Cover Page Footnote
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Introduction
This is the first collection of clinically-related experiences of students, faculty, employees, patients, and clinicians associated with PCOM, audiotaped by the editors in a conversational setting.

Individual experiences narrated here often are shared with family and close friends. The collective PCOM community, however, is frequently unaware of such experiences and therefore unable to benefit from these situations.

Many of these encounters provide valuable insights relevant to the practice of medicine. Others contain a reassuring familiarity that helps us understand that we are not alone in our efforts to arrive at appropriate solutions to healthcare-related issues.

This anthology was designed to provide a vehicle of education and communication for the individuals most essential to the vitality and function of our Institution.
ONE DAY AT A TIME WITH MICHAEL

By Mary DeJoseph, D.O. and Paul DeJoseph, D.O.

Mary DeJoseph: I'm thirty-eight years old and I thought to myself: "Here we are going to be writing about Michael, a six year old boy who has changed our lives, our professional lives, our philosophy, our marriage, our family." But, I think every child does that; certainly all three of ours have changed our lives. Michael has special needs above and beyond what a healthy, normal developing six year old might have.

Paul DeJoseph: Essentially from birth on, Michael was always at a very low percentile as far as physical characteristics. When he reached the 5% milestone it was a big thing.

(continued on page 2)

The Bloodless Medical Care Option

By Ronald C. Morgan

My family has always participated in a bloodless medical care program because of our religious convictions. Cooper Hospital has operated such a program for about twenty years. In the past, most Jehovah's Witnesses would go to Cooper exclusively.

About five years ago a nurse at Graduate Hospital started the bloodless care program there. Now this program attracts patients from the tri-state area and other hospitals have expressed interest in operating similar programs. Likewise, the Graduate Hospital City Line (Allegheny) is the only hospital on the east coast that provides complete bloodless care for pediatric patients. They have physicians on the patient liaison committee, and an orientation program that provides information about the alternatives to using blood. We have a medical directive card that is carried in our possession at all times. Should we be involved in an accident and become unconscious, this card instructs (continued on page 3)

GOING HOME

By Maria J. Hoertz, MPH, MSIII

I'm going to tell you a story about a patient assigned to me. This gentleman came in and his blood sugar for just a normal exam was over 800 mg/dl. His doctor called him up when the lab results came in the next day and told him "you have to go directly to the hospital".

He went directly to the hospital and that's where I met him. I was on call that night and I admitted him. When he first got to his room the blood sugar was 754 mg/dl. We gave him some insulin and his blood sugar two hours later was down to 454 mg/dl. I spoke to him that night, got his history, and did a physical on him. He was a healthy, 74-year-old man before this, with no medical problems to speak of to this time.

His family medical history included a wife, legally blind from diabetes, who had also had a stroke and was in a wheelchair. The two of them lived alone and he cared for both of them. His son lived close by and visited daily. His daughter had died the year before from a neuromuscular disease.

So, here he was saying, "I just don't understand why this happened to me. I know about sugar and I never had sugar before and I don't" (continued on page 2)

The Humors in Uniform

By Suzan Entwistle Marshall, MSII

I don't know which is more ironic—that I'm in medical school or that I'm in the military. I originally expected to go pre-med back when I was eighteen, but I questioned what it would be like for a woman to be in medicine: how would you juggle that particular kind of career with having a family? My father is a surgeon, and I knew what kind of sacrifices he had made, and I knew that we were part of that sacrifice at times. He has some regrets about that, too. At the same time that I was having reservations about medicine, I was being recruited by the Literature Department as an undergraduate (no kidding, this is actually done). It was pretty easy to let go of pre-med courses when I got so much encouragement elsewhere.

In my senior year at American, I was accepted into Columbia's graduate program. I was pretty excited. My goal at that time was to become a professor of comparative literature, and I was Ph. D. tracked. I loved the school—they have something like 27 libraries. The field of literature at the time, though, looked very bleak. I don't know how many PhDs are turned out every year as specialists in Nineteenth-Century British literature, (my specialty), but there only may be two jobs available per year in the entire US. You could put in all those years and end up working for the Association of Associations being a copy editor.

