wife and daughters objected to tying him down “like an animal,” and suggested giving fluids by mouth, a course his clinicians believed would lead to aspiration. In fact, when his wife covertly gave him sips of juice, he spit them out. Nonetheless, as the patient’s health care agent, she took a firm stand that her husband should not be in restraints. She was also opposed to heavy sedation, given his precarious clinical state.

That’s when his attending consulted the ethics service. The surgical attending asked me to “make her understand that he needs to be restrained.”

This was going to be difficult. Mrs. Williams had the legal right to prevent the use of restraints. The urological team might argue that repeated insertion of a new PEG tube was futile since Mr. Williams was only going to pull it out again, and that each insertion carried a risk of tissue damage and infection.

Since his stroke, the patient had lived in a state veterans home where he was confined to bed and a wheelchair. His Alzheimer’s was moderately advanced, but he seemed to enjoy watching TV and having the companionship of fellow veterans, although his expressive aphasia limited verbal communication. There seemed to be no definite barrier to him recovering this baseline level of functioning.

I arranged a meeting for late afternoon with Mrs. Williams, her daughters, and members of the surgical team. The next step was to visit the patient, an emaciated elderly man with right hemiplegia, squirming and groaning in his bed. His left arm restraint was loosened so he could move his hand and arm freely.

As I stood beside the bed, I noticed that he tended to touch and rub his upper right arm. You could characterize his left arm movements as random or flailing if you just glimpsed for a moment, but over time his hand kept
coming back to the same area, which seemed a little swollen. When I palpated the area, he reacted violently. Clearly, he was in pain.

I also noticed that Mr. Williams was not on a regimen of pain medication, other than Demerol when necessary, which he had not received for several days. The nurses’ notes consistently documented agitation, moaning, and crying out. They expressed frustration each time Mr. Williams pulled out his PEG tube. However, there was nothing about pain. He was unable to request the analgesic, so it was never given.

Could this be the cause of his agitation? Might pain be contributing to his delirium? I spoke with his attending, who was happy to follow-up. An arm X-ray revealed an osteoporotic humerus with a proximal fracture, possibly sustained during transport or transfer. The urologist prescribed an analgesic every four hours.

It didn’t take long for Mr. Williams’ agitation to disappear, and he became more alert. His new PEG tube remained in place without incident. And the ethical question of restraints was promptly resolved.

I agree with Peter Martin that reasoning from principles is often useful in clarifying ethical issues in medicine, but sometimes they can be clarified—and resolved—at the bedside without resorting to second level deliberation. Mr. Williams taught me that careful observation, along with clear communication, lies at the core of ethics in medicine.

Clinical parsimony: “Personalized” patient care

John A. Benson Jr., MD (AΩA, Oregon Health & Science University School of Medicine, 1968, Faculty)

Dr. Benson is a member of The Pharos Editorial Board. He is an internist, and Dean and Professor of Medicine, Emeritus at Oregon Health & Science University; Professor Internal Medicine, Emeritus at University of Nebraska Medical Center.

In the current cultural-economic era of unsustainably high costs of medical care, Choosing Wisely®, an initiative of the ABIM Foundation that promotes patient-physician conversations about unnecessary medical tests and procedures, provides a stimulus to eliminate many tests and therapies throughout the specialties. It provides multi-sourced advocacy for professionalism in health care, explaining that clinicians of all professions must eliminate unnecessary care. At the same time, risk-averse hospitals and insurers desire the protections of certainty and safety.

During a shift in the urgent care clinic, my new patient was a retired college professor, more than 90-years-old, who complained of four days of unfamiliar, spasmodic bilateral mid-back pain without radiation. At times, and during undisturbed sleep, there was no pain or soreness. No particular activity provoked the pain. Lying flat, ibuprofen, and heat offered limited relief. No recent upper respiratory illness, fever, cough, rash, urinary, or digestive track symptoms. For two days prior to the onset of the spasms, he had been a passenger on a long automobile trip.

Relevant past history included L 3–5 laminectomies 10 years ago, and aortic valve replacement five years ago, but generally good health and activity for his age.

Physical examination showed normal vital signs; firm erector para-spinal muscles; no tenderness over spinous processes; normal spine mobility; good bilateral strength in hip, thigh, and leg muscles; and equal patellar reflexes and femoral pulses. Cardiorespiratory and abdominal exams were negative.

The temptation to order various tests, imaging, and consultation in this senior academic was strong. Was there new spinal stenosis? Zoster and renal disease seemed unlikely, but could there be early aortic dissection or osteoporotic vertebral collapse?

The choice of expensive studies over a course of conservative management at home was eased by this elderly patient’s preference—not demand—for the latter. He wanted relief more than a firm diagnosis.

Ordinarily, I would recommend heat, acetaminophen, continued moderate activity, perhaps a muscle relaxant (at bedtime to avoid falls), and specified early follow-up. Did I need to know the results of an MRI, chest X-ray, and urinalysis? We both decided to wait and see.

Most patients are intelligent observers of their conditions, not anxious for an immediate definitive diagnosis, and willing to permit—even suggest, a period of conservative care. Clinicians dedicated to shared decision-making should take the time to recognize this cohort. The yield can be patient satisfaction, cost savings, unnecessary attention to adjunct findings on testing, and avoidance of potential safety issues. To experienced clinicians, this degree of confidence may be second-nature. To trainees and acolytes in large health care systems, especially among specialists, such assumptions may seem too risky.

Calibrating the patient’s wishes and choosing wisely comprise good clinical judgment. This time, we both proved right. The happy outcome included advice to break up long automobile trips with stops for stretching and walking.
Illustration by Jim McGuinness.
He trusts us

Andre N. Sofair, MD, MPH
Dr. Sofair (AΩA, Albert Einstein College of Medicine, 1986) is Professor of Medicine, Epidemiology and Public Health at Yale University School of Medicine in New Haven, CT.

My wife and I sat in my father’s hospital room. He had pneumonia and was not improving after three days of treatment. I sat on his bed, my hand touching his as I looked at his face. His mouth was wide open, gasping for breath, his face was drawn and ashen, and he was minimally responsive to my voice. He would not eat, not even his favorite Iraqi dish of stewed okra over rice that I cooked for him that morning, following the exact specifications from the recipe book he had written and given to me many years before. The photographs of his brothers and sister, his parents, and his favorite picture of my mother were around him. But even they were unable to arouse his listless body.

I had been here before, needing to make decisions about how aggressive to be with his care. This time seemed different, and the prognosis more critical. In the past, he would improve by the second day of antibiotics and hydration. During this stay, what little energy he had left seemed to wane with each passing hour. I called family in the United States, Canada, and England to inform them of his condition. I even called his rabbi from his synagogue in Maryland where he had been a founding member and congregant for more than 40 years.

As a general internist and educator with more than 30 years of clinical experience, I have counseled countless patients and families through terminal illnesses. I felt that I usually had a good sense of prognosis and could guide people to make decisions using understandable language. I always found this easier from the perspective of an objective third-party, seasoned in both clinical reasoning and shared decision-making.

However, when a relative falls ill, I have always found it to be very difficult to serve in the role of decision-maker. Despite knowing the objective facts of the disease and its prognosis, it takes on a different meaning when it strikes so close to home. I play a dual role: physician and family member, with added pressure to be “right” in terms of making appropriate medical and ethical decisions. This makes the process that much more difficult as the physician in me knows likely outcomes as well as the complications that may arise.

My father, now 99-years-old, moved to Connecticut to be closer to me. He was always an independent man, having left his native Baghdad at the age of 18 to study civil engineering in the United States, finally making America his home a decade later when he returned with my mother and my older sisters. Prior to moving to Connecticut, he had been in surprisingly good health, suffering only from mild cognitive impairment.

Not surprisingly, at age 98, he began to experience progressively serious afflictions: first an upper respiratory infection with vertigo and falls, then urinary tract infections, a hip fracture complicated by pneumonia, and an aortic rupture, all of which he survived and was able to return to a good baseline and enjoy a good quality of life. I would have thought that his advanced age and full life would have made it less difficult to witness his illnesses and easier to come to terms with his impending death. I never felt either of these emotions. He was still my father and friend so each moment together was precious.

For me, one of the most difficult aspects of being his son, as well as a physician, was to relinquish his care to others. It made me realize in a very personal way the trust that our patients place in us, and the responsibility that comes with the title of physician.

This was made even more complicated by the fact that he was cared for at the hospital where I practice and teach.
For this admission, it even came down to making a decision with the emergency department staff about the floor where he was to be admitted. Would he go to the hospitalist or the housestaff service? The latter would place him under the care of the trainees I oversee on the ward where I attend and have an administrative role.

I decided to place him under the care of my housestaff. I had worked with them and trusted that they would take outstanding care of my father. I knew that I had made the right decision when one of my senior residents told me on the night of admission, “Dr. Sofair, understand that we are here for you. You can call us any time.” This gave me tremendous comfort that my father was in good hands.

I realized that this could be a difficult position for the housestaff, caring for the father of one of their attendings, delivering prognoses to their teacher, and assisting in making very challenging decisions. Having cared for health care professionals and their family members as a houseofficer and as an attending, I knew that position to be stressful, and I would spend extra time with the patient during their stay. Perhaps the housestaff felt the same way toward my father. With that in mind, I wanted to keep the appropriate level of involvement to maintain communication yet allow them the freedom to care for my father as they would any other patient.

I think that the comment that summarized it for me was when one of my senior houseofficers told me how initially they were nervous caring for my father, but they knew that the fact that I put my father on their service meant that I trusted them, which I did. After all, what higher compliment could I pay to my housestaff than to place my father under their care?

As I sat at my father’s bedside and tears welled in my eyes, some of my housestaff came into the room with the attending physician. The intern looked me in the eye, took my hand, and gave me an embrace. The group sat down, reviewed the events of the night, and listened carefully to my dilemma regarding whether or not to continue treatment. My father had been through so much and at this moment could not speak for himself. The attending, offering me a glimmer of hope, said that he thought that we should continue antibiotics and hydration for one more day to see if there might be some improvement by morning.

Considering his age and how poorly he looked, combined with my fatigue from a lack of sleep over the past few days, I had a difficult time arriving at a decision regarding what to do. The team certainly had more optimism than I did. After they all left, I spoke with my wife and decided to stay the course. There was no harm in continuing fluids and antibiotics. I knew the outcome if I withdrew support. I spent that night sleeping in the recliner by his bedside fully anticipating that it would be our last night together.

