

## Topic Essay #1: Suffering

Suffering extends beyond the stereotypical meaning associated with physical pain. Trillin's "Betting Your Life" unfolds her dire situation emotional and physical suffering, while battling disparate physician accounts of her medical treatment and ultimate healing. She received inconclusive doubting diagnoses and had constant physical back pain to the point where she "couldn't find a hopeful way out..." causing her to doubt her usual optimistic viewpoint (Trillin 2001, 36). Her emotional suffering and feeling of powerlessness was not addressed by physicians; rather, many of her physicians were focused solely on the results of medical tests. Healing came in stages: first with trust and reconciliation with her physicians and second, with time, growth and restoration, as her narrative was written ten years later. Only until two of her physicians were able to view her case subjectively to consider her as a whole person were they able "to "look beyond the prognosis [of metastatic cancer] for another cause of [her] symptoms" (40). In comprehending the whole person, her antecedents and subjective feelings, these two physicians were able to ameliorate her physical and emotional healing. Suffering affects the whole subjective person and its severity and causes are often overlooked by the medical profession; suffering is a distressful debilitating disease that threatens individual assuredness, interfering with social interactions. Healing is the relief of pain; it involves acceptance, reconciliation and restoration that transcends suffering.

The traditional goals of physicians "have mastered skills aimed at diagnosing and curing diseases, and yet they may be at a loss when it comes to relieving suffering" (Dobkin 2009, 1). To remedy physical diseases, physicians focus on objective data that is measurable through laboratory and diagnostic tests, but fail to take into consideration that their treatment often is the source of emotional suffering, impeding healing. "Medicine has no model for what it means to

be whole as a person ... and gives negligible consideration to spirituality,” according to Egnew’s “The Meaning of Healing: Transcending Suffering” (2005, 259). Suffering affects the mind and the body. Training and professional development of physicians is necessary to address the subjective, non-physical sources of suffering to give them equal weight and value to the objective data. In Cassell’s “The Nature of Suffering and The Goals of Medicine,” he describes a 35-year old sculptor, diagnosed with cancer that “lost strength in the hand that she had used in sculpting, and she became profoundly depressed” (1982, 639). After chemotherapy treatments, the duality of her suffering was fraught between hope and fear. Anxiety overcame her to the point where her self-perception disintegrated and she exhibited signs of social isolation. She “suffered not only from her disease but from its treatment” (Ibid). Her emotional suffering was overwhelming and chronic, but documented as “ordinary characteristics” (640). There is nothing ordinary in a person’s emotional suffering; suffering is personal. Physicians need to validate and acknowledge the nuances of individual patient emotional and mental suffering and place value and importance on that suffering. In class, we learned that suffering starts with recognizing it’s duality. This type of suffering is experienced by persons with severe stress and any aspect of personhood whether it be social, physical, or transpersonal. If physicians are able to engage in caring for the whole mind-body of patients’ suffering, then those relationships will foster personal growth and healing to lead a repurposed life.

“Healing is the personal experience of the transcendence of suffering,” according to Egnew (258). Healing is ... “fostered by a loosening of the ego’s need to control,” providing an open door to renewal (Mount 2003, 42). Healing can only occur if a person is: actively willing to accept the circumstance of the suffering, receptive to reinterpreting one’s life by “picking up the pieces,” willing to find hope, forgiveness and restoration. In the patient-doctor relationship,

emotional healing in the best case scenario would work concurrently with physical healing. “Physicians are not trained to hear patients’ stories ... and avoid confusion and unpleasant feelings,” purposely circumventing questions that they may believe are personal, symptomatic and perhaps, unethical (Egnew 1982, 259). Physicians need to look beyond the data to an inclusive mindset to harness human suffering. Trillin’s healing came with context and a reflection of “what was happening” and through that acceptance, her narration was her catharsis and restoration (38). In Egnew’s qualitative study about healing it was revealed that the healing process takes place within trusting relationships between “real persons in connection with other real persons” (257). Physicians are the “real person” primary point of contact to provide this continuity of care and “curricula for teaching patient-centered communication are extending into the clinical years of training” (260). Although this theoretical communication training is being extended into medical school, will it be practiced in the office visit? Can physicians resist the pressure to “churn-out” volumes of patients, in a practice, to engage in dialogue with the whole person focusing on patients’ emotional, mental and spiritual suffering and respective well-being? Or, perhaps the integration of training and communication between specialists and mental health providers will be facilitated to shift to a more collaborative culture? While undergoing medical treatment, individual emotional and physical intactness and suffering is constant, but through acceptance and understanding of the whole person, physicians can play a vital role in acting as a protector of healing and not a perpetrator of suffering.

