AMERICAN OSLER SOCIETY

November 2024

Volume 25 - Issue 3

The Oslerian

A Message from the President

Joan Richardson

President
Joan Richardson
55th AOS President
Installed at the 2024 Annual Business Meeting.

By the time you read this latest of my messages, the 2024 U.S. presidential election will be done---maybe! I will not miss the monopolization of the media with ads, insults, fabrications, outrageous behavior, and at times, quite inspirational rhetoric. I learned more that I will ever want to know about threats to democracy, immigration reform, the economy, inflation, the right to choose, voter fraud, swing states, the electoral college, and childless cat ladies. However, what I heard virtually nothing about from either candidate was the U.S. health care system. Among its peer countries the U.S. is in a class by itself for underperformance in fulfilling its fundamental obligation to promote and maintain our nation's health.

The September 2024 Commonwealth Fund report "Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System" is a chilling review that compares the performance of 10 countries' healthcare systems: Australia, Canada, France, Germany, the Netherlands, New Zealand, Sweden, Switzerland, the United Kingdom, and the United States. I believe our collective AOS membership hail from many of these countries and can attest to their individual uniqueness in history, evolution, resources, and political culture will find the report fascinating, alarming, reassuring, and for those of us who practice in the United States, not surprising.

The Commonwealth Fund, whose stated mission is to promote a high-performing, equitable health care system that achieves better access, improved quality, and greater efficiency for all, extensively examined the health systems of the 10 countries previously listed in five key domains: **access to care; care process; administrative efficiency; equity, and health outcomes**. Although there was some variability and some individual highs and lows, nine of the ten countries studied were more alike than different. The one glaring exception was the United States of America. What follows is my Cliffs Notes version of the report, and I hope it will pique your interest in reading the entire report and studying its extremely thought-provoking exhibits, methods, and analyses.

The first performance domain, **access to care,** focuses on the affordability and availability of health care at the population level. The Netherlands, United Kingdom, and Germany performed best on access and the Netherlands and Germany

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rank high for affordability with the U.K. at the top. The United States ranked 10th. The leading countries have low cost-related barriers to care and minimal out-of-pocket expenses. If any co-payments at all, they are small. In Germany, co-pays are capped at a fixed percentage of income—2 percent for all patients and 1 percent for chronically ill patients. Above this, all care is fully covered.

About half of Americans spend $1000 per year or more out of pocket on health care, and 26 million are still uninsured. Current out of pocket limits for Affordable Care Act marketplace plans are capped at $9,450 for single plans and $18,900 for family plans. Of Americans who have insurance, a quarter are underinsured with extensive cost sharing requirements that make many unable to visit a doctor when medical issues arise and result in skipping treatments, follow-up visits, filling prescriptions, or skipping doses of medications.

Patients in the U.S. are more likely than their peers in other countries to report lack of a regular doctor or place or care and limited options outside regular office hours. Shortages of primary care providers magnify the problems with availability. Both the Netherlands and Germany ensure health services are available after hours through established systems of after-hours care and networks that provide care during evenings and weekends that limit the need for emergency room visits.

Care process examines whether care delivered encompasses features and attributes that most experts around the world consider essential to high-quality care. Elements of this domain include safety, prevention, coordination, patient engagement and sensitivity to patient preferences. In this domain, the U.S. ranks second behind New Zealand with Canada and the Netherlands following closely. The strong U.S. performance likely results from the last two decades' emphasis on preventive services such as mammograms and flu vaccinations and concerted efforts on improving patient safety and reducing adverse patient events. Positive yields for the U.S. may also relate to the vigorous pay-for-performance policies implemented by Medicare and other payors.

New Zealand, the leader is this domain provides incentives for primary care providers who meet targets for disease screening, follow-up care, and vaccinations. The Netherlands, another high performer, benchmarks quality of patient interactions, continuity of care, and physician knowledge of their patients' personal situations. Ninety-five percent of Dutch citizens choose and register with a general practitioner and may switch doctors at their discretion.

Administrative efficiency focuses on measures of the challenges physicians have in dealing with insurance or medical claims issues, requirements for reporting clinical or quality data to governmental agencies, and patients' time spent resolving medical bill disputes and completing paperwork. Australia and the U.K. are tied for first and have minimized payment and billing burdens. In Australia, electronic claims processing ensures instantaneous payments from public and private payors. In the U.K., services are free to patients at the point of care. Thus, physicians do not bill patients or the government directly and are compensated directly based on data acquired from patient's electronic medical records.