Surprisingly, conversations about these issues with my housestaff felt natural and unencumbered. At our medical school and in our residency program, we pride ourselves in our emphasis on bedside teaching and role-modeling; we highlight small group teaching on professionalism and doctor-patient communication. We hope that this will translate into our housestaff becoming independent and empathetic patient-centered physicians.

Over the four weeks that my father spent in the hospital for several prior admissions, he was cared for by many attendings and houseofficers as well as nurses, physical and occupational therapists, clinical technicians, discharge planners, and dietary staff. I can say that to a person they worked together to provide state-of-the-art care delivered with kindness and respect, and communicated with us clearly, consistently, and professionally. We never felt that we received different messages from the various providers, or that we were rushed to make decisions or transition to another level of care. I am also proud to say that I do not believe that we received care that was any different from other patients.

That next morning, I awakened early to find that my father’s eyes were open and brighter. He said that he was thirsty and asked for something to drink. He even asked for soft-boiled eggs, one of his favorite dishes. Later that day, he asked to get out of bed and sit in a chair. Strengthening gradually over the next week, he was able to leave the hospital to continue his recovery, with assistance, at home.

More than any accolades one may receive as a physician-educator, none compares with the knowledge that you have had a role in the training of physicians who you feel are competent to care for the dearest ones in your life, as well as all of the patients under their care. These days, as I push my father in his wheelchair along the flower-lined paths by his home, and talk about his grandchildren and days gone by, I am overcome by the gift of time we have been granted—given to us by my housestaff through their outstanding care and support over many admissions.

I have learned the lesson of trust—trust of those junior to me who helped me to see a clearer path when my vision was obscured.

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The doctor’s white coat: A symbol of the U.S. medical profession

David A. Nardone, MD

Dr. Nardone (AΩA, Oregon Health & Science University, 1983) is retired Clinical Director of Primary Care at the VA in Portland and Professor Emeritus at the School of Medicine, Oregon Health & Science University.

The white coat has served as the symbol of doctoring in the United States from the late-19th century to the present. The evolution of physician attire, from black to white, demonstrates how the profession has been grounded in the trust gained from a commitment to science, has applied that science to the bedside, and to its dedicated pursuit of medical education reform. The white coat remains the most common symbol of the medical profession when compared to other symbols of attire and common bedside diagnostic instruments.

Mid- to late-19th century

Traditionally, black was the formal attire for physicians, nurses, and nuns in the mid- to late-19th century. Black connoted seriousness, as well as the anticipation of death and mourning.1-3

Photos from the Civil War document attending surgeons attired mostly in black. The painting by Thomas Eakins in 1875, featuring Dr. Samuel Gross and his Jefferson Medical College students performing surgery, is frequently cited as one of the most prominent examples of physicians of the era. It depicts all participants dressed in black.

However, 14 years later, Eakins painted Dr. D. Hayes Agnew, professor of surgery at the University of Pennsylvania and his students, in the surgical suite. They are dressed in all white.
The doctor’s white coat

Louis Pasteur and Joseph Lister laid the foundation for establishing the important connection between the scientific method and the practice of medicine. Despite the discovery of pasteurization in the 1860s, and of antiseptic surgical technique a few years later, U.S. physicians were slow to accept and adopt scientific breakthroughs, specifically the germ theory causation of disease.

The prolonged death of President James A. Garfield from sepsis in 1881 was likely the result of improper wound exploration, debridement, and treatment administered by his attending physicians, rather than from the bullet fired from the gun of Charles Guiteau. Garfield’s public suffering was indicative of the poor quality of care of the era. It isn’t surprising that the citizenry lacked confidence in medicine and in its doctors, felt much of the medical care provided was quackery, and believed medical education was grossly inadequate.

Early- to mid-20th century

In the beginning of the 20th century, with Walter Reed’s definitive research on yellow fever transmission, Sir William Osler’s recognition as an esteemed clinician-educator, and Abraham Flexner’s (ΦΩΑ, Raymond and Ruth Perelman School of Medicine at the University of Pennsylvania, 1946, Honorary) treatise on the necessary reforms to correct deficiencies in medical education, the public began to view physicians and the profession in a more favorable light. The successes of biomedical science and education, as well as the meticulous attention to detail in infection control and surgical outcomes, portrayed cleanliness, and by association whiteness.

The Latin term candidus, means white. The descendant word, candor, reflects a valuable asset for physicians as they foster and nurture trusting relationships with their patients. Whether by association or chance, physicians discarded the black attire and donned white clothing, which became the new standard symbol representing the medical profession, its value, and authority.

It would be remiss not to recognize two technological advances occurring almost simultaneously in the transition from black to white attire—the manufacture of cotton, and the development of commercial washing machines. Both allowed for large quantities of washable cotton apparel to be made available for repetitive use more quickly and efficiently. Prior to the mid-19th century, most clothing was made from leather, linen, and wool, all requiring shaking and brushing for removal of dirt and debris.

Wearing all white became required for medical trainees of the early 1900s, a tradition that continued until the late 1970s. As a result, doctors became members of the “uniform” society.
Mid- to late-20th century

In 1976, in one of the first studies of patient approval ratings, physicians were reported to have high or very high public approval ratings of 56 percent, a seemingly low figure.

At the time, there was ample reason for the credibility of doctors to be suspect in the public eye. One was the perception that hospitals and their practitioners prolonged agony more than restored quality to life. Ethical breaches of major significance in research and the practice of medicine also did much to erode public trust. From 1936–1970, the U.S. Public Health Service conducted the Tuskegee observational study of African-American men with syphilis, who were not administered penicillin, despite its efficacy for treating the disease since the 1940s.

Equally controversial was the use of the cervical cancer cells from Henrietta Lacks for research without her, or her family’s, express permission.

On the positive side, the credibility of physicians and the profession of medicine was enhanced by many noteworthy successes. Dr. Jonas Salk’s (AΩA, New York University, 1937) discovery of the polio vaccine spared many children the ravages of its neurological complications. Dr. Frances Kelsey, a physician at the Food and Drug Administration, was the guiding force in blocking the approval of the drug thalidomide from being prescribed in the U.S., thereby preventing disastrous musculoskeletal birth defects that had plagued European children and their families. The massive expansion of the National Institutes of Health budget from $8 million in 1947 to more than $1 billion in 1974, and the passage of the U.S. Medicare Act by President Lyndon B. Johnson in 1965, were also factors in improving the health of the country and the credibility of physicians and the medical profession.

Subsequently, health delivery systems became more advanced. There was the advent of intensive care and hemodialysis units. Medical evacuation innovations—air transport—accounted for saving many lives, especially in combat.

Television also brought popular and admired fictional doctors into the lives of everyday citizens. Between 1961 and 1966, Dr. Ben Casey (Vince Edwards), and Dr. Kildaire (Richard Chamberlin) inspired generations of aspiring physicians.

In the 1970s, Blumhagen set out to address whether the white coat held its privileged position in the eyes of the public as the symbol best depicting and representing physicians, their presumed trustworthiness, and their healing
role in society. He reviewed 11 comic strips and 45 publications from four medical journals. He recorded 70 observations of “doctoring” symbols including 36 white coats (51 percent of total), 18 stethoscopes (26 percent), 11 head mirrors (16 percent), and five black bags (seven percent). Blumhagen concluded that the white coat had retained its prominence as the symbol of physicians and doctors. He suggested that it contributed to, and reinforced, the perception that physicians, as figures of authority, used the best available scientific evidence to protect their patients.

The white coat was felt to be powerfully symbolic for placing patients at ease, and reassuring them that physicians would address their complaints with competence.16

Late-20th century to early-21st century

Over the last 35 years, clinicians, medical scientists, and those in allied-health industries have continued to identify breakthroughs for improving health, extending longevity, and enhancing quality of life. Society has benefited from the availability of advanced diagnostic and therapeutic technologies, along with biological and pharmaceutical agents for combating many chronic diseases, cancers, and disabilities. Collaboration among scientists globally improved to meet the challenges of deadly infectious disease epidemics. Public policy proved beneficial with federal legislation, including the Medicare Prescription Drug, Improvement, and Modernization Act, and the Patient Protection and Affordable Care Act.

Despite all of the clinical and policy breakthroughs, patient approval ratings of physicians in 2016 only improved modestly over 1976, to 65 percent.10

In 2016, as a follow-up to Blumhagen’s work,11 a much larger study was undertaken by reviewing a total of 235 separate publications from the medical and lay press, identifying 360 symbols of the profession. The following were identified:

- 151 white coats (42% of total);
- 74 stethoscope/white coat combinations (21%);
- 48 individuals in scrubs (13%);
- 44 stethoscopes (12%);
- 27 surgical gowns (8%);
- 7 scrubs/stethoscope combinations (2%);
- 5 scrubs/white coat combinations (1.4%);
- 3 scrubs/stethoscopes/white coat combinations (<1%);
- 1 scrubs/surgical gown combination (<1%).

The 2016 study confirmed Blumhagen’s findings, demonstrating that the white coat had maintained its status as the symbol most commonly representing doctoring.

How does doctors’ attire, portrayed by lay and medical publishers, correlate to what patients and health professionals prefer? Petrilli and colleagues found that 20 percent of patients preferred to have their physicians dress formally, with or without a white coat; 20 percent preferred to have their physicians wear scrubs; and 60 percent offered no preference.17 There were also differences in preferences based on the location of care. Fifty-five percent of outpatients preferred
physicians to be formally attired, with or without a white coat; more than 25 percent preferred the white coat; and 18 percent had no preference. In the acute care setting, 20 percent of patients preferred formal attire, with or without a white coat; and 80 percent had no preference. Inpatients universally prefer physicians wear white coats.

There is ample discordance in how publishers depict physicians as opposed to what patients prefer, and this discordance extends to the profession. Most, if not all, U.S. medical schools conduct annual white coat ceremonies for beginning students. A rite of passage, the white coat ceremony signifies the unique contract between physicians and their patients, emphasizing humanism, professionalism, compassion, honesty, and empathy.18

To many physicians, the white coat signifies a unique bond that brings them together, as colleagues, out of mutual trust and respect. The bond allows them to collaborate in caring for each other’s patients, conducting research, fostering public good as members of professional societies, and supporting each other in times of personal crisis.

