Digest of the Philadelphia College of Osteopathic Medicine (Winter 2013)

Philadelphia College of Osteopathic Medicine

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THOUGHTS ON ETHICS, VALUES & HEALING
Dear Alumni and Friends,

It has been said that the “first step in the evolution of ethics is a sense of solidarity with other human beings” (Albert Schweitzer). I offer this thought as an introduction to this issue of Digest Magazine, a theme edition which recognizes that as the abilities of medicine and science progress, ethical questions about the fundamental values that govern personal and professional actions multiply. Each of us holds great responsibility to use our knowledge and abundant skills for the benefit of others. We must practice—whether as osteopathic physicians, health practitioners, behavioral scientists, teachers or leaders—with humility, humanity and with an ethicality of conduct.

Articles included in this issue explore ethical considerations for mental health service providers working with various psychiatric populations (“Body, MIND, Spirit: How Can We Improve Mental Health Services?”). Legal and ethical challenges present in counseling at-risk adolescents are explored in “The Ethics of Youth Suicide and Risk Assessment in Practice.”

“Linking Faith, Health and Healing,” profiles Philadelphia College of Osteopathic Medicine alumni who are members of the clergy or professed religious. These men and women share their experiences as healthcare providers who understand that religion and spirituality are distinct components that allow many patients to make sense of their experiences with health and illness.

“Ethics in Healthcare Education” acknowledges advancement in the teaching of medical ethics; nearly every medical school in the Western world now offers some instruction in ethics. The article delineates an important subset of PCOM’s curricula goals—including the teaching of medical ethics in both the preclinical and clinical years, within the framework of a multi-disciplinary approach and across academic programs (osteopathic medicine, physician assistant, clinical and school psychology, forensic medicine and pharmacy). “Making Ethical Decisions in Pharmacy Practice” showcases in greater detail how students at PCOM School of Pharmacy – Georgia Campus are benefitting from frontal teaching about ethical decision making rooted in principles of beneficence, nonmaleficence, justice, confidentiality, autonomy and veracity.

I thank you for your continued interest in and support of PCOM.

With warmest regards,

Matthew Schure, PhD
President and Chief Executive Officer
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ON THE COVER


Cover image by Bruce Fairfield at the Rodin Museum, Philadelphia (with permission).
School Psychology Gains New Approval

The master’s in school psychology program with an emphasis in behavior analysis has been approved by the Behavior Analyst Certification Board. This recognition provides graduating students the opportunity to sit for certification in behavior analysis.

“School psychology and behavior analysis are a natural pairing,” says Jessica Kendorski, PhD, director, MS in school psychology. “The practice of school psychology has become increasingly diverse, and behavior analysis has become an important method for providing psychological services by school psychologists. Board-certified behavior analysts find they have increased employment options.”

The one-year, 33-credit master of school psychology program is in the unique position of preparing students for two certifications. Upon completion of the MS program, students are equipped to continue toward school psychology certification via the educational specialist degree; they also have the necessary course requirements to complete their practicum and sit for their certification exam in behavior analysis. “Professionals who are certified in both behavior analysis and school psychology are a very valuable asset to school districts,” notes Dr. Kendorski.

Diversity Officer Joins the College

Lisa M. McBride, PhD, has been appointed the College’s first chief diversity officer. “I’m very excited to join Philadelphia College of Osteopathic Medicine, especially in this inaugural position,” says Dr. McBride. “My role will be to guide efforts to conceptualize, define, assess, nurture and cultivate diversity as an institutional and educational resource.”

Dr. McBride comes to PCOM from California University of Pennsylvania, where she served as special assistant to the president for equity and diversity as well as the university ombudsperson. She earned her doctor of philosophy degree in conflict analysis and resolution from Nova Southeastern University, Fort Lauderdale, Florida, and her master of science and bachelor of science degrees in criminology from Indiana State University in Terre Haute.

After earning her master’s degree, Dr. McBride worked as a police officer before becoming a senior special agent with the U.S. Drug Enforcement Administration, a position that gave her the opportunity to travel extensively throughout the world.

“My real desire, however, was to be a professor,” she admits. She began her academic career as a college instructor in New Mexico. Dr. McBride went on to hold positions as assistant professor and associate professor in criminology within the State University System of Florida. It was as a tenured professor that she began developing and testing multiple diversity models.

Among her accomplishments, Dr. McBride points to two research projects as her proudest achievements. In one, she was awarded a $10,000 grant from the American Association of University Women for her project “Breaking through Barriers for Women and Girls in STEM Areas,” which addressed how to prepare girls in middle school for careers in science, technology, engineering and mathematics. She also refers to “CAL U Men United,” a mentoring group designed to aid young men of color in facing unique challenges as they pursue academic, career and social success, which was funded by a grant from the Pennsylvania State System of Higher Education. As a result of implementing this initiative and similar programs for women of color, California University of Pennsylvania saw graduation rates for African-American students increase 33 percentage points.

“As chief diversity officer, I will provide and coordinate leadership for diversity issues institution-wide. Yet no one person or department can infuse diversity throughout the College without input from the entire campus community,” notes Dr. McBride. “I will create a diversity council that will include members of the College administration, faculty and staff members; students who represent various student groups; and members of the community with interest in diversity in higher education. I’m looking forward to making PCOM a national model for diversity in graduate institutions across the country.”
Kerin Claeson, PhD, assistant professor, anatomy, is passionate about fish: the older, the better.

As a vertebrate anatomist and paleontologist, her interest stems in part from the fact that “there are more species of fish than there are birds and mammals combined; there are a lot of new discoveries to be made.”

Before coming to Philadelphia College of Osteopathic Medicine, Dr. Claeson taught human anatomy at Ohio University Heritage College of Osteopathic Medicine, where, she says, “I learned significantly more clinical anatomy and learned about the osteopathic principles of health. The osteopathic approach of treating the body as a unit and obtaining the whole picture before making informed decisions is akin to the way that I conduct my research on the origin, evolution and variability of vertebrate form. When I joined PCOM, I was excited to bring my background of anatomical research to a school founded with the understanding that the body is essential to understand in its fullest.”

Ruth Thornton, PhD, likes to step outside her comfort zone. So it was only fitting that when she joined Philadelphia College of Osteopathic Medicine’s Department of Biochemistry/Molecular Biology, her first year was, as she describes it, “trial by fire.” Eugene Mochan, PhD, DO ’77, former associate dean of primary care and continuing education, was the new chair of the department, “and he introduced 50 new cases that I had to learn everything about,” Dr. Thornton recalls. Nevertheless, her first year was a success. During the next 20 years she taught both medical students and new faculty how biochemistry relates to the practice of medicine.

When Dr. Thornton was offered chairmanship of the department, she viewed it as “an opportunity of a lifetime. I learned a lot about myself. I gave up research in the lab and discovered that I like administrative work.” But teaching, she admits, was her favorite role. Her commitment to making the subject matter accessible found her one Halloween morning in front of her class dressed as an ATP molecule. “I thought, why not be a nucleotide?” she recalls. Her receipt of the Christian R. and Mary F. Lindback Award for Distinguished Teaching (2003) attests to the effectiveness of her sometimes unorthodox methods.

Always eager to do something she’s never done before, Dr. Thornton undertook projects unrelated to her field. When she learned that the College’s Healthcare Centers needed to assess patient satisfaction, Dr. Thornton collaborated with Robert A. DiTomasso, PhD, ABPP, professor and chair, psychology, to create a research project to measure it. Over the next five years, three students worked on the project, in partial fulfillment of the requirements for their master’s degrees.

For many years, Dr. Thornton worked with Katherine Galluzzi, DO, professor and chair, geriatrics, to create and teach an interdisciplinary course that introduced fourth-year medical students to end-of-life issues. She was also the faculty advisor for the Student National Medical Association, which twice awarded her the group’s mentoring award.

In retirement, Dr. Thornton looks forward to traveling, mentoring, volunteering and lecturing.

Philadelphia College of Osteopathic Medicine dermatology residents bested 47 other resident programs, including Stanford University, the University of Pennsylvania and Yale University, in the seventh annual Dermpath Bowl held during the American Academy of Dermatology meeting in March. The competition, open to all residency programs, requires teams to correctly diagnose dermatopathology slides.
Kudos from AACOM

Matthew Schure, PhD, president and chief executive officer, Philadelphia College of Osteopathic Medicine, received the Robert A. Kistner Award at the annual American Association of Colleges of Osteopathic Medicine (AACOM) convention held in April. Named for Dr. Kistner, who served at Chicago College of Osteopathic Medicine for 26 years, the award is presented to individuals who have made a significant contribution to osteopathic medical education.

In presenting the award, the AACOM Board of Deans referenced Dr. Schure’s more than two decades of unrelenting dedication to osteopathic medical education including his leadership at PCOM, his commitment to AACOM as a member of its Assembly of Presidents and the Audit Committee and his support to the AACOM Board of Deans.

Known throughout the medical education community for his many years of service and profound appreciation of the distinctiveness of osteopathic medicine, Dr. Schure has garnered a national reputation that reflects his commitment to excellence and devotion to the field.

“I’m touched and honored to receive this award,” Dr. Schure says. “The fact that AACOM gave one award to me, a psychologist, and the other to AOA Executive Director John Crosby, a lawyer, shows the openness of the osteopathic profession. It’s a pleasure to walk life’s journey as part of the osteopathic community, and I hope to do so for many years to come.”

Congressman Applauds Energy-Saving Technology

An advocate of environmental preservation and clean air, Congressman Jim Gerlach (PA–Sixth District) visited PCOM in March to learn about the College’s new energy-saving microturbines.

PCOM prides itself on its progressive use of cutting-edge technology to power the College, so when Frank Windle, director, operations, began looking for an energy solution to power 172,000-square-foot Rowland Hall, he explored technologies that would also reduce the College’s carbon footprint.

The original focus was on solar and wind power; however, those technologies proved to be unfeasible because of the College’s location. PCOM decided on Capstone gas-powered microturbines.

“They were a good choice,” says Mr. Windle, “because they provide an energy-efficient solution with low emissions and a small footprint, and they fit well with the College’s existing HVAC system.” The microturbines provide electric power to the building; recaptured waste heat is used for hot water, heating and cooling. “The monetary savings helps us meet the College’s goal of keeping tuition increases at the lowest levels possible,” he says.

PCOM is already seeing a 10 percent reduction in energy demand. “One hundred kilowatts popped off the grid right away,” says Mr. Windle. “We’re waiting for the first electricity bill to see the savings, but we’re really pleased so far.”

Congressman Gerlach, a member of the U.S. House Committee on Ways & Means, says the visit gave him a chance to learn more about the use of microturbines and the College’s process for selecting this technology. “The College certainly has taken an innovative approach to controlling energy costs,” he says.

VIPS for the Day

PCOM School of Pharmacy – Georgia Campus students joined their counterparts from local colleges and universities at the Georgia State Capitol on February 14 for VIP Day, organized by the Georgia Pharmacy Association. Guest speaker Assistant Surgeon General Rear Admiral Scott Giberson encouraged students to learn about state bills that may affect their profession, including Senate Bill 85, which would allow pharmacists and nurses to give vaccinations to adults.

Students met with Governor Nathan Deal and their local representatives to discuss the expanding role of pharmacists in the healthcare arena. Coordinated by Class Representative Joy Speaks (PharmD ’16), the day gave students not only access to legislators, but the opportunity to network with pharmacy students from Georgia.
PCOM Hosts Historic SOSA Conference

When Mike Tecce (DO ’15) pitched Philadelphia College of Osteopathic Medicine to host the National Student Osteopathic Surgery Association (SOSA) Convention this spring, he used the theme “the best.” Philadelphia, the second largest city in the Northeast, is a “mecca,” Mr. Tecce, president of PCOM’s SOSA chapter, pointed out, with its density of hospitals and easy accessibility. But mostly his case was made on the strengths of PCOM’s vast reserves of surgery residents and its robust simulation program.

