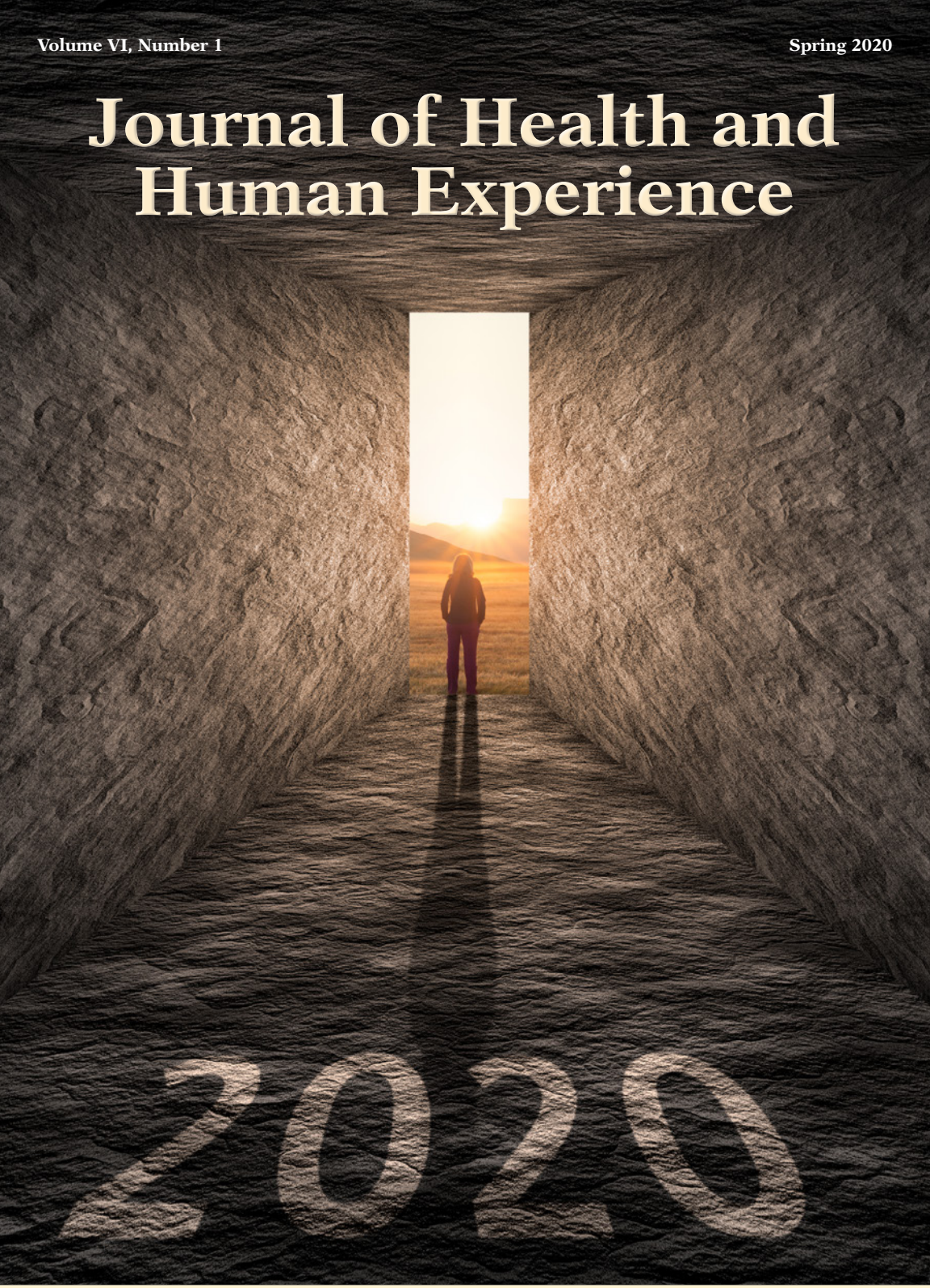
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Journal of Health and Human Experience



RECLAIMING OUR 20/20 VISION


The Semper Vi
Foundation
From Victim
To Survivor
To Victor

Journal of Health and Human Experience

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The Journal is an interdisciplinary, academic, peer reviewed international publication. Its mission is to explore the full expanse of holistic and integrated health within the nature and meaning of human experience. Its scholarly and professional explorations richly convene all possible areas within the arts/humanities and the sciences, cultural and social concerns, diverse technologies, ethics, law, civil rights, social justice, and human rights. The Journal invites the reader into the fullness of our human nature, our history, and the expanding futures before us.

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MISSION



The Semper Vi Foundation



"From Victim to Survivor to Victor"

Mission: The Semper Vi Foundation is a 501(c)(3) tax exempt public charity dedicated to the design, development, implementation, and promotion of social justice and human rights resources, programs, and diverse opportunities in education, publishing, research, and services that help the suffering find healing and meaning in their lives. Of particular interest for the Foundation's mission is Wounded Warrior Care and, equally, the care of all those who suffer in our wounded world.

Vision: Semper Vi reaches out to all who have known the many forms of life's suffering and tragedy. Semper Vi activities and opportunities seek to help all those who suffer, not only to survive, but also to become victorious so that their wounds become sources of healing for others. Semper Vi assists those who have benefited from our programs and activities to help others in need. Some of those who benefit from Semper Vi's humanitarian and relief commitments include our Wounded Warriors and their families, as well as individuals and communities who have experienced violence and terrorism, victims of assault and destruction, those who have suffered discrimination and the loss of their human or civil rights due to religion and values systems, race, gender, sexual orientation, socio-economic status, national origin and ethnicity.

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Programs: Semper Vi Foundation activities are organized into four programs.

> ***Education:*** The Semper Vi Foundation convenes a community of international, interdisciplinary scholars and professionals who develop and promote a wide range of educational programs and resources for enrichment in the humanities, health and healthcare, the physical and social sciences, human development and human rights

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Research: The Foundation serves as a sponsored projects college for investigators looking to promote a wide variety of academic and professional domains of inquiry. The Foundation promotes such programs in collaboration with various global universities, centers and institutes.

Social Justice Services: The Foundation serves as a gathering point for individuals and communities who design and promote diverse social justice services and resources supporting human and civil rights. The Foundation supports already existing approaches and promotes the invention and launching of new services to meet emerging social justice needs across the globe.

Reflection: Tales of heroes abound throughout world literature. Our attention is always captured by the stories of those who accomplish great deeds that benefit others and the world. Yet what is it that we mean by the term, "hero?" When is something "heroic?" A hero is one who, despite danger and weakness, musters the courage to sacrifice herself or himself for the needs of others. Sometimes this comes at the price of the hero's life. However, in all instances, the hero vanquishes the danger and rises above it as victor. Yet there is another nuance. The work of the hero often goes deeper. In many tales, the hero not only fights the oppressor, but also suffers grievous wounds in doing so. The hero embodies the suffering and takes it into her or him self. The hero endures and survives. Yet even more amazingly, in these stories the suffering and pain are transformed from curse to blessing. The hero matures from victim to survivor to victor! The hero becomes *"semper victorius!"* Always the victor!

Invitation: Join us as we build Communities of Victors, for today and tomorrow!

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FROM THE EDITOR-IN CHIEF





The Needed New

Dr. Edward Gabriele
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Do we have the desire and the energy and the diligence and the courage
to join our disparate voices into one singular choir
that refuses to stop loudly singing songs of freedom for everyone?

– John Pavlovitz
This Is How Holocausts Happen, How Nations Lose Their Humanity
August 30, 2019

In this calendar year of 2020, our world is faced with areas of concern and distress that are of immense importance for us today and into our future. As the Journal is ever dedicated to exploring and promoting the fulness of health as a human experience, each of our editions promotes what it truly means to be both human and truly healthy.

In the past, I have written about some reflections concerning the definition of health that have struck me over time. It always intrigues me that our English word "health" has its origins in the Latin term, *salus*. Fascinating. Salus. And what always catches my attention in this ancient word is that it also is the basis for the English term "salvation." No, not "salvation" as in a necessarily religious term. Rather, like its Italian usage, *saluté*, it also means what we "salute" and that to which we raise up our lives, most especially the Unforeseen Possible!

This is a most broadening appreciation of what health really is. And it moves us to consider deeply how we must face those things in our world that are far from being healthy at all. One of these deep areas is the lack of insightful awareness of the immense number of situations in our world today that are anything but healthy. Are we really aware of what is going on in our lives, our nation, and our world? Do we see with all reality the nightmares that are being perpetrated by power-mongers and suffered by the most vulnerable? Do we see all this with the fulness of our interior soul-vision; or have we turned our minds and selves away because of the pain of acceptance and the price that must be paid for standing up and fighting for The Good?

Indeed, in this year, we have a need for something new. And it is to this need that all of our Journal editions this year are dedicated -- dedicated to a unique theme in this unique 2020 calendar year. In this year, we are caught up in a special and powerful call:

Reclaiming Our 20/20 Vision!

From the Editor-in-Chief

In this Spring edition, this special theme is movingly enfleshed as we remember this year the 75th anniversary of the Liberation of Auschwitz. The horrors of the Holocaust are importantly thrown before us this year. Indeed, this critically important anniversary reminds us as we are often told: ***Remember. Never Forget!*** Indeed, we must. We must always remember what is possible. We can never forget the pits of hate and discrimination into which our world has fallen in the past – and into which we still can fall at any time. We are all very much aware that the same nuclear hatred that fueled the Holocaust is fueling actions today that are destroying people's lives and decimating our common calling to social justice and human rights.

Indeed, we must remember. We can never forget. Always we must have our awareness dilated to take in the fulness of what is going on in our world. We cannot close our hearts or eyes or ears to those who ever cry out for freedom, happiness, loving, and the fulfillment of life itself. We must be moved in every possible way to see with greater clarity, to join our voices together to sing and shout for every freedom, to feel most deeply all that is needed by all who suffer, and to stretch our arms and legs to stand up and fight for and build a world dedicated to freedom and justice and peace. Indeed, we have an imperatively and most urgent need today for a new 20/20 vision of life that empassions us to stand up against every evil -- and stand up for Every Good.

Our various works in this edition are, as usual, amazingly powerful. Covering so many areas, this edition once again calls us to be moved. The readings you are about to enjoy will provide you with extraordinarily powerful multidisciplinary opportunities to explore what it truly means to be human and healthy.....to be Salus-People! This edition presents deeply moving explorations from all across the globe. And in these explorations, just like Alice experienced in Wonderland, a doorway will open through which we are invited to enter into The New so as to see with ultimate clarity what is needed by all, what we can to do to bring The New to birth, and how we can raise up one another into a liberating freedom whose sight and voice can never be destroyed again.

The door is opening.

Onward!

ARTICLES




STACIA BELYEU

Resilience: A Necessary Requirement for Health, Well-Being, and Survival for Caring Professionals

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Resilience has been identified as an important health and life-saving approach for caring professionals who are experiencing stress and distress. There is a growing well-documented need for resilience in a world and nation that experience burnout, empathy/compassion fatigue/distress, and moral distress of caring professionals. Types of distress are fairly well defined in the literature, however, the concepts and strategies for building resilience are emerging as important to distressed societies. This article will primarily focus on resilience strategies/programs for caring professionals in educational institutions, healthcare systems, and communities. The author is solely responsible for the contents of this article. The author has no financial conflicts of interest.

Abstract

Resilience is a topic that is increasingly emerging in the literature as a necessity, not only for individuals who are suffering trauma in our society, but also for the health and well-being of caring professionals from first responders, interprofessional providers, and the clergy. The need to identify and develop more strategies to enhance resilience on an individual level is recognized as a priority for the health of these caring professional(s) in the United States and across the world. Newspapers and literature are increasingly filled with documentation, stories and statistics of the impact of stressors, emotional distress, burnout related to empathy/compassion fatigue, and moral distress caused by many different societal and workplace factors. There is a well-documented growing need for resilience in a world and nation that is experiencing burnout, empathy/compassion fatigue/distress, and moral distress of caring professionals. Due to the increasing numbers of mass shootings and documentation of workplace stress, bullying, and even suicide. Although most definitions of resilience are somewhat similar, there are different approaches including, but not limited to: emotional resilience, psychological resilience, and moral resilience which is rapidly emerging in the literature. This article provides the background for a thorough discussion of the critical importance of individuals recognizing the need for and adopting a workable strategy that fits

the individual's resilience; sometimes this is supported by resilience coaching and/or training. With increasing disruption, challenges, and distress in organizations and in society, resilience coaching is emerging as an effective strategy to assist individuals, groups, teams, organizations, and communities to recover and heal.

Keywords: Resilience, psychological resilience, emotional resilience, moral resilience, resilience coaching, stress and burnout, empathy fatigue, compassion fatigue, neuroscience of resilience, caring, ethics, self-compassion, and self-care

Introduction

This article will first explore the wide-ranging documentation and literature related to the stress and distress of caring professionals. This section will cover examples from interprofessional healthcare providers, first responders, and even clergy. Before exploring the different types of resilience, the growing crisis in the lives of caring professionals will be described. This section of the article will highlight the different types of crises which focus the need for individual caring professionals to recognize their personal need for resilience. Documentation of the challenges of caring professionals in many different settings and situations sets the stage for the importance of developing resilience and understanding it at a personal level. Although healthcare providers, organizations, and communities can offer services, it is ultimately incumbent on the individual caring professional to recognize the need to build resilience early and to address it before it becomes a problem. For example, in "A survey conducted by Nursing Standard magazine ... found 69% of nurses who reported depression, blamed work for their illness. A total of 229 nurses completed a questionnaire of whom 80% had had time off work for their illness ranging from two to six months. Nineteen had stopped working" (Laurance, 2000).

The second section will address the relationship of types of stress and need for resilience. Many individuals use the broad term resilience, but they may be describing either emotional, psychological, and/or moral resilience. It is important that these definitions be clarified. By differentiating these terms and diving deep into the issues related to the conceptualization of these terms, this article attempts to identify the relationship of the value of finding the right approaches to re-build resilience in many interprofessional roles in the caring professions. The emerging literature related to resilience is increasingly highlighting questions related to neuroscience and other physiological responses. More scientists are exploring how resilience affects the brain and body along with the relationship of this to stress, burnout, and moral distress. Included herein are historical definitions with the differentiating definitions of emotional, psychological, and moral resilience, along with knowledge and discussions related to how to address this before the caring professional becomes mentally ill or commits suicide.

The last section of this article will address the different approaches that an individual caring professional can explore to build and address the need for resilience. Since it is so important that individuals first understand their own challenges, it is critical that internal motivation and access to different approaches be explored. One approach that is becoming more common is that caring professionals are seeking "resilience coaches" to address their own symptoms of distress early to explore and implement individual approaches before experiencing illness, leaving their profession, losing their license to practice or even suicide. Some state license renewal systems can cause system-driven stress in the sense that physicians, for example, are expected to "gut it out or get out." "...the Oregon Medical Board disciplined six doctors so severely that they committed

suicide" (Leveque, 2009). Sometimes our systems are set to push out competent physicians because of perceptions of not being able to handle the stress and will cause the physician to make mistakes/cause problems. In coaching, according to the International Coaching Federation, the client is seen as "whole, resourceful and creative," and coaches do not impose solutions but assist caring professional clients to find their own strategies and motivation to build and/or maintain resilience (ICF, 2002).

The Growing Crisis in the Lives of Caring Professionals

Healthcare providers, first responders, and even the clergy today are exposed to stressors, some like those most people experience; however, there are some specific events and situations present in their lives that are not present in most people's lives. Experienced over time, these stressors can cause healthcare providers to look for a way out. Some continue working at their stressful jobs in a depressed and fearful state of mind, single-handedly battling post-traumatic stress syndrome (PTSD) or other conditions such as compassion fatigue. Some quit to look for respite, and some make the ultimate exit. In any of those cases, the United States healthcare system and its providers frequently suffer, and in some ways, patients do, too. Most individuals are not placed in situations that cause extreme physical, ethical, or moral distress, nor are they skilled in being resilient, or somehow mentally handling the distressing situation and returning to normalcy.

Suicides among healthcare providers are high nationally and internationally. Dr. Kelly says, "Occupations with high suicide rates are dominated by the medical professions" (Yazdi, 2017). In the United Kingdom, similar statistics are found. "Nurses and doctors are more likely to take their own lives than anyone in Britain. In this study, nurses had a suicide rate 37% above the population between 1991 and 1996. "The stressful environment of nursing can support many of the triggers and traumas of PTSD, Dr. Mealer said. Nurses see people die. They work on resuscitating patients. They try to control bleeding. They have end-of-life discussions. And sometimes they are verbally or physically abused by patients or visiting family members" (NYT, 2019).

> Among doctors, the rate was 47% above the average for male practitioners and ... higher for female practitioners" (Laurance, 2000). "Mitchell Hardison, 62, was a well-known family doctor in Raleigh, North Carolina. He had what appeared to be a perfect life with a family, success, and patients who respected him. But Hardison ended it all on a fall day in 2015. He drove to a secluded cul-de-sac a few miles from his office and shot himself in the chest. A construction worker found his body the next day. Hardison had a secret: He was depressed and felt he couldn't seek treatment without jeopardizing his career. He was 100% positive that if he came forward and said he needed help that there would be a reprisal of some sort" (Cochran, Machles, Narayan, & Terpstra, 2019).

> I'm realizing more and more how many physicians are suffering with PTSD, even residents and medical students at the very earliest stages in their careers....so tragic that the very people who save hundreds and thousands of lives yearly are left as mere shells of the people they used to be. They're no longer able to relax, feel joy. They're stuck in this never-never land of misery and pain. It's just so maddening to hear the same stories over and over when it feels so preventable" (Wible P. , Physician PTSD—Are you a victim? 2017).

According to Dr. Wible, there are five top things that "... lead to physician PTSD:

- Number one is medical training. We have a fear-driven medical education model that teaches us by terror.
- Number two, human rights violations that include chronic sleep deprivation, hazing, bullying, lack of access to food, water, inability to see your family, take care of your own bodily functions.
- Number three, vicarious trauma. Of course, high risk specialties like emergency department and neonatology and such are going to feel more of this vicarious trauma.
- Number four, losing colleagues to suicide. I bet there are hardly any physicians out there who do not know of another physician who has died by suicide and you've probably not been able to properly grieve the death of that suicide. This is terrible. You're going back to work every day feeling at risk yourself.
- Number five is just the chronic toxic workplace environments that we are in every day. Shoved in this assembly-line, big-box clinics, which are dangerous for our own health and the health of our patients (Wible P. , Physician PTSD—Are you a victim? 2017).

In Dayton, Ohio, Kayla Miller "...was running for her life when she spotted victims who had been hit by the flying bullets. I look down the sidewalk and see just a row of bodies," Kayla Miller told NBC's TODAY. People shot, some alive, some not; so putting her own life in danger, Miller, a critical care nurse, stopped to perform CPR on some of the wounded victims on the sidewalk. "I'm grateful to be able to be alive and talk to my family and friends and tell them I'm OK," she told TODAY, sobbing. "But my heart breaks for these families. It's just not fair," she said (Baker, 2019). "In caring for people who are ill, injured, and dying, nurses routinely bear witness to others' pain, loss, and suffering. In addition, hospital-based nurses work closely with family members who often feel anxious and fearful for their loved one's future. Although empathy allows many nurses to experience great satisfaction in their work, repeated exposure to others' emotions may lead to compassion fatigue--a term often used synonymously with 'secondary traumatic stress'" (Barkin, n.d.).

> Despite nurses' routine exposure to loss and tragedy, their reactions to these have not been systematically addressed. The most empathic and idealistic of us respond by intensifying our caring, trying to be all things to all people. When these nurses fail at this impossible task, they feel guilty and miserable. Other nurses respond by becoming indifferent and distant, busying themselves with tasks and technology. This reaction may be similar to the 'silencing response' as described by Baranowsky in which caregivers redirect, shutdown, minimize, or neglect the traumatic material brought by another to the care provider. When nurses respond to compassion fatigue by creating emotional distance, their patients, in turn, may feel neglected or abandoned. Nursing school does not prepare nurses for the experience of witnessing pain and suffering....our bodies bear the brunt of our stress. This may be expressed in irregular eating and sleeping, musculoskeletal tension, respiratory problems, substance abuse, and decreased immune system functioning. Too many of us teeter too close to the precipice of chronic illness. It is not surprising that a study by Welch found that 35% of nurses sampled were clinically depressed. The Academy of Traumatology/Green Cross has proposed the following standards of self-care: do no harm

to yourself in the line of duty while helping others, and, attend to your physical, social, emotional, and spiritual needs as a way of (providing) high quality services to those who look to you for support as a human being" (Barkin, n.d.).

Local violence can cause significant and long-lasting negative effects if not ameliorated via communal listening/interacting or other ways to increase resilience and to treat the condition. Dr. Alejandro Rios Tovar, a surgeon at the University Medical Center of El Paso, had just returned home from a 30-hour shift when he was summoned back to the hospital. The story of the medical staff who cared for the victims "is one of heroics in the face of violence," Kolata writes. However, she noted that in the wake of care the doctors and nurses struggled to live with the horror of what they had experienced. McLean said that, when she made rounds the next day, she noticed a lot of the medical staff were in tears. It's unreal what these patients went through, she said. The day of the shooting, Tyroch managed to keep from crying until he drove home. Weber said she barely made it to her car before she started sobbing. There is a sense of relief when they say, "OK, there aren't going to be any more victims"--that's the first time you take a deep breath," she said. Then, you go home and you cry and you pray and you hug your loved ones." (Kolata, 2019). Another example from Las Vegas . . . "For the survivors of the Las Vegas shootings, overcoming emotional wounds may be just as tough as recovering from their physical injuries. The psychological fallout is likely to hit countless others--doctors, nurses, and bystanders who treated them, along with eyewitnesses to the nation's worst mass shooting. Some of the victims and others may be affected long term and experience symptoms of post-traumatic stress disorder. Some studies suggest full recovery may take as long as three years, or longer for those who never receive treatment" (Tanner, 2017). And finally, "Outside of a Southern California hospital, an ER doctor crouched down against a concrete wall grieving the loss of his 19-year-old patient. A paramedic snaps a photo of the tender scene. His coworker, a close friend of the doctor, posts the photo (with permission). Minutes after the photograph, the doctor returns to work 'holding his head high'" (Wible P. , Heart-wrenching photo of doctor crying goes viral, 2015).

Aside from the above-mentioned stressors, there are other healthcare provider workplace stressors such as long hours, being on call at a moment's notice and bullying by patients, other healthcare providers, and administrators. And, healthcare providers can step into unexpected stress-filled situations. Theresa Mills warns, "Everyone seemed to have friends and family who returned from WWII who sometimes acted odd," she said. It was often referred to as shell shock. While the symptoms of PTSD are more widely recognized and studied today, she explains that healthcare providers need to remain vigilant in evaluating the patient's past experiences. "A healthcare provider could easily be mistaken for the 'enemy' and be at risk of injury by a patient with PTSD" (Mills, Theresa;, n.d.). Stressors in medical, nursing and dental education settings such as faculty or other student bullying also can add to healthcare provider stress (Randle, 2003) (Mukhtar, Daud, Manzoor, Saeed, & Javed, 2010) (Dellasega, 2009) (Rowland, et al., 2011) (Wood, 2006). Additionally, there are more system-driven stressors such as time spent at EHR computer terminals; those minutes spent on a computer mean less time with patients (LaPointe, 2018) (Snell, 2018) (Ford, Peterson, Menachemi, & Huerta, 2009) (Yu, 2016).

In recent years, another important group who struggle with maintaining resilience are members of the clergy. This group of caring professionals increasingly find themselves consoling

victims of manmade violence, shootings, and terrorist attacks. "One of the biggest challenges pastors will face is the pressure to explain why someone would do something like this. Yet, no answer will take away the pain and heartache. What will be most helpful to those struggling is to meet them in their suffering by creating space for lament, providing comfort, encouraging community, and reminding others of the hope we have in Christ," Jamie Aten, Humanitarian Disaster Institute at Wheaton College founder and executive director said. (Shellnutt, 2018). These efforts may help reduce the severity or longevity of trauma following mass shootings.

According to the Council of Religious Leaders of Metropolitan Chicago, "We are outraged by the increasing normalcy of racist violence in a sacred space. The victims at Tree of Life join the victims at the Sikh Gurdwara in Oak Creek, Wisconsin, and at Emanuel African Methodist Episcopal Church in Charleston, South Carolina... We pray for comfort and hope for the families and friends of those affected by this act of hate." (Response to the Synagogue Massacre in Pittsburgh, Pennsylvania, 2018). Although they recognize that our democracy is very diverse, they are very concerned about some individuals and groups expressing their differences through violence.

Pastor Mark LaFollette writes eloquently about the pain and PTSD that creates challenges for pastors to bounce back after traumatic events in their communities. He states, "When I compare a pastor's pain with PTSD, I am not equating church stresses with the terrors of war. But when you get inside the causes and symptoms of PTSD, you can find parallels." (LaFollette, 2016). LaFollette further comments on how physical violence and the threat of trauma are frequently associated with a PTSD diagnosis. In addition to these traumatic situations that are impacting churches and synagogues, he speaks to "non-violent" conflicts and situations in churches that can also have a traumatic impact with three symptoms common to PTSD. So, today, pastors, families and congregations are challenged with some of the PTSD symptoms, including avoidance, self-protection, constant alert, dreams/flashbacks. What is so difficult for pastors and families is that they cannot always get away from those members/situations that hurt them.

And last but not least, another group of caring professionals are first responders, who also have their share of traumatic experiences. First responders have always been the earliest on the scene in these traumatic and violent attacks as well as in natural disasters. Their challenges were highlighted after the Parkland shooting and the Pulse nightclub massacre in Orlando, with Aboraya also highlighting historical national incidents like the Columbine shooting and the mass shooting tragedy in Las Vegas. Aboraya discusses that, "PTSD, which is characterized by reliving an event through flashbacks and nightmares, often isn't diagnosed immediately in the aftermath of a tragedy. Being hypervigilant and startling easily are normal reactions to experiencing or witnessing trauma. It becomes a disorder if the symptoms don't subside in a month or two, or start causing trouble at home or at work." According to Jim Brinkley, director of occupational health and safety for his firefighters union, "There is a fear that if you reach out for help within your own department, there may be adverse action. You may be removed from duty and you're not allowed to get back on the rigs. By having those who serve outside the area come in, we find the members are more likely to open up and tell us exactly how they're feeling." (Aboraya, Parkland Shooting Gives First Responders PTSD Bill New Life, 2018).

Resilience: Definitions, and Interprofessional Perspectives

In order to clarify what resilience is, it is important to examine a variety of early exploration and definitions. "Resilience has been most frequently defined as positive adaptation despite adversity. Over the past 40 years, resilience research has gone through several stages. Contemporary researchers have found that resilience factors vary in different risk contexts and this has contributed to the notion that resilience is a process (Fleming & Ledogar, 2008). The American Psychological Association defines resilience as "the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress (para.4)" (The road to resilience, 2014). It is clear from several sources in the literature that beyond this definition, resilience is very complex. "Determinants of resilience include a host of biological, psychological, social and cultural factors that interact with one another to determine how one responds to stressful experiences. In defining resilience, it is important to specify whether resilience is being viewed as a trait, a process, or an outcome, and it is often tempting to make a binary approach in considering whether resilience is present or absent" (Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014). Another perspective used in resilience coaching is assisting individual clients to differentiate between resilience and resiliency. According to Carol Pemberton, "Resilience is sometimes approached as though it is a bank account that has a balance figure that can be drawn upon when needed. . . how confident, decisive, creative and able to manage emotions. Resiliency is the degree to which you are able to put that credit balance into action" (Pemberton, 2015).