## Topic Essay #2: Professionalism

Physicians and medical students have a societal perception suggesting god-like qualities. They are medical masters and their methods, techniques, and clinical experiences are rarely, if ever, questioned. Yet, as Gunderman's "Success, Professionalism, and the Medical Student" reports, "there are times when our patients need us to be human beings first and experts second" (2012, 7). Medical training that focuses primarily on clinical medical skills is inadequate; it threatens the acquisition of knowledge for the moral and ethical physician who has an opportunity to bring added-value to the patient-doctor relationship. Successful physicians initiate communication expressing genuine interest in patients' lives, their cultures and their fears; this hidden curriculum builds fundamental trust. In a teaching hospital, the nonmedical, patient-centered, curriculum is as important as the medical curriculum. Would a physician operate on half of a patient? So, why service a patient's medical treatment only, and disregard the social person? Residents need to consider presenting patients with an anticipatory set of questions and a "repertoire of strategies and skills, [to] respond to patients in a flexible way" (Brunett 2001, 391). Residents need to be trained in cultural competency and human relations to develop their "tool-box" and enrich their training to serve all patients, without marginalization. A collaborative patient-centered curriculum will support the whole person, create professional physician behaviors that are ethical, honest, trustworthy, effective and compassionate, focusing on the moral dimension of medical care.

Compassion, trust and understanding is critical in-patient care. In Brewster's "A Student Teacher's View of a Medical Teaching Exercise," a neurologist alludes that a patient "... is obviously volatile and disinhibited ... for she was ... being very uncooperative," after an initial consultation (1993, 128). The resident gave that patient's medical history to the neurologist,

citing that the patient is a 52-year-old, mentally alert, black woman with severe back and leg pain (127). Speaking in a heavy southern Arkansas accent, the patient was apprehensive about answering the neurologist's questions. During the consultation, she informally addressed the neurologist as "honey" and the neurologist, unfamiliar with her accent, thought she said, "money" (128). This cultural divide led to laughter, embarrassment by the neurologist and humiliation by the patient; she was unintentionally mocked. In defense she said, "I'm not trying to pick you up or nothing, I'm just calling you "honey;" it's just a saying" (Ibid). Because of her race, accent and slang, the neurologist formed a dispassionate, unflattering stereotype. The neurologist's deficit in understanding the patient's perspective hampered a proper diagnosis. The resident should have provided the patient with "more context" to clearly understand her expectations before, during, and after the visit. "Patient-centered care is becoming increasingly important as health professionals work towards providing emotionally accurate, culturally competent care ... [and to communicate] with patients of different walks of life" (Riess 2014, 1109). If professional education was emplaced to include patient-centered care with compassion, cultural competency and contextual understanding, a drastically different outcome to this session would have led to an appreciation of the patient's candor and proper healthcare.

Full transparency and honesty is important in any organization. In the medical profession, physicians are in a unique position of privilege, healing patients, but they need to earn their trust. Providing full disclosure with patient-doctor collaboration involving open and honest dialogue builds trustworthy relationships that are highly valued by patients and medical institutions. "In medical practice, telling the truth ... is ... an important aspect of trust, and trust is fundamental in the doctor-patient relationship" (Basson 1982, 122). In "The "Student Doctor" and a Wary Patient," James Denton, a third-year resident, is unsure of his clinical skills in performing a

spinal anesthesia lumbar puncture (Ibid). He is told by other residents to introduce himself to his patient, Mr. Criswell, as Dr. Denton, but settles for an introduction as, “a student doctor from Anesthesiology” (121). During their discussion, Criswell expresses doubt about, “those medical students ... [that] practice on the vets leaving them paralyzed for life,” implying he did not want care from a resident (122). Denton had an opportunity to disclose to Criswell the truth about his qualifications, inexperience and his residency status, yet he lies, is complacent and disguises the truth. Denton’s behavior is wrong. Denton should have told Criswell the truth. Truth could have fostered informed dialogue and trust from Criswell. In “Medical Students and Professionalism: Why it Matters,” Alam, a third-year resident, insists that “Maintaining honesty and integrity, and not acting beyond one’s limitations is absolutely crucial ... for the safety of our patients” (2015, 2). Patients entrust themselves to physicians, believing them to have divine, unwavering power and authority. The medical profession needs to continue to earn this reputation by demonstrating proficiency to practice morality and trust by “... [noting] the importance of socialization and implicit learning in the development of professional attitudes and behaviors” (Cooke 2006, 1342). Can medical professionals risk dismissal of their professional duties of social and moral responsibility? Or, will they embrace an interdisciplinary approach that puts patients first through ethical and effective patient-centered collaboration based on trust, honesty, compassion and cultural competency.