The conference, held this March, was the best attended in SOSA’s history, with 230 students and 20 residents from across the country participating. “Drs. Sesso [Arthur Sesso, DO ’81, chair, department of surgery, and director, PCOM general surgery residency program] and Piccolo [Carmen Piccolo, DO, chief resident, PCOM general surgery] were incredibly accommodating,” notes Mr. Tecce. “The residents were happy to share what they knew, and they enjoyed the opportunity to teach us. They were very generous with their time and knowledge.

“In addition to workshops in suturing, casting, trauma and simulator training, we thought outside the box and brought in Mohit Sood, DO, from Shore Physicians Group and the Center for Plastic and Reconstructive Surgery for a workshop on skin grafting,” Mr. Tecce notes. This year’s conference also changed the lecture-to-workshop ratio. “We wanted students to have the opportunity for more hands-on workshops, so we limited the lectures to a half hour and offered 90-minute workshops.

“The opportunity to work hand-in-hand with doctors who do this surgery every day is one you don’t usually get outside a hospital,” says Mr. Tecce.

On Cultural Diversity

Philadelphia College of Osteopathic Medicine’s fourth annual Cultural Diversity Conference challenged participants to explore their cultural empathy, with the goal of stretching their comfort zones. “There can be a disconnect between our intentions and our impact when dealing with diversity,” says conference coordinator Yuma Tomes, PhD, associate professor and director, PsyD program, school psychology. “Very few of us intend to offend others,” explains Dr. Tomes, “but if we don’t know an individual’s culture—their beliefs and their values—it’s easy for what we hope to be a positive interaction to turn into a negative. The goal of this conference is, in part, to challenge our assumptions.”

Coordinated by both the PCOM Department of Psychology and Culturally Aware Psychology Students (CAPS), the conference dovetailed with CAPS’ mission of building a multiculturally competent learning community and creating a safe environment in which to expand personal and professional awareness of differences. “We want diversity to be an integral part of PCOM throughout all walks of life,” says Erin Potts (PsyD ’16), president of CAPS.
Alumni Association Makes $100,000 Gift

The Alumni Association has made a gift of $100,000 to the Clinical Learning Laboratory at Georgia Campus – PCOM. The reception area of this facility will be named in honor of the association and its philanthropy. Last year, the association made a $100,000 commitment to help fund the renovations for the new Clinical Learning and Assessment Center (see story at right).

Training Local, Staying Local

Philadelphia College of Osteopathic Medicine has teamed with Heritage Valley Health System to create housing and classroom space for DO students who choose to complete their third- and fourth-year core rotations in Western Pennsylvania. The facility, the PCOM Living-Learning Center, embodies the College’s commitment to continue strengthening its clinical rotations and to address physician workforce needs throughout the Commonwealth. Many students who come to PCOM from Western Pennsylvania want to return to the region for their clerkships and residencies, with the goal of practicing medicine in the region.

Various naming and giving opportunities exist for alumni to participate in this newest College venture. PCOM is proud to announce that Pennsylvania Osteopathic Medical Association District 8 has pledged $30,000 to name the “smart classroom” in the new center.

New Clinical Learning and Assessment Center to Be Built

Philadelphia College of Osteopathic Medicine is building a new, 11,000-square-foot Clinical Learning and Assessment Center (CLAC), to be located on the fourth floor of Rowland Hall. The total cost for the purchase and installation of leading-edge instructional technology and a state-of-the-art simulation management system is $2,352,000. A $1 million Economic Growth Initiative grant from the Commonwealth of Pennsylvania provided the critical funds to begin construction. Announced in February, this grant is a tremendous investment in the College.

The CLAC will train 1,700 PCOM students—both future physicians and health professionals. And its reach will extend to post-graduate training of physicians associated with PCOM’s MEDNet (43 affiliated hospitals) for maintenance of licensure programs and for first responders in the region.

The new CLAC will prioritize patient safety, a new healthcare discipline that emphasizes reporting, analysis and prevention of medical error that often leads to adverse healthcare events. Medical education experts predict that in the near future, physicians’ first point of contact with patients will be with simulated patients, as medical education adopts lessons learned from other high-risk fields such as aviation and the military.

The CLAC will provide a safe, controlled and fully monitored environment in which students can learn and practice clinical skills, develop crucial communication abilities and demonstrate clinical competencies through the use of live standardized patient encounters, high-fidelity robotic simulators, virtual simulators and task trainers.

It’s Almost Tee Time!

PCOM’s 21st annual Golf Classic will be held on September 16 at the Whitemarsh Valley Country Club, Lafayette Hill, Pennsylvania. All proceeds will benefit the PCOM Healthcare Centers, which provide medical care to underserved communities and training to PCOM students. Sponsorship information will be forthcoming.
When Saul Jeck, DO, began practicing obstetrics and gynecology in 1957, there were no fetal monitors or ultrasounds, no high-risk pregnancy specialists or laparoscopic surgery, and no instant over-the-counter pregnancy tests available at the local drugstore. Through the years, as each new technological advance in care came along, Dr. Jeck eagerly brought it into his practice at the earliest possible moment. "I’ve always loved learning and innovation and moving forward," he says.

When he first read about a new device called a fetal monitor, Dr. Jeck rushed to New York to check it out, and convinced the administrator of PCOM’s City Avenue Hospital of the importance of purchasing one. When he first heard about laparoscopic procedures being performed at a hospital in Washington, DC, he hurried there to learn how to perform them himself, and then used his new cutting-edge skills to help patients at PCOM.

As professor and chairman of PCOM’s Department of Obstetrics and Gynecology and director of the College’s obstetrics and gynecology residency program since 1990, Dr. Jeck has shared his love of innovation with the many students and residents he has taught.

“I encourage innovation in my students by asking them to imagine something that we are doing today in obstetrics and gynecology that will be done completely differently 10 years from now. As an example of how things can change, I have them read an excerpt from a 1969 textbook that describes the use of rabbits for pregnancy tests, and they can’t believe it! The only pregnancy tests they know are the instant kits you buy in the drugstore. So I use this as a springboard to discuss what we are doing now that could change dramatically in the future.”

Dr. Jeck’s greatest pleasure is training medical students and residents. He himself was the first and only obstetrics and gynecology resident when the program began at Parkview Hospital in 1958, training under the late Emanuel Fliegelman, DO ’42, and Simon Lubin, DO ’38, in their private practice. After completing his residency, he joined their practice and began training residents as well.

He enjoyed teaching so much that when former PCOM president Leonard Finkelstein, DO ’59, called in 1990 to ask if he would consider leaving private practice to take over...
as chairman of the College’s Department of Obstetrics and Gynecology, it didn’t take him long to accept the offer. “The idea of teaching and running the residency program while continuing to see patients and perform gynecologic surgery was very appealing,” he recalls. “I have looked forward to coming to work every day since. I love teaching students and residents in my office and in the operating room.

“Allowing students in the operating room during medical training is somewhat unusual,” he continues. “In the beginning, I had to negotiate for one or two students to be allowed in to watch procedures. There is no substitute for firsthand observation.”

With his trademark happy-go-lucky demeanor and supportive manner, Dr. Jeck has formed strong bonds with many of his students over the years, including one of his earliest, Fred Steinberg, DO ’64.

“Saul was my guiding light,” says Dr. Steinberg. “There is a tremendous amount of stress in OB/GYN, especially back in those days with no ultrasound, no fetal monitors, and no high-risk pregnancy specialists. OB/GYNs saw all patients, even high-risk. We were always concerned about making the right decisions for our patients because every decision was critically important. Saul was always calm and in control no matter what crisis was happening. We all needed to know that a person was there to handle things if a situation was getting out of hand. It was critical then and it is still critical today. Saul was that person for me. As a teacher, he gives confidence and support and direction that make you feel comfortable and allows you to expand and evolve rather than feeling afraid.”

“Teaching requires a lot of care,” observes Dr. Jeck. “You can’t just come and go. It’s not just a job.”

Indeed, another of Dr. Jeck’s former residents, Vanessa Junor, DO, recalls that she and other residents could even call Dr. Jeck at home if they had a question and needed help. Yet he gave them the freedom to operate as independently as possible, which enhanced their ability to learn. “I appreciate the fact that he was always willing to take on students and residents and, as a result of his example, I am now teaching in my practice,” says Dr. Junor.

In particular, she notes the valuable lessons learned in Dr. Jeck’s operating room. “When I began practicing after my residency, other surgeons were impressed that I was classically trained and had experience in performing open surgeries as well as laparoscopic surgeries,” she says. “Many residents these days are being trained only in robotic surgery, but Dr. Jeck teaches both, and that continues to be very beneficial.”

Dr. Jeck emphasizes that it’s important not only to learn so you can pass exams, but to develop medical knowledge so you can diagnose and help patients without subjecting them to a lot of testing. “You have to formulate the diagnosis by talking to the patient,” he urges. “I want my students to learn to talk to the patient, not the computer. This can be a challenge with today’s electronic medical records, but it’s important to find a way around it so good communication with the patient is not lost.”

Dr. Jeck also emphasizes the value of osteopathic manipulative medicine in obstetrics and gynecology. He has used OMM as part of prenatal care to help relax the pelvic area and make labor and delivery easier for his patients, as well as in gynecologic care for pain relief. He takes pride in an original research study he published on OMM and pain management. Conducted at PCOM, the study showed that patients who received osteopathic manipulative treatment in the hospital after major surgery required statistically less pain medicine for two to three days following treatment while they were still hospitalized.

In addition to teaching and providing patient care, Dr. Jeck has served PCOM as a member of numerous committees over the years. He has been a member of the Research Committee and Executive Faculty Committee since 1990, and has served on the Admissions Committee and Risk Management Committee since 2005.

Beyond the PCOM campus, Dr. Jeck has served the osteopathic profession as president of the American College of Osteopathic Obstetricians and Gynecologists (ACOOG). He has been recognized by ACOOG for his outstanding contributions with numerous awards, including the ACOOG Distinguished Fellow Award, President’s Award and Outstanding Service Award.

Dr. Jeck has also been lauded as a teacher and mentor. In 2004, he was named to the American Osteopathic Association Mentor Hall of Fame. At PCOM, he has received the Christian R. & Mary F. Lindback Distinguished Teaching Award (two times), the Dean’s Appreciation Award and a Distinguished Service Award for the obstetrics and gynecology residency program.

In addition to his professional achievements, Dr. Jeck takes pride and pleasure in his family. He and his wife of 53 years, Sheila, met in Iowa when he was a student at the Des Moines College of Osteopathic Medicine. They have two sons—Charles, a 1985 PCOM graduate, and Daniel, an attorney—and four grandchildren. Dr. Jeck enjoys playing the violin, especially when his granddaughter joins him on the viola. An accomplished musician, he aspired to be a professional violinist while an undergraduate student at the University of Pennsylvania. His family doctor, an osteopathic physician, inspired him to change his career path to medicine.

“I had many great mentors along the way, and I’ve always enjoyed providing the same support to my students and residents,” he reflects. “I hope they remember me as a happy person who was always there when they needed help or advice.”
The annual observance of Founders’ Day honors the founders of Philadelphia College of Osteopathic Medicine: Oscar John Snyder, DO, and Mason Wiley Pressly, DO.
Under the old quintile system, DO students were simply divided into five quintiles by grade average. This did not provide a fair representation of student performance, according to Mr. Vila. “In medical school, you don’t see a bell curve. Instead you see a massive spike. So in a class of 250 students, you may have a large majority of students within a few percentage points of each other in the middle with outliers on both sides,” explains Mr. Vila. “The problem is that there were many students included in the lower quintiles even though they were right at or on the back end of the ‘spike.’ And that quintile ranking is the first thing the residency directors see when they open the dean’s letter with your residency application.”

Mr. Vila took this issue to the DO Council, whose 45 members promptly tackled it. After conducting research, they developed a formal proposal that was presented and approved with what Mr. Vila describes as relative ease. “Now the dean’s letter shows the student’s average over the first two years, the class average over those two years and a distribution bar graph,” Mr. Vila explains. “As a result, fewer people are negative outliers. This is a plus for students and for residency directors who now receive a more complete and accurate picture of where the student lies within the class.”

