HEART: Humanism in Medicine

UNIVERSITY OF LOUISVILLE
SCHOOL OF MEDICINE

The newly renovated women's campus Healing Place on S 15th Street

HUMANISTIC, EMPATHETIC, ALTRUISTIC, RELATIONSHIP CENTERED TEAM

An Unconventional Model

by Sarah Khayat, MS2

An egalitarian system boasting peer accountability, genuine camaraderie, and a sustainable economic model is a tall order. Some would say that it is downright impossible. A system like that would be fraught with corruption and abuse; how would order be maintained? Could one hope that established metrics of efficacy and success be met in such a free-for-all working model? I agree, it doesn't seem likely. The closest approximation, however, I believe exists in our very own Louisville community.

The Healing Place is a rehabilitation program that opened its doors 15 years ago and serves more than 600 men and women on two campuses. It's a 'twelve-stepper' that has put Louisville on the map for its remarkably low rates of recidivism, high rates of recovery (65% by most estimates), and for its impressive lineup of services tailored to getting addicts to a level of independence that enables full immersion in civilian life after completion of the program. It espouses a model that does not charge its clients for its services, in stark contrast to the high-brow beach escapes that promise would-be clients resort worthy accommodations tacked onto a drug-free recovery guarantee within mere weeks of treatment and which cost, on average, $3-6,000 per day.

The entire community meets three times a week to discuss personal issues. These meetings are exclusively client-led, and as part of our Healing Place preceptorship, MS2s had the privilege of sitting in on one of them.

After the monthly election to fill housekeeping positions, the room grew almost palpably frenetic. People chatted excitedly and expectantly with their neighbors and it seemed like whatever was coming would be rife with an appreciable degree of controversy. We were told that individual clients could then formally- and respectfully- lodge complaints against other community members on the basis of a lack of adherence to the program; a lapse in responsibility in one's designated job (cook, launderer, grounds keeper, etc) or even just a generally foul attitude not conducive to an environment focusing on treatment and recovery. What ensued was perhaps the most candid and most purely democratic process I have ever witnessed. In a society that prides itself on propriety and parrots the Golden Rule in a context that often frowns upon forthright confrontation, this was anything but 'proper' and non-confrontational. Clients identified themselves and respectfully explained to a room with upwards of 80 people why they took issue with one other person in the room. That person got the opportunity to defend or refute the accusation- how unnerving. The community then decided, as

HOW TO GET INVOLVED WITH HEART

you have questions about or wish to participate in ny of HEART's projects or initiatives, please ontact the designated representatives below.

/e look forward to welcoming new members to our eam!

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Lette from the Editors

In this winter edition of the H.E.A.R.T. Newsletter we have a collection of writings from medical students that see hope in what our community has accomplished and opportunity for change in the many challenges that still exist.

A shared theme among the pieces in this edition is solidarity in healthcare. Whether it's the solidarity of a group that face drug rehabilitation together or the solidarity of physicians with their patients, seeking a more equitable future for healthcare at home and abroad. The writers explore some of the important roles physicians are able to play, not just in patient advocacy and policy considerations, but in the simple, yet invaluable, act of bearing witness to another's plight.

A new writer with the newsletter, Erin Baumgartner (MS2), tells us the story of a patient she met while at a rotation at the Johnson City Community Healthcare Center, in the rural Northeastern corner of Tennessee. This man's severe injuries and lack of health insurance bound him into a cycle of poverty that many others currently share. In our front-page feature, Sarah Khayat (MS2) takes us inside the mechanisms of combating substance abuse at The Healing Place, offering great insight into how they have maintained such amazing success rates on a meager budget. Allison Wilcox (MS3) looks at an article recently published in the New England Journal of Medicine by University of Louisville's own Drs. Stillman and Tailor, and explains what the article, "Dead Man Walking," meant to these two doctors. Francesca Pribble-Kingery (MS2) takes a closer look at the teaching of medical ethics and examines its relevance to those who lack basic access to healthcare. And, Daniel Roberts (MS4) reports from the office of Dr. Erica Sutton, a renowned general surgeon who has created her own change in the system by performing life-saving surgeries for free here in our own city.

A big Thank You to all of our contributing writers and editorial staff as well as to all of those in the hospitals and clinics, practicing untold acts of humanism all in a day's work.

We hope you enjoy and Happy Holidays!

