



Physicians as Advocates

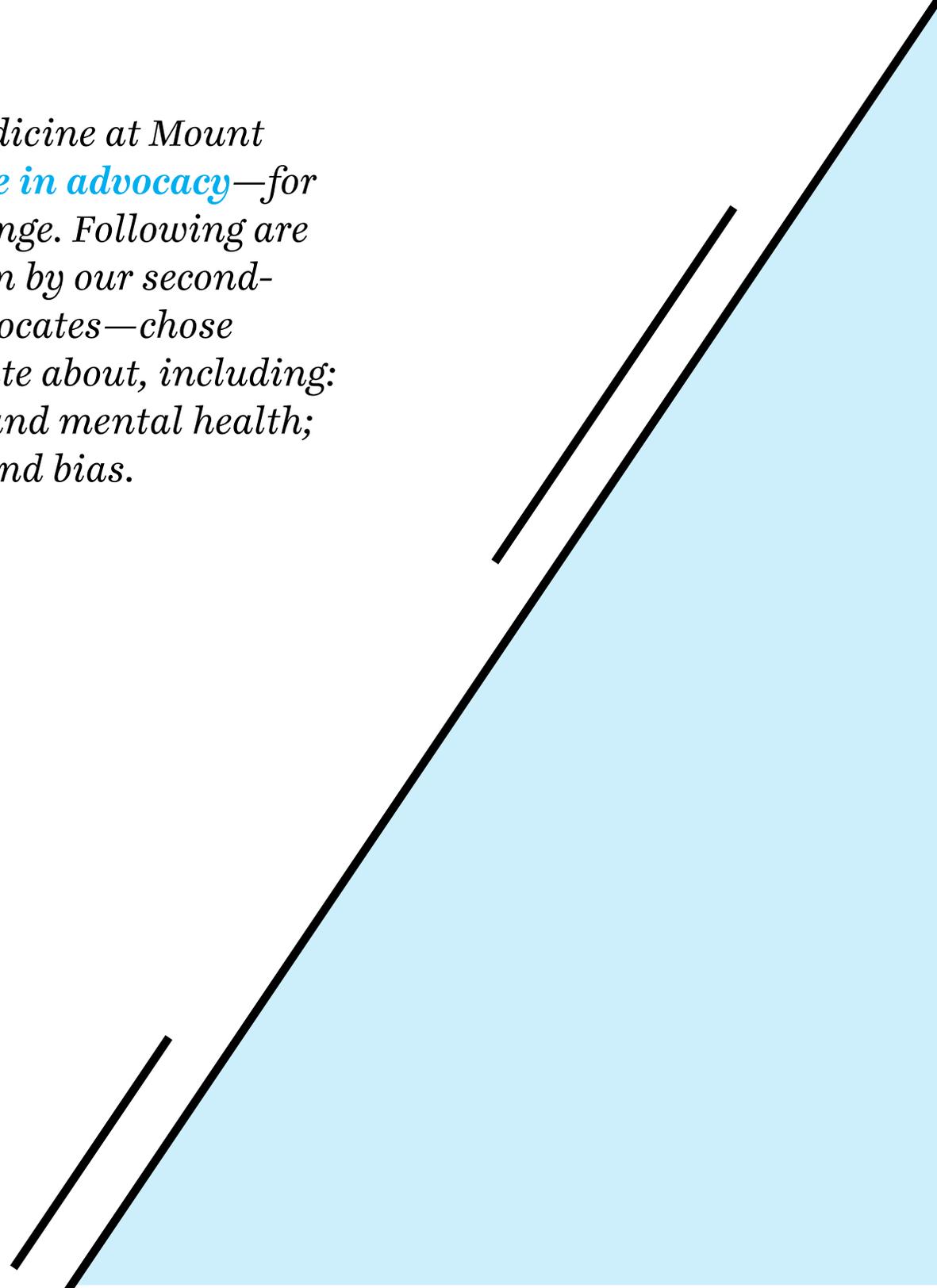
InFocus 4



Icahn
School of
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Mount
Sinai

*InFocus 4 at the Icahn School of Medicine at Mount Sinai examines the **physician's role in advocacy**—for patients, colleagues, and social change. Following are 10 exemplary Op-Ed articles written by our second-year medical students who—as advocates—chose health care topics they are passionate about, including: infectious disease; environmental and mental health; spiritual assessment; and racism and bias.*

*We are **proud** to share their work.*



Water— Better for Your Bottom

David Ali MD 2018

Hand washing is the hallmark preventive measure against harmful microorganisms. In hospital settings, it's actually the [single most effective measure](#) one can take to prevent the spread of bacteria and viruses. Needless to say, when our hands become soiled, we wash them. And boy, do we wash them. Standards of hand washing have even become implemented in health care settings, and a slew of [educational materials](#) currently circulate around its benefits from frequent practice. However, when it comes to our bottoms, we seem not to afford them the same luxury. Despite many who might enjoy a mid-day bathroom break, [an overwhelming majority opt for toilet paper](#) instead of water to cleanse themselves afterwards. Why? As uncomfortable as this might be to read, water is the superior cleaning agent, better for your bottom, and awaits its embrace from the Western world.

Advertised as “medicated paper” in the nascent era of toilet paper of the mid 1800s in the United States, in its early days, the toilet paper industry competed with the likes of newspapers, corn husks, and [old catalogs of Sears Roebuck & Co.](#) as cleansing modalities. Clearly, marketing was on their side. However, the origins of toilet paper have been speculated to have been around since the [sixth century](#) in medieval China, and throughout history, numerous iterations to its use have been well-documented. The usage of water as a means of cleansing “down there,” too, dates back to the early seventh century in the Middle East and India. Its usage has been rather consistent throughout history and at present reigns the dominant method of cleansing for over two-thirds of the world's population.

