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Founded by William W. Root in 1902

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Scholarship has long been and continues to be an important and vital responsibility for physicians. *Doctor, from Latin *docere*, means "to teach." Physicians have a responsibility to use observation and reasoned thought to expand human knowledge and ameliorate suffering. All physicians are teachers and are called on to teach. Throughout history physicians have endeavored to learn and understand from their work with the sick and injured and taught about the science and art of medicine. It has been said that the researcher at the bench, the clinician in the ward or office, and the epidemiologist in the field are all making "experiments." We are, therefore, all scholars in medicine and health.

Research may be defined as careful or diligent search, studious inquiry or examination, or the collecting of information about a particular subject. Many physicians equate scholarship with biomedical research, even though it has been estimated that only about two percent of physicians are directly involved in basic research. Medicine and patient care have been dramatically improved by these physicians through their scholarship in biomedical research, its applications and translations, and publications.

I believe that all physicians do research every day in the care of patients, and that we also have an obligation to participate in active scholarship. Clinicians carefully evaluate the patient's history, perform a thorough examination, develop a hypothesis based on the clinical findings, and then gather data and information to support or reject their hypotheses. They then make informed decisions and act to make a diagnosis, predict prognosis, and determine treatment. They often study the medical and scientific literature to learn about their patient's illness and other diagnostic possibilities and to find current diagnostic and therapeutic best practices. They implement a clinical plan, inform and teach the patient and staff, and then record the information in the medical record. Physicians observe, discover, study, interpret, and teach. This is scholarly activity by every physician.

Here is one contemporary example of a physician scholar. In the 1970s, Dr. Joel Weisman, an osteopathic family practitioner practicing in Southern California, began to see young men with shingles, Kaposi sarcoma, and lymphoma-like illnesses. In 1980, he cared for a number of gay men with a puzzling constellation of symptoms, including weight loss, lymphadenopathy, fever, rashes, low WBCs, and fungal infections that appeared to be immunological in origin. Some of the patients also had pneumonia. Weisman consulted with Dr. Michael Gottlieb, who diagnosed these and other similar patients as having biopsy-proven pneumocystis pneumonia. Weisman then took the next step in scholarship. He published a description of five cases, a case series, in the Centers for Disease Control June 4, 1981, *Morbidity and Mortality Weekly Report.* This case series report is recognized as the first scholarly publication describing AIDS. Dr. Weisman's clinical observations, reflection, and clinical reasoning in the care of his patients was followed up with a crucial step: publication of his case series. This starting point led to the application of epidemiologic, social, and biomedical research that has taught us much about HIV and AIDS.
Scholarship in medicine

Scholarship and experimentation in medicine has a long history. Plato defined science as “the discovery of things as they really are” based on observation and reasoned thought. In Babylon in the second millennium BCE, the concepts of symptoms, physical examination, diagnosis, etiology, prognosis, treatments, and traditional herbal practices based on empirical observations and the use of logic were taught. The literature in medical compendia defined the purpose of medicine to cure diseases of the sick, protect the healthy, and prolong life. Although their concepts were based on the preconceived notion of the imbalance of body elements and humours, among the achievements of medicine of the time were the isolation of some patients with infectious diseases, performance of surgical interventions, food prohibitions, and the treatment of patients with herbal medicine, acupuncture, massage, and other remedies.

Hippocrates observed and described the clubbing of the fingers in lung and cyanotic heart disease, the Hippocratic facies, and other physical manifestations of diseases. He categorized illness as acute, chronic, endemic, and epidemic. He was the first chest surgeon to operate for thoracic empyema.

Galen was a great surgeon performing many complex surgeries who wrote extensively on anatomy based on his human dissections.

Avicenna wrote The Canon of Medicine (1025) and The Book of Healing (1027). At this time books, mostly religious and some medical texts, were hand written and copied. Gutenberg’s invention of the printing press and movable type in 1455 led to the rapid rise of science and medicine.

Many other medical scholars followed and contributed by cataloging their observations and experiences. William Harvey in seventeenth century described the circulatory system, by deducing that the presence of valves in veins and their absence in arteries determined the direction of blood flow, as well as the necessity for pulmonary circulation to oxygenate the blood and the heart as the pump to maintain circulation.

Developments in pharmacology and technology led to other important medical discoveries. In 1676 using the new technology of the microscope Anton van Leeuwenhoek first observed bacteria and microorganisms. In 1842 anesthesia, both nitrous oxide and ether, was used for dental extractions and surgeries. In 1847 Ignaz Semmelweis dramatically reduced the death rate of mothers by requiring physicians to clean their hands before assisting in childbirth. Joseph Lister in 1865 proved the principles of antisepsis in the treatment of wounds by using phenol/carbolic acid to sterilize surfaces before surgery and promoted handwashing and wearing gloves to further maintain asepsis. Louis Pasteur linked microorganisms with disease and developed the process of pasteurization.

During the 1854 cholera outbreak in London, John Snow documented the location of each of his cases with a “dot map” that showed a definite cluster around Broad Street. After learning through interviews that most of his patients drank water from the Broad Street pump, he caused the pump handle to be removed, ending the outbreak. Snow is now considered the

Ignaz Semmelweis  Edward Jenner  John Snow  Robert Koch
The founder of the science of epidemiology. He published his findings in a letter to the editor of the *Medical Times and Gazette*. In 1796, Dr. Edward Jenner, after learning that milkmaids were usually immune to smallpox, hypothesized that previous exposure to cowpox protected them from the more severe disease. Jenner tested the hypothesis by inoculating an eight-year-old boy with pus from a cowpox blister. After the boy recovered from the mild case of cowpox he acquired, Jenner inoculated him repeatedly with pus from smallpox blisters; the child never developed smallpox. Jenner continued his research and finally published his findings on 23 cases. The results spread through Europe and beyond; vaccination became widely accepted as a safe means to prevent smallpox.

Dr. Robert Koch is considered the founder of modern bacteriology. He identified the causative bacterial agents for anthrax, cholera, and tuberculosis, successfully culturing organisms obtained from patients treated in the examination room next to his laboratory, staining the cultured organisms, and observing them under the microscope. While many authorities of the time believed that tuberculosis was a hereditary disease, Koch believed it was an infection caused by a bacteria. He confirmed the crucial stepwise tests: mycobacterium was present in all cases of tuberculosis, the organism could be isolated and grown in healthy guinea pigs, the isolated and cultured organism caused tuberculosis when inoculated into healthy guinea pigs, and the recovered organism from the diseased guinea pigs was the same as the organism cultured from the original diseased patient. These are now referred to as Koch’s postulates. He published papers on each of these infectious diseases and won the Nobel Prize in Medicine in 1905.

Sir William Osler is an example of a great clinician scholar. He was not a research scientist, but his scholarly work at the turn of the nineteenth to twentieth centuries transformed clinical medicine and medical education. Osler firmly believed in the scientific basis of medicine and he worked to disseminate the research and discoveries of others. Osler’s clinical practice, keen observations, teaching, lecturing, and writing made major contributions to medical education. Osler’s *The Principles and Practice of Medicine*, published in 1892 was for decades the seminal textbook of modern medical practice. Osler made many other contributions to medical education and practice, including requiring that medical students participate in bedside teaching with direct care of patients, establishing the first residency training program for physicians, creating one of the first organized educational journal clubs, founding of the Association of American Physicians, and establishing the Johns Hopkins University School of Medicine. He emphasized and taught students and physicians to, “listen to your patient, he is telling you the diagnosis.” His participation in the creation and development of the Johns Hopkins School of Medicine was pivotal in the 1910 Flexner Carnegie Foundation Report that revolutionized medical schools and medical education in the United States.

The twentieth century produced amazing research and scholarship in medicine, science, engineering, technology, health, and patient care, fueled by research in many areas of science and engineering. The National Institutes of Health (NIH) was established in 1930; its subsequent research role began in 1937. In 1946, the NIH became the engine for biomedical research with government support and funding. While not all of the discoveries related to medical science and medicine were made by physicians, physicians adapted and applied the discoveries to patient care and actively taught about the new discoveries and their clinical applications. The following table summarizes some of the highlights of progress, discovery, and application of advances in the science of medicine and health in the twentieth century.

Standing out from among the many advances in scholarship
Twentieth-Century Research and Scholarship in Medicine

<table>
<thead>
<tr>
<th>Event</th>
<th>Year(s)</th>
</tr>
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<tbody>
<tr>
<td>Aspirin</td>
<td>1828</td>
</tr>
<tr>
<td>Clean water, safe food, electricity, education</td>
<td>1900–1950</td>
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<tr>
<td>Discovery of blood groups</td>
<td>1901</td>
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<tr>
<td>Endoscopy</td>
<td>1901–1923</td>
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<tr>
<td>X-Rays</td>
<td>1902</td>
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<tr>
<td>Flexner Report on Medical Education</td>
<td>1910</td>
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<tr>
<td>Vitamins A, B, C, D, E, K (vital nutrients not made endogenously by humans)</td>
<td>1913 on</td>
</tr>
<tr>
<td>Electrocardiogram</td>
<td>1914</td>
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<tr>
<td>Vaccines</td>
<td>1920s</td>
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<tr>
<td>DPT</td>
<td>1945</td>
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<tr>
<td>Influenza</td>
<td>1937</td>
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<tr>
<td>Yellow fever</td>
<td>1955</td>
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<tr>
<td>Polio</td>
<td>1971</td>
</tr>
<tr>
<td>Measles, mumps, rubella</td>
<td>1980s–1990s</td>
</tr>
<tr>
<td>Hepatitis A and B</td>
<td>1977</td>
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<tr>
<td>Pneumonia</td>
<td>1980</td>
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<tr>
<td>Eradication of smallpox</td>
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<tr>
<td>Discovery of insulin</td>
<td>1922</td>
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<tr>
<td>Control of infectious diseases</td>
<td>1930s</td>
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<tr>
<td>Discovery of sulfa</td>
<td>1928</td>
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<tr>
<td>Discovery of penicillin</td>
<td></td>
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<tr>
<td>Other antibiotics</td>
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<tr>
<td>Flame photometer (electrolyte measurements)</td>
<td>1936</td>
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<tr>
<td>Cardiac catheterization</td>
<td>1941</td>
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<tr>
<td>Modern randomized controlled trial</td>
<td>1948</td>
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<tr>
<td>Framington Heart Study</td>
<td>1948–present</td>
</tr>
<tr>
<td>Radioimmunoassay to measure peptides</td>
<td>1950s</td>
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<tr>
<td>Open heart surgery</td>
<td>1952</td>
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<tr>
<td>DNA structure</td>
<td>1953</td>
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<tr>
<td>Diagnostic ultrasound</td>
<td>1954</td>
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<tr>
<td>Kidney transplant</td>
<td>1956</td>
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<tr>
<td>Contraception</td>
<td>1960s</td>
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<tr>
<td>Computer assisted tomography (CT)</td>
<td>1970s</td>
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<tr>
<td>Magnetic resonance imaging (MRI)</td>
<td>1971</td>
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<tr>
<td>Angioplasty</td>
<td>1974</td>
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<tr>
<td>AIDS epidemic</td>
<td>1981</td>
</tr>
<tr>
<td>Reduction in mortality from heart attacks and strokes</td>
<td>1969–</td>
</tr>
</tbody>
</table>

In medicine during the twentieth century is the development of the Randomized Controlled Trial (RCT), now accepted as the “gold standard” for acquiring scientific evidence to evaluate therapeutics in medicine. Another pivotal research project was an observational study, the Framingham Heart Study, begun in 1948. It had been established by then that cardiovascular disease, including heart attacks and strokes, was a rising epidemic. The debate about high blood pressure ranged between two positions: One group hypothesized that the aging vascular system became stiff and required a higher blood pressure to adequately provide circulation. Another group believed that hypertension contributed to heart disease and stroke by exposing the vessels to increased vascular pressure.

