Why The World Needs Saving

Tomorrow’s Physicians Speak

A compilation by students at the University of Pittsburgh School of Medicine
About this page: During Orientation Week, first year medical school students were asked what they thought was the most neglected issue in the US or world. Some of their responses are shown here.

How beneficial is vegetarianism? Why don't we have more safe-sex and needle-exchange programs? What is the increasing possibility of becoming a caregiver to someone who is chronically ill? How beneficial is preventative medicine? What is the cost of pharmaceutical drugs? What is the housing situation? What is the economic structure? How can we address social inequality? Dying uncleaned on the street is a health education issue. What is the structure of economic inequality? Why do we have more free sex and needle-exchange programs? What is the political corruption in the US? How can we improve health education?
Why The World Needs Saving

Tomorrow’s Physicians Speak

A compilation by students at the University of Pittsburgh School of Medicine

Mirat Shah
Editor
For information regarding this publication contact:

Mirat Shah  
Medical Student, Class of 2012  
University of Pittsburgh School of Medicine  
Office of Medical Education  
M-211 Scaife Hall  
3550 Terrace Street  
Pittsburgh, PA 15261  
Phone: 412-648-8714  
shah.mirat@medstudent.pitt.edu  
http://www.omed.pitt.edu/speak

© 2010 Mirat Shah
The idea for this 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 kind of impact they hoped to achieve 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. Over a year later, this publication is the result. Though the election is long over, the importance of the ideas presented here remains.

This publication asked medical students across all years to answer the following question: *What is the most neglected issue in the U.S. or 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 will undoubtedly be colored by personal experiences, beliefs, and values. They will be more opinionated, more passionate, and ultimately, more engaging.

The 16 essays compiled here are definitely engaging. The problems outlined run the gamut from healthcare to roads, water, and food. Some proposed solutions 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 that we want to do it.
A project of this magnitude is made successful by the contributions of many individuals.

Laura Goodman, Timothy Laux and Jessica Lee are medical student colleagues at the University of Pittsburgh. Their enthusiasm and support encouraged me to persevere over the past year and they provided invaluable assistance with review of the submitted essays.

The Pitt Med chapter of Student Physicians for Social Responsibility provided essential help in launching and promoting the project.

I also wish to acknowledge the MIT Forum on American Progress, whose prior work partly inspired the undertaking of this project.

I am grateful to Dr. Maria Magone for performing the final review of submitted essays and making sure that they were ready for the spotlight.

I extend special thanks to Dr. John Mahoney, Associate Dean for Medical Education, and the staff of the Office of Medical Education at the University of Pittsburgh School of Medicine, for their assistance with production of the final publication and website.

Finally, I want to thank all of the medical students who took the time to write their thoughts down and all of the people who will take the time to read their words.
Pave Some of Paradise .................................................................31
   Timothy Stoker

Knowledge is Power! .................................................................33
   Semara Thomas

Tap Tap: A Narrative on Cataracts, the Number One Cause of Blindness Worldwide ..........................................................35
   Allison Ungar

Some Food for Thought .............................................................37
   Meme Wu

Access to Healthcare: Missing the Trees for the Forrest ..........................................................39
   Jonathan Zipkin
The patient is not a consumer but a person, with needs existing beyond the “doctor’s appointment” of that day.

Peter Asante, Jr. is a first-year medical student originally from Pawtucket, RI. He graduated from Harvard University in 2007 with a Bachelor of Arts in Biological Anthropology. After college, he moved to Bronx, NY, where he assisted children with developmental disabilities and their families with accessing the public insurance system. Peter’s passion for working with the underserved—particularly children—and interest in learning about the effect of universal healthcare on the general population, inspired him to write this piece.
As medicine continues to evolve, the profession will have to reconcile the doctor-patient relationship. The growing need to attenuate 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, thus impacting patient outcomes and quality of care. “I am running behind” could impinge upon the commitment to provide quality care to all who need it.