However, some pediatricians and psychiatrists choose not to wear white coats as they believe that their patients may feel overwhelmed by the perceived excessive authority embodied by the white coat.11 Infectious disease specialists believe white coats represent a patient safety hazard.19 In addition, studies have suggested that the doctor’s white coat may have an exaggerated effect on blood pressure, commonly known as “white coat hypertension.”20

The white coat is the profession’s symbol

It was not until the late-19th century that the white coat became the symbol most relevant and prominent for representing the medical profession. The change from black to white attire has been linked to scientific discoveries, the adoption of these discoveries into clinical practice, and the inferred associations of cleanliness to whiteness, whiteness to candor, and candor to trust and credibility.

References


When you start, bright-eyed, at first whiff of formaldehyde—it’s hard to recognize yourself in the dead. They bend the light differently.

Your pulse is a panther, painted in twilight and violet as it sleeps in the hollow of your throat, and jumps at the flick of your wrist

Her pulse is faded like a memory, color of fog above the canopy.

But, you make her acquaintance.

You trace the lines on her palms, and the nerves beneath them amateur fortune teller reaching out for a greeting, inching toward an introduction.

Her heart perches in the cage of her ribs, memory of a melody, and you remember your own nested in your chest.

You too are only a handful of heartbeats, made of veins and clay and haste, numbered exhales and sinewy folktales.

To you, who gifted us with seeds to plant flowers in our minds, we have not forgotten to water them. We will tend gardens and dedicate forests in your memory. Thank you.

Irtiqa Fazili

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I passed the piano every day. Hidden on an upper level of the National Institutes of Health (NIH) hospital, it was always closed and covered—except when Dmitri visited.

I had been on my routine march through the building when the music caught me by surprise. I found a man playing the piano—talkative, taking requests, outwardly jovial. It was clear that he was no amateur. I paused to listen with other passersby, then lingered, captivated. Before I realized it, an hour had passed, and it was just Dmitri and me.

Dmitri shared stories of great pianists, and surveyed their works. What did I hear in this passage from Shostakovich? Something militant? It’s the cadence of the galloping cavalry!

He invited me to play, and laughed at my simple, bouncy phrasing, and assigned practice exercises with the mien of a kindly Old World music teacher. He recalled his own teacher, a man whose death recast his future from conservatory to high school, and from concert pianist to electrical engineer. One would never guess Dmitri was anything but a professional artist.

Over time, Dmitri learned why I was at the NIH. I was a student, conducting research in between passages of medical school training.

I learned that Dmitri was there for his son Maxim, roughly my age, who was receiving an MRI for a metastatic ependymoma. As Dmitri phrased it, it was no longer a question of whether, but when. Faced with separation from his son—in these few hours of imaging, and in an impending, more irreversible future—Dmitri had sought out the piano.

While he played many pieces, the one that stayed with me was Brahms’s Lullaby. We all recognize it—the singsong melody of “Lullaby, and good night.” It has been played frivolously so many times to signify sleep in commercials, or on The Simpsons. Yet, Dmitri put its parodies to shame. “I used to play this one for Maxim. When he was just a baby,” Dmitri explained. And with that, he fell into the opening notes.

The piece started with the sweetness of the simple lullaby. I felt the confidence of a father 20 years younger, promising his healthy son protection from harm. Swelling, louder, the music saw these promises realized in a young man, held for a moment, a fermata of pride.

The tempo began to warp; the slow horror of promises distorted, and broken, by the force of a dismal prognosis. That a parent may outlive his child defies natural form and progression.

Crescendo, accelerando—a flurry of consults and procedures, testing and travel—faster, faster. If only something, someone, somewhere could alter the inevitable.

A flight across the keys—a flight across the country—and the question stood taut in the tension of the strings. Felted hammers striking out the phrase: not whether, when. Not whether, when. When? Forte! When? Is it today, downstairs? Right now? When?

And suddenly, mid-measure, silence.
Dmitri sat and wept.

We were still for a long time. At some point, Dmitri faded into the solace of another song. I could not tell you the name or composer.

When Maxim finally called, Dmitri wished me luck and was gone. I resumed the afternoon, stunned and not entirely aware of the world to which I returned.

Weeks later, at my own keyboard, I struggle to process what had happened. As much as I want to share it, I know I cannot record Dmitri’s music in words. The notes are already growing fainter with time. Yet, their authenticity haunts me.

Dmitri exteriorized the raw human experience of a man losing his son to brain cancer. His music did not just signify the illness; it was the illness, consuming the healthy baby and the sick young man, the father playing lullaby and the father playing requiem. It extended past the histologic diagnosis and MRI results, past clinic visits across the country, to a fearsome totality of human life intercepted by disease. In such experience, doctors are figures, interspersed; but a few bars show how vast the rest of it truly is.

I think of Dmitri, and his son, when I pass the silent piano. I hope they are able to find a measure of solace when the time comes.

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Of cinder, sea, and shotgun

Literary leitmotifs in a suicide ensued

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Whether we are concerned with the verbal or the written sign, with the monetary sign, or with electoral delegation and political representation, the circulation of signs defers the moment in which we can encounter the thing itself, make it ours, consume or expend it, touch it, see it, intuit its presence.

—Derrida

A neurologist sees a reflexive fanning of five. What she understands, however, is not pedal dysfunction, but something else entirely. Babinski’s sign is not the terrain of a podiatrist, but a primitive regression showing central pathology; it is a half-hidden, riddled residue still to be determined.

Psychiatrists read suicide notes and slips of the tongue. There is no pathological liar without a pathological lie. Language matters, or will become matter, as Derrida points out in Differance.\textsuperscript{1} When one asks for a glass of water, the intention is understood despite the physical absence of the vessel or its contents. Words are placeholders until the eventual touch or toast of the objects worth conjuring.

In the case of three artists—Sylvia Plath, Virginia Woolf, and Ernest Hemingway—certain works may be considered preludes to suicidal encounters.

Sylvia Plath

Sylvia Plath was born to a German father and Austro-American mother in Boston on October 27, 1932.\textsuperscript{2} She attended Smith College on a scholarship, and was elected Phi Beta Kappa.\textsuperscript{3} During her junior year, in 1953, she won a guest editorship at Mademoiselle in New York City.\textsuperscript{3} When she returned home, Plath attempted suicide for the first time by ingesting sleeping pills and crawling behind her mother’s boiler.\textsuperscript{3} She was hospitalized and received electroconvulsive shock treatment as well as lithium for a probable diagnosis of manic-depressive disorder,\textsuperscript{3} which is now described as bipolar disorder. Following her initial episode, Plath rebounded and was able to graduate summa cum laude.\textsuperscript{2,3} She then attended Cambridge University on a Fulbright Fellowship in 1956.
She married the poet Ted Hughes on June 11, 1956, shortly after their initial meeting. Plath continued to write and received the Saxton Fellowship to complete *The Bell Jar*. She gave birth to a daughter, and a son in 1960 and 1962 respectively.

In 1961, Plath completed 21 poems. This is a distinct contrast from her output in 1962, which totaled 56. She wrote the majority of the *Ariel Collection*, in October of that year, following a separation from her husband. One of the final poems Plath wrote in that collection was *Lady Lazarus*, wherein she chronicled her history of suicide attempts.

Themes of fire and ash dominate that poem. She writes:

That melts to a shriek
I turn and burn
Do not think I underestimate your great concern
Ash, ash—
You poke and stir.
Flesh, bone, there is nothing there—.

The tone is of a smoldering fury which ultimately catches flame as she challenges at the poem’s conclusion:

Out of the ash
I rise with my red hair
And I eat men like air.

There is an incandescent exuberance and gathering of agitated force at the poem’s terminus earning her the designation of “mad Lear ranting poetry at dawn.”

This heated ending is preceded by a hallowed beginning. In the first few stanzas of the poem, Plath makes a direct allusion to the Biblical tale of Lazarus noting:

Soon, soon the flesh
The grave cave ate will be
At home on me.

In the Bible, according to the Gospel of John, Jesus went to the cave where Lazarus was buried and called “with a loud voice, ‘Lazarus, come forth.’ And he that was dead came forth,” bound in cloth linen.

Feirstein comments that “a key metaphor gives form to the pathological part of the psyche.” This was described much earlier by Shakespeare as “The play’s the thing wherein I’ll catch the conscience of the king.”

The metanarrative of Lazarus woven into one of Plath’s final poems provides a macabre clue of her unconscious motivation. Years before penning *Lady Lazarus*, Plath identified with this figure. She comments in her journal:

I feel like Lazarus: that story has such a fascination. Being dead, I rose up again, and even resort to the mere sensation value of being suicidal, of getting so close, of coming out of the grave with the scars and the marring mark on my cheek which (is it my imagination?) grows more prominent: paling like a death-spot in the red, windblown skin, browning darkly in photographs, against my grave winter-pallor. And I identify too closely with my reading, with my writing.


In 1962, Plath committed suicide by putting her head in an oven.

**Virginia Woolf**

Virginia Woolf was born in London, in 1882, to a father who was an author, critic, historian, and biographer, and a mother who was a writer. She had five siblings, and a half-sister with schizophrenia. Her cousin James had bipolar disorder and committed suicide at 33 years of age. Woolf had her first manic episode at 13-years old, following her mother’s death from rheumatic fever.

In her twenties, Woolf became a literary critic and eventually a novelist and joined other artists as a member of the Bloomsbury group. She was hospitalized in 1904 at the age of 22 years due to psychosis following the death of her father from bowel cancer.

In 1912, she married Leonard Woolf and the two founded the Hogarth Press, which was responsible for publishing the majority of Freud’s works. A year later, she attempted suicide at the age of 31 years by swallowing sedatives. She was again hospitalized in 1915 for mumbling and insomnia. Ten years later she published her major work, *Mrs. Dalloway*.

In 1927, she completed the autobiographical work, *To the Lighthouse*, a poignant rendering of her family’s summer stays at St. Ives in Cornwall. Therein one finds themes of swallowing seas:

So that the monotonous fall of the waves on the beach, which for the most part beat a measured and soothing tattoo to her thoughts and seemed consolingly to repeat over and over again as she sat with the children the words of some old cradle song, murmured by nature, “I am guarding you—I am your support,” but at other times suddenly
and unexpectedly...had no such kindly meaning, but like a ghostly roll of drums remorselessly beat the measure of life, made one think of the destruction of the island and its engulfment in the sea, and warned her whose day had slipped past in one quick doing after another that it was all ephemeral as a rainbow—this sound which had been obscured and concealed under the other sounds suddenly thundered hollow in her ears and made her look up with an impulse of terror.