The U.S. and Switzerland are tied for dead last. Switzerland, with its many cantons and municipalities has fragmented systems that hinder efficiency. The U.S. system of public and private payers with thousands of health plans, individual cost-sharing and coverage limitations, pre-authorization requirements, and filing deadlines demands great time and effort to bill insurers. Denials are common and appeals burdensome to providers and patients.

The **Equity** domain reflects how individuals with below-average and above-average incomes differ in their access to care and their care experience. Australia and Germany rank one and two and have the smallest difference in health care access and care experience between below-average and above-average income residents. The U.S. ranks last and New Zealand next to last, having the highest income-related differences in reported cost-related access issues and instances of unfair treatment or health care provider nonconcern based on race or ethnicity.

High performing countries have limits on cost sharing to ensure that the ability to pay does not serve as a barrier to obtaining needed health services. Germany caps out-of-pocket expenses and cost of coverage is income-based. The U.K. has no cost sharing.

Even with an expanded definition of equity to include geography and gender, the U.S. continues to rank last with improvement in rankings for countries with better transit systems and improved funding for women's health, obstetrical care, and higher rates of post-partum check-ups.

Health outcomes refer to outcomes that are most likely to be responsive to health care interventions. The impact of the pandemic was considered comparing performance measures before and after the start of the COVID-19 pandemic. Also examined were specific COVID-19 related outcome measures. Outcome measures also included life expectancy at birth; excess deaths due to the pandemic; and deaths with preventable and treatable causes. Australia, Switzerland, and New Zealand ranked one, two, and three. The U.S. ranked last.

The top three performers' high performance reflect their success in managing COVID-19. Australia implemented border controls, lockdowns, quarantine requirements, and movement restrictions that prevented spread. New Zealand closed borders and implemented lockdowns and stay-at-home policies. Only after vaccinating about 90% of the population were transitions to mitigation policies permitted. Switzerland implemented public health measures including physical distancing, caps on numbers of people allowed in spaces, and contact tracing.

The U.S. response to the pandemic was slow, inconsistent, and politically influenced. Underfunding and decentralization of the national public health system and the vested authority it places in state and local governments proved to be a major obstacle in mounting an effective national public health response.

In summary, the 10 countries' overall performance ranked as follows:

Australia
The Netherlands
United Kingdom
New Zealand
France
Sweden
Canada
Switzerland
Germany
United States

Despite the cumulative overall performance and rankings, there existed wide variability in individual rankings for each of the five domains studied. For example, Australia, although ranked first overall, ranked 9th, 5th, 2nd, 1st, and 1st respectively in the five domains. This suggests opportunities for cross national learning from one another and a focus on what might be considered individual nation best practices.

Of the 5 domains, the U.S. ranked 10th, 2nd, 9th, 9th, and

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10th. Despite good performance on **care process,** U.S. health outcomes are the poorest. Life expectancy in the U.S. is four years below the ten-country average, and the U.S. has the highest death rates for preventable and treatable disorders as well as highest excess deaths related to COVID-19 for people under age 75. Gun violence and drug overdose deaths (43,000 and 100,000 respectively in 2023) contribute to the poor outcome.

The U.S. in 2023 spent 16.5% of its GDP on health care compared to France (11.9%), Germany (11.8%), Switzerland (11.7%), New Zealand (11.3%), Canada (11.2%), Sweden (10.9%), U.K. (10.9%), the Netherlands (10.1%), and Australia (9.8%). Thus, the U.S. arguably exemplifies the definition of a low value health care system, spending vast sums that yield generally low-quality care and poor health care outcomes.

Access to care and financial barriers to care in the U.S. are substantial. Despite the Affordable Care Act, 7% of Americans still lack insurance coverage. Insurance coverage is often suboptimal, and many insured Americans are actually underinsured with high deductibles and co-pays that impact the effectiveness of their insurance coverage in assuring access to needed care. The other countries in the comparison group have universal coverage, and much less likely to put their citizens in financial harm's way due to the costs of their health care.

The authors of the report suggest several deficiencies in the U.S. health care delivery system. First, they cite lack of investment in primary care with years of neglect and under compensation leading to a nationwide shortage of primary care providers and resulting in need for more costly and often unnecessary emergency, specialty, and hospital care. Even well-insured patients are challenged to find access to primary care.

A second area for improvement is administrative inefficiency. Vast numbers of health insurance products offer great variability in benefits along with complex, often nightmarish utilization policies. The authors also propose that the proliferation of mergers and acquisitions of hospitals and practices enable negotiation for higher reimbursement rates that result in higher costs of care, and suggest that few other countries, if any, rely on such an unregulated private market to allocate vital health care resources for its citizens.