I was also afraid that I wouldn't be able to do what I wanted to do with literature. Academicians were more concerned with publishing obscure articles that hardly anyone would read than actually teaching. I really wanted to teach.

Voices From the Floor—1
he did orthopedic surgery at Fort Bragg and went through jump school for paratroopers. He had never been in an airplane before, and the first time he was in one he had to jump out of it. His first case in the OR (mind you he had been a doctor for one year), his colonel drew him a picture of the procedure and said, "Call me on the 'squelch' box if you have a problem." So, the military

(continued on page 4)

2—Voices From the Floor
to 2 1/2 years of age.

Paul DeJoseph: His pediatrician had set in motion the various failure-to-thrive evaluations since he was below the percentiles most of the time. It included a full GI evaluation, a full neurological assessment, a hormonal evaluation involving all different kinds of x-rays, procedures, and things of that nature. It really made Michael fearful of going to hospitals. We worked very hard at bringing him with us to work sometimes just to make him realize that it was where we worked, not just a place that was there to cause him harm. For example, if I decided on a Saturday to stop at my office (which is within Parkview Hospital) with him to pick something up, he got spooked. He stopped talking as we would get closer to the buildings. His perception was “these big buildings are where the hospital is and I don’t like what takes place here”. After all, he had to have i.v. contrast, a nasogastric tube for GI reflux testing, plus all kinds of genetic testing etc. It was a real confusing time ... at this same time he had to have ear tubes placed over at St. Christopher’s—no it was CHOP—and that seemed to break him.

I brought him over to that appointment and my father went with us. He is very close to his grandfather. For some reason they hit it off very well and they bonded. He asked that he come with us because he was very scared to go there. That was such an excellent experience for him considering how procedures in the hospital had gone previously. They really make the kids feel at home and involve the parents so that you are right there in the action. They have a wagon that they use to take them to the O.R. They give them premedication before they take them anywhere near the O.R. It was really funny pulling

(continued on page 4)

Bloodless ...from page 1

medical personnel not to transfuse us with blood. We also have power of attorney forms that we have drawn up and placed on file with the hospital. In the event that an individual must undergo surgery it will be available and on record. The reason that we did it this way is because it eliminates a lot of court orders especially when it comes to children. So now when children or adults have to have a serious operation they can go to the City Line or Downtown facilities respectively and be admitted into the Bloodless Surgery Program.

My wife, Geraldine who is diabetic had quadruple bypass surgery last year. Both her primary care doctor and her cardiologist were osteopathic physicians and they coordinated her care with a thoracic surgeon on staff at Graduate Hospital. Once he had determined that the procedure was necessary, a protocol was initiated to try and build-up her red blood cell count through the administration of erythropoieten (Epo) injections. In her case they were only able to get her hematocrit up to 40%; ideally, they strive for 50%. Despite this, her actual hospital stay was shorter than most for a comparable procedure. The operation was performed on a Friday, she stayed in ICU for 48 hours, the step-down unit the remainder of Sunday, and was discharged on Tuesday. It took about three weeks for her hematocrit to return to within the normal range and her recovery at home was uneventful.

We have about 150 specialists in the Bloodless Care Program in the northeast and the numbers are increasing as others come to realize the benefits. Seventy-five percent of the patients are Jehovah’s Witnesses and 25% non-Jehovah’s Witnesses.
Most in the latter group are motivated by the risks of contagious disease transmission from transfusions, whereas, the majority participate purely on the basis of religious principles. A lot of people think that Jehovah's Witnesses are anti-doctors. This is not true, they don't try to tie the physicians hands. Your mind wanders... is everything going to turn out well...

(continued on page 6)

GOING
...from page 2

size bottle of water?” “You know, one of those bottles of water you stick into the refrigerator with the little spigot on it”. “Oh Mr. T.”, I said, “That's probably eight quarts of water that you are drinking a day!”. He said, “Well I don’t know...it just tastes real good to me.” It really was interesting because while he said he just was on a diet and drinking a bottle of water a day, it turned out he was doubling his calories and drinking eight quarts of water a day.

Time went on and he remained in the hospital getting his sugar regulated and he was on accucheck every 4 hours. We brought in the dietary people, the nutritionist, and the diabetes counseling people. They all talked to him about his diet, how to deal with his insulin, how to use the accucheck machine, and how many units of insulin he would need to give himself based on his blood sugar level. They also gave him the exchange diet and lots of booklets.