But what are in fact the benefits of using water to cleanse? Well, for starters, it's the most effective way to rid fecal material. Depending on technique, less fecal material is likely to remain after water cleansing, than by use of toilet paper alone. This is also a [doctor's recommended](#) “best practice” in reducing the spread of infections from fecal-to-mouth (fecal-oral). For those with sensitive bottoms, nothing is more irritating than rubbing dry (toilet) paper to clean yourself. With water, not only would this be a more effective

option, but also less irritable. There are even economic benefits. Every year, the average person will use 50 lbs. of toilet paper, [which will translate to over \\$6 billion across the U.S. population](#). Dumped into sewage and left for processing, the addition of toilet paper (and other slowly decomposed paper products) has played a significant role in the [rising sewer charges for U.S. households](#). One might argue, however, that by using water to cleanse oneself over toilet paper, sewage costs would increase more. However, [processing one roll of toilet paper requires on average 37 gallons of water](#) (in addition to other energy needs.) By switching to water to cleanse yourself, you would not only be saving your bottom from less clean, irritable, and expensive practices, but would also be preserving the environment.

Using water, however, may prove too difficult a task. It requires portable water, which sometimes might be cold and difficult to maneuver. For bathrooms without bidets (a built-in water cleansing appliance), it requires the stigma of bringing a bottle of water into your bathroom stall. It may be difficult to do, too, and inadvertently wetting yourself may prove too uncomfortable a task. (Some recommend mitigating this by using toilet paper to dry yourself afterward.) Still, some might argue that showering regularly will rid themselves of residual fecal material, regardless of their choice in the immediate cleansing ritual. It is clear that using water to cleanse oneself remains a challenging task, often not supported in our environments, and at very least might spring an awkward conversation with our colleagues.

But maybe water does not have to be such an awkward thing. After all, we use it for our hands, and for our bodies, so why not for our bottoms during the day? Why not give it a try if it might cut down on the irritation, cost, and carbon footprint—even if the odds are slim? Regardless of the social tribulation you might face, or the learning curve you might endure, one thing is for sure upon switching: your bottom end will thank you.

Looking In

Charlotte Austin MD 2018

You've heard the data before: in this country, black infants are four times as likely to die during birth as white infants, and twice as likely to die before their first birthday; black and native people have a shorter life expectancy than their white counterparts; and trans people are more likely to attempt suicide than their cisgender peers. Socially marginalized groups in this country—whether it be due to race, gender, or sexual orientation—are more likely to be unhealthy.

For a long time, medicine has pointed to “culture” to explain these inequities, arguing that black people have higher rates of heart disease because “soul food” is unhealthy or that immigrants are more often sick because they have too many people living in close quarters and have poor hygiene. More recently, science has looked to genetics to explain differences in disease prevalence and health outcomes between groups. To the extent these ideas have some truth to them, knowing them may have some, if limited, value. For example, doctors can educate their patients on healthy behaviors.

But blaming genetics and culture does not tell the whole story; instead, to do so only further stigmatizes already oppressed identities. Luckily, things may be changing. In medical school, we normally learn to explain health disparities in terms of behavior or genetics, but other explanations are permitted to seep in. For one, the physiologic hardships caused by stress are becoming better understood. It is well established that chronic stress can cause women to have premature babies or babies with low birth weight. In a class on LGBT health, I learned about “minority stress”—a medical euphemism that, true to its purpose, does not point fingers. (More accurate might be: “being the victim of homophobia or transphobia.”) The “social determinants of health” narrative has helped medicine better acknowledge that where a person lives and how much money she has can affect her access to healthy behaviors and health care. There is still a long way to go—for one, the medical establishment needs to become more comfortable naming racism as a risk factor for disease—but it's a start.

This said, there's still one area that medicine has great trouble finding fault in: itself. As a second year medical student coming to the close of my pre-clinical years, I'm continually surprised and amazed at how little recognition there is that the way that we are taught about something can

have a negative effect on our patient's health. When we learn about men who have sex with men only in the context of HIV and other sexually transmitted diseases, how can we be surprised when we learn that gay patients choose not to disclose their sexuality to providers?

It has long been known that doctors—who are overwhelmingly and disproportionately white—treat patients differently based on their race. Racism is deeply embedded in the American psyche—but medical education must take responsibility for its part in this. We must learn not to pathologize identities, rather than learning to associate being black with kidney and heart disease and being indigenous with alcoholism and obesity. And, significantly, we must increase the diversity of the physician workforce to match that of our nation—at all costs. Medical schools often emphasize the need for better early education to prepare applicants, but this argument ignores what can be done from within. This includes changing admissions criteria (standardized testing is an excellent predictor of one's ability to do well on standardized tests—and a person's wealth) and medical education to better suit the needs of a more diverse class.

Finally, when we speak of “access to care” issues in medicine, we act as if this is something abstract and outside of our control, due to issues like poverty and insurance status. We don't talk about how private hospitals segregate patients into two streams: one for those with private insurance, where wait times are short and physicians are experienced, and another for those with Medicaid, where wait times are up to five times as long and patients are more likely to be seen by residents. We don't talk about how Mount Sinai Hospital has no signs in languages other than English and only one full-time interpreter on staff. We don't talk about how NYU Hospital had a \$90 million surplus while the city's public hospitals—which provide care to those whom the private hospitals will not—are struggling to be financially viable.

It's time that medicine look inward to address health disparities.

So How Do We Actually *Die*?

Caitlin Braschi MD 2018

We stood around the patient as the circulating nurse called time out to administer the surgical safety checklist. A moment of silence was requested for the patient who would be losing her life that day. Or had she lost her life that day? I can't remember how it was phrased, but her pacemaker was going, an anesthesiologist was on the case, and we needed her liver to be viable. Before I knew it, my bloodied hands were deep in a person's abdominal cavity. The pressors started failing before the vessels were fully dissected, so there was a frantic push to preserve a blood pressure as the final cuts were made and cold perfusion was about to begin. Had we managed to keep her alive? The transplant fellow sliced open the right atrium. Exsanguination. To a second year medical student scrubbing in for the first time, cutting open the heart seemed like the antithesis of medicine. If the patient was alive before, she was certainly not now.