The authors also note that social influences outside the health care system strongly influence American's health and put added stress on the system. They point to gun violence, drug overdose, and centuries of racial discrimination along with the general lack of an adequate social safety net to mitigate the toll that hunger, homelessness, and poverty takes on the health of Americans.

The report concludes by recommending several key interventions. First, improve equity in health care by reducing financial barriers and extending coverage to our remaining uninsured. Reduce financial barriers by requiring that insurance coverage meets a minimal standard of adequacy, including reasonable limits on patient out of pocket expenses.

Next, reduce administrative burdens and minimize the variation and complexity of insurance plans. Make coinsurance and deductibles more predictable and easier to understand.

Third, make the delivery system more functional. Improve access by rebuilding our systems of primary care. Compensation must improve as well as systems for training primary care providers. Undertake innovative technologies to expand telehealth and to relieve non-medically related burdens on providers. Examine for its impact on the cost and quality of care the rather uncontrolled consolidation of health care resources and proliferation of investor-owned entities that buy and sell practices as tradeable commodities.

Next, create an effective public health system capable of responding to public health emergencies as well as the societal burdens of chronic disease. The next pandemic is not an "if"; it is a "when".

Finally, as a nation, seriously and methodically undertake interventions to mitigate social issues not related directly to health care systems but clearly intertwined, including the effects of racism on health and disease, gun violence, death from drug overdoses, and the toll of poverty, hunger, and homelessness on the health and well-being of our citizens.

As a citizen of the U.S.A. and a practicing physician for more than half a century, I waited for one of the two candidates to look Americans straight in the eye and say, "Despite spending enormous sums on health care, we are failing to meet an important obligation of our country, and that is to protect and nurture the health and welfare of our citizens."

No word yet from either camp. Read the report!

Reminder of American Osler Society Meeting Pasadena, CA May 2-5, 2025

As a reminder, the American Osler Society will return to Pasadena for the 55th annual, site of the 35th annual meeting in 2005. The meeting will be held at the Hilton Hotel near downtown Pasadena from May 2nd to May 4th. There are two major airports serving the area, the larger one is Los Angeles International Airport (LAX) located about twenty-eight miles from Pasadena – about a 40-minute drive. The other, more convenient airport is Burbank Bob Hope (BUR) airport. LAX offers more direct flights, but Burbank is easier to get in and out of.

We have arranged to visit the Huntington Library, Art Museum, and Botanical Gardens (https://huntington.org/) in nearby San Marino where we will have dinner on Saturday evening and are planning an exhibit of rare medical books in the Huntington's collection including books from the collections of former AOS presidents, Larry Longo, Bruce Fye and Earl Nation.

At the beginning of the New Year, meeting registration and hotel reservation information will be available at the AOS website, emailed to you and printed in the February *Oslerian Newsletter*.

Editor's Note

This edition of the *Oslerian Newsletter* is loaded with submissions for Medallion Awards contributed by students at the University of Texas Medical Branch in Galveston. The art, essays, and poetry are exceptional and offer due diligence to Oslerian values.

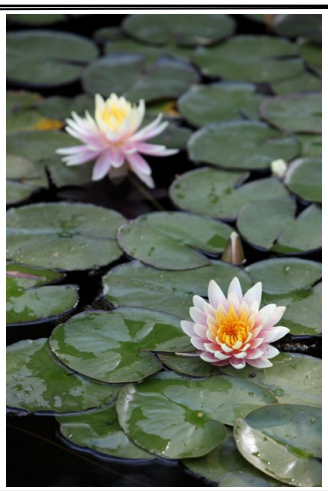
The awards were conceived in 2021 as a way to encourage medical students to explore their humanity through art, music, essays, and poetry. The variety of submissions received has been astounding. From original music compositions, to beautiful and meaningful art, to essays reviewing the rigors of medical school and incorporating Oslerian values into their perspective of medical school. The poetry submitted is often very personal and, as is the art and essays, a means of expressing grief as well as joy.

There is incentive to submit. A monetary award and Medallion Plaque are given to the best submission from each class as judged by a panel of four judges comprised of McGovern Academy of Oslerian Medicine members and an Osler Student Scholar. The awards are funded by the John P. McGovern Academy of Oslerian Medicine and is one of the several outreaches of the Academy to support the humanities in medicine. Another humanities outreach effort supported by the Academy is a Humanities in Medicine Lecture Series run by an organizing group of 2nd year students that offers a series of 4-6 lectures during the year that highlight art in medicine, music in medicine, poetry in medicine, and several lectures dealing with issues such as grief and social medicine.