The last day he was in the hospital I went in to him and I asked him how things were going and he said, “good”. I said, “I would really like to encourage you to come to the outpatient diabetes center that they have here. From what I understand

(continued on page 8)

ONE DAY
...from page 3

him in the little red wagon because the anesthesia was starting to take effect as he's sitting there and he's not knowing exactly what is going on. He is riding in there, playing real nicely, and they take him to the second room where they give him the preanesthesia and you go in with him. They say to just stay near him because he will start to get a little woozy and he will cling to you and he is not going to know what is going on. But, he was very pleasant with the whole thing and it was a very, very, upfront, worthwhile experience for him. The problem was on the back side. He got very sick from the anesthesia; nauseated, and he was so tiny to start with that he didn't have a whole lot of room to move in that regard. And he has always had difficulties with vomiting whenever he got a virus or GI problem. It was very bad there for several hours afterwards. Up until then it was great to say “Oh this is what hospitals are like Mike, it isn’t always that bad stuff”. Then he had that experience again. So, it kind of set him back a little bit but, he seems more comfortable now. And I think it has a lot to do with the pediatrician he has at present... he likes him. And I think it is very important that you have someone who is understanding, that knows what the child is going through and knows when to say NO...you don't need this, you don't have to have that done. That's been great because that coordination has been real helpful.

Mary Dejoseph: These children get started against tremendous odds. They have daily struggles like weighing by the ounce every meal. We didn't have the luxury of saying don't battle with him. We had to get something into him, little meals, like fruit treats or something. This went on for years, until finally he got into early intervention and he started school and finally got transferred into the Delaware Avenue Program that he is in now. He had school, he got glasses, he could hear, and his world expanded and he has progressed in leaps and bounds. Every year he has progressed logarithmically beyond the curve that was expected.

Michael was born at a time when Steven was at an age and personality to really take care of this kid. He has been fabulous... and still protects him during the after-school program. I'll still ask Steve when Mike is very, very, tired and it is hard to understand him. “What is he asking for”? Michael is now in multiply-handicapped kindergarten where I have started to teach every afternoon. Paul has become involved there as well. Michael has finally reached the stage, only in this past year, where we started saying to him something I never thought we would say: “Could you please be quiet for a moment?” (And Steven tells him that as well!). He has even gotten to the point where he interrupts Steven. His younger sister has had a lot to do with that. She also has that same sense of responsibility, like checking around for him, “Come on Michael”, and holding his hand to help him across the street. They are now 9, 6, and 3 years of age. She does something that Steven hardly ever does and that is to boss him around: “Michael, do this... pick this up... don't do that... Mommy says...”.

Paul Dejoseph: Her perception is that they are “her boys”, (as she says) “My boys, come here, my boys” and she calls them that way. Now Steven rolls with it, no problem. Michael rebelled against it for some time. We really had to watch those two because when she started to get real bossy, he had no problem rebelling against her behavior. He is now his own little individual and we saw this

4—Voices From the Floor
development over the past year; he speaks for himself and does his own thing. You have to watch them in that regard but for the most part it is not too much of a conflict.

Mary DefJoseph: I think the interaction now between the three of them is such that I have to keep an eye out for Michael and Christina ganging up on Steven (and they do it very effectively). He is so easy-going.

Michael's official classification by the State of New Jersey is multiple handicapped, neurologically impaired, and communications impaired. This is a kid that we live with and he has changed our lives, but these are scary terms. When people hear words like this it makes them think that you have a kid that just sits in a corner like these children use to do. Nothing could be further from the truth. He is in first grade, he is swimming, running, and riding a bike.

Paul DefJoseph: One of the interesting things about the program we are in is that they give you a full delineation of what the parents' rights are, the child's rights are... the whole program. They lay that out for you and go through all those issues in lay terms not like "this is title 16 and this is title so and so pursuant to thus and such".

Mary DefJoseph: A lot of people feel out of control when it comes to mapping out this developmental course. However, we do sit in on his individualized educational program (IEP) and have input regarding various aspects and it doesn't have to be a battle. The system provides a package of 50 services...they don't have to be individually obtained but, it is still, at times, massive and confusing.