The National Heart Institute at NIH in collaboration with Boston University advanced a hypothesis that the development of cardiac disease was influenced by lifestyle and family history. The group devised a long-term observational study to identify potential factors for heart disease in a large cohort of people originally without evident heart disease in Framingham, Massachusetts. They enrolled 5,209 men and women between thirty and sixty-two years of age and observed them over many years to elucidate the differences between those who developed heart disease and those who did not. Participants were given extensive physical examinations and lifestyle interviews, with follow-up every two years for a medical history, physical examination, and laboratory tests. There have now been more than 1,000 publications on this population. The Framingham Study demonstrated the association of cigarette smoking as a cardiovascular risk factor in the 1960s. Subsequently other major cardiovascular risk factors were identified, including high blood pressure, elevated cholesterol, physical inactivity, and others.

Perhaps the next most significant achievement of twentieth-century research has been the Human Genome Project, which was initiated in 1990 by the Department of Energy and NIH to sequence the human genome. Three non-physician scientists led the projects to sequence the human genome, James Watson and Francis Collins at the NIH and J. Craig Venter at the private company Celera. The human genome was sequenced and the results published in 2000 and 2001 and has now greatly advanced our understanding of human biology and medicine.

“Scholarship Reconsidered”

In 1990, Ernest Boyer from the Carnegie Foundation for the Advancement of Teaching published his seminal report,
Scholarship Reconsidered: Priorities of the Professoriate, in which he advocated for expansion of the traditional and widely accepted definition of scholarship and research. He focused primarily on scholarship for faculty of traditional colleges and universities, particularly their roles and responsibilities in a milieu in which scholarship was equated with traditional research and the scholarship of discovery. Boyer’s model of scholarship has subsequently been widely adopted in many academic institutions and medical schools. I believe it is directly applicable to the scholarly and scholarship responsibilities of physicians in their multiple professional roles and functions, including the care of patients. It also directly relates to the physician’s fundamental responsibility for continued learning. Boyer’s model is also based on the concept that “Theory surely leads to practice. But practice also leads to theory.” He noted, “Surely, scholarship means engaging in original research. But the work of the scholar also means stepping back from one’s investigation, looking for connections, building bridges between theory and practice, and communicating one’s knowledge effectively to students.” He then presented his concepts of the types of scholarship.

The Scholarship of Discovery

For many, scholarship means engaging in original research in biomedical sciences, humanities, social sciences, epidemiology, and translational research that advances knowledge. He quoted William Bowen, former president of Princeton University, who said that scholarly research “reflects our pressing, irrepressible need as human beings to confront the unknown and to see understanding for its own sake. It is tied inextricably to the freedom to think freshly, to see propositions of every kind in ever-changing light. And it celebrates the special exhilaration that comes from a new idea.” And a quote from Lewis Thomas on major medical breakthroughs in the twentieth century: “It was basic science of a very high order, storing up a great mass of interesting knowledge for its own sake, creating, so to speak, a bank of information, ready for drawing on when the time for intelligent use arrived.” Scholarship of Discovery is usually documented in peer-review publications of original research.

The Scholarship of Integration

This represents scholars who give meaning to isolated facts, putting them in perspective and context by integration. It involves the synthesis of information and the making of connections across disciplines, across topics within a discipline, or across time, illuminating data in a revealing way to bring new insights. It means interpretation into larger intellectual patterns to learn “What do the findings mean?” It is scholarship that is interdisciplinary, interpretive, and integrative. It naturally leads to the next category, scholarship of application and engagement.

The Scholarship of Application and Engagement

This gets at the question, “How can knowledge be responsibly applied to consequential problems? How can knowledge be useful and helpful to physicians, patients, and society?” How to connect knowledge and theory to practice? It is the scholarship of service. Scholarly service both applies and contributes to human knowledge, resulting in the application of knowledge and skills in medical practice, including diagnosis, serving patients, shaping public or institutional policy, providing leadership, demonstrating professionalism, and serving society. Scholarly service often involves presentations at professional or community meetings, case reports, case series articles, and sharing information in diverse ways.

The Scholarship of Teaching

We in medicine have an obligation to teach what we know. As Aristotle said, “Teaching is the highest form of understanding.” Most of us can attest that we also learn from having to teach and from the process of teaching. Teaching contributes to the continuity of knowledge and stimulates creativity and curiosity. It actively promotes and contributes to scholarship. Physicians have many opportunities to teach, from bedside or clinic rounds, to patient consultations, to journal clubs, to organized teaching conferences, to mentoring of other physicians and students. Teaching promotes a spirit of inquiry and scholarship.

Scholarship in medicine today

Many medical schools have developed a Mentored Scholarly Activity requirement for medical students. The term “scholarly” is used purposefully, recognizing that some students will choose to do bench or clinical research for their project, but many are more interested in scholarship in the humanities, arts, social sciences, epidemiology, public policy, and other areas.

The Accreditation Council for Graduate Medical Education (ACGME) established a requirement for each resident to demonstrate acceptable scholarly activity to complete his or her training. They explain that for residents to pursue scholarly activities, they not only need to work and learn in a culture that values and nurtures scholarship, but also need to learn specific skills, such as transforming an idea into a research question (experimental, descriptive or observational), choosing an appropriate study design, determining what instrumentation to use, preparing for data collection, management and
analysis, ethical conduct of research, and the rules and regulations governing human subjects research. ACGME and their RRCs have adopted the Boyer concepts of scholarly activity. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included within each program. Both faculty and residents must participate actively in scholarly activity. Scholarly activity is a common program requirement for accreditation by the Accreditation Council for Graduate Medical Education. Scholarship is defined as one of the following:

- The scholarship of discovery, as evidenced by peer-reviewed funding or publication of original research in peer-reviewed journals.
- The scholarship of dissemination, as evidenced by review articles or chapters in textbooks.
- The scholarship of application, as evidenced by the publication or presentation a local, regional, or national professional and scientific meetings, for example, case reports or clinical series.
- Active participation of the teaching staff (including residents) in clinical discussions, rounds, journal club, and research conferences in a manner that promotes a spirit of inquiry and scholarship; offering of guidance and technical support, e.g., research design, statistical analysis, for residents involved in research; and provision of support for resident participation as appropriate in scholarly activities.

All physicians need to pursue scholarship that “promotes a spirit of inquiry and scholarship.” I encourage physicians to write about their observations and experiences and submit their work for publication. While many physicians are not good writers, all have some experience writing personal statements and essays, as well as clinical histories. Unfortunately, many of us have developed nonclinical “writing apraxia,” a common condition in which the physician has no problem talking about complex topics, but can’t write cogently about them. It is a poorly understood but common condition. The idea that your writing must be perfect results in not writing at all. But writing well can be learned, and we all need to learn to do it, and do it better. It is an important part of scholarship. We need to overcome writing apraxia because we need to share our observations and experiences with the medical profession. Remember Dr. Weisman’s five cases and the difference his observations and publication made in the recognition of a new disease, HIV and AIDS.

Alpha Omega Alpha (AΩA) has long been an advocate and supporter of scholarship. We provide more than three-quarters of a million dollars per year for programs and awards that are mostly to support scholarship. These include: Four Robert J. Glaser AΩA Distinguished Teacher Awards; about 50 AΩA Medical Student Research Fellowship Awards; Edward D. Harris AΩA Professionalism Awards and support of national meetings on medical professionalism; AΩA Medical Student Service Leadership Awards; about sixty AΩA Visiting Professors; AΩA Clinical Faculty Awards; AΩA Postgraduate Awards for resident and fellow scholarly projects; and AΩA medical student awards for essays and poetry. AΩA also publishes the society’s journal, The Pharos, a peer-reviewed means to publish articles other than biomedical research and related to health and medicine.

I encourage all of us in medicine to rethink scholarship and I urge all of us to more actively pursue scholarly work in our practices, communities, and societies. I also hope to promote a keen “spirit of inquiry and scholarship” in our profession.

References
But it's so sad!” Every time I mention that I am interested in pediatric hematology/oncology, this is what I hear. Sparked by an undergraduate research experience investigating the pathways involved in hematopoietic stem cell emergence, I became fascinated by the concept of bone marrow transplantation. But before committing myself to a career in pediatric hematology/oncology, I wanted to deal with my lingering fear of being unable to cope with death.

In the foreword of Bernice Harper’s *Death: The Coping Mechanism of the Health Professional*, Dr. Jesse Steinfeld writes that many health professionals “unfortunately will contribute to their patient’s anxiety” because they are “unable to cope with [their] own discomfort about death.”

I was afraid I would be one of them.

The seminal *On Death and Dying* by Elizabeth Kübler-Ross helped me understand why I was so uncomfortable with death. In our society, children are excluded [from coping with death] with the presumption and pretext that it would be “too much” for them . . . we ship the children off to protect them from the anxiety and turmoil.

I was one of those children. Relatives who passed away did so on an island 6700 miles away. I did not attend a funeral until college.

My first experience witnessing the death of a stranger was during a premedical shadowing program. A young man was brought in after committing suicide by jumping off a building. My memories of the exact series of events are hazy; I was too excited, too scared, too horrified. Throughout the entire resuscitation, I kept thinking, “He’s too young to die,” and simultaneously, “But he wanted to die. We’re trying to give life back to someone who no longer wanted it.” Finally, the code was called, and as our team trudged back to
our floor, a third-year medical student turned back to me and asked if I was okay. It was her second experience with death, she admitted, and no less difficult than her first time. “I’m okay,” I assured her. My muscles, each and every one tense in the ED, gradually relaxed. I was walking and talking, my heart was still beating, my vision still clear—physiologically, I was okay. Mentally, though, I was still dazed. We returned to rounds, and the topic was not brought up again.

More recently, during my third year of medical school, I was part of the surgical team responding to a pediatric trauma event. I felt the same flood of emotions, the same tightening of my entire body, but with more anger. There was more I could not process, especially the nagging “Why?” and the unanswerable “How could this happen?”—unhelpful questions that made me uselessly rail at the world and its injustice. Before I left for the day, I sought out the pediatric trauma nurse who had been with us and asked her how she could deal with seeing cases every day. “It doesn’t ever get easier,” she told me, “but given all of her injuries, she is in a better place now.” For her, the cases were also a constant reminder to value the relationships she had with the people around her. This was the most satisfying, most helpful response I could have received at that moment. Her words forced me to accept that what had already happened to the patient had happened and that what could have been done for her in the emergency department had been done. They redirected my attention from my own mountain of unmanageable emotions to the patient—and left me at peace.

Those were my experiences with traumatic death. While situations in the emergency department quickly declared themselves as black or white, oncology has all shades of gray. How do health professionals face patients and their families every day with the uncertainty they carry? How do they bear this emotional weight?

I spent a month reading the literature on coping with death and end-of-life care, hoping to resolve my own nagging fears about death. I hope that what I learned will work for me in the future, and I am sure more experience will help me develop coping strategies. For now, I believe that a foundation of clear and honest communication with our patients, particularly about death, allows us to concentrate on realistic goals for both ourselves and them. While doing this, we must also be mindful of our own reactions and practice self-care.