The patient is not a consumer but a person, with needs existing beyond the “doctor’s appointment” of that day. The real challenge will be to negotiate this humanism in medicine with the more objective measurement of medicine’s economics. Physicians must resolve the tension of what is most time efficient (i.e., simply prescribing another drug) with what is best for the person (i.e., unearthing the psychosocial issues that may account for the “ailment’s” presentation). In order to fulfill the obligation of effectively providing medical care for all, medical professionals will need to reconcile their call to serve their communities with the economic struggles of providing that service.

By extension, the subject of universal health care will have a profound impact on the doctor-patient relationship, for the medical community’s statement on the matter will serve to outline the values surrounding that partnership. Physicians (myself included) must remain vocal in the healthcare debate, and find their voice in outlining the future construct of the doctor-patient relationship.
The potential to strive for social justice is subverted by the false notion that we’ve already achieved it.

Inti Flores is a first-year medical student from Morgantown, WV. Working in the interdisciplinary field of gender and sexuality studies at NYU inspired Inti to go into medicine, where intersecting identities involving gender, sexuality, race, and class, have very real impact on patients’ lives, interventions, and outcomes. A strong personal commitment to social justice, especially within the context of medicine, was instrumental in deciding to participate in this project.
Reimagining the Role of the Physician

Inti Flores

I
n America, you can mold your life into any shape you’d like. All you have to do is want it badly enough. Indeed, the trajectory taken by our current President is a prime example of the kind of ‘pull-yourself-up-by-the-bootstraps’ story that underpins the ideological constructions of the great American meritocracy. And yet somehow, in spite of powerful inspirational tales like that of Barack Obama, ultimately, the story of American meritocracy is exactly that: a story.

American nationalism is itself a web of stories that inspire pride in the American people. These stories are ubiquitous, taught in classrooms of even the most disadvantaged inner-city school districts where pupils are painfully aware that real life doesn’t resemble the gilded national identity constructed within history textbooks. The potential to strive for social justice is subverted by the false notion that we’ve already achieved it.

It’s neither the Muslim woman nor the transgendered person who can’t separate America’s ideology from its reality. Americans occupying privileged positions too often believe that their privilege has been earned. We who have must not let having dull our responsibility to those in need. In medicine, part of the problem is the focus on treating individuals. Broadening the scope of health interventions not only familiarizes doctors with specific barriers to achieving health faced by undervalued communities, it also blurs the distinction between ‘our’ problems and ‘theirs.’ As we strive to improve diet in inner-city housing projects, their frustrations become our own as we see that fresh produce isn’t just unavailable, it’s unaffordable, and that deeply embedded, institutionalized racism maintains these conditions.

Individual health, the cornerstone of modern medicine, depends upon community and societal health. Broadening the scale of health interventions can enact important shifts in medical practice. And political action can help to achieve targeted goals, alleviating specific problems, along with broader goals of social justice. Perhaps in time, rather than gilded tales, we’ll tell stories truly reflecting the great nation we’re working to become.
we cannot accept the destruction of the biotic communities or ecosystems in which we live

*Laura Goodman is a second-year medical student and a graduate of The Colorado College. She lives with her husband and spends her spare time raising laying hens, tending her vegetable garden, and reading about the environment. She wrote this because she is passionate about making the practice of medicine ethically in line with the underlying principle of medicine, nonmaleficence. She hopes to make medical students, physicians, and others attentive to the necessity of change so that they can work together to begin effecting it.*
Community is often defined as a group of people living in close proximity or united by interests, but community can and must include the non-human biotic community. By definition, community members are responsible to their community. Just as we cannot accept a community member who hurts a neighbor, we cannot accept the destruction of the biotic communities or ecosystems in which we live.

With acknowledgement of our responsibility to our communities, we would change the way we live. We would choose not to burn coal for electricity, emitting carbon dioxide, increasing the temperature of the planet and the frequency of extreme deadly weather events, so that we can heat microwave dinners and watch television. We would not do those things because we would recognize that we are responsible for harming our communities and causing some of our own health problems. We need to stop pretending that what we do doesn’t have an impact on our communities and the planet as a whole.