Paul DefJoseph: We go to the meetings and listen to the reviews where they go over all the skills. First, they give you an assessment of what's going to be done in the course (continued on page 7)

Humors

...from page 2

background that I had was based on his crazy experiences.

Strangely enough, the year before I went to medical school, I said the one thing I would never do is go into the military. Within six months, I was applying for a military scholarship. Part of the decision was influenced by my father's discouragement about what was happening in medicine today. I realized how much autonomy was taken away from him and that the way he had to treat patients was not the way that he liked to care for them. Another issue was the tremendous debt with all those zeroes that medical school hangs over your head. But, I don't think people should look to a military scholarship for financial reasons alone, because it could make them very, very, unhappy, if that's all they're in it for.

Being a good physician, to me, means that I must have the autonomy to work with my patients, to work out a treatment plan...how WE can attack whatever is going on. I understand the apparent dichotomy of my seeking a greater autonomy by practicing medicine in the military. However, most of my understanding comes from my husband's experiences in the Marine Corps. The kind of leadership training that he received was phenomenal. They really eschew the principle of integrity and initiative with an intensity that we seem to be lacking in the civilian world. This is the core of military leadership.

As reserve officers in medical school, we are required to do 45 days of active duty each year. I did my first temporary active duty the summer before medical school in the Officer Basic Course (OBC) down in San Antonio, Texas, which was the exact same program that my father went through in 1958. You take classes about the different branches of the military, their roles, and cover topics such as military principles, what is expected in the leadership roles, and how the medical corps is set up. You could be a physician here in the US, for instance, then suddenly be deployed to Bosnia, and all of a sudden become the leader of a platoon. This would involve setting up a battalion aid station and determining how casualties are handled. You need to be aware of how your role could change overnight. There is a week of field training in OBC, where you carry around an M-16 rifle and gas mask 24 hours a day. You have to be able to take your M-16 apart, put it back together, within two minutes. Other tests involve putting on your gas mask and clearing it in under 12 seconds. Then, you get tear gassed. You hump up and down hills with a pack in 110 degrees with your rifle, two canteens, and a gas mask, traipsing around in the middle of nowhere. Another test is land navigation where you are given coordinate points on a map and ordered to get from Point A to Point B (then C and D—I think I accidentally went straight to D). There is an obstacle course, and you run around carrying "casualties" on stretchers, jumping over brooks, running through tubes, crawling under barbed wire. You rappel down a six-story wall and go through a leadership challenge course where in a certain amount of time and with a certain number of objects, you must complete some task with your group. Someone has to take charge, others must follow. Inevitably, it ends up with too many chiefs and not enough Indians; people argue, and then the buzzer goes off. Most everyone made it through the training, although there were a couple that bailed out.

For most of the women, myself included, it's unlike anything >

Voices From the Floor—5
we've ever done. I thought it was a positive experience in that I learned a lot about myself, although, I can't say it was a good experience. I don't think society or the military are very well adapted to women in these roles. During my flight to San Antonio, the businessman next to me saw my paperwork and said, “Oh, are you already a nurse?” I had a class in OBC on military courtesy. There was a section in our book called “Guidelines for the Military Wife”. I wasn't sure if I was supposed to follow it or give it to my husband.

What we went through in OBC is nothing compared to the rigors of Officer Candidate School or Basic Training for enlisted. Even so, although I didn't get hurt, I got some heat injury, dehydration, and heat exhaustion which caused me to fall out of a run. The most important thing that I learned, which will be a concern later, (and I hope that I handle it better), is that you have to take care of yourself. As the officer in charge, you are responsible for the health and well-being of all of your troops. If you're not taking care of yourself you can't possibly take care of all of them. If you're not drinking enough water and get dehydrated, that's your own fault, but look what kind of example you just set for your troops. There is quite a lot of pressure on officers to set the standard, not to complain when conditions are bad, and to constantly be a good example.

