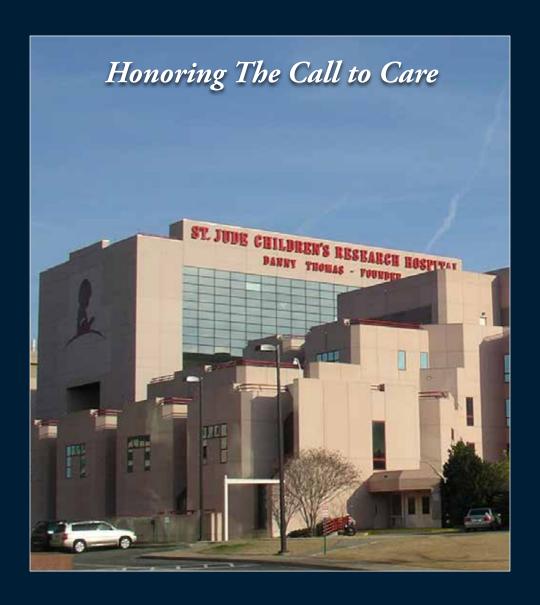
# Journal of Health and Human Experience



The Cure That Is Care



Remembering this year's 60th anniversary of St. Jude Children's Research Hospital being founded by Danny Thomas in 1962.

# Journal of Health and Human Experience

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# 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.

The Editorial Leadership enthusiastically welcomes academic and research investigations, reviews, commentaries, creative writing such as poetry/short stories, new and emerging scholar submissions, and other possibilities.

The Journal makes use of a highly innovative four-stage academic mentoring review process.

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#### 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.

**Values:** Those who become involved with Semper Vi programs practice the Foundation's three core values: *Learning, Healing*, and *Serving*. Foundation participants seek to show those who have suffered that healing can be theirs especially when their stories and experiences become sources of comfort and care for others

**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

across the globe. This Founation designs and provides workshops, seminars, webinars, podcasts, full conferences and continuing education courses at various international locations. Depending on resources, events are filmed and posted on the website.

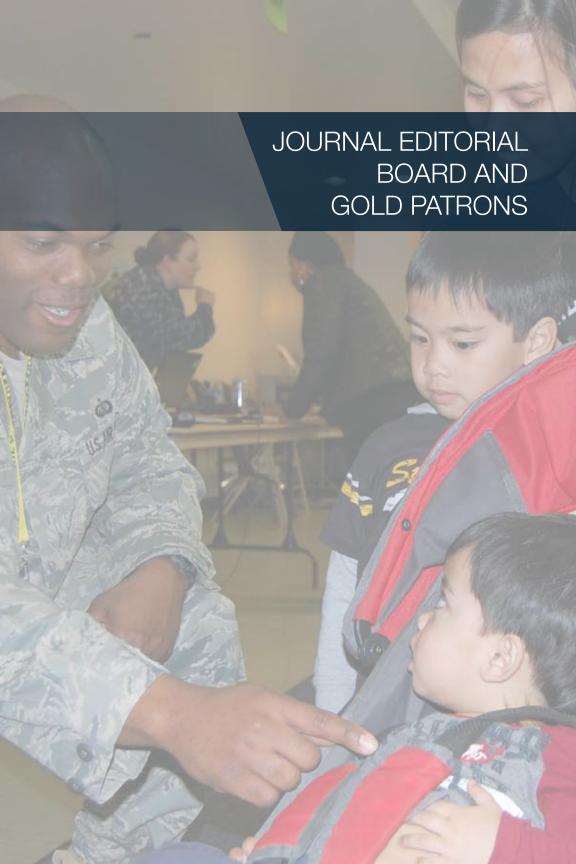
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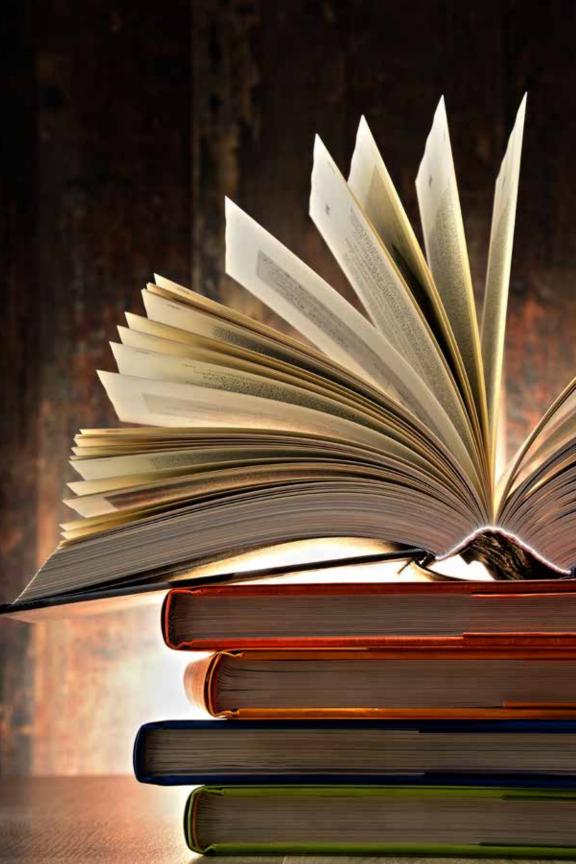
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**Social Justice Services:** The Foundation serves as a gathering point for individuals and communities who design and promote diverse social justice services and resources supporting human and civil rights. The Foundation supports already existing 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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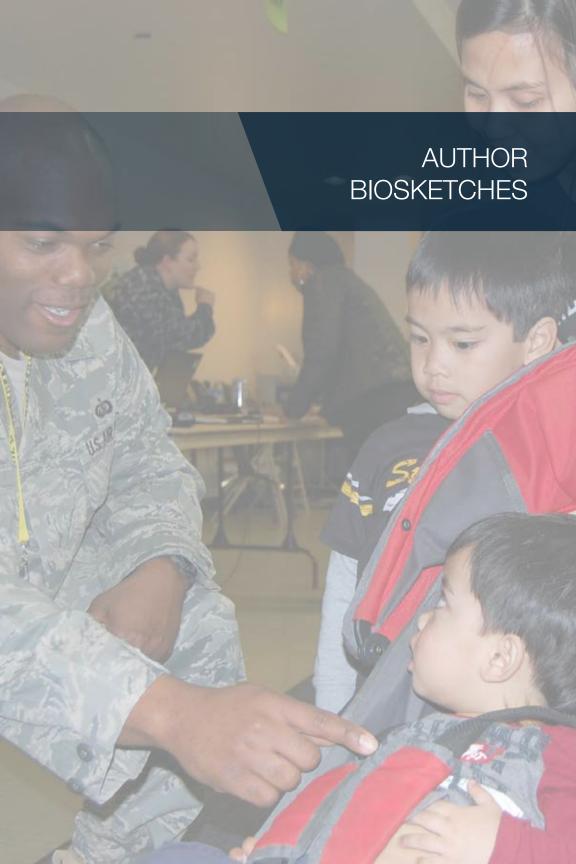
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# Healing's Heroes: Learning To Be

#### Dr. Edward Gabriele

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"Fear is a funny thing. Some of the time, it brings out the worst in people. But fear also brings out our very best...love, loyalty, care, and kindness...support, generosity, and appreciation. And for a certain few among us, fear brings out something different, their choice to be heroic. To stand steady, to hold onto each other, to find a way to hold onto hope, and to lean on each other like family."

— Sharon Goodwin (played by S. Epatha Merkerson) *Chicago PD, Season 7, Episode 4* October 16, 2019

As each of us grows older, the experiences of our lives take on ever deeper meaning. This includes our memories of those we have met, the places we have gone and the events we have known. Interestingly enough, such remembrances seem to become like doorways that continually open us up to new insights about who we are and, most deeply, what is the meaning of our lives---and so often the meaning of life itself. This certainly has been true for me in so many vast and definitely unforeseen ways.

I grew up in a military family in the Italian Market area of South Philadelphia. And my immediate family members all contributed in many diverse ways to services for the health and well-being of those in great need...especially our Wounded Warriors from the military, public servants who worked in impoverished areas, as well as the poor themselves and the dispossessed. Eventually, my own pathways led me to various healthcare services and experiences that stoked the fires of my imagination and my own feelings about myself and my life, including deep internal feelings of fear whether of life itself or about me as a growing person.