Life being now strong enough to bear her on again, she began all this business, as a sailor not without weariness sees the wind fill his sail and yet hardly wants to be off again and thinks how, had the ship sunk, he would have whirled round and round and found rest on the floor of the sea.7

The soothing sea, turned terrorist at a sudden instant, vacillates with violence, not unlike the course of her manic-depression. Water is woven throughout the tale, and by the end, to drown seems a sweet and inevitable surrender:

The sea was more important now than the shore. Waves were all round them, tossing and sinking, with a log wallowing down one wave; a gull riding on another. About here, she thought, dabbling her fingers in the water, a ship had sunk, and she murmured, dreamily half asleep, how we perished, each alone.7

Half asleep, in a dream-state, Woolf echoes the words of William Cowper’s 1799 poem, The Castaway, which depicts a drowning sailor:

For then, by toil subdued, he drank
The stifling wave, and then he sank...
No voice divine the storm allay’d,
No light propitious shone;
When, snatch’d from all effectual aid,
We perish’d, each alone:
But I beneath a rougher sea,
And whelm’d in deeper guls than he.9

On March 28, 1941, at the age of 59 years, Woolf put stones in her pockets and submerged herself in water.10

Ernest Hemingway

Ernest Hemingway was born July 21, 1899, in Oak Park, Illinois, to Dr. Clarence Hemingway,11 a tempestuous man who later shot himself with a civil war pistol.

Hemingway was notoriously fierce and competitive, sustaining many hunting, fishing, boxing, and skiing accidents.12 He won the Pulitzer Prize in 1953, and the Nobel Prize in 1954 for Old Man and the Sea.11

Matching physical fitness with creative prowess, he trained for writing by swimming 80 laps in the morning before beginning his drinking bouts at noon.11 He had many love affairs and four wives.11

In 1959, he began experiencing psychotic delusions and was hospitalized for symptoms consistent with manic-depression.11 Two years later, he was again hospitalized and underwent electroconvulsive therapy after having attempted suicide three times in four days. His wife caught him loading a shotgun which prompted her to get him help.

Hemingway’s fascination with shotguns mars the landscape of many of his narratives, including the tale of The Short Happy Life of Francis Macomber.13 In this short story, Hemingway writes of a husband and wife on a big game hunt in Africa. The protagonist, Macomber, is initially portrayed as a coward who eventually confronts his fears and is then shot by his wife in the midst of a buffalo hunt.14

Multiple passages presage Hemingway’s own demise:

‘You’re very mistaken,’ she told him. ‘And I want so to see you perform again. You were lovely this morning. That is if blowing things heads off is lovely.’
...Macomber did not know how the water buffalo felt before he started his rush, nor when the smash of the .505 with a muzzle velocity of two tons hit him in the mouth, nor when the second shot smashed his hind quarters and he crawled toward the crashing, blasting thing that had destroyed him.

...Hope the silly beggar doesn't take a notion to blow the back of my head off, Wilson thought to himself.

...Macomber aimed carefully at the center of the huge, jerking, rage-driven neck and shot. At the shot the head dropped forward.

...aiming carefully, shot again with the buffalo's huge bulk almost on him and his rifle almost level with the oncoming head, nose out, and he could see the little wicked eyes and the head started to lower and he felt a sudden white-hot, blinding flash explode inside his head and that was all he ever felt.

As in the previous examples of Plath and Woolf, Hemingway provides a kernel of his unconscious death wish in the form of a literary reference. He borrows a line from Shakespeare’s Henry IV. Spoken like a specious poetic paradox from the mouth of a hardened huntsman, Robert Wilson suggests to Francis Macomber:

By my troth, I care not; a man can die but once; we owe God a death and let it go which way it will he that dies this year is quit for the next.

In Shakespeare’s version, this line is spoken by the tailor Francis Feeble who is readying himself for membership in the King’s army and eventual battle. The meaning is echoed by Macomber remarking, “You know I don’t think I’d ever be afraid of anything again,” prior to his being shot to death.

On Sunday, July 2, 1961, Hemingway shot himself in the head.

Compulsory creation

Leenaars and Wenckstern credit Shneidman and Murray with the notion that for certain writers a “unity thema” emerges that is a recurrent psychological theme enabling death. For Plath, Woolf and Hemingway, the cinder, sea, and shotgun, respectively, are repetitive representations of their specific suicidal modalities. The metanarratives woven within each author’s text serve to demonstrate the latent saliency of their suicidal obsession. Andreasen and Jamison reported that the incidence of bipolar disorder is more frequent in writers and their relatives than in other populations.

Many agree that the three authors share this commonality. But what about compulsory creation? According to the Diagnostic Statistical Manual for Psychiatric Disorders-5 (DSM-5):

Obsessions are defined by (1) and (2):
1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):
1. Repetitive behaviors (such as ordering)...that the individual feels driven to perform in response to an obsession...
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation...

Describing her writing process, Woolf remarks, “It is only by putting it into words that I make it whole; this
wholeness means that it has lost its power to hurt me, it gives me, perhaps because by doing so I take away the pain, a great delight to put the severed parts together.”

Plath states, “I re-create the flux and smash of the world through the small ordered word patterns I make. I have powerful physical, intellectual and emotional forces which must have outlets, creative, or they turn to destruction and waste.”

And, as Young describes Hemingway, “If he wrote it he could get rid of it...He had gotten rid of many things by writing them.”

Bipolar disorder (BD) and obsessive compulsive disorder (OCD) frequently co-occur. In a recent meta-analysis, it was demonstrated that there was a 17 percent pooled prevalence of OCD in BD (95 per cent CI 12.7–22.4). A higher prevalence of co-occurrence was specifically found in patients qualifying for bipolar 1 disorder. Psychotic delusions and a requirement for hospitalization, as in the example of these artists, qualify for a type 1 diagnosis. Violent obsessions, defined as obsessions of harming self or others, are an independent risk factor for suicidality over and above depression.

One of the primary treatments for the obsessive-compulsive dyad is exposure. However, is there such a thing as overexposure? Can narrative therapy reduce anxiety to the point, as Francis Macomber put it, “I don’t think I’d ever be afraid of anything again,” including an encounter with death that cannot be undone.

Commenting on Plath, Leenaars and Wenckstern reference Schneidman’s theory that, “The role of writing, whether a note, a diary, a novel, fiction and so on, may be a ‘death facilitating process in certain authors lives.’” And, referring to Plath, Feirstein suggested, “The curative power of art did not help her. Perhaps writing the book bound her to the horror within her.”

Kay Jamison’s work on art and madness in Touched with Fire poses the provocative question of whether or not we are ridding the world of artists by treating them. It is also worth asking, are we ridding the world of certain artists by allowing them to continue to create?

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I work in a walk-in clinic located in a county hospital. On the first floor, there is a miniature three-dimensional model of a beautiful harbor with blue water, ships, and cargo trains that go from the port to the surrounding valleys and mountains. The model is inside a big, dusty glass box with a tag that reads: “Welcome to Sunny Side Hospital Safe Haven.” It was a donation from a local family. If you look carefully at the details, you’ll realize that the train is derailed and one of the ships is leaning on its side, sinking into the water. How ironic it is to see something like that at the entrance of a hospital, where so many lives are sinking, derailed by disease. With those thoughts on my mind, I enter the clinic and my day starts.

“If I were on drugs I wouldn’t have cared”

“Doctor, my boyfriend is a drug addict. I am a drug addict, but I’m in a rehab program. I’m 28-years-old. I have no family. I’ve learned a lot in the program. I’ve learned that I’m codependent. If my boyfriend does drugs, I do drugs. I want to be part of the group. I want to be cool, but that’s not cool, doctor. It’s not cool at all, mainly when people have children. I have three children. My children think I’m a super hero, a super mom, but what kind of a mom can I be if I do drugs? I’m hooked on methamphetamines. I’m here because I have a terrible smelly discharge. My boyfriend was diagnosed with chlamydia and gonorrhea and I think I’ve got it too. I had it
before and it feels the same. I want to be treated. If I were on drugs, I wouldn't have cared, believe me. I would not have cared about this problem. It's like, so what? I have a smelly discharge. Who cares? But I care now and I want to be treated. If I can smell this mess, people can smell it too. I don't want to be like that anymore. Thank you for helping me. Can I get the medications here in the clinic? I have no money to buy them.”

“It's the only pair of shoes I have”

“Doctor, I have a lot of body aches. I hurt everywhere; my back, my shoulders, my buttocks, my hips. I didn’t get these pains before, and I’m worried about it. I also got a bad cold about three weeks ago and I can’t shake it off. My throat is still sore and I have a cough. I don’t think I have a fever. I’m not short of breath. I’m worried that I might have the flu. I was told that people can die if they catch the flu. I’d like to get a flu shot. I know people shouldn’t get the flu shot when they are sick, but it’ll be impossible for me to get here again. I have no transportation. I’m homeless. I was wondering if I have these body aches because I sleep on concrete. When I was younger it didn’t bother me, but I guess I’m getting older. It’s been cold outside. I don’t go to the shelter, I sleep outside, under one of the bridges downtown. I don’t have blankets anymore, and no sweater, they got stolen when I went to the shelter. That’s why I never went back. I was afraid somebody would steal my shoes too. It’s the only pair of shoes I have.”

“There are too many things going on in my life”

“My legs are very swollen and painful, doctor. I was told that I’m too fat and I need to lose weight. That’s why my legs are swollen. Because I’m too fat. But I’m in a lot of pain, and I worry about having a clot in my legs. Can you help me? I know I’m very anxious, and I’m very depressed. I see a psychiatrist, and I’m a little better now, but there are too many things going on in my life. My mom died two months ago, my husband is in jail—He was found with cocaine in his pockets. But I don’t use that stuff. I have to take care of my children. One of my children is disabled; the other one has juvenile diabetes. We have no insurance. I eat because I’m nervous. I get up at night and I can’t stop eating.”

“He was diagnosed with adenocarcinoma of the maxillary sinuses”

“Dr. F, he has a lot of pain in his face, and terrible headaches. They sent him home from the hospital. He lives in a trailer with his brother who is mentally ill. They both need a lot of help, but there are no parents, only some aunts and uncles who live far way. He was admitted to the hospital for a bad sinus infection, and was diagnosed with adenocarcinoma of the maxillary sinuses. A terrible case. No insurance. He was asked to apply for Medicaid, but it’ll take a while. What do you want to do, Dr. F? They don’t want us to prescribe narcotics at all. Should we call the social worker?”