The leading cause of death in the U.S. is heart disease followed by cancer. Since the beginning of medical school, we have studied the pathophysiology of a multitude of disease processes and learned which carry the highest mortality rates. Yet no instructor has walked us through the pathophysiology of dying. Preclinical years are meant to prepare us for the wards, for the responsibility of having real patients. But real patients die, and about a third of them die in hospitals. Yet, nearly a quarter of graduating medical students feel that their schools provided inadequate education about death and dying. We will not be equipped to educate, counsel, and support our patients and their families without a fundamental understanding of the dying process.

How is it that cancer patients ultimately succumb to their diseases? I would imagine lung cancer and ovarian cancer manifest differently in the final days. Or do they? And what do I tell my future Alzheimer's patient and her family about the sixth leading cause of death in the U.S.? What should they expect in the last months and days?

Perhaps our professors of medicine did not have these discussions early in their medical training. After all, it has only been in the last 15 years that there has been a push to include end of life care in the standard medical school curriculum. And recognition and acceptance of palliative care has seen significant gains just in the last decade.

Maybe medical educators are not immune to the difficulties of facing mortality that haunt most people at some point in their lives. Is death too personal, too frightening to discuss?

Could it be that it doesn't matter? We treat the disease; we don't treat the dying process.

I think that it does matter. It matters to patients with terminal illness who want to maintain a certain quality of life. I know that it matters to family members who wonder if their loved one has given up when he stops eating, or if he's tortured by thirst in his final days. I know that it matters to daughters who want to know if their fathers can hear their "I love you's."

As physicians we are tasked with the responsibility to save lives. Patients' lives are in our hands but so are their deaths. As we closed the abdomen of the patient that day, I glanced over at the collection canisters that were overfilled with her blood. Yet there was her liver in a bucket on ice, ready to be rushed across town to save someone else's life. So how do we actually die? Please explain.

It's time that medicine look inward to address health disparities.

Vampires of the Hospital

Iris Chen MD 2018

It's 5 am, and you're just about to fall asleep despite gnawing pain. In that brief moment, on the cusp of consciousness, you are oddly aware of everything around you. You notice a shift in the air. It could be an encroaching dream, your imagination, or an unsolicited presence. In the dead darkness of the room, you sense that it draws closer. You feel the ghost of a touch on your arm. You awaken, confused and afraid. The start of a scream dies as the breath escapes your lips before you realize that you are in the hospital, and the presence is just the phlebotomist preparing tubes for your daily blood draw.

While appropriate as a setting for the start of another popular vampire drama, overutilization of daily lab draws is an inappropriate reflection of modern medicine's dependence on tests. Countless patients are unnecessarily stuck with needles every morning in order to draw labs such as complete blood counts (CBCs) and basic metabolic panels (BMPs) despite the same labs being normal the previous day. Aside from patient pain and discomfort, daily lab draws cause high rates of iatrogenic anemia and delirium. Furthermore, incidental findings may lead to costlier specialty tests and additional waste of nursing and phlebotomy time—all of which comes to a financial loss for the hospital and ultimately contributes in part to the \$906 billion wasted health care spending in the U.S. every year.

So why do we let this happen? Convenience, for one. On a drop-down menu on the electronic medical record, medical providers can easily order labs for newly admitted patients for multiple weeks with one click. Ordering labs for consecutive days saves time—a precious commodity in any busy health care provider's life. Furthermore, the practice of defensive medicine is deeply rooted in American medicine. Attending physicians fear being responsible for not ordering labs when indicated, whereas medical interns fear being reprimanded for failing to order labs. These all lead to unnecessary lab tests and our national health care debt. But should we compromise patient safety for convenience and fear of a slap on the wrist?

There is a lack of cost awareness due to a lack of training provided to medical professionals. With no national guidelines on when and how often certain labs should be checked, there are no clear expectations for those still in clinical training. Even if one provider does pay attention to ordering less labs, there is no recognition for reducing lab overutilization.

With such high stakes involved, many hospital quality improvement projects have tried their hand at tackling lab overutilization. To address a lack of cost awareness, randomized controlled trials have studied the effects of computerized display of lab charges; unfortunately, that has not led to any change. There have been computerized restrictions in ordering labs for more than 24 hours at a time, but that garnered a wave of physician dissatisfaction. There have been interventions that have tracked lab orders and provided “report cards,” or regular feedback, on performance to health care providers, which resulted in measly reductions in lab overutilization.

In the end, there needs to be a multipronged approach to addressing this issue to effect a sustainable significant change. We need to implement both a top-down and bottom-up approach to education—increasing training of lab indications for health care providers and even increasing awareness in patients themselves. We need to provide constant reminders to health care providers in the hospital to strongly consider indications before ordering certain labs—from posters, to screensavers, to even pop-up signs on the computer. We need to take a stand in addressing wasted health care spending, by starting with unnecessary daily lab draws that also come at a cost to patient safety. Solving this is a win-win. And, with this in mind, you can get a peaceful night's sleep in the hospital. Win-win-win.

Going Vegan: Another Trend or the Key to World Salvation?

Marisa Cornejo MD 2018

Have you ever been at a dinner party and as you are piling on the juicy mini burgers, there is that friend standing away from the food saying “Gah, so sorry, I just can’t eat any of that.” And you know in their head what they are actually thinking is “how could you expect me to eat any of this, you uncivilized carnivore?” You ruminates, “Geez, I could never live like that. This ‘vegan’ thing is just another trend that will soon pass and they are not as superior as they think they are.” But... what if they were right? What if their lifestyle was not just some animal-loving-self-loathing torture but could actually save the planet? What if, in reality, not eating meat is great for everyone: you, the animal, and the world?