In the pages that follow you will encounter "A Eulogy for the Woman in Tank #05"' by Laura Geddie; an "Embroidery of Healing Blooms", by Fatima Naqvi; a poem, "The Path to Light", by Nizam Karim; an essay, "A Patient's Silent Plea", by Rija Sood; the art of Annie Tao, "Bouquet of Compassion"; and the poetry of Andrew Thornton, "I Want to Be a Doctor".

Enjoy these gifts from some very creative students and if the opportunity arises, please encourage students that you come in contact with to express themselves in these various forms of medical humanities. It is truly a life-giving and meaningful process.





Images from the Norton Simon Museum Asian Gardens

AOS Art Exhibit in Pasadena

We are excited to announce that there will be an opportunity for members, spouses, trainees and guests to show their art during the AOS meeting next spring. More details will follow, but please start to dust off those paint brushes, charcoal sticks, cameras and sculpting tools so you can share your creative work with others. For questions, please contact Herbert Swick (hmlswick@msn.com)

COMMITTEE	CURRENT CHAIR	CURRENT MEMBERS	NEW CHAIR	ROTATES OFF	NEW MEMBERS
Bean Award	J. Harris	K. Klaas, S. Moss, T. Frank	No change	K. Klaas, S. Moss, T. Frank	M.Trotter, K. Klass, T. Frank,
McGovern Award*	C. Boes	M. Jones, B. Mennel	R. Del Maestro	M. Jones	None
Lifetime Achievement Award	L. Drevlow	J. Howell, F. Neelon, H. Swick	No change	J. Howell	None
Nominating*	C. Boes	B. Mennel, M. Jones	R. Del Maestro	M. Jones	None
Finance	F. Bernadett	F. Bernadett, M. Molina, M. Stone	No change	No change	None
History & Archives Committee	H. Swick	S. Arfaie, R. Del Maestro, M. Hague-Yearl, D. Kratz, R. Stone, L. Wang	No change	None	None
Membership#	J. Wright	L. Geldenhuys, S. Kelen, P. Kernahan, D. Wolf,	J. Harris	J. Wright	TBD
Media & Technology Committee	P. Travers	G. Frank, J. Klaas, M. Malloy, M. Abdalla, J. Crevero, M. Stanley	No change	G. Huston	None
Annual Meeting† – Program Committee	J. Richardson	G. Jackson, M. Malloy, B. Mamlock, B. Thompson, J. Wright	J. Wright	G. Jackson, M. Malloy, B. Mamlock, J. Richardson B. Thompson	J Harris, L. Drevlow, R. Mackenzie, M. Molina, H. Scofield
Annual Meeting – Local Arrangements Committee	C. Crenner		M. Molina	C. Crenner	TBD

* Chaired by the most recent living Past President and include the 3 most recent living Past Presidents
# Chaired by the Second Vice-President
† Chaired by the First Vice-President

YOUNG OSLERIAN VIEWS

Hand in Hand
GAR Lab, 8/20/2024
A Eulogy for the Woman in Tank #05

By Laura Geddie

In 1934, a pair of pudgy pink hands were given to the light. Balled fists punched the air as tiny lungs fought for it. They grasped a father's finger and a mother's breast. The hands grew day by day, finding new sensations: cold water, hot stove, hard pebble, soft hair. They learned to pinch, grab, hold; they learned to hit, throw, let go. They liked the feeling of cowhide and dirt floors. They hated feeling Father's uniform, and worse, having nothing to hold but a folded flag. Thanks to countless crude attempts, the hands learned strength and dexterity. They pushed the grass under handstands and planted seeds for coming seasons. They became familiar with the stiff pencil and sting of a ruler on their wrists. They braided hair, stirred pots, washed up. Enclosed in their friend's hands, flying down the street, they felt free. Soon those hands that were not so pudgy anymore learned how to dance from a boy's gentle grasp, melted chocolates, wrote love letters, while the heart learned to give away pieces of itself while remaining whole. Summoned by Uncle Sam, her hands learned to dress wounds, place IVs, and try to stop shaking while the mouth promises the pain will be over soon. They came home and learned to hold another boy, one who did not tremble or drink or scream about foreign forests in his sleep. After six months, the third finger was bound by a golden promise. Soon the uterus felt the kicks of a stranger inside itself. With back-breaking fanfare the body ushered a new being into the world, only now in a white hospital room, not a prairie cabin. Arms cradled the slippery baby with unimaginable adoration. Rough hands taught soft ones every skill they knew, and callouses grew as the adult frantically washed dishes, laundered clothes, tidied and cooked at the same time. The years ran on. In the blink of an eye, the hands were empty. Though stiff and arrayed with sunspots, they managed to dig in the garden and carry casseroles to friends in need. Fighting tremors, they learned something new, and after nine months of practice, proudly extended a knitted blanket to their first grandchild– and every grandchild after that. They held their husband's cold hands, wiped away tears, and laid a homegrown rose upon his coffin. After 90 years, the hands were pricked with needles nearly daily, wheeling in and out of hospital wards. The fingertips that had touched the world and held a lifetime of love became cyanotic as the lungs fought for air yet again. They hugged their child one last time until blood ceased to flow, and darkness fell. In 2024, an anonymous set of grey, gnarled hands were lifted from the waters and laid in center spotlight. Callouses were excised from arthritic knuckles and soil debrided from the nails. Articulations of the extremities were manipulated by blue gloves seeking understanding of the function of human hands. Then a stranger's hands typed a story.

