WHY THE WORLD NEEDS SAVING

MED STUDENTS SPEAK

COMPILED BY MIRAT SHAH

What follows are excerpts from the booklet Why the World Needs Saving, *edited in 2009 by University of Pittsburgh med student Mirat Shah (Class of 2012). Reprinted with permission.*

The idea for a publication grew out of conversations I had with my classmates during the 2008 presidential election. The national focus on the state of the country and the world led my peers to think about what issues were important to them and also what kinds of contributions they hoped to make as physicians. I wanted to record this dialogue. Moreover, I wished to capture what it felt like to be a medical student at this point of personal development, against a backdrop of national transition.

This publication asked medical students across all years to answer the following question: What is the most-neglected issue in the United States or the world, and what will you do as a physician to address this? The choice of the word "neglected" was deliberate. Ask what the most important issue is, and people will try to be objective. They will think about what affects the most people, or costs the most money, or causes the most destruction. They may quote statistics and provide fact-based arguments. Ask about the most neglected issue, and the responses change. They undoubtedly will be colored by personal experiences, beliefs, and values. And they will be more passionate.

The topics students chose to write about ran the gamut from health care to roads, water, and social justice. Some proposals focus on broad systemic changes while others describe specific interventions. All of the essays show us that medical students are both pragmatists and optimists. They also illustrate the importance of thinking about why we do what we do and what we hope to accomplish. The only way to achieve change is by remembering what we'd like to do. *—Mirat Shah*

NOT ENOUGH TIME TO CARE

As medicine continues to evolve, the profession will have to reconcile the doctor-patient relationship. The growing need to lessen costs will detract from how doctors engage with patients. Current reimbursement practices could lead to fewer physicians providing treatment to underserved populations—especially in primary care. The economic dilemma could also force doctors to overburden themselves with unmanageable caseloads, impacting patient outcomes and quality of care.

The patient is not a consumer but a person, with needs existing beyond the doctor's appointment that day. The real challenge will be to negotiate humanism in medicine with the more objective measurement of medicine's economics. Physicians must resolve the tension of what is most time-efficient (e.g., prescribing another drug) with what is best for the person (e.g., unearthing the psychosocial issues that may account for the "ailment's" presentation).

Physicians and physicians-to-be must remain vocal in the health care debate and find their voices in outlining the future construct of the doctor-patient relationship. *—Peter Asante Jr.*

Peter Asante Jr. is a first-year medical student originally from Pawtucket, R.I. He graduated from Harvard University in 2007 with a Bachelor of Arts degree in biological anthropology. After college, he moved to Bronx, N.Y., where he helped families with children with developmental disabilities access the public insurance system.

VEER

A feeling of voicelessness,

SCHIZOPHRENIA: A BURDEN FOR THE AGES

Schizophrenia has a long history of being misunderstood and is still shockingly neglected in our society. Approximately one in 100 Americans will develop this devastating illness, with symptomatic onset typically occurring in the late teens to mid-20s. The disease robs people of their formative years and leaves them trapped on psychological islands of desolation.

While the most dramatic and typical features of schizophrenia—hallucinations, delusions, and loose associations—are common knowledge because of movies like *A Beautiful Mind* and *The Soloist*, early prepsychotic cognitive dysfunction is more pervasive and debilitating on a daily basis. One of my goals as a physician-scientist will be to raise awareness and generate enthusiasm about the real potential to identify early markers and pursue novel treatment strategies for schizophrenia. As we learn more about core features of this syndrome, we will be better equipped to identify and treat various subtypes of schizophrenia based on biological insights. Equally importantly, I will fight for the rights of each of my patients and battle the stigmatization of the illness. *—Gil Hoftman*

Gil Hoftman is from Calabasas, Calif., and a first-year graduate student in the MD/PhD program. He is interested in the clinical neurosciences.

A NEED FOR COMMUNITY

The paradox of our age: As population density increases, our communities become more dispersed. Those of us living within the Western gospel of individualism are especially likely to forget that we are a collective organism: Individual circumstances—be they financial or medical—have widespread effects on our neighbors and ourselves.

When our communities fall into disarray, the fabric of our collective health disintegrates (as we see with the influx of illicit drugs or in the Gulf Coast post-Katrina). Indicatively, our family and friends are often more aware of our poor health and the toll it takes than anyone else. And they are our strongest motivators, speaking to our most intimate values.

Not coincidentally, the largest gaps in our current health care system concern matters best addressed by interpersonal dialogue outside the clinic and in the community: preventative medicine, stigmatization of mental health issues, and end-of-life care. At the same time, examples as disparate as cystic fibrosis and drug abuse demonstrate that communal support makes an immense difference in prognosis, even in the face of daunting biological challenges.

As a physician, I will seek to implement treatments that create and reinforce positive social relationships. Support groups, walking/running clubs, interest groups, information forums, home visits, and community health workers are all variations of the same idea. Still, we must expand our repertoire further, capitalizing on tools like social networking that are not limited by geography. Most importantly, we must limit our tendency to deconstruct multifactorial diseases. We should begin thinking more like community organizers and less like mechanics.

—Benjamin Meza

Benjamin Meza is a second-year student from Arlington, Va. He has worked with refugees and juvenile offenders and intends to be a primary care physician who serves children and adolescents.