Many people have been told that eating less meat has health benefits. However, the extent to which a meatless lifestyle increases overall wellbeing is overlooked. A vegetarian diet, where meat but not all animal products are off the table, lowers your risk of death due to heart disease. It lowers bad LDL cholesterol, blood pressure, rates of type 2 diabetes, and even lowers risk of cancer. In fact, not eating meat has been associated with an increased life expectancy!^{1, 2} A recent 2016 review study found that participants on a vegetarian diet lost significantly more weight than those in the non-vegetarian diet group.³ Not eating meat can help you get healthy, lose weight, and live longer.

The health benefits are undeniable, but how do our meat-loving tendencies affect animals? Seventy billion farm animals are raised each year worldwide and more than six million are killed for food every hour.⁴ The rate at which animal agriculture is growing is not sustainable, and animal welfare has been ignored in order to address the insatiable demand for animal products. Newborn animals are taken from their mothers and put into social isolation. Farms now resemble industrial factories where animals are packed into small spaces and can barely move. Many animals never have access to the outdoors and are forced to live in a constant state of severe physical and mental distress.

The knowledge of vegetarian diet health benefits and the questionable animal welfare issues involved in animal agriculture are well known but have still proven insufficient to encourage lifestyle changes in the majority of Americans. However, there is another factor to bear in mind the next time you decide what’s for dinner. The 2014 documentary *Cowspiracy: The Sustainability Secret* shed light on an important issue that has been kept surprisingly quiet. Animal agriculture brutally impacts the environment. It directly influences climate change, fresh water resources, deforestation, land use, and waste production. Here are some quotes taken from the documentary fact page⁴: “Livestock and their byproducts account for at least 32,000 million tons of carbon dioxide (CO₂) per year, or fifty-one percent of all worldwide greenhouse gas emissions. Twenty-five hundred gallons of water are needed to produce one pound of beef. Five percent of water consumed in the U.S. is by private homes. Fifty-five percent of water consumed in the U.S. is for animal agriculture. Animal agriculture is the leading cause of species extinction, ocean dead zones, water pollution, and habitat destruction. The leading causes of rainforest destruction are livestock and feed crops.” The profoundly negative effect of eating meat on the environment is undisputable.

Even with this information, I must acknowledge how difficult it is to restrict your meat and dairy intake. Current America is just not set up for vegetarians. Burger King now offers a bacon cheeseburger with a side of fries, a small drink, four-piece chicken nuggets, and a cookie for only \$4.00. Not to mention, most meat eaters might find it hard to know what to eat if they went vegetarian. It is not easy. But, why? Our society is brainwashed, from a very young age that animal products are necessary components of our diet. For proof of this, simply look at the food pyramid!

Change is not easy. I ask you to try going one day a week not eating animal products. Just one: “Each day, a person who eats a vegan diet saves 1,100 gallons of water, 45 pounds of grain, 30 sq. ft. of forested land, 20 lbs. CO₂ equivalent, and one animal’s life.”⁴ Then if you want, slowly increase your vegan allowance to twice or three times a week. With open minds and steady determination we can change the current trajectory of our world’s future.

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Having Faith and Medicine

Mian Khalid MD 2018

Jamal*, a man in his 90s*, was admitted to the hospital for metastatic lymphoma. He was to be discharged to a rehab facility because there was no treatment his wife, Ayesha*, told me. She did not know that I was a medical student because I did not wear my white coat and I introduced myself as a volunteer from the Department of Spirituality Care. I was following my training by the Chaplain to talk to my patient about his emotional and spiritual needs. But this training of medical students is not commonplace.

In college, one of my English professors shared her feedback on my medical school personal statement: “Mian, Americans, because of separation of church and state, are uncomfortable talking about spirituality in ways other cultures are not.” Immigrating to the United States at the age of 16, I qualified as hailing from an “other culture.” I also did not feel uncomfortable discussing my commitment to community service through the lens of my spirituality. References to my spirituality motivating me towards service and patient care survived my final draft revision. And I was accepted into medical school.

Dispassionate research lectures and medical textbooks initially challenged my perception of spirituality in patient care. If trastuzumab can treat breast cancer and if macrolides are effective against atypical pneumonia, then what is the effectiveness of spirituality? I struggled to reconcile regenerative healing of the soul with clinical treatment of the body. When I reached out to the Chief Chaplain of my main hospital, I sought to answer my own question by starting a program for medical students to see patients about their emotional and spiritual needs. My interactions with patients through this program have been my most impactful experiences in medical school thus far.

Jamal was in a contact-precaution room. I tried to gain his attention, but Jamal just blinked at the wall. “He ignores everyone. He is not feeling well,” Ayesha explained. I acknowledged her with a thank-you and requested talking to him through her. She agreed. I recalled open-ended questions from my training, ranging from the opener, “How are you feeling today?” to the more personal, “Would you like to share what’s on your mind?” Jamal did not flinch and Ayesha filled me in with his daily activities. She seemed

grateful that I cared about Jamal’s emotional needs beyond his body’s obvious medical needs.

In medical school education, a patient’s spirituality is not considered an integral aspect of patient care. Perhaps the jam-packed nature of a comprehensive social history does not allow for significant time to be spent on talking to a patient about their spiritual needs in an open-ended fashion. However, research studies have shown that ninety-four percent of hospitalized patients believe spiritual health is as important as their physical health, forty percent of patients use their faith to cope with illness, and twenty-five percent of patients use prayer for healing. Spirituality is an extremely important aspect of patients’ identities and is tied to their perception of their physical and mental wellness. Thus, it is crucial that medical students, as physicians in-training, learn how to engage their patients about emotional and spiritual needs.