In the literature, there are at least four different types of resilience that are relevant to this article: psychological resilience, emotional resilience, nurse resiliency, and moral resilience. "Psychological resilience is the ability to mentally or emotionally cope with a crisis or to return to a pre-crisis status quickly (de Terte & Stephens, 2014). "Resilience exists when the person uses mental processes and behaviors in promoting personal assets and protecting self from the potential negative effects of stressors" (Robertson, Cooper, Sarkar, & Curran, 2015). Emotional resilience relates to an adaptation to events or situations that the person experiences as stressful. And to some degree, "Emotional resilience is also related to some factors that aren't under your control, such as age, gender, and exposure to trauma" (Scott, 2019). "Nurse Resiliency" is specific to "...the ability of a nurse to accurately perceive and respond well during stressful situations" (Sieg, 2015). Moral Resilience "...is an emerging concept that leverages resilience concepts and research to specifically focus on the moral adversity that arises in clinical practice and the capacities needed to transform moral distress and other forms of moral suffering from only a negative experience to one of hope and positive forward movement" (Holtz, Heinze, & Rushton, 2017).

As previously mentioned, moral resilience is one of the newer and most relevant areas of resilience that is beginning to emerge in order to address various type of ethical and moral challenges that contribute to moral suffering and moral distress. The elements of moral resilience are still being organized, discussed, and studied, so there is no widely accepted definition. However, some elements of moral resilience seem more important and fruitful for future exploration and discovery such as adaptation to the situation, return to a normal life, and as the author believes, communal support during and after the distressing event. Rushton posits that "...moral resilience requires ongoing inquiry to discern the boundaries of integrity preserving action." With this, she offers an expanded notion of ethical awareness by leveraging

somatic cues that accompany threats or alignment with integrity to guide action, suggesting that self-regulatory functions of mind, emotions, and bodily sensations are necessary tools in upholding one's beliefs and adhering to core values" (Young & Rushton, 2017).

To further explore this new and emerging concept of moral resilience, it is important to note that moral distress was first identified by Jameton as occurring "...when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6) (Jameton, 1984). Sometimes different people respond differently to the same situation. "Moral distress has been further developed introducing the differentiation between initial and reactive moral distress. Additionally, the factors which can rise to moral distress have been identified, such as factors internal to the caregiver, factors external to the caregiver and clinical situations" (Defilippis, Curtis, & Gallagher, 2019). If distress is caused by the person's response to the difficult situation, then strategies such as individual and organizational remedies such as coaching can counteract the distress and increase the person's resilience.

Building Resilience: A Deliberate Personal Journey to Health, Well-Being, and Healing

One of the primary purposes of this article is to focus on the individual and the opportunity for each caring professional to realize that resilience starts and ends with each person recognizing their own vulnerability and committing to taking the specific action(s) needed to begin the very personal journey to health, healing, and well-being. Putting resilience in context, the author sees the following sequence; first, there is a caring professional who has accepted certain responsibilities to/for other individuals, along with a set of beliefs, core values, ethics, and morals. Secondly, a situation develops wherein the caring professional realizes that as she/he carries out responsibilities or may be required to act in situations that violate beliefs, core values, ethics, or morals, causing herself/himself significant stress or strain. The situation causes the person to realize that the pain of "caring" is so great and/or there is no "right" pathway because the pathway sometimes being pushed upon the caring professional feels impossible or sometimes even the like the "wrong" path. So, the caring professional experiences distress. Merriam-Webster defines distress as pain or suffering affecting the body, a bodily part, or the mind and this author would add "the spirit." In addition to the impact on the body, it is the "of the mind" and "of the spirit" portion(s) of the definition that are also of importance in assisting the person with strategies for health and well-being.

There are many common-sense approaches that an individual can take initially to address burnout, empathy/compassion fatigue, and/or moral distress. The first and most important factor is for the person to understand what they are feeling and why (Scott, 2019). Additionally, it is critical that individuals recognize their symptoms of distress early and begin to address the impact of the distress early. For some providers, long hours and a stressful shift requires some form of quiet permission to release the tension or pressure in order to reduce the stress hormone, cortisol which can last up to 72 hours after leaving their workplace. Other strategies include relaxation techniques including yoga and different forms of meditation. Some find strenuous exercise helpful or just taking a walk and experiencing nature. Other individuals may just need to find space for quiet reflection and/or connecting to their internal spiritual place in the sanctuary of home or worship places.

The American Association of Colleges of Nursing has created a very thoughtful framework to alleviate moral distress. "Promoting a healthy work environment is a priority initiative of the AACN. To give nurses the tools to recognize and address moral distress in their work environment, the AACN Ethics Workgroup developed the 4 A's to Rise Above Moral Distress." "The first step is to ASK - to become aware of the moral distress one is experiencing. The next step is to AFFIRM - to recognize one's moral distress and one's professional responsibility to address this distress. The Third Step is that of ASSESSING--and analyzing the risks of doing what one believes is the right thing to do. And the Fourth Step is to ACT-- utilizing her/his newly acquired knowledge to allay the apprehensions of the senior management team and strengthen her/his resolve to assist the staff nurse, a valued member of the organization, while ensuring quality patient care" (McCue, 2010).

Social connection is another way that some can "escape their trauma" through strategies which include the development of a social support network with family and friends. These relationships with family and/or friends can allow time for a stressed out, sad, or compassion-fatigued caring professionals to share frustration, moral outrage, and the impact of compassion fatigue. "Even just slowing down for a long hug or look into someone's eyes can foster connections and understanding. **The Four-Minute Experiment** paired refugees with people in the host country--strangers--to just sit in front of each other and have eye contact for four minutes. The compassion, emotion, and openness that resulted was palpable." (Luest, 2019) (Luest, Connection--The Key to Healing and Resilience, 2019). It is also important to mention that there is growing research that encourages the use of music for resilience. "Active engagement with music has a number of intrinsic properties that mirror and enhance the protective factors of self-regulation, initiative, and relationships with others. Resilience supports learning in other areas in the same way that it supported better health outcomes in a music therapy study" (Ruksenas, 2014).

According to Carol Pemberton, "It is important to work with three themes in mind, Personality Traits, Protective Factors and Learning from Difficulty." And to work with the client's needs which encompass: "Building protection--through taking action; Building capacity--through developing resilience skills; and Building renewal--through being helped to use the learning from difficulty to move forward." She states that "Herbert Freudenberger first coined the term "burnout" in 1974. "Burnout builds slowly, but its key feature is that in order to burn out, a fire needs to be burning. It is when the fire is raging that the individual begins to recognize that they are being singed" (Pemberton, 2015). It is also important to recognize the impact of cortisol and weakening of the adrenal glands which as Pemberton says "... is distinct from loss of resilience." She further says that only when the client's body has somewhat recovered from the stress can individuals explore what they need to learn about what happened to them and why they were 'burned out" (Pemberton, 2015).

Two very important contributions to resilience come from Diane Coutu, a journalist. Based on her research about some of the Holocaust victims and prisoners of the Vietcong, she explored who did not make it out of the Nazi camps. She learned "it was the optimists." After more interviews and research, she posits that "Resilient people possess three characteristics: a staunch acceptance of reality; a deep belief, often buttressed by strongly held values, that life is meaningful; and an uncanny ability to improvise." Then, after exploring more about optimism, she wrote: "That's not to say that optimism doesn't have a place . . . but for bigger challenges, a

cool, almost pessimistic, sense of reality is far more important." She further learned that from Frankl's book, Man's Search for Meaning, "He realized that to survive, he had to find some purpose . . . Frankl created some concrete goals for himself. In doing so, he succeeded in rising above the sufferings of the moment." "Frankl's theory underlies most resilience coaching . . . what we now call hardiness--as a way for us to help people construct meaning in their everyday lives" (Coutu, 2002).

For more critical needs and greater distress, it may help to bring some of the strategies used in resilience coaching such as "expressive writing" and/or using "art prescription." These approaches were originally introduced by James W. Pennebaker and John F. Evans. "Since the mid-1980s, an increasing number of studies have focused on expressive writing as a way to bring about healing. Expressive Writing (EW) can positively affect people's sleeping habits, work efficiency, and connections to others" (Pennebaker & Evans, 2014). Individuals were encouraged to write about their trauma, by hand . . . not by typing on a computer. In an experiment conducted by Pennebaker and Evans, individuals had "forty-three percent fewer doctor visits for illness than those who were asked to write about superficial topics." Another approach was a workshop called "Art Prescription: Write to Heal." In this workshop "cancer patients were asked to write about their experience with cancer at any stage of treatment. Then they were given watercolor painting materials . . . and instructed to paint any vision, any feeling the writing seemed to provoke in them" (Pennebaker & Evans, 2014).

In closing, long before James Pennebaker's research and contributions focused on resilience, it is very interesting to find a beautiful example of Clara Barton's creative "expressive writing." Clarissa Harlowe Barton, otherwise known as Clara Barton, was a pioneer nurse, teacher, and humanitarian who had an historic career helping others. Because of her experience helping victims of war and disasters, she founded the American Red Cross.

In 1869, she (Clara Barton) was scheduled to give a lecture but found herself before an audience, unable to speak. Throughout her life, Clara had experienced recurrent episodes of depression. It seems that the exhaustion of the travel involved in her work, coupled with the depressing effects of the constant repetition of her war memories, contributed to her physical and mental exhaustion. She consulted several physicians who advised her to spend some time in Switzerland to recover her strength. Her sojourn to Europe lasted until 1873 and introduced her to new ways of channeling her energies for her humanitarian efforts. (Barton, C. Angel of the Battlefield, n.d.).

The Women Who Went to the Fields
A Poem by Clara Barton
(A tribute to the Civil War nurses. Excerpts)

Show us the battle, the field, or the spot
Where the groans of the wounded rang out on the air
That her ear caught it not, and her hand was not there,

Who wiped the death sweat from the cold clammy brow,
And sent home the message; -'Tis well with him now,
Who watched in the tents, whilst the fever fires burned,
And the pain-tossing limbs in agony turned,
And wet the parched tongue, calmed delirium's strife
Till the dying lips murmured, 'My Mother,' 'My Wife'!

Did these women quail at the sight of a gun?
Will some soldier tell us of one he saw run?
Will he glance at the boats on the great western flood,
At Pittsburg and Shiloh, did they faint at the blood?

And the brave wife of Grant stood there with them then,
And her calm, stately presence gave strength to his men.
And Marie of Logan; she went with them too;
A bride, scarcely more than a sweetheart, tis true.
Her young cheek grows pale when the bold troopers ride.
Where the 'Black Eagle' soars, she is close at his side,
She staunches his blood, cools the fever-burnt breath,
And the wave of her hand stays the Angel of Death;
She nurses him back, and restores once again
To both army and state the brave leader of men.
She has smoothed his black plumes and laid them to sleep,
Whilst the angels above them their high vigils keep:
And she sits here alone, with the snow on her brow
Your cheers for her comrades! Three cheers for her now.

And these were the women who went to the war:
The women of question; what did they go for?
Because in their hearts God had planted the seed
Of pity for woe, and help for its need;
They saw, in high purpose, a duty to do,
And the armor of right broke the barriers through.
Uninvited, unaided, unsanctioned oft times,

With pass, or without it, they pressed on the lines;
They pressed, they implored, till they ran the lines through,
And this was the 'running' the men saw them do.

Twas a hampered work, its worth largely lost;
Twas hindrance, and pain, and effort, and cost:
But through these came knowledge, knowledge is power.
And never again in the deadliest hour
Of war or of peace, shall we be so beset
To accomplish the purpose our spirits have met.
And what would they do if war came again?
The scarlet cross floats where all was blank then.
They would bind on their 'brassards' and march to the fray,
And the man liveth not who could say to them na;

They would stand with you now, as they stood with you then,
The nurses, consolers, and saviors of men."

– Clara Barton
The Women Who Went to the Fields



Clara Barton
1821-1912

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OK Boomer: Ageism Comes of Age in 2020

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Abstract

This analysis examines the origins, patterns, and consequences of ageism over the past several decades. Rooted in childhood impressions, ageist attitudes and negative stereotypes endure into adulthood in both implicit and explicit ways. Consequently, older persons may adopt and embody ageist stereotypes. Unlike race- or gender-based discrimination, ageism affects everyone who does not suffer premature death. Fear of one's future elder self can motivate terror-management behavior by younger persons that fosters ageist behavior. In the healthcare setting, older adults may be denied access to medical or preventive care. In the workplace, older workers may become marginalized, lose opportunities for training and advancement, or suffer outright discriminatory behavior. In the waning years of the two-thousand-teens decade, even as other forms of prejudice declined, overt ageist behavior accelerated as older persons became more devalued and/or were held responsible for societal ills. Ageism threatens to persist in modern society, unless confronted with the same zeal and perseverance as racism, sexism, and similar prejudices now on the wane.

Keywords: ageism, age discrimination, age stereotypes, terror management, intergenerational conflict, boomers, millennials

Introduction

And so he plays his part. The sixth age shifts
Into the lean and slipper'd pantaloon,
With spectacles on nose, and pouch on side,
His youthful hose well sav'd, a world too wide,
For his shrunk shank, and his big manly voice,
Turning again towards childish treble, pipes
And whistles in his sound. Last scene of all,
That ends this strange eventful history,
Is second childishness and mere oblivion,
Sans teeth, sans eyes, sans taste, sans everything.

– William Shakespeare,
Seven Ages of Man

Geriatrician Robert Butler first coined the term "ageism" in 1969, which he defined as a combination of prejudicial attitudes toward older people, old age, and aging itself; discriminatory practices and policies that perpetuate stereotypes about them. Popular media soon adopted the term, which was also added to the *Oxford English Dictionary*. (Applewhite, 2016).

Similar definitions now appear in most print dictionaries and online resources, including the World Health Organization:

> Ageism is the stereotyping, prejudice, and discrimination against people on the basis of their age. Ageism is widespread and an insidious practice which has harmful effects on the health of older adults. For older people, ageism is an everyday challenge. Overlooked for employment, restricted from social services and stereotyped in the media, ageism marginalises (sic) and excludes older people in their communities. Ageism is everywhere, yet it is the most socially 'normalized' of any prejudice, and is not widely countered—like racism or sexism. These attitudes lead to the marginalisation (sic) of older people within our communities and have negative impacts on their health and well-being. (World Health Organization, 2019).

Five decades after Butler's original definition, ageism remains pervasive in current society, while other "-isms" (e.g., racism, sexism, and anti-Semitism) have declined over the same time period—notwithstanding recent upswings that seem related to partisan rhetoric and assumed empowerment of hate groups over the past few years. The long-term effects of anti-racism and anti-sexism progress will likely endure the current onslaught, especially as movements such as #MeToo continue to gain momentum.

The ageism construct that Butler codified now boasts a multitude of scientific literature across a wide variety of disciplines and has maintained steady interest in popular media as well. Yet ageism remains a mere youngster in the history of humanity. In pre-industrial, agrarian societies, older persons occupied positions of respect and high social standing. Young people considered their elders to be the guardians of history, fonts of wisdom gained from life experiences, mentors, teachers, and quintessential leaders; holding positions of authority to which younger people could aspire, but achievable only when they reached older age. Tectonic change in perceptions and attitudes occurred around the turn of the nineteenth century and the advent of

the Industrial Revolution. Old age became a biological problem that would burden society. As the birth of consumer culture fostered a "cult of youth" it engendered the notion of intergenerational conflict and fear of aging. The rise of the Internet and explosion of online resources and social media further influenced this generational divide. (Applewhite, 2016; Nelson, 2017).

Ageism has been described as a stigma that fosters oppression, reinforced throughout society by economic, legal, medical, commercial, and other systems that affect the daily lives of elders. Negative messages about aging color every aspect of life, with deleterious effect on prospects, economy, and civic life. Some believe these messages and effects constitute oppression, i.e., being controlled or treated unjustly by others. (Applewhite, 2016). Many aging Americans have yet to understand ageism, appreciate its negative effects, or become energized to resist it. Far too often, elders buy into negative stereotypes about the effects of aging, and thus diminish their own stature in society.

Origins of Ageism

Childhood Socialization

Honor your father and your mother, that your days may be long in the land which the Lord your God gives you.

Exodus 20:12

Imagine this scenario: A young military family returns from overseas to a new assignment at a U.S. base. Their first holiday season back in America is in full swing. The parents and their five-year-old son and three-year-old daughter (the latter born overseas) await a much-anticipated visit from the father's parents who have not seen the family in three years. Both grandparents are in their 70s and afflicted with poor health. Within the last year, the grandfather underwent surgery and permanent colostomy for colon cancer. The grandmother suffers from chronic metabolic syndrome and depression that mar her face with a permanent scowl.

When the happy day of the grandparents' arrival and family reunion dawns, the parents throw open the door and embrace the elders. The children draw back. The three-year-old sees the grandmother in the image of Snow White's wicked queen, a "mean old lady." The young boy recoils from his grandfather because "he smells funny," a reminder of the grandson's concept of the odor of death. (Bergman, 2017).

From the first moments of socialization through passage to adolescence and early adulthood, children learn stereotypes about older people. Depending on family traditions and cultural factors, names such as "Grandma, Gramps, Memaw, Nana, Pops, Gigi, Pop-Pop" carry different connotations dependent on the tone and body language used by the immediate family members. Ageist attitudes translate to children's perceptions of older adults (Robinson & Howatson-Jones, 2014). For instance, if a child's mother or father addresses older persons in the same tones, language, and voices they use in talking to a small child, it sends a clear message how the most important adult in the child's life perceives the older person. (North & Fiske, 2012). If the elder person exhibits physical characteristics of the aging process (e.g., stooped posture, slow speech, halting gait), the child may interpret it as sadness, weariness, or mental slowness—qualities the child may generalize to all aging adults. (Montepare & Zebrowitz, 2004).

While subtle ageism influence on children by adults may vary among families, the depiction of older adults in child-targeted media, especially television, is pervasive and consistent. (Bergman, 2017). Fairy tales, picture books, cartoon shows, movies, and online entertainment occupy prominent, sometimes intrusive roles in the lives of children. Aging stereotypes, positive and negative, wield serious influence on the attitudes, assumptions, and world view of even the youngest children—and may be their first exposure to older adults beyond their immediate family. (Bergman, 2017). Elderly women are particularly subject to stereotypical roles as sexism merges with ageism. Only a handful of ageing female character types persevere throughout the history of children's literature, and those exist in diminished scope, i.e., the wicked old witch, the demented hag, or the selfless godmother (Henneberg, 2010). The latter, often characterized as a "sweet old lady," offers little substantive value. (Cuddy, Norton, & Fisk, 2005). Not an Iron Lady in the bunch.

Positive endings in children's media add a not-so-subtle twist on the depiction of older adults in marginal roles. The personal characteristics of the younger, often male, protagonist typically save the day; relegating the older person in the story, regardless of their actions, to a secondary role of bystander at worst, cheerleader at best. The influence of such characterization on the developing perceptions and attitudes of children can be profound, as demonstrated in both direct and indirect experiments and measures. (Bergman, 2017).

Do these observations mean that the likes of Disney movies and shows, especially the older ones, should be purged from the repertoire of childhood entertainment? Of course not. The opportunity exists for parents, teachers, and other influential adults to provide positive information regarding older individuals, to counteract the formative inclination of children to view them in a negative manner. (Bergman, 2017). Just as it is easier to control erosive garden weeds by treating their young roots, so our society and families can curtail the destructive effects of covert ageism by substituting derogatory stereotypes and portrayals of elders with positive experiences and affirmative characterizations.

Implicit and Explicit Ageism

Picture the checkout line at a busy grocery store on a Friday evening. The place is crowded with people, most of whom stopped in at the end of a busy workweek, focused on stocking up for weekends of leisure or social activities.

A 60-year-old male executive falls into line behind a 75-year-old woman whose stooped posture and disfigured fingers suggest debilitation from some form of arthritis. She, in turn, waits behind an 85-year-old thin but not emaciated gentleman wearing a jogging suit. What do each of these shoppers expect from the person in front of them?

The executive sees the older woman in front of him but not the very old man in front of her. He glances around to find another checkout line, expecting a long delay as the old biddy in front of him fumbles her way through the process. He might think, with a modicum of annoyance, that she should have come earlier in the day when the store was less crowded while people such as he worked long hours, in part to fund her social security entitlement. Failing to find a shorter line, he glances at his watch, taps his foot, sighs, crosses his arms, and makes other outward indications of impatience.

How does the 75-year old woman perceive the older man in front of her? Maybe she expects the octogenarian to slog through the checkout process in slow motion, holding her up long enough to miss the bus to her neighborhood, making her wait another twenty minutes for the next bus. Her blood pressure rising to the point of chest palpitations, she huffs and frowns, pushes her cart forward as if to push the old fool through the line.

The 20-year-old checkout clerk sees three old people in his line, and it matters little to him that each has a significant age difference with the next one. To him, the gray-to-white hair, wrinkles, postures, and other outward indicia of aging suggest the same thing: old, slow, dense, dithering, demanding, deaf people. He heaves a sigh and looks at the clock. Thirty minutes to the end of his shift. He glances behind the 60-year-old, relieved to see a fit young woman in a relaxed posture actively engaged with her smartphone. She, at least, won't be a bother.

What of the octogenarian? A widower, he's come from an exhilarating, age-appropriate workout at a local gym, stopping by the store to pick up some fresh fish and salad fixings for his dinner. A retired history professor, he keeps his mind and body sharp with his daily gym workout, gardening, reading, writing, and teaching a weekly undergraduate class at the nearby university. As he takes his turn at the front of the line, he perceives, in a subliminal way, the attitudes of those around him, especially the clerk. He usually goes earlier to the grocery store, where he navigates the checkout process with alacrity; places his reusable bags first on the conveyor, then his groceries neatly arranged by bulk and size—his loyalty card and debit card out and ready for the clerk. But this evening takes a different turn as he embodies the perceptions of those behind him. Fumbling in his wallet, he drops his debit card onto the floor, requiring the woman and the rest of the line to back up so he can retrieve it. In full fluster, he inserts the card the wrong way into the card reader, resulting in a loud, admonishing beep from the machine. The clerk huffs, scowls, and hurries him through the rest of the process, dropping his filled bags back into the cart, then turns his attention to the next customer. "Thank you," the old man mutters as he slinks toward the store exit, embarrassed and humiliated.

The 75-year-old, a published author who has just finished her thirtieth novel, fares better. Although she can no longer type with her disfigured hands, she has learned to dictate her work using voice-recognition software on her computer. She pays with a tap-and-pay application on her smartphone, declines the printed receipt for an emailed copy, and exits the checkout line with her reusable bags tucked into her cart.

Frustrated and angered by the octogenarian's plight, the 60-year-old executive fails to notice the swiftness in which the woman in front of him cleared the line. Caught unprepared, he rushes his own checkout process—realizing at the last minute that he left his wallet in his car. Chagrined, he meekly asks the clerk to put his groceries aside while he scurries to the parking lot to retrieve his wallet.

The frustrated clerk nods impatiently, sets aside the man's groceries, and turns with relief to the young woman. He shakes his head. She gives him a knowing, conspiratorial smile. "Codgers," she says.

This scenario illustrates several aspects of ageism. The clerk is the same boy described in the previous section on childhood associations. Now a young adult, he reflects the implicit ageism

learned from his early-age interactions with older adults, the effects of his parents' attitudes, memory associations linking older adults to negative traits of being fragile, slow, and dependent. (de Paula Couto, 2017; Fazio, 2007). The young woman's scornful response is more explicit and outward. Both represent age stereotypes, i.e., negative representations of older people resident in long-term memory, and age prejudice, i.e., negative assumptions of older people triggered by age-related clues. (de Paula Couto, 2017). Implicit ageism is associative and non-subjective. Associations in memory will activate whether the person believes them or not. Explicit ageism, on the other hand, is a product of personal beliefs and feelings organized by persons as they differentiate selves and others. (de Paulo Couto, 2017; see also Gawronski & Bodenhausen, 2006, 2007).

The responses and actions of the three older shoppers in the scenario demonstrate a phenomenon of "stereotype embodiment," a process by which older persons adopt and/or endorse the same age stereotypes as younger persons. (de Paula Couto, 2017). This internalization of stereotypes can occur over a lifetime, function in the subconscious realm, gain prominence from self-relevance, and function through multiple pathways. (Levy, 2009). These embodiments may be negative, as with the two older male shoppers, or positive, as exemplified by the older female. (See Chasteen, Schwartz, & Park, 2002, and Wentura and Brandtstadter, 2003). The positive/negative attitude variance may relate to how older adults relate to their own group. High-self-esteem older adults tend to prefer and identify with young persons, holding negative attitudes toward their own contemporaries. (Levy & Banaji, 2002). When not challenged by negative stereotypes like he experienced in the grocery line, the octogenarian's continued engagement in the academic milieu demonstrates a preference to associate with younger people. The septuagenarian author prefers seminars at a local writing studio where the age distribution ranges from teens to nonagenarians. The sexagenarian executive may be a runner who participates in a local running group where the average age is around 40. In each case, these high-esteem older adults exercise their preference to mingle with younger groups, perhaps eschewing more sedentary or lower-esteem age contemporaries.

Researchers have further examined the effects of positive or negative aging stereotype embodiment on older persons' well-being and cognitive, physical, and physiological function. Levy reports on the influence of age stereotypes on blood pressure and skin conductance as measures of cardiovascular response to stress. Positive and negative age stereotypes resulted in diminished or enhanced responses, respectively. (Levy, 2009). Levy and colleagues further examined the effect of aging self-stereotypes on the will to live among older and younger individuals. Among older persons, those exposed to positive age stereotypes would engage in medical interventions, whereas those carrying negative age stereotypes would opt to refuse lifesaving medical interventions. Young participants' will to live was unaffected by either positive or negative subliminal aging stereotypes. The investigators conclude that socially transmitted negative aging stereotypes can weaken elderly person's will to live. (Levy, Ashman, and Dror, 2000).

Terror Management Perspective

Recall the 3- and 5-year-olds with the aged grandparents in the section on Childhood Socialization. The grandmother suffered from metabolic syndrome, while the grandfather had colon cancer. Within five years of that holiday encounter, both grandparents died. The children may have witnessed one or both deaths, and/or attended funerals or memorial services—

perhaps with open caskets. Maybe they were affected by one of the grandparents' prolonged illness and progressive debilitation. What have they learned from those experiences, what takeaways that may affect their attitudes toward older people when they become young adults? "Old = death?" With what social groups will these young adults identify? Will they welcome or marginalize older adults within their chosen milieus?

Unlike race, gender, sexual orientation, or ethnic origin, old age is a physical condition that inevitably affects all humans except tragic victims of premature death. All old people were once young, and most young people will one day become old. Old people subjected to an "out-group" on the basis of age alone were once members of a younger "in-group." (Greenberg et. al., 2017). This fact has implications for both older and younger persons.

Death from some causes may be avoidable, e.g., automobile safety factors reduce highway deaths, healthy lifestyles reduce risk of death from major causes, i.e., heart disease and stroke. Preventive measures may reduce risk of death from cancer. But in no case can death of any individual be permanently postponed. The sight of an older person can remind someone younger of their inevitable destiny. (Greenberg et. al., 2017; see also Martens et. al., 2004, Martens, Goldenberg, and Greenberg, 2005, & Bodner, 2009).

In formulating terror management theory, Greenberg et. al. summarize the work of cultural anthropologist Ernest Becker and other pioneers: The juxtaposition of humans' innate desire for survival against awareness of their vulnerability and inevitable mortality creates a potential for paralyzing terror. Humans react by belief in a "cultural anxiety buffer" consisting of two parts: 1) an individualized but culturally derived view of ordered reality that transcends death ("cultural worldview") and 2) an individual's value within the context of that worldview ("self-esteem"). They describe a consistent finding that "mortality salience increases positive to those who uphold or validate the individual's worldview and negative reactions to those who violate or challenge the individual's worldview." (Greenberg, et. al., 2017). The so-called generation gap might constitute an example of this phenomenon.