Considering my chosen profession as a physician, I see a conflict in providing healthcare with one hand, while the other hand is producing wastes that harm the very communities I am trying to help. I will advocate for changes in practice that will lessen the harm we are causing to our communities and to the planet. I will try to reduce the energy consumption in the hospitals I work in, as well as the amount of waste created by every procedure. I will take responsibility and try to change the way that medicine is practiced to make it sustainable.
I will fight for each of my patient’s human rights

Gil Hofman is a first-year graduate student in the MD/PhD program from Calabasas, CA. He is open to the range of options within the clinical neurosciences. He enjoys soccer, guitar, and all forms of artistic entertainment.
Schizophrenia has a long history of harsh misunderstanding and is still shockingly neglected in our society. Approximately 1 in 100 Americans will develop this devastating illness, with symptomatic onset typically occurring in the late teens to mid-twenties. Schizophrenia robs its sufferers of their formative years and leaves them trapped in psychological islands of desolation.

The economic burden of schizophrenia in the US was $62.7 billion in 2002, with only $22.7 billion for direct healthcare costs. Indirect costs accounted for $32.4 billion and the largest component by far was unemployment. In stark contrast, only $1.25 billion was allotted to the National Institutes of Mental Health in 2002, and only a percentage of this was for schizophrenia-focused research.

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 pre-psychotic cognitive dysfunction is more pervasive and debilitating on a daily basis. One of my future goals as a physician-scientist is 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 each of my patient’s human rights and battle illness stigmatization, both implied and enacted.
By ignoring the gaping hole in our current education system...we are doing a whole generation a great disservice.
The hope to effect “change” is a recently well-publicized sentiment which I feel represents a desire widely-held by many in my generation. What we desire to change is greatly influenced by what we experience. One of the hardest truths I have had to face has been the large portion of our nation’s adolescents who are making poor decisions about their health and interpersonal relationships due to insufficient and outdated health education. I believe this issue is, by far, one of the most neglected matters in the United States. Without proper knowledge of STIs and contraception, our nation’s youth are at a distinct disadvantage when making choices that will affect their lives and the lives of their loved ones. By ignoring the gaping hole in our current education system, which, in many states, relies completely on abstinence-only education, we are doing a whole generation a great disservice.

As a future pediatrician, I will have the ability to help kids gain necessary knowledge in a safe, confidential, and private setting. Regardless of whether schools change their policies, I will be able to provide accurate statistics, social support, and guidance to teenagers as they navigate the perils of adolescence. I will also have a strong voice to influence alterations in the current education system. By working with activists and legislators, I can help improve the content of and the approach to sex education and enable kids to make more conscious decisions about their relationships and risk-taking behaviors. In this way, perhaps I can effect a “change” in the decisions many adolescents will make that directly shape not only their future, but the future of this country.
Being born premature is the main cause of death in the first month of a baby’s life

Jessica Lee is a second-year medical student from Chelmsford, MA. At Pitt she is involved in the Pregnant Adolescents Learning with Students program and also helps to run a discussion group at the local women’s shelter. In her spare time Jessica can usually be found dancing. From Chinese traditional dancing to bhangra, you name it, she loves it!
Walking through Magee-Womens Hospital’s neonatal unit, one encounters room after room occupied by tiny premature babies hooked up to a dazzling array of blinking machines and beeping monitors. It is a situation not unusual to any hospital as the rate of preterm births in the United States has reached a shocking 12.7%—an unacceptable rise of more than 20% since the year 1990.1 Being born premature, or earlier than 37 weeks of gestation, is the main cause of death in the first month of a baby’s life, can result in a multitude of negative effects on a surviving infant’s health and personality, and costs our country more than $26 billion annually.2 This problem is unexpected in a highly developed country with sophisticated healthcare technology, as well as difficult; it has a myriad of medical and social causes, none of which can be easily or quickly remedied.

The U.S. flounders in many areas of pregnancy and infant care; our nation ranks globally as 41st in maternal mortality and 29th in infant mortality. To tackle the neglected problem of prematurity rate, one must address the health of the infant, and more importantly, the mother. Aside from behavioral factors such as a lack of breastfeeding and the rise in medically unnecessary C-sections, there needs to be a refocus on issues of public health. For example, maternal and infant health could be improved by helping women access needed health services during pregnancy, ensuring pregnancies are planned, and even supporting smoking cessation. As a physician, I will improve maternal and infant health by being actively involved in these simple yet vital initiatives.