Implementation of the new DO rank structure is a testament to the efficiency of the new SGA model, notes Mr. Vila. “It would have been very difficult to resolve an issue like this in the past when 170 people from all degree programs and student clubs met together in an auditorium,” he observes.

Mr. Vila also takes pride in two annual community outreach events he helped to spearhead: the PCOM Winter Gala, an annual fundraiser for local nonprofit organizations, and PCOMmunity Outreach Day, a signature event in which all PCOM classes and degree programs work together in the community for one day.

Mr. Vila’s activist inclinations were sparked in college when he discovered a passion for politics and business as well as medicine. A political science major, he considered switching career paths, but ultimately returned to his long-time goal of becoming a physician while also earning an MBA. Currently pursuing an internal medicine residency, Mr. Vila says his ultimate goal is high-level hospital administration. In the current healthcare climate, Mr. Vila emphasizes the importance of medical students and physicians speaking out on important national issues. He has already published articles on the Affordable Care Act and the need to streamline undergraduate medical education.

“We can’t just sit back and let business executives and politicians dictate how we practice medicine,” he says. “The key is not just to say, ‘We have a problem.’ You have to be willing to provide a solution.”
Ethics is the field of understanding human behavior in relation to values. Ethicists examine how we think about and determine right and wrong and analyze the standards and motivations that govern personal and professional actions.

This issue of Digest Magazine is dedicated to exploring some of the ethical issues that members of the Philadelphia College of Osteopathic Medicine community encounter daily. The articles that follow address strategies that underlie responses to ethical dilemmas and conflicts in clinical practice and treatment, spiritual dimensions that undergird health and healing, obligations that foster ethical foundations in healthcare education, and codes and principles that protect against a range of legal reprisals. Each article seeks to promote a greater scope of awareness and an intensification of ethical sensibility.
Tragedies such as the deadly school shooting in Newtown, Connecticut, have refocused attention on improving mental health screening and treatment in the United States. Everyone wants to know how to prevent similar rampages; yet there are no easy answers, mental health experts say.

At least two separate media analyses found that a majority of recent mass shooters had signs of mental illness before the shootings. However, the 2001 MacArthur Violence Risk Assessment Study found that mentally ill individuals are no more likely to commit violence than those in the general population when substance use is not a factor.

Violence screening tools and psychological tests are available, but threat prediction remains challenging, says Claudia Lingertat-Putnam, PsyD ’05, a clinical psychologist who is an associate professor and chair of the Department of Counseling at the College of St. Rose, Albany, New York.

The numerous risk factors for violence include biological/genetic traits; social characteristics, such as poor peer relationships; and personal and environmental factors, such as depression, substance abuse, cruelty to animals, history of child abuse or repeatedly being bullied. Of course, many people with one or more of these risk factors never become violent.

“Prediction of violence is not an exact science. It’s a complex issue,” Dr. Lingertat-Putnam says. “When multiple risk factors come together, it creates a perfect storm.”

ETHICAL CHALLENGES

Even when potential risk factors for violence are identified, there are ethical issues related to intervention.

Health information privacy laws, for example, prevent family members of a legal adult (or younger person, in some states) from receiving his or her mental health information from the provider without that person’s consent. Providers can and must breach patient/client confidentiality only when the client has committed a crime or has threatened to harm himself or other people, under “duty to protect” or “duty to warn” laws (known as the Tarasoff decision). These laws exist in almost every state, including Pennsylvania, the National Conference of State Legislatures reports.
“When people refuse psychiatric treatment, there’s nothing you can do unless they are dangerous to themselves or others,” says Ralph S. Wolf, DO ’82, who is board certified in adult psychiatry and forensic psychiatry and practices in Dover, Delaware, and North Palm Beach, Florida.

BARRIERS TO CARE

Screening for mental health problems at an early age is an important first step in improving mental healthcare, Dr. Lingertat-Putnam says, but adds, “Screenings need to be part of a systemwide comprehensive plan to identify and intervene with youth in need of assistance.”

However, systemwide interventions at any age—and the healthcare workers needed to implement them—often require state and federal funding, which has been cut in recent years. The Patient Protection and Affordable Care Act is expected to expand insurance coverage of mental health and addiction care. In the meantime, barriers to access mental healthcare exist.

Currently, students with mental health issues can receive support through a school-based mental health provider for

PROTECTING CLIENTS’ MENTAL HEALTHCARE CHOICES

Since 2005, Pennsylvania law has required mental health providers to ask all their mentally capable adult clients if they have completed a psychiatric advance directive called a mental health declaration. But many providers in the state are unaware of this requirement, says Matthew Weinberg, MB, assistant professor of medical ethics, PCOM, who holds a master’s degree in bioethics and lectures on the subject.

“The primary reason for a mental health declaration is for clients receiving mental health services to express and protect their preferences for future mental healthcare in the event they become mentally incompetent,” Mr. Weinberg says.

He believes the law to inform all mental health clients, including those seeking counseling for everyday stress, is “overly broad.” However, Mr. Weinberg says it is important for mental health professionals to discuss mental health declarations with at least those clients most likely to lose the mental capacity to make healthcare decisions during a future acute episode of psychiatric illness.

Some other states also have a mental health declaration, which is similar to a living will. Although it does not prevent an involuntary hospitalization, a mental health declaration allows clients to detail their treatment preferences, including whether or not to receive electroconvulsive therapy, setting limits on medication dosage and choosing a treating physician and facility.

In Pennsylvania, a mental health declaration may stand alone or may accompany a mental health power of attorney, which allows the person to select a surrogate (“agent”) to make decisions for him or her regarding mental health services if the patient becomes incompetent. People can execute a mental health power of attorney without executing a mental health declaration.

By law, mental healthcare providers must comply with these documents or, if they cannot do so for reasons of conscience, must transfer their client to another provider who will comply. Mental health declarations in Pennsylvania automatically expire in two years unless the person is mentally incompetent at that time.

Forms for mental health declarations are available through the Mental Health Association in Pennsylvania (www.mhapa.org/help-resources/materials).

Practitioners outside Pennsylvania should be aware of their own state laws on mental health advance directives, Mr. Weinberg says. At least 25 states have adopted statutes on psychiatric advance directives in the past decade, according to the National Resource Center on Psychiatric Advance Directives, whose website (www.nrc-pad.org) has information by state.
INVISIBLE WOUNDS: MILITARY PERSONNEL WITH PTSD

Many U.S. military members are returning from combat with “invisible wounds”—psychiatric symptoms such as depression and, increasingly, post-traumatic stress disorder (PTSD).

Consider these PTSD statistics from the Department of Veterans Affairs (VA):

- PTSD is the most common mental illness diagnosed in veterans of the Iraq and Afghanistan wars, affecting nearly 200,000 of those who receive treatment at VA hospitals.
- PTSD diagnoses increased in VA hospitals by more than 5 percent per quarter in 2011.
- The VA treats only 53 percent of U.S. veterans, whereas the others receive care elsewhere or not at all, suggesting the prevalence of PTSD is greater.

Some authors say PTSD is being overdiagnosed in service members and costs too much to manage. Other people, like Louis J. Papa, DO ’98, a military psychiatrist and chief of a U.S. Air Force traumatic stress response team at Royal Air Force Base Lakenheath in England, believe we have an ethical duty to give support to those who earned it in combat.

The U.S. Department of Defense’s stepped-up efforts to prevent and screen for PTSD are greatly needed, Dr. Papa says. So are programs such as the Real Warriors Campaign to encourage military personnel and veterans to seek help for psychiatric symptoms.

Many of the people being deployed are reservists or National Guard members who after completing their tour of duty return to civilian life. They may not have access to the mental health screenings that active-duty personnel receive after transition from combat, Dr. Papa says. In the Air Force, for example, airmen who are more likely to experience traumatic events receive pre-exposure briefings about the challenges they may face, PTSD symptoms and where to get help.

A traumatic stress response team gives psychological first aid to the first responders to traumatic events and provides mental healthcare services to unit members. With other mental health providers and chaplains on the team, Dr. Papa has rendered psychological first aid to first responders in situations such as a plane crash on base and provided long-term treatment to security forces members who witnessed the Frankfurt, Germany, shootings of two U.S. airmen in March 2011.

Previously Dr. Papa was in charge of a combat stress unit in Kuwait, whose goal was to keep service members with milder forms of PTSD and other mental health conditions in their deployed location (“theater”) by building resiliency. “We had a 98 percent return-to-duty rate, which is very good for being in theater,” he comments. He credits their success to limiting the number of psychotherapy sessions, providing reachable treatment goals, improving coping mechanisms and having base commanders play an active role in treatment team meetings.

Says Dr. Papa, “Treatment of PTSD has come a huge distance since it was first recognized as an illness. The VA centers now possess some of the most diverse and efficacious treatment methods.”
healthcare providers, are located at nearly 2,000 U.S. schools, according to the National Assembly on School-Based Health Care. Dr. Lingertat-Putnam says these clinics increase access to care for students and their families, and make it more likely that students will seek help from a mental health provider.

**INNOVATION NEEDED**

Dr. Yanek has a different suggestion for improving the system in schools. “Mental health providers in schools need to use more innovative ways to reach students,” she says. “Talk therapy can be overwhelming and intimidating for middle-school students.”

In her work with individuals and groups of students, Dr. Yanek has found it useful to apply the core concepts of adventure-based counseling. Modeled on Outward Bound’s concept of fostering development and self-confidence through adventure and challenges, adventure-based counseling uses group trust-building and problem-solving exercises as well as games that foster team cooperation. Project Adventure, a Beverly, Massachusetts–headquartered organization, founded this type of experiential learning in 1971.

“Adventure-based counseling can be very meaningful for students who struggle with social skills, have difficulty making good choices, are resistant to more traditional talk therapy or are at risk of having behavior problems or mental health issues,” Dr. Yanek says.

Adolescents also respond better to treatment, particularly substance abuse treatment, that is targeted to their age group, Dr. Capretto says. “Adolescents feel they can open up more when they are with their peers. They also have more peer and family issues to deal with than adults do,” he comments.

At the school level, adolescents should know that they can be part of the solution to the problem of youth violence. Often after a school shooting, fellow students say they thought the perpetrator was kidding about threats to commit violence, Dr. Lingertat-Putnam says. School personnel, she says, should tell students and parents, “If you hear something, say something.”

**CARING FOR THE WHOLE PATIENT**

While mental health services need improvement, some areas already have become better, experts say.

For instance, people with the common dual diagnosis of mental illness and substance abuse—occurring in approximately 50 percent of mentally ill individuals nationwide—formerly were told that they needed to treat their mental illness before they could undergo addictions treatment, and vice versa. This guidance left them less likely to receive treatment for either illness, Dr. Capretto says. Today, he notes, “more and more mental health programs have capabilities to treat people with addictions.”

Even as more care providers treat the whole mental health client, Dr. Capretto believes that osteopathic-trained health-care providers have an advantage because of their training in treating the whole person: body, mind and spirit.

Similarly, Dr. Yanek states that if a student comes to her because of academic problems, she tries to get the whole picture because there may be more going on below the surface. She says, “My holistic training at PCOM reminds me that nothing is in isolation.”
In 2010, suicide claimed 4,600 youth between the ages of 15 and 24 years, and 274 children under the age of 15. Approximately 13 adolescents take their own lives daily. Suicide is the third leading cause of death for youth in the United States, and it rivals homicide (accidents are in first place) as the second leading cause of death for adolescents (CDC, 2012). The actual suicide rate is likely even higher than indicated, since not all cases are reported.

Schools, primary care settings and emergency departments are key locations for early identification of youth mental illness and suicide prevention (Horowitz, Ballard and Pao, 2009). The majority of patients who are depressed reportedly prefer to be treated by their physician rather than be referred to a mental health specialist, likely because of both stigma and the comfort level and rapport they have with their primary physician. This fact strengthens the need to actively conduct suicide screenings not only in schools, but also in medical care practices. While validated screening tools can identify suicide risk in adolescents who may otherwise go unnoticed, clinical interviews regarding behavior and emotional functioning are integral.