When caring for patients, communication is key. Kübler-Ross emphasizes the need to communicate early and often in the course of the illness. She highlights the importance of interpreting body language, noting that caretakers often focus on the equipment rather than on the facial expressions of the patient, which can tell us more important things than the most efficient machine.3

While there were certainly times when variations in the blips and beeps of the monitors caused momentary panic, I learned that more reliable indicators of how kids felt were their crossed arms or their pouting lips. Likewise, when my stethoscope on bare skin caused a grimace, I knew it was not the time to wean pain medication. By watching and listening, we give the patient a voice in the direction of care.

To Cicely Saunders, founder of the palliative care movement, it was important to have someone, such as the bedside nurse, there to explain what a doctor had said and to listen endlessly to fears.3 [since] so many crippling emotions are less powerful to hurt once they have been expressed to another person.

As the third-year medical student, officially the lowest ranking (and in my case also shortest) member of the team, I considered myself the least intimidating person. As the one
with the most time, I felt that I spent the most time with my patients and that that time, together with my approachability, made it obvious to me that I should be their confidante. But as much time as I thought I spent with them, I quickly realized that their nurses spent more. More times than I can remember, nurses raised concerns that parents or patients were hesitant to bring to the attention of the medical team.

When death is possible or probable, it must be addressed. As Kübler-Ross puts it, death is often “a frightening, horrible, taboo topic,” our real-life Voldemort. To the superstitious, and sometimes even the usually-nonsuperstitious, talking about death will cause it to happen. That fear seizes our hearts and evicts reason. We do not need to talk about death in every conversation with the family; we do not need to bludgeon it into them until they accept. But we must be open to discussion and brave enough to initiate that first discussion, and afterwards, continue our support of the patient and family throughout the entire process. To the uncomfortable question of “Should a patient know . . . ?” Saunders argues that the answer is, undoubtedly, yes. It is our duty to patients—“If they do ask I believe they should be told.” She does advocate for some degree of knowing and understanding the patient first, since sometimes “we judge the patient to be unready as yet to face the full knowledge. But then we must return, for this may need a whole series of exchanges.” Avoiding the topic of death will not prepare the patient for this news; rather, honest communication and unhurried exploration of his or her understanding of the condition and beliefs about death are excellent starting points. If and when patients reach the final Kübler-Ross stage of acceptance, the family needs usually more help, understanding, and support than the patient himself. While the dying patient has found some peace and acceptance, his circle of interest diminishes. He wishes to be left alone or at least not stirred up by news and problems of the outside world.

And after death, especially for pediatric death, our role is not silence. It is, in the words of Joan Arnold and Penelope Gamma,

> To listen and to speak of child death, recognizing it for all that it is—an unparalleled human tragedy. To ensure that families will be respected and admired for their ability to deal with the vastness of their loss, we need to legitimize their loss, to talk openly about the dead child. To continue the silence is somehow to deny the child’s very existence.

Several resources are available to help us find just the right words, especially in difficult situations with their own nuances, such as death in the delivery room and in the ED. For both health professionals and parents, the United Kingdom’s Child Bereavement Trust website (www.childbereavement.org.uk) specifically addresses what to say to the bereaved about the death of a child. Although a few choice words may suffice to start that difficult discussion, one may also turn to those who are experienced to learn how to sustain such a conversation. In *The Anatomy of Hope*, Dr. Jerome Groopman writes that learning how to care for patients was still very much like being an apprentice in a medieval guild. You closely and repeatedly observed master craftsmen at their work and then, largely on your own, tried your hand at it.

I have always learned by modeling my teachers, whether it was crossing out units in dimensional analysis or using a suction pipette. But opportunities to observe my medical school teachers engaging in serious discussions with their patients were neither open nor plentiful. Our Practice of Medicine course supplemented discussions about the art of medicine with role-playing sessions, but all of the role-playing sessions in the world could not reassure me that I would be competent in the delivery of bad news. As an MS3 and MS4 I seized every opportunity to go
with my team to any serious discussions. Unlike the traditional see one, do one, teach one, I knew I needed more than one experience, and even now, I know I need to observe more master clinicians at their compassionate best. With their guidance, and most importantly, with more practice of my own fledgling skills, I hope to develop a level of mastery in the art of delivering and discussing bad news that will allow me to be a source of comfort to patients and families in distress.

One communication pitfall I have been guilty of is that of telling patients and their families only what they want to hear. I am an inherently optimistic person, but as the bearer of news and the interpreter of test results, I felt pressure to set a good mood for the day. Knowing that both content and delivery matter, I always tried to emphasize the good things or the progress they achieved. Even if it was not what they wanted to hear, I tried to balance unwanted news with something positive. But when I was asked a tough question or when the answer was bleaker than having to stay in the hospital for a few extra days, I faltered. Unable to depict the situation positively, and still inept at delivering bad news, I dodged the question and desperately emphasized the few things that were going well. Unconsciously, I was probably in the Kübler-Ross stage of denial; I wanted to protect the family from my own despair. As Groopman tellingly describes it,

The evasions, the elliptical answers, the parsed phrases were all supposed to be in the service of sustaining hope. But that hope was hollow.7p53

Not only was I starting down a slippery slope of half-truths, where my integrity could be questioned, but I was also a textbook example of a health professional contributing to her patients’ anxiety by avoiding their questions. Worse, my attempts to protect the family were also weakening their basis for hope, as I denied them the knowledge of what they could even hope for. Laying out the risks and benefits of treatment, talking about what a sixty percent chance of survival really means, and distinguishing between curative and palliative treatment are not easy. But this is what patients have the right to expect of us, and what we must do. Only with understanding of the facts, probabilities, and options available to them can patients have true hope.

Furthermore, for patients to believe that there is a way to a better future, the medical team must have hope, too. My attempts to dodge the patient’s and family’s questions betrayed my own hopelessness, and they probably saw through it.

**About Yunzu Michele Wang, MD**

I grew up in Arcadia, California, reading all the time. I continued to do so while obtaining my degree in biochemistry at UCLA, albeit less for personal enjoyment and more to pass my classes. My childhood was full of the outdoors, bargain shopping, delicious Taiwanese food, and my parents’ emphasis on the value of education. I am incredibly grateful for the support of my family, friends, and all of my twenty-one years of teachers from the Arcadia Unified School District, UCLA, and Washington University School of Medicine. Currently, I am a Pediatrics intern at the University of California in San Diego.
According to Harper, “To consider a disease or patient hopeless is often to render them so,” which Groopman reiterates: “for a physician to effectively impart real hope, he has to believe in it himself.”

This is more than the so-called power of positive thinking. Neither physician nor—especially—patient may consider alternatives or take risks if they feel that nothing will make any difference. Our only option is to use our knowledge and experience to guide our patients. Groopman relates the thoughts of Richard Davidson, PhD, Director of the Laboratory for Affective Neuroscience at the University of Wisconsin,

Hope does not cast a veil over perception and thought. In this way, it is different from blind optimism: It brings reality into sharp focus. In the setting of illness, hope helps us weigh highly charged and often frightening information about the malady and its therapies. Hope incorporates fear into the process of rational deliberation and tempers it so we can think and choose without panic.

How do I find hope in seemingly hopeless situations? By reframing—looking beyond the ominous circumstances to see that there is much I can do for the patient in front of me. By ceasing my own useless and unsatisfying “why?” questions and, above all, by making it about my patients and not about me.

Unconsciously, or perhaps sometimes deliberately, as August M. Kasper writes,

The dying are thus not neglected, but they are very rarely approached with hope or even interest, because, I suppose, they simply will not feed the doctor’s narcissism by responding and getting well. Their care is demanding, frustrating, and far from helpful to the medical magician’s self-esteem.

Things do not feel so awful when we focus on our patients instead of ourselves, and give instead of looking to gain.

The advice I received following my own experience in pediatric trauma exemplified such an attitude. It was a reminder to focus on doing what I could for the patient, instead of allowing myself to be overwhelmed by my negative emotions. With her experience as both a nurse and physician, Saunder stresses that

Much can be done to control pain, nausea and vomiting, to relieve dyspnoea and confusion, both so frightening to any patient. Skill at this stage helps us come to a patient with ever renewed interest and that positive feeling which is transferred without words. It can do so much to lift the feeling of helplessness from a patient as well as from ourselves.

As a medical student, the opportunity to do something, anything, to be helpful—as opposed to hopelessly helpless—was especially significant in emergency situations. I can imagine that the satisfaction of being able to medically manage and ease a patient’s long-term suffering and death must be magnified manifold.

In addition to reframing our own mindsets, helping the patient and family reframe theirs may bring further satisfaction. Instead of hope as a single entity, “alluring but vague,
revered but ineffable, aloof from daily life and mostly inac-
tionable,” identifying “smaller, salient, and steady-ing” hopes
brings to light more achievable, and perhaps more meaningful,
goals.9 Recognizing “hope as a force that helps to carry the
unbearable,” patients can be asked about their “hopes for the
future and the good things that inspired [them] to continue to
live.”10 In the same way that we need to refocus our attention
on matters within our control, we should also help our patients
acquire some measure of control over their own conditions.

Beyond doing the best for our patients in the hospital or
office, we also need to deal with our thoughts and emotions.
Burnout and compassion fatigue are common in physicians
caring for patients with end-stage illness; they need not be
inevitable, however, as several self-care and self-awareness
methods to prevent burnout can help.11 A very delicate balance
in the physician-patient relationship needs to be maintained.
As oncologist Dr. David Steensma writes,

If I get too close to my patients and allow myself to become
emotionally entangled in their suffering, every death feels
like the loss of a family member. I risk becoming paralyzed
in grief. But if I don’t allow my patients’ agony to hurt me
at all—if I attempt to preserve myself by making myself
untouchable, emotional Gore-Tex—then, like old Tithonus,
who was granted immortality but not eternal youth, I am
condemned to shrivel up into a grasshopper, abandoned by
the voice needed to give comfort to my patients.12

Recognizing risk factors related to closeness of the physi-
cian-patient relationship may help one avoid both compromis-
ing clinical judgment and physician burnout.13

In addition to self-awareness, a supportive environment at
work is championed in almost every work I have read. It is a
very special bond formed by shared experience. Already, in my
brief years of clinical experience, residents, nurses, and attend-
ings have provided the necessary “listening ear with simple
support and encouragement”,14 and I know I will value their
help even more in my future. While studies show that an of-
official debriefing following a traumatic event carries both risks
and benefits,15,16 I believe that the health professionals involved
in such an event should not be expected to mute their grief any
more than the family should.

I know this is not the end of my learning. I wanted a how-to
guide, an instruction manual, but this is not that kind of expe-
rience. I wanted to cross off “confront fear of death” from my
to-do list, and then run away and get as far as I could from it
until having to confront it again. What I have learned, however,
is that it is really not so fearsome. Developing the courage and
confidence to approach patients about the possibility of their
deaths will certainly take more observation and experience,
just as it will take more experience to learn to manage the clin-
cal aspects of end-of-life care. But understanding our patients’
views and goals and what we can help them achieve will give us
hope. And practicing consistent self-care and promoting a sup-
portive work environment will allow us to endure and carry on.

Death, and pediatric death in particular, is a terrible tragedy
but as one social worker put it, “I cannot stop that, or make it
go away by running away from it, so I must turn around and
help.”160 And so I will.