“I think I have cancer”

“Good morning Sir, I’m Dr. F. I was asked to see you because you have lost a lot of weight and your psychiatrist is concerned that you might have cancer. They told me that you have some speech difficulty. I have an accent, so I’ll talk slowly, and as clearly as I can, and, please, you do the same. Do you have any difficulty swallowing? Nausea or vomiting? Abdominal pain? Any fever, chills, swollen glands, unusual headaches, chest pains, heat intolerance, tremor, nervousness? Okay. So, you feel fine, no aches and pains, and you can eat, but you’re still losing weight. Please, tell me what you eat for breakfast, lunch, and dinner in a normal day. Lets’ start with breakfast.”

“Nothing? What about lunch? A piece of bread? And dinner? Nothing? Say that again. I’m sorry, I can’t understand you well. Say that again. You’re saying that you can’t get to the grocery store. Is that right? So, don’t you have any family member or neighbors that could take you grocery shopping occasionally? No, I see. Where do you live? I’m going to repeat it, what you said. Please, nod if I got it right.
You’re saying that you live in a shack, with no heating and no electricity. Where do you get food? Did you say from the trash containers in the park? When you are strong enough to walk all the way to the park? So you get what you can and then you go back home. Did I understand well? I see. You’re happy here because here you can eat three meals and have snacks, bananas and a bed and heat. Oh! In jail too you got regular meals, but they beat you up and you want to stay away from that place. Sir, I really don’t think you have cancer. Don’t worry about that. I’ll talk to the social worker and see what we can do to help you out. Dr. F., we can’t do anything about it. We could send him to a shelter, if he accepts to go, otherwise we can’t do anything about it.

“I’m only 22 years old”

“Dr. F., are you sure there is nothing more that can be done for me? How can that be? I’m only 22 years old. What’s going to happen now? Will I die? How’s that possible? I haven’t done anything wrong. I want to be a ballerina. I am a ballerina. I’ve been training hard for it and then all this happened. I was dancing one day and I noticed that something was off. I couldn’t move my leg properly and couldn’t get through my choreography without stumbling. Then it got worse. I can’t walk anymore, and my head hurts all the time. The pain medications are not helping. They said the cancer has spread everywhere. How can that be? Can you do something for me? I have no insurance.”

“I need a place to sleep tonight”

“Good morning Ma’am, how can I help you?” I know you were in the ER last night because of knee pain. I understand you came here today for the same reason.”

“My knees are hurting more than usual. I’ve been walking a lot, and standing up a lot, and my knees are killing me. I became homeless three days ago, and I don’t have a place to go. I came here today because I need a place to sleep tonight. I’m 70 years old. I’ve been walking everywhere. I had to walk all the way to this hospital. It’s hot out there.”

“When you went to the ER last night, did you tell them you needed help?”

“No, I went to the ER because I needed a place to spend the night. I slept on a chair in the waiting room, but I said nothing.”

“I’m sorry this is happening to you. I can take you down to the ER again. They have a social worker on call 24 hours a day. Since, you were seen there last night, we could ask to talk to the social worker and see if she can find a shelter for you to go to.”

“Thank you. I would appreciate that.”

“There is only one social worker, and she’s swamped, so you might have to wait a while before she gets to you.”

“I have nowhere to go. I’ll wait. I need all the help I can get.”

“It ain’t easy”

Early one morning, while sitting at the traffic light, the very last one, right next to the garage where I park for work, I saw a man in a wheelchair trying to negotiate the bumpy sidewalk of the county hospital. He was using his hands to push the wheels and was carrying a plastic bag in his mouth. I couldn’t see the contents of the bag, but it looked like there were clothes in it, along with other things. I thought about how hard it must be to carry that weight around in his mouth, and my heart ached. I knew life hadn’t been generous with him.

Later that day, I met the man as one of my patients in the clinic.

“I saw you earlier and felt bad about how you were struggling to get here.”

“All of my possessions are in the bag, and I don’t want to hang it on the back of the wheelchair, because I live on the streets and am afraid somebody will steal it. I can’t put
it on my lap because while using my hands to roll the chair it falls to the ground, and I can’t pick it up. I can’t afford to lose this bag, doctor, this is all I have and if somebody takes it I can’t run behind them and get it back. I have bad teeth, though, so it really hurts. That’s why I came in. I need something for pain. My teeth are loose and cracked. I can’t chew food anymore. Can you help me with that?”

How do you manage out there, being homeless and in a wheelchair?”

“It ain’t easy.”

“I’ll ask the nurse if the social worker can see you and help you out.”

“Dr. F, the social worker sees only the patients who are in the hospital or down in the ER. He will have to get to a homeless shelter. All we can do is to give him a list of shelters.”

“How is he going to get there? He has no transportation and he’s in a wheelchair?”

“Dr. F., unless you want to give him a ride, there is nothing we can do here.”

An inescapable network of mutuality

When my shift ended, later than usual that night, around 9 p.m., I collected my bags and walked to the parking garage. I took the stairs to the 8th floor in a final effort to gather a few more steps before going home. When I got to the parking ramp, I placed one of my bags in my mouth and tried to carry it like that all the way to the car. My mouth—filled with healthy, strong teeth—couldn’t handle the load. Saliva started coming out of the corners of my mouth, and my jaw got tired almost immediately. I couldn’t find a good position for my tongue. I had to cough and the bag fell out of my mouth and landed on my feet.

I thought of my patient, of his trials and tribulations, as I was driving to the comfort of my home. I thought of his strength, the inner strength he must have had to survive and go through life every day like that, hanging on to it, precariously, as the bag in his mouth.

When finally I arrived home, I felt exhausted—not physically, but mentally. I saw so many homeless people—people with very little, or no resources at all. I saw racial and ethnic minorities, indigent and low income families with no roof over their heads. People who had been evicted, not once but many times, and lost all they had. These are people who don’t eat every day, or eat out of the garbage containers in downtown or in the parks. If they get lucky, they can get a meal at a local church or shelter.

They’re all facing insurmountable challenges: homelessness, poverty, lack of education, the scourge of mental illness, poor physical health, and the shortcomings of our health care system.

I felt overwhelmed by the intricacy and the enormity of the problem. To make changes it takes resources, but, most of all, it takes will, determination, and a fundamental change in the philosophy of life, the most difficult to achieve.

A wealthy ranch owner once told me that health care is a privilege and not a right. “Health care is like a TV set,” he said, “If you have the money, you buy it, if you don’t, you have to do without it.” Should this be the philosophy by which a civilized society lives and operates? Should this self-centered approach to life dictate our health care policies? Should this lack of empathy and inability to relate to people in a humane fashion guide our actions?

I started feeling somewhat discouraged and I sank into the couch. I reached for a book of inspiring quotes that I keep on the coffee table and opened it. I laid my eyes on the words of Dr. Martin Luther King:

We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly.¹

That’s truly the way it is, and what it comes down to: when we deny people food, shelter, education, and health care the resulting damage inflicted upon those members of our society will eventually have negative repercussions on all of us. Shouldn’t we all work together toward achieving a more fair society, and a better health care system, if not out of empathy, out of the need to save ourselves?

My mind kept on churning, busy, crowded with thoughts, trying to find the answers that could save my patients, until my eyes became too heavy, and I finally fell asleep.

References


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Anatomy of the physician

The eyes that seek to see the sick
As others look askance,
The ears that hear a lub dub drum
And recognize the dance,

The hands that feel a fragile pulse
And soothe with warming touch,
The shoulder, broad to lean upon
When patients lack a crutch,

The arcing back that bears their burdens
Never giving out,
The countenance that comforts
Others overwhelmed with doubt,

The lungs that gust the breath of life
To those who gasp for air,
The voice that advocates aloud
And whispers quiet prayers,

The mind that siphons equal shares
Of science and of art,
The compassion amaranthine
Of the ever-pumping heart,

And last, the inmost wish to heal
Exhaling from the soul—
Parts that come together
For physicians to be whole.

Mark Rudolf

Mr. Rudolf (AΩA, University of Virginia, 2016) is an MD/PhD student at the University of Virginia School of Medicine. His poem received second place in The Pharos Poetry Award competition 2018. Mr. Rudolf’s e-mail address is mar4as@virginia.edu.

Illustration by Aaron Kuehn
Esther Schwartz's Monument in Acacia Cemetery, Ozone Park, New York.
Courtesy Anthony Pisciotta
Esther Schwartz’s monument stands at the southern end of Acacia Cemetery, a Jewish cemetery in Ozone Park, Queens County, New York. Her grave is adjacent to the black wrought iron fence that runs along the north side of Pitkin Avenue. Her headstone, like the others in the row, faces out toward Tudor Village, a community of 300 brick homes built in the late 1920s south of Pitkin Avenue. It is placed east of the main north-south road that traverses the cemetery.

Those who lived in Tudor Village during the 1940s and 1950s collectively referred to the cemetery as the graveyard. Tudor Village residents would regularly witness burials, and, prior to the Jewish high holy days of Yom Kippur and Rosh Hashanah, the arrival of numerous families who visited the graves of their relatives. They often placed small stones on top of the tombstones to mark their visits. The neighborhood’s young children sometimes placed small stones on top of monuments near the fence out of a sense of empathy for the deceased who they thought were either neglected or forgotten.

Few people visit the cemetery today as many descendants of those long ago interred have themselves passed or relocated to other parts of the city and country. However, until the 1960s, large numbers of visitors came, especially at the time of the high holy Jewish holidays. Those who did not know the required prayers often hired men who stood at the cemetery gates offering to recite them in Hebrew at a given grave. They were generally older bearded men who wore black hats and long black coats, commonly known as “professional mourners.”

Most children who lived in Tudor Village were not Jewish, yet they were aware of activities at the cemetery including funerals, the placement of monuments, the cutting of the grass, and visitation cycles. They were also familiar with some who were interred near the fences where their names, ages, familial status, and epitaphs were easily read. Frequently inscribed on the headstones are the phrases “Gone but not Forgotten,” and “At Rest.” Most monuments have inscriptions in both Hebrew and English, with the former often providing the name of the deceased person’s father and the date of death according to the Jewish calendar.
Esther Schwartz’s grave and monument

Esther’s monument provides basic information about her. Her photograph, encased in a glass and metal frame, depicts a pretty young teenage girl with short hair wearing a dress with a white collar. She is not smiling. This may be because of a chronic illness or because the photograph represents a formal studio portrait associated with an important event, such as her bat mitzvah, when young Jewish girls come of age and are considered full-fledged members of the community. Literally translated, bat mitzvah means “daughter of the law.” In the conservative or Orthodox community in which Esther was raised, she would have celebrated her bat mitzvah at 12 years of age, shortly before her death.