Ethical issues in cases of suicide typically include questions of negligence and foreseeability. As Griffin (2011) states, a clinician “cannot be expected to implement preventative measures in a case where the potential suicide of a client was not reasonably foreseeable.” So negligence would be an issue of concern only if the clinician was aware that a client was likely to engage in self-harm. Does this sometimes prevent clinicians from asking questions surrounding the topic of suicide at all? It may—which of course presents another ethical dilemma, as an adolescent’s life is at stake. Clinicians in these settings therefore have an ethical responsibility to ensure appropriate assessment of suicidal ideation and intent, particularly as suicidal ideation is rarely communicated spontaneously during healthcare visits (Hendin et al., 2001).

To protect themselves against legal reprisals, clinicians should have adequate training on suicide risk assessment, diagnosis and intervention and be familiar with referral agencies in their locale in order to provide clients with adequate support. Further, because suicide risk waxes and wanes, clinicians may have an ethical responsibility to conduct multiple screenings over time. It is of utmost importance to be thorough because if adolescents are indeed at risk, and we do not hospitalize them, the consequences can be fatal. Clinicians should know what their peers would do in similar situations, because seeking consensus in decision making for providing a reasonable standard of care to clients is one of the best ways for clinicians to protect themselves (Remley and Herlihy, 2001). Further, clinicians can protect themselves by documenting everything and including in the documentation why particular steps were taken.

Initial suicide risk assessment screenings could include questions about risk factors and warning signs. According to
In reality, these “contracts” are not a
considerable controversy regarding their efficacy.
widely used, but there is increasing ethical
consideration regarding their viability.

Adolescents are particularly vulnerable
to copycat suicides, because their brains are still maturing and they are therefore more likely to act impulsively. Finally, adolescents are particularly at risk for suicidal ideation after release from hospitalization for mental illness or incarceration, since reentry into society and school can be a challenge. Helping teens find ways to resocialize may be especially important in these cases.

Clinicians consistently face another major ethical dilemma: the practice of drawing up “no suicide contracts” for suicidal adolescents. These have been widely used, but there is increasing ethical controversy regarding their efficacy. In reality, these “contracts” are not contractual, nor is there empirically based evidence to support their use (Garvey et al., 2009). “No suicide contracts” therefore may give clinicians a false sense of security, particularly as a compliant teen may feel coerced into signing one. Further, these are not legal contracts and therefore do not actually decrease legal liability (Garvey et al., 2009). As these contracts emphasize what teens won’t do rather than what they will do, they are also not effective treatment planning. A more effective approach may be to build rapport with adolescents and encourage them to commit to a comprehensive treatment plan for maintaining safety, which may include outside referrals to those specializing in treating suicidal youth. David Brent’s research has focused on the use of “no suicide contracts” as a part of the assessment procedure rather than as a medicolegal procedure (cited in Garvey et al., 2009).

In summary, identifying children and adolescents who are at risk for suicide is vital. As Edwin Shniedman, the father of modern suicidology, states, “Currently, the major bottleneck in suicide prevention is not remediation, for there are fairly well-known and effective treatment procedures for many types of suicidal states; rather it is in diagnosis and identification” (cited in Shea, 2002, p. xii).

WHAT TO DO WHEN A PATIENT MIGHT BE SUICIDAL

• Screen carefully for risk factors and warning signs.
• Be direct and unambiguous in asking questions.
• Assess intensity, duration and frequency of suicidal thoughts.
• Assess whether there is a suicide plan and assess lethality of method.
• Assess protective factors.
• Use effective listening skills by reflecting feelings, remaining nonjudgmental and not minimizing the problem.
• Communicate caring, support and trust while providing encouragement for coping strategies utilized.
• Gather information about the patient’s and his/her family’s history, with emphasis on suicide, trauma, grief and substance abuse.
• Consult with guardians and, if possible, teachers, to gather information about the patient’s behavior or changes in social, emotional or academic functioning. Ask guardians about trauma, recent loss, a history of familial mental illness or recent changes in the family.
• Don’t make any “deals” to keep suicidal thoughts or actions a secret.
• Do not leave high-risk patients alone.
• Get supportive collaboration from colleagues.
• Be familiar with community resources.
• Outline the steps that will be taken to help the patient.
• Keep detailed notes of procedures (in part to protect yourself).
• Be aware that suicidality waxes and wanes. Patients with low-level risk may spike in suicidal ideation at certain times.
• If a patient appears at risk, refer to a mental health provider.
• If imminent risk is noted, call 911 or contact a crisis center directly.
• Share the immediacy of the situation with the patient or patient’s guardian to ensure he or she understands the urgency of treatment needed.
• Be prepared to take phone calls for follow-up questions, medication review and guidance.

REFERENCES


A spiritual dimension undergirds health and healing for many medical practitioners. But for a subset of Philadelphia College of Osteopathic Medicine alumni—members of the clergy or professed religious—the “body–mind–spirit” core of the osteopathic philosophy resonates profoundly. Four of these alumni are Jon J. O’Brien, SJ, DO ’75; Sister Eileen M. Gallagher, OSB, DO ’91; William J. Librizzi, PsyD ’06, MS/Psy ’04, LPC; and Sister Joan Loretta Henkel, RSM, PsyD ’07. In the following pages they share their experiences as healthcare professionals whose lives are shaped not only by their PCOM training but also by their formal affiliations with religious life spanning a variety of faith backgrounds.
Jon J. O’Brien, SJ, DO ’75, occasionally uses Skype to chat with far-flung friends—not so unusual for a typical member of the Class of 1975. But the 87-year-old Dr. O’Brien is in no way typical. He became a physician and then a psychiatrist about a decade after he was ordained as a priest, two decades after entering the Society of Jesus (Jesuits) and 25 years after graduating from Yale Law School. He also holds honorary doctorates from both Philadelphia College of Osteopathic Medicine and Georgetown University.

Dr. O’Brien lives and works at Georgetown, where he spent several segments of his rich career, beginning with his residency and fellowship in psychiatry. Today he does pro bono pastoral work on campus and at a suburban mission church. He also sees “a number of priests, seminarians, and lay people for spiritual direction and others for a kind of growth counseling—anyone who wants to come ‘to talk things over.’”

**AN OPEN DOOR**

After completing his theological studies in Rome in 1967, Father O’Brien taught at St. Joseph’s College (now University) in Philadelphia from 1967 to 1971. Curious about “the makeup and care of the human person in sickness and health,” he says, he decided he wanted to study medicine. He fulfilled pre-med requirements while teaching, and then took the MCAT.

He was in his early forties, and allopathic medical schools were not receptive to older students. PCOM “opened doors when others closed them,” Dr. O’Brien recalls. “I still remember my interviews with Tom Rowland [Thomas M. Rowland, Jr., president, 1973–1984] and Carol Fox [associate vice president for enrollment management, retired in 2011], and I am eternally grateful for their acceptance and for the encouraging support of faculty and classmates.”

Father O’Brien soon found himself at ease with the osteopathic approach. “My Catholic and Jesuit foundation of wonder and gratitude to God for creation, the universe, and the mystery of human life blended well with the osteopathic concern for the health of the whole person, and with psychiatry’s concern with the biological (and neurological), psychological and sociological aspects of human life.”

“And,” he adds, the College “was trying to establish itself, and I enjoyed being with the underdog.”

**FROM WASHINGTON TO ROME AND BACK**

Dr. O’Brien joined the faculty of Georgetown’s psychiatry department in 1979. Two years later he also became dean of students at the medical school. He “continued these two activities with delight and enthusiasm,” he says, until he was assigned, from 1994 to 2000, as staff psychiatrist at the Pontifical North American College in Vatican City, a residential seminary operated by the American Catholic Bishops. He later taught at a residential seminary at the Catholic University of America in Washington, DC, and maintained his connection to the medical school at Georgetown.

Medical students and seminarians, he says, have a lot in common: “Bright and dedicated, and a number felt that the public expected more from them than they could give. They wore their great gifts very unpretentiously.”

**MORE THAN HALF FULL**

“Through medicine or psychiatry,” Dr. O’Brien says, “we try to ease people’s burdens and liberate them from addictions or impedances that are holding them back. And that’s very much what I see Jesus doing in the Gospels and what is reflected in most other religions.

“It’s easy to become pessimistic about the world and humanity,” he continues, “but the pull of the goodness, the potential pulls me along. The glass is still very much more than half full. And it’s being filled up by the Lord.”

At the age of 19, the New York–born Eileen M. Gallagher, OSB, DO ’91, found herself listening through the clapboard wall of a tiny office in the Mississippi Delta, trying to hear how an older colleague counseled people. Having joined Missionary Servants of the Most Blessed Trinity the year before, the young woman was now a social work assistant assigned to cover 38 counties for the Catholic Social Services of Mississippi. Tenacity has been the hallmark of her religious and medical careers.

In Gadsen, Alabama, at the Holy Name of Jesus Hospital School of Nursing, Sister Eileen received a diploma in nursing in 1975, while living next to the hospital in a convent built from an army barracks. She earned a bachelor of science degree in biology in 1981 from Birmingham Southern College.

Sister Eileen learned about PCOM by picking up a brochure; the holistic approach intrigued her. In the summer of 1980, while she was running an infirmary in Philadelphia, she visited PCOM; she then applied to the DO program and was accepted. But her community was poor. She continued her nursing and social work.

**ALL IN THE TIMING**

Several years later, she returned to Philadelphia to run the medical program of Catholic Charities. “After spending 13 years in rural Southern missions,” Sister Eileen says drily, “I thought I was going to get killed driving in Philly.”

When her community asked her, “Do you want try medicine again?” her answer was yes, and (for the second time) so was PCOM’s.

After a three-year residency at the University of South Alabama in Mobile, Dr. Gallagher again worked in Gadsen and lived in the Benedictine Sacred Heart Monastery in Cullman, Alabama. She loved the rhythm of life there, so she joined the Benedictine Sisters. Nearby Eva, a small, geo-
Librizzi, this meant, "How can I use the narratives of holy learning to condition yourself and on thinking. For Dr. Librizzi immersed himself in at PCOM focuses both on standing of God."

...can be more targeted in focusing on their under..."extremely supportive," he recalls, and "they saw me as recognizing the need to draw on evidence-based care."

In the beginning, he was made welcome. William J. Librizzi, PsyD ’06, MS/Psy ’04, LPC, a licensed clergy with the General Counsel of the Assemblies of God, recalls his first day as a PCOM student in 2000: “Dr. Art Freeman [Arthur Freeman, EdD, ABPP, clinical professor], who had started the Clinical Psychology program and was a world-renowned psychologist, had me come up and give a benediction at the end of orientation.” PCOM faculty were “extremely supportive,” he recalls, and “they saw me as bringing a valuable perspective.” He felt “not just toleration, but genuine regard.”

The feeling was decidedly mutual. Dr. Librizzi credits his PCOM education with making him a better clergy.

INTEGRATING THEOLOGY AND PSYCHOLOGY

Having been a pastor for a decade, Dr. Librizzi had started to appreciate that “theology and psychology make a good fit.” Either a good clinician can accommodate the patient’s faith, or "someone who understands the patient’s faith more deeply can be more targeted in focusing on their understanding of God."

The cognitive behavioral therapy approach that Dr. Librizzi immersed himself in at PCOM focuses both on learning to condition yourself and on thinking. For Dr. Librizzi, this meant, “How can I use the narratives of holy stories to help people think differently? The Bible says, ‘Don’t be surprised when you go through various difficulties and trials. Consider this with joy; they will be meaningful.’”

Dr. Librizzi reconceptualized Aaron Beck’s cognitive triad—encompassing the self, the world and the future—as a quadrant, adding one’s beliefs about God.

Dr. Librizzi recalls that Bruce S. Zahn, EdD, ABPP, professor, director of clinical training, stressed the need to be theoretically and technically consistent. Over his six years of study at PCOM, Dr. Librizzi says this approach “really solidified what I believed. A theoretical orientation helps you understand why there is suffering and how to fix it. Your problems don’t disappear when you walk into a church.” He adds, “The church has historically been antagonistic with regard to psychology, but is now much more accepting and realizes the need to draw on evidence-based care.”