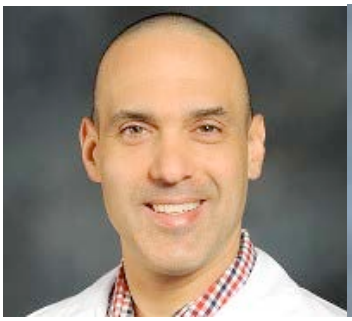
Allison Wilcox, Jessica Huber, Francesca Pribble-Kingery, Ben Belknap, Daniel Roberts, & Pradip D. Patel, MD; Co-Editors

The State of Healthcare & Us

by Allison Wilcox, MS3

From health care costs to insurance marketplaces, the news media are flush with worrisome facts and figures about the US health care system. Recently, the *New York Times* reported that the average cost of an inpatient hospital stay is $4000. In the same article, the *Times* reported anecdotes of patients being charged more than $2000 for a few stitches, and attempted to explain the obscure, even secretive, pricing schemes in large hospital systems. Given the complexities of the finances and politics involved, the news media faces a great challenge both investigating and reporting on the current state of health care. Arguably, the most compelling accounts are those that center on patients and their personal experiences navigating the system.

Often, instead of a journalist, it is a physician who is best able to craft these pieces. Dr. Michael Stillman, Assistant Professor of Medicine and Associate Director for the Internal Medicine Residency Program at UofL, is one such physician-writer. Dr. Stillman has written and published numerous pieces in journals like *JAMA* and *Annals of Internal Medicine*. He explores general themes about the health care system in each of these pieces, but what makes them exceptional is the tenderness and skill with which he shares his patients' stories.



Dr. Michael Stillman

Dr. Monalisa Tailor

Dr. Stillman co-authored his most recent piece, "Dead Man Walking," in the storied *New England Journal of Medicine*, with one of the Department of Medicine's Chief Residents, Dr. Monalisa Tailor. "Dead Man Walking" is a powerful essay that tells the story of Tommy Davis (name changed), a patient of Drs. Stillman and Tailor who lacked insurance or other means of paying high medical bills. As a result, he received substandard preventive care and was first diagnosed with colon cancer after the disease had metastasized – in a single visit to an Emergency Department he spent his life savings to learn this devastating news. Mr. Davis's story is an earnest challenge to physicians to find ways to help their patients – those with insurance and those without. To truly *care* for their patients by helping work toward a system in which healthcare is not something that can be bought only by the wealthy, but something that is available to all.

According to Dr. Tailor, there are many efforts in place at UofL to help patients who cannot afford the standard prices for labs, imaging, and other elements of their healthcare. However, it is a challenge for physicians to gain a firm understanding of hospital pricing, which can make it difficult to help limit their patients' costs.

"The truth is, there's very little formal education at any level about the cost of care," says Dr. Stillman. "We all know it's expensive, we all know that a great deal of what we do is carelessly unnecessary, and we all know that costs of services vary greatly between even neighboring institutions."

Dr. Tailor adds, "Dr. Casper, our program director, is very cost-conscious. We have tried to incorporate the lab and pharmacy costs in some of our orientation material for the residents starting on their wards rotations to give them an idea. The other best thing to do to get a perspective is ask your patients. Mr. Davis brought his ER bill in to his clinic visit, which was the first time I got to see the actual breakdown of a patient's visit. I don't know if there is any better way to learn it."

The compassion that Drs. Stillman and Tailor have for their patients is palpable. Their writing serves to educate and challenge their colleagues and students to comprehend some of the vast challenges that their patients face. It also gives us ideas of how we can help. When asked why he writes, Dr. Stillman summarized his thoughts by saying "when I tell stories—or link stories together—I'm essentially teaching myself lessons. Drawing conclusions. And permitting readers to share in that very personal process. I'm certain I've become a more capable and clear-headed physician for my writing."

When Tommy Davis referred to himself as a "dead man walking" it was a melancholy, heartbreaking truth. But thanks to the work of Drs. Stillman and Tailor at least his story will live on, giving some needed inspiration to the medical community to dig in and work toward a more caring system that can provide affordable care to all in need.

Surgery on Sunday

by Daniel Roberts, MS4

Right here in Kentucky, a sort of medical mission occurs every 3rd Sunday of the month. This mission, called Surgery on Sunday, transcends the limits of our healthcare system by providing surgical services to the poor. Despite our country's system of absorbing the cost of care for many medical services to those below the federal poverty level, there are some unfortunate holes in this system. Two such discontinuities in the system include absent coverage for those above the poverty level (but those still quite poor and uninsured) and for a long list of elective surgical procedures. Even with the approaching changes in American healthcare, such as the Affordable Healthcare Act, there will still be underserved populations in our country.