Benjamin Meza is a second-year medical student from Arlington, VA. He intends to be a primary care physician and wants to work with kids and adolescents in some way. In his free time, he likes catching up on schoolwork, eating vegan food, working with refugees and juvenile offenders, musing with his brother about life, and - when possible - closing his eyes.
A Need for Community

Benjamin Meza

The paradox of our age: as our population density increases, our communities become more dispersed. Especially within the Western gospel of individualism, we 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 (e.g., the influx of illicit drugs or the Gulf Coast post-Katrina). Indicatively, our family and friends are often better aware of our poor health and its effects than anyone else. And they are our strongest motivators, speaking to our most intimate values.

Not coincidentally, the largest gaps in our current healthcare system concern matters best addressed by interpersonal dialogue outside the clinic and in the community. This includes preventative medicine, stigmatization of mental health issues, and end-of-life care. Simultaneously, 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.

In an increasingly mobile and diverse society, physicians inhabit the confluence of the individual's needs and social capital. 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 the myriad of organic social-networking tools 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.
Jaime Moore is a third-year medical student originally from Rockville, MD. She plans to go into primary care, and has a particular interest in the financial burden of the uninsured in our country. She wrote this because as future physicians, we have the responsibility and great opportunity to strengthen our nation’s health care system. We are uniquely positioned to do so right now, as health care reform has become a priority of domestic policy.
ew people argue against the potential benefit of better preventive healthcare in the US.

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 general 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 (e.g., to lose weight or to quit smoking), which requires considerable effort and variable degrees of 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, in order to craft effective preventive strategies for patients of any age, we must first understand the social constructs that shape their health, such as education/literacy, family support structure, and financial resources, and be responsive to their underlying vulnerabilities.

To better understand these factors that define barriers to care for so many, I propose that U.S. medical schools require a year of post-graduation practice in a medically-underserved area, like many other countries do. Such a program could foster or re-establish trust between young physicians and depressed communities in our country, and would be a sustainable way to facilitate access to health care and health education. This would be one way to re-energize our efforts to address prevention.
Emily Rosenberger is a first-year medical student in the MD/PhD program. She graduated from Wesleyan University where she studied history, sociology and anthropology of science and health. Her interest in medicine stems from an interest in health literacy, the lack of which she has observed in areas as diverse as the Brazilian Amazon, the rural Philippines, Seattle, Washington, and Washington, D.C. Emily hopes to combine medicine with public health research in order to impact health at both the community and policy level.
Health in an Illiterate World

Emily Rosenberger

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 reading this unthinkingly live our lives. They are excluded by a lack of literacy, which is as repressive to individual autonomy as is any political dictatorship. In the broadest sense, literacy means more than being able to read; it encompasses access to unbiased information, knowledge to understand this information, and freedom to discuss it. Literacy creates the chance to learn, to question, to decide, to escape—in sum, to engage. Having that opportunity, 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.

This feeling of invisibility seeps into all aspects of life, and it is particularly crucial to health. Without literacy, healthcare can be nothing but one-sided and foisted blankly onto the patient. For too many, this is the standard of care—and life—they have no choice but to accept.

The key to better health is literacy. Literacy means having the knowledge to take care of one’s own health and one’s family’s health. We as physicians must make literacy as much a goal of our practice as healing. We must strive to understand the frameworks that shape our patients’ understanding of their health in order to enable them to participate in their own care. This matters not just for healthcare’s sake but also for self-defense, survival, and personal dignity.
Jason Sanders is a second-year medical student in the MD/PhD program from Framingham, MA. His professional and research interests include medical education, outcomes research, and the biology of aging. He hopes to become a surgeon. He wrote this because he feels medical professionals have a broader role in society than caring for individuals, including educating and leading others to solve the most substantial problems facing the planet.
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 man and his environment.

To provide every person with renewable clean water requires collaboration between diverse groups of professionals and non-professionals. Engineers, for example, should continue inventing effective, portable, high-volume, long-lasting filtration devices that clean water from the dirtiest of sources for individuals and communities. Distributing these devices requires infrastructure from government and NGOs, which in turn necessitates political and economic support. Conservationists must work with industrialists to ensure whole populations have access to water without crippling the environment. At all times, the public must sit at the decision-making table and have a hand in executing solutions.