One of the more recent experiences in my life that also continues to lead me to reflect deeply on what is health and the care of others was when I was invited to teach at St. Jude Children's Research Hospital in Memphis, Tennessee. We all know St. Jude very well. And this year marks the  $60^{th}$  anniversary of its founding by Danny Thomas. Indeed, he is one of the great people whose service of others continues to be an amazingly deep inspiration for us, especially in our times today. In fact, his life story that led him to found St. Jude teaches us one of the most important lessons about what is the heroism that is healthcare itself and what it means to be a servant leader, a "hero," of healthcare for others.

As I mentioned, I was privileged to teach at St. Jude and to collaborate with various individuals who served there. When I went there a few years ago, the experience was breathtaking. From the moment I arrived on the hospital campus, something grabbed my inner self and once again shoved my face and heart and soul into vistas that I have always been called upon to explore...and definitely not to avoid. Standing in front of Danny Thomas' and his wife's

#### **Prelude**

burial site, I remembered his life story and how he suffered from various life-wounds. From his own spiritual tradition, he prayed to St. Jude, Patron Saint of the Impossible, promising that if new doors would open up for him, he would build in return a tribute of thanksgiving. With his being led to new pathways of success, in all faith he kept his promise and founded St. Jude Hospital to bring healing care to children suffering from cancer and other catastrophic diseases. Thus, Danny Thomas looked deeply within himself and allowed the pathways of his own life to lead him to a doorway that opened him up to the amazing experience that is the selfless service of others...especially those who are famished and hungering for the ultimate cure of human experience, namely the experience of care. Indeed, Danny Thomas was himself a wounded warrior of life....and then grew to become a wounded healer!

My experiences at St. Jude became another of my many critical life-doorways...another doorway in which to be invited yet again to look deep inside myself to see where I am always being called to go beyond my own self to hear the cries of those most in need and dedicate myself to be there for them in any and all ways. The people I met, the children I saw, the healing presences I encountered struck me to the depths of my very self. These experiences to this day lead me to ever-explore the meaning of health itself and of healthcare. And in our lives when all of us continually look for what it means to be a hero, the experiences I had at St. Jude, as well as in many other areas in my life, have had much to teach me...and all of us...about the essential nature of heroism itself...especially that to become a hero for healing means beginning the journey within one's self.

One of the most profound lessons of my own life was coming to understand that the hero is not one who dazzles with mercurial glitter from heights above us all. The hero is absolutely and completely different. The real hero, ultimately, is one who looks inside the self and realizes the importance of being authentically present to and serving those most in need...and serving them with utter and complete selflessness, humility, care and love. Regardless of the context, whether objectively large or smaller in life, the call "to be present" to others in need is a common calling for each and every one of us. This call is one that never stops. In fact, it begins most deeply when we realize that we ourselves are also people who are in need. All of us are wounded warriors in so many vast and differing ways. None of us is self-sufficient. None of us journeys through life without pain or difficulties. None. We all are needy. And when we learn to look within and discover our own neediness, then something can move us to look outward through the opening doors of life to hear the cries of others who also are in need...especially those who are wounded and suffering the most. When this happens, our hearts and souls and selves expand in ways that are incredible and incapable of imagining beforehand. Such is truly what occurred in Danny Thomas' life. It is also what we experience in so many incredible leaders in our world... especially many who have recently passed over such as Archbishop Desmond Tutu who suffered the horrors of hate and racism and then totally dedicated every moment of his life to raise up all those who are bowed down.

Indeed, the call to be heroes is an extremely demanding life-experience, but also one filled with the incredible expanse of what it means to be who we are called ever to become. In this sense, we are all given the call to become "Wounded Healers," those who from the depths of their own woundedness arise and become those who are ever present to serve all others who are suffering. And this has particular importance when we recall that healthcare is a much more fundamental experience than being a business. Fundamentally and primordially, healthcare

is human care. And today, more than ever, we need to remember that all of us are called to dedicate ourselves to the cure that is care.

As we remember the selfless heroism of Danny Thomas, as well as some of our recently passed heroes such as Archbishop Tutu, we are called to remember that each one of us, in some way, is also called to the selflessness that is true heroism. Ever embarking on the journey within our own selves, the doors of life open before us and we see the many women, men and children who are hungering and thirsting for food and drink, for shelter and security, for dignity and love... for true health, true humanness and true fulfillment. Especially today, their voices cry out to us from the nighttime of their lives. Are we listening? Do we hear them? Are we ready to help in whatever ways may be possible for us given our own life circumstances?

In our times today, there is a critical need for healing's heroes who can be present to our world itself---especially to all those in need who are suffering from the cancers of hate, discrimination, power and domination.

Are we ready to look within? Are we ready to hear the call? Are we ready to learning how to become healing's heroes?

Are we ready?



# Special Notation

The Prelude's opening photograph is an adaptation of an original photograph depicting Seva volunteers serving children suffering from cancer at Kidwai Hospital in Bangalore. It is the 2004 artistry of UnspokenTruth obtained from and used freely per Wikimedia Commons: https://commons.wikimedia.org/wiki/File:Seva\_volunteers\_with\_children\_with\_cancer. jpg. The closing is an Official White House photograph in the public domain. Attribution is found in the caption and per Wikimedia Commons: https://commons.wikimedia.org/wiki/File:P091714AL-0344\_(16600458958).jpg.







# **Time for a Paradigm Shift:** The Necessity for the Human Side of Patient Care

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#### Special Editorial Notation

This article was originally published in a previous edition of the Journal. Given the deeply powerful theme of this current new edition and this year's special anniversary remembrance of the founding of St. Jude Children's Research Hospital, this article is most moving. Its academic scholarship, perspectives and approach comprise an important gift for our readers. Permission to re-publish the article has been officially given by the author. The author has provided various updates from the original.

#### **Author Note**

The opinions of this review are those of the author alone and do not represent the views of the Helen and Arthur E. Johnson Beth El College of Nursing and Health Sciences at the University of Colorado, Colorado Springs, or other institutions or organizations the author may serve. The author has no financial conflicts of interest.

#### **Abstract**

This article discusses the need to bring caring and compassion back as the core of caring for human beings. It addresses a number of perspectives, including the explosion of knowledge in the last 50 years, the potentials and pitfalls of technology, and the role of healthcare reform in degrading a caring atmosphere. It attempts to define the human side of caring, provides a very abbreviated history of healthcare, the physiological benefit and cost of caring, and some of the ethical issues involved. It concludes with a reflection of the article's content and a call for healthcare providers to begin to examine their own caring practice and to create an atmosphere for others to do so.

Keywords: Care, compassion, healthcare, empathy, sympathy, technology

#### Introduction

It would be very easy to sum up this entire article in one sentence, and that would be a statement made by Geraldo Rivera when speaking about his watershed moment while covering an exposé of the Willowbrook State School (Film Rise, n.d.). He stated "...The assembly line works for cars. It does not work for people. People need humanity. They need the spirit of compassion. They need to be loved....." Though he was speaking of the horrific conditions he saw at Willowbrook in 1972, his comment seems to be even more relevant in today's healthcare environment. However, to fail to delve deeper into this important topic would be dismissive of this topic as unworthy of further examination. Therefore, this article will look at this problem from a number of perspectives including: the explosion of knowledge in the last 50 years; the role technology is playing, and the contribution of healthcare reform. It will attempt to define the human side of caring, provide a very abbreviated history of healthcare, the physiological benefit and cost of caring, and ethical issues involved. It seems a very large undertaking and perhaps it is. Yet the bottom line is and always has been that there is the ultimate human experience of suffering and illness that we must recognize from the humanistic point of view.