Further research describes the psychological processes of young adults in response to thoughts of mortality: First, remove such thoughts by telling oneself that death is far in the future; second, distract oneself from the threat, thus denying one's vulnerability to death; third, physically remove oneself from reminders of death. (Greenberg, et. al., 2017; Pyszczynski, Greenberg, & Solomon, 1999). The implications of these processes on implicit and explicit ageism seem self-evident.

A direct method of dealing with the implied threat of death embodied by older people would be to avoid them. For instance, a younger person might choose (consciously or not) to stay away from places frequented by older people: senior community centers, church-related bingo games, golf courses, or concerts featuring rock stars from previous decades (e.g., Rolling Stones, Metallica, Fleetwood Mac). One might also avoid certain geographic locations know to be favored by older people (Florida, Sun City, AZ). A second, more deleterious avoidance strategy would be to keep older people out of the workplace through processes such as forced retirement or discriminatory hiring practices. At the family level, the desire to place parents and older relatives into assisted living facilities or nursing homes removes the salience of these older relatives as they near death. Psychological distancing constitutes another avoidance process,

referring to older people with stereotypical derogatory terms such as "codger," "old hag," or even "old-timer." (Greenberg, et. al., 2017).

Indirect methods of managing the terror of death triggered by old people might include "increased self-esteem striving" by emphasizing negative reactions to older people perceived to challenge one's worldview, with proportional positive reactions to those (usually younger) individuals who hold a similar worldview. (Greenberg, et. al., 2017). Hence the "gender gap" that includes its own lexicon. Oppositional terms like "boomer" and "snowflake" are examples.

A final consideration in regard to terror management theory is the role of the human body as a cultural symbol, including a fanciful flight from death that fulfills positive and negative attitudes about one's body or those of others, the role of sex as a common source of problems and difficulties, and romanticized cultures that value physical attractiveness and objectify women. (Goldenberg, Pyszczynski, et. al., 2000; See also Goldenberg, McCoy, et. al., 2000).

Older people may strive to preserve their bodies through physical activity, plastic surgery, or a host of cosmetic products advertised as aids to maintain a youthful appearance. However, should older individuals indicate an attraction to younger persons or an interest in sex, they are often rewarded with disparaging labels such as "dirty old man," or "cougar." (Greenberg, et. al., 2017).

Healthy older persons, in both physical and psychological realms, can mitigate the ageist effects of terror management as a defense against the inevitability of death. Through the last few decades many older persons have demonstrated remarkable results in slowing the aging process and lengthening life expectancy through healthy lifestyles, preventive health practices, positive mental outlooks, and exercising mental acuity. (Greenberg, et. al., 2017) Many older persons, including artists, scientists, and executives, have not only maintained productivity into their waning years, but in many instances achieved their most renowned results well past the stereotypical retirement age of sixty-five. These older persons have little difficulty mingling with and establishing positive, healthy relationships with people decades younger.

Finally, older persons with healthy mental attitudes toward life and death can motivate younger people to face the inevitability of death with equanimity. When an elder approaches the nearness of death with a sense of gratitude and satisfaction for a life well-lived and pride in one's accomplishments, it can motivate their children and grandchildren to perceive death as the final fulfillment, not the ultimate threat. (Greenberg, et. al., 2017) As a result, the negative ageist forces of death-terror can foster healthy relationships between elders and youngsters.

Manifestations of Ageism

Elder Mistreatment/Abuse

"The mistreatment of older adults is one of the more egregious issues confronting society." (McDonald, 2017). It is also the least well-known or understood discriminatory practice in the world today. Regardless of attitude, most people—certainly most Americans—are familiar with the terms racism, sexism, religious prejudice (e.g., anti-Semitism), homophobia, xenophobia, and others that connote oppressive or prejudicial attitudes and practices toward people who are different. Ageism belongs in any such list, but does not carry the same emotional impact as, for

instance, racism. Elder mistreatment and abuse, therefore, often occur outside the sensitivity of others, even when done in plain sight.

McDonald analyzes a global scoping review of population-based studies estimating the prevalence of five types of elder abuse (physical abuse, psychological abuse, sexual assault, material exploitation, and neglect). The review calculated an aggregated prevalence of 2.2 to 14.0%, with mean of 7.1%. (Pillemer, Burnes, Riffin, & Lachs, 2016). These studies involved community-dwelling older people, and therefore may underestimate true population-wide prevalence because of a) exclusion of older people suffering some form of cognitive impairment, and b) reluctance of some respondents to admit to or report mistreatment. Based on several studies, McDonald reports that elder mistreatment is "extensive, predictable, costly, and often lethal to older adults." (McDonald, 2017). Another cited study calculated a 47.3% prevalence of at-home caregivers mistreating older persons with dementia, of which 88.5% suffered psychological abuse, 19.7 % experienced physical abuse, 29.5% experienced neglect. The combination of physical assault and psychological aggression yielded the best sensitivity (75.4%) and specificity (70.6%) for identification of elder mistreatment. (Wigglesworth et. al., 2010).

In their literature review, Pillemer and colleagues identified risk factors for mistreatment of older adults, from the perspective of both victim and perpetrator. They further categorized the factors as "strong," "potential," or "contested." "Strong" individual-level victim risk factors included functional dependence or disability, poor physical health, cognitive impairment, poor mental health, and low socio-economic status. "Potential" victim risk factors included gender (women more likely than men to experience abuse), age (younger age at greater risk), financial dependence, and race/ethnicity (in the US, older African American adults more at risk than Caucasians). Regarding individual-level perpetrator risk factors, "strong" indicators included mental illness, substance misuse, and abuser dependency, i.e., abusers rely on their victims for emotional support, financial help, housing and/or other assistance. In terms of victim-perpetrator relationship-level reviews, "potential" risk factors included relationship type and marital status. Looking at societal-level risks, the reviewers found "contested" factors in negative views on ageism, i.e., negative attitudes and stereotypes may drive acceptance of elder abuse; or that older people may be perceived as fragile, dependent, or burdensome, thereby enabling younger generations to mistreat them. Finally, the review suggested that two "strong" factors may protect individuals from elder abuse or promote resilience: higher level of social support and embeddedness in a social network, and separated living arrangements, i.e., a shared living arrangement is a major risk factor for elder abuse, especially physical and financial abuse. (Pillemer, Burnes, Riffin, & Lachs, 2016).

Elder abuse pervades modern society, albeit difficult to quantify with accuracy. Substantial opportunities exist to mitigate risks of abuse and identify its victims. Ironically, while the association of ageism to elder abuse makes intuitive sense, there is a paucity of empirical evidence to demonstrate that as a reality. (McDonald, 2017)

Elder Disparagement/Patronage

Picture the earlier grocery-store scenario occurring on a different day. The same three elders hold places in the checkout line. The clerk is a twenty-year-old young woman, perhaps the same person depicted as a 3-year-old in the scenario on childhood socialization. As the octogenarian professor approaches the cash register, the clerk speaks to him in a loud voice. "Do you need

help? Just insert your debit card into the slot there. That one, right there, sir. Go ahead and do it now, please." The elder gentleman, whose hearing is fine, already has his card in hand and was about to insert it into the card reader—as he has done many times before without assistance.

As the arthritic septuagenarian author completes her purchases, the young woman places her filled reusable bags into the cart and speaks to her in a singsong voice. "Do you need someone to push your cart to the lot for you, sweetie? If you'll just wait a minute, I'll get one of our young men to help you." The older woman sighs and pushes her cart out of the store by herself.

When the sexagenarian businessman approaches the register, the young woman stares at him, making prolonged eye contact, then speaks in a normal tone of voice. "Wife make you do the shopping today?"

Two studies by Fiske and colleagues (Fiske, Xu, Cuddy, & Glick, 1999; Cuddy, Norton, & Fiske, 2005) set up a theoretical framework for the common practice of ageist bias, positive or negative, most often through disparagement or patronage, the latter manifested by a pattern of patronizing speech and/or unnecessary helping. Those researchers identified two "clusters" of out-groups: incompetent but warm (promoting paternalism) and competent but not warm (promoting envy). They further characterized the incompetent group as being low status and those perceived to be warm as being more cooperative than competitive. Applying these concepts to ageist stereotypes, older adults were typically perceived as high in warmth but low in competence. This characterization might lead to paternalism, but also to social exclusion; consistent with the categorization of older adults as weak (however warm) and of marginal contribution to society—therefore earning less respect. (Bugental & Hehman, 2017).

In a study of communications patterns in a retail environment, Ryan and colleagues (Ryan, Anas, & Gurnier, 2006) looked at communications directed at older people and those with disabilities. Communications styles were categorized as professional, overhelping, and underhelping. In contrast to "professional" interactions, "overhelping" patterns tended to be patronizing, oversimplistic in vocabulary, and exaggerated in tone. Overhelping led to both diminished customer satisfaction and lower salesperson effectiveness. They also described a "Blame-the-recipient" phenomenon, wherein "underhelped" customers were rated low on competence, while those "overhelped" scored low on benevolence. In short, the older people received communications the salespeople perceived they deserved, based on the communicator's biased assessment of the recipient's status.

The above phenomenon recalls the "stereotype-fulfilling prophecy" outlined by Bugental & Hehman (2017), citing, in part, the work of Baltes and Whal (1996). Exposure of older persons to a consistent pattern of patronizing or disparaging interactions enhances the elders' dependency and minimizes their independence. They behave in ways that reinforce the negative aging stereotypes as they accept the validity of negative evaluations about their competence. Another study indicated that older adults exposed to patronizing speech reported lower assessments of their own intrinsic communication abilities than did older adults not subjected to such negative speech patterns. (Kemper, Othick, et al., 1996).

Citing a wide swath of relevant studies, Bugenthal & Hehman (2017) conclude that "both explicit and implicit activation of negative age-based stereotypes fosters deficits in older

adults across a wide variety of tasks and domains." These include memory deficits, handwriting abilities, gait and walking speed, will to live, and motivation to seek life-prolonging medical treatment. The earlier referenced "stereotype embodiment theory" (Levy, 2009) seems to be an important driver throughout these examples.

Patronizing speech directed at older adults can be verbal, non-verbal, or both. Verbal patronizing speech is often high-pitched, slower in cadence, and louder in volume, with exaggerated intonation. Bugenthal & Hehman (2017) cite multiple studies, from as far back as 1981, that liken these speech patterns to "baby talk." In a series of related studies, Kemper and colleagues coined the term "elderspeak" to characterize systematic speech accommodations directed at older adults by younger caregivers and service providers under controlled conditions. The speakers tended to use shorter, simpler utterances, often in the form of sentence fragments, used words under three syllables, and more repetitions. In all cases, the younger speakers adjusted their speech to accommodate for real or perceived cognitive needs of their older adult subjects. (Kemper, 1994; Kemper et al., 1998). A literature review by Brown and Draper (2003) reported a similar pattern they described as "accommodative speech," wherein health workers often used patronizing or disparaging speech patterns based on perceived capacities (or lack thereof) of elder patients; and that their subjects found it to be unwelcome, condescending, offensive, disempowering, and demoralizing. They described possible consequences of over-accommodation to include dependence, diminished self-esteem, avoidance of speech situations, and ultimate acceptance of impolite speech by their caregivers. Regarding the inappropriate use of non-verbal communications directed at older adults, Bugenthal & Hehman (2017) describe the work of Armstrong & McKechnie (2009): inappropriate gaze, i.e., low or high eye contact, dominant spatial distances (e.g., young person stands while older one sits, young person placing hands on hips), and inappropriate touch (head patting by younger person).

Manifestations of ageism that include mistreatment, abuse, disparagement, and/or patronage can occur in any setting where older people interact with younger ones. Two settings of particular interest here are the healthcare environment and the workplace.

Ageism in the Health Professions

The first wave of elder baby boomers turned 65 in 2011. By the time the last wave reaches that age in 2030, even accounting for deaths, the estimated number of Americans over age 65 will exceed 70 million — almost double the 37 million in that age group in 2005. Elder Americans (defined as over age 65) will make up 20% of the population, an upward change from the 12% in 2005. The population of "oldest old" persons (those over age 80) will also increase, from 11 million to 12 million. This demographic stems not only from the relatively larger population of "boomers" compared to other generations, but also from the long-term effects of healthier lifestyles (improved health behaviors, especially the decline in smoking) and advancements in medical technology and treatment (e.g., enhanced diagnostic imaging and earlier diagnosis, and widespread treatment of hypercholesterolemia, hypertension, and many forms of cancer.) (Institute of Medicine, 2008). As an example, the most life-threatening form of skin cancer, malignant melanoma, claims few lives today through the combination of early detection and advanced immunotherapy. (A former president of the United States, an active nonagenarian, is a prime example.) Not so long ago, a diagnosis of malignant melanoma often harbingered death within a few years.

The unintended consequence of reduced deaths from acute or untreated conditions is "an epidemic of chronic disease" as 80% of aging Americans develop long-term diseases (Anderson & Horvath, 2004). Nevertheless, even as chronic conditions become the leading reason for people seeking medical care in the United States, the current medical care financing and delivery system is based on an episodic, acute care model. Medicare's non-coverage of hearing aids or eyeglasses are two examples. As a result, about 75% of the public believe it is difficult for people with chronic conditions to obtain care from physicians and healthcare providers. Many physicians perceive the same problem. (Anderson, 2003).

The combination of an aging population, the increased prevalence of chronic diseases, lower availability of physicians specializing in elder care, antiquated health delivery models and health financing processes, and pervasive ageist attitudes and practices among health professionals constitute a formula for disaster as the boomer generation joins Medicare and becomes a real or perceived burden; not only on the system but on individual providers or group health provision settings. The macro realities of this movement toward an increased older population seeking care for chronic diseases are outside the scope of this monograph, but the resulting overt or subliminal issues of ageism in the healthcare setting deserve discussion.

All manifestations of ageism previously discussed remain pervasive in the treatment of elder patients throughout the healthcare system: stereotype-driven attitudes, elder mistreatment and abuse, elder bashing and patronizing speech, and resultant stereotype embodiment and self-deprecation by elders themselves. Kagan (2017) posits a "jeunist" underpinning wherein younger persons are favored over older ones. The younger people enjoy higher status and preferential treatment, albeit mostly unaware of their privilege and benefits. As a result, older people often feel depersonalized and devalued as they are subjected to ageist attitudes and acts. (Kagan, 2017). The outcome for elders is negative effects on health, and poor health care experiences. (Kagan, 2015).

Applewhite (2016) summarizes the effects of ageism that lead to a lower standard of care for older patients within the context of physician-patient interactions:

1) Physicians and nurses often consider symptoms like balance problems, incontinence, and memory deficits as inevitable consequences of advanced age rather than as treatable conditions.
2) Health professionals are often dismissive of elders' symptoms. "At your age, what do you expect?" Older people with chronic pain are less likely than younger patients to receive adequate amelioration. (Pasupathi & Lockenhoff, 2004).
3) Physicians are more open to younger patients' concerns and communicate better with them, while older patients get less time with doctors.
4) Physicians fail to consider age-related changes in medication absorption and side effects, or the synergistic effects of multiple medications.
5) Many physicians assume elder patients are not sexually active and don't take sexual histories or consider sexually transmitted diseases, including HIV, in their differential diagnoses.
6) Secondary prevention programs and counseling, including cancer screenings, often overlook older patients.

The expanding population of elderly Americans presents an additional challenge as the healthcare system struggles to recruit and retain practitioners devoted to elder care. Nursing is a prime example, "an ageing profession caring for an ageing society where age discrimination takes many forms and has broad impact." (Kagan, 2015; Harris et al., 2010). Other health professions, e.g., occupational therapy, face similar challenges in recognizing and mitigating their own ageist attitudes as they themselves grow older. (Chippendale, 2016). Collectively, these phenomena of an aging population, aging health providers, and pervasive ageist attitudes compromise healthcare workforce development and competence for maintaining effective healthcare and social systems. (Kagan, 2017; Institute of Medicine, 2008).

The irony of pervasive ageism in professions dedicated to the care of all humans regardless of race, ethnic origin, gender, sexuality, economic status or other social measures—professions that espouse intolerance for these latter forms of prejudice—may relate to a topic discussed earlier, i.e., fear of one's future older self. (Nelson, 2005.) This terror might peak in healthcare settings, where that future self exists in the extreme stages of life that many health professionals encounter almost daily. Do health professionals see and fear their future selves suffering in the weakened, shriveled bodies, scourged by chronic disease—incurable yet progressive, or in the throes of imminent death? Do they lack compassion? (Kagan, 2015). Or do their defensive minds trick them into believing they will become otherwise in their own waning years, and does that belief drive an incoherent logic to justify ongoing mistreatment of or negative attitudes toward older patients? (Jonson, 2012).

As older persons experience negative beliefs and attitudes about aging when they seek and receive needed healthcare, they risk internalizing those beliefs—an example of self-stereotyping. (Kagan, 2017). Some may adopt ageist phrases and attitudes, expressed in apologetic language or in jocular fashion. Prime example is the phrase "senior moment," which often reflects real or perceived brief memory lapses but may also be symptomatic of cognitive impairment or functional incompetence. Seniors might use the phrase as a socially acceptable excuse or concession for verbal or physical lapses. (Bonnesen & Burgess, 2004). As disparaging attitudes remain the norm in healthcare provision to senior adults, they affect the attitudes, cognitions, and behaviors of older adults. The cumulative effects result in chronic stress and high effort coping that influences physical health, which in turn can cause or contribute to premature aging, chronic disease, early mortality, and other adverse health outcomes. (Allen, 2016).

The intersection of longevity, an outcome of healthy lifestyles and improved medical technology and treatment, with pervasive ageism among healthcare professionals, however subliminal, creates a dichotomy for aging adults. Longevity becomes both a desired and feared consequence of life well-lived. A recent news article shows the effect of this conundrum in a poignant human way. (Saslow, 2019). As waves of boomers continue to wash upon the healthcare shore, social, economic, and political solutions must include a concerted effort to rid the healthcare milieu not only of chronic disease, but also of chronic ageism.

Ageism in the Workplace

The previous section discusses the increasing population of older adults in both numbers and percentage of total population. Additional studies examining not only the aging population but also the trends toward later retirement age, the effects of the Age Discrimination in Employment Act (ADEA) and its amendments, and fewer younger adults to enter the

workforce will result in a higher percentage of older persons across the workforce—with multilayered consequences. (Griffin, Bayl-Smith, & Barbour, 2017). A study by the American Association of Retired Persons (2013) predicted that by 2020 the 55+ age group would increase their share of the labor force by 38 percent. Moreover, the 65+ age group has surpassed the participation of workers 55-64, and the AARP study predicted participation rate by this age group in 2020 to be 22.6% of the total workforce. (American Association of Retired Persons, 2013). These trends have significant potential impact in economic and social terms, but what of their effect on age discrimination in the workplace?

Griffin and colleagues (2017) define age discrimination against older workers in several parameters: 1) overlooking them for promotion, 2) not offering training opportunities, 3) preferential hiring of younger workers, 4) forced redundancy, 5) ageist attitudes, and 6) treating older workers more poorly than their younger counterparts. Multiple studies, mostly qualitative in nature, have attempted to measure incidence and prevalence of workplace age discrimination, but with variable results. Nevertheless, subjective input from elders themselves indicates that such discrimination exists in all the categories described above. (Griffin, Bayl-Smith, & Barbour, 2017).

Generic factors that contribute to ageism in general also persist in the ageist treatment of older workers, i.e., stereotypes, social categorization, terror management, and organizational diversity. Most stereotypes do not spring from malevolence or harmful intent; they tend to be more insidious as a result of unconscious thoughts or feelings. (Posthuma & Campion, 2009). Indeed, some stereotypes may be positive, e.g., perception of older workers as wiser and having better interpersonal skills than their younger colleagues. However, negative stereotypes are more prevalent. (Griffin, Bayl-Smith, & Barbour, 2017).

Postuma and Campion (2009) conducted an extensive review of 117 articles and books describing prevalent ageist stereotypes in the workplace, evidence that refutes those stereotypes, and moderators of age stereotypes. Other studies support general stereotypes that exist in most workplaces. (Griffin, Bayl-Smith, & Barbour, 2017). The most prevalent stereotype assumes poor performance, i.e., that older workers have lower ability, less motivation, and less productivity than younger workers. In contrast, little evidence exists to support the notion of declining job performance as workers age. The converse appears to be true, that performance improves with age. Individual skills and health status seem more important than age in determining job performance. More differences in performance exist within age groups than between age groups. (Postuma & Campion, 2009).

A second prevailing ageist workplace stereotype holds that older people resist change and therefore are more difficult to train as they are less adaptable and less flexible than their younger colleagues. Therefore, older workers represent a lower return on investments in training and other performance-enhancing activities, an attitude that may lead to excluding older employees from training opportunities. A related stereotype suggests that older workers, perhaps due to assumed cognitive decline, have lower ability to learn and therefore less potential for career or job development. A third related stereotype suggests that older workers have shorter job tenure, and therefore represent a lower return on investment in training and other opportunities. In truth, research suggests that older workers are less likely to quit, less often seek more prestigious or high-paying jobs. Even if older workers have shorter tenure, the payback for investments in training is realized in the short term. (Postuma & Campion, 2009).

Another common workplace stereotype holds that older workers are more costly to the employer because they receive higher wages, use more benefits, and are closer to retirement. Related stereotypes hold that certain jobs or industries (e.g., information technology) require a "right" age, i.e., someone in a younger age group. However, little evidence exists to support these notions. Conversely, some evidence suggests that older workers are not more costly, need less training, their salaries generally level off after age 50, and they have lower rates of absenteeism. (Postuma & Campion, 2009).

Applewhite summarizes baseless ageist stereotypes that stunt workers' prospects in terms of the myths that older job seekers confront:

1) **Can't master new skills**. In truth, older workers score high in leadership, detail-oriented tasks, organization, listening, writing skills, and problem solving—especially if new tasks relate to their preexisting skill or knowledge.

2) **Aren't creative**. In truth, mixed-age teams are highly productive in areas that require creative thinking.

3) **Can't handle stress**. In truth, older persons have the experience, patience, and coping skills to put crises into context and ride them out.

4) **Slow things down**. In fact, output among older and younger people tends to be equal as younger persons work faster but make more mistakes, whereas older workers may work more slowly, but with better accuracy.

5) **Miss work because of illness**. As previously stated, this myth assumes an erroneous equation of age with illness.

6) **Can't handle physically demanding tasks**. On the contrary, most jobs today do not require manual dexterity or endurance. Health and experience are better indicators than age for predicting workplace fitness.

7) **Are burned out**, occupying space while waiting for retirement. Most data show that persons who continue working in their 60s and 70s enjoy their jobs and are happier in their work than younger counterparts. Applewhite concludes that "not one of the negative stereotypes that older workers confront holds up under scrutiny." (Applewhite, 2016, pp. 143-144)

Blackstone (2013) described the four most common behaviors that participants said they encountered at work: having their work contributions ignored (25.1%); being left out of decisions that affect their work (23.0%); being talked down to by coworkers (20.8%); and being talked down to by bosses (20.2%). All four of these experiences fueled older workers' sense of devaluation in the workplace. Twenty-four participants experienced verbal exchanges characterized by yelling or swearing. In response, 45.8% told a coworker; 33.3% told a boss; 8.3% told a family member or friend; 4.2% told someone else; and 37.5% told no one. Only one participant told an attorney or government agency about any experience, and that was in response to unwanted questions about his/her private life. Study participants were more likely to confront their harassers directly, especially if talked down to by coworkers or bosses.

Consequences of unproven ageist stereotypes in the workplace may include negative performance feedback, exclusion from innovative work domains, denial of promotion, and being

shut out of development opportunities. These factors in turn lead to negative effects on company performance. (Griffin, Bayl-Smith, & Barbour, 2017; Kunze, Boehm, & Bruck, 2011, 2013). Ageist stereotypes in the workplace, which are more attitudinal than fact-based, have the multidimensional negative consequence of inadequate utilization of experienced, tempered talent—with a resulting negative effect on company performance and competitive position in the marketplace.

In addition to the stereotypes described above, descriptive age-based norms also exist. These prescribe how an older worker ought to be and may motivate managers to decide what career or job milestones must be achieved by a certain age. Timing of retirement is another descriptive tenet that might discourage an older worker from continuing a job beyond traditional retirement age—no matter how capable or indispensable that older worker may be. (Griffin, Bayl-Smith, & Barbour, 2017).

Social identity theory and social categorization play a related role in the treatment and self-perception of older individuals in the workplace. Becoming a member of an in-group or out-group depends less on personal talents, experiences, and capabilities and more on arbitrary or trivial categories, such as age. (Rijswijk, Haslam, & Ellemers, 2011). As individuals strive to enhance their self-esteem by categorizing themselves as members of their chosen in-group, they are motivated to identify out-groups in terms of their differences (e.g., age), use negative stereotypes to defend against perceived out-group threats, and facilitate their own self-worth by acting on this bias. Such age-related categorization does exist within organizations. (Griffin, Bayl-Smith, & Barbour, 2017).

The previous discussion of terror management theory in ageism (i.e. fear of one's future older self) described two defensive strategies: physical avoidance of older people, and psychological avoidance by construing older people as "other" and therefore non-relatable. In the workplace, these defense mechanisms can play out in discriminatory hiring practices (albeit in violation of the ADEA), derogatory speech, or social isolation by not including older employees in workplace events. Additional defensive measures might attempt to build the younger person's self-esteem by denigrating older workers through negative stereotypes or discriminatory behavior that emphasizes the differences between the younger in-group and the older out-group. Carried to an extreme, such attitudes and behavior could lead to discrediting or devaluing the technical or professional experience and wisdom of the older person by characterizing the individual as "behind the times," unable to think clearly, or slow in mentation, memory, and speech. (Griffin, Bayl-Smith, & Barbour, 2017). In such cases, the organization suffers.

An earlier section discusses the effect of age discrimination as a stressor experienced by older adults. The same process occurs in response to ageism in the workplace. In such cases, the stressor threatens older worker's sense of well-being, actual or perceived status, access to social and managerial support, and advancement or other career opportunities. In response, the older worker may seek additional resources or connections to preserve the things they value, may devote additional time at work, above and beyond the minimum requirement, in order to outperform their younger colleagues or make themselves above reproach. They may try to identify with the more socially advantaged in-group; or conversely with the similar-aged out-group, creating additional division between older and younger workers. Alternatively, they may seek to de-identify themselves with their peer group, i.e., portray themselves as different in talent or work ethic from the aging out-group, and putting in additional hours, self-training, or other effort to prove their case. (Griffin, Bayl-Smith, & Barbour, 2017).

An older worker feeling the stress of age discrimination may take an opposite tack, i.e., reduce effort, disengage from work, or resort to counterproductive behavior. Taken to extreme, they may resort to discrimination claims or seek retribution in the form of court-mandated monetary compensation. These counterproductive behaviors tend to occur less often in organizations that emphasize reciprocity, i.e., demonstrate a nurturing, supportive milieu that will motivate the employees to respond in kind. A growing body of evidence suggests that age discrimination, group disparities, and real or perceived disenfranchisement of older workers can be mitigated or diminished in an inclusive work environment that supports and motivates workers on the basis of skills and productivity, and further recognizes the unique value that older workers bring to the organization's mission, goals, and objectives. (Griffin, Bayl-Smith, & Barbour, 2017).

Contrary to often endorsed ageist attitudes and behaviors in the workplace, the preponderance of data indicates that an organization that embraces not only cultural but also age diversity, eschews stereotypes and counterproductive management practices, and supports and rewards workers on the basis of performance and talent can achieve a more competitive position in the marketplace. In short, fostering age diversity in the workplace is a win-win tactic for both employers and workers.