THE REINVENTION OF PREVENTION

Few people argue against the potential benefit of better preventative health care in the United States. The challenge is how to achieve this in a culture that endorses and rewards excess and instant gratification. We are a reactive society that thrives on and is concurrently plagued by insatiable appetites—for all kinds of things.

For health care providers, this mentality is difficult to approach. We are up against insidious chronic diseases that lull their hosts into a comfortable lifestyle for decades without apparent consequence. Our task then so often is to convince patients to change behaviors (perhaps lose weight or quit smoking), which requires considerable effort and, often, discomfort to accomplish.

The earlier we help establish healthy behaviors, the more successful we'll be. We especially need more aggressive and creative strategies aimed at our nation's kids. But to craft effective preventative strategies for patients of any age, we must first understand the social constructs that shape their health—like education/literacy, family support structures, and financial resources.

To better understand these factors that define barriers to care for so many, I propose that U.S. medical schools require a year of postgraduation practice in a medically underserved area, as many other countries do. Such a program could foster or reestablish trust between young physicians and depressed communities in this country and would be a sustainable way to facilitate access to health care and health education. It would reenergize our efforts to address prevention. *—Jaime Moore*

Jaime Moore is a third-year medical student originally from Rockville, Md. She plans to go into primary care.

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or of invisibility, seeps into all aspects of life, and it is damaging to health.

HEALTH IN AN ILLITERATE WORLD

It's easy to forget that much of the world never has been and never will be part of the "information age" in which many of us unthinkingly live our lives. They are excluded by illiteracy, which is as repressive of individual autonomy as any dictatorship. In the broadest sense, literacy connotes more than being able to read. It also means access to unbiased information, the ability to understand this information, and the freedom to discuss it. Literacy creates the chance to learn, to question, to decide, to escape—in sum, to engage. Having the ability to participate actively in one's own life is what differentiates those who feel they have a voice from those who feel unheard.

A feeling of voicelessness, or of invisibility, seeps into all aspects of life, and it is damaging to health. Without literacy, health care can be one-sided and, in a sense, foisted onto the patient. For too many, there is no choice but to accept that this is the standard of care—and to accept that this is life.

The key to better health is literacy: having the knowledge to take care of one's own health and that of one's family. We as physicians must strive to understand the frameworks that shape our patients' understanding of their health so they can participate in their own care.

Literacy matters not just for health care but also for personal dignity. *—Emily Rosenberger*

Emily Rosenberger is a first-year medical student in the MD/PhD program. She graduated from Wesleyan University in Connecticut, where she studied history, sociology, and anthropology of science and health.

NOT A DROP TO DRINK

Ninety-nine percent of the water on earth is unsafe or unavailable to drink. Consequently, one-third of the world has limited or no access to clean water, and millions die each year as a result. This essential, natural resource engenders unnatural war, and the hunt for safe water creates a constant struggle between humans and their environment.

For everyone to have clean water will require collaboration between diverse groups of professionals and nonprofessionals. Engineers, for example, should continue inventing effective, portable, high-volume, long-lasting filtration devices that clean water from the dirtiest of sources. Distributing these devices requires infrastructure and the support of government and nongovernmental organizations. Conservationists must work with industrialists to ensure that populations have access to water without crippling the environment. At all times, the public must sit at the decision-making table and have a voice in executing solutions.

Physicians can fill many roles to help these groups succeed. They can treat those suffering from dehydration or consumption of unclean water. On a broader scale, they can use their knowledge and good standing in the community to coordinate sanitation education campaigns. And as advocates for patients' well-being, physicians should press governments to meet the water needs of their people.

Can we work together to equitably use the 1 percent of water available to us? We must try. *—Jason Sanders*

Jason Sanders, from Framingham, Mass., is a second-year medical student in the MD/PhD program. His professional and research interests include medical education, outcomes research, and the biology of aging. He hopes to become a surgeon.

TAP TAP: A NARRATIVE ON CATARACTS, THE NUMBER ONE CAUSE OF BLINDNESS WORLDWIDE

Tap. Tap. Tap. Tap. A long, thick wooden stick hits the rocks on the remote, dusty Honduran road. The stick is worn smooth underneath a woman's darkly pigmented hand; her skin sinks in between the muscles, ligaments, and joints. Her world is veiled in a thick fog. People appear as shadows. Familiar obscured images guide her along the path to the community clinic. She is met by a group of nurses who lead her into a room to shower and to change into a strange dress that leaves her backside exposed. After a few moments of rest in the clinic, she hears a gentle voice and feels a soft, warm hand on her forearm.

"Bienvenida a la clínica de oftalmología señora Martínez. Yo soy la doctora Allison Ungar y hoy voy a operarle su catarata." *Welcome to the ophthalmology clinic, Mrs. Martínez. I am Dr. Allison Ungar. I will be taking out your cataract today.* Mrs. Martínez reaches out for the doctor's hands to say a prayer with her.

The following day, her eye shield is peeled away to reveal a bright vision. She is surrounded by family—her children with faces decades older than she remembers and beautiful grandchildren seen clearly for the first time. She stands up inches taller than before and walks down the same dusty road. Her walking stick is missing, but she is too distracted by the colors to notice. *—Allison Ungar*

Allison Ungar is the 2009-10 UPMC Department of Ophthalmology Research Fellow and will be graduating with the Class of 2011. She is interested in combining her passions for underserved and international medicine with a career in ophthalmology. She volunteers with a mobile free eye clinic, the Guerilla Eye Service, which serves the Greater Pittsburgh area.

less like mechanics.