Teaching medical students about the art of active listening and engaging with patients about their spiritual needs is challenging, given the constraints in medical curriculum. However, hospitals across the United States employ chaplains to address patients’ needs. Chaplains are non-denominational and offer patients emotional and spiritual support regardless of their religious identity. They can serve as effective teachers in educating medical students on how to engage with patients who need emotional and spiritual support.

Another group of teachers well-versed in the art of conversing with the patient are palliative care physicians. Since the goal of palliative care is to improve the quality of life for patients and their families, they understand the critical need of connecting with patients on a deeper level, beyond clinical treatment. Palliative care physicians can also serve as role models for medical students because they undergo residency training.

I felt disappointed at not being able to talk to Jamal, but I knew I was not there for me. Focusing on the patient, I asked him, “Would you like me to pray with you?” Ayesha responded, “He won’t talk, but I know he would.” I tenderly held Jamal’s right hand in both my gloved hands. It was warm. I closed my eyes and whispered a prayer in a low, almost musical, tone. I felt his hand flinch. I opened my eyes and saw silent tears streaming down his face. I felt as if his pain was receding from his body.

*Patient details have been anonymized.

-Statistics paper citation: Saguil, Aaron, and Phelps, Karen. “The Spiritual Assessment” American Family Physician, 2012. <http://www.aafp.org/afp/2012/0915/p546.html#afp20120915p546-en>

Mental Health is Health

James Murphy MD 2018

I had just finished a run and was about to shower when the phone rang. I picked up and heard my mother screaming “He’s dead! He’s dead! Daddy is dead!” over and over. After being bounced around over the phone between several family members and the NJ Transit Police, it became clear that my father had jumped in front of a northbound commuter train on a warm September day.

Mental illness is kept fairly invisible in America. Some of this naturally stems from the impossibility of perfectly visualizing what is going on in the synapses of a person’s brain in the moments before they hurl themselves in front of a train. Some of this, however, stems from a culture of secrets, a stigma attached to a family of illnesses that share many traits with other diseases to which few would attach moral judgment.

It’s funny how similar cancer, always popular in the media, and mental illness really are. Both can strike at any time, to anyone, but can also have strong associations with family history, environmental exposure, and substance abuse. However, communities rally around people with cancer. We host walks, we shave our heads in solidarity, we blame the disease and not the person it afflicts. Fewer people want to discuss what makes living every day harder for some people than others, and this prevents them from getting help.

To be sure, there are some symptoms of mental illness—*anxiety, lack of energy, or inattentiveness* that make self-advocating and asking for help difficult. Similarly, diagnosing colon or prostate cancer can be difficult as they require testing in a sensitive part of the body. Still, we are sure to test everyone at risk on a regular basis—something we should be doing to all patients who may be suffering from “invisible illness.”

A PHQ-2 (a quick assessment for depressive symptoms) is much less invasive than a colonoscopy.

What is such a shame, is that if given the chance the medical profession can treat, and sometimes even cure, these diseases. Per medical literature, “Individuals with an untreated DAS [depressive, anxiety, and substance use] disorder at baseline have a substantial likelihood of remission without any

subsequent intervention.” These are much better success rates than those boasted by oncologists, or even knee surgeons.

As a medical student, I was taught that having a first-degree relative commit suicide puts a patient at at least a two times higher risk of committing suicide as compared to the general public. As a human being, I knew that I was distracted, having trouble getting out of bed, and contemplating my own death far more than the average 24-year-old. In light of my father’s death, I critically evaluated my own wellbeing, and took myself in for a checkup. And then a series of weekly appointments. And finally, various doses of Wellbutrin, until we found a level that made me feel, well... well again.

Revealing this is hard. Despite the improved clarity of thought and energy levels that have come with treatment, the stigma attached to mental illness made this difficult. But, the only way to fight that stigma is to normalize mental health as just plain old health. I never think to hide my Advil or multivitamin, so why should I hide something that has helped me so much more?

In exchange for me opening up to the whole wide world here in this paper, I want to ask you to open up to a friend, a neighbor, a loved one. If you’re suffering, share that burden with someone. Every person I’ve opened up to has responded positively, and most have shared a direct experience with mental illness right back to me. Start the conversation. Encourage people to get the help they need.

If you aren’t feeling your best, don’t be afraid to go in for a check-up, just as you would if your back was sore or your ears were ringing. And for all the health care providers out there, ask the “sensitive” questions. You wouldn’t skip over discussing allergies, medications, or past surgeries, so don’t skip over questions of mental health. Together, we can have a happier and healthier tomorrow.

If you or someone you know is considering suicide, the National Suicide Prevention Lifeline is available 24/7—please call 1 (800) 273-8255.

Let All Children Benefit from the HPV Vaccine

Kyle Riley MD 2018

We have a winner! No, I am not talking about the ongoing 2016 Democrat and Republican debates that are currently front and center in the news. Instead, I'm speaking about the study in Pediatrics (March 2016) that reveals that the human papillomavirus (HPV) vaccine, whose acceptance has been debated since 2006 when health professionals recommended it for females 11-26 years old, is successful in decreasing HPV.

Why the debate? The CDC details the need for the HPV vaccination. HPV is the leading sexually transmitted infection in the U.S. Seventy-nine million Americans have HPV, with 14 million new infections annually. Most people with HPV are symptom free and their infections eventually go away. There are many strains of HPV, with more than 40 that can cause cancer in both women and men. This is why in 2011 the vaccine was recommended for boys as well. The list includes cancer of the cervix, vagina, vulva, penis, anus, and throat.