Ageism Enters the 2020s

#OK Boomer; #OK Millennial

Sometime in the middle of the two-thousand-teens decade, society underwent cultural shifts that pushed ageism to the forefront of -ism discrimination. Due to multiple factors—including the discord-sowing impact of social media, divisive rhetoric and political polarization, and forced or chosen identification with antithetical loyalties to religious or political ideologies—time-cherished and society-honored concepts of decency, respect for differences in others, and polite discourse gave way to egocentric, tribal, and offensive attitudes and behavior. Except for those hard-core segments holding onto primal hatred of different others, racism, sexism, ethnicism, homophobia, and the like became off-limits for most Americans. Not so with ageism. Older adults became overt targets of bias, discrimination, and flagrant epithets like that directed in the past to differences in race, gender, national origin, sexual orientation, or beliefs. As one researcher put it, "Age-based prejudice is the last acceptable form of prejudice. People are making age-based generalizations and stereotypes that you wouldn't be able to get away with about race and background." (Michael North, New York University, in Heller, 2019).

From the perspective of many younger adults, especially those identified with the millennial or gen-Z generations, the so-called boomer generation is responsible for the declining health of the planet, waste of economic resources, college debt, dysfunctional national government, and even plastic straws. (Heller, 2019). Many of these younger adults perceive the boomer generation as a greedy, self-indulgent, wasteful monolith that ignored the needs of future generations, hocked their futures, and left them with fewer opportunities, lower incomes, and less education. This frustration spawned the flippant retort, "OK Boomer," meant to convey a fundamental disconnect between younger and older people, the latter perceived as clinging to outdated, off-base ideas. (Noguchi, 2019).

An older person rants about how they had to struggle and work hard to get what they have.

"OK Boomer."

An older person complains that young college students are too pampered and sheltered.

"OK Boomer."

An older person refuses to accept gender identification other than male or female.

"OK Boomer."

An older person denies the existence or threat of climate change.

"OK Boomer."

In short, "Okay, whatever you say." (Heller, 2019).

Some older people took serious umbrage with the phrase and its perceived intent, even equating it to the vilest of racial slurs. Others lashed out with youth-directed insults, using phrases such as "snowflake" to characterize a generation considered to be lazy, self-entitled, and unappreciative that their elders once faced daunting financial and social challenges, put on their grown-up pants, got to work, and earned their economic status instead of expecting it to be handed to them. A senior executive at AARP spoke out with an apparent retort that younger adults found offensive: "Okay, millennials, but we're the people that actually have the money." (Beachum, 2019).

Given the fiery polemics over these issues occurring at this time, can hope for intergenerational harmony, mutual respect, and cooperation survive through the next decade? Is modern society doomed to suffer further escalations of internecine conflict and polarization on multiple levels, including intergenerational hostilities, mistrust, and odium? Will older adults strike back by engaging in overt "youthism" as their defense against ageism? Or will they choose survival by adopting ageist stereotypes at the cost of self-esteem? Or will generations find a common ground, focus on problems and solutions rather than blame and prejudice, and discover shared values, aspirations, and futures.

Applewhite describes "the nature of prejudice: always ignorant, usually hostile. It begins as a distaste for others, and in the case of age (as opposed to race or sex), it turns into distaste for oneself." (Applewhite, 2016, p. 17).

Stripped of prejudice, innuendo, social media twists, divisive rhetoric, hostility, and ignorance, the current intergenerational divide, however flagrant it may appear, reduces to the same evidence-based and data-driven concepts discussed earlier. As one pundit puts it, "Generational conflict has been around since adolescents perfected the eye roll." (Heller, 2019). Actual evidence suggests that while ageism (and the "youthism" countermovement) demand current attention, significant positive data exists on which to build the bridges toward intergenerational mutualism. Previous sections of this monograph have examined the evidence that debunks many ageist stereotypes and prejudices. What about the millennial generation? What are the facts?

A recent Pew Research Center report highlights several important findings: In general, millennials are better educated than their grandparents, a factor that leads to improved employment opportunity and financial well-being. However, earnings for young adults have only increased for the college-educated, and women outpace men in college completion. In 2018, the median income for millennials with a college education more than doubled that of their peers with only a high-school education. Beginning with the boomer generation and increasing through the Gen X and millennial generations, young adult women remain employed (72% for millennials vs. 40% for the "silent generation"). Compared to previous generations, millennials delay or forego marriage or forming their own households, and millennials without a bachelor's degree tend to still be living with their parents. Gen Xers and younger generations, including millennials, now make up the majority of eligible voters in the US. Whether they exercise that privilege in 2020 could have significant impact on the nation's future course. Finally, in 2020 millennials will number 73 million, surpassing baby boomers as the largest living adult generation. (Bialik & Fry, 2019).

Given the actual evidence and demographic realities, a prescription of cooperation based on mutual concerns and recognized facts seems a better strategy toward solving intergenerational conflict and reaping the benefits of teamwork. However difficult or imperfect initial efforts at finding common ground may be, they promise better results than continued hurling of insulting epithets or posting of derogatory memes on social media.

Conclusion

In late 2019, two older men—a 69-year-old and a 73-year-old—jogged together on their regular Saturday morning 6-miler, a life-prolonging fitness routine they have shared for 16 years. In the course of conversation, the older gentleman learned that the soon-to-be septuagenarian did not know the term, "ageism." He was familiar with racism, sexism, anti-Semitism, and homophobia, but had never heard of ageism. As these two elders continued their run, the one explained the concept of ageism to the other. Soon, a young male runner—estimated age mid-30s—approached them at a brisk pace. When he reached the older pair, he stopped, pulled out a smartphone, took a "selfie" with the elders, and congratulated them on their extraordinary fitness effort. As the young man resumed his run, one of the elders, a veteran of over 100 marathons, commented to his companion that they had most likely taken up running before their youthful admirer was born.

Was that an ageist encounter? Maybe. Maybe not. Perhaps the young runner's admiration for the older men stemmed from a learned stereotype that older adults are incapable of or not interested in aerobic exercise. Perhaps the older runners misjudged his enthusiasm, instead of accepting his admiration that men more than twice his age were still capable of his chosen pursuit. Perhaps his congratulatory demeanor reflected his own terror management determination to avoid the effects of aging. "When I grow up, I want to still be running like these two, not be confined to a wheelchair or bed—or worse."

The experience of aging is a personal experience. To whatever extent tempered by positive attitude, health maintenance, or fitness activities, aging remains the inevitable consequence of living. How one ages, and how one perceives or reacts to ageist behaviors of others, becomes a personal choice (within limiting parameters). Programs or initiatives designed to empower

older persons to adopt a self-actualizing aging strategy that rebuffs stereotype embodiment are examples of combating ageism on the individual level. The AARP provides several options, including a recent "Staying Sharp" online program. Other examples might include fitness and community centers; although these may risk isolation if not based on a heterogenous age population. Perhaps most effective are those enlightened workplaces that integrate older persons into strategic and production teams that foster inter-age collaboration to enhance the final product.

Beyond one's personal management of the process and its consequences, older adults affected by ageism must take up their own cause, just as those who fought racism, sexism, homophobia, and the like have long done with measurable success. Whether ageism is a social oppression as Applewhite (2016) suggests, or an ongoing stereotype, or an intergenerational conflict, unless ageism is called out and confronted, it will perpetuate; not only as a conscious prejudice or deliberate discrimination against groups and individuals, but through any older person's subjugating acceptance and self-embodiment. Without persistent, committed advocacy by and on behalf of older persons, the scourge of ageism will continue to plague society and diminish the potential contributions of its most experienced members.

For old age is respected only if it defends itself, maintains its rights, submits to no one, and rules over its domain until its last breath.
– Marcus Tullius Cicero



Photo by Sharada Prasad

Old Hands

As you grow older, you will discover that you have two hands, one for helping yourself, the other for helping others. – Audrey Hepburn

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The Obesity Epidemic and the Application of Kingdon's Theory of Multiple Streams

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Abstract

Public health researchers are concerned with rising obesity rates, which have triggered greater focus on higher-quality nutrition consumption. As a result of the obesity epidemic, the U.S. Congress has mandated programs such as the Food Insecurity and Nutrition Incentive (FINI) program, which extended the Agriculture Improvement Act of 2014 (Farm Bill). This program is designed to reduce the incidence of unhealthy eating by incentivizing individuals to consume more fruits and vegetables through a prescriptive initiative. However, barriers such as military sustenance allowance and the number of individuals in a household, or "household count," were highlighted in a Government Accountability Agency (GAO) report, *DOD Needs More Complete Data on Active-Duty Servicemembers' Use of Food Assistance Programs*, which may affect junior-ranking military personnel. The report also disclosed that a large subset of junior-ranking military personnel subsists at low-income levels and are currently struggling to make ends meet, with cost exerting the greatest effect on their food options. This policy article analyzes an aspect of the Farm Bill (FINI program) using John Kingdon's multiple-streams framework in order to offer two policy proposals that may increase higher-quality nutritional consumption among junior-ranking military personnel.

Keywords: Farm Bill, Food Insecurity and Nutrition Incentive Program (FINI), obesity, military

Introduction

According to the Centers for Disease Control (CDC), $1.5 billion is incurred annually in obesity-related healthcare costs (CDC, 2019; Stokes, Ni, & Preston, 2017). Obesity is defined as relating to an individual having a body mass index greater than 30 kg/m^2 (Rush, LeardMann, & Crum-Cianflone, 2016; Stokes et al., 2017). Obesity can affect an individual's psychological wellbeing and quality of life. Currently, it is a primary cause of chronic health conditions, the most significant one being cardiovascular disease (Breland, Donalson, Nevedal, Dinh, & Maguen, 2017; Brug, Kremers, Lenthe, Ball, & Crawford, 2008; Tanofsky-Kraff et al., 2013). Obesity tops the policy priorities of several agencies such as the U.S. Department of Agriculture (USDA) and the Department of Defense (DOD), and has been noted by several high-level congressional committees. These entities have universally recommended strategies to deter an increase in obesity cases and to reduce the current levels. Some causes of rising obesity rates include increased fast-food intake, decreased fruit and vegetable consumption, poor lifestyle choices, lack of physical activity, genetics, and inequitable access to markets and stores that offer healthier food choices (Webber, Sobal, & Dollahite, 2010). For some time, researchers have noted the effects of obesity on the civilian population, but it is now clear that the problem is similarly widespread within the military population. In fact, the CDC estimates that obesity costs the nation $103 million in lost job productivity and factors into the 71% of young adults in the United States who are unfit to serve in its armed forces (CDC, 2019).

With this in mind, Congressman Frank Lucas from Oklahoma (Congress, 2014a) introduced and sponsored the Agriculture Improvement Act of 2014 (Farm Bill). This multi-year bill not only addresses disparities in food security and rural and environmental policies, but may also improve warfighter nutrition in its revised bill of 2018. The policy analysis in this report will examine the benefits and constraints of the Farm Bill's Supplemental Nutrition Assistance Program (SNAP) as it relates to military personnel and reviews the latest solutions to the problem of insufficient fruit and vegetable consumption. To this end, Kingdon's (1995) multiple-streams framework will provide an illuminating model to approach the obesity crisis.

Kingdon's Multiple Streams

Kingdon's multiple-streams framework encompasses several explanations of how ideas are incorporated into the governmental agenda, how solutions are proffered, and the means by which these proposed solutions evolve into law. Kingdon's multiple-streams framework has been applied to various topics such as tobacco cessation, immunization programs, and other public issues that may exert a political will. Kingdon's model indicates three streams to analyze and address: problem streams, policy streams, and political streams (Kingdon, 1995a). Other contributing factors include the promulgation of a problem by interest groups and the media, and shifts in the national mood, all of which play a role in the general perception that new laws should be proposed and passed. When streams converge, they create policy opportunities to introduce legislation that may eventually become law. Once a law affects one segment of society, there is a good chance it will spill over to adjacent segments.

Problem Streams

Kingdon defines problem streams as those activated by indicators, events, or crises (Kingdon, 1995b). In regard to the obesity epidemic, noticeable indicators of rising healthcare costs associated with obesity and comorbidities ensued. For instance, in 2014 the economic burden of obesity in the United States was estimated at $2 trillion (Tremmel, Gerdtham, Nilsson, & Saha, 2017). Also, in 2013, the Military Health System (MHS) absorbed medical-related costs of $1 billion in obesity-associated claims. At the same time, research reports brought closer scrutiny to the rising overweight and obesity rates within the active-duty military community (Tanofsky-Kraff et al., 2013). Due to the rising medical costs of obesity and associated comorbidities, the government agenda included this problem stream as described by Kingdon (1995). In fact, the Farm Bill received great support from both the House and the Senate (after some convincing) due to economical threats (Congress, 2014b). Further solutions to obesity were proposed that would modify the SNAP program, such as encouraging healthier food options. In addition, some states passed sugar taxes to reduce sugar consumption. The problem stream of rising medical costs and economic burden increased the urgency of the issue on the federal government's agenda.

Policy Streams

According to Kingdon (1995), the element of "primeval soup" (policy streams) also increases the chance that a problem will be recognized and addressed on the government's agenda. This "primeval soup" results when several ideas about a situation float around and bump into one another (Kingdon, 1995c). When this occurs, some ideas float to the top while others do not. Those that take precedence do so because they interest a critical mass of community specialists or policy communities composed of researchers, interest groups, and health or environmental specialists. In addition, they may present papers, proposals, briefs, or testimonials to persuade the public. The Farm Bill took up the concerns of individuals and policy entrepreneurs such as Congressman Frank Lucas, the then Agriculture Committee chairman, to elicit significant interest. Additionally, agencies like the USDA and the American Heart Association sounded the alarm on rising obesity rates. These organizations proposed solutions that would increase fruit and vegetable consumption and simultaneously benefit local farmers, who would provide fresh produce to consumers.

Advocates who claimed that obesity had become a public health epidemic triggered the development of the Health Initiative Incentives program. This successful pilot program became the impetus for the 2014 Food Insecurity and Nutrition Incentive Program (FINI), which was housed under the Farm Bill's Supplemental Nutrition Assistance Program (SNAP) (Berkowitz, Seligman, Rigdon, Meigs, & Basu, 2017; Mozaffarian et al., 2018). The purpose of FINI is to provide access to healthier foods such as fruits and vegetables through a prescriptive partnership between an individual's health or nutrition provider and participating grocery stores. Eligible participants for this incentive include individuals with low incomes who are at risk of developing chronic health conditions (Mozaffarian et al., 2018).

Political Streams

According to Kingdon (1995), political streams can include changes in organizational administration or alterations in national health priorities. Regarding the obesity epidemic, several political forces shaped national perceptions. For example, studies showed that higher obesity rates resulted from individuals dining out while unaware of the high caloric content of the foods they were consuming. The Obama administration's Let's Move! campaign brought greater awareness for an opportune window (Obama, 2012; Penney et al., 2017; Story, Kaphingst, Robinson-O'Brien, & Glanz, 2008). These political streams helped to shape public opinion, enhance bipartisanship, and increase traction for public health initiatives on the government agenda. The existing national priority to reduce childhood obesity further supported the success of Let's Move! It is important to note that one stream alone cannot bring to fruition a program that requires the effort of multiple streams to create the synergy necessary for "primeval soup" (Kingdon, 1995a). In essence, the convergence or "coupling" of the three streams provides greater impetus to set agendas and formulate legislation that eventually becomes law (Kingdon, 1995a).

The Power of Spillovers

While the FINI program housed under the Agricultural Improvement Act of 2014 should be applauded for its bipartisan passage, there is a value-added opportunity to increase the promotion of fruit and vegetable consumption among junior-ranking military personnel. This is the potential of spillover, which Kingdon (1995a) defines as a phenomenon that occurs once a principle has been established to the degree that its acceptance encourages results in areas adjacent to the primary one. A hypothetical example, one with potential for implementation, involves the economic barrier to a subset of junior-ranking military personnel who receive FINI incentives according to modest levels of sustenance pay based on household count. Most of those affected are junior-ranking military personnel (i.e., E-1 through E-4) desiring FINI incentives for healthier eating (GAO, 2016). They may qualify for the FINI program based on their income status but not their sustenance allowance. In fact, stipulations may inadvertently disqualify military personnel from procuring FINI incentives. For example, some stipulations require an applicant to reach a certain household count in order to qualify. Take, for instance, the case of a junior-ranking military member (i.e., E-1) with one child who is struggling to make ends meet; due to the stipulations of household count and insufficient dependents, they would not qualify for a need-based incentive. For this reason, several states have been forced to navigate military pay constraints such that soldiers can qualify for FINI incentives. Unfortunately, not all states have a mitigation strategy to account for this policy issue. Thus, as future Farm Bill proposals are considered while military obesity rates continue to climb, alternatives or amendments to the current bill may help decrease unhealthful dietary choices for junior-ranking military personnel. To address poor dietary habits among low-income soldiers and promote healthy eating, other possible initiatives may include modified farm bills and higher taxes on unhealthy food. For example, at the municipal level, certain large American cities have introduced surtaxes on sugar-added beverages, thereby incentivizing the consumption of more healthful choices such as fruit and vegetable juice.

Proposal One

The need to decrease constraints that block access to fruits and vegetables is evident. According to one major GAO report that monitored the progress of soldiers, nutritional barriers, and Farm Bill implementation, active-duty soldiers spent more than $21 million-worth of food stamps at their local commissaries from 2014 to 2015 (GAO, 2016). In the same report, the researchers acknowledged that the financial burdens of some military members may disadvantage them from making healthy dietary food choices (GAO, 2016).

Although the SNAP program currently offers incentives whereby military personnel qualify for food stamps based on income criteria, there remains a major gap in delivering incentives to struggling junior-ranking military personnel (GAO, 2016). As a proposed solution, a macro-level policy revision of the FINI program should exclude military sustenance allowance and household count from the formula to determine food stamp eligibility. This policy change may improve warfighters' health status by encouraging nutritious food options in the form of fruits and vegetables from local participating grocery stores and markets. The advantage of this proposal is that the recommended intake of fruits and vegetables ensures that funds are spent on nutritious foods instead of lower-cost consumables with high sugar and fat content.

One danger in enacting this proposal is that individuals may fear stigmatization if others learn that they rely on a government food-assistance program (Gaines-Turner, Simmons, & Chilton, 2019). While the SNAP program offers incentives to supplement a family's income and increase the quality of consumable foods in the home (Berkowitz et al., 2017), little research has been conducted into whether such incentives have a paradoxical effect, that is, whether they disincentivize recipients who fear the social stigma of accepting government aid to assist with household expenses. Nevertheless, there are some advantages to instituting a revamped policy. Since the FINI program is designed to increase fruit and vegetable consumption, eliminating sustenance pay as a stipulation would decrease financial hardship among military personnel.

Proposal Two

A second proposal would increase junior soldiers' sustenance allowances so that personnel within this group automatically receive additional funding to assist in purchasing healthier foods and decrease financial burdens. Also, nutrition education should be implemented at the entry point of a military member's career and throughout their career lifecycle in an effort to optimize healthier food choices. Perhaps the best timepoints to incorporate nutrition education training occur during milestone military school trainings, where a nutritionist or qualified healthcare professional with a nutrition-related background could facilitate lessons. Equipping soldiers with the best nutritional options improves health outcomes.

One possible benefit to this proposal is that, unlike the FINI program where funding is allocated specifically for fruits and vegetables, this option is designed to encourage individuals to make healthy food choices that improve their entire diet. The advantage of this option is that there is no social stigma linked to using a government-sponsored program to assist with food purchases.

Conclusion

Alternative policy proposals in the Farm Bill seek to address rising obesity rates and improve the diet of our country's most precious human capital, military servicemembers. We must seek to improve on the current Farm Bill by allowing junior-ranking military personnel to obtain fruit and vegetables incentives without stipulations of military pay allowances and household count. Kingdon's (1995) multiple streams theory provides a valuable framework to describe how a prosocial idea progresses through various political stages to become law.

Although the 2014 Food Insecurity and Nutrition Incentive (FINI) program from the Farm Bill was discussed in this article, it is important to note that the 2018 Farm Bill has not addressed the aforementioned concerns over stipulations of military pay allowances and household count that may impose barriers for some military members to receive incentives for the purchase and consumption of fruits and vegetables. Implementation of the 2014 Farm Bill illuminated further considerations for military members who may be disadvantaged by stipulations of military allowances and household count. As a further recommendation, ongoing discussions of policies that reduce financial burdens and advocate for improved nutrition among military personnel should include the Armed Services Committees.

In conclusion, as public health concerns stemming from an obesogenic environment continue to grow, future discussions on a wider civilian scale should be contemplated by applying John Kingdon's multiple streams theory in order to optimize health solutions. For instance, the National School Lunch Program (NSLP), which provides low-or no-cost breakfast and lunches to school children in need, has garnered greater public attention since making changes in healthy food choices. After high school, however, the financial burden of rising college tuition rates has impacted the quality of student diets. At present, the NSLP solely provides nutritious meals until a student reaches the age of 18. Extending the NSLP through the age of 21 may offer a cost-effective way to decrease the rising obesity rates and increase diet quality among college students. All in all, efforts to maximize access to healthy food choices in both the military and civilian population may help to improve health outcomes and decrease rising obesity rates.

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Detection of ESBL-Producing *E. coli* Isolates from Selected Water Sources in Abakaliki, Nigeria

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Abstract

Recently, there has been concern that some strains of *Escherichia coli* can produce small proteins (enzymes) called extended-spectrum beta-lactamases (ESBLs). Hence, this study was designed to evaluate the ESBL production by multidrug resistant (MDR) *E. coli* isolates obtained from wells and borehole water samples using double disc diffusion synergy test (DDST). The resistance and susceptibility patterns of the isolates were determined by the Kirby and Bauer susceptibility test method. The results indicate that the *E. coli* isolates were highly resistant to Ceftazidine, Cefuroxime, Cefotaxime, Ceftriaxone and Amoxicillin/clavulanic acid which belong to the class Cephalosporins and Penicillins, thereby prompting the need for this test so as to ascertain if ESBL was responsible for their high resistance to the conventional antibiotics used. Out of the 36 isolates used for this study, only three isolates (8.3%) from the well water samples were positive for ESBL production. This study concluded that while the prevalence of ESBL producing E. coli isolates in these water samples is currently not very high, it may increase rapidly and may lead to a serious health problem, if not treated appropriately.

Keywords: Escherichia coli, extended spectrum beta lactamases, antibiotics, multidrug resistance, Double Disc Synergy Test

Introduction

This article has emerged from research that was conducted as a means of understanding the serious problem of water-borne disease outbreaks in Ebonyi State due to local conditions. The scientific explorations that follow in this article are from the author's doctoral research conducted in the period from 2015-2018. The author's research central to this article originally aimed at looking for ESBL-producing organisms in the water samples collected because they may cause antibiotic resistance in humans, thereby making treatment difficult. Therefore, the original research and this article are critically important for understanding factors around infectious disease prevalence. Such understanding is critical for microbiological scientific discoveries for the advancement of needed healthcare innovations and needed approaches to successful healing practices.

Beta-lactamases (β-lactamases) are enzymes produced by bacteria that provide multi-resistance to β-lactam antibiotics such as penicillins, cephamycins and carbapenems (ertapenem), although carbapenems are relatively resistant to beta-lactamase. Beta-lactamase provides antibiotic resistance by breaking the antibiotics' molecular structure. These antibiotics all have a common element in their molecular structure: a four-atom ring known as a β-lactam. Through hydrolysis, the lactamase enzyme breaks apart the β-lactam ring, deactivating the molecule's antibacterial properties. Beta-lactam antibiotics are typically used to treat a broad spectrum of Gram-positive and Gram-negative bacteria. Beta-lactamases produced by Gram-negative organisms are usually secreted when antibiotics are present in the environment (Neau, 1969).

ESBL (Extended Spectrum Beta-lactamases) are mostly produced by Gram-negative bacteria with *Escherichia coli* (some strains) and *Klebsiella* species being the most common ESBL producing bacteria (Abera et al., 2016). These enzymes breakdown commonly used antibiotics such as penicillins and cephalosporins and render them ineffective for treatment. The abbreviation--ESBL has now become common and describes resistance to β-lactams conferred through production of beta-lactamase enzymes which break down β -lactam antibiotic molecules (Sibhghatulla et al., 2015). If an ESBL-producing bacterium causes an infection, a different antibiotic may need to be used to treat the infection. People who carry ESBL-producing bacteria, without any signs or symptoms of infection, are said to be colonized. The most common ESBL-producing bacteria are some strains of *Escherichia coli* and *Klebsiella peumoniae*. ESBLs are spread via direct and indirect contact with colonized/infected patients and contaminated environmental surfaces. ESBLs are most commonly spread through unwashed hands of health care providers (PIC-NL., 2011)

The ESBLs are frequently plasmid encoded (Deepti *et al*., 2010). Plasmids responsible for ESBL production frequently carry genes encoding resistance to other drug classes (for example, aminoglycosides). Therefore, antibiotic options in the treatment of ESBL-producing organisms are extremely limited. Carbapenems are the treatment of choice for serious infections due to ESBL-producing organisms, yet carbapenem-resistant (primarily ertapenem resistant) isolates have recently been reported (P.H.A.C., 2010). ESBL-producing organisms may appear susceptible to some extended-spectrum cephalosporins. A number of studies have documented the presence of ESBL in food and water. These pathogens gain entry into humans by the faecal-oral route, with the common source being water contaminated with animal excreta and food contaminated with faecal pathogens (Walsh et al., 2011; Kluytmans et al., 2013).

It is essential that antibiotics are only used when necessary and, when they are needed, the full dose and full course of the antibiotic must be taken. This will help to reduce the number of bacteria that are becoming resistant to antibiotics.

Methods

Antimicrobial Susceptibility Studies

The resistance and susceptibility patterns of the isolates were determined by the Kirby and Bauer susceptibility test method as recommended by the National Committee for Clinical Laboratory Standards (NCCLS), now the Clinical Laboratory Standard Institute (CLSI). An overnight culture of the test bacteria grown in nutrient broth (Oxoid, UK) was adjusted to 0.5 McFarland turbidity standards. The inoculum was aseptically inoculated on the surface of Mueller-Hinton (MH) agar plate(s) using sterile swab sticks. Fifteen (15) Single antibiotic disks from different classes were aseptically impregnated on the surface of the inoculated Mueller-Hinton agar. The antibiotics discs include tobramycin (10 µg), amikacin (30 µg), cefuroxime (30 µg), cefoxitin (30 µg), ceftazidime (30 µg) and cefotaxime (30 µg), imipenem (5 µg), meropenem (5 µg), ertapenem (5 µg), amoxicillin\clavulanic acid (30 µg), sulfamethoxazole\ trimethoprim (25 µg), nalidixic acid, (3 µg) ofloxacin (5 µg) and ciprofloxacin (5 µg) (Oxoid UK). The plates were incubated at 37°C for 18-24hrs, and the inhibition zone diameters (IZDs) produced by the antibiotic disks were measured with a meter rule and recorded and the inhibition zone diameter was compared to the standard breakpoints of the CLSI (CLSI, 2015).

Phenotypic Determination of ESBL Production by DDST

The *E. coli* isolates were highly resistant to Ceftazidine, Cefuroxime, Cefotaxime, Ceftriaxone and Amoxicillin/clavulanic acid which belong to the class Cephalosporins and Penicillins, thereby prompting the need for this test as to ascertain if ESBL was responsible for their high resistance to the conventional antibiotics used. The evaluation of ESBL production by the test isolates in this study was done using the double disc synergy test (DDST) as was previously described by Iroha et al. (2008).

Isolates suspected of producing ESBL after being screened with cephalosporins--ceftazidime (30µg), (30µg), and cefotaxime (30µg)--were swabbed on a Mueller-Hinton (MH) agar plates. A disk containing amoxicillin/clavulanic acid (30µg) was placed at the center of the MH agar plates and any of the above cephalosporins (ceftazidime and cefotaxime) was placed adjacent to the central disk at a distance of 15 mm. After an overnight incubation at 37°C, a ≥ 5 mm increase in the inhibition zone diameter for either of the cephalosporins tested in combination with the central disk versus its zone when tested alone confirms ESBL production phenotypically by the DDST method (Iroha et al., 2008).