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Food Fight

Matthew Molloy

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Obesity. America's epidemic. I remember the first time we were shown the CDC National Obesity Trends maps in medical school. Beginning in 1985 with light blue and lighter blue, we watched as the years progressed and new colors were added. Dark blue. Yellow. Orange. Now twelve red states in 2010. It seemed almost comical in a way, the colors resembling political party designations. The colors changed as the average waist size expanded. Democrat, then Independent, now Republican. One can only wonder what color we will use for states that tip the scales with greater than thirty-five percent obesity. Perhaps black. As the months rolled by, the maps lost their comic relief and turned into annoyance. It seemed as though every tenth lecturer felt the need to remind us about the trend. We were about to be thrown into the trenches of medicine's war on food. I remember looking around the room and wondering if there were any new recruits to the war. Me? I was a veteran. I'd been fighting the Food Fight for years.

My decision to enter medicine was a roundabout one. I haven't wanted to be a doctor since I was born. It wasn't even on my radar when I started college. In fact, I remember finding many premed students off-putting. I studied biology and chemistry because of a passion for understanding how the world worked. Every pathway, every reaction, every explanation taught me more. I was fascinated by research and the opportunity to contribute to the collective knowledge of the scientific community. I conducted assays and Western blots to elucidate the aberrant signaling in cystic fibrosis cells. I performed microarray analysis of the African malaria vector to ascertain differing responses to stress. It was all well and good, but something was missing.

I also found passion in politics. A card-carrying liberal, I joined the College Democrats and began...
working on local campaigns in northern Indiana. I even worked as an intern on Capitol Hill for a summer. I craved the rush that comes with a heated policy debate and the satisfaction of enacting something into law. I treasured my time working in the political realm, but knew it wasn’t for me.

As a cradle Catholic, I sought to infuse my education and career with meaning. I was enthralled by ethics and perused philosophical and theological literature. I fervently argued my opinions and developed a strong foundation for my own ethical conscience. Yet the theory of it all seemed so dry at times—I wanted to act, not philosophize.

There was no epiphany, no thunderbolt moment. I realized eventually that medicine could let me combine the things I was most passionate about. Science for the betterment of humanity. Political debate and policy wrangling at every level. Morality and ethics in practice.

Only one problem: I was obese. You can’t be a doctor if you’re obese.

I met Carlos on my ambulatory clerkship during my first year of medical school. He was twelve years old, five-foot-one, and 168 pounds. Clinically obese. Looking at his growth curve, it was a diagnosis that he had carried for many years. I was asked to counsel him on weight control and diet modification. I sat down with him and his mother, a caring woman struggling with her own weight. I began by asking Carlos what he thought about his weight.

“I’m big. I’ve always been big. It’s hard sometimes at school. Kids can be mean to me, but it doesn’t really bother me.”

“Kids can be mean sometimes. I’m sorry about that. I’m glad you don’t let it bother you too much.” I glanced back at his growth curve. It was true. He had always been big. My eyes drifted to another area of the chart: family history. Diabetes. Cardiovascular disease. Hyperlipidemia. MI. My stomach dropped. Suddenly, getting this kid to realize the importance of the situation seemed more real. I caught the twinge of pain he had in discussing the issue. I know what it feels like, I wanted to tell him. But I didn’t. Carlos needed a plan. Where to start? Fast food? Soda? After school snacks? I decided to put the ball in his court.

“I see that the doctor has talked to you about what you eat before. Have you tried anything in the last year to change your eating habits?”

“We don’t eat out as much. And I stopped drinking a lot of soda.”

“That’s great!” His mom interjected, “Yeah, we got him to stop drinking so much soda by getting him to drink fruit juice. And I’ve been trying to cook more at home.”

Fruit juice. My mind jumped to the sugary, calorie-dense juices I used to drink as a kid. “What kind of fruit juice?” I asked.

It wasn’t diet. It was full-sugar fruit juice. Full-calorie fruit juice. And he sure was drinking it. A lot of it. I asked Carlos and his mom if they knew how many calories were in a serving. They didn’t. To be fair, I rarely used to know what I was putting into my body. Carlos seemed interested in the answer,
so I got onto the Internet and we figured out together that he was drinking over 1000 calories a day in juice. The number sunk in.

“Wow. I had no idea. I thought I was giving him something healthy,” his mom said. A dangerous and common misconception. I could tell that I had convinced mom, but I needed to convince Carlos.

“Well, Carlos, if you’re on board, I think that this is something that you all can target. Drinking water instead of juice every day would eliminate a huge amount of calories and will definitely help you manage your weight. I think that would be a great first step.”

Carlos seemed to be pondering the situation. “It’s going to be hard. I like juice,” he said.

Hard, I thought. That’s an understatement. “You can have juice from time to time,” I pointed out. “Maybe you and your mom can go to the store and look for some drink options that would still taste good and have a lot fewer calories.”

“Yeah. That sounds good,” he said.

I never saw Carlos again, so I’ll never know if I got through to him. Maybe he did what we decided and cut out the fruit juice. Maybe he decided that he wanted to make a change. Or maybe his mom decided for him. Or maybe he’s still drinking five servings of fruit juice a day and continuing to tip the scales, barreling down a road that will lead to his genetic gifts of cardiovascular disease and diabetes.

I left clinic that day wondering how I could reach out to my patients. How could I tell them that I understood their plight and seem genuine? How could I tell them that we were fighting the Food Fight together? That I wasn’t just another skinny doctor wanting them to lose weight? Tell them, “It gets better.” Or rather, “It can get better.”

I’ve been overweight for as long as I can remember. Looking at old pictures, it appears that I started to look chubby at the age of eight. Being the fat kid affected me in more ways than I think I will ever realize. I went to Catholic school and always had to wear uniforms. They came in three sizes: slim, normal, and husky. I was always “husky,” a terrible term. Like a nice way of calling you fat. I was lucky to have very few instances of bullying because of my weight. I was never really teased, but I always struggled. I grew up in Arizona, where swimming during the summer is a way of life. All fun and games, unless you’re a twelve year old with noticeable gynecomastia. Or, as the skinny kids like to call it, “man boobs.” Nobody had to say the words aloud, I said them in my own head. Every year during our “Health Safari” I watched the number climb higher and higher. Into the three digits. As puberty hit, my other chubby friends sprouted up and lost their baby fat. I grew, too, but in both directions.

I tried my hand at my first diet as I approached the dangerous 200 mark at age thirteen. My mom and I joined a weight loss program, and I stayed motivated all summer, dropping almost twenty pounds. My parents and I were very proud. I finally seemed to be moving in the right direction! My eighth-grade year started with excitement as I prepared for high school life. We bought new uniforms and registered at my new school. Then the celebrations hit: holidays, end-of-year parties, graduation, summer sleepovers. And with
them the pounds came back. When I tried to get into my new high school uniform, it didn't fit. Not even close. I remember crying when I brought the shorts out to my mom. I didn't need one size up. I needed two sizes up. I overheard my dad saying, “Did he really gain that much weight?” I guess I had. I guess I was always going to be the fat kid.

My biggest enemy in my Food Fight was body image. I had great friends. I was relatively popular. I had dates to the dances and even a girlfriend at times. I was successful in the classroom. In fact, I was at the top of my class in grade school and high school. Summa cum laude at a prestigious university. I was constantly busy with outside activities. I traveled and studied abroad. I had a happy, stable family. But none of that could get rid of the internal struggle I had when I looked in the mirror every morning. I hated wearing the baggy jeans and hunting for the largest sizes at the store, dreading the day when I might have to shop in the “Big and Tall” section. I feared not fitting into the safety harness on the roller coaster. I was ashamed at the possibility of needing an extra seatbelt to fly home on an airplane. My weight fluctuated from time to time as I slipped in and out of “health eating” and coped with a modest student stipend. I hovered just below 300 through most of college, always staying below that magical number that seemed to portend something truly wrong. I didn’t like how I looked, but I seemed to avoid the worst consequences of being obese. I was the biggest “normal” weight that you could be; at least in my mind. My BMI was misleading, I thought.

And there I stayed.

I sat in a small group room rehearsing motivational counseling. Convincing people to change their habits for the better. We all practiced on a standardized patient who was trying to quit smoking, artificially fast-forwarding from clinic visit to clinic visit as our fake patient struggled with modifying her lifestyle. My group was not very successful at moving the actress to her goal. She broke character to give our group feedback at the end of the session.

“I felt like you didn’t understand the fact that deep down I wanted to quit, but couldn’t find a way to make it work for me.”

We had failed her. We had failed to understand her struggle. She didn’t need convincing, she needed guidance.

About Matthew Molloy

I am a fourth year medical student at the Johns Hopkins University School of Medicine and am currently pursuing a Master of Public Health degree from the Johns Hopkins Bloomberg School of Public Health. I am originally from Gilbert, Arizona, and attended the University of Notre Dame, where I studied Biological Sciences. I now live in Baltimore, Maryland, with my wife, Molly. I intend to pursue a career in Pediatrics and Public Health. I hope that my own struggle will make me a more compassionate and effective physician.
and support. She needed someone to fight with her.

One of the tools in our tool bag as medical-professionals-to-be is the Stages of Change model. People move through these stages: precontemplation, contemplation, preparation, action, and maintenance. Oh, and relapse. Don’t forget about relapse.

Our actress-patient modeled the various stages of change in smoking cessation. Despite the make-believe environment and timeline, it was useful and instructive to see her progress through the stages from visit to visit. In her struggle with cigarettes, I saw my own struggle with weight loss. The same struggle that so many people go through as they try to conquer their own BMIs.

Precontemplation. The days before I realized that I was more than just “big-boned,” when I convinced myself things were fine. Food was delicious, life was short, my weight had plateaued. I had no time to exercise.

Contemplation. Looking at pictures tagged on Facebook and not liking what I saw. The sense of disgust when you feel too full to move and only then realize how much you had eaten. The promise you make to yourself when you hear the statistics about heart disease. The inspiration you feel when, here and there, a victor emerges in the Food Fight.

Preparation. The plan. How am I going to do this? What didn’t work about the diet last year? I’m about to start interviewing at medical schools and I need to start acting the part, practicing what I preach. I guess I should look up the gym hours.

Action. Only two pieces of pizza. I know the cake looks good, but vegetables and hummus are just as tasty. Right? Finding a way to fit in time for the gym every day, even if it means scurrying across the parking lot in the snow.

Maintenance. What? I can’t go back to my old ways? I guess that’s what they mean by changing your lifestyle.

As I reflected more, I felt a more appropriate term would be “Cycle of Change.” Action isn’t the end. Not even maintenance. Change is a vicious cycle and relapse is the enemy. The Food Fight rages on with no cease-fire in sight.

Shortly before embarking upon my own weight-loss journey, my older cousin achieved what I never before thought possible. Growing up, we were always the big kids in the family. We were both plagued with thinner siblings and a love of calorie-packed foods. But she was much bigger than I was. In fact, in my own way, I was able to make myself believe that my own weight wasn’t that bad because it was nowhere near as bad as hers.

Then everything changed. She made a decision to change her life and lost nearly 200 pounds. I don’t know what clicked for her this time. I’m not sure if she does, either. I have rarely been more proud of anybody in my entire life and was overjoyed to see her success. The only downside: now I was the only fat one. I had no more excuses.

By this time, I was an adult. I had no one to answer to but myself. Nobody to blame for my habits but myself.

With my cousin’s victory as the final catalyst, I waded into the trenches. The most epic fight of my life thus far.

I decided, once again, that it was time for a change. I began my final year of college, submitted my medical school
applications, and made a promise to myself that this time I was really going to lose weight.