Yet there has been pushback in making this vaccine mandatory. The National Conference of State Legislatures website discusses that some parents have a moral objection to the vaccine being mandated. For example, in 2007, then Texas Governor Rick Perry approved an executive order that made it necessary for Texas girls to get the HPV vaccine before starting sixth grade. Even though Perry provided an opt-out alternative, his order was finally quashed because some religious parents were upset with the idea of vaccinating young children against a sexually transmitted virus. There have also been concerns expressed that the vaccine would make a young child more sexually active. Cost and safety issues have also been mentioned.

However, the latest research in Pediatrics compares the HPV rates of a group of 14 to 34 year old women from 2003–2006 (before HPV vaccine recommended) to a group of 14 to 34 year old women from 2009–2014 (after HPV vaccine recommended). The results show that the vaccine decreased HPV in females 14 to 19 years old by a whopping sixty-four percent and thirty-four percent in women 20 to 24 years. We have a winner with the HPV vaccine, and we need to make it a required vaccine.

Mandating the HPV vaccine would further decrease the number of HPV infections. Currently the HPV vaccination completion rate for the recommended three doses is relatively low. For 2014, The CDC noted that for girls 13-17 years old sixty percent had one dose, while only forty percent had all three doses. For boys the rates were forty-two percent and twenty-two percent respectively. Eighty percent is the Healthy People 2020 goal.

The stigma that the vaccine would increase sexual activity in young children needs to be addressed head-on. The vaccine is recommended for both boys and girls starting at age 11 in order to have all three doses completed before he/she becomes sexually active and could be exposed to HPV. The CDC also highlights that the vaccine has a higher immune response in younger children. Research to-date has shown that the stigma is not true. A study published in Pediatrics in 2012 revealed that “HPV vaccination of girls at the recommended ages was not associated with increased markers of sexual activity, as measured by pregnancy, sexually transmitted disease infections and/or contraceptive counseling for up to three years after vaccination.” The latest 2016 Pediatric study also notes that between the pre-HPV vaccine group (2003-2006) and the vaccine group (2009-2012) “there were no significant changes in the percentage of females who reported having had sex or in past year or lifetime sexual partners in any age group except 20 to 24 year olds.” But no differences were identified in the young pre-teen and teen years.

Making the vaccine mandatory would also position it alongside other child and teen vaccines such as mumps and measles. Parents would have the opportunity to discuss the vaccine and any concerns with their child's doctor. Hopefully, with time and the understanding that it helps to prevent certain types of cancer, more parents will support the vaccine.

The benefits of the HPV vaccine are known. It has been tested and researched. It is currently available. It is safe with limited side effects. It does not make young children more sexually active. IT LOWERS HPV INFECTIONS. It is time to end the debate on the HPV vaccine, call it the winner it is, and save more lives by making it mandatory.

What to Do with Illegal Immigrants and Are We Scared of the Wrong Monster?

Olga Salianski MD 2018

Nice to meet you, I'm the boogeyman. I am one of the people you are taught to fear—the illegal immigrant. Indeed, I once spent two years in this country as one of its 11 million illegal immigrants. Years have passed since then; I have gone through a long and arduous asylum process to become an American citizen, and now that I have the privilege and protection of citizenship, it is my duty to speak on behalf of those who can't.

The anti-illegal immigrant rhetoric is built on the myth that “the illegals” are scary and dangerous people who bring drugs and crime and who take jobs from Americans. They drain our resources and perpetrate violence against us. Life will be great only when the last bus full of deportees crosses the Mexican border! This nebulous but terrifying image of “the illegals” has successfully attracted many Americans to the political candidates who promise to deliver them from the evils of illegal immigration.

This image also couldn't be further from the truth. As an illegal immigrant myself, I lived, worked, and made friends with many others like me. What I learned from that experience was that we, the illegal immigrants, were in fact among the most hard-working and yet the most defenseless people in this country.

First of all, none of us “illegals” would ever dream of committing a crime or doing anything that could lead to arrest and deportation. In our effort to stay under the radar of immigration authorities, we were the most law-abiding New Yorkers. Conversely, we were often on the receiving end of violence and crime at the hands of those who knew our status and knew we would be too scared to go to the police no matter what was done to us. An example of this was my first job.

I was an enamel painter at a jewelry manufacturing facility in Queens, where almost all other workers were illegal immigrants as well. We created enamel designs on gold jewelry to be sold at fine department stores. We worked 14-hour days in a dirty, poorly ventilated room, handling smelly, toxic chemicals with our bare hands. An industrial-size air compressor roared behind our backs, giving us one migraine after another. A month into this job, my hands became covered with an itchy, painful rash which cracked, bled, and made washing my hands feel like waves of electric shock were spreading through my body. I had no health insurance and no money to see a doctor. Neither did the rest of my co-workers whose hands, elbows, and faces broke out the same way.

For our work, we were paid pennies of commission, and if the boss wasn't happy with the result, he threw our day's work into a bucket of paint stripper and paid us zero. The worst part, however, wasn't the money or the lack of employee benefits. It was the abuse. The boss would scream insults in our faces, throw things, curse, and call us stupid. He made heinous sexual, racial, and homophobic comments. He groped women and put a metal detector to their breasts looking for body piercings.

And yet no matter what happened, everyone came back to work the next morning because everyone had important reasons to be there. Some of us had escaped from persecution by dictatorial political regimes; some were nearly killed for being gay in their home countries; many had families abroad who depended on the money they sent. With each illegal immigrant came a dramatic story, and sometimes a tragic one. Each one of us hoped for a better future for ourselves and our families, so we sacrificed our health and endured mistreatment.

Having experienced life on the other side of the “illegal” paradigm, I see how absurd it is to demonize and blame illegal immigrants for this country's problems. They are invisible and powerless, denied of basic humanity, living in dingy basements and doing jobs no one else in their right mind would ever agree to do. Instead of spending billions of dollars on deporting these already marginalized people, how about we give them work permits and essential human rights? That's all they ask for. In return for this gift, I know they will fully dedicate themselves to making their new home country a better place. And this, not mass deportation, can make America great again.