#### The Human Side of Caring

Because of the profound advances in the science of healthcare, the organizational and system changes, and advances in technology, the human side of caring and healthcare seems to have taken a back seat. The following is an exemplar of the current lack of consideration of the personhood of the patient as related to this author very recently:

John had suffered some sort of spider bite that was beginning to look more and more like a brown recluse bite. Often with these bites, there is significant tissue loss, requiring intensive and early medical intervention. After a few days, the bite began to look angry, red, and was quite swollen with some tissue necrosis. The usual home remedies were not working. A call to John's family practice provider's office for a same day appointment was unsuccessful. The untrained medical assistant who was in charge of triage gave John the next appointment, which was 3 days away. It was suggested that John visit an urgent care clinic in the meantime. Therefore, John went off to a local urgent care. After waiting some 30 minutes (considered a short wait), he was taken to a room where vital signs were taken, then left alone. The person doing this never introduced herself, just performed her tasks with no interaction. Sometime later, another person came in, told John it was red and infected, and then gave him a prescription. As well, this person never introduced himself. John had a few questions about the bite, but was not given an opportunity to ask them; instead, he was ushered back out to the waiting room so the next person could come in. John then went to his appointment 3 days later and was told it was indeed a spider bite, it was infected and he needed stronger antibiotics. At this point there was significant skin breakdown and it was still red. He was given a referral to a dermatologist and told to wait for a phone call. The next day, the dermatologist's office called and explained to John the next available appointment was in 6 weeks. When he tried to tell the office scheduler (not a medical person) that this was an acute problem and he was concerned about it, the scheduler simply responded with "Well, this Dr. is very busy and I cannot get you in to see him." John felt belittled by someone who seemed to have no empathy for his situation. So, John was left to continue the antibiotics and hope the bite healed on its own. All indications were that it would. John related to me, "I believe I would have been better treated by robots."

Fortunately, this story had a good ending. Unfortunately, this is an all too frequent experience in healthcare today. Patients are shuttled through a system that seems to have little regard for the human condition when a person, a human being, is ill or injured. Instead, they are a "number," even called so. The provider often spends more time staring at a computer screen than genuinely communicating with the patient. A barrage of standardized questions are asked, all in the name of collecting metrics to provide data for regulators. The numbers in the computer are thought to tell the story, yet they do not. The response by big data managers is that a small number of anecdotes simply cannot be relied upon to drive healthcare when compared to the large amount of quantitative data collected.

The following serves as a stunning example of what can happen when individuals at all levels of a hospital organization fail to attend to patient care issues in the midst of a massive reorganization of the healthcare system. This event occurred between 2005 and 2009 at two Mid Staffordshire hospitals in Great Britain. An inquiry into patient complaints and a higher than normal death rate showed, according to a report by Robert Francis, QC,

.....failure on a scale that cannot be adequately expressed in statistics. The individual accounts of suffering are too numerous to list here, nor could they be done justice; but they spanned almost every aspect of care and painted an overall picture of a trust devoid of humanity, totally incapable of recognising patients as people. (Holmes, 2013; p. 521)

#### Francis concluded:

The shock that is the appropriate reaction to many of the experiences the Inquiry has been told about reflects the distance between the standard of basic care that is every patient's legitimate expectation and what has, on too many occasions, been delivered at Stafford Hospital. (Ibid)

The conclusion of the report was that this was an immense failure of all involved, from less than adequate care by caregivers to disregard by managers and overseers. The result was injury and death to patients. In the current unknown state of healthcare in the United Sates, we too, risk a similar event in our system. We are at a point where definitive action must be taken to preserve the dignity of healthcare.

Recently a very small boy with a very rare genetic disorder has been headline news. Charlie Gard's case had been considered futile and too expensive, so he was ordered off life support and experimental treatment denied, citing the statistics and unsubstantiated claims of harm as reasons for the denial. While court battles raged for several months, Charlie remained on life support and his disease went untreated. What is so interesting about this case is the fact that the doctors stated they believed he "might" be suffering, so to end life-support would be more humane, overruling even the parents' ability to pay for an "as yet unproven" treatment. At the same time, this little boy's parents were suffering from their own kind of battle, dealing with a devastating disease and the reduction of both them and their child to numbers and headlines. After Charlie's case was deemed to be catastrophic and irreversible, and the European Court of Human Rights rejected the patents' final appeal, the parents subsequently decided not to waste any more of the time they wanted and needed with their son in seeking further treatment for him. Even then, Charlie's parents and the hospital could not agree on how Charlie was now

to die. He was put into hospice, immediately taken off life support, and subsequently died the next day. This was despite the fact that Charlie's parents had asked for a few more days to spend privately with their little boy who had valiantly fought for his life.

This case illustrates the collision between science and humanity. Charlie's parents believed their son deserved a chance; the providers thought his case was futile and that he was likely suffering, though there was no proof. They thought he should be allowed to "die with dignity." In the end, he was not even allowed to die with dignity in his parents' sense of the term. The science of Charlie's disease had advanced to the point where a treatment was available that might offer improvement. The courts sided with the providers. The case went international with President Trump and Pope Francis becoming involved, siding with the parents. The parents' opinion never really had a chance. The window of opportunity for Charlie's successful treatment closed with his and his parents' humanity pushed to the background. What kind of "care" was shown to Charlie?

## Caring, Compassion and Empathy

Hence, exactly what is meant by the term "caring" in the context of this article? Throughout the literature, the word "care" is used differently and in different contexts. Merriam Webster (Healthcare, n.d.) defines the term health "care" as, "the maintaining and restoration of health by the treatment and prevention of disease especially by trained and licensed professionals (as in medicine, dentistry, clinical psychology, and public health)". Nowhere in this definition can one find the words, human, care, or empathy. The same dictionary defines the term "care" in two contexts: one as a noun in the sense of things achieved to avoid harm to persons or things, the other as a verb in the sense of feeling concern or affection for another. The term "care" in the context of this article is used in the latter definition. That is, it includes the concept of empathy and compassion for another human being. The term health "care" could be called a misnomer when discussing the human side of disease treatment and prevention. One might suppose that care in the sense of the first definition of receiving a treatment or physiological care would constitute exemplary care. It would seem to be sufficient in today's healthcare framework of product lines and emphasis on clinical competence. Still, this is not enough to alleviate the needs and suffering of the human condition. As so eloquently expressed by Mr. Rivera above, humans need compassion and to feel loved. Caring in this sense implies an act based on concern for and understanding of another's burdens. In today's framework, this human viewpoint is quite frequently missing and healthcare is undergoing a crisis where compassion is scarce.

Care by health professionals frequently is touted as both an art and a science. In the current knowledge explosion, the art of medicine has been largely lost to the science. Shelley (2015) provided an excellent editorial describing how medical professionals need to reintegrate spiritualism (not in the organized religion sense), dignity, and compassion. He describes an "empathy gap" in medical education, with new knowledge focused mainly on learning the treatment of underlying disease processes (pathogenesis), as opposed to the role of humanism and compassion on the healing process (salutogenesis). Clark (2016) also described the difficulty nurses and nursing students currently have with integrating transpersonal caring into their practice and offers advice to educators for helping students assimilate this aspect of patient processes.

Jean Watson, a nurse theorist, has been instrumental in beginning to bridge that gap with her Caring Theory. She began to define this in her early work in the late 1970's and described this as central to a nursing caring relationship. She believed an integral part of nursing's healing role was to help an individual to maintain humanity and individual wholeness. Her work had deep philosophical and international experiential roots and had at its core, a genuine caring relationship as integral to healing. Later, she further evolved her theory to develop the 10 Caritas Processes (Watson, 2008). These included such things as being completely present to the person being cared for and creating an environment that allows for healing on physical, spiritual and emotional levels. Her work was so groundbreaking in nursing that it has been adopted by numerous hospitals world-wide as the foundation for their patient care practices (Watson, 2008). Dr. Watson has led the field in defining a caring philosophy for practice for all healthcare professionals. Even with the advances in her work, genuine caring and compassion seems to continue to be lacking. Most of the literature on compassion is concerned with compassion fatigue and burnout experienced by caregivers.

Lown, McIntosh, Gaines, McGuinn, and Hatem (2016) discuss the need for compassionate care as vital to medicine and that this should be a part of the provider's education. They state:

...compassion without collaboration may result in uncoordinated care, while collaboration without compassion may result in technically correct but depersonalized care that fails to meet the unique emotional and psychosocial needs of all involved. (p. 310).