Dr. Erica Sutton of Surgery on Sunday

The Surgery on Sunday endeavor is a nonprofit organization that began first in Lexington, founded by Dr. Andrew Moore. Since August of this year, the organization has successfully been extended to include Louisville. The majority of the patients served by Surgery of Sunday are referred by medical homes and from charitable clinics such as the Park Duvalle Community Health Center. Another small percentage of patients are self-referrals. Dr. Erica Sutton, a general surgeon at the University of Louisville SOM, is one of the generous people who have enabled Surgery on Sunday in Louisville to occur. "It would be great if, one day, initiatives like Surgery on Sundays become obsolete, but that isn't likely in the foreseeable future," Dr. Sutton says. Thanks to people like Dr. Sutton, the organization's presence in our community is here to stay. The procedures performed are all elective and include colonoscopies, hernia repairs, and various excisions of polyps or other masses. Many of these procedures are indeed life-saving. Dr. Sutton recounted, for example, effectively eliminating a cancer in one patient by excising a colon polyp that was found in pathology to be an early cancer.

That the Surgery of Sunday endeavor is provided entirely by donation is especially remarkable. Offering free medical services is relatively common, as it is done in a variety of clinics in our community, but offering free surgery can be a bit more of a complicated venture. Considering that the procedures must be completely free of charge to the patients, there must be more than a group of volunteer surgeons. Rather, it is quite helpful to have an operating room with supplies, as well as anesthesiologists, nurses, scrub techs, and pathology services. Remarkably, the Surgery on Sunday program accomplishes all of these components at no cost. Even the hospital provides the free use of the operating facility and donates the supplies, with a tax write-off in exchange for this charitable gesture.

Dr. Sutton provides her expert skills completely free and says that she enjoys the gratification of being able to provide the opportunity of free care to people who would not otherwise be cared for. If only every patient who fell through the holes of our system could be rescued by the generosity of those who so firmly stand by their mission to heal.

(Continued from "An Unconventional Model")
as a whole, what the appropriate punishment should be. This was all based purely on majority vote. What was miraculous, from the standpoint of a garden-variety cynic, was the manner in which this was all conducted. This system was much more effective in fostering a sense of accountability and responsibility than if a graduate degree holder in addiction rehab was conducting the session and doling out platitudes on how clients should appropriately deal with conflict. The community meeting was a quixotic, perhaps impractical way of addressing conflict, but one that I could see had a tangible effect on the way these people were choosing to live their lives.

This is what I gathered from a day of shadowing at the Men's Healing Place as well as what I've witnessed while interacting with clients at the Women's Healing Place. It is a very limited and narrow scope. Regardless, the figures and outcomes of clients at the Healing Place is a testament to its efficacy and novelty. The U.S. Department of Health and Human Services has designated the Healing Place as a "model that works." Many different cities across the nation have already or are in the process of implementing the same model. With the issues of addiction and homelessness often being two sides of the same bankrupt coin, The Healing Place offers something that should be recognized and lauded for what it seeks to accomplish and, more importantly, how it does so. I am proud to add this to the growing list of reasons why Louisville certainly lives up to its moniker of a "compassionate city."

Access in Appalachia

by Erin Baumgartner, MS2

The Johnson City Community Healthcare Center, of Johnson City, Tennessee is an unassuming building from the outside. It is set off from the street, away from the cluster of looming hospitals and clinics. The interior is beautiful; brand-new, with soft pastel walls, and filled with light from the high set windows. The JCCHC serves a specialized purpose within Johnson City. The clinic is first and foremost meant to give aid to the underserved. Consequently, the vast majority of the patients either do not have a job, health insurance, or even a home.

It was here that I spent several weeks over the course of the summer shadowing and working with the nurse practitioners that staff the clinic. In my time at the JCCHC, I gained valuable experiences in navigating the complications that accompany working with indigent patients. How do you prescribe medications for patients who cannot afford them? How do you refer a patient for a surgery that they cannot pay for? Providing adequate healthcare to underserved areas is an ever-developing issue. Many patients forgo care, or receive incomplete treatment because of their inability to pay for the service. They may struggle in gaining access to specialists, who are likely to be located in more cosmopolitan areas, and whose healthcare services are more expensive. Likewise, many patients often cannot afford proper healthcare, since many do not have health insurance, or are restricted by Medicare or Medicaid. There were many such patients at the JCCHC. One in particular haunts me, in part because of the severity of his condition, and also in reaction to the supreme injustice of his situation.