The three lines in Hebrew at the top of the monument provide Esther’s name, her father’s name, Isaac, and her date of death according to the Jewish calendar. The presence of her photograph on the tombstone indicates that her parents may have immigrated to the United States from Russia.

The surface carvings on Esther’s monument are delicately rendered. The dominant feature is a double-lined heart shape at the top beneath her photograph. It encloses the Hebrew inscription, and beneath this is her name and date of death in English. Farther down, and engraved in the gray granite on a scroll design, are the words “AGE 13 Y’RS.” At the base of the monument is a rectangular configuration enclosing the words, “SISTER, DAUGHTER.” The stone stands on a substantial gray granite base with an intentionally roughened surface.

The grave also has a small footstone on which the words “AT REST” are rendered in relief. Besides her photographic likeness, which has survived the ravages of time and weather, the monument displays exquisite surface designs carved by a master artist. It is significant that at the base of the stone, she is first identified as sister, and then as daughter. This opens the possibility that the monument was ordered by a sibling.

The influence of Esther Schwartz’s monument

There was no other grave in Acacia Cemetery that moved Tudor Village children as Esther’s did. It was her photograph at the top of the monument that drew children to her. She looks out, her mien immutable, onto a busy road and the world beyond, almost as a silent witness to the tragedies and joys that unfold beyond the fence. The light gray color and sculptural form of her tombstone is appealing, which also drew children to it, as did the engraved notice of her death at the age of 13 years.

Children, especially young teenage girls, regularly passed Esther’s grave on their way to and from school, and bonded with her. Even though deceased, Esther became a part of their living childhood universe. My older sisters often stopped to look at her monument, wondered why she had died so young, and where she had lived. They were also interested in knowing something about her life and family.

Esther’s early death made some children grateful that they were still alive. Although parents told their children of Esther’s era, they also reminded them of how they were the beneficiaries of great advances in medicine such as antibiotics and vaccines. However, even with these medical advances, a number of children still came down with scarlet fever, or their blood “turned to water” (leukemia). There was no effective treatment for leukemia, and thus most children diagnosed with it soon died.

One of my sisters had a classmate who became ill with leukemia, and in order to bring some happiness into her

Photograph of Esther Schwartz on her monument at Acacia Cemetery, Ozone Park, New York. Courtesy of the author
life, the teachers gave her the lead role as a good fairy in a school play. Two months later she died from the disease, and her classmates attended her funeral.

Another of my sister’s classmates died of complications from thyroid surgery for hyperthyroidism. Most children knew of “blue babies,” infants who had died from what were then inoperable congenital cardiac malformations. Accidents and drownings killed other schoolmates, especially during the summer months.

From one perspective, Esther symbolized these collective childhood losses, and her grave was thus a place where they and other tragedies could be mourned. In later years, adults, who as children had been greatly affected by their association with Esther’s grave, expressed these sentiments. They were also interested in knowing if her picture was still intact, and if her grave was well maintained.

These inquiries spoke of the enduring influence well into adult life of a childhood association with the grave of a young girl who no one in the neighborhood had ever met.

The life and death of Esther Schwartz

Esther’s date of death in 1933, along with the name of her father facilitated accessing information about her and the Schwartz family in the Fifteenth United States Census, conducted in 1930.

In 1930, Esther’s family was renting an apartment at 72 Chester Street in the Brownsville section of Brooklyn, Kings County, New York. At the time, this area was a predominately Jewish neighborhood populated by immigrants from eastern Europe and Russia. Esther’s father’s name was listed as Ike, an American nickname for Isaac. He was 48-years-old, literate, and his place of birth was Poland. His first language was Yiddish, and he worked as a tailor. His wife, Ida Pura, was 45-years-old, and illiterate. Her first language was Yiddish, and she was a homemaker.

Esther was the youngest of four children, all of whom were born in New York City. Her siblings were David (24-years-old), Lillian (19-years-old), and Rose (14-years-old). David worked as a salesman in a sweater store, and Lillian was a saleslady in a dress shop. Esther’s age was listed as eight-years-old; therefore she was born in either 1921 or 1922. As Alter F. Landesman notes, the Jews of this area were among the most industrialized groups in New York City. Many had migrated to Brownsville in Brooklyn from the Lower East Side of Manhattan after public transportation became available. Seventy percent of working adults were in the apparel industry.

Esther’s death certificate lists her cause of death as cardiac disease of 10 years duration. However, no details are provided about the nature of her heart disease. It is reasonable to assume that Esther died from either a congenital cardiac defect, or rheumatic heart disease. The latter, very common in the pre-antibiotic era, often resulted in valvulitis and pancarditis.

The legacy of Esther Schwartz

Neither Esther nor her family could have possibly foreseen the influence she would have on young children long after her death. Her death at an early age, the proximity of her grave to a cemetery’s fence, and her poignant photograph on a unique monument attracted the attention of young passersby. Her grave symbolized not only the tragedy of her death, but also the loss of other close childhood friends. It became a place where neighborhood children could mourn their losses and seek solace.

Perhaps the most remarkable aspect of Esther’s legacy is that decades later those who are now grandparents still cherish memories of her place in their early lives.

Acknowledgments

Special thanks to Daniel Ilyayev and Leslie Schechter for translating the Hebrew inscription on Esther Schwartz’s monument. I am very thankful to Lois A. Hahn, who prepared the typescript, and to Dorine Cooper for her assistance with the technical aspects of this publication. I would also like to thank the administration of Acacia Cemetery for their assistance.

References


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In this timely and well written book, biochemist Jennifer Doudna, with the assistance of her former student and co-author Samuel Sternberg, tells the story of how, since 2015, she and her students and colleagues working in her laboratory at the University of California at Berkley helped discover and create, along with scientists around the world, as she writes “the newest and arguably most effective genetic engineering tool, CRISPR-Cas9 (CRISPR),” and that thereby “the genome—an organism’s entire DNA content, including all its genes—has become as editable as a simple piece of text.”

She describes a few of the early marvels achieved with CRISPR such as hyper muscular beagles, more cashmere wool from Shannbei goats, and perhaps soon a revived woolly mammoth. She notes that there will also be impacts on plant food sources, and human and animal diseases.

The book is divided in two sections: the biochemical work in Doudna’s laboratory and in other research centers, around the world, and the potential consequences and ethical questions that have arisen from the discovery of CRISPR.

CRISPR-Cas9 stands for a region of bacterial DNA where clustered regularly interspaced short palindromic repeats are found. Cas9 is the enzyme that the organism uses to snip out an invading virus.

For hundreds of millions of years bacteria have been in a continuous war with viruses that seek to penetrate and take over their DNA. This struggle was first recognized by the British bacteriologist Frederick Twort in 1915, and Canadian-born physician Felix d’Herelle who studied the bacteria that caused Shigella dysentery during World War I. In subsequent decades it was discovered that viruses that attacked archeal and bacterial cells—bacteriophages—are exceptionally abundant. As Doudna writes, “Incredibly, there are many, many more phages on earth than there are bacteria for them to infect: abundant as bacteria are, bacterial viruses outnumber them ten to one. They cause roughly a trillion infections on earth every second, and in the ocean alone, about 40 percent of all bacteria die every day as a result of deadly phage infections.”

Thus, “CRISPR was likely part of an archeal and bacterial immune system, an adaptation that allowed microbes to fight off viruses.” Doudna points out how these observations support Darwin’s theory of evolution.
Doudna presents a comprehensive and lucid description of the research on CRISPR and other forms of gene editing. Her explanations are greatly enhanced by simple diagrams and drawings. Her writing is enriched by memory as she recalls her studies at Harvard and Yale, and summers as a student in research facilities. Fond memories of her parents and especially of her late father, a professor of English at the University of Hawaii, add an attractive quality to her writing. Recalling a summer spent in a laboratory at the University of Hawaii she writes, “The peace and quiet concentration that characterized Don Hemmes’s small research team drew me in, but over the years I became aware of being part of a much bigger community of scientists, each of us seeking, in our own ways, nature’s truths.”

Doudna considers the importance of transplantation to medicine, “Some scientists hope that pigs can offer even more: a vast, renewable source of whole organs for xenotransplantation into human recipients.”

Doudna points out that, “In the United States alone, more than 124,000 patients are currently on the waiting list for transplants, yet only 28,000 procedures are carried out annually. Gene editing is now being harnessed to shut-down pig genes that might provoke the human immune response and to eliminate the risk that porcine viruses embedded in the pig genome that could hop over and infect humans during transplantation.” But, she asks, will we retain a concern for animal welfare?

She also brings up her concern that gene editing will be used for aesthetic reasons, but is not convinced that “this is categorically a bad thing.”

Doudna touches on the concept of gene drives stating, “There is one way, at least, in which the power to edit the genes of other species (such as malarial mosquitos) could prove to be more dangerous than any changes humans have made to the planet so far.” “With gene editing, however, any off-target DNA sequence, once edited is irreversibly changed. Not only will unintended edits to DNA be permanent, they will also be copied into every cell that descends from the first one. And although most random edits are unlikely to damage the cell, if we have learned anything from certain diseases and cancers, it is that even a single mutation can be enough to wreak havoc on an organism.”

In considering germ line editing, which of necessity affects future generations, she states, “Essentially, we wanted the scientific community to hit the pause button until the societal, ethical, and philosophical implications of germ line editing could be properly and thoroughly discussed—ideally at the global level.”

She concludes with the hope that scientists can communicate more honestly, effectively, and openly with the public thereby rebuilding the public’s trust. We are lucky to have scientists like Doudna who have both the intelligence to accomplish complex, creative research, but also are not blind to the promethean bargain of which they must always be aware as humans gain ever greater power to alter nature.

Dr. Bennahum is a member of The Pharos Editorial Board, and one of its Book Review Editors. He is Professor Emeritus of Internal Medicine and Resident Scholar at the University of New Mexico’s Institute for Ethics. His e-mail address is dbennahum@salud.unm.edu.
Some of the resulting books focus specifically on the bones. Was Homo habilis a distinct species? How does Homo erectus relate to Homo ergaster? Others, using DNA analysis, track the radiation of our ancestors to all parts of the world, and still others consider the question of why our near cousin, Homo neanderthals, some of whose genes are part of us, became extinct?