To help these groups succeed, physicians must fill many roles. First and foremost, physicians 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. Concurrently, as advocates for patients’ wellbeing, physicians should press governments to meet the water needs of their people. Finally, as researchers, physicians may unravel the pathophysiology seen outside of the laboratory to produce new treatments.

Can we work together to equitably use the 1% of water available to us? We must try.
Aalap Shah is a third-year medical student from West Bloomfield, MI. He is interested in surgery. He loves cityscapes and indulging in music.
With the nation enduring a tumultuous era filled with economic and social crisis, it is inevitable that the resulting stress will burden the typical American household and bring it closer to dysfunction. Child abuse and neglect, issues that are often undetected and underappreciated by those in proximity to the victim, will become more prevalent as time goes on. In addition to struggling with social issues during adolescence (peer conflicts, academic difficulties, substance abuse), neglected children are likely to have persistent psychological problems leading to psychiatric diagnoses in adulthood. Eighty percent of 21-year-olds who were abused as children meet criteria for at least one psychological disorder.\(^1\) This creates a feed-forward cycle of increasing comorbidities and healthcare costs that will become regrettable in the future.

As physicians and our patients’ confidants, we are responsible for picking up and acting on the puzzle pieces our patients give to us. Unfortunate circumstances, from abuse, to changes in family status or dynamic, to a variety of other troubling situations, manifest themselves in the histories and exams of children and their family members. We should train ourselves to anticipate rather than intervene once a child has become victimized, and we can help families get on the right path by becoming aware of the community resources in our neighborhoods of practice. Furthermore, as abuse and neglect become more pervasive in American society, we should not hesitate to be more aggressive and to take the necessary action when the situation warrants it.

1. www.childhelp.org
In rural Nicaragua, the political equivalent of promising to lower taxes is to repave major roads in election years.

Timothy Stoker – sometimes known as Timothy Laux – chooses to write under his mother’s maiden name out of respect for the love of reading and writing and all things artsy that his Mom instilled in him from a young age. Dad helped too. Tim is currently a second-year medical student with an interest in pediatrics.
Pave Some of Paradise

Timothy Stoker

Streets. Highways. Infrastructure. This may seem trite and overly simplistic, but I have a summer of watching bolts shake off of motorcycle tires and riding buses covering 30 km in 1.5 hours to bear me out. In rural Nicaragua, the political equivalent of promising to lower taxes is to repave major roads in election years – just good enough to last through the ballot.

True, improving the roads long-term would affect a lot more than local health care. Development can change a place and not for the better, and sometimes more access introduces not a better capitalism (with more goods and services available at a lower price) but simply a new kingmaker in town. Disease profiles may change – more diabetes, more HIV – both of which were very low where I lived in rural Matagalpa.

But I'm not talking superhighways and illuminated casinos – I'm talking a better version of the present – keeping local quality of life the same while coaxing a little more movement out of everybody – including health care personnel – to enhance interaction, hopefully communication, and maybe life expectancy.

I do not own a paving company, but a career in medicine is all about choices. I intend to keep sweating in overloaded buses with balding tires. And, in the rare instances where appropriate, I will bear witness that just because it's the easiest and most obvious choice, a life of comfort is not the only way that opens before you.

A stretch? It's a smaller pothole than you think.
Semara Thomas is a second-year medical student from Los Angeles. She is interested in combining public health with clinical research and pursuing a field in internal medicine. She loves dogs, tea, traveling the globe (or cool U.S. destinations), and is the youngest of five.
One of the greatest challenges in public health is finding a way to bridge the gap between physicians and patients. This is particularly evident in underserved populations. The underserved community is any group that lacks adequate research, medical/nutritional knowledge, policy initiatives, and adequate access to health care treatments, providers, and insurance. Many of these problems can be addressed through quality advocacy and public health programs that seek to bring awareness, funding, and solutions to these global challenges. The need for more information is especially significant in underserved communities as health care providers and policy makers don’t fully understand the biological, behavioral, cultural and socioeconomic factors that lead to disease in underserved groups.