I waited in line at the Subway in the hospital cafeteria. An obese man verbally constructed his sandwich a couple of spots in front of me in line. A hospital visitor, his wristband told me. Presumably here to visit a sick friend. Or family member. Or child. He had ordered a foot-long steak and cheese. It looked delicious. Maybe he was going to split it. Maybe he was going to gobble it all down himself. Maybe it wasn’t even for him and he had a healthy lunch packed back in the room.

Between us were two hospital workers in green scrubs. After the man paid for his meal and departed, one of them commented, “I think he could have used half a sandwich. Or maybe a salad, instead.”

“It surprises me that they even offer food like that in the cafeteria. Not exactly staving off obesity,” the other added. They laughed. I didn’t.

It’s so easy to fall into the trap of moral superiority. Assumptions made about the moral weakness of a patient who can’t quit smoking. Can’t put down the gin and tonic. Can’t stop shooting heroin. Can’t shed those last few pounds. It’s almost easier for us that way. We remove ourselves from the puzzle. It’s their failure, not our failure. I wonder if either of those employees ever had to worry about their own weight. I wondered if either of them ever had to counsel patients about changing the way they eat.

My Food Fight is a personal one. The war against obesity that our country and our profession is waging is really a series of personal struggles. Stories of people who hate what they look like. People who love food and don’t care about the supposed risks. Former athletes whose metabolism has played a dirty trick on them. Mothers who can’t afford healthy food. Hard-working individuals who have already lost the weight—three times. Sons and daughters cursed by the genetics of ancestors they never knew. Patients dealing with more pressing health concerns. Addicts struggling with more difficult life changes. Teenagers who can’t run around outside because it’s not safe. Lawyers who barely have time to grab a bite to eat, let alone cook. Frustrated hypertensive patients who really have tried their best for years. The thirty-two year old who was teased in grade school. The sixty-eight year old for whom this just became an issue.

We are their allies. Here not to judge, but to offer assistance. To not roll our eyes. To not throw the food back in their faces. To stand with them on the front lines if they are willing to fight. To trudge with them through boot camp. I remember the doctor visits of my past, standing on the scale, watching the nurse push the weight higher and higher. Sometimes there was no acknowledgment of the obvious. Moving to the “250” part of the scale was enough. Sometimes there was the half-hearted banter about trying to lose weight. What I needed was an ally who recognized the difficulty, who would congratulate me on past success, who could reaffirm my desire to lose weight, who would simply ask, “How do you think I can help you?”
They say each journey begins with a single step. Mine began with a single lap. After doing some soul searching, I realized that the one thing I had never really tried in the past when trying to lose weight was exercising. I knew that if I was going to be successful this time, I needed to incorporate exercise into my life. And the only way was to do what I’d never done before: run. I started a “couch to 5k” program that I found online one afternoon. The first couple of weeks were horrible. I simply could not understand how people ran a full mile, let alone 3.1 miles or 26.2 miles. But eventually I was able to run half a mile. Then two. Then three. I stopped making excuses and fit exercise into my day instead of only going to the gym when I had free time.

I changed the way I ate, too. I tried to forgo the desserts. Cut back on the alcohol. Paid attention to portions. Didn’t go back for thirds. Packed my own lunch. Drank lots and lots of water.

Most importantly, I stepped on the scale every day. At first, it was discouraging, but the number slowly came down. Every new low was another victory. It was slow going, though. After all, I was still in college! Plus, I was interviewing for medical school. Traveling back and forth across the country every other weekend and eating the delicious pastries they put out in the morning—not taking one would be rude. Coping with the stress of uncertainties that plagues seniors about to enter the real world.

Then, finally, the magic happened: people began to notice. Friends, family, and even strangers started making comments about how good I looked. It was invigorating and kept me going. After an unforgettable senior year, I stood on the scale one day in May before graduation and moved the scale balance to the “200” mark. 249 pounds. Another victory.

I graduated, celebrated, and drove across the country with my girlfriend. Back in Arizona that summer, I sweat off another dozen or so pounds with the help of a particularly pushy personal trainer. Before I knew it, I was walking down a busy street in Baltimore to my first day of medical school. Still obese, but more determined than ever to reach the end of my journey. I slaved through anatomy, biochemistry, and genetics, all the while continuing my clash with the scale. I remember getting stares from strangers as I read a dissector on the treadmill, but it was worth it. It was working. I even had to buy a whole new professional wardrobe for my clinical skills class. It was an expensive trip to the mall. It was the best trip to the mall I had ever made.

One cold December morning, I stepped on the scale and the three-digit number I saw began with a one. I can’t even describe what that felt like. By the end of that first semester, my BMI dipped below 30. I had made it: no longer obese.

I went to see my new primary care physician. I was a victor, I thought. A conqueror of obesity. I had won my fight with food and was proud to step on that scale in a fresh environment
and not have the label of “obese.”

It was a standard history and physical. She did everything right. Personal medical history, family history, review of systems. When we finished, one of the first sentences out of my doctor’s mouth was, “Your BMI is 28.8. We like it to be below 25. Have you ever thought about trying to lose a few pounds?”

I flushed. What she was saying was true—I was still overweight. In my Food Fight, I guess I had forgotten about the other categories below a BMI of 30. I had come so far only to fall short. My “ideal” weight was still twenty plus pounds away. My thoughts raced as I stammered, “Actually . . . um . . . I’ve lost about 100 pounds in the last year.”

She looked at me for a moment. I knew what must have been going through her head. It had gone through mine a hundred times before as I stumbled through my patient interviews as a medical student: I said the wrong thing. How do I recover?

“Oh. Wow! You lost this weight on purpose?”

“Yeah. I exercise about five days a week and I try to watch what I eat.”

“That’s amazing. Congratulations! You should be very proud.”

I am proud. It’s a weird sense of pride. To be proud of yourself for doing things that you know you should be doing anyway. To be proud of taking care of your body. To be proud of finally starting to look like most of your peers have looked their entire lives.

At the end of the visit, my doctor asked one last question. “I have to ask. I have so many patients that struggle with their weight. If I may, how did you lose all the weight?”

Fair question. I’ve been asked that a thousand times by family, friends, and strangers. I’m still not sure how to answer.

“I lost weight by dieting and exercising. Mostly exercise, I would say,” I replied. “But there isn’t really a secret. You have to want it. You have to commit yourself to it. And I don’t know what was different for me this time than the previous dozens of times that I tried. This time it worked.”

Driving home, I was bothered by my answer. I didn’t just have trouble explaining to someone else why I was able to lose weight, I had trouble explaining it to myself. I had dieted many times before, reached many points in my life when I had said “now or never.” I guess this time I had the motivation of seeing someone close to me achieve weight loss success. This time I had the motivation of becoming a healthy role model for my future patients. This time I had the motivation of being in a serious relationship with my now-wife. But I don’t even know if that is the whole answer. There were always motivating factors in previous attempts. This time I pushed through and something clicked. I finally moved past the Action point of my cycle into that place between Action and Maintenance that we never talk about: Success. I made a lasting change.

I don’t think there is a secret. No trump card that I can dish out to my patients. No battle-ending move. No checkmate. No motivational speech that could turn that CDC map blue. It was a combination of motivation, luck, and timing.

I think I finally realized a message that I could share with patients: Losing weight is hard. It’s probably the hardest thing I’ve ever done. It’s something that is still very much a part of my life after three years, and that will probably always be a part of my life, like cigarettes for a former smoker. But victory is possible if you persevere. If you commit. You might fail or relapse, despite your best effort, but you can regroup, tweak your strategy, and attack from a different angle. Someday, you just might win.

Relapse. The word still sends shivers through my spine every time I think back to the Stages of Change. I’ve been able to maintain my new weight for over two years now, but I suspect some sort of relapse is inevitable. The fear grips me every time I see the numbers creep back up on the scale. Working exercise into my schedule becomes more difficult with every passing month, and I see my old eating habits slowly inching their way back into my life. It’s proud of what I’ve done and I truly believe I have made some permanent lifestyle modifications, but only time will tell the story of my success. I may have won a decisive victory, but the war, the Food Fight, continues.

Soon I will be a doctor. I will enter the trenches of medicine’s war on food, on infection. The battles we wage are many. And the map continues to turn a deeper shade of red.

I don’t know what the answer is. We can’t legislate the problem away. We probably won’t find a pill that melts the pounds, or a gene that explains why we can’t put down the cupcakes. We can try to incentivize good behavior, but—really—we need to rethink how we live our lives. But that will take years, or generations.

In the meantime, we can be there for our patients. Every patient is fighting his or her own war. For some, that war is with food. We can join them in the Food Fight. Every patient’s battle means something different—for me, for Carlos, for the man at Subway, or the frustrated patient sitting across from you in clinic. We know the different battles of many individuals, every day. We can learn the art of war and pass on the hope of victory. We can ask how we can help. Patients are on different parts of their journeys through life and we have the privilege of being invited to walk with them, if only for a few steps, a mile, a marathon, or a spin on the elliptical. If there’s one thing I’ve learned on my own journey, it’s that food fights are messy, but so is being a doctor.

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On July 1 and 2, 2013, Alpha Omega Alpha, with support from a President's Grant from the Josiah Macy Jr. Foundation, sponsored a meeting in New York City on medical professionalism. The host of the meeting for Alpha Omega Alpha was Richard L. Byyny, MD, Executive Director of the society.

The focus of the meeting on July 1 was Use of Systems to Enhance Professionalism. July 2 centered on Best Practices for the Remediation of Lapses in Professionalism.

Moderating the meeting were:
- Douglas S. Paauw, MD, Professor of Medicine, Rathmann Family Foundation Endowed Chair for Patient-Centered Clinical Education, and Head of the Section of General Internal Medicine, University of Washington School of Medicine
- Maxine Papadakis, MD, Professor of Medicine and Associate Dean for Student Affairs, University of California, San Francisco, School of Medicine

Presenting were:
- Catherine Lucey, MD, Vice Dean for Education, University of California, San Francisco, School of Medicine, “21st Century Professionalism: New Thinking about an Old Topic”
• Rebecca Saavedra, MD, Vice President for Strategic Management, University of Texas Medical Branch, “Interprofessional Systems to Enhance Professionalism”

Gerald B. Hickson, MD, Joseph C. Ross Chair of Medical Education and Administration, Professor of Pediatrics, and Associate Professor of Family and Health Systems Nursing, Vanderbilt University School of Medicine, “Pursuing Professionalism (But Not without a System)”

• Jo Shapiro, MD, Chief, Division of Otolaryngology in the Department of Surgery and Director of the Center for Professionalism and Peer Support at Brigham and Women's Hospital, “Cultural Transformation in Professionalism”

• Richard M. Frankel, PhD, Professor of Medicine and Geriatrics, Indiana University School of Medicine, Director of the Mary Margaret Walther Center for Palliative Care at the Simon Cancer Center, and Associate Director of the VA Center of Excellence in Implementing Evidence Based Practice at the Richard L. Roudebush VAMC, “Remediating Unprofessional Behavior in Medical Students: Each School an Island?”

• Anna Chang, MD, Associate Professor of Medicine and Director, Foundations of Patient Care Course, University of California, San Francisco, School of Medicine, “Clinical Skills Remediation: Strategies for Intervention of Professionalism Lapses”

• Dennis H. Novack, MD, Professor of Medicine and Associate Dean of Medical Education, Drexel University College of Medicine; and Deborah Ziring, MD, Assistant Professor of Medicine, Drexel University College of Medicine, “How Do Medical Schools Identify and Remediate Students with Professionalism Lapses?”