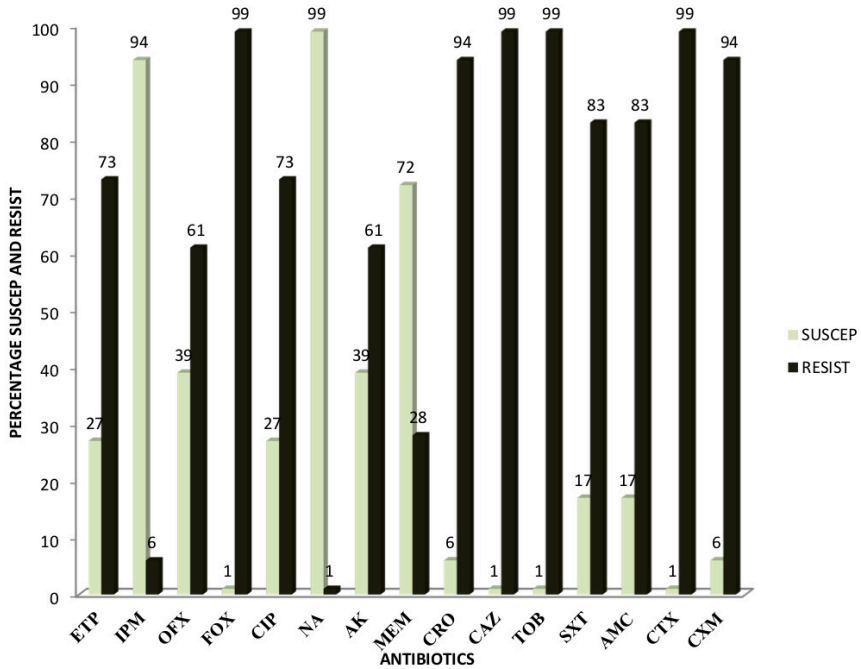
Isolation, Identification and Characterization of Escherichia coli

Pour plate method was used to determine the total viable count of bacteria. Serial dilutions of the water samples (Boreholes and Well water) were carried out aseptically up to 10^4 dilutions. Dilutions were plated out for enumeration and isolation of bacteria on nutrient agar and were

incubated for 18-24 hrs at 37°C. Colony growth were sub-cultured to obtain pure culture and were plated out on different selective media such as Eosin methylene blue (EMB), MacConkey agar and Cystine Lactose Electrolyte Deficient agar for further characterization and identification (Chessbrough, 2006).Standard microbiological techniques were used to identify and characterize the bacteria isolates which includes the following: gram staining, motility test, catalase test, Voges-Proskauer test, indole test, oxidase test and sugar fermentation test.

Results

E. coli is one of the most common ESBL producing bacteria. Because the *E. coli* in the collected samples was highly resistant to the antibiotics used in this study (especially cephalosporins), the isolates from both water samples were screened for ESBL production. Three isolates from the well water samples produced ESBL and none from the borehole water samples. The following figure and two tables from the study provide highlighted detail for these results.



KEY: ETP = Ertapenem, IPM = Imipenem, OFX = Ofloxacin, FOX = Cefoxitin, CIP = Ciprfloxacin, NA = Nalixidic acid, Ak = Amikacin, MEM = Meropenem, CRO = Ceftriazone, CAZ = Ceftazidime, TOB = Tobramycin, SXT = Trimethroprim/Sulfamethoxazole, AMC = Amoxicillin/clavulanic acid, CTX = Cefotaxime and CXM = Cefuroxime.

Figure 1. Antibiotics susceptibility pattern of E. coli isolated from well water samples collected from different locations in Abakaliki Metropolis.

Table 1. Frequency of isolation of ESBL producing E. coli from borehole water samples collected from different locations within Abakaliki Metropolis.

SAMPLE CODE	ESBL NEGATIVE	ESBL POSITIVE
AB_3	-	
AB_2	-	
AB_3	-	
AGB_1	-	
AGB_2	-	
KPB_1	-	
KPB_3	-	
UB_1	-	
UB_2	-	
UB_3	-	
UB_4	-	

KEY: AB = Azuiyiokwu, KPB = Kpirikpiri, UB = Udensi, AG=Aguogboriga

Table 2. Frequency of isolation of ESBL producing E. coli from well water samples collected from different locations within Abakaliki Metropolis.

SAMPLE CODE	ESBL NEGATIVE	ESBL POSITIVE	SAMPLE CODE	ESBL NEGATIVE	ESBL POSITIVE
AW_1		+	KP W_1		+
AW_2		+	KP W_2	-	
AW_3	-		KP W_3	-	
AW_4	-		KP W4	-	
AW_5	-		U W_1	-	
AW_6	-		U W_2	-	
AW_7	-		U W_3	-	
AW_8	-		U W_4	-	
AW_9	-				
AW_{10}	-				
AW_{11}	-				
AW_{12}	-				
AW_{13}	-				
MW_1	-				
MW_2	-				
MW_3	-				
MW_4	-				
MW_5	-				

Key: AW = Azuiyiokwu well water, MW = Mile 50 well water, KPW = Kpirikpiri well water,

UW = Udensi well water

Discussion

Of the 36 *E. coli* isolates from both borehole (11) and well (25) water samples, only three (3) isolates from well water samples were ESBL positive while others were ESBL negative. The decreased susceptibility of ESBL producing *Escherichia coli* to the tested antibiotics may be due to the multidrug resistance gene in plasmids that they are harbouring (Rooney et al., 2009). However, the non ESBL producing *Escherichia coli* were also significantly ($P<0.05$) resistant to the various antibiotics tested. All ESBL positive *E. coli* strains were resistant to cefotaxime, ceftazidime and ceftriaxone. This result obtained in this study is in agreement with the study done by Islam et al.(2014) and Sharma et al.(2013) that also identified *E.coli* isolates which were resistant to cefepime, cefotaxime, ceftazidime and ceftriaxone but remained susceptible to imipenem. This study is also in line with the study of Sompolinsky et al. (2015) whose findings also showed that identified *E. coli* isolates were resistant to cefepime, cefotaxime, ceftazidime and ceftriaxone and after performing phenotypic confirmation test on these isolates, they were confirmed ESBL producers.

ESBL positive isolates also showed high degree of resistance to other antibiotics like cefoxitin, cefuroxime, nalidixic acid, ciprofloxacin and ofloxacin. ESBL positive strains being resistant to cefoxitin is abnormal, as they may be harboring ESBL and Amp-C, where Amp-C is more expressed than ESBL, they become resistant to cefoxitin. Antimicrobial resistance surveillance done by Nepal Public Health Laboratory (NPHL) found that ESBL *E. coli* were susceptible to imipenem (98.5 %), and amikacin (96.1 %). High percentages of isolates were susceptible to the carbapenems. The study done by Kader and Angamuthu (2005) revealed more than 89 % of the ESBL producers were susceptible to imipenem and meropenem, however this study is slightly in contrast to the reports of Mekki et al. (2010) who found 100 % MDR *E.coli* isolates to be sensitive to the carbapenems.

The isolation of *E. coli* expressing ESBL enzyme should be considered as a signal of an urgent need for proper sanitary method and inspection of all water producing municipal stations to enforce that water production is according to WHO standards (2006). This will help in eradicating the existence of these resistance organisms that could lead to a very serious public health problem in the near future. ESBL producing organisms are known worldwide to harbor multidrug resistance genes in plasmids, which confer resistance to wide range of antibiotics. The majority of these wells are poorly constructed and sited near pit latrines as we observed making them vulnerable to contamination. The presence of *E.coli* detected in the various well water sources could possibly be due to heavy contamination of faecal bacteria origin emanating from heavy rainfall patterns resulting into floods and indiscriminate disposal of garbage which poses a potential public health hazard (Ramphal and Ambrose, 2006).

Conclusion

The results showed that *E. coli* isolates concealing ESBL enzymes are multi-drug resistant and may have substantial therapy challenges. Organisms may easily transfer ESBL-containing plasmids to other organisms because bacteria readily exchange drug resistance plasmids amongst themselves, the 8.3% ESBL samples from wells could swiftly increase if given the opportunity, such as in a flood. Results of antibiotic sensitivity tests in our study revealed that ESBL-producing isolates were more resistant to certain members of cephalosporins, floroquinolones and aminoglycoside antibiotics than carbapenems. Antibiotic resistance has been reported

in different parts of the world where *E. coli* was found to be resistant to all fluoroquinolones, aminoglycoside and some beta lactam antibiotics (Pruss et al., 2002).

In conclusion, the result of this study confirmed the presence of ESBL producing *E. coli* isolates that are multi-drug resistant and thus, are difficult to treat also while the prevalence of ESBL producing *E. coli* isolates in these water samples is currently not very high, it may increase rapidly and may lead to a serious health problem, if not treated appropriately. This is an important screening procedure for water safety in communities. It will inform proper placement of wells and latrines.



Photo by: Uncle Udeaku 2016

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Joanna Macy, PhD: The Tireless Voice of a Wise Elder Activist

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Author Note

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Abstract

One is never too old to be a catalyst for positive change. Indeed, the voices of our elders are needed now more than ever. Joanna Macy is a prime example. The seasoned activist, still writing, continues to advocate for social and environmental justice as she elucidates the intersection of Buddhism and systems science. The challenge for humanity is to awaken, demonstrate care for one another over financial gain, change our thinking and behavior, and celebrate life on Earth.

Keywords: Buddhism, ecology, social justice, environmental justice, systems theory

Introduction

The most remarkable feature of this historical moment is not that we are on the way to destroying our world—we've actually been on the way quite a while. It is that we are beginning to wake up, as from a millennia-long sleep, to a whole new relationship to our world, to ourselves, and to each other. Active Hope is waking up to the beauty of life on whose behalf we can act. We belong to this world.

– Joanna Macy
Joannamacy.net

This is how Joanna Macy, PhD sees humanity at this time in the story of our existence.

Joanna is a visionary, anti-nuclear activist, writer, deep ecologist, systems theorist, teacher, Buddhist scholar and, at 90, a wise elder. It has been a long and circuitous life journey, woven by the threads of spiritual seeking, insatiable curiosity and passion for justice and activism. Her work "addresses psychological and spiritual issues of the nuclear age, the cultivation of ecological awareness, and the fruitful resonance between Buddhist thought and postmodern science." (*Joanna Macy and Her Work:* www.joannamacy.net)

For 40 years Joanna taught her signature program *The Work That Reconnects*, a practice that:

> . . . helps people transform despair and apathy into constructive, collaborative action. It brings a new way of seeing the world as our larger living body. This perspective frees us from the assumptions and attitudes that now threaten the continuity of life on Earth. (*Joanna Macy and Her Work:* www.joannamacy.net).

Put another way, the work guides participants to "find solidarity and courage to act, despite rapidly worsening social and ecological conditions." (*Coming Back to Life*, p. xviii) Her work continues, unabated, through the numerous facilitators trained to teach it. To provide a full portrait of Joanna Macy's important leadership in these critically important areas, this article presents a recent interview with her. The interview Joanna Macy granted for this Journal article in August 2019 is excerpted below following a biographical sketch.

Background

Joanna Rogers, a Depression era child and the middle of three children, was born in California and grew up in New York City, where she was educated at the Lycée Français. Her father, a Yale graduate, chose a life outside the Protestant ministry of his forbears and became a stock broker and an angry, controlling and withholding individual.

Life in New York City was fraught with tension, and Joanna longed for peace. She felt most at home at her paternal grandfather's farm, east of Buffalo. The seven summers she spent there from ages 9 to 16 would inspire the growing girl's lifelong bond to nature and spirituality, reinforced by her relationship with a maple tree and a horse.

Joanna's troubled teenage years coincided with World War II. She found refuge inside New York City's Cathedral of St. John the Divine and at a conference for young Presbyterians where she felt a deepening connection to God and Jesus. During the summer of 1946, before entering Wellesley College, Joanna participated in a Presbyterian youth program where she led worship services and taught Bible School, which influenced her academic choices.

At Wellesley, she pursued a major in Biblical History, only to become disheartened in her senior year by neo-orthodox theology and its dialectics. What once had felt like her vocation had come to feel burdensome and suffocating. When a favored professor noticed her resistance and challenged her to relinquish her Christianity, she realized she could choose to walk away. It would take Joanna years --- through worldly travels, studying international conflicts, marriage to Fran Macy, mothering three children, life overseas and engagement with Tibetan refugees --- to redefine her identity and find the Buddhist path that truly spoke to her soul.

Upon returning to Washington, DC in 1969, Joanna committed herself to civil rights work and anti-war action. Hungry for intellectual stimulation, she took graduate courses in world religions, particularly Buddhist philosophy and, in 1972, when her husband's work took the family to Syracuse, she entered Syracuse University's graduate program in religion. In 1974, Joanna happened upon and enrolled in a Religion Department seminar on general systems theory. "Almost immediately I saw that the systems view of reality fit the patterns I had been seeing...flows of energy, matter, information--flows that interacted in coherent patterns, patterns that gave rise to cells and galaxies and minds." (*Widening Circles*, p.142)

Studying systems theory, a Western discipline, enlivened and consumed Joanna, for it confirmed an ancient Buddhist Dharma (teaching) she had received, "That the ground of being is fluid. That it is empty of everything but relationships. Systems theory...brought language and concepts and empirical data, showing how these relationships constitute our world, and how they work." (*Widening Circles*, p. 142) It was this confluence of Buddhism and science that she chose for her dissertation topic.

A turning point in Joanna's life came in 1975. Alarmed by the OPEC oil crisis, the Macy family began to examine the issues of living in a wasteful society vs. conserving resources and cultivating ways to live in harmony with the natural world. Their reflections took place in community, from local social gatherings in Syracuse to a Movement for a New Society Quaker workshop on simple living in Philadelphia. Joanna writes:

> How is it for us to live in a country that consumes half the world's resources? In the group we looked at the wasteful clutter that clogs our lives. We considered our truer needs--the need for community and creative work. And we took a fresh look at how we were actually spending our energy, money, and time. (*Widening Circles*, pp. 151-152)

The workshop experience prompted the Macys to sell their suburban home and create a cooperative household within the city. Welcoming housemates from outside their family and sharing food costs and communal responsibilities freed up time and energy to devote to studies, and get more involved in social issues and travels.

Joanna traveled back to India to immerse herself in the Tibetan community-in-exile her refugee friends had established. She relates an ancient prophecy shared by one of her teachers that deeply resonated with her:

> There comes a time when all life on Earth is in danger. Barbarian powers have arisen. Although they waste their wealth in preparations to annihilate each other, they have much in common: weapons of unfathomable devastation and technologies that lay waste the world. It is now, when the future of all beings hangs by the frailest of threads, that the kingdom of Shambala emerges.
>
> You cannot go there, for it is not a place. It exists in the hearts and minds of the Shambala warriors...Now comes the time when great courage is required of the Shambala warriors, moral and physical courage. For they must go into the very heart of the barbarian power and dismantle the weapons. To remove these weapons...they must go into the corridors of power where the decisions are made...These weapons are made by the human mind. So they can be *un*made by the human mind! The Shambala warriors know that the dangers that threaten life on Earth do not come from evil deities or extraterrestrial powers. They arise from our own choices and relationships.
>
> So, now, the Shambala warriors must go into training...They train in the use of two weapons...compassion and insight. Both are necessary. We need this first one because it provides us the fuel...to act on behalf of other beings. But by itself it can burn us out. So we need the second as well, which is insight into the dependent co-arising of all things. It lets us see that the battle is not between good people and bad people, for the line between good and evil runs through every human heart. We realize that we are interconnected, as in a web, and that each act with pure motivation affects the entire web, bringing consequences

> we cannot measure or even see...We need as well the heat of compassion, our openness to the world's pain. (*Widening Circles,* pp. 161-162)

As the 1970's progressed, Joanna's knowledge of humanity's capacity to destroy our world was expanding. From her son Jack's studies in environmental engineering, Joanna learned about thermal pollution from nuclear reactors. A Cousteau Society symposium barraged her with many threats to the biosphere: decimation of marine life from oil spills and plutonium pollution, dying plankton, radioactive contamination from nuclear power plants, industrial resistance to environmental responsibility, desertification, acid rain, drought. Joanna sank into grief. What released her malaise was learning from and connecting with others in the anti-nuclear power movement and the Sarvodaya Shramadana Movement in Sri Lanka. There, Ghandi and Buddhist-inspired village organizing strategies showed how working from the bottom up and trusting the intelligence of the people could create positive change.

In 1978, taking lessons from grassroots activism, wisdom from East and West and her spiritual stirrings, Joanna initiated the workshops that would eventually be known as *The Work That Reconnects*. More than 40 years later, the workshop exercises invite participants of all ages and backgrounds "into fresh relationships with our world, and not only arouse our passion to protect life, but also steady us in a mutual belonging more real than our fears and even hopes." (*Coming Back to Life* p. xxiii)

Joanna continued writing, teaching, and speaking across the globe about our living Earth. Her 1991 book, *World As Lover, World As Self* begins with these words, "Our planet is in trouble. It is hard to go anywhere without being confronted by the wounding of our world, the tearing of the very fabric of life." After referencing the 1986 chemical fire in Basel and the Chernobyl nuclear plant disaster, she continues:

> In the face of what is happening, how do we avoid feeling overwhelmed and just giving up, turning to the many diversions and demands of our consumer societies? It is essential that we develop our inner resources. We have to learn to look at things as they are, painful and overwhelming as that may be, for no healing can begin until we are fully present to our world, until we learn to sustain the gaze. (*World As Lover, World As Self*, pp. 3-4)

Interview

In an interview with this author in August 2019 in Berkeley, California, Joanna Macy shared her perceptions of Earth, human beings, and our responsibility to repair the damage we have wreaked.

What grounded you early on and how did it influence you or inspire your life's work?

A spiritual outlook and practice has been important to me from the beginning. I come from a long line of liberal Protestant preachers, Congregationalists and Presbyterians depending on where they were setting up their church, New England or western New York. From that and from my experiences with the New England student Christian movement, which politically radicalized me. This was right after the second World War which brought me into keener awareness of political and social challenges. But then I left --- I walked out on the institutional

church. It was the study of the early church fathers that I could not stomach. They were an argumentative bunch determining who was right and who was wrong, meanwhile excluding the rest of humanity. After dropping the studying of the faith of my fathers, I felt somewhat at sea until 15 years later with three children and a husband helping run the American Peace Corps in India. There I encountered the Tibetan refugees. I was working with them, for them, so they could stay together --- both lay people and lamas and monks --- and not be scattered into road gangs and residential schools. In serving them, my life was changed by their way of being human and from then on I was devoted to the study and practice of Buddhist teachings.

How had the early teachings you received inspire your life's work or did it really radically shift when you adopted Buddhism?

It was the same. The Mahayana Buddhist figure of the bodhisattva fit exactly what I heard from Jesus and from the luminaries, the saintly people, the revolutionaries. There was Oscar Romero, Pope Francis now and Laudato Si. All of that was totally right down that faith didn't amount to a hill of beans if it wasn't for making a joyous and just life for everyone.

Do you currently have a spiritual practice? And, if so, what is it?

It's basically Buddhist, but I'm doing it with a heart that grew up with the Sermon on the Mount. I'm laughing now because I was about to do a teaching for a Buddhist magazine. There was a little q & a and one of the questions was, "Is there a non-Buddhist teacher or guide in your life who you would turn to? And I thought, and I just answered, "Jesus," but also two of my great teachers were trees--an apple tree and a maple tree --- and a horse.

You talked about the horse from your grandfather's farm?

Yes, and I also talk about the maple tree. I started the first chapter of that memoir with what she meant to me and then the fact that the Buddha got enlightened under a tree. And Buddha, Jesus, Moses, they were outside all the time! They were being taught by the sun and the moon and the raging storms and the hunger and the thirst and their fellow beings. Part of what's dooming us as a species now is that we've sealed ourselves up indoors. So many people who are making the decisions just go from their office building or their presidential palace or White House to the limousine. That's their out of doors. No wonder we're in a pickle.

Reading your memoir, I was struck again and again by how you recounted very felt-sense images and dreams with great detail and clarity and how you got propelled forward with them. I was thinking particularly about the eight-spoked wheel when Jack was born, and I'm wondering if these kinds of images and dreams continued to arise in you in recent years and through your eldering years.

They've just started up again. I was struck in the last week where my heart is breaking over the loss of the Amazonian rain forest, because I think that we can't lower our greenhouse gas emissions an iota without the rainforest down there. With Bolsonaro's election in Brazil declaring his plan to declare the Amazonian rainforest open for business, I had a vision of two curtains closing over our future — one was the IPCC report, the other was Bolsonaro's purchase. Visions and dreams are very strong in my life right now.

Is there any one in particular in this last week that is coming to you right now that you can share?

Yes. One is very simple. I seem to be having trouble writing as easily. The dream was of a wave at the beach. The sand is marked by many footprints. With the incoming tide, there's a whoosh and a great flat circle of water washes up on the beach and withdraws. And it just wipes out everything. And so I thought, that's what can happen. With the societal collapse that is coming with climate breakdown, it shows all we'll lose. And I shudder. Whether Shakespeare or the Buddha, the cultural gifts of our whole human story could all just go...pshhhh. After that wave receded, it looked as if nothing had ever been there.

As you reflect back on this lifetime of yours--what you've studied, what you've seen, what you've experienced--what are the things you most want your children and grandchildren to receive as your legacy?

That I love this world. I hope they get that from me. That I love this world. And the world loves you back. There's this reciprocity. What's coming so strongly now are the memories of my years at my grandfather's farm. It's where my mind wants to go now. It's interesting how it was just seven summers, just between the ages of 9 and 16, and barely a quarter of those years. I was bored a lot of the time — no kids my age, no programs, no sports, no theatrics, envying my friends who went to camp. But I was there and it's inside me now. I close my eyes and I can almost smell again, hear the thudding of the horses' hooves and the cows' returning from pasture, coming into the barn. This seems so vivid to me. It's been 75 years and it still fills me with longing and gratitude.

And my own Buddhist scholarship, because I'm not just a practitioner. I am teacher, writer, scholar and I've done pretty original things, showing how systems theory and Buddhism are the only highly developed schools of thought that are non-linear. And that's where we have to go now for our planet is a living system. It's alive. When I believed in a God, I could feel supported and guided by God and that's called grace. You can also feel supported by Earth herself and the life of Earth, and her own rising consciousness, especially from a systems perspective. At any rate, there's a kind of pantheism, an animism the sense that everything's alive. And it leads me to know I belong to Earth no matter what, that we're already home.

Yes, thank you. So that leads into this next question. I was looking at activism and the drive to foster positive change, especially regarding Earth and healing right now. In your writing, in talking about the central tenet of the Dharma, what I got was dependent co-arising and I'm wondering if this concept is related to what I've heard called the "hundredth monkey effect," the hypothetical phenomenon in which a new behavior spreads to a whole group once a critical mass adopts it.

Yes, I think it is. The thrust of what the Buddha taught two and a half millennia ago is that we inter-are or inter-being, and that is coming forward now with the teachings of the Vietnamese Zen master Thich Nhat Hanh. And so the hundredth monkey story illustrates how we influence each other and in that influencing we can shift toward inter-thinking, collective awareness, collective consciousness. That interests me. And, in a way, the hero figure of the bodhisattva is the one who is the boundless heart and sees others as equally valuable as herself or

himself. You just automatically feel/see us as a collective and our natural desire is for honoring and celebrating life together and working for justice. And I'm greatly inspired by your tradition [Judaism], right from the get-go. The Hebrew prophets had a huge impact on me when I was studying them in college: Isaiah, Amos, and all those great old guys. Too bad they didn't hear what the women were saying! But then there's so much to do and to see what we can rebuild after patriarchy before patriarchy stamps out life.

Can we do it? My teacher Reb Zalman Schachter-Shalomi said, "The only way we can get it together, is TOGETHER!" These teachings are so vital to doing this work, while technology seems to be running amok, and we have simultaneously the capacity to do instant communication, seconds…

Nanoseconds.

Nanoseconds, and at the same time be consumed by this device that we carry around that gives us information, whether it's true or not, and we can stare at it all day long, and we can play games with people on the other side of the world. I'm curious about how we can get the most vital teachings out there in this urgent moment.

It's a big question. It's just nip and tuck because so many of those who have enough food in their stomach to be able to think, enough freedom of movement to be able to act, are zoning out over their email. You just go to anywhere in any city, in any conveyance, in any bus, airport, anywhere --- it's like we're in little bubbles of isolation and we need desperately to act together. And how can we pull our attention away from this or break this bubble open?

How can we? These are useful tools if we use them as a tool.

Oh, yes, that's true. But, it's almost as if I go into any public spot and I look around and I see what everybody's doing. It's as if they don't even see each other. It's preoccupying young people and burdening them and obsessing them and making them so anxious.

So, speaking of young people, I saw on your refrigerator you have a photograph of Greta Thunberg.

Oh, she lives in my heart.

Mine, too. If she were sitting here right now, what would that conversation between you and Greta be like do you think?

Oh, my, why I would want to thank her, and bless her. And encourage her to keep on. I was called by the student strike leaders last week. And they said, "The grownups, the adults, take hope from what we're doing. But we don't. We're feeling more despair."

I find myself driven to try to understand what we can expect and what we cannot expect from the corporations that run the governments. With the corporate globalization of our planet they've gone beyond the control of humans. This of course is scary, to put it mildly, but I'm

looking for any evidence that anyone can make it up the ladder from board of directors or the CEO or the CFO and not make profits their final choice. Corporations used to have a triple bottom line: profits, social equity and ecological sustainability. The last two were shrugged off quickly, if they ever mattered. Now it's just profit. When there's only one variable in a system it cannot maintain balance, and it ends up in a positive feedback loop that's on runaway, heading toward a collapse. It's devouring itself and devouring its larger body.

So, how did we get to that? No wonder the young people are in despair. My hope is that the adults and even those within the corporations would allow themselves to feel despair. Or those out here, just an hour away at the Lawrence Livermore Nuclear Lab where the latest forms of nuclear weapons are being insanely produced, far more than we need, far more different ways to kill, millions pouring in there, and they're automatic --- preparing a collective death, as if we have abdicated our capacity to choose. So, my question for your publication or your readers or for any of us, since what distinguished humans, what was the sophisticated capacity to self-reflexive consciousness, giving us this capacity to choose: I'm going to go here and not there, I want to do this, not that? How can we retrieve that again and choose, therefore, choose life? That's what Yahweh said right at the beginning, didn't He? "I've set before you, Life and Death. Therefore, choose Life." It's that simple! It's like we've all put our heads in a bag. Such a beautiful species, such a complex, beautiful brain. And the brain that's here; it's so complex.

If we could only connect the neck, the head and the heart. It's like the neck has taken off from here up. Well, I think you've already answered this, but I'm going to pose it anyway, because it's not only the current leader of this country who suffers from what a friend of mine calls malignant narcissism, a condition that has no treatment or cure. And he's not the only world leader who's suffering, incapable of empathy and compassion and really self-reflection. So how do you, if you do, maintain hope in the face of all this?

My hope comes from, what I was just saying, this capacity to choose. Just because we haven't been using it doesn't mean we cannot. We could wake up and choose. Because it's not the demented narcissists that just now have forbidden the Democratic candidates to debate on climate. It was the centrists in Congress. They can't be qualified as narcissists. But you can qualify them as having accepted money from Wall Street. Does their complicity with and their obedience to Wall Street mean you can't talk about the most important issue of our time?