This past summer I did a clinical rotation at Walter Reed Army Medical Center, half in Hematology/Oncology, and the remainder in Surgical Oncology. It was clear to me that teaching is paramount, and that the attendings are concerned about putting out physicians who are good decision-makers. The military is a “sink-or-swim” system, meaning that you will be put in a challenging leadership position very early, and be expected to figure out how to do things on your own. They’re not trying to produce robots. Even though everyone has to have the same priorities and code of ethics, they must carry their assignments out to the best of their ability, and that can mean different things at different times. This is where the military allows you, as a physician, a large measure of independence.

The challenge and excitement of military medicine is that it’s very unlike that of civilian medicine because of your patient pool - retired military, active duty, and their family. I had a patient this summer, an absolutely outstanding, nationally-recognized non-commissioned officer who was having severe neurological problems. He was 33 years old with a seizure disorder, and was air-evacuated to Washington, DC from Michigan. He was separated from (continued on page 9)

Bloodless
...from page 4

I had some discussion with one of our clinical faculty members which started with his statement that “When it comes to blood and children then I have a problem with Jehovah’s Witnesses.” I asked him what was his problem and he said that he couldn’t understand how we could stand by and let our children die. I said, “Well first of all the percentage of people that die from not taking a blood transfusion is very low compared to the percent of people that do take blood transfusions and die as a direct result.” “The only difference is that the statistics receive much less publicity in the latter case.” Secondly, I said, “Doesn’t your religion dictate that you should not eat pork?” He conceded this was true. I then asked him how he would feel if someone forced pork on his child? He didn’t answer for a moment and then said “Your point is well taken”.

We feel that a surgeon who doesn’t use blood is more skilled than one who does. Dr. Koop, when he was Chief of Surgery at Children’s Hospital always performed surgery on the children without using blood and never lost one. Everyone that worked under him in the operating room had to go along with the program of no blood or they were not able to work with him. There are also a lot of physicians not associated with the Bloodless Surgery Program that are aware of Jehovah's Witnesses' stand on receiving blood and respect it. On the other hand, there are some health care institutions that refuse to comply with our wishes. We then have to go in and physically remove the patient and transport them to the site of a Bloodless Care Program. For example one individual had a blood clot in her leg. It necessitated the use of a filter procedure. This in itself posed no problem. It is just that if there is significant leakage of blood from the vein, what will be done next? The physician, when queried, replied that blood would be given when needed. He had no other backup; he didn't know what else to do. We then let him know that there were other options--perhaps I should have called him out into the hall and talked with him...but, he had students with him so I assumed that he was knowledgeable and would be receptive to discussion. However, he later told the family that he didn't appreciate being questioned about the possibility of his use of alternative therapy. I did not intend to be disrespectful, but he felt that I was and would not cooperate. However, the patient and family decided that the situation would be best resolved by moving the patient to the site of the Bloodless Surgery Program.

An added benefit from
centralizing the bloodless surgery is the continual sharpening of the skills and expertise of the clinical staff, which even lay people have observed, has noticeably improved over the years. More of the surgeons and other professionals are coming to an understanding of the value of this type of therapy because of the educational initiatives of the Center. The professional staff has grown from 50 to more than 200 physicians now in the program and it is constantly expanding. Graduate Hospital (Allegheny) has instituted formal newsletters, pamphlets and educational programs to disseminate information about the bloodless care program.

Jehovah's Witnesses will under appropriate circumstances permit the administration of serums that are extracted from whole blood. It is really a matter of conscience for the individual members. Hepatitis vaccine, for example, I have no problem taking in relation to my job which requires that I come into close contact to material used in many experimental studies. Conversely, we do not participate in bone marrow transfers because they directly utilize blood-forming tissue. This is not a conscience issue, it is not a grey-shaded area. We address the associated disease by other "INTERVENTIONS" that are open to us through our religious convictions. Organ transplants are a matter of conscience. The bypass procedure does not require this kind of decision-making for most members. It is carried out in a closed system using the patient's own blood. Even though there may be residual blood in the reservoir at the end of the procedure it can be returned to her without first removing it from the system. Therefore, the blood is not considered to have been "stored".

