As part of the Icahn School of Medicine at Mount Sinai's InFocus Week 4 on advocacy and the physician’s role as an advocate, Year 2 students wrote an OpEd or created a stand-alone OpEd Illustration on a health topic they were passionate about. The following seven submissions were selected as exemplary examples and we are proud to share them here.
“I could never be a primary care doctor,” my friend and fellow medical student says as she pops a french fry into her mouth. There are five or six of us sitting around a hospital cafeteria table, grabbing a quick lunch between our morning and afternoon lectures. “I mean, seeing fat people with diabetes and heart disease all day. It would just be so frustrating, because they did it to themselves, you know?”

My friend is not alone in her attitude towards fat patients. Most experts agree that genetic, socioeconomic and environmental factors all contribute to obesity, many of which are out of patients’ control. Nearly one in six students agreed with the statement, “I don’t like fat people very much.”

Sadly, anti-fat attitudes do not disappear upon medical school graduation. Physicians’ level of respect for patients has actually been shown to decrease as a patient’s BMI goes up. Even health professionals who specialize in obesity have shown high levels of anti-fat bias — including endorsement of stereotypes that fat people are “lazy,” “stupid,” and “worthless” — according to a study published in the Journal of General Internal Medicine in 2009.

The numbers are disturbing, but not surprising. At my medical school, I find that obesity is frequently regarded as a punch line rather than a category of discrimination. When we learned that obesity exacerbates arthritis due to increased weight burden on the joints, our lecture hall erupted into giggles. Our teachers and mentors are no better. One of my professors actually showed us a slide with two stick figures, one fat and one skinny. He drew a check mark above the skinny one, an “X” above the fat one. More laughter.

Does it matter that physicians are biased against their fat patients? On a public health level, the answer is a resounding yes. Obese patients are less likely to access care due to fear of mistreatment. Physicians spend less time with obese patients. The barriers to care that arise from fat bias have been well documented.

I can already hear the voices of my opponents: “but isn’t fat unhealthy? ” That question has already been extensively addressed — and challenged — by people much smarter than I am. Obesity is certainly a risk factor for many diseases. So are age, race, gender, and family history. It is unclear whether and to what extent we can choose our body size any more than we can choose those characteristics. All too frequently in medicine, the terms “fat” and “unhealthy” are mistakenly collapsed.

Still, even if being fat were somehow a choice, would that give us an excuse to treat fat patients poorly? When has judgment ever been conducive to taking care of a patient? Creating a clinical environment so hostile that fat patients are afraid to access care is not helping anybody.

Obviously many paradigm shifts need to take place in order to reduce fat bias. Yet I think one place to start is in medical schools. Despite its pervasiveness, fat bias has never been mentioned — much less formally addressed — in my medical education. As trainees of the medical profession, we will inevitably take care of thousands of overweight and obese patients in our careers. Yet we get no formal training in sensitivity to weight issues.

As we build our medical curricula to include cultural competence training around race, gender, and sexual orientation, we should include body size. We need mentors to guide us in critically examining the assumptions we make about fat patients (and people). We need to learn to challenge the implicit and explicit biases we hold. We need to reiterate, over and over, that fat patients cannot be written off because they “do it to themselves.” Our future patients deserve better.
WHO SHOULD WE EXPECT TO TELL THE DIFFERENCE?
Alzheimer’s Association estimates that by 2050, as many as 16 million people, aged 65 and older, will have dementia. Furthermore, the current and anticipated financial cost and caregiver burden correspond with these staggering numbers.

But right now, there is no easy solution to this disease, not for patients, caregivers, scientists, or legislators. It is a complex disease that progresses at a glacial pace with devastating results. Anyone who has lived with dementia, as a patient, family member, or caregiver, knows that there is so much to be done. A short list includes fostering scientific research to find a way to cure or slow the progression of this disease, providing support and educational programs for caregivers and family members to help them meet the diverse and unpredictable needs of Alzheimer’s patients, and raising awareness about the disease and the burdens that caregivers face day to day.