Shelley (2015), a neurologist, believes strongly there is a physiological mechanism for healing based on humanism and spiritual wellbeing. He iterates that compassion and humanistic care is vital and necessary for creating health and that such education also should be requisite for healthcare providers. Fiering (1976) discusses a term he calls, "irresistible compassion" in which a human being is compelled to move toward relieving suffering. Also termed sympathy and humanity, it described our need to assist others. By contrast however, during the eighteenth century, if we as humans are irresistibly compelled to relieve suffering, then anyone who showed apathy was considered as less than human (Fiering, 1976). Fernando, Arroll, and Consedine (2016) differentiate compassion and empathy, stating one can feel empathy, for example with the patient who may have a broken leg, cannot walk and is in pain. However, they assert compassion is the next step on the continuum whereas one takes action toward alleviating the suffering of the patient. Empathy can occur without compassion, but compassion cannot occur without empathy.

Philosophically, compassion could be compared to caring. The two terms are often used interchangeably, yet they are different, or at least differently considered. To have compassion means to have deep empathy for an individual and to have a desire to alleviate their pain and suffering. Caring has many meanings and can be used in the above sense with a person, but can also be used with an inanimate object as in to care for a book, or a watch. The term compassion is a much deeper representation of the concept as it is coupled with the desire to remove distress where as it is not necessarily so with the term "caring." (Care, n.d.). Thus, when we are discussing the need for a shift to humanity in health care, we should probably use the term, "health compassion."

Humans have the unique ability to elevate empathy to higher realms and in more complex situations, even to extend it to other species. Darwall (1998) compares sympathy to care

as a synonym, but differentiates it from empathy. Whereas empathy is more a first-person experiencing something from another's standpoint, sympathy involves a caring response. He goes further to declare that empathy is dependent on the perspective of the observer and can range from indifference to deep, visceral feelings of sharing mental turmoil. Both empathy and sympathy are conditions of, but do not necessarily lead to, the act of compassion (Von Dietz & Orb, 2000).

Goetz, Keltner, and Simon-Thomas (2010) provided an evolutionary picture of compassion, referring to three different types as a trait that "enhances the welfare of vulnerable offspring.......a desirable emotion or attribute in mate selection processes and..... it enables cooperative relations with non-kin" (p. 354). It is the third evolution that gives rise to compassion in the healthcare context. Von Dietz and Orb (2000) attempted to define compassion as conceptually different from both sympathy and empathy. They describe compassion as having both an emotional component, but also what they term, a "rational dimension and.....deliberate altruistic participation in another person's suffering" (p. 168). The work setting in which clinicians practice is a highly stressful and demanding environment that leaves little time for compassion (Graber & Mitcham, 2004). The literature on compassion in healthcare professions continues to be scant, except in terms of compassion fatigue. Even though different conceptually, it is a term that continues to be used synonymously with empathy, sympathy, and caring. They are all often referred to as the most valuable attribute of healthcare, yet appear to be lacking (Schantz, 2007). The very fact that it must be defined and described in some detail speaks volumes as to the search for its true meaning.

Traditionally, medicine has been thought of as both a science and an art. Bronowski (1956) discusses the truthfulness of science, but also admits that the truth cannot be extricated from meaning. He implies that meaning is simply more challenging to communicate, but is an integral part of science. The science of healthcare has expanded exponentially. We are at the point where we can identify even pieces of a gene that will affect expressions of health and behavior. This enables very targeted interventions, giving rise to the terms "precision," or "personalized," medicine. Use of the term "personalized" can be misleading in that it is simply a misnomer. Aspinall and Hamermesh (2007) go so far as to state that our outdated systems and even physicians create barriers that need to be surmounted, as if use of genomic medicine would constitute a new medical panacea. It does have promise, but overlooks an important factor, the human who owns the genes.

Almost 100 years ago, M. Adelaide Nutting, in a speech to students at the Vassar Training Camp on September 9, 1918 titled, "Apprenticeship to duty" stated,

We may have great and imposing buildings, the last word in hygienic and sanitary appliances, dazzling operation rooms and laboratories, but that stricken human being lying there has many needs that none of these can satisfy. We must lean also upon the soul and spirit of the place to sustain and strengthen him. Such a soul and spirit many generations of workers,-nurses, doctors and others, have constantly striven to keep alive in our hospitals (Nutting, 1918, p. 162-163).

Though spoken years ago, this statement is as relevant today as it was then. We must continue to strive to care for the human, to keep the kindness and empathy necessary for the person to act.

Even so, there is a physiological cost to empathy and caring. Manczak, Delongis and Chen (2016) describe an increased parental inflammatory response to empathy toward adolescents in parent/adolescent dyads. Even though increased empathy was beneficial to their children, it came at a cost to the parent. Bevans and Sternberg (2012) described a case study of a caregiver in which the caregiver experienced numerous negative physiological health effects. Of course, there is a growing body of literature explicating the psychological effects of caregiving, including compassion fatigue and caregiver burn out. However, this only serves to stress the importance of care for both patient and caregiver, because the physiological effects of being genuinely cared for are enormous. Lebowitz and Ahn (2014) discuss the positive outcomes based on a therapeutic relationship between clinician and patient. Some would suggest patient adherence to a medical regimen is greater in the presence of perceived empathy by the clinician through both social and neurobiological actions. (Decety & Fotopoulou, 2015; Kelley, Kraft-Todd, Schapira. Kossowsky, & Riess, 2014).

## In Examining the History of Caring

There are three principal requirements in a medical man (sic passim): first, that he be skilled in the curative arts and familiar with the resources of the body, the powers of diseases, and the treatment to use for each illness; second, that he should be sincere and not have his eye on anything except the health of the patient, for many are led on by ambition or money to the point of administering poison instead of medicine; third, that he should pay close attention and take the necessary pains.

Erasmus (Albury & Weisz, 2001, p. 36)

Caring for the sick has ostensibly been done since the beginning of humanity, but has taken on numerous forms and been performed differently by different people. Philosophically speaking, using Laudan's Historico-Social assumption, one could surmise caring is a consistent feature of alleviating suffering (Laudan, 1977). Contextually, social scientists would say caring arose from the natural nurturing instinct of mother and child and was done by the women members of a tribe. However, despite the caring aspect carried out by women, the practice of medicine and rituals was performed by a medicine man, or shaman (Dock, 1920).

Greeks were the first to take care of the sick away from superstition and magic and into the realm of scientific and rational thought, based on nature (Longrigg, 1993). Interestingly, the Hippocratic Oath, purported to be written in the fourth century BCE, and which is used today as one of the oldest "rites of passage" into medicine, uses as its foundation, medical practice based on science rather than caring. The oath does not mention caring in the human sense of the word (Hulkower, 2010).

As humanity progressed in both knowledge and ability, there was a differentiation of duties, again according to those who healed and those who cared. Interestingly, Maggs (1996) identified a gap in historical accounts of nursing in which caring is consistently omitted in favor of political, social and demographic accounts of the progression of the profession. He asserts that throughout its history, nursing is simply an imitation of familial roles whereas the women assume the role of caregiver, thus yielding power to the more male medical roles. In his paper, he calls for a unification of theory and practice such that caring becomes part of the history of the profession.

Dock (1920) explained that the profession of nursing and of medicine closely parallels the standards of present humanity. Her lengthy History of Nursing follows the profession from ancient times to the modern day (at least in 1920). She discussed the impact of the Christian religion on the role of carrying out "God's work" in caring for the sick and the fact that, even though they had equal status in the early church, women were primarily the ones caring for the sick. Even during the Middle Ages, women held high-ranking positions in the monasteries, where hospitals were developed for housing the sick. During the Middle Ages those caring for the sick, both men and women (Dock, 1920), were from upper class families and this was considered part of their duties to society, especially during the Crusades; and institutions enjoyed the benefit of growth from land and monetary donations. However, in the thirteenth century, church oppression overshadowed growth of charitable monastic institutions. For example, in 1212 the Council of Bishops developed strict regulations for French hospitals and, in the name of efficiency, ordered patients to be cared for by as few Sisters as possible. This seriously affected the flourishing Hotel-Dieu in Paris, resulting in the Sisters becoming cloistered and in the degradation of their abilities. Because of this and the necessity to close huge numbers of hospitals, leaving few options for the poor, nurses at that time were drawn primarily from lower classes and were untrained, generating a disinterest to suffering (Dock 1920). Later, during the Renaissance, physicians were educated at universities while women simply took on the role of caregiver. One of the most immortalized stereotypical characters of that period was Charles Dickens' Sairy Gamp, a crude and untrained medical attendant who was given to drink. Some believed that women healers practiced among the commoners, yet were persecuted based on the existing political themes of the era, including religious persecution of women healers as witches (Ehrenreich & English, 1973).