### Topic Essay #3: Nurses

Nurses are in a unique clinician-patient relationship that could comfortably veer into territory that is unprofessional. Nurses have a code of ethics to abide by that covers four responsibilities: “to promote health, to prevent illness, to restore health, and to alleviate suffering,” according to the *ICN Code of Ethics for Nurses* (2012, 1). With potential to jeopardize their career and harm patients, nurses confront a complex criterion of emotions that transition personal and professional boundaries. The American Nurses Association *Code of Ethics for Nurses with Interpretive Statements* defines “The work of nurses is inherently personal” raising intimacy, trustworthiness, privacy and confidentiality issues (2015, 7). In class discussions, importance is placed on medical professionals incorporating holistic treatment alongside medical treatment; a patient’s social and emotional well-being is essential to quality of care. So, how do nurses perform their job best? The fundamental nature of the nursing practice is subject to physical, emotional, personal and psychological intimacy that may place vulnerable patients at risk. Should nurses maintain an atmosphere of therapeutic care, compassion, and personal interaction and jeopardize crossing boundaries of professionalism and creating violations?

“In school, nurses are taught to be gentle but professional,” reports Laura DeVaney in “Becoming A Nurse,” understanding professional conduct restrictions and medical treatment of patients, avoiding personal interaction (Gutkind 2013, 47). But, in doing so, it limits her ability to care for the ‘whole person.’ DeVaney ponders “... I am the robot nurse I was taught to be ... but not overly compassionate. Roger, however, has worn a soft spot in my heart. For him, I am human” (51). Roger, the devoted husband caretaker for his wife, Rose, one of DeVaney’s unresponsive patients, confides in her, “Getting old sucks” (52). In hearing these words and

witnessing Roger's intimate and caring relationship with Rose, DeVaney breaks the rules she is told to embrace, she begins to care for Roger and in his absence, with empathy, she approaches Rose's bed whispering, "you need to open your eyes and get out of bed soon, or you'll grow too weak" (Ibid). This personal side of DeVaney is as important as her role in restoring health; it shows that she cares, but she knows when to draw the fine line in her relationships. DeVaney understands that her personal opinions should be guarded, but the humanitarian in her believes that she needs to take action to support Roger, so he is not left a widower. Her last words to Roger are, "I worry about you," furthering her emotional attachment (54). With DeVaney's four years of experience, she makes an informed decision based on listening and individual family circumstance. She navigates the subtle nuances between boundaries, being careful to delicately select her words in personal situations and to withdraw into her professional role. This balance of theory and practice, along with self-reflection and exposure to different ailments and medical scenarios, can invigorate nursing to provide optimal health care by building strong clinician-patient relationship, without foregoing professionalism.

Unfortunately, "getting too close to my patients was something I had been taught to avoid," according to Josephine Ensign's "Next of Kin" (65). In *Don't Cross the Line: Respecting Professional Boundaries* "... setting boundaries isn't straightforward...when acting within one's role as a professional, the nurse recognizes and maintains boundaries that establish appropriate limits to relationships" (Hanna and Suplee 2012, 40). Ensign claims to have "crossed so many professional lines that it was impossible to turn back" (Gutkind 2013, 57). After Lee, an HIV homeless patient under Ensign's care, is discharged she soon receives a phone call from him, pleading, "'Nurse Jo, you [have] got to come get me out of this place--talk to them and tell them I'm not crazy!'" (60). Ensign goes to Lee's aid, with compassion, defending him at a mental



health hearing and agreeing to release him under her care. In his apartment, she receives a warm welcome from Lee panting, ““I wondered--when--you’d get here,”” as he becomes dependent on her as ‘his next of kin’ (64). She takes him to the hospital and guides him to make a self-determination decision as he “signed the Do Not Resuscitate form,” deepening her emotional involvement understanding the multiple dimensions of his illness and suffering (65). She is uplifting, never infringing; she is welcoming, never violating. Is she unprofessional? With her three years of experience, Ensign employs “holistic nursing practice drawing on knowledge, expertise, intuition and creativity,” according Frisch’s *Standards for Holistic Nursing Practice: A Way to Think About Our Care That Includes Complementary and Alternative Modalities* (2001). Ensign makes Lee comfortable, alleviates his suffering, and offers emotional support. She did what was in Lee’s best interests without compromising his primary healthcare, definitely breaking protocol.