Laura Geddie is a first year medical student at UTMB. Her essay won the Medallion Award for first year students.

Embroidery Healing Blooms

Fatima Naqvi

A doctor's hands, like needle and thread, stitching a path of healing ahead. Through the delicate weave of floral grace, lies the power to heal, to nurture, to embrace. Osler's virtues in every petal, each seam, weaves a healing touch for each patient's need. As I contemplate the delicate embroidery of the uterus, I'm struck by how art and medicine converge in their essence. My embroidery speaks to me of the physician's role, where life's fragility and the art of healing intertwine. The uterus, as the origin of life, symbolizes both resilience and vulnerability, mirroring the human spirit and the artistry involved in medicine. In my journey as a medical student, I've learned that vulnerability is not a sign of weakness but a profound strength, akin to the raw and honest expression found in art. By allowing myself to be vulnerable with my patients—acknowledging uncertainty, admitting what I do not know, and embracing our shared humanity—I find that it fosters a deeper trust and more meaningful healing, much like how art can evoke profound emotional responses. Sir William Osler emphasized the importance of compassion and empathy in medicine, virtues deeply tied to vulnerability, similar to the emotive power of art. Osler taught that a physician must approach each patient with humility and a willingness to truly listen, to understand not just the disease but the person who suffers from it. In embracing my vulnerability, I align with this Oslerian ideal,

offering not just medical treatment but also emotional support and understanding, much like an artist creating work that resonates with the viewer's innermost feelings. The uterus, with its nurturing capacity and role in sustaining life, reminds me that my role as a doctor is not merely to heal the body but to care for the whole person, much as an artist's work reflects a deep engagement with the human experience. It is through vulnerability that I connect with my patients, offering a space where they can feel seen and heard. In doing so, I find the delicate balance between medical knowledge and compassionate care, akin to the balance an artist strikes between technique and expression. In the end, the embroidery of the uterus symbolizes the intricate weaving of vulnerability and strength that defines my path to providing compassionate care. It is a reminder that in the practice of medicine, just as in the realm of art, our shared humanity—our ability to be vulnerable — weaves the patient-provider bond

Fatima Naqvi is a 2nd year medial student at UTMB. The embroidery and explanation were her submission for a Medallion Award.

The Path of Light

By Nizam Karim

In the quiet of dawn,
We begin with a spark of wonder
Learning is our compass,
Guiding us through the maze of mystery

To understand is to embrace,
Embracing the unseen
To comfort is to hold,
Holding the fragile threads of life

Healing is our sacred art,
A tapestry woven with care
To restore is to mend,
Mending hearts and minds with gentle hands

As seekers of light,
We traverse the unknown
Each step a blend of science and soul,
Each touch a whisper of hope

Through corridors of silence,
We move with purpose and grace
Listening to stories untold,
Finding truth in whispered breaths

Our journey is painted with hues of compassion,
Every encounter a lesson in humanity
To witness is to honor,
Honoring the sacred trust bestowed upon us

In the pulse of the night,
We stand as sentinels of solace
With every glance, every word,
We forge connections, unseen yet unbreakable

To be a healer is to be a beacon,
Illuminating paths of possibility
To mend the shattered,
To soothe the storm within

And in this dance of healing,
We find our own wholeness
For every life touched,
Echoes in our own heart

So we continue our journey,
A symphony of care and resilience
"To understand sometimes, to comfort often, to inspire always."

In the end, we are more than mere fixers,
We are the keepers of light
Bringing warmth to the cold,
Hope to the desolate

Thus,
we travel,
With open hearts and steady hands
"To understand sometimes, to comfort often, to inspire always."