Historically, war seems to hasten the proliferation of knowledge for the healthcare field. One of the most notable examples is Florence Nightingale's contributions to the significant decline in the mortality of soldiers simply based on keeping meticulous records and instituting sanitary conditions in the hospitals (Kopf, 1916). War is where advances in specific diseases and surgical innovation are used in an effort to improve survival rates and techniques (Bennett, 1990; Clifford, et al., 2014; Dock 1920; Salcido, 2015; Schwab, 2015).

A theme that seems to appear over and over again throughout the history of caring for the sick is one in which there is division of labor and differing roles in care of the sick. The "treating" role has traditionally been reserved for men, while the "caring" or "caregiver" roles were reserved for women. The medical profession seems to be cyclical, transitioning between lay and religious influences, and having periods where suffering and humanity were important and periods where this was not focal. Additionally, in most of the historical texts, the context of "caring" is not seen, except to mention its origins and the fact that it was separated into those who treated and those who cared for the sick. What has remained constant through the historical evolution of healthcare, though not always emphasized in the same way, was the fact that humans who are sick and suffering have basic needs to be treated humanely.

# Medicine as Big Business

It appears that the modern concept of healthcare is more business oriented than caring oriented. Currently, a basic motivation is to "process" as many patients through as possible to obtain the maximum reimbursement to meet the office overhead. So, what has driven healthcare to this point? It is extremely complex and is not the subject of this article. However, it currently

boils down to dollars and product lines. Moreover, contributing to the confusion is a lack of healthcare literacy, sometimes-unreasonable expectations by patients, and lack of insurability and healthcare access by the poor, causing them to use the emergency room for services because there, they will not be turned away (Joseph & Marrow, 2017).

Castano (2014) stated the business model should take precedent over the "oversimplifying approach to patient satisfaction with amenities and interpersonal skills...." He further posits that business models would do well to be substantially innovative. He does however, address the fact that patient-centeredness is an essential, but often overlooked component of such innovation. Angeli and Jaiswal (2016) go so far as to state that using efficient business models in underdeveloped countries can influence a decrease in poverty. Many espouse the notion that healthcare professionals also need to be educated in business practices to increase their awareness to entrepreneurship and business acumen (Castano, 2014; Hill, 2014; Miron-Schatz, Schatz, Becker, Patel, & Eysenbach, 2014; Peterson, Adams, & Demuro, 2015).

Yamamoto (2013) distilled the cost of healthcare down to per capita spending for each age group, as if humans were simply a number on a graph. He further refined it to the type of insurance plan on which an individual was enrolled, which showed no significant differences. Devaraj, Ow & Kohli (2013) examined data from 567 hospitals and concluded that efficient flow of patients through a system positively affects performance and the quality of patient care. The question remains, however: What is meant by quality of patient care? Even more so, what is meant by the term "care." In the business sense, it seems to mean treatment and prevention of a disease (Kahn, Maurer, Wartman & Sachs, 2014; Miron-Schatz, Schatz, Becker, Patel, & Eysenbach, 2014).

It appears in recent years, Accountable Care Organizations' (ACO) patient care quality has been linked with lowering care costs as a method to manage healthcare. In her paper explaining the origins of the Affordable Care Act, nowhere does Quadagno (2014) mention caring, but rather government reform of the US healthcare system from an economic perspective. This is all well and good, but there is some literature where this can be found to be linked with patient perceptions. For example, Kerrissey et al. (2017) conducted surveys of patients in structurally integrated care and found they perceived care was less integrated in patient-centered domains. By integrated, they meant a seamless organization of multiple caregivers to address the entirety of the patient's health issues. A study by Fryer, Friedberg, Thompson, and Singer (2017) concluded that increased patient integration as reported by patients could improve efficiencies of the healthcare system. Nowhere in these studies did they include patient perceptions of the humanness of care delivered. Their surveys only included demographics and care utilization and how their care was administered across services. As well, some literature links ACOs to provider perceptions of healthcare based on utilitarian perspectives (Noble, Greenhalgh, & Casalino. 2014).

A perfect example of this is outlined by Khouzam (2016) where he commented on the evolution of psychiatriatry from psychotherapy, now offered by psychologists and counselors, to the overprescribing of antipsychotic medications. Part of the reasoning for this was the fact that psychiatrists were reimbursed at a higher rate for a 15-minute medication management visit than for a 60-minute psychotherapy session. He proposed that, as a profession, psychiatry needed to reestablish its place in healing the human psyche and refrain from just prescribing medications, some with significant side effects (Khouzam, 2016). Similarly, Turabian (2019) discussed inappropriate prescription of multiple medications for those with chronic conditions and

suggested that the economic cost of this to patients is far more than conceived by the healthcare system only interested in metrics. One renal failure study patient voiced this quite eloquently, "Some physicians are bad – just pill pushers." Participants attributed their mistrust to an overall lack of "physician presence" (Pham, Beasley, Gagliardi, Koenig, & Stanifer, 2020, p. 2960).

As of this writing, the United States is in the midst of a great debate on healthcare. The Affordable Care Act (ACA), was signed into law in 2010 and fully implemented in 2014. It was designed to provide greater healthcare equity to an increasing the number of insured Americans. It created healthcare exchanges and a Medicaid expansion plan, using subsidies to insure more people. However, the result for many was a decrease in services covered and rising premiums (Gaffney & McCormick, 2017; Joseph & Marrow, 2017). Disagreement in Congress led to the creation of the American Health Care Act (ACHA) that would limit Medicaid expansion, eliminate the employer mandate and lower tax credits for lower and middle income Americans. Also known as the "repeal and replace," this bill has failed to gain support enough to pass the Senate. What is most interesting in this entire discussion of American healthcare is what is not being said. What is missing is the patient, the human, and any mention of compassion or caring. Additionally, most of the literature did not mention sustainability of the flawed system. However, the Massachusetts Health Reform could serve as an example of longer-term effects of healthcare reform. Garabedian, Ross-Degnan, Soumerai, Choudhry, and Brown (2017) only make a passing mention of sustainability related to short-term enrollment of patients with higher costs. In all the literature, the business model seemed to be the intent of the primary discussion. There is much literature in educating healthcare professionals toward a business model of care and in improving business skills (Hill, 2014; Kahn, Maurer, Wartman, & Sachs, 2014; Miron-Shatz, Shatz, Becker, Patel, & Eysenbach, 2014).

In his speech to the Waldo Symposium, Gawthrop (1997) stated,

The façade of pretense applied in the name of public service tends to project bureaucracy in its most unfavorable light. If this perception is to be changed in the years ahead, it is incumbent upon public servants, individually as professionals and collectively as a profession, to create a new reality for themselves, a new image that rings true of a service in the name of democracy. (p. 205)

This is most certainly true of healthcare, if we are to move away from the hypocrisy of product lines, polypharmacy, and profits to a profession that genuinely cares about and sympathizes with those under our care. Patient engagement in their care should revolve around goal setting with patients, monitoring and reporting. Again, this literature only implies these activities constitute caring and compassion, but business models typically lack in the humanity of caring.