The patient was a young man, new to the state of Tennessee, and hoping to establish a primary care provider. At first glance he seemed to list strangely off to one side, and a second glance revealed why. One arm was bound up into a sling. He later informed us he had sustained a severe fractured dislocation of his shoulder. During the physical exam, it quickly became apparent just how extensive the damage was. It was an eerie feeling, skimming my fingertips over what should have been the familiar shape of his scapula. His arm was strangely shortened; the head of the humerus was broken off and shoved back behind the scapula, whose spine had been crunched flat. *(Continued of page 6)*

(Continued from "Appalachia")
Disuse had atrophied his shoulder to a shriveled knot of bone and sinew, and the muscles of his neck and upper back appeared curiously lopsided as well. Clearly he had lived with this injury, and the pain, for months. His predicament was a hellishly circular one. With such an injury, he was unable to work, and therefore was without insurance. Unable to pay for the surgery to repair his shoulder, he was unable to return to work. This sequence of events, and its myriad of variations became a disturbingly familiar pattern after extended time at the clinic.

The JCCHC provides medical care to those who cannot pay for it, and if the clinic cannot provide that care, they connect the patient to any number of charity or state run programs. Unfortunately, I was not able to follow this young man's story to a resolution. I know that the JCCHC aided him in beginning the process of obtaining assistance through one of the state programs; however, admittance into such a program is lengthy process. When he was informed of this, I could see his face fall, and my heart fell along with it. I was relieved, though, that he had found a place that could direct him towards the specialized help that he needed, regardless of his ability to pay.

I tried to take away more than just indignation over such a stymied predicament. I gained a new found appreciation for those that work in the tangled web that surrounds the indigent, the homeless, and the uninsured, as well reassurance that there are places, like the JCCHC, where healthcare providers can find a way in which to work within a system that all too often makes it difficult to care for indigent or uninsured patients.

A Leap from the Ivory Tower

by Ben Belknap, MS2

When immersed in the relatively great fortune of America, a limited perspective may lead us to believe that finding solutions for any number of public health issues in the developing world is not incredibly difficult. It is a common perception that with little more than generous funding, problems ranging from water contamination to the spread of HIV within a community may be altogether eliminated. Logistics in the hypothetical are easily understandable and not very expensive. For example, chloride water treatment systems and free condoms alone could eradicate the aforementioned problems if funding was the only challenge. However, when considering the mediocre results of many such Western efforts over the last half century, and further examining the myriad factors that create these massive global health issues, one may see that they are far more complex than any simple solution, prescribed and funded from afar, could feasibly solve.

In recent years, Engineers Without Borders Canada (EWBC) began publishing a "Failure Report", documenting a plethora of water sanitation projects and other development work failures in the countries they serve. This is remarkable in that the organization has documented many of their own failed projects, something few other NGOs would even consider. In one case, they found that 72% of their water systems in Malawi were no longer functional a few years after installation. However, it was in this project to document failures that EWBC was able to transform its staff to one that now speaks local languages, spends time in the recipient communities, and gains the knowledge required for them to understand the factors preventing their projects from becoming locally sustained.

It is from this idea, of finding solutions through greater understanding, that I see physicians to be crucial in affecting positive and sustainable change for the downtrodden throughout the world. Good doctors know the communities they serve and have no choice but to be pragmatic in the face of failed efforts. It is in their everyday work that primary care physicians may develop an intimate knowledge of a community that transcends the depth attainable for most other professionals. *(Continued on page 7)*

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I suspect that this is why Rudolph Virchow asserted that "physicians are attorneys of the poor, and social problems fall to a large extent within their jurisdiction." It is the physician who, though likely an outsider, may fully understand the plight of the impoverished, if by little more than the diseases from which they suffer.

For those who wish to make helping others their life's work, the requirements are manifold. Empathy, pragmatism, and a lot of time are certainly requisites. Of these, the empathy to understand that the human experience is anything but singular, the pragmatism to change plans when ideas fall flat, and the time to truly learn about the people you intend to help, building the foundation of your work on the knowledge and personal relationships derived thus. It is in this that I believe many physicians possess the unique skill-set and experiences granting them a great deal of authority when considering societal problems and their possible solutions. The waste that follows when these assets are not sufficiently valued is something that many in development work know too well.

In one of Tanzania's regional government hospitals, a foreign funded project arrived while I was working in a village within this hospital's service area. The project brought loads of baby formula with the goal being to massively decrease the incidence of mother to child HIV transmission. They had little trouble handing out many free bottles of formula to HIV positive mothers of infants and it was determined to be a success simply by the great number of units that had been dispensed. However, a Tanzanian doctor I worked with in that region informed me that to examine the efficacy of this project, one only needed to look in the shrubs outside the hospital's exit where a small mountain of beige powder had been growing since the project's launch. It seems that to many Tanzanian women the act of breastfeeding was too important to be easily given up and, furthermore, in many villages, the stigma that follows a woman who does not breastfeed her child was too dreadful to consider. The project was simply not working within the cultural confines; the provider and the recipient did not seem to fully understand one another and success would require more than the simple act of giving.