“The business of nursing brings us into the messy swampland of human suffering ... [as] it is impossible to erect walls” to divide ... responsibilities of nurses, yet nurses are warned to maintain “healthy emotional distance” (Gutkind 2013, 65). Nurses *regularly provide* medical and holistic care, taking detours, circumventing walls and getting emotionally attached to patients; those with experience, trust their instinct and know their boundaries, like DeVaney and Ensign. To continue in these roles, education, experience, training, and self-reflection is required. Perhaps, medical professionals should form committees to merge the American Nurses Association with the American Holistic Nurses Association to lobby for the best practices of conduct and ethics in medical and holistic healthcare. This will ensure the integrity of the clinician-patient relationship, so that nurses can comfortably treat the whole patient, displaying empathy and compassion with personal interaction, under *revised* professional boundaries.

#### Topic Essay #4: Twelve Patients

“The trajectory of chronic illness assimilates to a life course, contributing so intimately to the development of a particular life that illness becomes inseparable from life history,” according to Arthur Kleinman’s *The Illness Narratives: Suffering, Healing, and the Human Condition* (1988, 8). Living with a chronic illness is so much more than biomedical physical pain. It has social, familial, and cultural aspects that manifest throughout one’s life, as Soraya Molino’s history is revealed by her sister, Clara, in Dr. Manheimer’s “A Heart for Rabinal.” Soraya’s bleak past begins in a poor farming neighborhood in Guatemala City where “there was barely enough to eat when we were kids,” as retold by Clara (Manheimer 145). With “no education . . . my sister, barely reading and writing” was innocent and married an older man. There was no other feasible route for an uneducated woman in a society on the brink of terrorism and destruction, where social and gender dysfunction was the norm (147). Soraya contracts Chagas’ disease in Guatemala, probably because of inadequate hatched housing. The cultural significance and social meaning of Soraya’s illness is amplified where “the initial symptoms of Chagas’ disease is usually trivial and brushed off” (142). Her symptoms as meaning, are “standardized truths in a local cultural system . . . [taken] for granted” (Kleinman 1988, 10). Her illness went untreated in her youth and developed to the point where she required a heart transplant at thirty-nine years of age. Her chronic illness is synchronous with her cultural history and social antecedents, frayed by her tragic and underlying poor conditions of life. Multiple meanings of illness impact treatment; the symptoms, the cultural significance and the life of the patient are essential to understand disease. Clinicians need to engage the patient in dialogue to elicit personal and social meaning to uncover historical, lifelong conflict unique to the patient and family, together with a medical plan.

Eliciting the Patient's Explanatory Model of Illness, in "Clinical Lessons from Anthropologic and Cross-Cultural Research," uses a series of interpersonal questions to facilitate cross-cultural communication to hear a patient's illness narration. Dr. Manheimer is told Soraya is "... undocumented," from Dr. Perham. Her sister, Clara, is her primary caregiver and spokesperson, who is dealing with her own cancer. Soraya and Clara are close-knit sisters. In assessing Soraya's "diagnostic evaluation, ... pushing ten medications at last count," Dr. Manheimer expresses concern as she vomits her food, leaving her fragile and pale. Considering Soraya and Clara's culture and wanting to provide nutrition, Dr. Manheimer suggests, "it's dinnertime ... there's a place across the street with cooking Latino-style ... but may pass inspection with two Guatemaltecas?" (2012, 143). With personalization and compassion, Dr. Manheimer acts reasonable and appropriate. Eating rice and beans, Soraya, Clara and Dr. Manheimer speak for "three hours without a break," unraveling the cultural history of the sisters, as Dr. Manheimer asks, "Tell me, where are you from in Guatemala? How did you end up in Brooklyn?" (144-145). Clara discloses Soraya's story, "her husband's right hand [was] left outside her doorstep" (147). On other days, Dr. Manheimer learns Soraya's second husband "Roberto tries to help out," but, he struggles. While immigrating from Guatemala to Brownsville, Texas, "for sixty days she was raped by a dozen men" (152-153). "At the General Hospital in Guatemala City the ... violence, beatings and rapes increased, ..." citing a culture bent on intimidation and disregard of human existence with barricades to proper healthcare (146). Using a psychosocial approach, eliciting introspective questions, "[where] illness represents personal, interpersonal, and cultural reactions to disease or discomfort," Dr. Manheimer gains trust, clarifies concerns, and understands Soraya's beliefs about her illness (Kleinman et al. 1978, 251). Understanding a patient's history in the context of culture and life