It's not too late for us to wake up, so what do you want to do? What makes you wake up glad in the morning? What makes your heart sing? It's linking arms with others and working for our beautiful world and working for the youngsters and the young people and working to feed the hungry. There are so many wonderful things to do. Look beyond the media and get out and see how people are showing so much bravery and initiative, taking care of each other in so many ways. So, something might wake people up. Maybe it's the Amazonian rainforest. Maybe something will make a difference more than their money and their comfort, their political and physical comfort. And just look at the people you've mentioned: Zalman Schachter and your son and the people in Takoma Park and the people that we love to link our arms with around the world. We're not going to stop that. We wouldn't think of stopping that. And, to give up is so boring! That's my final statement.

Conclusion

Perhaps that fuller presence is beginning to occur. Swedish teenager Greta Thunberg, 17, speaks truth to power before world climate summits and propels global mass climate strike demonstrations. Young people sacrifice school days or even postpone college to work with Fridays for Future. Extinction Rebellion activists employ nonviolent civil disobedience to avert ecological collapse. Actor and activist Jane Fonda, 82, uses her celebrity and civil disobedience to teach and activate citizens about the climate crisis through Fire Drill Fridays. Citizens Climate Lobby, Climate Action Network, Health Care Without Harm, 350.org, Pachamama, Drawdown.org and many other organizations are attracting more participants to get involved in their communities to research and implement carbon sequestering solutions. Now in 2020, with the 50th anniversary of Earth Day coming on April 22nd, the question looms: Are enough earth stewards waking up and collectively engaged to effectively reverse the human emissions of greenhouse gases and the existential threat scientists have been warning about for half a century?

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Joanna Macy

PROFILES IN COURAGE





Before he developed the lifesaving maneuver that made his name a household word throughout the world, Henry Heimlich had another career as a Navy medical officer serving in China during World War II.

Dr. Heimlich's Maneuvers

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Introduction

Dr. Henry Heimlich was undeniably one of the icons of 20th century medicine. Without doubt, his name is recognized throughout the world as the developer and promoter of the Heimlich Maneuver, a simple technique that has saved an incalculable number of choking victims worldwide. Even more significant was his invention of the Heimlich chest drain valve in the 1960s, a simple device that has revolutionized the treatment of lung injuries. Many years ago, someone pointed out to me that it is one thing to get your name in the encyclopedia, but it's another thing to have your name in the dictionary.

I became familiar with the Heimlich name many years ago when an uncle told me that one of his cousins was married to the famous physician. At the time, I tucked that bit of family lore into the recesses of my brain and promptly forgot about it. Years later, I could not have predicted that as the Navy's chief medical historian, I would interview Henry Heimlich as part of the Bureau of Medicine and Surgery's oral history program. In that session with him at the Heimlich Institute in Cincinnati, Ohio, he spoke about his early life growing up in New York, the son of a social worker whose beat included New York State's prisons. He also told me about his special and unusual assignment in the Navy during World II, and the incident that convinced him to become a chest surgeon after the war. The following excerpts are taken from that interview conducted in late 1994.

The Interview: December 15, 1994

Had there been a tradition of medicine in your family?

Both my father and mother had been social workers. They had a very poor background but my father had gone through City College of New York, now the City University of New York, which was a free school. As a social worker, he was primarily involved in prison welfare work. In the last year and half of his life he lived with us. He would tell me things I never knew those last few years. He told me he had gone into social work because he said that when he stuttered, people were so nice to him that he decided to give of himself. I think he made $2,000 a year full time.

He worked in the New York State prisons for an organization called the Jewish Board of Guardians, which is now part of the Jewish Federation in New York. He would visit Jewish prisoners in the state prisons. They [prison authorities] would actually allow my sister and me to go with him. She was about 16 and I was 11 or 12. We could walk through Sing Sing Prison or Attica Prison unattended, and sit and talk to the prisoners in their cells. When they [prisoners] had an auditorium meeting we would sit among them.

One time we went to the warden's office and a man visiting him, who, I think was a commissioner of corrections, said, "How do you let these children go through the prison alone?" And the warden responded, "Oh, all the men know they're Phil Heimlich's kids." And nothing more had to be said.

So, it was this idea of service that got you interested in medicine?

No, it was the anti-Semitism of the times. You have to remember that even when I was going through medical school before the war, the biggest indoor Nazi rally in all history took place in Madison Square Garden [February 20, 1939]. I was outside at that time. If you were Jewish in this country, you could start your own business, but you could not get a corporate or a government job. The only thing you could do that had real prestige was to become a doctor. Perhaps that fact alone made me reach out to other people. There were quotas on how many Jews could get into a particular college. Blacks couldn't get in at all. It's true there were exceptions but they were very rare.

How did you get involved with the Navy?

If you wanted to continue medical school after Pearl Harbor, you had to join the Naval Reserve or the Army Reserve. I became an ensign in the Navy. I hadn't yet graduated from medical school. Then they cut out summer holidays so instead of graduating from medical school in 1944, I graduated in the class of December 1943. The following month, I was appointed lieutenant junior grade, U.S. Naval Reserve.

Author Note: After a series of short domestic assignments, Heimlich was assigned to the Chief of Naval Operations in Washington, D.C.

Where did you actually report?

Shortly after arriving in Washington, I was taken into a room at the main Navy building on the National Mall. There I met with two officers. "All we can tell you about this duty is that it is voluntary, and it's extra hazardous overseas duty in China." And that's all they could tell me and that's all I knew until I got to China. I remember thinking that if I was going to get it, I'd rather see China than some landing beach. And so I took the assignment.

Author Note: One of the lesser known naval activities of World War II took place in the China-Burma-India theater of Operations. In 1943, the Nationalist government of Chiang Kai-shek, in cooperation with the U.S. Navy, organized what became known as the "Sino-American Cooperative Organization" (SACO). Because weather affecting the Pacific Fleet originated in greater China, planners desperately needed reliable meteorological information. A pressing need also existed for accurate intelligence regarding Japanese fleet movements. Navy personnel were flown from India over the Himalayas, "the Hump," into China to set up and monitor weather stations in far western China. In eastern China, a network of coast watchers reported Japanese fleet movements. The Nationalist Chinese government had fled to the central part of their country, and a strong Navy presence in that region had yet another vital task: to arm and train a Chinese guerrilla army to fight the Japanese invaders. Lt. (j.g.) Heimlich became part of this Navy effort in central China.

Who went with you?

Some Corpsmen, but really quite a variety of other specialties--radiomen, scouts, raiders, and Marines. I would guess there were about a hundred of us. We left from the railroad station in Washington on February 17, 1945, bound for San Pedro, California.

We departed San Pedro on February 26th aboard the USS *Admiral W.S. Benson*. I got sick as a dog for 12 days right after we left.

Did you travel in convoy across the Pacific?

No, we traveled alone. These ships were very fast compared to submarines. On the way out of San Pedro, the ship's crew took antiaircraft practice on a towed target. When we got a direct hit, all of us just yelled with glee. When we were out for a few days, we encountered an unidentified ship and had to go to general quarters. As a doctor, I had to go down into the hold and open an emergency medical unit there. It turned out to be an American destroyer.

We arrived in Bombay on March 29, 1945, and took a train, which went completely across India for four days to Calcutta where we reported to the commander of the India unit of SACO.

By this time, did you get any more information about your mission other than what you had heard in that room back in Washington?

No, not a word. I stayed in Calcutta for about two weeks and then received orders to proceed to U.S. Naval Group China via commercial air transportation. I was to take a CNAC [Chinese National Airways Corporation] plane over the Hump.

As you proceeded on this journey to China, from time to time did you get new orders, or was it a-step-by-step procedure?

Yes, I never knew what was coming next. On April 17th [1945], I was designated an "official courier" for the purpose of transporting official U.S. Navy communications from Calcutta to the Commander U.S. Naval Group China in Chungking. The reason they made me a courier was to allow me to carry on the plane mail and materials they needed in China. Until that point, I traveled in a gray or khaki uniform without insignia.

The CNAC was flying old C-47s over the Hump. As a regular passenger, you couldn't take very much luggage but, because I was a special courier, I was allowed to take large bags of stuff.

Did you have any medical gear with you?

No, just my personal things and this large shipment of "things." As a doctor, I wasn't supposed to be armed. But I was loaded down with I can't remember how many guns--side arms and carbines. These were desperately needed in China.

Did you have any idea what was in the bags?

No idea whatsoever. Before boarding the plane, I had to check through immigration, and they were mad as hell because they knew this courier thing was a line. They had seen it time and time again and couldn't do anything about it.

We left Calcutta and then came to another airfield closer to the Hump, where I got aboard another C-47. The windows had holes in the middle, presumably so if we were attacked, we could shoot back with our rifles. All that nonsense didn't make any difference because when we got to a certain height, I began gasping for breath and then passed out, as we all did. Only the pilot and co-pilot had oxygen. We had to climb over 17,000 feet to get over the Hump. I got to see a little of the Himalayas before I passed out. The next thing I knew my eyes suddenly popped open and there were rice paddies all around.

First, we landed in Kunming, which seemed like a little village. There were some Navy people there and also a substantial Army presence.

Then we took off for Chungking. The airport where we landed was a small sand island in the middle of the Yangtze River between the hills. Then I boarded a sedan chair with a guy in front and one in back carrying me. They climbed many, many stairs to the top where they dumped me on the street with my bags and my guns. I remember the children laughing at me and coming over and touching the guns. Suddenly, I felt I was back in America.

Finally, someone from SACO headquarters came in a jeep and picked me up. Again I was taken to a room with two officers and they explained what SACO was all about. In the pact with the Nationalist Chinese government, the U.S. was to get weather information and aid in direction finding, gather intelligence information, and sabotage of Japanese targets in return for which we provided guns, materiél, training schools for guerrillas, medicines, and medical care.

You must have felt incredulous when you heard all this.

No, not at all. I was a young guy in the Navy and it didn't seem strange at all.

What was your specific role?

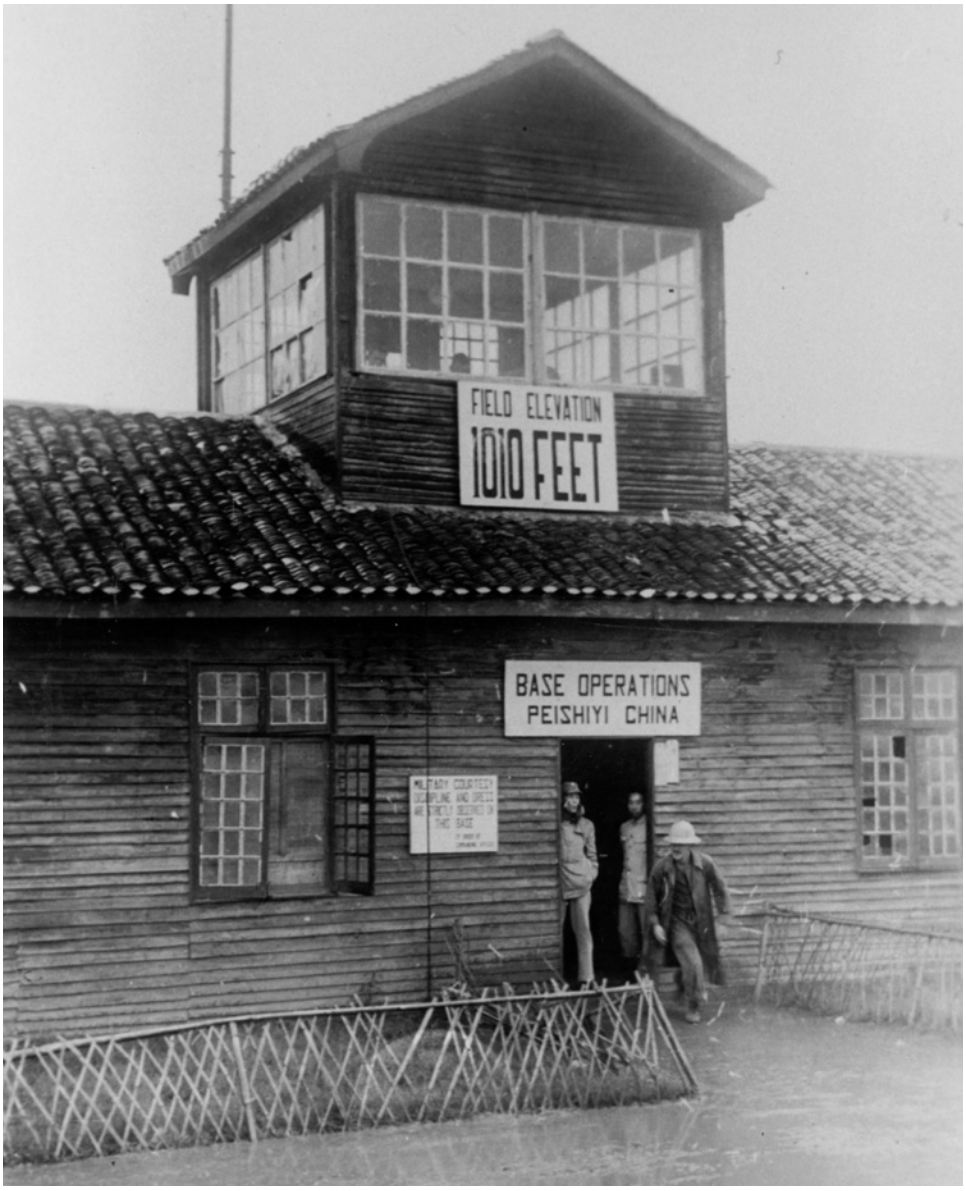
I had come to China to replace a doctor at one of the Navy camps in the Gobi Desert--Camp Four--in Inner Mongolia. We went to a place called Penglai and set up a weather station there. Weather information was then radioed to Chungking, and then relayed to our ships in the Pacific. We also had coast watchers who would radio that a tanker just departed from Shanghai, for example. Then our subs could be in a position to intercept it.

Did you have any medical equipment?

No, I had no medical duties, I was simply traveling to get to Camp Four.

Did you have Chinese guides?

Yes, we had Chinese guides and drivers. But we didn't have interpreters so we communicated with sign language. We made it to Mongolia on the 4th of June [1945].



During his service in China, Dr. Heimlich and other Navy personnel frequently encountered airfields like this. (Base Operations Peishiyi China)

What did you see at Camp Four?

The closest town is Shenpa in Suiyan Province, part of Inner Mongolia. It was a walled town and had been a French mission at one time.

My group originally had 12 members, thus our code name was "The Apostles." After I reported, I was assigned a horse.

A horse?

Yes, we all had horses.

What kind of medical equipment did you have?

The doctor I replaced left all his equipment. We had sulfa drugs, but no penicillin. I constructed a steam sterilizer out of a 5-gallon oil tin, and also had a still to make distilled water. I very quickly went to the local coffin maker and had him make me an operating table out of wood with iron hinges and ratchets so I could raise and lower the head and feet.



Chiang Kai-shek's troops await transportation to the front to do battle with the Japanese invaders.

What were the other functions of the camp?

A few of our people were advising Chinese guerrillas who were fighting mostly puppets of the Japanese.

I did my first experiment there on the disease trachoma, an infection of the eyelids that causes blindness. I thought sulfadiazine would work against it. I powdered some sulfadiazine and put it into Barbasol, the shaving cream. I had my corpsmen put some in each eye of an infected Chinese. The patients would roll in anguish and pain at first. But over time the trachoma cleared up. After the war, I discovered a study done by the U.S. military in Egypt that had proven sulfadiazine was a curative for trachoma.

Did you treat any of the locals?

Yes, the first doctor up there did an occasional surgery, but treated only a few locals. One evening, shortly after I arrived, an 18-year-old girl came in with a distended abdomen and severe dehydration. I didn't know whether it was a tumor or an infection, but I knew she needed surgery. As we didn't have electricity, I couldn't start a major surgery so close to nightfall so I decided to wait until morning. If she had died, our mission would have been in jeopardy. Although her father was not a warlord, the Chinese did not really trust us. I could have let her die, but instead I told her dad I would operate if she lived through the night.

I sterilized instruments and was assisted by one of my Corpsmen. I gave her a spinal and gingerly cut into her abdomen. As soon as I hit the peritoneum, green and yellow pus gushed all over us. I screamed with joy since this was the only thing I could handle. She had a pelvic abscess. I cleaned it out, left it open, and put drains in. She recovered.

From then on, I was mobbed by hundreds of patients. Everyone came to see me. I saw a lot of syphilis and many other diseases and infections most American doctors would not see. It was one of the last areas of plague, both bubonic and pneumonic. It was a wonderful medical experience.

How did you find out the war was over?

We could hear Armed Forces Radio, and that's how we learned that the first atomic bomb had been dropped [August 6, 1945]. We all felt it was very promising. About a week later, we received a regular message, the first ever not in code. "It's Over." We screamed and yelled.



Following his stint in Inner Mongolia, Dr. Heimlich was assigned to the hospital ship USS Repose moored in Shanghai.

How long did you stay at Camp Four after the war?

About two months. I got orders to go to Chungking and left on November 1st. Just before I left, one of our soldiers was shot accidentally during training. I did nothing the first night, just put on a bandage because the light was really bad and I had never opened a chest before. It was a through-and-through wound [bullet entered and exited the body] and by morning he was near death. Therefore, I decided to operate. I found a huge hole from the entrance wound to exit wound. I also found a 3-inch hole in one of his lungs and sutured it up. But closing was basically impossible due to massive amounts of torn tissues. Unfortunately, the patient expired during final closure. I always felt guilty. Should I have done anything else?

As a result of that incident, I was determined to become a chest surgeon when I returned from the war. In the early 1960s, I developed the Heimlich chest drain valve. You put the tube through the bullet wound and pack dressing around it, and the tube connects to the valve. Air, blood, and fluid can come out, but nothing can go in so the lung doesn't collapse. I presented it at an AMA [American Medical Association] meeting in 1963.

Following my presentation, four Navy officers came over to me and asked for six of them [chest drain valves] to take to Vietnam the next day. At that point, the valves had been made by hand. We were able to get together six of them. A week later I got a telegram saying the valve was a lifesaving item and the military must have 100 immediately. The company that made them couldn't put them out fast enough.

After the Vietnam War, I was at a meeting where a Navy admiral was giving a reception. He said my valve saved lives and there were six congressional investigations looking into why the military didn't use them. I met someone at a meeting who was at Hill 881 [a ferocious Vietnam battle in December 1967]. He told me that 34 of his men were shot in the chest, and 32 made it off the hill alive. What more do you want in your life?

After the Vietnam War, I was with a group of heart surgeons in Vietnam as part of the People-to-People Ambassadors program. A group of Vietnamese were at the airport in Hanoi to meet us. One came up to me and said, "Ah, Dr. Heimlich, everyone here knows your name." I figured he was referring to the maneuver. Then he said, "Your chest drain valve saved tens of thousands of our people." I wondered how they got the valves into North Vietnam. Apparently, a Quaker organization from Philadelphia supplied the valves, and the North Vietnamese reused them. So I was saving lives on both sides without even being there. Why should I have been lucky enough to hear that? They kept repeating, "Dr. Heimlich will live in the hearts of the Vietnamese people forever."

Was your chest drain valve invention directly related to that soldier with the chest wound you lost back in China during World War II?

Maybe if I had known the drainage techniques then. Yes, I feel I've paid that soldier back. He was always in my mind and therefore the chest valve.

So, the chest wound incident in China was the inspiration for the chest drain valve. How did that inspiration translate into the actual invention?

I just took the idea of a valve and experimented with different types of valves. The flutter valve seemed to be the best solution because it prevents air from traveling back through a chest tube. I got a Chinese noisemaker with a rubber mouth, corked one end and put a tube through it. I then hooked it up to a patient's chest tube and it worked. Armed with only that and a description of what it does, I was able to sell it to Becton Dickson and that company began manufacturing it.

The first real test came in Vietnam. The Navy got them first, but then the word got out and everyone seemed to want them. In June 1967, when the Six-Day War broke out, I packed a case for the Israelis. They sent a plane to the U.S. to pick them up. I went to Israel in the 1970s and saw Heimlich valves being used in their military hospitals. The company that manufactures them can get an idea of where trouble is breaking out by who orders lots of these valves. For example, before the [Persian] Gulf War [1990-1991], we got the biggest order ever for Heimlich chest drain valves.

You're a household name today because of the Heimlich Maneuver. How did that come about?

In publishing my first medical article on the maneuver, I clearly said I wasn't sure it was going to work. We had done some experiments but we weren't positive. The alternative was to do a tracheotomy.

Where did the article first appear?

It appeared in *Emergency Medicine* in June 1974. A syndicated writer in Chicago picked up the story. The first life was saved within a week in Seattle. A restaurateur read the article and did the maneuver on a choking woman.

How did the idea germinate in your mind?

I had read in *The New York Times Magazine* that the sixth leading cause for accidental death was choking on food. I always thought it was a rare occurrence. I remember reading about famous people dying from this, such as Ethel Kennedy's sister-in-law and Tommy Dorsey.

I began looking into it and discovered the Red Cross was telling people the wrong thing--the backslapping and putting fingers in the throat.

We practiced some maneuvers on each other to measure the pressure and the flow. Of course, it was the flow of air not the pressure that pushes the food out. The flow provides the kinetic energy to the object always in the direction toward the mouth.

The trick is to find a way for anyone to do it. You would die in four minutes so you didn't have time to wait for an ambulance. Actually, a 6-year-old saved a 5-year-old a few years later. This told me you can't make it any simpler than that.

The first experiments I did were on dogs. I had taken an endotracheal tube, blocked off the end, blew up the balloon and put it into the dog's larynx. I tried different ways of pressing on the chest. So, I went under the diaphragm and the tube and the balloon went out like that.

You also invented another valve for a tracheotomy?

It's called a MicroTrach. People taking oxygen are always gasping for air when given nasal tubes. Why? Because they have to suck air. I knew if you did a tracheostomy, you would make it easier. If you put in a tiny tube under local anesthesia, then jet the oxygen into the lungs from the tank, the patient doesn't have to breathe heavily. With nasal prongs, you waste up to half the oxygen back out of the mouth and nose. With this tube, the air goes directly to the lungs. This also means the tank will last longer or it can be a much smaller tank. Therefore, people are not tied down to a big tank at home and can get up and about.

Postscript

In the years following my interview, Henry Heimlich, working under the aegis of the Heimlich Institute, began promoting the maneuver as an emergency procedure for resuscitating drowning victims. Other physicians and researchers questioned this treatment. Drowning rescue guidelines, published by the American Heart Association, raised doubts about the Heimlich Maneuver's safety and usefulness. Indeed, the American Red Cross, which refused to recognize the Heimlich Maneuver in its guidelines for many years, finally did so, but now uses the term "abdominal thrusts" to describe the procedure. Well into the new millennium, Heimlich promoted the use of a benign form of malaria to treat HIV, a highly controversial course of treatment that demonstrated no apparent benefit.

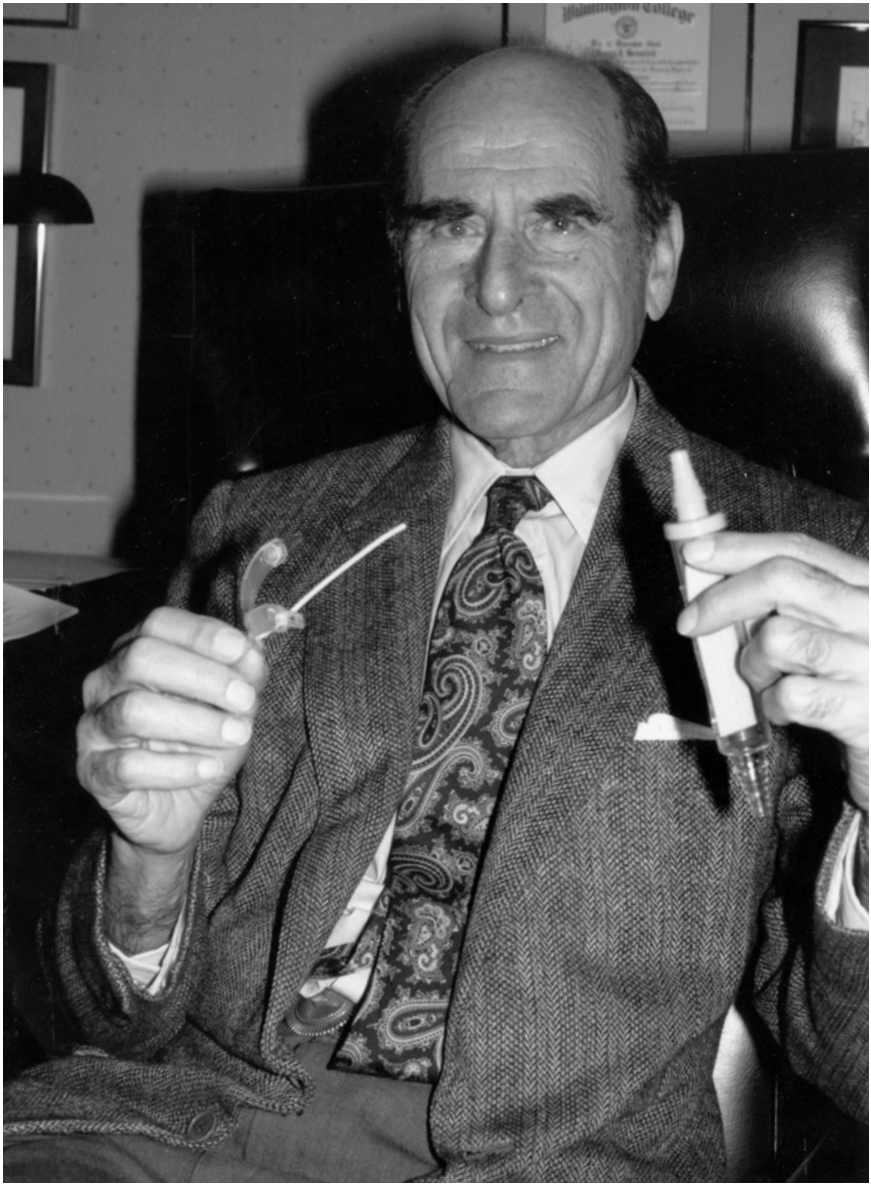
Despite these controversies, Henry Heimlich's contributions to medicine are legion. As a Navy surgeon general once exclaimed when discussing this world-famous physician: "Never mind the [Heimlich] maneuver and how many victims it has saved. His Heimlich chest valve has saved hundreds of thousands!"

Once, while aboard a Navy C-9 ambulance plane, I noted a checklist fastened to the aircraft's bulkhead itemizing the essential equipment that needed to be aboard. Third on the list were so many Heimlich chest drain valves. I asked a member of the crew how important those valves were. Without hesitation, she emphatically replied, "This aircraft does not leave the runway without those chest valves."

I recall a conversation I once had with Dr. Heimlich after enjoying dinner at his home. Much to my surprise, I learned that although he had performed many experiments while developing the maneuver, he had never actually performed it on a victim. In the spring of 2016, however, while having dinner at the assisted living facility where he resided, a fellow resident at his table began choking on a piece of meat. Without hesitation, the then 96-year-old physician performed his maneuver, saving the woman's life. Henry Heimlich died seven months later.

As is true with all those who make a difference in our world, Henry Heimlich left an important legacy. His life story, however, is not only critically important for his specific inventions and innovations for medical practice, but, upon reflection, for the very nature of what we know as health and healthcare. Dr. Heimlich was able to restore breath and life to those who could not breathe. What we should remember is that "suffocation" is not just something physical. It has a wider meaning. History reminds us how individuals, families, communities, and nations have been tragically suffocated and still are today, deprived of their rights to life,

freedom, and happiness. Individual tragedies are too many to repeat here. In our time and in the spirit of Dr. Heimlich's inventiveness and care for others, we need to remember and take action so that our world today is "heimlich-ed" back into life.