It is my conviction that physicians can embody the leap from the ivory tower that is necessary to properly guide aid initiatives. The era of a disengaged aid industry has drawn many critics in the countries where they operate, and these critics are demanding that results come in the form of comprehensive development and independence from aid. However, the pervading disconnection between the walled-off aid brokers and the host country populations seems to be one of the greatest barriers to achieving these goals. Perhaps, a future where physicians play a greater role in articulating the *real situation,* and where their knowledge and methodology are more widely incorporated in the shaping of aid, will help set these countries on a more reliable path to positive change.

Reflections on Ethics Week

By Francesca Kingery, MS2

In October, second year medical students took part in a weeklong ethics curriculum designed to expose students to the basic principles of bioethics and medical professionalism. Topics ranged from the history of these subjects, as far back as Hippocrates, to present day issues of autonomy, beneficence, nonmaleficence, and justice. Today we view issues such as respect for privacy and confidentiality in terms of patient data and records; however, these concepts were first deemed important as physicians would visit their patients' homes to provide treatment. These professional

(Continued from "Ethics Week")
standards were encouraged to prevent physicians from divulging sensitive information about the home life of their patients. Over time, professional standards were questioned and modified. For example, paternalism in medicine was a common theme until the 1960s. Before this time, physicians would withhold poor prognoses from patients, in an effort to build up hope in the face of despair. This pattern started to change as paternalism led to abuses of power documented in the Eugenics movement and the Tuskegee Syphillis Study. These events precipitated the development of the Belmont Report that laid the groundwork for the development of the 4 principles of bioethics: autonomy, beneficence, nonmaleficence, and justice. Today, bioethics literature of the developed world focuses on issues like withdrawal of care at the end of life, privacy in the realm of genomics, and issues surrounding denial of care regarding religious, cultural and personal considerations.

With the help of medicine's accrediting bodies, the push to incorporate modern bioethics into medical education has been successful. Most U.S. medical schools provide formal training in ethics and the subject is tested on the USMLE board examinations. This increase in formal training has led our instructors to inform current students that their generation might enter the clinical setting having received more formal ethics training than any other generation. With this in mind, I asked myself what responsibility, if any, does our generation have to further the goals of bioethics? One weakness of current bioethics training across the industrialized world is that it focuses primarily on issues one may find only after having *received* healthcare. But, before a patient can engage in autonomous decision-making, he or she must first have access to treatment and treatment options. In order to respect one's right to be removed from a ventilator, a patient must first have access to this life saving intervention. When ethical medical treatment is dependent on access to treatment, what responsibilities do we have as an ethically conscious generation to break down this barrier?

For me, bioethics isn't just about handling ethical quandaries in a traditional healthcare setting it's also about expanding the reach of bioethics to include physicians as advocates for the marginalized. For example, in this issue, Allison Wilcox (MS3) reflects on the NEJM piece recently published by UL internal medicine physicians. In this piece, UofL physicians describe the story of a patient with terminal colon cancer. Colonoscopies provide a screening test for colon cancer, and early detection and intervention improve survival of this otherwise deadly disease. However, without access to these advancements, many patients find themselves foregoing treatment and, unfortunately, their diseases progress to malignant states. On a global level, there is a larger disparity in access to simple medical therapies. When thousands die of cholera each year because they can't receive electrolyte replacement, or when millions die of preventable diseases such as HIV or TB, what is that the role of bioethics to confront these topics? Paul Farmer, Harvard physician and global health advocate, is a strong critic of the modern bioethics discourse. He states that "when the end of life comes early- from death in childbirth, say, or from tuberculosis or infantile diarrhea- the scandal is immeasurably greater, but these tragedies meet with far too little discussion in the medical and bioethics literature." His point is that when bioethics focuses on end-of-life issues that affect a minority of the world's population, there is a greater injustice done as more of the world suffers from easily preventable maladies.

We are fortunate to be schooled at a time when medical education is broadening its base to cover ethics recourse. I am grateful for the faculty at ULSOM for the passion, time and commitment they make towards this aspect of our education. Now, it's up to our generation to expand the scope of bioethics to cover the neglected topics that still affect millions, if not billions worldwide. Whether it is engaging in policy and law development, or ensuring the hospital where we work has an adequate policy for indigent patients, or being conscious of health issues of the developing world, we can all play a part. Ultimately, by connecting these roles to the responsibility of bioethics, we can ensure that a future bioethics curriculum dedicates more time to this realm.