events, coupled with a biomedical treatment formulates a supportive clinician-patient relationship to cure illness.

“Acting like a sponge, illness soaks up personal and social significance from the world of the sick person” (Kleinman 1988, 31). Soraya’s life narrative details a series of losses; loss of her youth, loss of attainment of education, loss of her first husband, loss of her second husband, loss of dignity, and more. After hearing the account of Soraya’s humiliating migration trek from Clara, Dr. Manheimer continues, “How did she recover?” (Manheimer 2012, 153). Yet, “despite all the things in her life she still trusts people” maintains Clara, “... even her landlord, [an American citizen] had begun to protect her and her kids” (154). Dr. Manheimer is able to earnestly discuss Soraya’s “clinical reality ... essential to effective care” (Kleinman et al. 1978, 254). “I sat on her bed and held her hand,” recounts Dr. Manheimer explaining she will need a new heart transplant within a few months (2012, 155). Because of Dr. Manheimer’s advocacy and psychosocial technique, she is able to “frankly discuss [her] problem and ... came to accept [her] disease” (Kleinman et al. 1978, 254). Soraya inquires, “How can I get a heart if I don’t have papers?” (Manheimer 2012, 155). Dr. Manheimer collaborates with social workers and a non-negotiable legal system, preventing undocumented immigrants from being organ transplant recipients. With Soraya’s trusting life, she marries her landlord and receives the heart transplant, which unfortunately is unsuccessful. However, Dr. Manheimer gives personal attention to Soraya’s culture, her lifestyle and her family. He views her suffering through a lens of polysomic or multifocal meaning, realizing that her illness is constructed through her unique historical and social context. What is the best interest of patients? Investment in the medical community’s understanding of patient symptoms, cultural competency and social life history, while applying

effective communications to elicit a patient's illness narrative, combined with biomedical treatment, is mandatory. They are "stronger together."

#### Topic Essay #5: Impaired Clinicians

Physicians and healthcare providers are human, subject to illness and impairment, akin to others in stressful careers. In *Policy on Physician Impairment*, "impairment is the inability to practice medicine with reasonable skill and safety as result of: mental and [medical] disorder, physical illness or condition, or substance-related disorder" (House of Delegates 2011, 7). When a healthcare provider "has an impairment that substantially limits a major life activity," how can they deliver patient treatment if their skills are compromised? (Rothstein 2015, 2219). Should a medical director hire interns with documented impairments? What restorative practices or accommodations are available for impaired practitioners? "Professionalism is the basis of medicine's contract with society ... placing the interests of patients above those of the physician, ... maintaining standards of competence and integrity ..." (ABIM Foundation et al. 2002, 244). Medical professionals provide exceptional services to maximize patient wellness; however, impaired medical professionals may suppress their own disabilities to avoid discrimination and license suspension. So, how can the medical profession support their own, being "doctors for doctors," servicing impaired medical practitioners, while retaining their professionalism? Support for impaired medical professionals should have standardized policies to identify, intervene, monitor and restore their status to treat patients with skill and safety, maintaining professionalism.

"The dual role of protecting the public through licensing and discipline as well as the provision of a mechanism for the successful rehabilitation of impaired physicians is the ... public protection mandate" (House of Delegates 2011, 11). The definition of an impaired physician,