GENERATIONAL RABBINATE

Hillel E. Wiener, DO ’05, received rabbinic ordination in 2000. Ordination is technically the transmission of rabbinic authority to give advice or judgment in Jewish law, which those who are ordained have exhaustively studied. But he has never sought to serve as a rabbi professionally.

“The rabbinate goes back for generations on my mother’s side,” explains Dr. Wiener, and he wanted “to keep the chain going” (as did his brother and his cousins). He finished all his rabbinic studies before entering medical school. At one point he considered becoming a teacher, but once his path in medicine was forged, he didn’t look back.

“PCOM was the best experience I ever had,” Dr. Wiener says unequivocally, reflecting on his teachers, classmates and the administration. His enthusiasm is untarnished by his admitted surprise at the demands of the curriculum, which he had expected to be no greater than his dual curriculum as an undergraduate. Dr. Wiener received a bachelor’s degree in biology from Yeshiva University in New York and also studied at a New York seminary.

His rabbinic status rarely comes up in Dr. Wiener’s professional career. Nonetheless, he acknowledges, “Rabbinic training has to influence you as a doctor—in matters of ethics, for example, or dealing with death.” And the notion that the body heals itself is consonant with Judaism, says Dr. Wiener. “As a doctor, I’m God’s helper; you, the patient, are getting better.”

After working for several years in Allentown, Pennsylvania, Dr. Wiener and his family moved to Memphis in 2011. They are enjoying the city and their involvement in its Jewish community. He will join Penn Marc Internal Medicine in July.
RECOVERY THROUGH FAITH

How does faith help people heal? Tamika A. Thomas, MS/Psy ’10, PsyD ’11, conducted her dissertation research on ten African-American women, participants in a church-sponsored support group who were survivors of childhood sexual abuse.

Some of the women had had therapy earlier; others had never spoken of their trauma. “Some said, ‘My faith has helped me process what happened’; others said, ‘My faith is helping me, and I’m not there yet,’” reports Dr. Thomas. The one constant was the women’s certainty that God was with them in spite of their ordeal. They told Dr. Thomas, “I can use this experience to help other women; it doesn’t necessarily define me. I’m working toward being whole in spite of what happened.”

Dr. Thomas, currently a postdoctoral fellow at PCOM, is a behavioral consultant at the Cambria and City Avenue divisions of the PCOM Healthcare Centers. In the next phase of her career she hopes to continue and expand on her dissertation work, while teaching and developing a private practice.

Knowing when she came to PCOM that she wanted her dissertation to address childhood sexual abuse and religion, Dr. Thomas found her teachers and colleagues tremendously supportive. The arduous coding of the open-ended interviews was relieved by the camaraderie of her fellow coders/classmates.

The women she interviewed knew that Dr. Thomas is herself a survivor of childhood sexual abuse. Amplifying their voices, she says this abuse “is devastating, but you can have a full life; you don’t have to be suspended in that time.” She adds, “God has a plan for those experiences all along, and I’m happy that I am finally in a place where I can see how the pieces all connect.”

OSTEOPATHY AND SWEDENBORG

Like many physicians, David B. Fuller, DO, FAAO, associate professor, osteopathic manipulative medicine, PCOM, was a first-year medical student when he encountered the “mind–body–spirit” triad of Andrew Taylor Still, the founder of osteopathy. But his reaction was uncommon. “That sounds a lot like Swedenborgianism,” he thought.

“Swedenborg was an 18th-century scientist/philosopher who studied natural sciences in great depth in order to learn more about the spirit-body connection,” explains Dr. Fuller. “He recognized religion and science as diverging in his time and strove to unite them.” Swedenborgianism, or the New Church, is a Christian denomination based on Swedenborg’s theological writings.

The ultimate product of Dr. Fuller’s insight was a 2011 book of more than 600 pages: Osteopathy and Swedenborg: The Influence of Emanuel Swedenborg on the Genesis and Development of Osteopathy, Specifically on Andrew Taylor Still and William Garner Sutherland (available at Amazon.com). The book traces Swedenborg’s ideas as they spread across America in the 1800s, and the influence they had on both Still and Still’s student Sutherland.

Dr. Fuller notes that “Swedenborg described body, mind and spirit in great detail, but he never developed any specific therapeutic approach. That was the genius of A. T. Still.”

Although Dr. Fuller grew up near Chicago, the Philadelphia-area native finished high school at the Academy of the New Church in Bryn Athyn, Pennsylvania. He and his wife, Janet M. Krettek, DO, made a similar move in 2011, this time from Alabama, so that their three children could also attend that school.

Dr. Fuller earned his doctor of osteopathic medicine degree from the Chicago College of Osteopathic Medicine in 1992. He had his own integrative medicine family practice and taught part-time before joining PCOM full-time in July 2012.

Dr. Librizzi is a licensed professional counselor in the state of New Jersey. At the Wellspring Center for Christian Counseling in Manasquan, which Dr. Librizzi founded and directs, he and his team of six clinicians all use an integrative approach, “integrating the word of God with sound psychological principles.”

Besides his two PCOM degrees, Dr. Librizzi has a master’s degree in counseling from Liberty University, Lynchburg, Virginia, and a bachelor’s degree in theology from Liberty Christian College, Pensacola, Florida.

Joan Loretta Henkel, RSM, PsyD ’07, concluded the acknowledgments in her dissertation by thanking God “for the ability and strength that I needed on this journey and the perseverance that it took to finally reach my academic destination.” Her journey was, and continues to be, an uncommon one.

A MINISTRY BEGINS

After a decade spent working in mental health counseling, in 1994 Sister Joan Loretta found herself treating substance abusing/addicted male inmates. As soon as she first stepped “inside the walls of a prison,” she says, she felt “the most incredible sense of peace. It was a transformative moment for me.” The next 17 years were the most rewarding part of her career: “where my prison ministry began.”

She recalls, for example, an “older inmate, a long-term heroin and cocaine addict, who seemed deeply entrenched in his addicted lifestyle.” “Addiction affects body, mind and spirit,” says Sister Joan Loretta, but this man “used his time in prison to strengthen his faith in God and work toward healthier relationships with his family.” After his release...
from prison, he periodically stayed in touch with Sister Joan Loretta over the next 15 years, maintaining his recovery from addiction and actively practicing his Christian faith. At the end of his life, Sister Joan Loretta visited him at his home. She recounts that “he passed from this earth just as he had lived over these many years—at peace with both God and himself. Although he was not cured of his physical illness, he was most surely healed.”

Sister Joan Loretta is a member of the Sisters of Mercy, an international religious community of more than 3,400 Roman Catholic women who take lifelong vows of poverty, chastity, obedience and service to people who suffer from poverty, sickness and lack of education. She considers her service a “two-way street: For me, just seeing an individual turn his or her life around in a positive direction is a spiritual blessing that cannot be equated with anything else.”

A RETURN TO PSYCHOLOGY

Sister Joan Loretta’s prison work involved collaboration with psychologists, rekindling her desire to pursue a career in that field (20 years earlier, she had earned her master’s degree in psychology). With her religious community’s support, she entered the doctoral program in psychology at PCOM, taking evening courses while continuing to work full time.

During a year’s leave of absence from her job, she completed her predoctoral internship in the Center for Brief Therapy at PCOM, which included working as part of the medical team in family medicine and geriatrics—“a very broad and diverse experience that you don’t often see in an internship.”

The Department of Psychology faculty at PCOM, Sister Joan Loretta says, “focus not just on academic excellence, but also on maintaining high moral and ethical values that are congruent with my own.” Her PCOM training, especially the internship, provided her with a “greater appreciation of the body–mind–spirit connection” that she says enhanced both her personal and professional development. By the same token, both faculty and other students told her that she helped them to view religious life in a new and positive way.

Sister Joan Loretta retired from prison ministry in 2011. She currently serves in another rewarding ministry experience as an adjunct instructor in the Master of Arts in Community Counseling program at Alvernia University, Philadelphia campus. This program is designed to foster the core Franciscan values of service, humility, peacemaking, contemplation and collegiality that are central to the mission of Alvernia University.
Healthcare providers are confronted daily with ethical issues. Some are subtle and not always identified as ethical concerns. For example, a patient who isn’t following medical advice may be labeled “difficult” or “non-compliant,” while in reality the patient was not properly informed about a medical treatment. In other situations, an issue raises an explicit ethical concern. For instance, a client may want to know his or her diagnosis, but the psychologist believes the therapeutic relationship would be in peril if the diagnosis of a borderline personality disorder was revealed.

The ability to recognize ethical issues, and to understand why they are indeed ethical issues, is the key to a healthcare student’s maturation into a healthcare professional. Without this ability, and an understanding of ethical theories and the principles that ground them, future osteopathic physicians, physician assistants, clinical and school psychologists, pharmacists and forensic scientists will be unable to fulfill their obligations to their patients, clients, colleagues and professions. Therefore, institutions tasked with educating and training future healthcare providers must provide their students with the intellectual tools necessary to navigate the ethical issues that arise in professional practice. These institutions are obligated to foster an understanding of basic concepts of medical ethics, professionalism and clinical moral reasoning, and nurture the attitudes and inclinations that enable trainees to emerge as exemplary healthcare providers.

As moral conflicts continue to complicate modern healthcare practice, Philadelphia College of Osteopathic Medicine has reaffirmed—and, in fact, strengthened—its commitment to ethics as a key foundational component of study in program curricula. The Department of Medical Humanities and Education has recently taken the lead in fulfilling this commitment.

Beginning in fall 2012, the department assumed responsibility for several courses including Preventive and Community-Based Medicine (osteopathic medicine course); Medicine, Law and Health Care Ethics (physician assistant course); and Bioethics in Professional Practice (forensic medicine course). [Next year these courses will expand to include Advanced Ethics, Health Policy...]

by Matthew D. Weinberg, MB, assistant professor of medical ethics, PCOM
and Multiculturalism, a psychology course.] In addition, a new program for fifth-year clinical psychology doctoral students was implemented. During this monthly Ethics and Professionalism Seminar, participants are required to maintain an ethics log of ethical concerns or conflicts that arise while they are providing mental health services as part of their internship. Based on the seminar discussions, students will be able to implement strategies to address their concerns or conflicts or proactively address similar issues encountered.

To fulfill its mission, the Department of Medical Humanities and Education has established a strong collaborative relationship with the Departments of Family Medicine, Geriatric Medicine and Surgery as well as with the Clinical Learning and Assessment Center.

Next year, Preventive and Community-Based Medicine will be a completely revised three-credit course, taught throughout the second year to DO students. The course will consist of didactic and interactive case-based lectures and small-group discussions that will focus on medical ethics, professionalism, health policy, public health, epidemiology and clinical research assessment skills. The course will be refined over the next several years based on student feedback and a comprehensive review of best practices of medical ethics instruction identified in the literature. To ensure that students are able to apply the ethical theories, principles and concepts taught in this course, professionalism and ethical considerations will be explicitly incorporated into the Clinical Reasoning in Basic Science grading matrix.

A new program also to begin in the fall of 2013 will provide third-year DO students with the skills necessary for discussing end-of-life issues and delivering bad news. The program, developed in collaboration with the Departments of Family Medicine and Surgery and the Clinical Learning and Assessment Center, will be a facet of the Advanced Clinical Skills rotation. It will consist of a didactic session on advance directives, DNR orders and the SPIKES model (a six-step protocol) for delivering bad news, and two simulated experiences with standardized patients. In one scenario, for example, a patient must be informed that her chronic disease has progressed to the point where she must stop her professional practice.

Furthermore, in collaboration with the Department of Geriatric Medicine, students learn the ethics of end-of-life care during a palliative care rotation (third year) and during an urban healthcare rotation (fourth year). During the palliative care rotation, students will attend didactic sessions on ethics and participate in small-group exercises on advance care planning, hospice and DNR orders. The program provided as part of the urban healthcare rotation consists of a simulated experience that requires students to inform a family member that a patient has died. Prior to the simulated experience, during which students will meet with a patient’s family member, they will attend a didactic session in ethics that reinforces what they learned during the end-of-life program provided during their Advanced Clinical Skills rotation; a debriefing session will be held after the simulated experience.