In The Creative Spark, Agustin Fuentes sticks to a single narrative, and excludes other branches of the hominid tree. He aims to identify the crucial factor that initiated the long trek toward modern human society. What was the critical brain function that first emerged? Fuentes calls it the “creative spark,” which eventually developed into human imagination and an array of other capacities. The creative spark occurred more than 2.5 million years ago, long predating our massive brain enlargement.

Fuentes discovers its earliest traces in the innovation that produced Oldowan tools about 2.5 million years ago. While earlier ancestors, like today’s chimpanzees, probably used stones or modified tree twigs, only Australopithecus and the earliest members of the genus Homo invented the sophisticated process of striking one stone against another to create sharp flakes to cut and scrape animal carcasses. A cursory look at photos of these tools leaves the reader unimpressed. It took another million years to initiate a broader and more sophisticated Acheulean toolkit that included a variety of cutters, scrapers, axes, and spear points.

Fuentes sketches the environment and circumstances under which Oldowan tools were made, showing how truly innovative the stone flakes were. The first toolmakers, whether they were Homo or Australopithecus, lived as bands of medium-sized primates who lacked speed and other protective adaptations. They were extremely vulnerable to predators. They learned to identify advantageous stones for chipping; carry them to a safe place where repeated striking would not attract predators; and engage in a series of calculated blows that resulted in knife-sharp flakes. This is a process that modern imitators require considerable time to master.

Fuentes documents power scavenging, which developed about 1.8 million years ago. Our ancestors could not compete with larger, faster predators for prey. The best they could do was passively scavenge whatever meat was left behind by the big cats and vultures. Bands of hominids developed flexible methods of social cooperation that allowed the group to chase predators away from their kills. They quickly employed their stone tools to cut prime chunks of meat, and then run back to safety before the predators were able to attack them.

Shortly after power scavenging, our ancestors developed social organization. Cooperative parenting, whereby some females and perhaps males, would remain in the living space to take care of the children while others gathered edible plants or scavenged for meat, was developed.

Fuentes’ deep storytelling describes the transition from a hunter-gatherer lifestyle to early pastoralism and agriculture. Other books tend to present this change as undeniable progress, but don’t say very much about how or why it happened, or how long it took. Fuentes discusses multiple steps in the gradual process of animal domestication, e.g. goats (8,000 years to 12,000 years ago) and sheep, pigs, and cattle (8,000 years to 10,000 years ago) in Western Asia. He shows that settled agriculture arose independently in several Old World and New World locations after long periods during which humans had altered edible plants by conscious selection of favorable variants, e.g., those with larger or more easily accessible edible parts. For example, in Central America a species of grass called teosinte was gradually transformed into maize or corn over several thousand years. Likewise, 10,000 years ago in East Asia, sinewy grasses of the genus Oryza had evolved by human manipulation into rice.

Paradoxically, the evidence indicates that settled agriculture was associated, at least initially, with a decline in human fitness. Skeletal remains from pre- and post-agricultural societies in the same geographical settings make it clear that hunter-gatherer bands enjoyed a rich, varied diet and were relatively disease free, while their early farmer descendants were smaller in stature and often malnourished. Why, then, did agriculture flourish? Fuentes discusses several factors, the most compelling of which is population pressure. A settled lifestyle led to rapid population increase followed by the creation of towns and cities. Traditional hunting and food gathering practices could no longer sustain the greater population. Humans became locked in to the new, less nourishing, but still sustainable mode of existence.

What is the essential creative spark that initiated our long road—albeit short on an evolutionary timeline—to human culture and civilization? Fuentes does not attempt to identify the critical mutation or neurophysiological development. There seems to be no way to pinpoint that. However, he makes it clear that the spark occurred much, much earlier than the proliferation of art 40,000 years ago, or the emergence of a fully human skull and skeleton 200,000 years ago.

Fuentes tells a compelling story of deep origins—a
Editor’s Note: We received several comments, e-mails, and messages regarding the medical mnemonics article in the Winter 2018 issue of The Pharos. Following are excerpted pieces from a few of those messages.

MAP UR GOAL(S)
“The importance of medical mnemonics in medicine” by James Lewis (AΩA, University of Tennessee College of Medicine, 2007) and Rebekah Mulligan (The Pharos Winter 2018, pp 36–42) reminded me of my early days in training when, as a new intern, Drs. Robert Freeark and Robert Baker at the Cook County Hospital in Chicago taught us to write post-operative orders. The article challenged me to test my now Swiss cheese-like memory, and sure enough, more than 50 years later, their mnemonic came back to me.

Freeark and Baker asked the question, “What do you do when you have places to go or a set of orders to write?” Answer: You MAP UR GOAL.

M - Medications: new that are needed or ones that need to be renewed.
A - Alimentation: diet, from nasogastric tube to full as tolerated.
P - Pain: for relief and avoidance if there is a problem.
U - Urologic: catheter, special medication, or none.
R - Respiratory: special observations or treatments.
G - Gastrointestinal: in addition to diet, like observations, colostomy care.
O - Observation: routine blood pressure, pulse, I&O, etc., plus special.
A - Ambulation: from bed rest to walking at will.
L - Laboratory: any special need like hemoglobin, blood gases, etc.
S can be added if help is specifically needed for a reminder so as not to be called in the middle of the night.

This little challenge suggests the lasting value of

Letters to the Editor

References

Dr. Coulehan is a member of The Pharos Editorial Board, and one of its Book Review Editors. He is Emeritus Director of the Center for Medical Humanities, Compassionate Care, and Bioethics at Stony Brook University in New York. His e-mail address is john.coulehan@stonybrookmedicine.edu.
mnemonics (or maybe the value of a sponge-like 25-year-old’s memory).

Robert E. Bunata, MD  
AOA, Northwestern, 1964  
Fort Worth, TX

VINDICATES vs GIT MVN

I was extremely interested in the very current, yet historical medical mnemonics article. At the University of Arizona-Tucson College of Medicine, my colleagues who direct the bedside preclinical program have promoted the mnemonic VINDICATES as the approach to differential diagnosis. This complements a mnemonic that I contrived in medical school (Class of 1966), GIT MVN.

VINDICATES

V - Vascular  
I - Inflammatory/Infectious  
N - Neoplastic  
D - Degenerative  
I - Intoxication/Drugs  
C - Congenital  
A - Allergic/Autoimmune  
T - Traumatic/Iatrogenic  
E - Endocrine/Metabolic  
S - Sychosocial

GIT MVN

G - Genetic/ConGenital  
I - Infectious/Immunologic*  
T - Traumatic/Iatrogenic  
M - Metabolic#  
V - Vascular  
N - Neoplastic

*includes Allergic/Autoimmune  
#includes Endocrine/Degenerative/Intoxications/Drugs

Ronald E. Pust, MD  
AOA, University of Arizona, 2010, Faculty  
Tucson, AZ

HALT

H - Hungry  
A - Angry  
L - Late  
T - Tired

HALT is a great strategy to mitigate bias, using the slow thinking mode as described by Kahneman. (Kahneman D. Thinking Fast and Slow. New York: Farrar, Straus, and Giroux; 2011.) It is common sense but worth revisiting as a principle.

Eve Higginbotham, SM, MD  
AOA, Morehouse, 2008, Faculty  
Philadelphia, PA

UNLOAD ME

Student and intern rounds: Treatment of acute pulmonary edema. Think UNLOAD ME

U - Upright  
N - Nitrates  
L - Lasix  
O - Oxygen/Bipap  
A - Afterload  
D - Dobutamine  
M - Morphone/Milrinone  
E - Electricity

Richard Byyny, MD  
AOA, University of Southern California, 2000  
Denver, CO

Protecting academic thought and patient humanism in private practice

I am an academic practitioner of medicine. I teach, publish, and lecture. Of all the things I am privileged to do, caring for patients is the most important, and most enjoyable. I believe in humanism in medicine, death with dignity, and practicing medicine with the best evidence available and high-quality clinical experience.

However, these fundamental principles are being snuffed out by practice administrators whose only agenda is profit. These non-physician administrators count the physician’s minutes in the patient’s examination room;
criticize if the billing code for reimbursement is not high enough for the practice-expected revenue; demand more patients per hour, per day; and threaten penalties or dismissal if the doctor doesn’t perform to an administrator’s expectations. Administrators have become the doctors, and the doctors have become a commodity.1

Administrators are consuming the cost of medicine. In a recent analysis of the contributing factors to health care costs, administrators now consume 31 percent of total health care costs.2

The practice group where I am employed is wonderful with a great group of physicians. However, the revenue (production), number of patients seen per day to keep the practice “above the hole,” and the required demands of electronic health records are all regularly scrutinized by regulators. Computer invasion is transcending health care.3,4

If I, as the only internal medicine specialist in a complex unispecialty practice, spend more time with a patient who has multi-system, complex diseases, the practice administrators admonish me. If I need more time to explain to the patient their disease or clinical pharmacology of the medications I am prescribing, I am told I am taking too long with one patient. I ponder, “What medical school did these people go to?”

The humanistic practice of medicine—as most of us were trained—is vanishing. The practice of medicine is being engulfed by regulators, administrators, corporations, and unaccountable insurance companies. The result is that the patients suffer.

What can we do? It is unclear if a universal health care implementation would lead to lower administrative costs. There will always be the need for some form of a safety net so we, as a civilized society, can protect the health of all of our citizens. However, the abdication of our physician intellectual and moral commitments to ethical health care is not what is best for our patients, or for us as physicians.

References

Paul D. Miller, MD
AoA, George Washington University, 1969
Golden, CO

Social determinants of health
Your excellent and stimulating editorial on social determinants of health (The Pharos, Autumn 2017, pp 2–7) was slightly marred by the comments on John Snow and the Broad Street pump. The account mistakenly mixed up the pump, which drew water from a well unconnected with any water mains, with the larger investigation Snow was simultaneously conducting in South London, comparing death rates of two water companies, one of which drew sewage-contaminated water while the other drew clean water upstream.

For the details of these investigations, please see “John Snow Revisited: Getting a Handle on the Broad Street Pump,” which appeared in The Pharos Winter 1999, pp 2–8.