It is important to let all patients know the risks involved in taking

(continued on page 9)

ONE DAY
...from page 5

of the year. Then, you have an assessment at the end of the year concerning how far he has gotten and where he is at this point (because they do testing throughout the year). They give suggestions of what we can do at home. For example, he had a problem of not chewing his food all the time. We went over muscles of mastication—just working on the musculature, working on doing certain maneuvers with his face that would help promote chewing. Also, going over issues of not squirreling food because he was like a hamster. He would hold out until his cheeks filled out and then he would be walking around talking with food in his mouth and then you couldn't understand what he was saying. Now, a lot of that had to do with muscle coordination. We'd say, "Steven chew your food", and then we would go to Michael; "chew your food, and he would just smile and you would have to get it out of his mouth because he would be holding it in there too long and he would start to choke. It just changed our perception of how we sit and eat to the point that we don't eat meals at prescribed times. We have to feed him whenever he is ready to eat because if you tried to feed him at dinner and that wasn't a time for him to eat, he wouldn't eat. I think the other children and ourselves, as well, have developed that sort of eating style. This has really worked because now he is about the twentieth percentile in weight whereas, for his whole previous life up until May he was below the fifth percentile. We had a big celebration when he hit the fifth percentile and from there his curve is going up into the normal range. He is growing taller and he puts his arms up for you to look at how the muscles are growing into there.

Mary DeJoseph: It really is a delay, its just that you can't believe it after years and years of struggle - the changes in leaps and bounds are a real shock.

Paul DeJoseph: Now he eats indiscriminately to the point where he's got a little pot belly. Only because he has eaten so much so quickly, but it will all balance out again with time. But, we joke. I say "look your trying to get a belly like Daddy's got" and he will laugh and say "naah" and point to mine and says that it's much bigger. But, its nice to see...

Mary DeJoseph: I think that the other children have mixed emotions about Michael's progress; especially Steven. He is so used to having Michael be dependent. Now that they are on more equal ground it's bewildering. However, he has always been encouraging to him, he doesn't stand in his way. The thing to do with Steven is to get him away from the others, to take him physically away. Michael has always needed a little more of our time and energy and now he is demanding of it. On the other hand, Steven withdraws a bit, isolates rather than being out there taking Michael around. I have to say, "come on we are going to take you to join a club" or "I have to take you to this..."

Paul DeJoseph: "... or c'mon now, we're going to ride bikes", or "We're going to play football". He wouldn't get involved in anything involving a team concept and we needed to work on his self-assurance.

Mary DeJoseph: Christina on the other hand, knows instinctively when she can bully someone, usually Michael. Sometimes, she will push him too far and then there is a screaming battle; it takes a long time for Michael to get physical but finally he will just knock her out of the way and take what she has taken from him, acting like: "that's it" 

Voices From the Floor—7
although, he doesn’t say much in that regard but you will know what happened when she comes crying in to complain. In other words, all of a sudden they are just six and three year old kids and we’ve got a normal family!

I hear most about Michael’s day when he is sitting at the top of the steps with his tape recorder singing about what happened. He has always been able to trance himself out when he is scared, or nervous, by playing his tapes. He likes a whole variety of music: rap, classical, Christmas music, all very loud. I can get information about his mood and his day and how tired he is and a whole lot of other stuff just by seeing his behavior with music. Michael has always been the one (even with his tiny little fingers) never to have banged on the piano - his fine movements have always been preserved; age appropriate.

Paul DeJoseph: He really plays, he moves his fingers when he does it, he does it in sequence and he can pick up vibratory rhythms, and he sways for as long as we can remember. He does this figure-eight-like motion with his head and he is in perfect time with whatever he is listening to and he has very distinct taste in music. When certain things are playing that he doesn’t like he says, “Turn it off”. But, when you get to some he likes he always starts swaying, his eyes are either opened or closed. However, you can stop him in the middle as he smiles and tells you what is going on, and he responds to other things, but you can really tell when he is having difficulties. Then, he will go listen to his music and he will not respond to you. When he gets calm he will stop and greet you appropriately and that’s how you know he is better. It is just his mechanism for dealing with stresses.

Mary DeJoseph: He is just starting piano lessons because I had trouble finding a music teacher in the area who didn’t require that the child know his entire alphabet “a” to “z”, forward and back, before starting.

He has always had access to a tape recorder. When we got him his own he took ours instead because he didn’t like the way his sounded. He has it plugged into the wall at the top of the stairs. It is a dual cassette player with great tone that can be turned up very loud. That is his space; he has it pushed back out of the way and there is a little shelf there underneath the small awning above the stairway. He eats his snack up there after school (we tell him to bring his plates down).