Other attendees:

• C. Bruce Alexander, MD, Professor and Vice Chair, and Residency Program Director, Department of Pathology, University of Alabama School of Medicine; President, ΛΩΑ Board of Directors

• Carol Aschenbrener, MD, Executive Vice President and Chief Strategy Officer, Association of American Medical Colleges

• William T. Branch, Jr., MD, Director, Division of General Medicine and Vice Chairman for Primary Care, Emory University School of Medicine

• Holly J. Humphrey, MD, MACP, the Ralph W. Gerard Professor in Medicine and Dean for Medical Education at the University of Chicago Division of the Biological Sciences, The Pritzker School of Medicine.

• Gail Morrison, MD, Professor of Medicine, Vice Dean for Education, and Director of the Office of Academic Programs, Raymond and Ruth Perelman School of Medicine at the University of Pennsylvania

• Maria Savoia, MD, Dean of Medical Education, University of California, San Diego School of Medicine

• George E. Thibault, MD, President, Josiah Macy Jr. Foundation

• Geoffrey H. Young, PhD, Senior Director of Student Affairs and Student Programs, Association of American Medical Colleges
She has become an intruder in my household. Possessed by an intruder of her own, visible only in its invisibility, recognized by all.

She prowls in the dark of night preceded by uriniferous scent and clicking teeth.

The creaking floor betrays her presence. Looking up, I see her glaring at me. “Where did you hide my bras . . . I know you hid them.”

Frequent vitriolic eruptions and foul language never before heard from a once religious woman. Now incontinent of faculties and functions, to remain ever so.

Sadly, loss of tangible reconciliation partners with dark appeal.

Dennis F. Devereux, MD

Dr. Devereux (αωα, Robert Wood Johnson Medical School, 1987) is a member of Albemarle Surgical Associates in Albemarle, North Carolina. His address is: Albemarle Surgical Associates, 103 Yadkin Street, Albemarle, North Carolina 28001. E-mail: dennis.devereux@stanly.org.
Reviews and reflections

David A. Bennahum, MD, and Jack Coulehan, MD, Book Review Editors

The book review editors request that books for potential review be approved by the editors before the reviews are written. Reader interest and space are always considerations in this section and unsolicited reviews may be rejected. Contact Dr. Bennahum at dbennahum@salud.unm.edu and Dr. Coulehan at john.coulehan@storybrookmedicine.edu.

Enhancing the Professional Culture of Academic Health Science Centers: Creating and Sustaining Research Communities

Thomas S. Inui (ΔΩΑ, Johns Hopkins University, 1988) and Richard M. Frankel, editors
Reviewed by Jack Coulehan, MD (ΔΩΑ, University of Pittsburgh, 1969)

In the final chapter of Enhancing the Professional Culture of Academic Health Science Centers, Richard Frankel and Thomas Inui write, “We are encouraged by the generosity of spirit that fills these pages.” They then conclude the book with their vision of a new culture for biomedical research, a multidisciplinary community of scientists “sharing our dreams, exchanging our inspirations, listening intently to our young, and setting out daily in new directions on the journey we have chosen.”

It’s an inspiring vision, but hardly the state of affairs in today’s cutthroat world of biomedical research. Neither sharing dreams nor listening to students ranks high among the priorities of America’s major research institutions. Yet, the genius of Inui and Frankel’s book—subtitled “Creating and Sustaining Research Communities”—is to show that a number of such multidisciplinary, relationship-based communities do, in fact, exist and at least some thoughtful scientists consider human relationships to be of fundamental importance in their research. The editors describe the process of appreciative inquiry, during which they conducted open-ended one-on-one interviews with twelve researchers of varied backgrounds and specialties, asking each individual to tell the story of one incident or situation “in which you have felt your best as a scientist.”

Most of the book consists of these stories, supplemented by each narrator’s reflections on his or her institutional program and personal experience. Appreciative inquiry is a technique that locates the energy or spirit of an institution in participants’ stories about their best work experiences; in this case, investigators and administrators relate stories of professional fulfillment. The reported incidents vary widely, but they cluster around a small number of themes: successful mentoring of trainees, persevering after initial failure, building trusting relationships with colleagues, using skills to help others, and convening or participating in a team “who loved to learn together.”

Several chapters are devoted to fleshing out the “multidisciplinary community of researchers” concept. For example, in “Breaking out of the Silos in the Heartland,” Anantha Shekhar describes the creation of a statewide Translational Science Laboratory in Indiana through the development of a network of institutional relationships and a successful application for an NIH Clinical and Translational Science Award (CTSA). The chapter on Seattle’s Group Health experience is another example. Eric Larson, Christine Tachibana, and Edward Wagner recount the development of the Group Health Research Institute (GHRI) and list a number of its myriad contributions to translational research. One important clinical example of synergy between Group Health’s clinical practice and GHRI is the team-based, patient-centered care model for patients with chronic illness, which arose from the findings of a number of GHRI studies.

Other chapters focus more specifically on interpersonal process. “The Relationship-Centered Care Research Network” by Richard Frankel and colleagues tells the story of the network’s creation and maturation during a series of informal meetings of eleven researchers that took place over four years, mostly at participants’ homes, with the help of an external facilitator. Network members attribute much of the group’s success to this context of freedom from “the ordinary constraints of doing science,” and being able “to relate to others personally as well as professionally.”

“Carrying a Center of Excellence through a Critical Transition in Leadership” explores interpersonal process at a different level, in this case an effective collaboration by senior investigators to steer a Department of Veterans Affairs Health Services Research and Development Center through an unexpected transition in leadership. The most significant lesson from this process was that “a successful center is built from strong relationships.”

Richard Gunderman’s story is one of the most engaging in the book. For nine years Gunderman helped care for a young man who suffered from
severe and progressive neurological disease. Many at the hospital criticized the team for investing so much time and effort prolonging the life of a patient who was “barely there” and terminally ill. When the young man died, his parents asked Gunderman to make some comments at the funeral. In reflecting on his own feelings, Gunderman realized that “there is something precious in a fragile, brittle life,” p110 no matter how limited. This realization gave Gunderman a feeling of immense gratitude, when he “felt at [his] best as a scientist.” In the rest of the chapter, with the help of the Book of Genesis, Gunderman explores the role of dreams in science. Yes, you read correctly: dreams. The author is not referring here to random eye movements during sleep, but rather to the remembered content of dreams, as well as the generic use of that word for visions, ideals, and aspirations. The chapter’s title is “Cultivating the ‘Research Mind’—Reason, Dreams, Discovery.” Gunderman’s point is that creative imagination is just as essential to the “research mind” as is reason and it must be cultivated—not suppressed, as is often the case in academic environments.

In their epilogue Frankel and Inui evoke another dimension of the creative life: sharing one’s dreams. They explain that in some Australian Aboriginal traditions people gather around the fire each morning to share memories of their dreams to assist them in communal decision making. “It is thought that the dreams of children are most important . . . [because children] have fresher imagination, less confusion about the reality of their dreams, and are a more secure source of creative thought.” p193 Application to biomedical research? Imagination, communication, trusting relationships, and willingness to learn from our students.

It is remarkable that the final thoughts of Enhancing the Professional Culture of Academic Health Science Centers are about sharing and dreaming. Inui and Frankel’s appreciative inquiry represents out-of-the-box thinking about scientific progress because it puts a premium on the lived experience of research and takes community seriously. Their book is the third volume of a series from Radcliffe that has the overall title, Culture, Context and Quality in Health Sciences Research, Education, Leadership and Patient Care. If the others are similarly enlightened, the series should be a significant contribution to conceptualizing tomorrow’s academic health sciences center.

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Hippocrates Cried: The Decline of American Psychiatry
Michael Alan Taylor
New York: Oxford 2013

Reviewed by Michael Schwartz, MD

Hippocrates Cried: The Decline of American Psychiatry by Michael Alan Taylor, is a trenchant commentary on the current state of American psychiatry. Dr. Taylor is with the University of Michigan, and prior to that he had been the Chairman of the Department of Psychiatry at Chicago Medical School. Dr. Taylor is extremely critical of what he considers to be psychiatry’s overreaching with regard to areas of claimed expertise and consequent ineffective and unethical methods of practice.

In the past year, the publication of DSM-5, as well as a series of horrifying mass murders and attacks by mentally imbalanced individuals has kept psychiatry and the mentally ill in the spotlight. The medical profession and the larger society tend to view psychiatrists and their patients with ambivalence and suspicion. The broad range of conditions that psychiatrists must consider, the lack of laboratory-based diagnostic assistance, the shame, stigma, and discrimination associated with a psychiatric diagnosis and treatment, along with the micromanagement of practice and payments by third parties, challenge psychiatric clinicians and researchers on a day-to-day basis.

Freud’s explication of the dynamic unconscious and the principles of psychoanalysis (along with its myriad derivatives) in the early twentieth century, coupled with the discovery and development of modern psycho-pharmacology in the mid-twentieth century have been the driving forces in modern psychiatry. Despite advances in neurochemistry, brain imaging, and psychiatric genetics, psychiatrists remain stymied in their ability to understand psychopathology at its most basic level, i.e., at the level of the brain mechanisms that are responsible for psychiatric disorders.

Psychiatry’s status and power is seen as suspect because of its shaky scientific underpinnings and this has opened
the door to a cottage industry of critics of psychiatry and psychiatrists. Some critics espouse radical change while others see the necessity for incremental change. The best known contemporary critic espousing radical change was the late Thomas Szasz, who was of the opinion that mental illness is a myth, and that psychiatrists do not concern themselves with true illnesses; rather, they deal with personal, social, and ethical problems in living.

More conservative, politically entrenched psychiatrists have tended to worry about the erosion of psychiatric authority and the declining public trust in the field. They believe that there needs to be some sort of overarching officially sanctioned scientific paradigm that guides psychiatry and psychiatrists in their work; they just disagree on what that paradigm should be.

Into this fray jumps Dr. Taylor, whose philosophy appears to put him in the camp of the radical critics. It is Dr. Taylor’s opinion that psychiatry is beset by many problems, including the outsize influence of psychoanalytically oriented psychiatrists and pharmaceutical companies, a scope of practice too broad to allow the specialty to put its efforts where needed, and diagnostic laziness and imprecision by its practitioners. Taylor directs his contempt at psychoanalysis, the modern editions of the Diagnostic and Statistical Manual (DSM), the current practice of psychopharmacology, the influence of Big Pharma, residency training in psychiatry, child psychiatry, and even the anti-psychiatry movement. Taylor believes that psychiatry should focus only on neuropsychiatric syndromes that have a clear basis in brain dysfunction. By this he means classical neuropsychiatric syndromes associated with seizure disorders, brain injuries, dementia, delirium, and other conditions like schizophrenia, manic depressive illness, melancholia, and certain anxiety disorders. He is dismissive of psychiatrists interested in less “severe” (i.e., neurotic) conditions. Although many of these conditions are now understood to be the result of neurologically based differences in temperament, influenced and shaped by critical experiences during development, and ultimately manifested as maladaptive personality traits, Taylor believes that these conditions have no place in modern psychiatric practice. Moreover, he condemns the gold standard treatment for these conditions, psychoanalysis, as completely ineffective.