Dr. Heimlich holds two of his inventions, the MicroTrach on the left, and the Heimlich Chest Drain Valve.

All of the photographs in this article are courtesy of the United States Navy Bureau of Medicine and Surgery Archives.

True Heroes: Honoring Congressman Elijah Cummings and His Nephew, Christopher Cummings

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"When we're dancing with the angels, the question will be asked: In 2019, what did we do to make sure we kept our democracy intact? Did we stand on the sidelines and say nothing?"

– Rep. Elijah Cummings

"Speak my mind, pour out my heart, love my soul."

– Christopher S. Cummings

We all have heroes in our lives. That is true for us as much as individuals as it is for society as a whole. From the moment we are born, into our lives come individuals that we recognize as important to us for so many reasons. As we grow older and expand our self-awareness and our recognition-giftedness, we come to appreciate those who step into the very center of our lives and inspire us to grow, evolve, and expand who we are as well as all we do.

Over the last years, two individuals who have inspired me are Congressman Elijah Cummings and his nephew, Chris Cummings. I had the utter privilege of meeting the Cummings family, including Chris, at a special celebration dinner for a mutually beloved friend. I had already known the Congressman's amazing giftedness and, at this dinner celebration, came to know and respect Chris deeply. Chris so obviously embodied and carried on the same values and sense of selfless otherness that were at the very heart of his Uncle Elijah's life and service to our nation.

So sadly, in October of 2019, Congressman Cummings passed over from this life. And we lost his earthly presence to us in a time when our world needs the voices of social justice and human rights speaking out courageously and boldly above the snarling of every form of hate and discrimination. Our world has seen a terrifying resurgence of the addiction to power and domination that robs so many of what is their right to human decency, freedom, equality, and joy. Congressman Cummings is deeply missed and always will be.

Christopher is also deeply missed by his family, friends and so many. Horribly, in June of 2011, Chris lost his life when he was made the victim of a murderer who still has not been apprehended after all these years. Chris lost his life at his off-campus housing while an undergraduate at Old Dominion University. He was a pre-law student who loved and admired his Uncle Elijah's pathways of personhood and selfless service. Chris wanted to follow in his uncle's footsteps. He even was serving as a very special youth counselor for those in great need.

Without question, both the congressman and his nephew are two individuals who truly are heroes. With his nephew following in his footsteps of integrity and goodness, Congressman Cummings raised his voice ever and always to speak out against every form of evil and injustice. His voice raised up those who are bowed down. He truly gave flesh in his life to the words of faith and human goodness that he heard and himself spoke. In that same pathway, Chris Cummings was one who always expressed and embodied his love and respect for others with a fulness that is critically central to the experience of being human and humane. Chris always was there for his family and his friends. And he clearly knew he was being called to be a defender of the Truth and a promoter of the Good.

As we honor in this volume our Journal's 2020 theme to "reclaim our 20/20 vision of life," we need to let the presence of true heroes like Elijah Cummings and Chris Cummings to remain close to us. We need to let them inspire us. In our world today, it seems so much of the ability to "see things clearly" has become clouded by cataracts of hate and discrimination. We need to be awakened. We need to regain the clear vision of what it means to be truly human and humane. Indeed, it is so clear that we must let the living presence of individuals like Elijah and Chris to walk with us now in this life until that Day when we all shall be seated with them again at the Promised Eternal Table of Love and Peace.

Congressman Elijah Cummings
1951-2019





The photograph of Christopher Cummings is used with his family's permission.

Christopher Cummings
1991-2011

THE CRITIC'S CHOICE




Harriet Tubman

Film Review

Harriet

A Film by Perfect World Pictures

Directed by Kasi Lemmons
Written by Gregory Allen Howard, Debra Martin Chase, Daniela Tapin Lundberg,
Produced by Gregory Allen Howard, Kasi Lemmons
(2019)

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Author Note

This special film review is written from the perspective of the author, a certified social worker and an ordained clergywoman who dedicatedly serves others in the areas of social justice and human rights. The insights or views expressed in this review represent those of the author herself and her faith communities. The author has no conflicts of interest.

Introduction

I was never yours, Gideon. I was never anybody's property. I reasoned I had one of two things I had a right to: liberty or death; and if I couldn't have one, I'd have the other.

– Harriet Tubman
From the movie, Harriet

By all worldly logic and standards, the woman who came to be known as the Moses of her people would be perceived as an anomaly. As the original Greek term *anomolia* means that which is or one who is "uneven" or "irregular," Harriet Tubman in no way fit the *regularly* expected description of one who was so courageous and daring as to almost single-handedly defy the immoral stranglehold that the human-created and human-imposed evil system of slavery had on her, her family and her people. Hence, as a perceived anomaly, Harriet's life begs the question, "How can we possibly account for a life such as hers by using mere worldly logic and standards alone?" Truth is, we cannot. Harriet, both as a person and a movie, cannot be grasped

or elevated to the high stature each deserve without viewing and valuing her life through the spiritual/theological lens in which she lived it. It is only by examining and appreciating the personally loving, intimate and dependent relationship of faith Harriet had in and with her God that context and credence can be given to the amazing, massive and even miraculous accomplishments she achieved, particularly in view of the legion of limitations she faced, both socially and personally.

As the film depicts, Harriet, a young enslaved, illiterate and financially impoverished woman prone to epileptic spells, found herself in her early twenties in the unenviable position of being forced to leave her family and husband, all of whom she dearly loved, to escape the cruelty of the enslavers and the slave system that sought to devalue, denigrate and destroy her. Equipped with total faith in her God and a burning zeal in her soul for what she knew rightfully belonged to her, this small-framed, iconic freedom fighter seized a moment in history that ultimately led her to actualize the high spiritual calling in her life: to obtain the God-given right to freedom for herself and countless others.

Hence, *Harriet* is as much a theological narrative on what can happen when one becomes a majority with one's God as it is a social critique on the unbridled evils of humanity, especially the still unfathomable evil that came to be known as chattel slavery. Harriet viewed slavery as a vile and wicked idea as well as a beast that needed to be slain, for, as she emphatically tells her attempted enslaver, Gideon Brodess, God created all people to be free, "not for people to own other people." In Harriet, we dramatically witness her vow come alive: to commit "every ounce of blood [she has] to this end." As one who both experienced and witnessed slavery's detriment and destruction to the lives of those it entrapped in its vice, Harriet knew all too well that slavery was not just a peculiar institution; it was a perverted and pathological one as well.

In Summary….

Harriet opens with Minty (Harriet's nickname, which is short for her birth name, Araminta) in a supine position on the ground obviously experiencing one of her *spells*. It is important to note here that Minty, superbly played by British-born actress Cynthia Enrivo, had experienced unexpected blackouts since her early teens as a result of being hit in the head with a lead iron by an overseer in her efforts to protect a field hand trying to escape the overseer's wrath. As later revealed in the film, Harriet attributes this injury to be significant to her revelatory relationship with God when she commented, "The hole in my head [from the lead iron] just made me hear God's Voice more clear." For her, this included receiving revealing dreams and visions that aided her in her many safe escapes from the South as she led herself and others out of the vile bondage of slavery to freedom.

As Minty awakens from her spell, John, her husband, played by Zackary Momoh, is leaning over her. After she lovingly speaks his name and he lovingly teases her back about it, he assists Minty up and shares the good news with her that they have a letter from the lawyer they hired documenting that Minty's mother, Rit (Vanessa Bell Calloway), was supposed to have been given her freedom at the age of 45 as well as any children she had while enslaved. This was extremely exciting news to John, a free man, and Minty, because they wanted to have children --free children, not enslaved children. And since the law said children will take the status of the mother, it was important that Minty, through the rights of her mother's freedom, become free as well. Her father Ben (Clarke Peters), already a free man (although not free to actually protect

or be with his wife and children), joins this opening scene in the hope that the lawyer's findings will result in the freedom for their family that they all desire and deserve.

The next scene is that of a religious service taking place in the front yard of Minty's enslaver, Edward Brodess (Mike Marunde). After the enslaved plantation minister, Rev. Greene (Vondie Curtis-Hall), finishes his sermon by reminding the enslaved to obey their enslavers and those gathered begin to leave, John and Minty, supported by Minty's father, get an audience with Brodess, along with his wife, Eliza (Jennifer Nettles), and her son, Gideon (Joe Alwyn). The Brodess' are already sitting on the front porch overseeing the outdoor religious service to make sure it favored their positions as enslavers. Rit and two of Harriet's brothers are present as well.

John shares with Brodess the information given to them by the lawyer along with the request for Minty's freedom so their children can be born free. Brodess becomes outraged by the request. After asking to see the lawyer's letter, which he instantly shreds into pieces, tells the family in quite emphatic terms that they will not be set free and will always remain his property. He also tells Ben and John they were no longer welcome to come and be around "his enslave[d]." Heartbroken and in tears, Rit tells Brodess that he "is the devil" and Minty, also visibly upset, is seen shortly afterwards running to her favorite tree where she goes to talk to God. Here, on bended knees and in tears, she pleads with God to change the heart of her enslaver; however, if his heart won't change, she states, "then take him." Gideon, who follows her, hears her prayer plea and tells her, quite condescendingly, that God does not listen to the prayers of a "n____." *(For personal reasons I do not let myself say or write this word when intended to ontologically devalue and demean people by denying the inherent sacredness of all)*. After expressing his hopes to forget her name as he would a favorite pig as well as slapping her after she hits him to stop his unwanted advances, Gideon summons Minty to "come on" back to the house.

Within two weeks, Brodess is dead and Minty is shown having a dream-image signifying his death prior to its occurrence. At his funeral Minty and Gideon look at each other, no doubt remembering her prayer asking God to "take him." Consequently, Brodess' death leaves the family in a vulnerable financial state and the proposed option to address their monetary woes is to sell some of their enslaved. Harriet then receives another vision of her need to run and she realizes she is going to be one of the ones sold. This invokes fear because of the painful memory of two of her sisters being sold in the South, never to be heard from again. Minty, more than anything, deeply fears being sold into a strange land and separated forever from her parents, husband, siblings and all whom she knows and loves. It is these fears, along with an unquenchable desire to be free from such an evil system that splits up loved ones, that propels Minty to escape. After saying goodbye to her parents and purposely leaving John out of fear of him being put back into slavery if they are caught, Minty runs away, literally, for her life.

Minty's escape is climatically dramatized in a scene in which Gideon, along with other slave hunters, closes in on her on a bridge. Well aware of the meaning of this impinging entrapment, she surveys the rushing waters below as Gideon approaches her, trying to make going back with him sound appealing. This includes him saying he decided not to sell her and that he "won't hurt [her] bad" if she returns "home." Unmoved by his disingenuous semantics, Minty looks at him and unwaveringly states, "I'mma be free or die!" With these words still reverberating for Gideon to comprehend, Minty jumps into the river. She not only survives, but, with reliance on God and the aide of humane others, finds her way to freedom over a month later in Philadelphia.

It is in Philadelphia that Harriet meets the abolitionist and Underground Railroad conductor, William Still (Leslie Odom Jr.), and others active in its operations. It is also the place where she takes on the name, Harriet Tubman -- Harriet being her mother's first name and Tubman her husband's last. Her meeting with Still along with her miraculously obtained freedom and her name change, changes the trajectory of Harriet's life and, as her life's purpose apparently dictated, the lives of countless others. For after a year of being free but lonely, Harriet makes the daring decision to return to the South to help free her husband and family. Although painfully learning on her first trip back that John has married a free woman with whom he is now expecting a child, Harriet, even in the midst of this great pain, realizes and accepts that God sent her south to free others. After freeing two of her brothers and several other freedom seekers on her first return, Harriet makes several dangerous trips back to free many others, including her parents and a niece, Anger (Aria Brooks). Not only does she join the organized multi-state abolitionist effort known as the Underground Railroad, but Harriet, with her continued reliance on and faith in God guiding and protecting her and all whom she helped lead to freedom, soon becomes known as the greatest conductor it ever had.

Harriet is a cinematic dramatization of how and why she rightly earned this title of "greatest conductor." You see, despite many posters widely spread throughout the entire region, as well as parts of the North, frantically and fanatically seeking her with a substantial reward affixed to her capture, she led countless enslaved safely to freedom without ever being apprehended. Even after congressional passage of the 1850 Fugitive Slave Act (a law even for free states that required all escaped enslaved persons upon capture, to be returned to their enslavers), Harriet was undeterred in her resolve to *help set captives free*. This resolve included, as was shown towards the conclusion of the film, her role as a commander during the Civil War as she serves with the Union to defeat the slavocracy of the South, while helping set free many other enslaved. Even after returning to her home and family and friends in Auburn, New York for the latter years of her life, Harriet continued to fight for the rights of women and helped to provide housing and care for the elderly and the newly freed enslaved -- all of which were a part of her push for human rights for all. For Harriet, there were no physical deterrents or social detractors significant enough to stop her from responding to the needs of others or what she believed God required of her. This was the source of her great power. This was the source of her ability to attract others, both Blacks and Whites alike, to her cause for freedom for herself and others.

While the film *Harriet* centers around Harriet's adult life as an abolitionist and freedom fighter, the film also exposes the life and character of the enslavers, bounty hunters and others also caught and bound in the web of human entanglement that slavery is. Both Eliza and Gideon Brodess as mother and son, represent the complex darkness of slavery. Eliza's whole sense of self was based on shallow values that required her, as she so thought, to compete with other enslavers in having "n's" to determine her self-worth and value. The sick irony of this was lost on her, Gideon and many other enslavers who failed to grasp that the very ones they mistreated so inhumanely were the very ones on whom they attached their own sense of self.

The peculiarity of slavery as well as its perversion and pathology are well illustrated in many scenes in *Harriet*. One in particular occurs when Eliza, after Harriet's sister Rachel (Deborah Ayorinde) dies, is so guilt prone about how badly she treated her and, undoubtedly, contributed to her death, that she becomes paranoid that Rachel's eight-year-old daughter, metaphorically named Anger, blames her for her mother's death and is trying to poison her. After whining and complaining to Gideon that she feels like she is "in prison surrounded by

hostile Black faces," Eliza, from her supposed sick bed, slaps the tea tray from the hands of a stunned and frightened Anger. Most revealing about this scene is how heartless, cold and disconnected both Eliza and Gideon are from the human reality of the lives of those they were imprisoning, including that of an innocent, naïve and traumatized eight-year old who is now an orphan. This film clearly reveals that while the system of slavery afforded whites the opportunity to vent and project the evils of their hearts onto the enslaved, it did not and could not eradicate their evil nor that their inner state of Being was just as miserable, if not more miserable, than those whom they evilly and miserably enslaved.

The reality of slavery's reciprocal bondage for the enslaver and the enslaved alike is witnessed in Gideon's complex and conflicted relationship with Harriet, to whom he was obviously attracted. Despite his natural and understandable attraction to her, his self-identity as an enslaver and hers as one who he believes, according to the social system of slavery, he has the right to *own as his property*, prevented him from approaching and treating her in the way he actually felt. His life is then consumed with his desire and need to find Harriet for these juxtaposed feelings of liking (and even loving her) and the belief that the only way to have her is by keeping her as his enslaved. Thus, we again see the peculiarity, perverseness and pathology of slavery.

We see this same peculiar perverseness and pathology play out in the character of Bigger Long (Omar Dorsey) who, as a free Black man, carves out a role in the madness of slavery by becoming a Black bounty hunter. Bigger, for a price that far exceeds money, ruthlessly tracks down his own enslaved brothers and sisters. The distortion of his conflicted and, apparently, haunting role plays out in the scene where he kicks and stomps to death another free person, Black entrepreneur Marie Buchanon (Janelle Monáe), in her own boarding house in Philadelphia where he and Gideon went on a tip that Harriet was staying there. Bigger's last stomp was particularly vicious as Marie named his evil by identifying him as the traitor he was and one who, although supposedly free, was not free at all, for he was still enslaved to an enslaver and slavery itself. Marie's words rang true not long afterwards. Gideon shoots and kills Bigger to prevent him from shooting and killing Harriet as they continued to pursue her capture. Ironically, Bigger, in the end, is killed for the very role he took on in his desperate efforts to be in the peculiar, perverted pathology that slavery is.

Just as *Harriet* is a study of the dark, dangerous and deadly complexities of human life, it is also about the hope, faith, determination and resiliency of the human spirit and will. It is also about the possibilities of conversion, transformation and redemption as evidenced through the character, Walter (Henry Hunter Hall). Walter, who knew and initially worked with Bigger, was a paid Black slave-tracker. Walter, however, has a conversion experience when he witnesses Harriet have one of her spells that made it obvious to him that she was talking to her God -- and that "it seemed God was talking back to [her]." Once Harriet came out of her spell, she knew to go in a different direction than where Gideon and Bigger were waiting to capture her and those with her. As he continued to watch the daring bravery of Harriet result in all of them risking their lives to walk through a river to freedom despite much fear and resistance from the group, Walter made a pivotal decision in his life. He no longer wanted to be a tracker, nor a traitor. Instead, recognizing and awed by the fact that there was apparently a force (and a Source) greater than the slavery system designed to entrap Harriet, Walter opted to offer his services to help Harriet assist other enslaved freedom seekers become free. And this he did, representing the transformation that is possible when our wills, hearts and minds are rightly aligned to higher ideals and purposes beyond our own limited and egoistic self-interests.

Upon Reflection…

Harriet is a film that should inspire, encourage and challenge us all to have our own inner reflections and *reckonings* as well as conversions and transformations as we examine where and how we genuinely are in advancing the cause of freedom for ourselves and others equally. It is a film that should have us identify and define the theological and the anthropological views we hold that determine our own way of perceiving and relating to others based on these views. The transcendent nature of Harriet's accomplishments is undeniable and can easily fall into the category of the incredulous minus this theological and anthropological understanding. And while there is an intensity about Harriet that creates an aura that seems to transport her beyond the worldly norm into the realm of the mystical, Harriet is very clear about how she was able to fulfill the daring feats she accomplished. As she tells William Still on return from one of her several freedom escapades back into the dangerous slave territories of the South, "God showed me how."

It has always been Harriet's tenacious faith that long ago gave me great appreciation for the role and contributions she made to our freedom journey as a people. This movie has helped me to appreciate her all the more. Even after seeing this film for the sixth time, I never tired of watching, witnessing, championing and being moved by her God-driven bravery. As an ordained minister, I was most impressed with how she was able, in a time when seemingly all odds were against her on all levels, to commandeer a different reality that she responded to based on her hearing and heeding the Voice of God. Indeed, she entrusted her fate and her freedom not to what she saw that sought to enslave her outwardly, but rather to what she knew and experienced that liberated her inwardly.

Unless we acknowledge and appreciate the highly evolved spiritual Being that Harriet, not just was but still is, we will keep her minimized in history and in our own lives as an anomaly. There is a danger to making people anomalies. When we do, we make the excuse that we have not the inner capacity to accomplish in our own current day the same needed great deeds that Harriet and many others of history have so courageously done. The Truth is: Harriet Tubman was not the anomaly; slavery was. Slavery was and always shall be a horrific anomaly to who we are and how we are to relate to one another. And this includes the slavery that is inherent in all isms that are used to pit us against one another by maintaining human hierarchies of insignificance. Just as human greed, ethnic arrogance and the disregard for the rights and needs of others ushered slavery onto the shores as well as into the soul of this nation, we find ourselves still today relentlessly plagued by those of us who wrongly believe we have the right to ontologically minimize and ethnically minoritize whole segments of people by claiming theological and anthropological privileges none of us have. *Harriet* is a powerful disclaimer to this illusion. It is a testament to what is possible when we commit the entirety of our existence to a cause that benefits humanity.

Given the indefatigable depth of Harriet's faith in God and her love for her family and for her people, even as she made her physical transition from this earthly world, her last words aligned with how she lived: "I go to prepare a place for you." *Harriet*, as a cinematic presentation that captures the indomitable spirit of its protagonist, is one we should all see. We should see it to be encouraged and inspired as we face our own life odds -- life odds that can be transcended as Harriet shows us through her own life of valiantly and selflessly being willing to die to honor her passionate knowing that all have the right to not just live, but to live free. We should see *Harriet* to be reminded that we have the right to claim this same freedom for ourselves, just as we have the responsibility to keep offering this same freedom to others. This is the summation of Harriet's raison d'être.



Harriet Tubman (far left) at her home in Auburn, New York, with family and neighbors rescued from slavery. Photograph circa 1887.

Book Review

It Shouldn't Be This Hard to Serve Your Country: Our Broken Government and the Plight of Veterans

By David Shulkin
New York: Public Affairs
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Author Note

The insights or views expressed in this review are those of the author. They do not reflect official policy of any of the institutions the author has served. The author has no financial conflicts of interest.

Introduction

To begin, imagine the following: a president perhaps unaware of the schemes of his political appointees ... public policies engineered by these scheming "politicals"... a well-intentioned and optimistic, if somewhat naïve, cabinet secretary stripped of his ability to run his agency. What could possibly go wrong?

In this book, these images or themes are introduced and developed as Dr. David Shulkin describes numerous unnecessary and insurmountable obstacles placed in his path during his short tenure (February 14, 2017 – March 28, 2018) as the ninth Secretary of Veterans Affairs (VA) in the Trump administration. Shulkin identifies key players in the chaos that characterizes this presidency.

Former VA Secretary Shulkin is a physician as well as a former firefighter and Under Secretary of Veterans Affairs for Health (July 6, 2015 – February 13, 2017) during the Obama administration. He was the highest-ranking person to serve in both the Obama and Trump administrations. Shulkin entered government service because of his dedication to United States veterans and their families. He came to the position of Secretary of the VA well prepared and highly endorsed by all who knew him, including President Trump. His intention was to strengthen and reform the VA. The abrupt termination of his short tenure meant that he was unable to accomplish much of his agenda; although, ironically, his successors put in place some of his initiatives after his departure.



Shulkin's purpose in writing this book was to share his experience, present the facts as he saw them, and allow his readers to draw their own conclusions concerning the future of the VA. He remains convinced that the VA is a "vital and irreplaceable American institution" (v). While his narrative offers a clear direction for the VA, his story also reveals the tragic fact that the VA appears to be headed for privatization because of the corruption in American politics today.

The book's title reveals Shulkin's extremely positive feelings about the dignity of government service, both for cabinet members such as himself and for the men and women in uniform. He is convinced that those who dedicate a significant portion of their lives to their country ought to be able to trust the promises made to them by those in positions of authority beginning with Abraham Lincoln. Sadly, Shulkin discovered again and again that this sacred duty is too readily disregarded by those with power over veterans and others who faithfully serve these United States.

It Shouldn't Be This Hard to Serve Your Country has bi-partisan endorsement. This is fitting, since Shulkin gave his best effort to garner bi-partisan support for his objectives and policy initiatives. Such notables as USA General (ret) Stanley McChrystal, former acting administrator of the Centers for Medicare and Medicaid Services, Andy Slavitt, 55th governor of New Jersey, Chris Christie, and former Senator, former Governor of Nebraska, and recipient of the Medal of Honor, Bob Kerrey, have given ringing endorsements of the book.

Summary

Because he was denied access to his records immediately after being fired, Shulkin is forced to tell his story without reference to official calendars and other material that would otherwise aid in the preparation of a narrative such as this. To insure accuracy, he was forced to rely upon his wife's meticulous record-keeping and other sources still available to him. Despite these obstacles, he engages the reader with seeming play-by-play precision as he recounts the events that led up to his being named Secretary of the VA, his leadership accomplishments while he held that position, and his sudden (if expected) termination.

The Prologue describes Dr. Shulkin's emotional roller coaster ride from the time he entered government service until he was fired by a Trump tweet. The author describes his intense desire to serve our country's fighting heroes in the VA, "once thought to be the only part of the federal government that was above politics" (4). The Trump era changed all that. Shulkin decries "the politicals," i.e., those who are associated with the Koch brothers' empire and others who are intent upon dismantling the VA. Indeed, Shulkin believes that these politicals can even bring down the honored tradition of public service in our country.

The early chapters of the book focus on Shulkin's path to Trump's cabinet. The former Secretary's first official glimpse into the confusion and disorganization of the current administration is vividly recounted in the first chapter. Having completed his obligations as Under Secretary of the VA, Shulkin was waiting in Washington, D.C. to discover what would be the next phase in his life. Ike Perlmutter, one of the politicals, summoned Shulkin immediately to Mar-a-Lago for an interview. Although the call came during a meeting with Congressman Beto O'Rourke, Shulkin answered the phone, apologized to the Congressman, left the meeting, and caught the next plane to Palm Beach for "an interview unlike any other" (16). This anecdote serves as a metaphor for the incredible journey that lay in store for the next VA Secretary.

Once appointed to his post, Shulkin describes the bizarre events and encounters that led to his termination. The most sinister plot by the politicals involved a European business trip Shulkin took with his wife. As happened in many other instances, the politicals leaked inaccurate information again and again to the press, both liberal and conservative. Reporters willingly broadcasted the misinformation and Shulkin's reputation nose-dived despite his significant achievements on behalf of the veterans and their families. Although investigation after investigation cleared him of any wrongdoing concerning that trip or any other, that information was very slow to reach the press. By the time reporters realized that they had been duped, it was too late. Meanwhile, President Trump and his then White House Chief of Staff, USMC General (ret) John Kelly, gave every indication to Shulkin that he would be around for a long time and was doing a great job. The triangle became clear to Secretary Shulkin: the politicals were working for themselves, the President was clueless, and the Secretary would lose his job.

Meanwhile, Secretary Shulkin continued to meet and treat veterans in their medical facilities. He also engaged with veterans' support organizations, high-ranking officials in companies that provide for veterans' needs, and members of Congress who could assist him in his drive to support veterans and improve the VA. Approaching his new post with substantial experience in veterans' affairs, Shulkin hit the ground running toward the goal of dramatically improving wait times, quality of care, telehealth equipment and delivery, as well as utilization of the private sector. He worked to gain benefits for the Blue Water Navy and expand choices for veterans without privatizing the VA. All this he did while being sabotaged by Darin Selnick and other political appointees who schemed with the Koch brothers and their favorite organization, Concerned Veterans of America, to severely weaken the VA.

Shulkin clarifies his attitude toward the civilian sector in the care of veterans. He notes that "there is a big difference between providing veterans greater access to care in the private sector (which I support) and privatization" (327). The VA needs to do what it does best, i.e., provide essential services to veterans, and allow veterans to choose the private sector when it makes sense medically. The cost of following this protocol, as Shulkin thoroughly demonstrates, will save significant government funds.

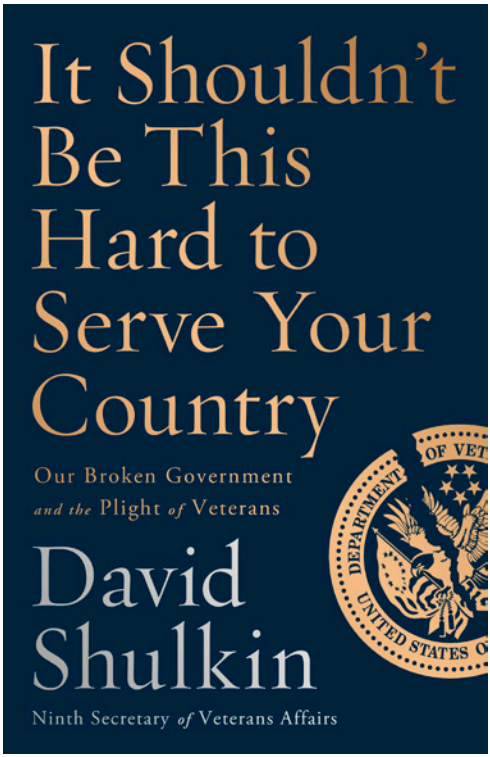
Shulkin's unwavering goal has always been to get it right for veterans. He was removed from office because of his dedication to veterans and not to the Trump agenda and political appointees. Shulkin's bipartisan approach was spurned and every request to include Democrats in photos or at meetings was rejected. Eventually, Trump fired him with a tweet.