Nizam Karim is a 2nd year medical student at UTMB. This was their submission for a Medallion Award.

OSLERIAN VIEWS

Figure. The author's collection of Oslerian, newly shelved in the CSB History of Medicine Room, The University of South Carolina School of Medicine, Columbia. Space did not permit shelving of the first through twelfth editions of *The Principles and Practice of Medicine* (1892–1935), the seven volumes of *Osler's Modern Medicine* (1907–1910), and various later editions, reprints, and memorabilia.

Journal of an Oslerian

COLLECTING OSLERIANA FOR YOUNG OSLERIANS

I never knew a second- or third-generation Oslerian who did not collect books pertaining to Sir William Osler. Today's medical students and young physicians, heirs to the digital age, seem much less interested. Most students, and even some librarians, now deem obsolete the very idea of ink on paper. Yet many of us are of the opinion that owning a hard copy of a book heightens the enjoyment of reading and may bring pleasure for years to come. I enjoy, for example, returning to a book I read in college and finding new meaning in an underlined passage.

Having recently shelved most of my Osleriana (Figure), I set out to price a starter set of ten recommended volumes of Osleriana for budget-minding young Oslerians (Table). An impecunious student could acquire the first eight of my top-ten suggestions for a mere $111, plus postage. Occasional sets of the luxurious, leather-bound, three-volume sets of the *Collected Essays of Sir William Osler* for as little as $55—but hurry! I am biased toward the two items on this list that represent collaborative efforts by AOS members—*The Quotable Osler* and *Sir William Osler: An Encyclopedia*. The latter, and also the leather-bound edition of *The Quotable Osler*, make excellent graduation gifts. Royalties from both go to the American Osler Society.

Charles S. Bryan
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Book (author or editor[s])	Amazon.com	AbeBooks.com
Aequanimitas, third edition (Osler)	$12.69 to > $250	$10 to $3,200
William Osler: A Life in Medicine (Bliss)	$22.37 to > $102	$5.93 to $221
The Principles and Practice of Medicine (7th edition or earlier) (Osler)	$30.95 to > $123.14	$13 to $11,000
The Quotable Osler (Silverman, Murray, Bryan, eds.)	$13 to $61	$6 to $146
The Life of Sir William Osler (Cushing)	$29 to $95	$28 to $5,000
Osler's "A Way of Life" and Other Addresses… (Hinohara and Niki, eds.)	$13 to $45.33	$7.45 to $74.35
Osler: Inspirations from a Great Physician (Bryan)	$18.76 to $84	$6.22 to $119.79
An Alabama Student and Other Biographical Essays (Osler)	$22.95	$16.87 to $400
Sir William Osler: An Encyclopedia (Bryan [ed.], with 135 contributors)	$125	No results
The Collected Essays of Sir William Osler (three volumes; Roland and McGovern, eds.)	$100 to $295	$55 to $209.00

YOUNG OSLERIANS

A Patient's Silent Plea

By Riya Sood

It was a perfect summer afternoon, with the sun casting its warmth on the blooming flowers at the Hospice facility where I had just begun volunteering. I was greeted by a cheerful nurse in lavender scrubs who led me towards the room of my first patient. Sunlight seemed to follow me and poured through the window as I entered Ms. Kay's room. The light softly illuminated her face as I saw her wide-brown eyes lie there in stony silence.

Five years ago, Ms. Kay experienced a seemingly innocuous symptom: slight muscle weakness in her hands. What started as difficulty gripping objects slowly progressed to more noticeable signs of weakness in her limbs. The diagnosis of amyotrophic lateral sclerosis came like a heavy cloud, casting a shadow on her once active life. As the months passed, the disease progressed relentlessly. Ms. Kay's legs began to fail her; her arms grew weaker too, robbing her of the ability to dress, feed, or care for herself. As I was informed about her disease, I watched the frames in her room that spoke about her illustrious journey taking on several roles as a grandma, mother, daughter, and wife. I saw the circle of life and her life journey, which had left her bed-bound. Eventually, her speech became slurred and, over time, she lost the ability to communicate verbally altogether. As her breathing muscles weakened, she relied on a ventilator for support. Despite these interventions, her condition continued to deteriorate. The loss of muscle function was total, but her mind remained painfully aware of every decline. With the disease ravaging her body, Ms. Kay made the transition to hospice care, where the focus shifted from treatment to providing her with dignity and comfort in her final days. It was here when I met her, bed-bound and unable to speak, her vulnerability ever-present.