He has really made us look at the other children differently, especially how important it is that every milestone be appreciated. It got so that Steven’s feelings were being hurt because of all the fuss made when Michael did some new thing like print an “A”. At the same time, here he was, bringing home 90’s and 100’s in tests. We would say “Oh good”, but we weren’t celebrating it.

Paul DeJoseph: That’s why he didn’t want to try anything. He thought that if he didn’t do really well he would get even less encouragement. He wouldn’t ride his bike for example. Finally, though, I said “we are going to go out and work on this until you get it”. Now, he has a great time with it and he is realizing that he can do other things, that he can fail at them and that it’s okay because he’ll eventually get it.

The thing that I got out of this situation from a professional view and which I try to help the residents understand is that you are going to run into kids that are “failure-to-thrive”. There are a whole lot of psychosocial issues that you have to address in addition to the medical issues. These kids are scared about what is going on; they don’t perceive

(continued on page 10)

...from page 4

it works very well also, it is support for you if you have questions.” He said, “Well that might be possible”. So I said, “Do you understand what you need to do and how to check your sugar level?” He then said, “Oh nothing to worry about, I don’t feel bad”.

I said, “Well, okay, but you understand that you need to take medicine now?” “I understand it but, I don’t feel any different and I don’t understand all of this.” So, I went back out to his chart and I was writing up things, because I was just a little...I just had a funny feeling. So, I went back to him and said, “Mr. T, I was wondering if you would help me. I’m a student and I have to practice my physical exam skills. Part of it is a mini-mental status exam as well as a neurological check. I’ve never done this and I was wondering if it would be ok to do it with you.” He said, “Why sure, I’ll do it.”

I then asked him what year it was and he answered correctly. Then I asked him if he knew where he was and he said, “Yes, in the hospital” and so on. Everything was going fine. Then I said, “Mr. T can you spell WORLD backwards for me?” He looked at me and said, “I don’t spell really well”. I said, “OK,” and continued on with, “Mr. T can you read the statement on this piece of paper and know what it says?” He looked at me and he said, “Ma’am, I don’t tell people this but, I can’t read. I can’t read or write or do arithmetic. I was never able to learn when I was a child and I learn real good by listening.” I said, “Mr. T I really appreciate you telling me that, it was probably really hard for you to do. It is real important for us to know this. We have materials that we can give you that will help you control your diabetes that don’t require that you

(continued on page 10)
any medication. In the early days of the AIDS outbreak, companies that manufactured blood-typing sera sent out letters to users informing them these products were manufactured by a process that necessitated pooling of a large number of blood samples. Therefore, the risk of disease transmission by handling could never be completely eliminated. This kind of decision is one many individuals may be faced with either as a question of conscience and religious conviction or on a scientific basis to avoid the use of a particular product. Basically, the individual must have a grasp of the various factors involved in order to make an informed decision.

We are not, I repeat, trying to tie the physician's hands. All we ask is that the doctors recognize that we hold deep convictions and adhere to our wishes that we not receive blood. Other than that we want physicians to do everything possible to treat us. We realize that it might be necessary to heighten their awareness of the alternatives available to them. Since the 1970's more and more physicians are performing bloodless procedures for which they would have employed blood transfusions without hesitation in the past. Many feel that they have become better surgeons through the process of adopting this alternative.

1. Leviticus 17:10 and Acts 5:29.
2. Editorial: Jehovah’s Witnesses: The Surgical/Ethical Challenge.

his wife and boys and had no one coming to visit him. He was still very polite, did not resent being there, was compliant, and very intelligent. He always addressed me as “Ma’am” and thanked me for coming to visit him. It's a pleasure and a privilege to treat these people. They work very hard, particularly the enlisted personnel. What they do for the little money they get is extraordinary, the hours they put in, what is expected of them physically, and the stress that is put on their families due to separation. I have a lot of respect for these soldiers.