An increased commitment to medical ethics instruction can also be found in the integration into the delivery of course content to physician assistant, clinical and school psychology, and pharmacy students. Individual lectures and small-group exercises are provided by the Department of Medical Humanities and Education as part of existing courses:

- Individual lectures on professionalism and research ethics are given to physician assistant students during their courses on Professional Practice Issues and Health Policy and Research Methods.
- Lectures and small-group exercises are provided to psychology students in the Clinical Assessment in Counseling Psychology and Practicum VIII courses.
- A lecture on ethics and professionalism is provided to school psychology students during their annual Supervisor Training Day.
- Twelve hours of lectures on ethics and professionalism are provided to students in the pharmacy program as part of their Pharmacy Law and Ethics course.

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Being a pharmacist involves much more than understanding pharmacology, filling prescriptions and counseling patients about their medications. Pharmacists also need to be prepared to make ethical decisions about a multitude of situations they face every day.

What do you do when you suspect that a patient’s prescription for narcotics is not legitimate? How do you maintain confidentiality when counseling a patient in a busy community retail pharmacy? What do you do when the patients can’t afford their medication? What do you do if you suspect a pharmacist colleague is drug impaired on the job?

Ethical decision making about these and many other issues is an important part of the course of study completed by PharmD students at PCOM School of Pharmacy – Georgia Campus.

“Learning ethical decision-making skills and instincts can help prevent a lot of legal misjudgments and unintentional violations of regulations,” says Candace Nichols, PharmD, BCPS, assistant professor of pharmacy practice, PCOM School of Pharmacy.

In addition to the Code of Ethics adopted by the American Pharmacists Association in 1994 (see sidebar on opposite page), students learn to apply principles of ethical decision making:

- **Beneficence** – Do or promote good for patients.
- **Nonmaleficence** – “Do no harm.”
- **Justice** – Distribute resources equally.
- **Confidentiality** – Respect and maintain patients’ confidentiality.
- **Autonomy** – Respect patients’ rights to participate in decisions about their health, as well as their personal and cultural differences.
- **Veracity** – Tell the truth and act with candor.

### “PILL MILLS” AND FORGED PRESCRIPTIONS

A patient comes into a pharmacy with a prescription for 300 oxycodone pills and wants to pay cash for it. The pharmacist suspects that this is not for legitimate medical use. This situation occurs routinely in many states where “pill
mills” abound because of a lack of regulations, according to Dr. Nichols.

Here’s how it works: “An individual who does not have a medical necessity goes to a ‘doc in a box’ clinic, and pays a lot of money to see the doctor who, without examination, writes the requested prescription for a high volume of narcotics,” she explains. “The ‘patient,’ who is often from out of state, then takes the prescription to a nearby pharmacy to be filled. This puts pharmacists in a tough situation, because they don’t know for sure whether the patient is truly in pain, using the medication illegally, or selling it. If they fill the prescription and legal action is subsequently taken, the pharmacist will be held accountable as well as the patient and physician.”

Pharmacists can avoid filling a suspicious prescription by saying, “We don’t have that medication in stock.” Some pharmacies have company policies against filling a large number of narcotics for new patients, which takes the responsibility out of pharmacists’ hands.

Stolen prescription pads are another big problem. When pharmacists suspect a forged prescription, they have a legal responsibility to call the physician to clarify whether or not the prescription is legitimate. If the physician confirms that it is not, pharmacists are legally and ethically bound to involve legal authorities.

“The pharmacist can stall the patient by saying, ‘Please wait a few minutes while we fill the prescription,’ and then call the police,” Dr. Nichols advises.

CONFIDENTIALITY: WORKING TO ENSURE PRIVACY

Maintaining confidentiality can be challenging, particularly in community retail pharmacies that are open to the rest of the store. Patients are often in a hurry and may ask the pharmacist to provide medication counseling at the cash register where many other customers can hear the conversation.

“The best practice is to ask patients if they’d like to step down to a more private counseling window which most pharmacies have,” says Dr. Nichols. “Even if they decline, you’ve made the effort to protect their HIPAA rights.”

Confidentiality can also be challenging in a hospital setting when family members haven’t been told about the patient’s condition—for example, an HIV/AIDS diagnosis. Dr. Nichols advises, “If the family is in the room, the pharmacist should always ask the patient, ‘Would you like your family to step out while we talk about your condition and medications, or is it okay for them to hear this?’”

JUSTICE: PROMOTING EQUAL ACCESS TO MEDICATION

A patient comes to a retail pharmacy with a prescription and discovers she can’t afford to pay for it. If she goes without it, she is likely to end up in the hospital with serious health consequences. Pharmacists face this ethical dilemma every day. Sometimes the prescription is not covered under the patient’s plan formulary, the co-pay is more than the patient can afford, or the patient doesn’t have a prescription plan.

In a retail community setting, the pharmacist can help by calling the physician, explaining the situation and asking if a less expensive alternative medication can be prescribed, according to Dr. Nichols. “That’s where our clinical knowledge is a benefit,” she says. “We may know that another drug is equally effective but costs less because it is on formulary. We can suggest it to the physician as an option and offer to provide the proper dosing information and help to monitor the patient.”

Pharmacists can also advise low-income patients to seek out charitable hospitals or clinics that sometimes provide medications free or at a reduced cost to those who can’t afford them. Other options lie in generic programs available at some retail pharmacies where patients can get a three-month supply of medication for $10, and assistance programs available through pharmaceutical companies.

NONMALEFICENCE: PREVENTING IMPAIRED COLLEAGUES FROM DOING HARM

It is estimated that one out of every 10 medical professionals, including pharmacists, will be drug-impaired at some point during their career. A pharmacist who suspects that a colleague is impaired may be torn by a sense of loyalty to the colleague, but clearly has an ethical obligation to patients who could be harmed if errors are made by the impaired pharmacist. Legally, the situation must be reported to a government drug and narcotics agency. Pharmacists who are found to be truly impaired will temporarily lose their license, but re-entry programs are available to them for support and to help them get back into the profession. Most importantly, harm to patients is prevented.

“When we teach ethical decision making, we advise students to think about the action they’re going to take,” says Dr. Nichols. “If you will be embarrassed if others find out about it, don’t do it. Don’t put your life, license and the patient’s health in jeopardy.

“Time and experience also gives pharmacists the confidence to say no when it is appropriate,” she concludes. “While it’s important to respect a patient’s autonomy, pharmacists can’t allow themselves to be bullied or coerced into doing something they feel is wrong.”

THE 1994 AMERICAN PHARMACISTS ASSOCIATION CODE OF ETHICS

I. A pharmacist respects the covenantal relationship between the patient and pharmacist.

II. A pharmacist promotes the good of every patient in a caring, compassionate and confidential manner.

III. A pharmacist respects the autonomy and dignity of every patient.

IV. A pharmacist acts with honesty and integrity in professional relationships.

V. A pharmacist maintains professional competence.

VI. A pharmacist respects the values and abilities of colleagues and other health professionals.

VII. A pharmacist serves individual, community and societal needs.

VIII. A pharmacist seeks justice in the distribution of health resources.
THE FUREY FAMILY

Legacies do go on

Two brothers, William and Charles Furey, graduated from Philadelphia College of Osteopathic Medicine in 1912, respectively married (Dr. Charles Furey wed fellow classmate Blanche Costello Furey, DO ‘12), and migrated to Cape May County, New Jersey, where they would begin their individual medical practices.

Following in their footsteps is a lineage of Furey family physicians, including William’s two sons, Dr. Robert Furey and Dr. William Furey Jr.; Charles’ two sons, Dr. Joseph Furey and Dr. Charles Furey Jr.; and three of Dr. Robert Furey’s children, Dr. Karen Furey, Dr. Robert Furey Jr. and Dr. William Furey III. Dr. Charles Furey Jr. was the last of the second-generation medical professionals in the Furey family; he passed away in March 2013 at the age of 97. His first cousin, Dr. Robert Furey Jr., preceded him in death in 2005.

Dr. Robert Furey, a graduate of Hahnemann University School of Medicine, was a family physician with a 39-year private practice in Wildwood Crest. His widow, Veronica, said her husband and his cousin, “Charlie,” had great admiration for their profession, particularly the opportunity it allowed them to serve and heal others.

“I really believe what you do in this world comes back,” said Mrs. Furey. “They were proud to be doing what they did, and they were proud to pass it on through the Furey family lines. It takes a special kind of person to become a doctor.”

The love of medicine has been passed down through the family and has affected many patients in several states, “and the seed is still growing,” Veronica says. She notes a younger Furey descendant, Sonja Kenney, PhD, is a 2006 graduate of PCOM. “Our legacies do go on.”

Story originally authored by Elisa Lala and published in the Press of Atlantic City. It has been shortened and updated for inclusion in Digest Magazine with permission from the newspaper.

CLASS OF 1945
Arnold Melnick, DO, Aventura, FL, published his book, Melnick on Writing: An Anthology of Columns from the American Medical Writers Association Journal. The book is a collection of the first 10 years of columns published in the American Medical Writers Association Journal that represent Dr. Melnick’s comments on all phases of writing.

CLASS OF 1961
Donald R. Stolz, DO, Philadelphia, PA, won top honors at the 2012 World Book Awards. His children’s book, Classroom Times: Charactoons and Rhymes, was named Best Children’s Book in the competition. The book features 120 clever verses about everyday objects that are found everywhere you look, each illustrated by a unique, colorful “charactoon”—a cross between a character and a cartoon. Dr. Stolz has authored several children’s books as well as publications on American illustrators, especially Norman Rockwell.

CLASS OF 1965
Vincent Lobo, Jr., DO, Bethany Beach, DE, was honored by the Senate of the 146th General Assembly of the State of Delaware on October 31, 2012, for his decades of service to the citizens of Kent and Sussex counties and surrounding areas and for his more than 35 years of service on the Delaware Board of Medical Practice, of which he has been both vice-president and president.

CLASS OF 1966
Bernard F. Master, DO, Worthington, OH, became the third American to see a representative of all 227 bird families in the world. On September 11, 2012, he found and photographed the Przewalski’s Rosefinch (Pink-tailed Bunting) at 11,800 feet in the Menyuan Preserve, Qinghai Province, China. He has birded on six continents and in 94 countries since 1989.

CLASS OF 1968
James I. Weinberg, DO, Haverford, PA, joined the physician network of Main Line Healthcare.

CLASS OF 1969
Sally Ann Rex, DO, Bethlehem, PA, was elected to the board of trustees of the Pennsylvania Osteopathic Medical Association. Dr. Rex is founder and medical director of Health Dimensions in Bethlehem.

James W. Ziccardi, DO, North East, MD, spoke at the Marine Corps’ Marathon Sports Medicine Symposium on “The Cardiovascular Risks of Endurance Exercise.”

CLASS OF 1974
George D. Vermeire, DO, Oreland, PA, was re-elected to serve on the board of trustees of the Pennsylvania Osteopathic Medical Association.

CLASS OF 1975
Wayne A. Hey, DO, Arlington, TX, has been recognized by The Global Directory of Who’s Who for outstanding contributions and achievements in the field of adult and child urology.

CLASS OF 1976
Ted S. Eisenberg, DO, Philadelphia, PA, released a book co-authored with his wife, Joyce, titled The Scoop on Breasts: A Plastic Surgeon Basts the Myths (Incompra Press, 2012). Dr. Eisenberg also presented a lecture on the IDEAL Breast Lift at the American College of Osteopathic Surgeons’ Annual Clinical Assembly in Chicago.

CLASS OF 1977
J. Michael Tedesco, DO, Scranton, PA, was inducted as the 135th President of the Lackawanna County Medical Society.

CLASS OF 1980
Lauren P. Argenio, DO, West Pittston, PA, was recently re-elected to serve on the board of trustees of the Pennsylvania Osteopathic Medical Association. Dr. Argenio is a physician with InterMountain Medical Group in West Pittston. She is also an active staff member at Geisinger Wyoming Valley Medical Center in Wilkes-Barre and Wilkes-Barre General Hospital.