Howard Brody, MD, PhD
AoA, Michigan State University, 1988, Alumni
Knoxville, TN

Correction
In the Spring 2018 issue, the article “Leonardo at 500,” the second paragraph should have read, “Within a year, he would suffer a disabling stroke, and within three years he died. He was 67 years old.”

We apologize for any confusion or inconvenience this may have caused.
Alpha Omega Alpha Honor Medical Society recently announced its 2018 Fellows in Leadership. This year’s recipients are:

Jennifer Hagen, MD (AΩA, University of Nevada, Reno School of Medicine, 1998), Senior Associate Dean for Faculty, and Professor of Internal Medicine at the University of Nevada, Reno School of Medicine;

Kaushal Shah, MD (AΩA, Icahn School of Medicine at Mount Sinai, 2015), Vice Chair of Education, and Director of the Emergency Medicine Residency Program at Mount Sinai Hospital in New York City; and

Joseph Weistroffer, MD (AΩA, Uniformed Services University, 1992), Orthopaedic Surgery Residency Program Director at Western Michigan University Homer Stryker M.D. School of Medicine.

Leadership in medicine, medical education, and health care is more complex in the 21st century than ever before. 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, 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 AΩA Fellow in Leadership recognizes and supports the development of outstanding mid-career physician leaders. Fellows spend one year honing their leadership skills and expanding their knowledge base in the areas of:

**Leading from within**—Creating access to a broader range of ways of being, thinking, and acting to become more effective in dealing with the challenges for which the usual solutions are inadequate. Unlike most existing programs that teach leadership by imparting someone else’s knowledge (a third-person approach), this Fellowship emphasizes creating leaders using a first-person “as-lived/lived-through” methodology. In working with Fellows to “unpack” their hidden beliefs and frames of reference, new contexts will emerge that give them more space and more degrees of freedom to lead effectively as their natural self-expression.

**Servant Leadership**—Based on specific core values, ideals, and ethics, effective, sustainable, and excellent leadership is based on core professional and personal values and a commitment to servant leadership.

The five essential components of the AΩA 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.

Chapter and National News

2018 AΩA Fellows in Leadership

The 2018 Fellows in Leadership met for orientation in Denver, July 15-19. The leaders met with their mentors, AΩA Board of Directors members, previous Fellows in Leadership, and renowned members of the medical community.

Pictured, from left: Dr. Richard L. Byyny, Dr. Alan Robinson, Dr. Eve Higginbotham, Dr. Wiley “Chip” Souba, 2018 Fellow Dr. Jennifer Hagen, Kathi Becker, 2018 Fellow Dr. Kaushal Shah, Dr. Diane Magrane, Dr. John Tooker, 2018 Fellow Dr. Joseph Weistroffer, and Dee Martinez. This is the fifth cohort of AΩA Fellows. Following their fellowship year, the 2018 AΩA Fellows will be joining their 12 colleagues in the AΩA Fellows in Leadership Community of Practice.
Recipients will receive a $25,000 award to be used for further development of their leadership skills through a specific year-long project. The award may not be used for salary support for either the Fellow or institutional mentors. The award may be used for attendance at a leadership development course or resources related to the Fellow's project or other expenses related to leadership development approved by AΩA.

Jennifer Hagen, MD

Dr. Hagen is a graduate of the University of Nevada, Reno School of Medicine and received her M.D. from UNR Med in 1993. She trained in pathology at the University of Wisconsin, before returning to Reno for her internal medicine residency training. She joined the internal medicine faculty in Reno in 1999, and served as its clerkship director until 2003, when she became the Associate Dean for Medical Education.

Dr. Hagen assumed the role of residency program director in November 2009, and she serves as the Associate Dean for Faculty Development from 2012-2017. She teaches fellows, residents, and students in the classroom and at the bedside.

Dr. Hagen previously practiced general internal medicine as a primary care physician and hospitalist, and is a founding member of the UNR Med Geriatrics Hospital Consult Service. She completed her training in geriatrics at the UNR in 2017. She is a fellow of the American College of Physicians, and is board certified in internal medicine and geriatrics. She is the recipient of the Outstanding Clinical Teacher Award (2001), the Leonard Tow Humanism in Medicine Award (2004), and ACP Nevada Chapter Woman Physician of the Year (2016). She is also the AΩA Councilor at the UNR Chapter.

Project: Creating a Faculty-Centered Culture of Success

This project will develop leadership skills relevant to any role in academic medicine, with an in-depth understanding of the special requirements of leaders in academic medicine, and develop and launch UNR Med’s new Office for Faculty.

Dr. Hagen will enroll in the Rudi Ansbacher Women in Academic Medicine Leadership Scholars Program to increase her understanding of principles of leadership. Mentoring will help her build skills to address areas for growth in leadership. Mentors will coach her to think and plan at a higher level and across a wider array of constituents in an evidence-based way, increasing her confidence to lead in more complex and challenging situations.

The units in the Office for Faculty have developed a value system for communication and an inventory of projects and programs identifying areas for synergy. With this foundational work in place, the next step is for team members to set priorities for their respective units. Further development of the office will include goal setting with timelines and defined outcome measures.

Having knowledgeable and trusted mentors during this process will be invaluable, and will be a stimulating challenge for all involved.

Kaushal Shah, MD

Dr. Shah attended Brown University, Dartmouth Medical School and the Harvard Affiliated Emergency Medicine Residency Program. In the last 15 years, Dr. Shah has become a recognized leader in trauma education and research. He has lectured throughout the country and at national meetings. In addition to being editor-in-chief of a textbook series, he is also the author of a children's book series entitled Junior Medical Detectives. Dr. Shah also works closely with the NFL as co-director of the Airway Management Physicians.

Project: Leadership Curriculum: Catalyst for Good to Great

Dr. Shaw will create an ongoing leadership curriculum for resident trainees with the goal of transforming very good leaders into great ones thereby improving the quality
of patient care delivered today and into the future.

In order to make this scalable to other departments and other institutions, he will create a toolbox of resources that any program director in the country can use to elevate the level of leadership training in their institution.

Trainees and faculty need to be continually engaged in system-based initiatives for evolution of the clinical learning environment. A leadership curriculum that entails a didactic curriculum and simultaneously a team-based experiential exercise focused on interdepartmental quality and process improvement under the guidance of a faculty mentor, will be an innovative system-based solution to improving the clinical learning environment.

**Joseph Weistroffer, MD**

Dr. Weistroffer graduated from the Uniformed Services University of the Health Sciences and was a Categorical Medicine Intern at the National Naval Medical Center, in Bethesda, Maryland. After his Orthopaedic Surgery Residency at the Naval Medical Center in San Diego, he completed the Twin Cities Spine Center Fellowship in Minneapolis, Minnesota.

His experiences in Orthopaedic Surgery include positions as Vice Chairman at the Naval Medical Center San Diego, founding Orthopaedic Spine Surgery Fellowship Director at Northwestern University in Chicago, and full partner at New England Neurological Associates in Boston, Massachusetts.

Though his understanding of leadership was founded at the U.S. Naval Academy in Annapolis, and enriched during a semester at the U.S. Military Academy at West Point, he credits his experience as a Marine Corps Platoon Commander for understanding the complexities of leadership.

He did a tour as an F-14 Fighter Pilot serving on the Admiral’s Staff in San Diego, and was the Submarine Medical Officer for the Navy’s Pacific Trident Submarine Fleet in Bangor, Washington.

He has served on the Leadership Development Committee for the American Academy of Orthopaedic Surgeons, written the curriculum for their Leadership Fellows Program, and currently sits on the Council of Orthopaedic Residency Directors/Academics Committee for the American Orthopaedic Association.

**Project:** A study to evaluate the effectiveness of a comprehensive, integrated leadership curriculum for healthcare professionals.

To create a leader development program for medical students and residents at Western Michigan University. He is a co-investigator in a research project to measure the leader identity of first-year medical students and last-year residents before and after exposure to this leadership training.

To apply to be a 2019 AΩA Fellow in Leadership visit [www.alphaomegaalpha.org](http://www.alphaomegaalpha.org).
When I was young
My mother’s hands were strongholds
Pulling the weight of her ancestors
Across an entire ocean
So that one day
My brother and I
Might be able to say
That we lived the American dream.

For years, my mother’s hands
Have been those of a physical therapist
Day in and day out
Giving her strength
To children with none of their own.
Her exhausted hands still
Would tuck me in every night.

My mother’s hands now
Are the textbook picture of osteoarthritis.
She hides them when we take photos,
And complains of how ugly they are—
Her hands which have built mountains.

I look at her hands and I see
Swollen joints, nodules,
Knobby knuckles glaring at me,
The product of her hard work—
My mother who stands at 4 feet 9 inches tall,
But whose spirit towers over skyscrapers.

The same hands that have held me forever
Now struggle to grip
The handle of her morning mug
Of coffee.
My mother’s hands are falling apart
Before my eyes.

My mother’s hands
Were her gift to me.
On the soonest day possible,
I will tell her to pick which planet she likes best,
And I will scoop it up and hold it there
Gently in my hands, with all that I am
Because of her,
And I will give my mother the world.

Gabrielle Espiritu

Ms. Espiritu is a third-year medical student at Louisiana State University School of Medicine at New Orleans. Her poem received third place in The Pharos Poetry Award competition 2018. Ms. Espiritu’s e-mail address is: gvespiri@gmail.com.
Seeking candidate submissions for 2018 awards

Visit http://alphaomegaalpha.org/programs.html for applications and more details.

Edward D. Harris Professionalism Award

**Purpose**
To recognize best practices in medical professionalism education.

**Award**
A one-time award of $10,000 to recognize and honor faculty, programs, and institutions with the best practices in medical professionalism education. Up to three awards will be presented each year.

**Eligibility**
Programs at medical schools, or institutions affiliated with medical schools, that have a professionalism program with proven outcomes, are eligible.

Robert H. Moser Essay Award

**Purpose**
To honor the late Robert H. Moser, MD (AΩA, Georgetown University, 1969), the essay award is presented to the author of an outstanding written piece celebrating the life of a physician (living or dead) who has enriched the world through his/her career in medicine.

**Award**
The winning essay will be published in *The Pharos*, and the author will receive a $4,500 award.

**Eligibility**
All physicians are eligible. AΩA membership is not required, however, AΩA members who submit an essay must have active status. Physicians on the AΩA Board of Directors or *The Pharos* Editorial Board are not eligible.

**Requirements**
Essay must be an original work and be biographical. The physician written about may be from any nation, and from any time.

Deadline extended to November 1, 2018