Additionally, as the breadth and depth of new knowledge explodes, providers are hard-pressed to keep up; technology will be used more and more in diagnosing and recommending treatment for disease (Khan, Maurer, Wartmean & Sachs, 2014). As they state, "...health care teams essentially become the human interface between patient and machine" (p. 1216). For example, the mobile health and related applications continue to grow at a deafening pace as more patients download personal applications related to tracking their health, making appointments and accessing records (Peterson, Adams, & DeMuro, 2015). Mobile health allows for patients to communicate with physicians' offices without a personal interface. Despite

widespread use, privacy concerns and safety issues continue to be worrisome to providers (Peterson, Adams, & DeMuro, 2015). There is a plethora of websites and blogs where health information is inaccurate. Yang, et al. (2017) describe robotic systems with differing levels of autonomy levels ranging from no autonomy to "full autonomy (no human needed)." Already robots and avatars are being used for telemedicine and are proposed for various tasks in hospitals and to perform transport, food delivery, information transmission (Rogatkin, Lapaeva, & Lapitan, 2016). Tanioka, Osaka, Locsin, Yasuhara, & Ito (2017), in a frightening article designed to assist in the theoretic development of Humanoid Nursing Robots (HNRs), discuss the need for some HNRs to have the ability to "care" and show empathy for those for whom they care. This is contextualized in the aging of the population and the need for eldercare. They speak in terms of these HNRs as replacing human-to-human interaction because of a severe shortage of human resources, as if the human capacity for caring will be exceeded. A very recent ad sent over the internet states, "Similarly, artificial intelligence will act as virtual clinical assistant, patient care bots and digital coaches which would enable mimicking one on one interaction that keeps patients disease free and happy" (OmniMD, 2017). This is very frightening indeed.

Sim and Aida (2017) describe the attempt to synthesize molecular machines as the "Holy Grail" of future medicine. These tiny machines have promise in the specific endogenous treatment of disease and could be considered differently from their larger counterparts that might be expected to replace the human touch in medical and nursing care.

One of the most important impetuses driving the use of robotics is they are more cost effective than humans. Hamet and Tremblay (2017) suggest that avatars may be used to provide care for older adults because of more frequent conversation that is comforting and thoughtful. They do however admit that more research and evaluation need to be done. Additionally, ethical challenges should be scrutinized before use of robots becomes the standard. By no means could or should a robot replace caring human interaction, but as social media and electronic communication becomes more sophisticated and humans begin to interact from a distance, the slippery slope may not be far away.

One of the latest innovations is personalized medicine, which seems to be synonymous with precision medicine. In a 2007 article, Aspinall and Hamermesh speak of personalized medicine, but not in the human sense of the word. Instead, they detail a more genomic approach, using a patient's own genetic make-up and physiology to treat disease. Even this, though called personalized, is based on the patient's cells, not the patient. As well, Crawford et al (2014) outlined several institutional barriers of conducting genomic testing within academic medical centers. They concluded that the institution and its processes precluded the human side of caring for patients.

#### Conclusion

Caring for and nurturing other human beings is and has always been the very root of healthcare in some fashion. At different times throughout our history, that purpose seems to have gotten lost in the weeds of the time. Currently, there is a pervasive atmosphere where genuine human caring is taking a back seat in health care. Additionally, our world has begun to go in a direction where our technology allows for non-human interaction. It is only too easy to hide behind the anonymity of a handheld device or computer to communicate with others. Our

## **Articles**

systems seem to be enamored with numbers as a metric for quality of care rather than stories or input from those being cared for as to how best to do that. The continued quest for the 'holy grail' of replacing humans with robots in an effort to achieve more efficiency will lead down a slippery slope from which there may be no recovery. Admittedly, as the population and lifespans increase, this necessitates finding other ways to use scarce resources, but it is not clear that it is better to seek to replace human-to-human interaction. To ignore the human in need of our care is not ethical, nor is it desirable. Humanity and dignity must be preserved.

In a very interesting talk, given by Dr. Robert Sapolsky to the Stanford graduating class in 2009, he stated that what makes us most unique as human beings is our ability to react to contradictory ideas. He stated, "At the end of the day, it is really impossible for one person to make a difference. And thus, the more clearly, absolutely, utterly, irrevocably, unchangeably clear it is, that it is impossible for you to make a difference and make the world better, the more you must." (https://www.ted.com/talks/robert\_sapolsky\_the\_uniqueness\_of\_humans)

Considering all that has been shared, permit me to provide some reflections from a personal perspective. As human beings we can, at our worst, hurt and injure one another; and, at our best, show genuine compassion and caring for each other. I, for one, as a human being, do not want to rely on a middleman to relay information back and forth between a machine and me. I would much rather spend more in order to be assured that I am listened to, and cared for, by another human being. We need to find our way again, remembering the basic human needs of those who need our help to alleviate their pain and/or suffering. Therefore, it is a moral imperative for us as healthcare providers to move beyond the business models, the barriers of complacency, the harsh work environments, and the incivility and begin to bring back the "care" into caring. We need to be intentional about patient-centeredness.

In light of this discussion, I wish to call for a change to the paradigm of our healthcare system such that health "care" truly becomes health caring as opposed to the current health product lines. How much difference can a single person make? This was clearly illustrated in a movie titled "Pay It Forward" in which a young schoolboy was assigned to find a way to change the world. He decided to do good deeds to others, without expectation of repayment in response to a good deed done by him. This created a cascade of good deeds that made a difference in the town surrounding this boy. In fact, there is even a movement called "Pay It Forward Day" in which 80 countries participate.

If there is any doubt about the difference one act can make, one only needs to read the short story titled "A Sound of Thunder" by Ray Bradbury to realize how one simple act has the ability to drastically change outcomes --- something our healthcare system is very concerned about, but cannot seem to grasp in the human sense of the concept. In this story, one has the ability to go back in time and hunt dinosaurs, but must stay on a path. One individual strayed off the path and killed a single butterfly, changing time forever. In the case of caring for a human, an act of concern and kindness could actually mean the difference between resignation of an illness and motivation toward health. It could mean the difference between a provider who is tired and ready to give up and a provider who gains the energy to keep going and pay the kindness forward.

When it comes to the need for more caring in our defunct healthcare system, there are more questions than answers, and numerous points to consider. What would be the results if healthcare professionals were to take the time to listen to a single patient on any given day? How might that change the face of healthcare, or the outcomes of that patient for the better? How might we act as an example for others to emulate? Can we encourage patients to assume responsibility for their own health rather than to leave it to the hands of others who are more interested in data points than the person? How can we use the information quite literally at our fingertips and leverage our technology to create a caring system? It only takes one person, one caring act, one at a time. What would it look like if multiple people committed abundant caring acts, many at a time? I highly suspect we could change the face of healthcare from a data driven, business model with dismal outcomes to a caring, efficient model where our patients not only feel well, but also feel good. Let us listen and let us care.

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# The Critically Needed Integration of Behavioral Health into Primary Care: A Case Study

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#### **Abstract**

Even though behavioral health and physical health conditions are often interconnected, providers in primary care often approach individuals as separate parts. The tendency to separate stems from stigma toward those with behavioral health conditions, insufficient training, and inadequate resources. The separation contributes to fragmentation of the assessment process, limiting to a particular focus which can lead to misdiagnoses followed by inadequate or inappropriate treatment. The individual continues to suffer. Research demonstrates the integration of behavioral health with primary care results in improved patient outcomes and can lower costs in the long run. This article uses a case study, narrated by the patient to illustrate the impact of stigma and the results of failing to see the individual holistically. The intent is to motivate providers to self-assess their own bias or stigma related to behavioral health. Healthcare providers can benefit from stigma reduction training. Incorporating behavioral health screening tools in primary care can facilitate holistic assessments of individuals. Reliable, easy-to-use tools are available as well as training models that have proven successful in primary care settings. These models promote a shift in the academic setting to better prepare the healthcare workforce. Sustainability of changes is still a challenge, most likely requiring policy changes for overall transformation to universal integration of behavioral health with primary care.

Keywords: Behavioral health integration in primary care, case study

#### Introduction

Mental health and physical health are intricately linked, yet healthcare professionals continue to be entrenched in dualistic thinking of either physical or mental health. As much as 75% of primary care visits include behavioral health components, not always recognized as such (Scharager, 2021). Behavioral health encompasses both mental health and substance use disorders. The prevalence of behavioral health needs has driven an increased integration of behavioral health with primary care, yet integration is not the norm and substantial barriers continue to interfere with achieving full integration, considered the "gold standard" (Baker & Naidu, 2021). Barriers that perpetuate the artificial separation impact the care provided and often involve stigma, issues with billing and coding, lack of provider education and training, as well as lack of resources, and the list of obstacles continues (Barry, 2020; Richardson et al, 2017; Rivera-Segarra et al. 2019; Shim & Rust, 2013). This article will focus on the impact of stigma in healthcare.