George K. Avetian, DO, Bryn Mawr, PA, serves as the Delaware County Senior Medical Advisor. He has created the “Ask the Doctor” mobile health van for the residents of Delaware County. The plan is to educate the community about available resources and needs such as nutrition, proper screenings and a healthy lifestyle.

Thomas M. Bozzuto, DO, Albany, GA, was elected president-elect of the Georgia Osteopathic Medical Association.

Certificates of Merit

David Coffey, DO ‘84, Montgomery, AL, was inducted as President of the American Academy of Osteopathy.

*Gregory S. Gaborek, DO ’96, Washington, MI, was designated as a Fellow of the American College of Osteopathic Surgeons.

John A. LaRatta, DO ’93, Berlin, NJ, was inducted as President of the New Jersey Association of Physicians and Surgeons.

Joshua C. Samuelson, DO ’06, East Arlington, VT, was certified as a Diplomate of the American Board of Integrative and Holistic Medicine.

*note originally included in error in Digest #3, 2012
CLASS OF 1981
Bernard J. Bernacki, DO, Pittsburgh, PA, a member of the PCOM Board of Trustees, was designated a Fellow of the American College of Osteopathic Family Physicians (ACOFP) during the college’s 2013 Annual Convention & Scientific Seminars in Las Vegas. Nineteen ACOFP physicians received this distinction that “recognizes members who show individual experience, dedication, and contributions through teaching, authorship, research and professional leadership.”

Neil A. Capretto, DO, Beaver, PA, was named Psychiatrist of the Year by the National Alliance on Mental Illness of Pennsylvania. Dr. Capretto is the medical director of Gateway Rehabilitation Center in Aliquippa.

Enrico A. Marcelli, DO, Sewell, NJ, was featured in an article, “Orthopedic Care at Kennedy,” published in the Courier-Post (November 4, 2012). Dr. Marcelli is associated with Reconstructive Orthopedics in Southern New Jersey.

Ray E. Sharretts, DO, Liverpool, PA, was appointed medical director of inpatient psychiatric services at Geisinger Medical Center in Danville. He is also on the clinical faculties at Philadelphia College of Osteopathic Medicine and Temple University School of Medicine in Philadelphia.

CLASS OF 1984
John C. Green, DO, Clarion, PA, was appointed medical director of the Center for Breast Health at Clarion Hospital.

Did you know?
The Library Alumni Portal gives you access to DynaMed, the Digital Commons@PCOM, drug information and mobile apps. Visit the portal at http://libguides.pcom.edu/alumni_portal

CLASS OF 1985
Daniel R. Black, DO, Gallipolis, OH, earned his board certification in sports medicine from the American Board of Physical Medicine and Rehabilitation. Dr. Black is on the medical staff at Holzer Health System – South Charlestown Outpatient Facility.

Thomas Costello, Jr., DO, New Hope, PA, was elected to a three-year term as treasurer of the American Osteopathic College of Anesthesiologists. Dr. Costello is medical director of Eastern Regional Pain Management, PC, in suburban Philadelphia, and is managing partner of Tревес Specialty Care Surgical Center. A clinical instructor for the International Spine Intervention Society, he is also on staff at James Hospital in Philadelphia.

Walter C. Peppelman, Jr., DO, Harrisburg, PA, co-authored the article “The da Vinci Robotic Surgical Assisted Anterior Lumbar Interbody Fusion: Technical Development and Case Report,” published in the July 2012 issue of Spine. Dr. Peppelman was part of a team that performed the world’s first robotic-assisted anterior lumbar interbody fusion surgery in March 2012.

CLASS OF 1987
Sheila E. Davis, DO, Philadelphia, PA, was the recipient of the 2012 Bradley Award presented by Saint Joseph’s University Medical Alumni Chapter for being one of the founders of Saint Catherine Labouré Medical Clinic in Germantown. The clinic provides compassionate, high-quality health care for the uninsured and underinsured, regardless of their ability to pay.

Katherine C. Erlichman, DO, Bedford, PA, was named Bedford Rotary Club’s 2012 Citizen of the Year for being the chairperson for the 1st and 2nd Annual Making Strides for Breast Cancer Walk. Dr. Erlichman founded Pennwood Ophthalmic Associates in 1991.

H. Jane Huffnagle-Marchesano, DO, Havertown, PA, was recognized by The Leading Physicians of the World for her exceptional successes in the anesthesiology community. Dr. Huffnagle-Marchesano serves as director of obstetric anesthesia at Thomas Jefferson University Hospital.

Richard E. Johnson, DO, DuBois, PA, was re-elected to the board of trustees of the Pennsylvania Osteopathic Medical Association.

Gwendolyn A. Poles-Corker, DO, Harrisburg, PA, was the recipient of the 2012 Robert S. Pressman Award for Distinguished Service to Internal Medicine presented by the Pennsylvania Chapter of the American College of Physicians.

CLASS OF 1988
Karel A. Keiter, DO, Harrisburg, PA, joined the medical staff at PinnacleHealth Weight Loss Center.

CLASS OF 1989
John E. Conlon, DO, Carmel, NY, was appointed vice president of medical affairs at Putnam Hospital Center.

CLASS OF 1991
Sean P. Harvey, DO, Southampton, PA, joined the department of medicine/internal medicine in association with Doylestown Hospitalists.

David A. Hoffmann, DO, Chambersburg, PA, was appointed vice president of Medical Service Line and medical director of Innovation at Summit Health in Chambersburg.

CLASS OF 1992
Gene M. Battistella, DO, Moon Township, PA, was re-elected to the board of trustees of the Pennsylvania Osteopathic Medical Association.

Vincent N. Disabella, DO, Vineland, NJ, joined the medical staff at Premier Orthopaedic Associates.

Stacy M. Kaplan, DO, Doylestown, PA, joined the department of surgery/plastic surgery at Doylestown Hospital.

ROBERT S. IVKER, DO ’72
Treating disease the holistic way by Colleen Pelc

In 1980, an ENT physician told Dr. Ivker that he would have to live with the misery of chronic sinusitis for the rest of his life. But Dr. Ivker was determined to cure it.

“I used all natural products while applying a holistic approach to address each of the causes of my inflamed mucous membrane,” he says.

By changing his diet to eliminate inflammatory foods and practicing daily nasal hygiene with saline sprays, steaming and irrigation, Dr. Ivker was able to cure his chronic sinus condition and experience a state of health far beyond anything he’d ever known.

Today, Dr. Ivker is the founder and medical director of Fully Alive Medicine, a holistic practice in Boulder, Colorado, focusing on treating chronic disease and teaching exceptional self-care. He is also the author of the best-selling book, Sinus Survival.

“Sinus Survival presents a comprehensive self-care approach for treating and preventing sinus infections, for significantly improving and, in many cases, curing chronic sinusitis, the world’s most common respiratory condition,” Dr. Ivker explains.

In addition, Dr. Ivker serves as co-founder and past president of the American Board of Integrative Holistic Medicine, whose mission is to teach and certify physicians in the specialty of Integrative Holistic Medicine (IHM). “There are approximately 2,000 DOs and MDs certified by the ABIMH,” Dr. Ivker reports.

“I believe IHM—Fully Alive Medicine—is the 21st-century version of the art, science and practice of osteopathic medicine.”
GEORGE KOENIG, DO ’03
Leading collegiate EMS groups and bringing the osteopathic approach to acute surgery by Colleen Pelc

Since 1994, Dr. Koenig has served as the president of the National Collegiate Emergency Medical Services Foundation (NCEMSF), an organization committed to creating a safer environment on college and university campuses through campus-based emergency medical services. Dr. Koenig, who is also an assistant professor in the Division of Acute Care Surgery at Thomas Jefferson University Hospital, has enjoyed seeing what NCEMSF has become over the years. “NCEMSF has grown into an organization that inspires college students to advance their understanding of medicine, an organization that develops leaders, and an organization that hosts an annual educational conference that rivals all other EMS conferences,” Dr. Koenig says. “As president, I have seen our annual conference attendance increase from 80 to nearly 1,000.

“I continue to uphold the belief that there is no ceiling or limit to what you can do with an osteopathic education. I completed a surgical residency, continued my training in trauma and critical care at Johns Hopkins, and now work at Jefferson,” Dr. Koenig says.

“I believe that if you work hard, you can achieve anything. I enjoy what I do. The care of trauma patients forces me to think outside of the box and to problem solve with limited information and little time. I find this is the most rewarding part of my job.”

CLASS OF 1995
Jeffery J. Dunkelberger, DO, Lewisberry, PA, was re-elected to the board of trustees of the Pennsylvania Osteopathic Medical Association.
Frances A. Feudale, DO, Drums, PA, was appointed medical director of the American Patient Transport Service in Hazleton.

CLASS OF 1996
James F. Frommer, DO, Bath, PA, joined the medical staff at J.C. Blair Memorial Hospital as a hospitalist.
David Kuo, DO, Blue Bell, PA, has been named assistant dean of graduate medical education and director of medical education of the PCOM Philadelphia consortium internship/residency programs. He will continue to practice medicine on a limited schedule at PCOM Healthcare Center – Roxborough Division and will maintain his position as program director of the Mercy Suburban/PCOM family medicine residency.
Dan W. Pulsipher, DO, Fort Meyers, FL, joined Access Healthcare and opened a new practice in Spring Hill.

CLASS OF 1997
Daniel W. Matkewsky, DO, Vernon, NJ, joined the medical staff at Skylands Medical Group, PA.

CLASS OF 1998
Francesco T. Mangano, DO, Loveland, OH, was appointed division chief of pediatric neurosurgery at Cincinnati Children’s Hospital Medical Center. He has been instrumental in developing Cincinnati Children’s nationally renowned Pediatric Epilepsy Surgery Program.

CLASS OF 1999
Jason R. Aronovitz, DO, Ambler, PA, was appointed director of Data Analytics for Einstein Health Network. Dr. Aronovitz will be building an enterprise data warehouse and analytics program for the entire health network.
Tammy L. McBride, DO, Spring Grove, PA, joined the medical staff at Hanover Medical Group Family Medicine – South Hanover and South Hanover Express Care.

CLASS OF 2000
Russell R. Bear, DO, Cherry Hill, NJ, joined the Aria 3B Orthopaedic Institute Team.
Monique M. Scally, DO, Stratford, NJ, joined the medical staff at Cape Regional Physicians Associates. Dr. Scally has a private practice, Coastal Cardiology, in Cape May Courthouse.
Italo A. Subbarao, DO, Hattiesburg, MS, is an associate professor of medicine and associate dean of planning, assessment and competency development at William Carey University College of Osteopathic Medicine. Dr. Subbarao was named to the editorial board of The Journal of American Osteopathic Association.

CLASS OF 2003
Mark D. Brayford, DO, Oreife,field, PA, joined Geisinger Health Systems as a non-operative orthopedic sports medicine specialist. He practices at Geisinger – Woodbine.
Terrance L. Foust, DO, Coulersport, PA, received board certification from the American Board of Orthopedic Surgery. Dr. Foust practices at Champion Orthopedics and Sports Medicine at Charles Cole Memorial Hospital.
Ann Marie Stephenson, DO, Philadelphia, PA, was featured in the article “Former Candy Striper Now Treats Patients” published in the Courier Times (February 5, 2013). Dr. Stephenson is a gastroenterologist at Lourdes Medical Center of Burlington County.

CLASS OF 2004
Michelle K. Dilk, DO, Greenville, TN, joined the medical staff at Laughlin Medical Group.
Rebecca Arnold Moul, DO, Morristown, TN, joined Lakeway Regional Hospital and will be practicing at East Tennessee Spine and Orthopaedic Specialists.
Richard F. Waters, DO, Kennett Square, PA, joined the medical staff at Geisinger – Lewistown.

CLASS OF 2005
Griffin K. Bicking, DO, Paducah, KY, joined the medical staff at West Kentucky Surgical Associates.
Jocelyn R. Iedma, DO, Frederick, MD, joined the medical staff at Mid-Maryland Musculoskeletal Institute.
Kathleen A. Koth, DO, Brookfield, WI, was appointed assistant professor of psychiatry and behavioral medicine at the Medical College of Wisconsin.
Jamie Bearden Lin, DO, Rome, GA, joined Floyd Primary Care Network and sees patients at Rome Internal Medicine.