under the Americans with Disabilities Act (ADA) “is much broader and includes the full range of physical, mental, and behavioral limitations” (Rothstein 2015, 2219). David Marcus, in “My Names,” “has Tourette Disorder, Attention Deficit Hyperactivity Disorder and chronic lower back pain” (Elders 2004, 145-147). With setbacks in medical school, he ingratiates himself with Dr. Smith, and although supportive, he warns Marcus, “in his experience, academic medicine discriminated against students with disabilities” (148). During his surgery clerkship rotations, “[Marcus] told the [Director of Surgery], ““with great anticipatory anxiety”” [he will] participate ... without any accommodations” (148). This is unprofessional and jeopardized the safety of his patient. After failing surgical rotations and undergoing rehabilitation for his back, Marcus discovers the ADA and advocates for himself to “repeat the surgical clerkships ... [to graduate]” (152). During conversations with Dr. Smith, Marcus was exposed to remarks that ““people with disabilities shouldn’t be allowed to be doctors and ... are slow,”” forcing him to rethink “it might not be a good idea ... to continue to be honest about my disability,” despite concerns that he was “aware of an awful feeling of insecurity ... and humiliation” (150). Marcus’s disability stigma caused him to compromise the safety of his patient; although he was honest about disclosure of his need for accommodations, he did not accept support, lacking professionalism and ethics.

Heather Goff, in “Poison In My Coffee,” suffered from Obsessive Compulsive Disorder, clinical depression and self-mutilation, but her impairment did not compromise patient safety. She navigated through a divergent path to medical school, obtaining clinical treatment, a regimen of medications and monitoring of her condition. With passion and drive, she states her professional concern thinking, “How can I sit and listen to a depressed patient without remembering some of my own pain?” (52). She is a successful medical student, “... convinced that [her] future patients will benefit from [her] ability to empathize with their experiences” (52).

However, she too thinks, "...I probably won't advertise my mental illness," understanding the prejudice of her impairment. Although she is "symptom-free," if she suffers recurrence of her illness, she should voluntarily enter The Federation of State Physician Health Program "to intervene, obtain treatment, and continual care" to ensure her restoration and patient safety (House of Delegates 2011, 10). While physician impairment comes in many forms, Linda Palafox, in "My Secret Life" began drinking "when [she] was thirteen years old" and was a confirmed alcoholic (Elders 2004, 80). Alcoholism "is the third largest risk factor for disease and disability in the world ... and represents a pervasive component of U. S. social life and the workplace" (Romo et al. 2015, 1). Palafox joined Alcoholics Anonymous (AA) when "[she] was just twenty-one years old ..." (Elders 2004, 82). However, "recovering alcoholics experience greater stigma because they can be judged not only for abstaining from drinking, but for formerly possessing the negative trait of alcoholism" (Romo et al. 2015, 2). As Palafox thought, "it was critical to keep my AA membership secret" as colleagues that were honest about their impairment, while in AA programs were denied licensure (Elders 2004, 84). She could not risk being honest as the "risk of disclosure, outweighed the benefits" (Romo et al. 2015, 4-5). Goff and Palafox should be hired as interns, as they did not threaten patient safety or the public; they are entitled to privacy to preserve their "desired self-image" (2). However, could they live with their consciences as their professional integrity could come under question, if their secret was divulged?

All three medical interns suffered impairment during their medical career and they feared retribution. Regardless of the impairment, labeling students with disabilities is a misnomer as every individual is unique. Medical professionals are *not* bound by the confines of the workplace and experience significant scrutiny. For impaired medical professionals, identification,

intervention and restorative practice is necessary; society needs divergent medical practitioners to care for a diverse community. To encourage medical professionals to disclose impairments, culture needs to embrace those with disabilities, be supportive, and provide ongoing programs. Perhaps if these programs were established and widely available all three interns could be hired, bound by professional standards, integrity and code of ethics to sustain the public's confidence in the medical profession.



## Topic Essay #6: Resilience and Hope

Imagine if resilience could be packaged and purchased off the shelf or sold on Amazon. “Resilience. We would prescribe it, if only we knew what it was and how to get it” wonders, Dr. Manheimer in his “Four Generations” (2012, 184). “Resilience refers to a dynamic process encompassing positive adaptation within the context of significant adversity” (Luthar, Cicchetti, and Becker 2000, 543). “Marta had a million issues to deal with. Now a million and one” after her pregnant, twenty-nine-year-old, daughter, Irene, suddenly died of a hemorrhage, while in the third trimester with her second child (Manheimer 2012, 164). “The baby’s life is giving them a focus” empathizes, Dr. Manheimer; they choose hope for the future as the Sahagun family tries to normalize their traumatic loss and reinvest in Isabela, Marta Sahagun’s new healthy granddaughter (162). Marta is the primary caretaker for her Mama, Olimpia Gutierrez, diagnosed with multiple ailments necessitating a high-risk six-hour bypass surgery as an intervention. In addition, Marta is suffering from generational obesity, sleep apnea, diabetes, hypertension and arthritis (173). Through these inherited illnesses, the Sahagun family physicians are professional, objective, compassionate and engage the family in dialogue to uncover social and emotional issues, and “four generations ... of medical diseases and all of their complications,” critical to healing (174). They take into consideration the family dynamics, respect their culture, sympathize with their loss and even attend Irene Sahagun’s funeral, despite that two of the medical professionals are recovering from cancer treatments, who are the epitome of fortitude. Olimpia Gutierrez’s physicians could have “buckled under pressure, ... [but rather offered] genuine informed consent” on the risk of her surgery and afterwards, “the team was indefatigable and kept pushing her to do more for herself,” working against all odds (168-9). With personal