There is no question that a cure would be ideal, but in the meantime, there is something else we can do: we can plan for the future. We can begin to think about our end of life preferences and the health care goals that we have for our final days, especially in the event that we suffer from a disease as devastating as Alzheimer’s. We know that those who engage in early communication about their end of life preferences have a better quality of life, reduced use of invasive procedures near death, and receive care that is more consistent with their wishes. Conversely, failure to address end of life issues often results in a lengthy death with greater suffering, increased grief and stress for family members, and higher health care costs.

These are not easy conversations to have, and research has shown that there are many barriers to communication about end of life care. One of the primary obstacles are health care providers themselves. Patients look to their doctors to initiate these discussions and provide a framework for thinking through their options and preferences. However, many clinicians feel they lack the training and time to adequately address these issues and manage their patients’ reactions.

As a second-year medical student at the Icahn School of Medicine at Mount Sinai (ISMMS) in New York City, I have started to learn how to have these conversations as a part of my clinical training course, the Art and Science of Medicine – and just how challenging they are. My classmates and I have practiced with each other, and we have gone out into the hospital and tried to have explore these issues with patients. It is clear that addressing a patient’s goals and values is a skill that will take time and practice to perfect, just as the skills of the physical exam or any procedure will.

It is imperative, then, that we adequately train current and future physicians to address advance care planning. This training should start in medical school, as it does at ISMMS, and continue through residency training, and beyond. It should include preparation for conversations about the end of life, as well as ways to identify patients who would benefit from these discussions and the optimal timing for these conversations (before serious illness strikes). Because these conversations can make all patients – with dementia and without – feel seen, heard, and respected.

Most people tune into the Oscars to see what the stars are wearing, check how their ballot will fare in the office pool, or witness the moments that will make up tomorrow’s punchlines on the late night shows. Most people do not tune in to watch the winners turn their acceptance speech into an advocacy platform. But perhaps the most important moment of the 2015 Oscars came when Julianne Moore used her Best Actress speech for her role the film Still Alice to shine a light on Alzheimer’s disease. She said, “So many people with this disease feel isolated and marginalized ... people with Alzheimer’s deserve to be seen so we can find a cure.”

And they do – finding a cure is of paramount importance to the estimated 5.2 million Americans who currently have Alzheimer’s and the millions more who will be diagnosed as the baby boom generation ages. The
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On Sunday February 15th, Steve Montador, a 10-year veteran of the National Hockey League was found dead in his Ontario home. Montador, a 35-year-old defenseman, had struggled with depression since 2013. Although the autopsy results are still pending, news outlets linked his depression and death to a career filled with concussions. In fact, Montador’s career was ended by a concussion sustained in 2012. Montador’s story is not unique to professional athletes. In May 2012, former NFL linebacker Junior Seau committed suicide. Just one year later, the NIH determined that Seau suffered from chronic traumatic encephalopathy (CTE), a progressive disease linked to repeated concussions and brain trauma. Many other former athletes with a history of repeated concussions have killed themselves. Despite increased news coverage about the consequences of head trauma in sports, scientific research has not yielded definitive results about the prevention of concussion. Even more surprising however, is the lack of data that is made available to the public (and physicians) about concussions in professional sports. Recently, the NFL has been lauded for expanding their concussion-reporting efforts, yet this data is locked away for league use only. If we are to prevent CTE, we need to prevent repeated concussions, and to do that, we must understand where and when athletes are at risk. Professional sports leagues must make their concussion data available to the scientific community for the health of their athletes and the 35 million American children who participate in organized sports each year.

Sports-related concussion is estimated to be the leading cause of CTE and traumatic brain injury (TBI). Approximately 2 million concussions occur each year in sports leagues across the United States. Despite its prevalence, concussions are vastly under recognized and under reported in both amateur and professional sports. In recent years, the NFL has received increased attention for its “concussion epidemic.” As a response to harsh criticism, the NFL instituted a number of rule changes designed to prevent concussion, though the data on their efficacy is not publically available. The league has reported that their independent analyses indicate that the rule changes are reducing concussion for at-risk players, but taking the NFL’s word at face value is insufficient. Their methods and data must be available for public consumption. There is no data on the football-related concussions that occur published by the NFL. The only such data is independently aggregated by PBS Frontline as a response to its unavailability. Believe it or not, other leagues are years behind even the NFL. The burden of concussion in the NHL, for example, is just coming to light.