Let's Not Forget About Alzheimer's

Eric Silberman MD 2018

My grandmother died from Alzheimer's more than 10 years ago, but the smell of her nursing home still haunts me today.

Grandma Esther died when I was 13. Going to visit her was a confusing, frustrating, scary experience. Over just a few years, a woman who once held us so close completely forgot us. She was a Polish Holocaust survivor whose first language was Yiddish, and by the time she was in the nursing home, Yiddish was all she remembered how to speak. I felt helpless.

It was hard to relate to anyone there. Some patients would yell; some would steal each other's belongings; and others would patrol the hallways with stern, grimacing looks. The dining room, where these and more would gather to eat—or refuse to eat—the uniformly brownish food, was a scene of complete chaos. And the smell—that haunting smell—was something of the worst combination of body odor, soiled garments, and disinfectant.

Seeing all of this so young was deeply upsetting. No child should have to watch the horrifying erosion of a loved one's mind, nor should any adult, for that matter. Currently, Alzheimer's disease is not a funding priority in our country. But with our changing demographics, more and more will suffer through experiencing or witnessing this disease. If we are to protect current and future generations from Alzheimer's, we need to act now to increase government funding to find a cure.

Alzheimer's, which is ultimately fatal, is the fifth leading cause of death for individuals above the age of 65. But, unlike heart disease, cancer, and the other leading causes of death, it is the only one for which incidence is not decreasing, but rapidly increasing. It is America's most expensive disease, costing the government \$200 billion annually, and the only one of the nation's top 10 causes of death that can't be prevented or cured.

Over 5 million Americans live with Alzheimer's disease. With our increased lifespan, that number could increase up to 13.5 million by 2050. Not only would this put a significant financial burden on even more American families, it would also put a possibly crippling burden on the Medicare system: the Alzheimer's Association predicts Medicare costs could rise to \$589 billion annually by 2050.

Unlike other diseases that receive much public attention, those with Alzheimer's do not have the opportunity to speak up about the experience of the disease; there are no survivors of Alzheimer's. Therefore, it is up to the rest of us to speak out. And there are many of us: 73 million voters in the upcoming presidential election have or have had a close friend or family member with Alzheimer's. Eighty-two percent of voters are concerned about Alzheimer's. So why isn't this an issue candidates firmly address?

Some progress has been made recently. In December of 2015, Congress increased funding for Alzheimer's to close to \$1 billion from \$586 million. But advocates say it's not enough, that we need \$2 billion annually to find a cure. And, though it is true that many of the leading presidential candidates of both parties have spoken about increasing Alzheimer's funding, it has been mostly in vague terms. Only Hillary Clinton has promised the \$2 billion. But this should not be a single-candidate issue, or a partisan one: all candidates should be giving concrete attention to this critical disease.

Cancer research receives more than \$5 billion annually and HIV research receives more than \$2 billion. But as we continue to treat, cure, and eventually eradicate diseases like cancer, heart disease, diabetes, and others—as we should—people live longer. With the only risk factor for Alzheimer's being age, as the rates of the other diseases drop, the rate of Alzheimer's can only rise.

We need to anticipate the economics of our current setup and act before it is too late. Too late means that by 2050 the number of people with Alzheimer's disease triples. By then, fundraiser after fundraiser will not slow the course of the disease. As much as we need to consider Alzheimer's a medical condition, we need to view it as a societal condition. We have an opportunity to avert an impending public health crisis, but we need political leadership to be proactive, and to take action while we still have the luxury of foresight. Our presidential candidates need to focus on Alzheimer's, so that no person—patient, caretaker, or loved one—has to experience the devastating effects of Alzheimer's.