perseverance, endurance, courage and hope, along with the support of medical professionals, Marta and others rebuild, restore and strengthen their families with shared hope for the future.

One of Marta's favorite expressions is "... life is not a dream" (175). Life is filled with wakefulness. Life is based on relationships with people; life evolves to form reciprocal bonds of support and comfort. Dr. Reyes recommends bariatric surgery to remediate Marta's obesity and other medical conditions, but Marta responds to Dr. Manheimer, who supports the procedure, "I simply cannot afford it," while also considering the danger of the surgery (175). Marta insists, "I have to look after my family," but later reasoning "I'm going to check out the surgery. I can't afford not to, not with my three babies--you know, including Mama" (179). Marta must live to provide unconditional love, support and comfort to Mama and her grandchildren, Isabela and Jaime, otherwise, the outcome for her family is dire. So, Marta agrees to undergo surgery after attending an open house to listen to Mr. Clark, an inspirational speaker and bariatric surgery survivor. Prior to Mr. Clark's surgery, he weighed three hundred pounds, was depressed, on disability and was taking six medications daily. Mr. Clark's endurance and the emotional support from Dr. Parikh who spends an enormous amount of time with each prospective bariatric patient to ensure he/she is ready for surgery, is a testament to his professionalism and ethical virtues. Mr. Clark's hope was contagious and after Marta's recovery from surgery, Dr. Manheimer meets her "again for coffee" providing social and emotional support through a consistent client-patient relationship that he nurtured, in getting to know Marta and her family (184). Marta welcomes his company and proudly announces, "I stopped smoking, Doctor [Manheimer]" and he wonders, "How do people survive?" (Ibid). She lost fifty pounds and with renewed energy, she is "... determined to survive, to care for those she loved, to connect effectively with the world around her" (185). She repurposes her focus to combat the public obesity and diabetes that plagues her

family for four generations and low-income families by joining “the board of Healthy New York City” to advocate for access to nutritious food options to end the epidemic of obesity (188).

Marta makes this announcement while presenting at the open house series of prospective bariatric surgery patients, following in the footsteps of Mr. Clark, inspiring others to endure, regain power and take control of their life by considering surgery. “It had been two years since [Irene’s] death. They had survived,” notes Dr. Manheimer with his celebratory support and as a protector of the healing (Ibid). He, along with Mama, Isabela, and Jaime are in the audience cheering Marta’s successful healing, endurance and restoration, reconciling with the death of Irene and choosing life by strengthening existing relationships and doing for others, despite her misfortunes.

Struggles and hardships often come by surprise, but having a protective environment can foster positive outcomes. Vulnerable individuals cannot conflate illnesses and generational hardships. When I was seventeen years-old, I was diagnosed with pre-syncope. Suffering during long periods exposed to the sun or during ovulation caused me to faint, which was scary at first as I was athletic. Visiting several doctors, I was eventually referred to Dr. Boris at Children’s Hospital of Philadelphia. With my supportive parents and Dr. Boris, I was prescribed Midodrine to intervene with my hypotension. With the help of family and physicians I endure, maintain a gluten-free diet, watch my sugar intake, try to manage my weight and ensure I take my medicine. This suffering has strengthened my outlook in consideration of the access I have to physicians and the attentiveness of my parents, ensuring I have the best care available. It is inevitable to face disappointments and misfortunes during life’s journey and it is appropriate to grieve. But to succeed in life’s unpredictableness, resilient outcomes and endurance can be achieved by

surrounding oneself with protective environments, caring physicians and relationships that are accepting, hopeful and encourage positive outcomes.

I pledge that I have neither received nor given unauthorized assistance during the completion of this work. *Caroline Schiavo*

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