Some days I felt the strength of Hercules and some days I shed a tear secretly. Even though she could not speak, I did not want her needs to go unheard. Despite her silence, I sat beside her, talked softly, hoping she could hear me, and stayed alert for visual cues. I assisted caregivers in addressing her unique medical conditions, from feeding pureed foods to changing diapers. I comforted her hands and legs with neuropathy oil to provide relief and sensation and gently stroked her face and hair in the hope of seeing a response. One day as I was leaving, she lifted her finger and blinked an eye to acknowledge my presence. That blink spoke a thousand words. It was then that I saw the profound power of human touch, how it connected us beyond words. Although it was impossible to have a two-way conversation with her, I learned that the desire for interpersonal connection remains and can still be fostered in ways I never imagined.

In my following visits, her vulnerability became painfully clear to me. As I focused on the tasks at hand—massaging her limbs, helping with her feeding, and ensuring her physical comfort—I also began to notice the subtle signs of her deeper distress. Though she could not speak, her wide eyes seemed to hold unspoken fears, perhaps about her own mortality, perhaps about the isolation of her condition. Her vulnerability was not just in her frailty but in her silent plea for connection, for someone to see her beyond her illness. I reflected on Sir William Osler's teachings to "treat the patient, not the disease" and realized how critical it is to address the person beyond the illness. Ms. Kay's quiet suffering reminded me that vulnerability is not just a medical condition to be treated; it is a human condition to be acknowledged. Her presence challenged me to be more attuned to the emotional and psychological needs of my patients, as MS2 Entries much as their physical needs.

Caring for dying patients revealed a new dimension of medicine to me. In my medical education until this point, I had come to believe that treating disease is the best way to alleviate suffering. The disease was an indistinct part of the person. However, hospice care taught me that disease becomes secondary to the person. I have much to learn from patients, not only about technicalities of illness, but also about the profound significance of vulnerability. Patients have goals that go beyond fixing medical problems. I am now more committed than ever to ensuring that my future patients feel seen, heard, and cared for on every level. I learned that living well in the time that remains is a goal as vital as extending life itself.

When I reflect on my experience caring for Ms. Kay, I realized that I did not do much to fix her ailments. It is not her death that I remember, but the peace I was able to offer during her last moments. I am reminded that as I strive to mend wounds, I must also be aware of my potential to inflict harm. When I fail to see and respond to my patient's vulnerability, I inadvertently create a barrier, shutting down the opportunity for creating a more meaningful connection. However, when I acknowledge and address their vulnerability, I deepen my connection with them. Trust, built through this connection, has immense therapeutic value and enhances the effectiveness of medical interventions. Embracing this vulnerability will not only make me a better physician but also a compassionate healer .

Riya Sood is a 2nd year medical student at UTMB. This essay was her submission for a Medallion Award.

Humanities

Bouquet of Compassion

By Annie Tao

Annie Tao is a second year medical student at the University of Texas Medical Branch in Galveston, Texas. She entered this piece of art and ***the accompanying explanation of the art on the next page*** *in the Osler Student Societies Medical Humanities Medallion Award competition. It won first prize among the second year student entries.*

Humanities

Bouquet of Compassion

By Annie Tao

Sir William Osler advocated for a better understanding about people's experiences with health and disease. Understanding the patient and providing them care meant more than just taking care of their physical health. It meant also taking care of their mental and emotional well being. A quote from Sir Osler that resonated with me was, "Keep a looking glass in your own heart, and the more carefully you scan your own frailties, the more tender you are for those of your fellow creatures."

During the summer, I had the experience of being involved in the Physician Healer concentration, where we specifically practiced with being a healer for ourselves and also for others. I enjoyed how it taught us about being comfortable with the uncomfortable. One activity we did that I will always remember is interacting with a standardized patient who was overjoyed with her baby being born, only to be devastated that the baby will not be living much longer. This experience was an emotional and saddening encounter to participate in. I learned over the encounter that seeing the patient feel so much grief, allowing myself to also feel those emotions, and providing support to the patient while acknowledging their feelings was the practice of providing patient centered care. As physicians, we are allowed to showcase emotions we are feeling towards the patient. Through those expressions of emotions, we are providing patient centered care.

My artwork showcases those emotions I and the patient's family had felt during the encounter. I was inspired to create this piece to showcase my practice and growth at providing patient centered care for my future patients when delivering sensitive news to patients. Each arm has flowers representing the emotions patients and physicians may feel during their encounter together. On the left arm, the white poppy, red columbine, and chamomile represent emotions of consolation, sorrow, pain, anxiety, and facing adversity. While the right arm showcases a daffodil, anemone, and aster to represent the emotions of what physicians can give towards the patient: love, faith, protection, and patience. With physicians opening up their own heart and showcasing their own emotions they have towards their patients, can they then provide tender and loving care and support towards their patients and strengthen the physician-patient relationship.