Bias or stigma has been a concern for decades. In an editorial in the *Journal of Public Health* (Rosen, 1958), the author discussed how human problems do not occur discretely, one problem leading to another. Those needing help were described as inadequately handled at times, to their detriment. This was attributed to professional and agency specialization. Rosen called for better healthcare planning and organization to obtain optimal efficiency, effectiveness, and economy. He ended by stating "human needs are indivisible" (p. 1530).

Achieving the gold standard of integration of behavioral health in primary care is complex. In clinical trials, integrated models have shown improved health outcomes. Challenges with widespread integration implementation have been identified in the research (McGinty & Daumit, 2020). The presence of stigma is one of the challenges. Stating that stigma is a challenge does not necessarily create an understanding of nor urgency to address stigma by those who most likely exhibit stigma.

Detailed information from a medical record can be reported. Facts alone do not tell the entire story and may not illustrate the presence of stigma. The impact of stigma cannot be captured by lab results or medical imaging equipment. The impact is personal.

Al Saif (2019) identified strategies to challenge the stigma that exists in the healthcare system. One of the strategies is to allow the voices of those with behavioral health issues to be heard and understood so providers of healthcare may learn and gain insights that allow for more holistic care and better outcomes. Storytelling can be an effective, non-threatening way to expand the understanding of the importance of integrating behavioral healthcare into primary care. Sharing Ann's story as part of the case study is intended to elucidate the experiences of physical suffering and emotional pain that resolved once there was consideration for and attention to the whole person and integration of her care. Ann is sharing her story in an effort to help healthcare providers recognize how important it is to self-identify and overcome stigma within healthcare. Successful models for training, as well as for integrative care, will also be identified in this article.

### **Definitions**

## Stigma

Stigma, for purposes of this study, is defined as a set of negative, often unfair beliefs (Scocco, et al. 2017.) Stigma is further categorized as public stigma, perceived stigma, and internalized or self-stigma. Public stigma is a set of negative, often unfair beliefs that a group of people holds, originating from poor or insufficient knowledge leading to social discrediting, disapproval or discrimination (Frey 2016; Rogers, et al., 2018; Scocco, et al., 2017). The evidence from Stone et al., (2019) indicated healthcare professionals share the same stigma toward individuals with behavioral health issues as those of the general public.

Perceived stigma is the supposed attitude of others (Scocco, et al., 2017). Perceived stigma is integrated or internalized into self-stigma, stemming from public stigma. The description of self-stigma, also referred to as internalized stigma, is compiled from several sources (Carpiniello & Pinna, 2017; Corrigan et al., 2016; Corrigan et al., 2017; Richards et al., 2019; Sudak, et al., 2008). Self-stigma is the application of perceived or public stigma to oneself. It can interfere with one's self-esteem and undermine self-confidence. There can be a devaluation of self, resulting in disempowerment. Additionally, self-stigma often involves a sense of shame and/or guilt, fear of consequences for oneself, and not wanting to be a burden to others. The impact of stigma can serve as a barrier to seeking help.

It is important to note the connection of self-stigma and public stigma as applied to this case study. With healthcare providers demonstrating stigma similar to the general public, it is feasible, healthcare providers may, unintentionally contribute to the self-stigma experienced by individuals with behavioral health issues, compounding the barriers to seeking care. Additionally, when healthcare providers harbor stigma toward individuals with behavioral health issues, there may be a direct impact on decisions in the diagnostic processes and subsequent treatment interventions (Al Saif, 2019).

# Storytelling

This case study incorporates narrative from the patient, Ann, and information from her medical records. After an in-depth review of Ann's medical records, questions for semi-structured interviews were constructed to gather further information and clarification of Ann's experiences and reflections. The interviews provided opportunities for Ann to narrate. Narrating a case study is like telling a story.

Stories can be one of the most powerful means to influence, teach, and inspire (Boris, 2017). Stories provide meaningful information in ways that hold true and are remembered better than a list of facts or numbers on a scale (Boris, 2017). Boris described the use of stories as a means to clarity with complex ideas. Because people identify closely with stories, imagining how they would respond or act in similar circumstances, stories enable the listener or reader to work through situations without risk.

Peterson (2017) explained that cortisol, dopamine, oxytocin, and chemicals in the brain are released when hearing a story. To make an important point "stick," cortisol assists with formulating memories. Dopamine helps regulate emotional responses and facilitates the listener's engagement. This level of engagement is distinctly different than what occurs when

reading numbers on a chart or reviewing a traditional research article. When it comes to creating deeper connections with others, oxytocin is associated with empathy, an important element in building, deepening, and maintaining good relationships.

Perhaps most importantly, storytelling is central to meaning-making and sense-making. It is through a story that individuals form and examine their own truths and beliefs, as well as discern how their own truths and beliefs correlate with the truths and beliefs of others. Through the use of storytelling, the audience for the story can gain new perspectives and a better understanding. Storytelling could be an effective way to challenge and expand the healthcare provider's understanding of stigma by helping them see through the lens of a patient.

## Methodology

Medical records, narration from the semi-structured interviews with Ann and later her spouse, were data sources. An intensive qualitative analysis of the data followed guidelines by Budgell (2008) and was informed overall by Stake (1995). Triangulation was used to enhance the rigor during the analysis process (Flyvbjerg, 2011). Not only are the sources of data important, but the order in which data are incorporated into the analysis is important. Documents are suggested to be used first in the process. In this case study, medical records were the first source of data to be reviewed and analyzed. The data added second in the process of triangulation were the narration obtained from four semi-structured interviews with Ann. These interviews took place over a three-month timeframe, starting May, 2021. At the start of the interviews, Ann considered herself to be in recovery. In the second step of triangulation, the researcher added relevant observational data, including information for consideration from the literature (Stake, 1995). Once there were preliminary findings from the first two steps, the third source for triangulation was obtained by sharing the findings with Ann. This is also referred to as member checking (Flyvgjerg, 2011; Stake, 1995). As part of the overall process, Ann's husband John was interviewed. Data from the interview with John and data from member checking was incorporated in the third step of triangulation.

#### **Case Presentation**

### Background

Labor Day weekend, 2019, Ann's husband John bumped his head but dismissed it. John experienced headaches, initially thought to be related to allergies. The headaches increased in severity and in mid-October 2019, John was diagnosed with two subdural hematomas for which monthly CT scans were recommended for ongoing monitoring. On December 23, 2019, a major intracranial bleed was detected, and John underwent emergency surgery. "The surgery was a success," according to Ann. Then on December 28, there was a sudden cognitive decline. John had extreme memory loss with cognitive impairment. "It really threw me." Ann further described taking her husband home from the hospital on New Year's Day 2020:

He could not even operate the remote control for the TV. He had to have speech therapy. I read up on his condition and it scared me. I was very worried. What if he does not get better? I was determined to do everything I could to make sure he recovered. I would make him write at his computer and do everything he was supposed to with speech therapy and everything that was

recommended. I was so demanding, but I had to be. I knew he had a window of opportunity to make improvements.

Months later, as Ann described the events during interviews, the emotional tensions were palpable. She indicated she did not recognize how stressed or anxious she was at the time. She went into a caretaker mode, a manner of functioning she was used to within her family system.

By the end of January 2020, Ann's husband was progressing well, even to the point of driving.

## Ann's Story

Ann, a 68-year-old married Caucasian female, appears younger than her stated age. At the start of this case presentation, she was a psychiatric nurse, teaching in a nursing program. She was socially active and involved in her church community. Ann had a history of what was described as mild hypertension and was taking Hydrochlorothiazide 12.5 mg daily along with Valsartan 320 mg daily, and Pepcid 20 mg twice a day. Ann also had a history of foot neuropathy and chronic back pain. Historically, walking helped relieve her back pain, but walking was becoming less effective, leaving her in constant pain. She was treated for a urinary tract infection and a yeast infection. At the onset of her husband's diagnosis, Ann experienced insomnia. She did not connect her insomnia or any of her symptoms to her husband's diagnosis until she reflected back later.