Taylor worries that psychiatrists do not commonly think about including neurological conditions, particularly seizure disorders, in their differential diagnosis. He is angered that the pharmaceutical industry has had undue influence on the way that psychiatry is practiced, effectively promoting expensive drugs that are not as effective as older medications. Finally, he accuses the field of having been seduced by a research paradigm mentality, while giving only lip service to the goal of clinical excellence.

Many of these criticisms will not be new to longtime practitioners and observers of psychiatry. Nevertheless, they demand thoughtful rebuttal. Unfortunately the tone of Dr. Taylor’s criticism contains a degree of hostility and contempt for psychiatry and his fellow psychiatrists that I found off-putting. Successful psychiatrists learn early on that the key to facing the daily challenges of psychiatric practice is to maintain a positive and supportive attitude, in spite of the many challenges that face us and our patients.

The book is generously sprinkled with cases histories of patients who presented with complaints that proved resistant to standard psychiatric therapies and who were then referred to the tertiary centers that Dr. Taylor was associated with. When Dr. Taylor consulted, he often uncovered a neuropsychologically based explanation for these conditions. Besides being great cases to learn from, they remind us that it is all too easy to become intellectually lazy in the day-to-day practice of psychiatry and fail to consider medical and neurological conditions as part of the differential diagnosis of patients who do not respond as expected.

Dr. Taylor is a little more on target with his criticisms of the embrace of newer psychopharmacological agents. He contends that the newer medications have not delivered on the promise of either being more efficacious or safer than older medications. In fact, the older medications may be more effective. Furthermore the marketing of these medications as safer than older medications has led to widespread usage of psychotropic drugs and broadening of diagnostic categories to the point of meaninglessness in order to justify their use. He sees this process as driven by the pharmaceutical industry and influential academic psychiatrists who have colluded with them over the years.

Dr. Taylor asks whether psychiatrists will still be needed by the end of this century. Already most mental conditions are treated by nonpsychiatrists who are viewed by many as less expensive and equally effective. If psychiatry is to survive, he thinks that its salvation lies in the embrace of neuropsychiatry, a subspecialty that avoids the fuzziness of thinking that he obviously detests. While Dr. Taylor is clearly opinionated, he has earned the right to these opinions, and readers who can get past his cantankerousness will find much food for thought.

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I got to know Bob Moser in 2001 when he became the book review editor for The Pharos. For the next three years, we talked on the phone every couple of weeks, discussing books and reviews and all the things he was doing in his life. He told me about his spinal stenosis and the high-tech surgery he had for it, his bike accident (this in his 80s), his wife Linda’s cat rescue operations, the sale of his home in New Mexico, his travels, his son’s death.

Bob was interested in almost everything and everyone. He wanted to know all about the ΩΩΑ office, my cats, The Pharos, and my childhood in Hawaii, where he had also lived and worked. Bob was witty, opinionated, and fun. As we continued our chats, it gradually dawned on me that he had had quite a life: service and decorations in the Korean War, medical flight controller for the NASA Mercury and Apollo programs, chief of Medicine at Walter Reed, editor-in-chief of JAMA, executive vice president of the American College of Physicians. More of his background emerged in the articles he wrote for The Pharos: “Mene, Mene, Tekel, Upharsin Comes to Medicine” (Fall 1999), “The Korean Experience: Vignettes from Cloister to Chaos and Back” (Summer 2002), “My Romance with Space” (Autumn 2003), and “Mene, Mene, Tekel, Upharsin Comes to Medicine—Redux” (Autumn 2009).

Bob was not one to sit back and relax in his retirement—one year he volunteered to read and review all the essays submitted to the ΩΩΑ Student Essay Competition. He raced through the more than fifty essays and wrote detailed reviews for each. From that year until this, he continued to read and review them all in a marathon session each February and March.

After Bob retired as the book review editor we kept in touch and he stayed involved in The Pharos, writing reviews, letters, and commentaries. In June the word came: pancreatic cancer. When I asked him if he would like to write one last article for The Pharos, a final laying-down-of-the-law for the profession, he said he was too tired. I knew the end must be near.

Bob died in hospice care in early August. I miss him dearly, but I know that the profession of medicine is richer for his life.

Debbie Lancaster
Managing Editor, The Pharos
Beginning in 2002, Alpha Omega Alpha’s board of directors offered every chapter and association the opportunity to host a visiting professor. Sixty-seven chapters took advantage of the opportunity during the 2012/2013 academic year to invite eminent persons in American medicine to share their varied perspectives on medicine and its practice.

Following are the participating chapters and their visitors.

ALABAMA
University of Alabama School of Medicine
James Madara, MD, University of Chicago Division of the Biological Sciences The Pritzker School of Medicine and the American Medical Association

ARIZONA
University of Arizona College of Medicine
David Alan Fox, MD, University of Michigan Medical School

ARKANSAS
University of Arkansas for Medical Sciences College of Medicine
Wesley Burks, MD, University of North Carolina Children's Hospital

CALIFORNIA
Loma Linda University School of Medicine
Timothy Brigham, MD, Association of American Medical Colleges
University of California, Davis, School of Medicine
Anthony Iton, MD, JD, MPH

DISTRICT OF COLUMBIA
George Washington University School of Medicine and Health Sciences
Mitchell Krucoff, MD, Duke University School of Medicine

FLORIDA
Florida State University College of Medicine
Steven Kanter, MD, University of Pittsburgh School of Medicine
University of Florida College of Medicine
Richard Gunderman, MD, PhD, Indiana University School of Medicine and AΩA Board of Directors
University of Miami Leonard M. Miller School of Medicine
Faith Fitzgerald, MD, University of California, Davis, School of Medicine

USF Health Morsani College of Medicine
Douglas Barrett, MD, University of Florida College of Medicine

GEORGIA
Medical College of Georgia at Georgia Regents University
Joseph Stubbs, MD, Albany Internal Medicine and AΩA Board of Directors

Mercer University School of Medicine
Randolph Canterbury, MD, University of Virginia School of Medicine

Morehouse School of Medicine
Erich Jarvis, PhD, Duke University School of Medicine

ILLINOIS
Chicago Medical School at Rosalind Franklin University of Medicine & Science
Kevin Weiss, MD, MPH, Accreditation Council for Graduate Medical Education

Loyola University Chicago Stritch School of Medicine
Hope Haefner, MD, University of Michigan Medical School

University of Chicago Division of the Biological Sciences The Pritzker School of Medicine
David Ansell, MD, MPH, Rush Medical College of Rush University Medical Center

INDIANA
Indiana University School of Medicine
Richard Lofgren, MD, MPH, FACP, Indiana University School of Medicine

IOWA
University of Iowa Roy J. and Lucille A. Carver College of Medicine
Ben Carson, MD, Johns Hopkins University School of Medicine

KANSAS
University of Kansas School of Medicine
Gerald Kerby, MD, MACP, University of Kansas School of Medicine

LOUISIANA
Louisiana State University School of Medicine in New Orleans
C. Bruce Alexander, MD, University of Alabama School of Medicine and President, AΩA Board of Directors
Louisiana State University School of Medicine in Shreveport
Ruth Parker, BS, MD, Emory University School of Medicine
Tulane University School of Medicine
Stephen Katz, MD, National Institutes of Health

MARYLAND
Johns Hopkins University School of Medicine
Daniel Sulmasy MD, PhD, University of Chicago Division of Biological Sciences The Pritzker School of Medicine

Uniformed Services University of the Health Sciences F. Edward Hébert School of Medicine
Colonel Todd Rasmussen, MD, Uniformed Services University of the Health Sciences F. Edward Hébert School of Medicine

University of Maryland School of Medicine
Fitzhugh Mullan, MD, George Washington University School of Medicine and Health Sciences

MASSACHUSETTS
Boston University School of Medicine
Richard Gunderman, MD, PhD, Indiana University School of Medicine and AΩA Board of Directors

Tufts University School of Medicine
T. R. Reid

MICHIGAN
Michigan State University College of Human Medicine
John Penner, MD, Michigan State University College of Human Medicine

University of Michigan Medical School
Ben Carson, MD, Johns Hopkins University School of Medicine

Wayne State University School of Medicine
Richard Gunderman, MD, PhD, Indiana University School of Medicine and AΩA Board of Directors

MINNESOTA
University of Minnesota Medical School
Robert Baron, MD, MS, University of California, San Francisco, School of Medicine

MISSISSIPPI
University of Mississippi School of Medicine
Gene Hoyne, MD, Sanford School of Medicine of the University of South Dakota
MISSOURI
Saint Louis University School of Medicine
Stefan Friedrichsdorf, MD, University of Minnesota Medical School
University of Missouri—Kansas City School of Medicine
Judith Bowen, MD, Portland Veteran's Affairs Medical Center

NEBASKA
University of Nebraska College of Medicine
Samuel Benson, MD, PhD, Registry of Physician Specialists

NEVADA
University of Nevada School of Medicine
John Pelley, PhD, Texas Tech University Health Sciences Center School of Medicine

NEW JERSEY
Rutgers, Robert Wood Johnson Medical School
Norman Edelman, MD, Stony Brook University School of Medicine

NEW MEXICO
University of New Mexico School of Medicine
David Grimes, MD, University of North Carolina at Chapel Hill School of Medicine

NEW YORK
Albany Medical College
Kimberly Davis, MD, MBA, FACS, Yale University School of Medicine
Columbia University College of Physicians and Surgeons
Daniel Lowenstein, MD, University of California, San Francisco, School of Medicine
Icahn School of Medicine at Mount Sinai
Karen DeSalvo, MD, MPH, MSc, Tulane University School of Medicine
New York Medical College
Joseph Fins, MD, Weill Cornell Medical College
State University of New York Downstate Medical Center College of Medicine
Robert Nussenblatt, MD, MPH, National Institutes of Health/National Eye Institute
State University of New York Upstate Medical University
Patrick Basile, MD, LCDR, MC, USN, Walter Reed National Military Medical Center
University of Rochester School of Medicine and Dentistry
Holly Atkinson, MD, Icahn School of Medicine at Mount Sinai

NORTH CAROLINA
Wake Forest School of Medicine of Wake Forest Baptist Medical Center
John Tarpley, MD, Vanderbilt University School of Medicine

OHIO
Case Western Reserve University School of Medicine
Richard Gunderman, MD, PhD, Indiana University School of Medicine and AΩA Board of Directors
Northeast Ohio Medical University
John Pelley, PhD, Texas Tech University Health Sciences Center School of Medicine
Ohio State University College of Medicine
Richard Schwartzstein, MD, Harvard Medical School

PENNSYLVANIA
Jefferson Medical College of Thomas Jefferson University
Steven Larson, MD, Hospital of the University of Pennsylvania
Pennsylvania State University College of Medicine
Richard Gunderman, MD, PhD, Indiana University School of Medicine and AΩA Board of Directors
Temple University School of Medicine
Paul Farmer, MD, Harvard College and Harvard Medical School

PUERTO RICO
Ponce School of Medicine and Health Sciences
Ana Puga, MD, Ponce School of Medicine and Health Sciences
Universidad Central del Caribe School of Medicine
John Prescott, MD, Association of American Medical Colleges
University of Puerto Rico School of Medicine
Chaim Colen, MD, PhD, Oakland University William Beaumont School of Medicine

SOUTH CAROLINA
Medical University of South Carolina College of Medicine
Paul Goepfert, MD, University of Alabama School of Medicine
University of South Carolina School of Medicine
John Prescott, MD, Association of American Medical Colleges

SOUTH DAKOTA
Sanford School of Medicine The University of South Dakota
Keith Lillemeoe, MD, Massachusetts General Hospital and Harvard Medical School

TENNESSEE
University of Tennessee Health Science Center College of Medicine
Layton Rikkers, MD, University of Wisconsin School of Medicine and Public Health
Vanderbilt University School of Medicine
Martin Kohn, MD, Massachusetts Institute of Technology

TEXAS
University of Texas Medical Branch School of Medicine
Ronald Rapini, MD, University of Texas Medical School at Houston
University of Texas Medical School at Houston
Thomas Force, MD, Temple University School of Medicine

VERMONT
University of Vermont College of Medicine
Richard Gunderman, MD, PhD Indiana University School of Medicine and AΩA Board of Directors

VIRGINIA
University of Virginia School of Medicine
Aaron Vinik, MD, PhD, Eastern Virginia Medical School
Virginia Commonwealth University School of Medicine
Doris Trauner, MD, University of California, San Diego, School of Medicine

WEST VIRGINIA
Marshall University Joan C. Edwards School of Medicine
Jeanette Norden, BA, PhD, Vanderbilt University School of Medicine
West Virginia University School of Medicine
Catherine DeAngelis, MD, MPH, Johns Hopkins University School of Medicine
This award recognizes the AΩA chapter administrators who are so important to the functioning of the chapter or association. The nomination is made by the councilor or other officer of the chapter. A gift check is awarded to the individual, as well as a framed Certificate of Appreciation.