Professional sporting leagues provide a perfect laboratory for the study of concussion: each game is recorded and broadcast, there are numerous doctors and healthcare professionals onsite, and each league has a vested financial interest in the health of their players. Therefore, if we hope to understand when and how concussions occur, we should start by looking at professional sports. While the degree of skill is much higher in pro-sports than, say, high school sports, the convenience of the data set is undeniable. To study concussion, we need the data. If data from professional sports leagues is made publically available, it can be used by the public. The success of crowd-sourcing and crowd-funding websites is constantly growing and should be exploited as a model for scientific exploration. Imagine the gains that could be made if concussion research could be similarly sourced.

The results of these findings will not only be impactful for the athletes participating at a high level of play, but will also help the millions playing in recreational leagues across the country. With available data, researchers could determine which positions in each sport are the highest risk, thus enabling interested youth to make informed decisions about their futures. This suggestion serves as only one example of the multi-faceted benefits that could be derived from making professional sports concussion data publically available. We must prevent TBI and CTE at its source by elucidating the factors that cause concussion.
In 1978, the total number of black men who graduated from medical school in the USA was 474. In 2008, that number dropped to 429.

The US is regarded as one of the most diverse countries in the world, and that diversity is increasing rapidly. Indeed, the US Census Bureau projects that, by 2043, the majority of people in the US will identify as non-white. However, the racial makeup of our nation’s physicians is an incredibly poor marker of diversity of our country. A mere 3.8% of our nation’s physicians are black (compared to 12.8% of the nation’s population), and only 2.7% of our nation’s physicians are Latino/a (compared to 16.8% of our nation’s population). One more statistic: In 1910, the percentage of physicians in the United States who were black was 2.5%. In 2010, a literal century later, that percentage has increased by only 1.3%.

For a nation that espouses the values of equality and opportunity, these statistics should be indicative of a profession (and a nation) in crisis. Although the low numbers of Blacks and Latino/as in medicine are concerning in and of themselves, the problem doesn’t stop there. The underrepresentation of people of color in medicine is one factor of a larger, structural problem that manifests as health disparities among our patients.

In 1999, Congress asked the Institute of Medicine to perform a study that would assess the extent of health disparities across the US, explore possible reasons for those disparities, and make recommendations about how best these disparities could be alleviated.

The result was a virtual behemoth of a report, 857 pages of documentation and analysis of the existing health disparities across our nation. Here’s what was found: even after correcting for insurance status, income, education status, and severity of conditions, non-white people in the US experience a lower quality of medical care than white people, across the board. Here’s what that means: If you are a white person in the US with a disease, chances are, you’re receiving better care than you would if you were a similarly insured, similarly paid, similarly educated, and similarly sick black person.

Non-white patients are less likely to receive kidney dialysis, receive kidney transplants, undergo cardiac bypass surgery, be given the appropriate cardiac medications, and, shockingly, to receive even routine medical procedures. However, this report did find that non-white patients were more likely to undergo a number of less-desirable medical procedures, such as lower-limb amputations in patients with diabetes.

When talking to Black and Hispanic patients, doctors deliver less information, deliver less supportive talk, and deliver “less proficient clinical performance”, even in the same care settings. However, the problem isn’t just with individual doctors whose implicit biases affect the outcomes of their patients. Many of the problems are structural, and include barriers to care such as: language barriers, the routine differential of care between public and private insurance (which disproportionately affects Black and Latino patients), and a deeply ingrained (and not altogether unjustified) mistrust of doctors by people of color.

The problems that lead to health disparities in our nation are structural ones, and as such, require structural solutions. It’s not enough to train individual doctors in anti-racist and bias reducing techniques (although this is necessary!). The solution must also include intentional, concentrated efforts to increase the diversity of our physicians. The solution must include an alleviation of the differential of care between public and private insurance. The solution must include attuning our physicians to the cultural needs of our communities.

For decades, patients and physician advocates have raised concerns, demanded reform, and clamored for change. Our response has largely been to turn a deaf ear to their voices. Can you hear them now?
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