As a physician, I hope to make changes in the way that certain medical conditions affect underserved groups disproportionately. I will challenge my profession to do more research that targets pertinent medical problems in the context of an underserved patient, such as cardiovascular disease, cancer, endocrine disorders, obesity and diabetes. Aside from typical clinical studies that target historically neglected groups, I would like to explore different angles, such as patients’ and physicians’ perceptions of barriers. This can be translated into what motivates a physician to recommend screening for colorectal cancer, and what prevents a patient from undergoing a procedure. The knowledge gained from these types of studies will undoubtedly improve quality of care and diagnoses.

I also plan to create non-profit programs to empower patients to take an active role in managing their own health, finance, education, and future. These programs will focus on prevention and education. I feel that creating education initiatives will bridge the gap between physician and patient, so that we can overcome the barriers to improving the health of women, immigrants, the historically disadvantaged inner-city or rural residents, and those without adequate health insurance coverage.
Her world is veiled in a thick fog; people appear as shadows.

Allison Ungar is the 2009-2010 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 local traveling free eye clinic that serves the Greater Pittsburgh area.
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 with skin that 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. “Bienvenidos a la clínica de oftalmología, Señora Martínez. Yo soy Doctora Allison Ungar. Voy a sacar su cataratas hoy.” Welcome to the ophthalmology clinic, Mrs. Martinez. I am Dr. Allison Ungar. I will be taking out your cataracts today. Mrs. Martínez reaches out for the doctor’s hands to say a prayer together. The following day, her eye shields are peeled away to reveal a bright vision. She is surrounded by her family, her children with faces decades older, 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.
GROWING TRENDS OF OBESITY IN PEOPLE OF ALL SOCIOECONOMIC BACKGROUNDS

Meme Wu is a second-year medical student who thinks too much about the what’s and how’s of food.
Some Food for Thought

Meme Wu

While the US is no longer infamous for its gruesome meat factories, issues such as E. coli and Salmonella outbreaks and antibiotic use in animals prove that there are still many flaws within the food regulation system. But beyond these basic safety issues, attention should be paid to the effect that our food has on the nation’s obesity problem. For example, soft drinks contain large amounts of high fructose corn syrup, which in recent studies has been shown to affect leptin levels, a known biomarker for adiposity and energy consumption. Nonetheless, these beverages remain on the market and are regularly consumed.

Recently, there has been an increased emphasis on the importance of healthy eating decisions, but there is still a growing trend of obesity in people of all socioeconomic backgrounds. As a physician, I think it is important to not just educate our patients about the importance of exercise and lifestyle, but also to encourage them to select nutritious food as well. Eating decisions have a significant effect on overall health and are a vital part of disease prevention.
it seems imprudent to believe that throwing more money at the issue will somehow solve problems

Jonathan Zipkin is a second-year medical student.
The misapplication of the term “access to healthcare” has persisted without challenge. In the U.S., despite healthcare being readily available, lack of access has been equated with “unaffordable.” In a system that fails its patients yet spends more money on unnecessary diagnostic tests than any other country in the world, it seems imprudent to believe that throwing more money at the issue will somehow solve problems. The most unfortunate aspect of the misuse of this term is that the financial focus completely overshadows many underlying impediments to healthcare access. Statistics generally cited include the number of people who are uninsured, not the number of young adults who do not believe they need health insurance, the number of people who must travel over an hour to the closest doctor, or the percentage of Americans who choose to rely on online medical information, sometimes misdiagnosing and mistreating themselves due to misleading online information.

Ensuring that 47 million more people have health insurance will only result in unnecessarily longer wait times to see a doctor and in millions of people paying for a service they still do not want, yet with many restrictions on access still unchanged. The aim of developing policy and incentives should focus not on money to insure every American, but on resource allocation and medical networking. Initial steps include providing larger incentives for doctors to work in underserved areas and promoting established relationships between all individuals and primary care physicians. Only after the healthcare system has been responsibly optimized by improving these types of access should additional financial growth of the healthcare industry be considered.