The following awards were made in 2012/2013:

**CALIFORNIA**
University of California, Davis, School of Medicine
Lao Thao

**INDIANA**
Indiana University School of Medicine
Ruth Patterson

**MICHIGAN**
University of Michigan Medical School
Charlotte Pierson

**NEBRASKA**
University of Nebraska College of Medicine
Vicki Hamm

**TEXAS**
Texas Tech University Health Sciences Center School of Medicine
Kim Johnson

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Lao Thao, Kim Johnson, Vicki Hamm, and Ruth Patterson.

Charlotte Pierson flanked by AΩA President Hasan Siddiqi and AΩA Vice-President Megan Beems.
The Alpha Omega Alpha Volunteer Clinical Faculty Award is presented annually by local chapters or associations to recognize community physicians who have contributed with distinction to the education and training of medical students. AΩA provides a permanent plaque for each chapter's dean's office; a plate with the name of each year's honoree may be added each year that the award is given. Honorees receive framed certificates and engraved key rings. The recipients of this award in the 2012/2013 academic year are listed below.

CALIFORNIA
University of California, Davis, School of Medicine
James Wiedeman, MD

DISTRICT OF COLUMBIA
George Washington University School of Medicine and Health Sciences
Hrant Semerjian, MD
Howard University College of Medicine
Juanita Archer, MD

GEORGIA
Medical College of Georgia at Georgia Regents University
Timothy Kinsey, MD

HAWAII
University of Hawaii, John A. Burns School of Medicine
David Waters, MD

ILLINOIS
Chicago Medical School at Rosalind Franklin University of Medicine & Science
Gail Bryant, MD
University of Chicago Division of the Biological Sciences The Pritzker School of Medicine
Michael Hughey, Jr., MD

INDIANA
Indiana University School of Medicine
Chad Davis, MD

IOWA
University of Iowa Roy J. and Lucille A. Carver College of Medicine
Shawn Jones, MD

KANSAS
University of Kansas School of Medicine
Greg Thomas, MD

KENTUCKY
University of Louisville School of Medicine
Jon Miller, MD

LOUISIANA
Tulane University School of Medicine
Raj Warrier, MD

MARYLAND
Johns Hopkins University School of Medicine
Catherine Parrish, MD
University of Maryland School of Medicine
Julio Menocal, MD

MICHIGAN
University of Michigan Medical School
Etienne Deboorne, MD

NEBRASKA
University of Nebraska College of Medicine
Jerry Seiler, MD

NEW JERSEY
University of Medicine and Dentistry of New Jersey—New Jersey Medical School
Ravi Munver, MD

NEW YORK
Icahn School of Medicine at Mount Sinai
Gaines Mimms, MD
New York Medical College
Benjamin Dodoo, MD
New York University School of Medicine
Paula Prezioso, MD
State University of New York Downstate Medical Center College of Medicine
Pierre G. Zalzal, MD
State University of New York Upstate Medical University
George Stanley, MD
University of Rochester School of Medicine and Dentistry
Daniel Yawman, MD
Weill Cornell Medical College
Morton Bogdonoff, MD

NORTH DAKOTA
University of North Dakota School of Medicine and Health Sciences
Rhonda Schafer McLean, MD

OHIO
Ohio State University College of Medicine
John O’Handley, MD
University of Cincinnati College of Medicine
Marianna Vardaka, MD

PENNSYLVANIA
Drexel University College of Medicine
Bruce Fisher, MD, FACP, FIDSA
Jefferson Medical College of Thomas Jefferson University
Gerald Fendrick, MD
University of Pittsburgh School of Medicine
William Lamb, Jr., MD

SOUTH CAROLINA
University of South Carolina School of Medicine
Michelle Tucker, MD

TENNESSEE
Vanderbilt University School of Medicine
Bradley Bullock, MD

TEXAS
University of Texas Southwestern Medical Center at Dallas Southwestern Medical School
Bruce Faust, MD

VERMONT
University of Vermont College of Medicine
Francis Cook, MD

VIRGINIA
Virginia Commonwealth University School of Medicine
Kara Somers, MD, FAAP

THE PHAROS/autumn 2013

WEST VIRGINIA
West Virginia University School of Medicine
Charles Bradley Franz, MD
On Finding a Slim Volume

(For John Conger, PhD)

I've done it again, John, failing
   to pay attention to what seemed
      a side issue.
Who knew the Dean wrote poetry,
   And if he did—
      while managing a medical campus—
how important
      it might be?
I found out . . . too late,
   that you were a close observer
of the silence of snow, a lover
   of the sudden red, who could discover
the shape of your
   life laid bare.
I imagine the conversations we might have had,
       Forgive me.

Henry N. Claman, MD

Dr. Claman (AOA, University of Colorado, 1979) is Distinguished Professor of Medicine and Associate Director of the Medical Humanities Program at the University of Colorado, Denver. He is a member of the editorial board of The Pharos. His address: Mail Stop B164, Research 2, 12700 E. 19th Avenue, Room 10100, Aurora, Colorado 80045. E-mail: henry.claman@ucdenver.edu.
In 2011, the board of directors of Alpha Omega Alpha established the Postgraduate Award to encourage and support AΩΑ residents or fellows from programs or institutions with an active AΩΑ chapter or association to pursue a project in the spirit of the AΩΑ mission statement. Project applications were accepted in the categories of:

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

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

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

4. Leadership: Leadership development.

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

Nine applicants received $2000 awards to support their work. The recipients of the 2013 awards are:

N. Teresa Bleakly, MD (AΩΑ, University of Washington, 2008)
Stanford University School of Medicine
Project category: Research
Cardiac function in malnourished children: an observational study in an urban hospital in Bangladesh
Yvonne Maldonado, MD, mentor

Christine Dinh, MD (AΩΑ, University of Miami, 2008)
University of Miami Leonard M. Miller School of Medicine
Project category: Research
Effects of dexamethasone on cisplatin ototoxicity in vitro
Thomas Van De Water, PhD, mentor

Adam Gepner, MD (AΩΑ, University of Wisconsin, 2009)
University of Wisconsin School of Medicine and Public Health
Project category: Research
Ultrasound Assessment of Carotid Arterial Stiffness with Speckle Tracking: A New Use of a Novel Imaging Technique for Predicting Cardiovascular Disease Risk
James H. Stein, MD, mentor

Rachel Issaka, MD (AΩΑ, Northwestern University, 2013)
Northwestern University The Feinberg School of Medicine
Project category: Service
Developing and implementing a community based program to increase colorectal cancer screening
Rajesh Keswani, MD, mentor

Brenessa Lindeman, MD (AΩΑ, Vanderbilt University, 2009)
Johns Hopkins University School of Medicine
Project category: Teaching and education
Cognitive Task Analysis to Identify and Assess Development of Competency in Decision-Making and Error Avoidance in Surgical Trainees
Pamela Lipsett, MD, MHPE, mentor

Victoria Mui, MD (AΩΑ, Jefferson Medical College, 2011)
George Washington University School of Medicine and Health Sciences
Project category: Service
Implementation of a Teaching Program for Midwives in Rural Guatemala and Its Impact on Postgraduate Global Health Education
Amr Madkour, MD, mentor

Peter Stanich, MD (AΩΑ, University of Toledo, 2008)
The Ohio State University College of Medicine
Project category: Research
Video capsule endoscopy completion and association with physical activity
Marty M. Meyer, MD, mentor

Talia Swartz, MD (AΩΑ, Mount Sinai, 2011)
Icahn School of Medicine at Mount Sinai
Project category: Research
HIV infection and inflammasome activation
Benjamin Chen, MD, mentor

Kija Weldon, MD (AΩΑ, University of Iowa, 2010)
University of Iowa Roy J. and Lucille A. Carver College of Medicine
Research category: Research
Late-Life Cognitive Outcomes in Schizophrenia: Does Treatment with Antipsychotic Medicines Protect from Alzheimer’s Disease
Susan Schultz, MD, mentor

Are you a multi-AΩΑ family?

Executive Director Richard Byyny and his son Richard are both AΩΑ members. How many AΩΑ members are in your family? Send us an e-mail at multiAOA@alphaomegaalpha.org. List all the AΩΑ members in your family and include the names of the schools at which they received their memberships and the years of induction. Include a photo if you have one. We’ll be publishing a list on our web site and in a future issue of The Pharos.
In this city of lawyers he finds himself held without charge, a prisoner of a totalitarian state of debilitating and unexplained signs and symptoms.

I don't know how much longer I can hold on, he confides at our initial meeting from the confines of his chair, solitary through illness, an aide standing by the door.

Part of the torture comes from not having a name for this.

And so, wearing my white coat like a barrister’s white wig I begin to assemble his case for scientific review—subpoena outside records, consult with colleagues, perform warranted searches of his body and his blood, translate his deposition of pertinent positives and pertinent negatives into a differential—all the while aware his day of justice may never come.

Adam Possner, MD

Dr. Possner (AΩA, University of Michigan, 2000) is assistant professor in General Internal Medicine at Medical Faculty Associates, George Washington University. His address is: Medical Faculty Associates, George Washington University, 2150 Pennsylvania Avenue, NW, Suite 5-416 North, Washington, DC 20037. E-mail: apossner@mfa.gwu.edu.
Scarves are 35 x 35 inches, of 12 m/m silk twill with handrolled hems. Four colorways are available as shown: red/black, turquoise/purple, peach/mint, and navy/lavender, $65 each. Scarf design by J&J Designs of San Francisco (jnjdesigns.biz).

To order, send a check for the appropriate amount to: Alpha Omega Alpha, 525 Middlefield Road, Suite 130, Menlo Park, CA 94025. Or order online at www.alphaomegaalpha.org/store. Price includes shipping and handling.

AΩA’s new scarf highlights the society’s insignia, based on the shape of the manubrium sterni. The center medallion feature the Pharos lighthouse of Alexandria, one of the seven wonders of the ancient world, for which AΩA’s journal is named. The borders are stylized DNA strands.

Alpha Omega Alpha neckties, $45, or freestyle bowties, $38, are fashioned from fine silk by Vineyard Vines of Martha’s Vineyard, Massachusetts.