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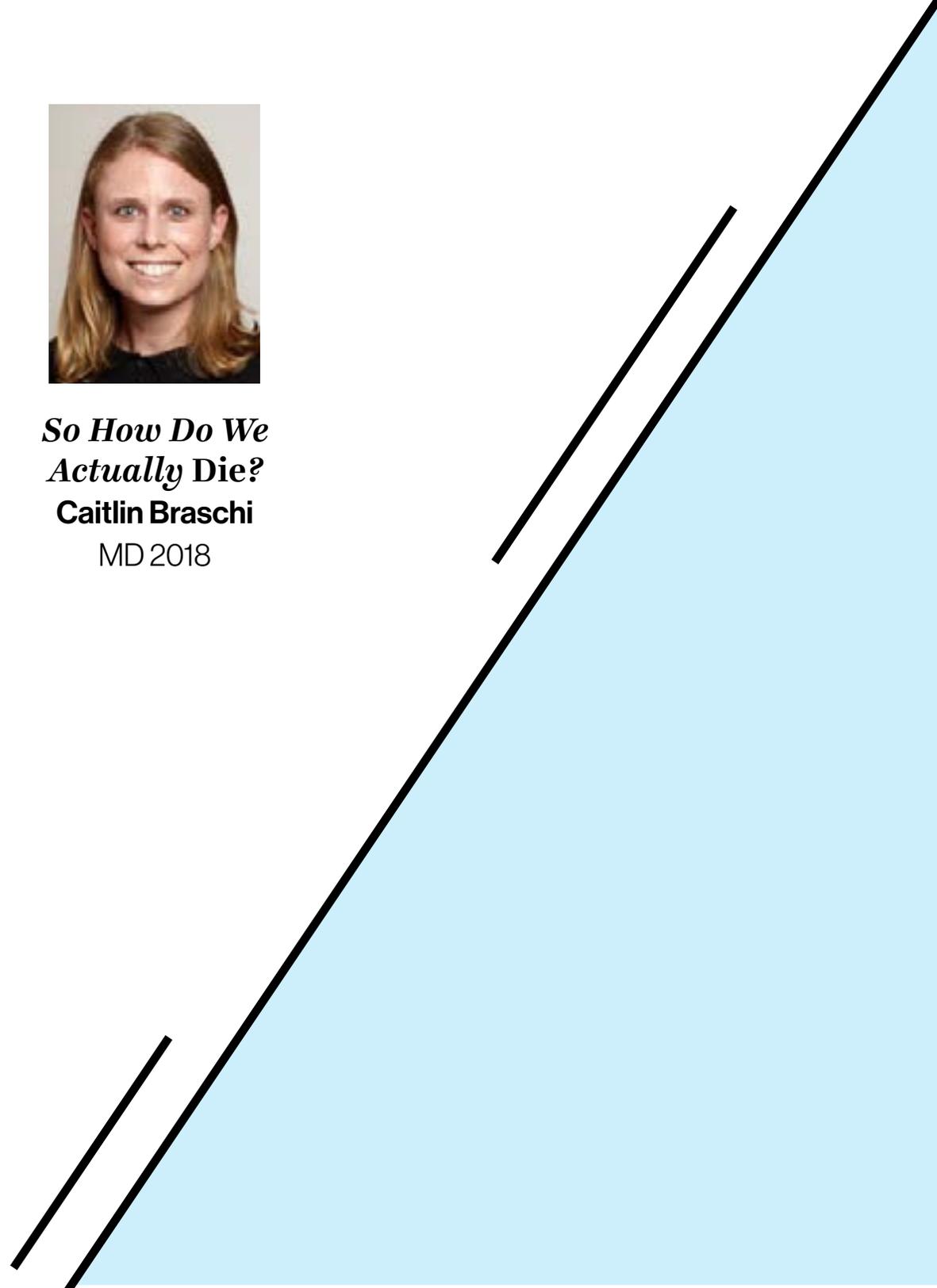
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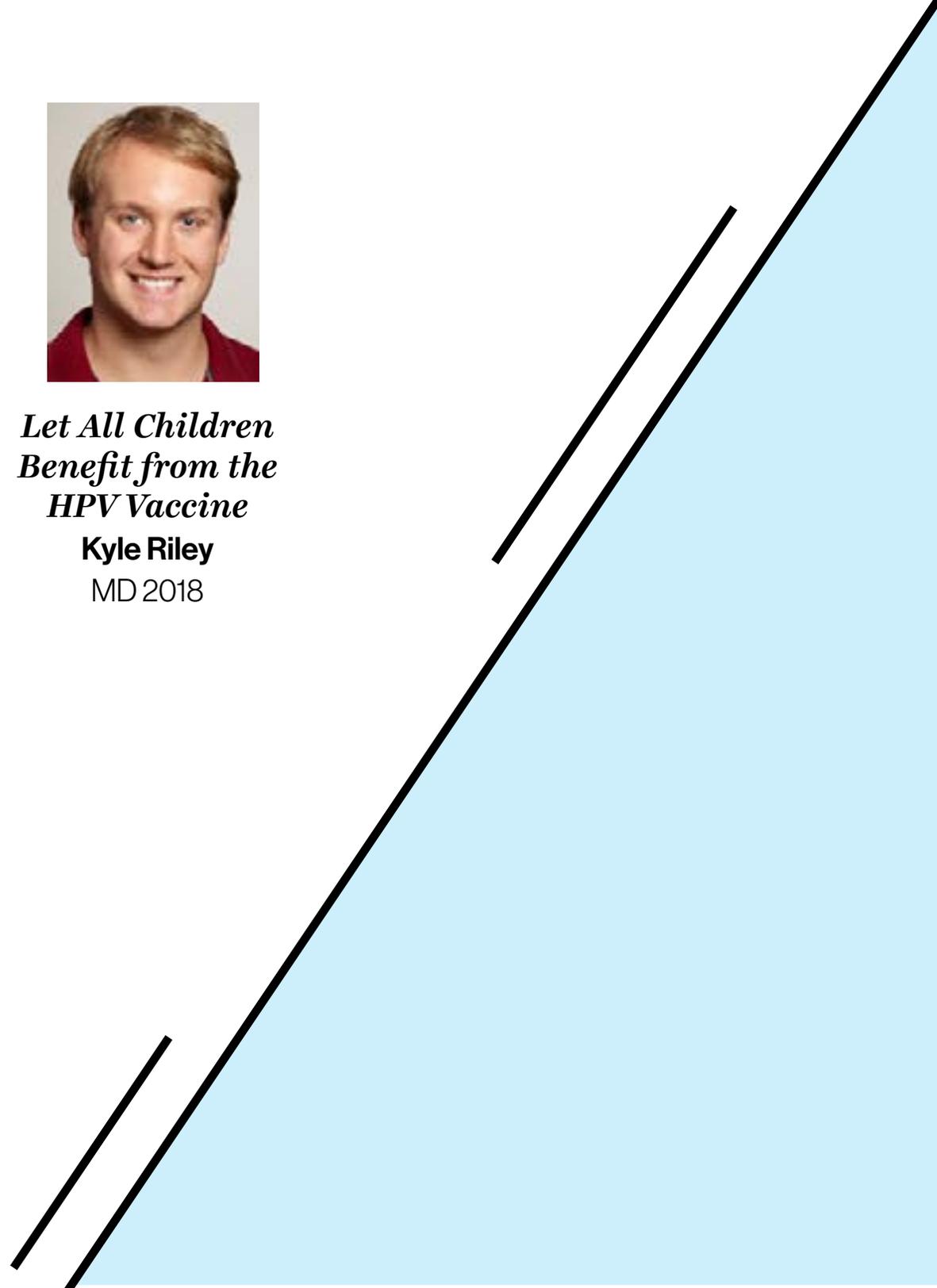
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