CLASS OF 2006
Mark R. Paiste, DO, Springfield, PA, joined the medical staff at Shore Orthopaedic University Associate Physicians in Somers Point, New Jersey.

CLASS OF 2007
Michelle Badorf Litsky, DO, North Haven, CT, joined the Complex Pediatric Care Program at the Hospital for Special Care.
Amy C. Schneider, DO, Levittown, PA, joined the medical staff at Rothman Institute at Nazareth Hospital.

CLASS OF 2009
Taimur Akram, DO, Kent, OH, joined Robinson Memorial Hospital and will be practicing at Ulrich Professional Group.
Preethi Ravichandran, DO, Erie, PA, received Honorable Mention in the 2012 POMA Clinical Essay Contest for her article on “Investigating Medication Compliance in Osteoporosis Patients within Erie, Pennsylvania.”

Did you know?
PCOM now has a mobile Web site, which means the most frequently visited pages of the site have been reconfigured so they are easily viewed and navigated on mobile devices such as smartphones.
A number of years ago, Ms. Young took a huge leap of faith when she walked away from her full-time job and decided to follow her vision to create an independent career helping organizations and people become successful. She started 1 Extraordinary!, a business that empowers and inspires people, businesses and communities to operate at full potential.

“I am wildly passionate about the concept that we all have what it takes to succeed in life, if only we were able to get on our path and awaken our inner potential and desire,” Ms. Young explains.

For individuals, 1 Extraordinary! assists with career development, offering interview preparation, resume writing, career coaching and personal branding. For organizations, the focus is more on talent development. “We create and facilitate leadership development programs for leaders and individual contributors, as well as conduct team-building exercises and provide motivational speaking engagements,” Ms. Young says.

Ms. Young has experienced the joy of achievement not only by creating her own business, but also by creating an enterprise-wide mentoring program at her former employer, Independence Blue Cross. For the work on this program, Ms. Young and her small team of two won the IBC Winner’s Circle Award of Business Excellence.

Ms. Young hopes to continue using her personal and career experiences to help other people and businesses reach their goals. “Extraordinary things happen to you when you believe they can and they will! My goal is to transmute all of the wonderful career experiences that I have had into impactful takeaways for my clients.”

**TOP DOCTORS**
The following physicians were selected by *Main Line Today* (December 2012) as “Top Doctors”:
- **Mark A. Ginsburg**, DO ’03, Aston, PA – Otolaryngology and Plastic Surgery
- **Lisa D. Held**, DO ’04, Radnor, PA – Anesthesiology
- **Norman A. Leopold**, DO ’68, Chester, PA – Neurology
- **Donald M. McCarren**, DO ’88, Media, PA – Neurology
- **Joseph J. McComb**, III, DO ’00, Broomall, PA – Anesthesiology
- **John J. Orris**, DO ’95, Chester Springs, PA – Obstetrics/Gynecology
- **Brian D. Rosenthal**, DO ’98, Blue Bell, PA, was named to *U.S. News & World Report’*’s “Top Doctors List” of 2012. Dr. Rosenthal is chief of the Division of Urologic Surgery at Mercy Suburban Hospital.

**Did you know?**
The Office of Alumni Relations and Development has created a Graduate Mentor Directory to increase collaboration between graduate students and alumni. Alumni wishing to be mentors can submit their contact information (name, preferred email, phone) to alumni@pcom.edu.

**On a Personal Note**

*Baby Kolter  Baby Barrizonte  Noreski-Cassidy Wedding  Sayegh-Suchter Wedding  Szentesy-Shotwell Wedding  Baby Talley  Baby Weingart*

**Top Doctors**
- **Melissa Taylor Bergonzi**, DO ’02, Fogelsville, PA, and her husband, Pete, adopted son Xander Habtamu from Ethiopia in October 2012. Little Xander was 17 months old when the Bergonzis brought him home.
- **Megan L. Kolter**, DO ’05, Chester Springs, PA, and her husband, Mike, welcomed their son, James Francis, born on October 30, 2012. Little Frankie joins big sisters Grace and Sophia, and big brother Johnny.
- **Jasmine Martinez-Barrizonte**, DO ’04, Miramar, FL, and her husband, Oscar, welcomed their first child, Mason, born on December 6, 2012.

**Gregory J. Sayegh**, DO ’09, and **Lori Suchter**, MS/PA-C ’08, Cherry Hill, NJ, were married on June 2, 2012, in Scranton, Pennsylvania. **Lauren (Tavani) Barrett**, MS/PA-C ’08, served as a bridesmaid.


**Charlene E. Talley**, MS/Biomed ’04, DO ’06, Browns Mills, NJ, and her husband, Michael Chick, are the proud parents of Alannah Michelle, born on October 23, 2012.

**Brian M. Weingart**, DO ’09 (GA–PCOM), Cherry Hill, NJ, and his wife, Jaime, welcomed their son, Aiden Grant, born on May 21, 2012.
**In Memoriam**

**Stanley T. Bohinski, DO '88**, Wilkes Barre, PA, February 19, 2013.


**Victor L. Flagiello, DO '70**, Houston, TX, February 18, 2013.

**E. Milton Friedman, DO '56**, Sarasota, FL, October 5, 2012.


**Albert M. Honig, DO '51**, Doylestown, PA, August 31, 2012.

**Robert J. Kane, DO '54**, Newtown, PA, January 24, 2013.

**Theodore M. Kellogg, Jr., DO '54**, Southwick, MA, March 9, 2013


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**John A. Cifala, DO '45**

Arlington, Virginia, February 23, 2013

From the age of eight years old, after he was healed of a serious injury by Della Mattson, DO, Dr. Cifala wanted to be an osteopathic physician. At 13, he was the youngest person ever to apply to PCOM, although it would be five more years until he was allowed to attend.

During his studies at PCOM, Dr. Cifala met his wife Laura Amalfitano, an obstetrical nurse, and upon Dr. Cifala’s graduation, the couple opened a family practice in Arlington, Virginia. They practiced for 60 years, he as a physician and she as a nurse and office manager.

In 1948, Dr. Cifala was the first DO to be accepted into the Veterans Administration in Washington, DC, where he was appointed head of the Physical Medicine Department. As a member of the House of Delegates of the American Osteopathic Association, he worked passionately to legitimize the osteopathic profession across the country, which at that time had only a handful of licensed states. As one of the first osteopathic physicians on the East Coast, he also helped found the Osteopathic College of Rehabilitative Medicine and served as its president. In later years, he became president of the Maryland, DC, and Virginia Osteopathic Medical Associations.

Dr. Cifala received the O. J. Snyder, DO, Memorial Medal, PCOM’s highest honor, in 2010. He was a life member of the Alumni Association of PCOM and served on its board until his death.

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**Ruth E. Purdy, DO '50**

Columbus, Ohio, April 2, 2013

Dr. Purdy was a trailblazer for women in osteopathic medicine. She was among the 20 female osteopathic physicians who graduated from PCOM between 1950 and 1969, a post–World War II era that was not conducive to women in medical schools nationwide. Her efforts for gender equality held constant over her illustrious and decorated career that spanned over 50 years.

A skilled clinician and mentor, she was the first female internal medicine resident at Doctors Hospital and later became the first woman to serve on the hospital’s Board of Trustees. In 1970, she was elected hospital chief of staff.

Dr. Purdy introduced Columbus to the concept of intensive care units housed in general care hospitals. After a 1960 visit to such a unit in New York, Dr. Purdy returned to central Ohio championing the idea to bring an ICU to an adult care facility. After she lobbied successfully for the unit, the ICU opened at Doctors Hospital.

Even during retirement she remained involved in medicine, serving for a time as a medical consultant for a local workers compensation organization, doing social security medical disability exams and volunteering at the Central Ohio Diabetes Association to provide guidance and education to clients. Her superb professionalism and diagnostic abilities were overshadowed only by her dedication to the people she treated.

In addition to receiving PCOM’s highest honor, the O. J. Snyder, DO, Memorial Medal, in 1989, Dr. Purdy received the American Osteopathic Association’s (AOA) first-ever Mentor of the Year award (2006). She was also the recipient of the OU-HCOM Phillips Medal (1984), the Sosnowski Distinguished Service Award (1992) and the Ohio Osteopathic Association Distinguished Service Award (2006). In 2008, the AOA recognized her as a “Great Pioneer in Osteopathic Medicine.”

Dr. Purdy was elected to the PCOM Board of Trustees in 1975; she served as a trustee for more than 15 years.
When Phillip entered my critical care service, he arrived on a stretcher. I estimated him to be no older than 18. He lay lifeless, an endotracheal tube forcing his airway open, a nurse feverishly compressing his chest. As his stretcher rolled into the catheterization lab, the on-call cardiologist informed me that the patient had been coded for nearly an hour. He remained pulseless.

No significant occlusions were found on his cardiac catheterization. It was anyone’s best guess if the cause of Phillip’s misfortune was an undetected congenital heart defect or a primary cardiac arrhythmia. His lab results were disconcerting; his downtime was so prolonged that he had developed profound acidosis. My job, should Phillip regain a pulse, would be to initiate the hypothermia protocol of critical care, which involves cooling patients for 24 hours to improve neurological outcomes following cardiac arrest.

After nearly an hour and a half—a period that felt like a lifetime—of chest compressions and countless rounds of epinephrine, Phillip displayed signs of life. Waves of electrical activity began to spike on the monitor, slowly at first, but ever increasing in frequency. His blood pressure climbed to a normal value. Echocardiogram tests revealed a well-functioning left ventricle.

But these signs of life would also bring about a regretful hope.

In my short time in critical care, I’ve learned that outcomes after 20 minutes of cardiac arrest are generally poor. Patients with significant acidosis and poor perfusion for extended periods of time suffer a high degree of end-organ damage. It was my prediction that Phillip would be placed on ice for 24 hours, and would never wake up. His respiratory function would worsen over a few days, and his liver and kidneys would fail. I expected that despite our best efforts, a neurologist would have no choice but to eventually declare brain death.

Yet, I couldn’t have been more wrong. With medical intervention, Phillip’s acid-base status normalized within 24 hours. His heart continued to beat without faltering. He was easy to ventilate. And after a few days, his sedation was stopped, he woke up and his breathing tube was removed. He received an internal defibrillator and walked out of the unit after only a week of hospitalization.

I heard the word “miracle” thrown around by staff many times in the days following Phillip’s hospital discharge. Doctors who had been practicing for decades told me there was no medical explanation for his full recovery, that anyone with realistic expectations would have told you the young man who came into the hospital without a pulse had no chance of regaining full functionality. He was one of those critical care case successes that fuels debates about healthcare budget allocation, application and the use of therapeutics wrought by research ethics boards, hospital administrators and health policy legislatures.

Phillip was—without a doubt—the kind of “save” that I’d witness once, maybe twice in a lifetime. Every link in the chain of his rescue functioned flawlessly to ensure his survival. From his friends who recognized distress and started CPR to the high-quality compressions provided by police and emergency medical services to the quick actions of the hospital’s doctors and nurses, each moment played a large part in Phillip’s survival. If any single link had been broken or a minute of the timeline had changed, I’m confident that Phillip would not be with us today.

When I first saw Phillip the morning after he was awakened and extubated, I asked him how he was feeling. He had a blank stare on his face, but then his brow furrowed with mild frustration. He ignored me at first, but after some prodding, began to open up. He related that his mouth hurt; I explained that his teeth had chipped during the intubation. I asked if he had any questions, needed anything or anyone. His only request was for his cell phone. He wanted to text his friends and play some games—to move forward from his near-death experience.

I walked away, cracking a smile. He was going to be fine. To this teen, I offer profound thanks.

In a field where our best efforts often feel futile, Phillip managed to remind me why I chose critical care medicine: in caring for the seriously ill, we gain a deeper appreciation of what it means to be alive.

Mr. DelRosario is a pulmonary and critical care physician assistant employed by Bryn Mawr Hospital, Bryn Mawr, Pennsylvania.

* The patient’s name has been changed to protect his privacy.
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