The kinds of things that you have to take into consideration when treating people is different. While I was in Washington last summer, a Marine colonel was brought up to Tumor Board. He was in his forties, ran twelve miles a week, and was on active duty at sea. A big consideration with a patient such as this is that you must realize is what you will be doing to his career if you side-line him or "board" him. He may not choose the chemo protocol because he may think it will ruin his career. It's in some ways analogous to treating a professional athlete. One of the questions in the colonel's case was if he goes back on ship, will he be able to get follow-up testing? Will he say to his commander, "I need to go on mainland and get testing", or will he feel that to do so would make him look weak so he'll just not do it? There are a lot of considerations when you are talking about people that are working toward their 20-years of service. Will they lose their pension? Will they and their families lose their health benefits? So, as a doctor you are making decisions that will not only affect the health of these people but also their careers and their families, and, for a lot who are career military, their identity. There is a thing called “boarding” people, where you as a physician say that this soldier is not fit for active duty. It can be devastating. A 33 year old in-patient that I observed had an incurable, aggressive cancer. This guy would get up every day and put his uniform on, and it was the saddest thing to know that he would never perform on active duty again. But he had not come to accept it yet. None of the doctors wanted to be the one to "board" him.

I'm at such an early stage in my training, I wouldn't have the kind of background that I have were it not for my husband. His training in the Marines was much different than mine in the Army. I think that with doctors, the Army sometimes tries to pamper you and tries to get you through OBC quickly. You don't have to go through what a Marine has to go through, and you don't gain the kind of respect for the military that every Marine has. There's so much respect for the Corps and what your position is as part of the whole. This is what I wish they would stress more in the Army. When I would complain, John would say, "This is just a small sample of what the enlisted people go through, the people that will work for you, and that you will work for as a physician. You need to understand where they are coming from, have some insight into what their lives are like and what they have been through, and have some respect for that". I wish the Army would have emphasized that more and what a privilege it is to be a military physician. A lot of times military docs are thought of as being a hindrance. Out in the field, the joke is, "Great, we gotta carry the doc". Often times doctors don't take care of themselves and are not as fit as other soldiers. They don't see themselves as true soldiers, only as physicians. It's unfortunate to have the reputation of being "slackers". It doesn't help that they often
don't wear their uniforms correctly or uphold or demand military bearing. This is an impediment and something that I wish they would work on, because it is a privilege to be a physician in the military and should be treated as such.

The whole hierarchy plays out differently in the military. I saw an awful lot of disrespect in civilian OR's. One afternoon at Walter Reed, we were doing a neck surgery that was very complicated, and a nurse came in and said, "We need this room. Why don't you tell him to hurry up?" She was sort of joking, and I really didn't think anything of it. She came back in at the end of the case and said "Colonel, I apologize for being smart. I didn't mean any disrespect, and I hope you didn't take it that way. I don't know if one of her seniors heard what she said and made her apologize, but in the civilian world, I never heard an apology for disrespect. There is decorum and anyone can tell you that you're not following decorum whether they are junior to you or not. If you are not wearing your uniform correctly, a private can come up to you and say, "Ma'am with all due respect, that's unauthorized". Your appropriate response should be, "Thank you, Private, for correcting me". Respect, professionalism, and military bearing are built into the system, and when the system runs well, you're proud to be a part of it.

For Additional Reading:


ONE DAY
...from page 8

it in the same way as other children and a lot of your training does not encompass the needed understandings. Your compassion needs to come into play and you need to answer questions when they ask them. You can't handle them routinely and you must make sure that your instructions to them are understood.

Mary DeJoseph: Paul and I have developed a balance. Paul tends to push and push and get the kids to do their very best and really encourage them. When they need a rest or a soft side they tend to fall back on me. And this is the area where we most end up disagreeing: "He just can't do this today", "Yes he can, let him try". We finally work out a balance. We're consistent with the kids. We try to take our clinical acumen home (patients will tell you what they need and so will kids if you listen). On the other hand you have to step back from your clinical role and let your doctors carry out their responsibilities while you take up yours as parents.

Paul DeJoseph: It goes back to our roll as primary care physicians. We know our patients best. We know what they can and can't tolerate and we have to get that across to them; that they can come to us with whatever they are worried about. That is what our role entails. We must take responsibility for our patients and be their advocate. It has worked in both our personal and professional lives. It is a principle that I have always believed in and it has been reconfirmed throughout this process.

FOR FURTHER READING


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