POETRY CORNER

(I Miss You, But) I Want to Be a Doctor

By Andrew Thornton

I wanted to be a doctor
Because every time my grandmother woke in the
Night, I ran to catch her before another fall.
My hands wrapped tight around her,
Holding her fragile body from meeting the carpet below.

I saw the look on my parents' faces after every
Visit to the doctor with my grandfather.
As Alzheimer's took
Those quiet steps toward us, until they grew too
Loud to turn away from.

I wanted to be a doctor, to be there for my family in
Those moments. And then medical school began.
I hold the phone to my tired face as I get updates on their health.
My grandparents ask, "When will you be back?"
I miss them too. "Soon," I say. "But…"

My parents have worked their whole lives to give
Me opportunities that led to this.
Gone in the morning before the sky held any color at all, my father
Carried boxes and restocked the grocery store shelves.
When we finally saw each other late at night,
His hug told me it would not always be this way.

I wanted to be a doctor
To give my mother peace of mind when she can no longer work.
Gone for days or weeks at a time, her love
Language was acts of service, she gift-wrapped
Her words of encouragement,
Shipped them from thousands of miles
She said, "I will not always be away.

I spend my days caring for other people's parents,
Learning their stories, taking notes on their ailments.
Their faces blur in my mind at the end of the day,
While I wonder how my own family is doing.

I learn to care for others' grandparents,
To hold their hands in hospital beds,
To ask about their memories, their aches and fears,
And I fear I am missing the last days to sit with my own.

A thousand miles from home,
I break up my love and send it far from here
In text messages and postcards and voice memos
How long will it be this way? Will I always be away?
I miss you so much, but—
I want to be a doctor.

Andrew Thornton is a 3rd year medical student at UTMB. This was his submission for a Medallion Award.

The* AMERICAN OSLER SOCIETY *exists to bring together members of the medical and allied professions, who by common inspiration are dedicated to memorialize and perpetuate the just and charitable life, the intellectual resourcefulness, and the ethical example of Sir William Osler, who lived from 1849 to 1919. The* OSLERIAN *is published quarterly.

We're on the Web!
√ us out at: www.americanosler.org

Looking Ahead to Pasadena, CA

The 55th meeting of the American Osler Society (AOS) will be held in Pasadena, California, from May 2-5, 2025 We enthusiastically await your arrival. The weather in Pasadena is usually perfect at this time of year. Save the date now!

Call for Abstracts for 2025 Annual Meeting in Pasadena, CA, May 2-5, 2025

Abstracts will be submitted this year via an online application process for the first time. The online site is available at https://www.americanosler.org/ from **Oct 1 to Nov 15**. There are no restrictions on who may submit an abstract**. The abstract title should be followed by the author(s) name(s), affiliations, and biographical sketch (limited to 80 words).** The biographical sketch is a description the moderator can use when introducing you. We will print exactly what you write here in the program. You should write in the third person, e.g., if you were William Osler, you could say, "Dr. William Osler is Professor of Medicine at the newly opened Johns Hopkins School of Medicine. He is the author of The Principles and Practice of Medicine, recently published by D. Appleton and Company. Dr. Osler has held previous academic appointments at Penn and McGill in Montreal."

The abstract should be no longer than 370 words. The text of the abstract should provide sufficient information for the Program Committee to determine its merits and possible interest to the membership. The problem should be defined and the conclusions should be stated. Phrases such as "will be presented" should be avoided or kept to a minimum. **Only one abstract per person will be accepted**.

Three learning objectives should be given after the abstract **(limited to 12 words each)**. Each learning objective should begin with an active verb indicating what attendees should be able to do after the presentation (for example, "list," "explain," "discuss," "examine," "evaluate," "define," "contrast," or "outline"; avoid noncommittal verbs such as "know," "learn," and "appreciate"). The learning objectives are required for Continuing Medical Education credit.

Each presenter will have a 20-minute time slot, which will be strictly enforced. Presenters should rehearse and time their papers to 15 minutes, in order to permit brief discussions and to be fair to the other speakers. Although 20 minutes might seem quite short for a paper in the humanities, our experience with this format has been overwhelmingly favorable.

AOS Members — *Please forward to the editor information worth sharing with one another as well as "Opinions and Letters".* - MHM (mmalloy@utmb.edu)