Reflections

This book is a tale of betrayal, scandal, and lies. The author reveals the havoc that results in a president's loss of control over the political appointees who supported his presidential campaign. Readers gain insight into what happens when a country is run by politicals who force their agenda in front of and behind the back of this president. The narrative also helps readers to discover what happens when these politicals ensure that a cabinet member is powerless to run his agency.

This book is also a tale of integrity, devotion to duty, and honor. In this sometimes painful and always honest work, Shulkin accepts the challenge to rebut the bad press he received and set the record straight about his accomplishments and shortcomings. In short, he is finally able to tell his side of a tragic story. When a man does his job competently and to the best of his ability, it makes no sense to terminate him, unless politicals succeed in their insidious plot against him in "a disorganized and unconventional White House" (330). Such was the case in the Trump administration. Shulkin had to go.

The author emerges in this text as a dedicated family man and an extraordinarily competent and compassionate professional. Several times he acknowledges his indebtedness to his wife (also a physician) and their two distinguished adult children. Shulkin continued to treat veterans when he visited their medical treatment facilities so that he would not lose touch with them and their experience. His hopes and dreams for them ring true.



The reader is left to wonder how much better the VA could be if Shulkin had had several more years to complete the tasks he initiated. The Washington environment, an attack culture, is not conducive to the best interests of those who serve our country in uniform. The ultimate tragedy is that the VA is not and does not seem to be becoming pro-veteran. Shulkin states: "If the United States intends to honor its promise to take care of all its veterans, then we need the VA. It's that simple" (335). Otherwise, we forsake this moral obligation.

One final thought …

This book should be required reading for all Americans. We may not turn our back on the problems Dr. David Shulkin experienced and foresees for U.S. veterans.

Book Review

You Are Worth It: Building A Life Worth Fighting For

By Kyle Carpenter and Don Yaeger
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Author Note

The insights or views expressed in this review are those of the author. They do not reflect official policy of any of the institutions the author serves. The author has no conflicts of interest.

To Begin…

If we don't spend time on this earth looking out for one another, what are we really doing with our lives?

– Kyle Carpenter, You Are Worth It

William Kyle Carpenter is the son of James and Robin Carpenter and the older brother of Price and Payton Carpenter. He is the youngest living Congressional Medal of Honor recipient and the eighth living recipient to be awarded the Medal of Honor for actions in Afghanistan. In the book, *You Are Worth It*, Kyle Carpenter and Don Yaeger meticulously describe the events leading up to the heroic actions performed by Kyle in Marjah, Helmand Province, Afghanistan, that resulted in Kyle receiving the Purple Heart and the Medal Of Honor.

The story that Kyle Carpenter and Don Yaeger tells is humbling, moving and inspiring. And this review presents the many aspects of this powerful story of Kyle Carpenter's service, life and significance for us all. Kyle was born in Jackson, Mississippi, but the family moved multiple times throughout Kyle's upbringing. When Kyle was in the second grade, the family moved to Gainesville, Georgia, where they lived for six years before moving to Savannah, Tennessee. As a child Kyle was very active with his church youth group and he enjoyed going on mission trips. Before Kyle could play on his high school football team, the family moved to South Carolina, where he spent the remainder of his childhood. After arriving in South Carolina, Kyle began



attending a large high school with over 900 students per class. However, it was after his parents transferred him to King Academy that he began to thrive. Upon enrolling at King Academy, Kyle found that it "immediately felt like home." He joined the baseball team and felt like a person with a purpose. He stated it "felt like there was already a place for me there." One day Kyle attended an event at King Academy where he heard a Vietnam Veteran named Clebe McClary speak. Clebe had served in the Marine Corps in 1968 and heavy shrapnel from a grenade had cost him his left eye and left arm below the elbow. Despite these challenges, Clebe was now running a nonprofit organization that helped military families navigate the stresses of deployment and combat injuries. Mr. McClary "remained active, engaged and dynamic in advanced age" and "created an indelible life, not just in spite of, but because of his injuries." Clebe McClary would go on to become one of Kyle's heroes and inspirations for joining the Marines.

Kyle credits his parents for teaching him and his brothers to be functional, rational and contributing members of society. His parents taught him the importance of being involved in the community and also helped him to develop character, humility and resilience. After graduating from high school, Kyle wanted to join the Marines. However, to honor his parents, he decided to go to community college for one semester "to give it a try." Although Kyle was enrolled in school, he felt called to serve and made that clear to his parents. Although his parents were initially concerned about him joining the Marines, they ultimately supported him 100%. Kyle describes his decision to go into the Marines by saying:

> Too often we focus on keeping our word to others while neglecting the value of keeping our word to ourselves. In the course of not letting others down, we may limit ourselves. One of the most difficult actions we can do is move past someone else's outdated and imperfect idea of who we are to be. Likewise one of the most difficult actions for someone we love is to accept that new vision of who we are.

Kyle went to boot camp at Parris Island in South Carolina where he officially earned the title of United States Marine. He embraced the Marine Corps motto "Semper Fidelis" (i.e. "Always Faithful") and said he wanted to be a leader who would always be faithful to the people with whom he served. He then went to the School of Infantry, where he was assigned to Fox Company, Second Battalion, Ninth Marines, also known as the 2/9. As Kyle prepared for his first deployment, he keenly observed that the military go through a great deal of training and

preparation to know what to expect during deployment and have an idea of how to handle various situations. However, it can be argued that troop families are not similarly prepared in their support roles.

Kyle arrived in Afghanistan in the fall of 2010. He described well the amazing care Hospital Corpsmen provided for the Afghan locals. They took their jobs very seriously. "The corpsmen saw the patients and they saw the need. They didn't see the political divisions or tribal affiliation or social standing of the people in front of them." This served as a great reminder of the oath that health care professionals take to provide care to patients without any form of bias or prejudice.

Experiencing the Ministry of Presence

On November 21, 2010, at 8: 30 AM, Kyle Carpenter's life changed forever. He was at Patrol Base Dakota in Helmand Province, Afghanistan. According to government records, Kyle threw himself on a grenade to save the life of his good friend, Nick Eufrazio. The Medical Evacuation Helicopter (MEDEVAC) arrived in 12 minutes to evacuate Kyle. Kyle's heart stopped twice during the evacuation. After he was stabilized, he was ultimately transferred to Landstuhl Regional Medical Center (LRMC) in Germany. Here we got the opportunity to learn about the patient-centered care offered at LRMC. A chaplain meets and prays for each service member as they arrive on the tarmac. This was considered an important part of respecting the humanity of every service member. Air Force Master Sergeant Chuck Williams from South Carolina made sure he would be the one to greet Kyle as he arrived because he felt it would be beneficial for Kyle to have a familiar accent praying for him at his bedside. After Kyle arrived, Master Sergeant Williams introduced himself, prayed for Kyle, and then Kyle was taken straight to the operating room.

Throughout the history of many religious faiths, the ministry of presence plays an important role. The ministry of presence continues to be one of the most important ministries in chaplaincy. The ministry of presence ultimately played a very important role in Kyle's recovery, particularly during his time at LRMC. Master Sergeant Williams went beyond greeting and praying for Kyle on the tarmac. He subsequently stopped by Kyle's room each day, spoke with Kyle, and prayed with him despite his being in a coma. There was a special young woman named Tawny who was the wife of an Army flight medic deployed to Helmand Province the same time as Kyle. She regularly came to Kyle's bedside and when she first came to his bedside in the ICU she placed her hand on his unbandaged hand. She connected with Kyle's family back home and gave them constant updates on his condition. One of the most remarkable and touching aspects of this book was Kyle's trip from Germany to the United States. A woman named Jennifer had come to Landstuhl to say goodbye to her son Ryan. Ryan survived and so they were on the same plane as Kyle headed to the U.S. on November 28, 2010. During the flight, she heard Kyle saying "Mom." She then situated herself between Kyle and Ryan and held both their hands the entire flight home.

Many other people had a tremendous impact on Kyle's recovery while he was in Landstuhl, but the three mentioned above were remarkable examples of the ministry of presence with one demonstrating the great worth of another person. Kyle later commented that "Chaplain Williams had provided one of the most beautiful ministries possible: He was home for me when I couldn't be at home. Funny how something you don't remember can also be something you will never forget."

Wounds and Scars: The Purple Heart

The survival of wounded combat personnel is very high once home. After arriving at Bethesda, it took 13 hours and several surgeries to save Kyle's right arm. His parents would not leave his bedside as he went through this ordeal. As he began his recovery, he reported being driven by three things:

1. The simple fact that he could not undo his injuries;
2. The desire to be strong for everyone around him who were struggling with how to support him;
3. Being motivated not to let his injuries or the Taliban have power over him for the sake of every Marine who had gone before him and for those still fighting.

As Kyle awakened, he began having recurrent nightmares. In one nightmare he watched his own funeral, and nobody was in attendance besides the pastor holding a Bible and standing at the head of his grave. He believed that the Marines he left in Afghanistan were so disappointed he left them that they did not come to the funeral. Another nightmare was of his father attacking the hospital because he thought Kyle would be discharged and could not afford the hospital bills. He also had nightmares of having both arms amputated and wooden stick arms. He went from nightmares to paranoid ideation and delusions that events from the nightmares were true. This made for a psychologically taxing early recovery process.

Of particular note: On December 30, 2010, General James Amos, Commandant of the United States Marine Corps, and Carlton Kent, Sergeant Major of the Marine Corps, visited Kyle in the hospital and awarded him the Purple Heart.

Kyle decided that he would have to make peace with his wounds and accept them for what they were. He made the keen observation: "Our injuries happened. Nothing would ever change that. Our wounds were a part of our bodies. We were the ones who would get to choose what role they would play in our stories." With regards to the other soldiers recovering with him in Bethesda, he commented: "We were reclaiming our lives and learning how to be our fullest selves because of our injuries, not in spite of our injuries."

He was subsequently transferred to the Veterans Administration Hospital in Richmond, Virginia. He underwent 24 surgeries over the course of 12 weeks. Despite the many hours he spent under the knife and in recovery, Kyle tried to find joy in everything he did. He felt that "circumstances may be bad, but you are not your circumstances;" and "the way you choose to ride them out will set the tone for everything that follows." He was finally given the option to go home for recovery. He had a hero's parade style welcome. However, after the celebration, the reality of his injuries set in: "Right eye missing, healing tracheostomy site, no teeth on bottom jaw, shrapnel embedded throughout body, black lined face tattooed by gunpowder that seared across it, Right arm heavily bandaged and fragile..." among other injuries. Kyle found that the more aware he became about the extent of his injuries, the more he realized what a miracle it was that he was alive at all.

Throughout his upbringing, Kyle has always found ways to connect with people from all walks of life. His multiple injuries showed him a new way that he connects with people, namely

through his scars. He commented on meeting gang members through a fellow Marine and he found that scars bridged the gap between him and the gang members. He went on to proclaim that scars are a universal language and connected him to people who would have been invisible to him. This includes people who were homeless or on parole among many other realities. He felt they all understood pain and brokenness, and that they had a clear bond through their scars.

He recalls exchanging scar stories with Kenny, a homeless gentleman on the street. He concluded that we should embrace the stories that made the scars and that the scars are a reminder of something that went wrong and something that went right because scars only heal if you are alive. Furthermore, he believes that scars represent a beautiful resilience and are evidence of healing. Most importantly, the scars give others hope that one day their wounds may become scars, too. He later decided that "wounds are part of our bodies, but we decide what part they play in our story."

His Caregivers

Throughout the book, Kyle regularly recognized his caregivers for the phenomenal care they provided. He refers to his large number of caregivers as the unsung heroes. He regularly commented on the great care provided by his family in taking care of him, including his parents missing his two younger brothers' birthdays so they could care for him at the bedside at the former Naval Hospital in Bethesda, Maryland. He remarked on a young doctor at the Naval Hospital who went far out of his way to find blankets to make him comfortable one evening while he was staying there. He recalls the great care provided by a nurse at the VA who meticulously worked on his feet to make it so it was less painful for him to walk, which led to him being more ambulatory. Later when Kyle was recovering at the Richmond VA, friends from 2/9 came to visit him and brought him his combat action ribbon. They spent two days visiting with him in Richmond. This helped him to see they did not see him as abandoning them. He recalled his friends from the Marine Corps who came from out of town and visited him to give his mother some respite. Those friends took the time to learn his needed wound care and really provided help. Ever introspective, Kyle acknowledged as he had earlier in the book that although he had enlisted, now his family was serving alongside him. He further refers to his caregivers and all caregivers as the unsung heroes who make great sacrifices for the people for whom they deeply care.

Once Kyle had recovered enough, he made sure to do what he could to thank as many of his caregivers as possible. Indeed, he reminds us of the great importance of saying "Thank you." He participated in "Operation Proper Exit" sponsored by the Troops First Foundation. This is a program that allows service members to leave the battle zone on their own terms instead of by MEDEVAC. This way the service member has an opportunity to have closure. While Kyle was visiting Afghanistan, he went back to thank the people currently working at the facilities where he was cared for. Through the Semper Fi fund he was able to go back to LRMC and he again thanked all the staff and let them know how valuable was the work they are doing. Even if the people who worked on him and with him were not there, he felt that the current workers can see how much their work is appreciated. He was even reunited with the MEDEVAC team that rescued him after the grenade explosion, and he thanked them as well.

When Kyle was being honored at the South Carolina legislature, he learned that Master Sergeant Williams, the chaplain who originally greeted him on the tarmac in Landstuhl, worked

as the Assistant Sergeant-at-Arms for the South Carolina State Senate. In preparation for the chance to meet Chaplain Williams, he painstakingly wrote a moving inscription inside a devotional book that he gifted Chaplain Williams that day: "People meet in terrible wonderful ways. I'm thankful we did. With love, Kyle. Thank you. Believe in purpose."

A New Beginning

One of the most remarkable scenes in the book occurred after an exhausting day of physical therapy. Kyle was sitting at a kitchen counter and struggling to eat a bowl of cereal, a task that was so simple before his injuries. He suddenly felt something inside him break. He found that every emotion, every fear, every effort to be brave to protect his family from his pain "came pouring out faster than the cereal he couldn't chew." At that very moment his mom walked in and she wrapped her arms around him. That is when he said: "Look at me. Who is ever going to love me again?" He immediately regretted saying those words. She responded: "I promise you are going to get through this and things are going to get better. Someday someone will love you and you will be happy for the rest of your life." That is when he had the realization that he could spend his life sitting at a counter, or he could get up and live. That happened only five months after the grenade attack and he decided to start a new life.

He felt a shift. He decided he could be honest about his pain, that he could let go of pretense and roles he thought he had to play. He realized that he did not have to pretend to be strong if he did not feel that way. He saw that he could move forward boldly and honestly. He could now allow his family to feel with him and to cry with him. He realized that if he kept pretending everything was fine, he would not be able to move forward. His trajectory for his future changed that night. From then on, occupational therapy was not about recovering motor skills lost but about challenging himself to see what abilities he could master.

In the midst of this realization, he decided he would now "fight for his future instead of against his past," that "there was not just life on the other side of this battle but in the middle of the battle" as well, that "recovery will never be over and that it would be best that he focus on the life that he was given." He decided that his past may have shaped him; but he will not let his past control him because you cannot change what is behind you but only what lies ahead. He added, "Too often we fall into the trap of thinking we have to have everything figured out before we can act...You just have to be willing to move and leave the past behind." As Kyle reflected on that moment in the kitchen, he stated that this was:

> . . . when I resolved not to be controlled by the worst moment of my life. If I had given in, I'd essentially of been giving my future over to the enemy who threw that grenade on the roof. And he had already taken enough from me. My life and my future belong only to me and I made the decision that I was worth fighting for.

He decided that he was going to fight for his future instead of chasing his past.

Kyle went on to cut the ribbon opening the new Walter Reed National Military Medical Center (WRNMMC) on September 15, 2011, and was part of the Wounded Warrior Regiment on the base. Being part of the regiment made Kyle start to feel like a Marine again. He made the decision that he would try something he never would have tried before his injury. He believes that this was necessary for a true rebirth. Kyle went on to participate in skydiving through the

program "Jumping for a Purpose" despite his fear of heights. He commented that he refused to let fears make choices for him. Tackling his prior fears was a way to "force yourself back into life" and he went on to say he reclaimed his life unapologetically and that "the only limitations are the ones you put on yourself." He ultimately ran three marathons, one of which was within a few months of his discharge from WRNMMC in 2013. He also went on to enroll and graduate with his bachelor's degree from the University of South Carolina. Indeed Kyle Carpenter gradually transformed himself into a combat survivor who did far more than survive. He continued to fight to live and he succeeded, claiming victories every day.

In Closing…

President Barack Obama called Kyle to inform him he would receive the Congressional Medal of Honor. The official announcement was made on May 19, 2014, and the official ceremony took place one month later on June 19. Kyle makes it clear that the Medal of Honor is not an individual award but rather it represents every person who has taken up arms against true injustice, standing as a beacon of hope for struggling and oppressed people around the world who risk their lives to save one another. He also makes it clear that there are no Medal of Honor winners; there are only Medal of Honor recipients. As Kyle continues to go through the healing process, he now sees the grenade explosion was part of a chain of events preparing him for life. "A life of purpose, service, leading and worth fighting for."

What Kyle Carpenter masterfully did in this book was remind those of us who are doing any form of work serving others, that the reason we continue to do this work day in and day out is because the people we are serving are worth it. The book opened with Kyle commenting on a taxi ride in which he told the driver his story. They both got to know each other quite well during that ride and bonded over many of their life stories. At the conclusion of the ride, the

driver thanked Kyle for his service and Kyle responded: "You are worth it." He had never said this to anyone before but found it to be the appropriate response at that time. Indeed as we get to know Kyle through this book we can see humanism at its finest and he is able to masterfully drive home the point that every human being on this planet is worth our time and sacrifice. Our families are worth it, our patients are worth it, our clients are worth it, our students and educators are worth it. Indeed, it is the great inherent worth of humankind that drives many of us each and every day to do what we do for the service of others. You are worth it, too.



Looking Out For One Another: The Never-Ending Call to Honor

UNDER CITY LIGHTS





A Poem

Mirror Image

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Introduction

Most of us realize that human beings are created good. At our roots, many of us want to believe that we wish to be good persons of service to our neighbors and our world. Yet there are times in our world and in our individual lives when we are puzzled by the curious flights we take from others who are in need. Any number of us can look back over the course of our lives and remember instances when we were less than eager to help another person. Perhaps the moment was filled with the conflict of schedules or of means.

However, there is the inevitable and gnawing inner possible truth that our flight from others could have been fired by something far deeper and more pervasive. When we look at other people in life, essentially, we are looking into a mirror. We see ourselves in others very often. That is part of the way we make our friends. We see in them our goodness or the virtue we wish to have. The same is more than likely true of those we dislike. We see in them the very things we fear or know are within us. They are our shadow-selves. We see them, and we run in fear.

In many spiritual traditions, both ancient and newer, there is often a belief that our human race is in an ongoing process of being "reconciled" to the Divine. The same is the common human experience of friendship and love. In love and friendship, perhaps with those with whom we have shared some woundedness, we become reconciled. A strange word this "reconciliation." It comes from the Latin root *cilium* meaning "eyelash." When we are reconciled with anyone, we and they stand eyelash to eyelash with one another. The other sees us intimately and loves us as we are. We see in their eyes our very selves, our hopes, our fears, our failures, all that we dream we can yet be --- and we are led to believe in a Greater Good

Especially for those who have suffered hate and discrimination of any and all forms, there are the experiences that bring isolation and the deadliness of ultimate rejection. Many of us experience these in many ways over all our lives from childhood onward. For all of us, in real reconciliation we have a monumental opportunity to serve others with grace and power in this world when we welcome them into our lives precisely because within them we see the totality of our own selves --- and we see the totality of the Possible. For women and men of spiritual faith, this is an opportunity to see in others that Other many call God.

Ultimately, in this unbridled welcoming there is no room for fear, only the adventure of the Greatest Good. And in taking steps with others on the road to that adventure, our valleys are filled, our pride is toppled, and hope is born again.....and again.

Companion

Like the paste-faced hunger of the city's homeless
pressing noses and eyes at the windows of well-lit restaurants
with the hunger steaming up the glass where their lips touch
she sat before me
wondering, waiting with longing
filled with all the human confusion and fumbling
that comes when you look into your own soul
and cannot make sense of the pieces of its puzzle:
looking and longing for something of substance
to still the ravenous hunger of her questions
knowing full well that the answers she feared within her
would mean to take a different fork in the road.
Such a road.
Never before thought, never ever dreamed, only feared.
A road before which she had always stood in absolute terror.
Her mind filled with images of stones and blood
aimed at her, pouring out of her:
the rejection of family and friends
and all those who once had walked with her in delight.
Now, the secret inside her no longer would remain silent
and cried out from deep within her body and spirit
like a new warrior whose name of gentle love
would no longer be kept a prisoner of her rage and nightmares.
I listened quietly to the storm that spewed around me,
a hurricane of meaning
garbled in the wake of anticipation
yet pregnant with a deeper living
beyond the death of leaving behind her hiding.
Once, a long time ago, I had stood at this same road-fork.
I knew the buffets and raging winds of fear
that had kept me from taking those first steps.
Then, there was no one to listen,
there was no one with whom to break some bread
and be companion to my nervous pacing
at the start-gate of discovery,
this race with one's self.
In those former days I had stood at a cliff-point
and never could believe that my leap of faith
would end in life and not damnation.

Now, resolved by my memories of my once lonely journey
my own soul can never leave in distress
those who stand at this same brink of their lives
and fear that at the bottom of the precipice
no Hands would catch them in their leaping.
She looked at me.
And in that looking I saw behind the mirror of her eyes
all the taunts she had received:
a family, that called her "leper;"
women, that called her "traitor;"
men, that called her "ungrateful;"
friends, that called her "no more;"
and holy people, that called her "sin."
Now, between us and around us
there was another Voice,
a Voice that knows the deeper Truth
more deeply than the human mind
which seeks to mount the Tower of Babel in every age
and believe that we set the standards of Truth
by the limits of our fears.
Now, this deeper Voice spoke clearly
within the brief whispers of souls embracing one another;
and in the quiet silence of the moment,
I gently stretched my hands
to touch the tips of her fingers
gnarled around each other.
And in that touching,
bread was broken,
stone-fears ever so slightly cracked,
one leg stirred with trepidation
and together we were stretched
to put one foot forward
and take the first step on that freedom-journey
together.

Closing Note

The author published this poem and its introduction for a volume of poetry in the late 1990s. The author holds the copyright. The introduction and the poem itself have been updated and revised. Note: The opening photo is the work of Tuur Tisseghem, available for free use on Pexels at: https://www.pexels.com/photo/close-up-photography-of-human-left-hand-159333/.

A Reflective Vignette

How Personal Experiences Can Help Professionals Become Better Practitioners

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I have often found it staggering to witness what some people consider emergencies. Panic attacks, being overwhelmed by work and family life, and needing to talk to someone from either loneliness or boredom are often put in the same category as suffering domestic violence or having a child with cancer. So, what is an emergency and who defines it? Perhaps an emergency must be experienced.

I have always considered that whatever interaction one has with another person, particularly a therapeutic interaction between a counselor or psychotherapist and a patient, is both beneficial for the patient and enlightening for the therapist. There is so much we can learn from patients about ourselves and yet, as professionals, we try to separate our work from our private life and pretend that whatever happens during a therapy session does not affect us.

Of course, this is not true. I have encountered many patients who touched a vulnerable part of my soul and changed me. Particularly important are those cases in which I felt I made a contribution to someone´s life. Originally, I was going to write a vignette about some of these cases that affected me. Then something happened that changed my mind and made me want to tell a more personal story, a story that gave me a different perspective on my practice, and hopefully will help me become a better practitioner.

I cannot recount how many times I have said to someone suffering from panic attacks: *Just breathe and don't worry about the symptoms you're experiencing; they're perfectly normal. Your body does not recognize whether the fear you experience is from a real danger or not. As a consequence, your body prepares for either fight or flight*. I have always reassured my patients in this way and have always gotten the same response from them: *Yes, what you say makes perfect sense. It's just that when I experience anxiety and panic, I can't think straight!*

A few days ago, I had a patient with a complex problem, and I stayed late to complete my notes. When I eventually finished and was ready to go home, I found myself locked in the building late at night in pitch black darkness with a very low phone battery, and the phone was my only source of light. Of course, my first reaction was that of annoyance. It was very late at night; I had a hard day and just wanted to go home. Not knowing what to do, I eventually texted a few of my colleagues without much hope that anyone would see my messages at that

hour. To my surprise and joy, some of them replied straight away with suggestions. However, this was not before I had the opportunity to have some disturbing thoughts of my own.

I thought about the funny situation I was in and that I would probably have to spend the night there in the building. Annoying, but not too bad after all. Next, I thought that, although I could not get out of the building, no one else could get in. Unless... unless someone else was already in the building with me!

In all the time I had worked there I had never found the lights off (there were lights everywhere in the building) or the front door locked. Then I began to panic. My heart began racing, I could not breathe, and I imagined all the possible things that could happen, as if I were living a horror movie. I was having a real panic attack...the first one in my life. I was having the same experience I had heard my patients relate so many times and that I had counseled them about. Only on this occasion, I did not have control of the situation; I was on the other side. I could not think straight. All the things I told patients to do when they were having panic attacks went out the window. I could not think of anything to do, and did not remember any of my training.

I will not go into any more detail. Suffice it to say I emerged from the building in one piece. Of course, there was no one chasing me with an insane laugh while I ran through the building desperately knocking on closed doors. It was just my imagination. There were no real facts on which to base my fears. But this did not stop my thoughts or my panic.

Moving forward, I think this frightening experience will probably be one of the most valuable lessons of my professional life. It will help me dispel the feeling of superiority of being a professional talking to a patient. This experience has made me realize that I must be humbler when talking to people who suffer and acknowledge the reality of how difficult it is to deal with fear --- however irrational it may appear.



A Closing Thought...

Dr. Benito's powerful vignette reminds us of what has been called "the paradox of healing." A healer heals not because of what he or she does, but because of who he or she is. But to be effective one must be authentic. And how much more authentic are healers who have borne the burden of illness themselves and know the suffering of their patients firsthand? In the healing arts our wounds are transformed into blessings when they enable us to heal others.

—Dr. Boynton, Editor

Henry M. Jackson Foundation
Special Military Health Film Series Continues…

The new YouTube series on military medicine and healthcare continues to be produced and directed by the Henry M. Jackson Foundation for the Advancement of Military Medicine. Information for the first two short episodes that have been completed thus far is found below. These episodes are immensely powerful. They demonstrate how military medicine/healthcare enriches healthcare for all people across the globe. For more information or for submitting suggestions regarding future topics, please contact the Creative Design Department at HJF c/o (240) 694-2000.

2018 Heroes of Military Medicine Ambassador Award

The Air Force's 99th Medical Group was awarded the Hero of Military Medicine Ambassador Award for its heroic response to the October 2017 Las Vegas mass casualty shooting.

Web Address: https://www.youtube.com/watch?v=9O7sL5WPPV0



The Veterans Metrics Initiatives

TVMI—The Veterans Metrics Initiatives is a novel public-private collaboration that unites multi-disciplinary research experts from the Departments of Defense and Veterans Affairs, academic medicine and social science, and industry to develop an evidence-based

Web Address: https://www.youtube.com/watch?v=U2PP1QqFFSM



The 75th Anniversary of the Liberation of Auschwitz
Remember. Never forget.



Always maintain the vision and strength
to prevent the worst, and promote The Good.

Lighting memorial candles for Yom HaShoah. Photo by Meagan Schutter, courtesy of U.S. Air Force.

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