Ann was referred by her primary care provider to an orthopedist for her back pain. There Ann had a magnetic resonance imaging (MRI) scan of her back. There were no significant findings and the orthopedist suggested Ann see a rheumatologist for possible fibromyalgia. She was preoccupied with her husband's condition, was working full-time, and never followed up with that referral. The primary care provider asked about the outcome of the referral to the orthopedist, and Ann explained what happened and indicated she was referred to a rheumatologist for possible fibromyalgia. The primary care provider dismissed the idea of fibromyalgia. He conveyed a negative attitude and doubt about the possibility of fibromyalgia. Ann never saw the rheumatologist.

In mid-December, prior to her husband's emergency surgery, there was a luncheon party to celebrate Christmas at Ann's place of employment. She went with a long-time friend and colleague who was retiring. This friend was also her neighbor. She recalled "feeling bad" but made no connection to her concerns for her husband, her own back pain, or her friend's retirement and failing health.

At the time of her husband's surgery and initial convalescent period, Ann's problems with sleep worsened. Her primary care provider reportedly called to check on Ann. He was aware of Ann's husband's condition and surgery. The primary care provider prescribed a low dose of Xanax. This is one of the only indications that he had an awareness of and concern for Ann's emotional state. Ann did not have the prescription filled; the pharmacist reportedly indicated they did not have the prescribed low dose in stock. In retrospect, there was no problem-solving around this issue. Additionally, on January 1, 2020, as part of their traditional celebration and celebrating her husband's homecoming from the hospital, Ann prepared a favorite meal and had champagne.

#### She reflected:

I had this metallic taste in my mouth. I was thirsty, but the metallic taste made me not want to eat or drink. I could barely smell anything. I don't think I paid much attention to any of this, I just didn't eat.

#### John:

Ann played down her stuff. I didn't realize what was going on. After my surgery, I don't remember much, at least not until the end of January. Then I remember thinking how frail she was. I would never have thought of her as frail. This was a bit disturbing. I didn't really know what to do.

On January 25, 2020, Ann's husband drove her to an emergency clinic. She presented with dizziness, excessive thirst, problems sleeping, and hypertension. Ann recalled being concerned that she was having a stroke and being grateful her husband could drive. (Medical Records from the emergency clinic were not available.) Ann was instructed to see her primary care provider. She did not schedule an appointment at that time.

On January 30, 2020, Ann was admitted to an acute care hospital with left-sided facial drooping and confusion. The initial bloodwork was unremarkable, head CT, head/neck CT were negative as were cardiovascular tests. The medical record indicated most likely transient ischemia attack (TIA). Ann did not recall any particular instructions at discharge, nor did her spouse recall discharge instructions at the end of Ann's brief hospitalization. Ann recalled thinking she needed to get out of the hospital, or she would be stuck there. She described thinking about suicide and thinking she could not even commit suicide in the hospital. At that time, she recalled questioning her own thinking processes. It is important to note, her friend, mentioned previously, died suddenly on January 26, 2020.

At an appointment with her primary care provider on February 1, 2020, right after she was discharged from the hospital, the primary care provider reportedly told Ann she was lucky to have nothing wrong with her and she recalled him telling her that she should enjoy her life. Ann attempted to describe her back pain, general malaise, inability to eat due to the metal taste in her mouth and being barely able to take sips of fluid. She also indicated her inability to smell anything. She described to her primary care provider how she stayed in bed all the time. She had experienced weight loss, but at that time, it was not enough to alarm her or her primary care provider. John's neurosurgeon was the one who approved Family Medical Leave (FML) for both John and Ann. The recommendation for FML was based on the complications John experienced post-operatively and the need for John to receive ongoing assistance. When asked in an interview if her emotional state was addressed directly during the February 1 appointment with her primary care provider, Ann reiterated her primary care provider told her how lucky she was and should go home and enjoy her life. There was no information regarding behavioral health in the medical record from that time. Ann explained:

At the end of the appointment, I just went to the car, went home, and got into my bed. I never said anything about anxiety. He (primary care provider) did not ask. It (anxiety)went from a low boil through the roof! I did not see that I was losing it. I did not connect my emotions to any of my physical conditions. I kept thinking – I have to figure this (overall status) out!

Then, it really doesn't make sense, but I thought – I had to figure out what we would do for my grandson's birthday, it was coming up. I had to rally!

And rally she did, at least partially and temporarily, just enough to celebrate her grandson's birthday. At the same time, Ann's husband indicated his concerns were increasing. As he recovered, John was able to see past his own health concerns and now was alarmed by what he saw in Ann:

She was not herself. I tried to get her interested in activities she has always enjoyed, like taking her for a drive to go birdwatching. It didn't help. I would attempt to ply her with favorite foods, but Ann would just move food around on her plate, like someone with an eating disorder. She did not eat anything. She always loved a certain candy bar; she literally took a bite then spit it out. I tried cooking different things she liked, that didn't work. She would tell me she was hungry for a patty melt, a favorite fast food. I would go get it. The first time, she ate maybe a quarter of it, then the next time a bite. I would give her Pedialyte. Then she refused that. I knew she was losing weight. She complained of unrelenting back pain. She was getting worse. I didn't know what to do.

As Ann continued to tell her story, she described herself:

I think I was bordering on agoraphobia, struggling to leave the house. Even going to get the mail seemed impossible. I just couldn't do it.

On February 28, 2020, Ann reportedly fainted in the shower. Her husband insisted on an ambulance. Ann was taken to an emergency department where she stayed for seven hours. An IV was started for hydration, she had a CT scan, and lab work. The only finding was a urinary tract infection and antibiotics were prescribed.

On March 4, Ann had another appointment with her primary care provider. Ann reportedly asked for something to help her sleep and Trazadone was prescribed.

I never took the Trazadone. I wanted something – but not that! Trazadone is too much. I wondered if I was going into kidney failure. Now, I realize, I didn't have much output because I really had no input. I didn't see that at the time. My sister (who lives out of state) thought something big was wrong. She thought I might be addicted to drugs or something.

At John's insistence, Ann returned to her primary care provider on March 17, 2020. This time, John accompanied Ann. He reportedly expressed his grave concerns for Ann and explained what he witnessed, confirming all of the symptoms Ann had complained of. The primary care provider referred her to a urologist and recommended a psychiatrist. On March 18, 2020, Ann did see the urologist. A kidney scan was negative. Ann's husband repeatedly attempted to call for an appointment for Ann with the psychiatrist, without success.

At this point, COVID-19 shut-downs were in full force. Ann reportedly was not asked about COVID-19 testing and there was no indication in her medical records. By Ann's report, neither her primary care provider nor any of the other physicians she had seen asked about or recommended COIVD-19 testing. The primary care provider did not acknowledge concern for Ann's complaint of an odd taste sensation and lack of smell. There was no indication in the

medical records up to this point of any screening or assessment of behavioral health-related issues. This is consistent with Ann's recollection; behavioral health was not addressed.

During this timeframe, John's concerns escalated:

I was worried that I would walk into the bedroom and find her dead. She would have me do taste tests with food, to see if I thought it tasted weird. It would taste whatever food, but there was never any weird or odd taste. Finally, I called something with our insurance called Second MD. I actually talked with a psych nurse practitioner. She accessed Ann's records and reviewed them. She was very gentle as she indicated her belief that the etiology might be psychological and suggested we follow up with the psychiatric evaluation.

On April 7, Ann had another appointment with her primary care provider. Her Body Mass Index (BMI) had dropped from 23.7 to 17.2 in just over three months. Ann's husband was again with her at this appointment. When her husband stated, "She is not going to make it – she is going to die!" the primary care provider asked if Ann had seen the psychiatrist he had recommended. Ann and her husband explained, they were unable to make an appointment, even with repeated calls to the psychiatrist's office. The primary care provider then phoned the psychiatrist and was able to arrange an appointment. This is a brief example that touches on the challenges to access resources for behavioral health treatment.

Ann recounted the thoughts she was having at this point:

I am not going to make it. I am going to die if I don't do something. (Her thoughts turned to John and her grandson and thinking about their lives without her.) I felt hopeless and helpless. I tried to make sense of this spiritually – I thought about the devil, and I had to find strength so the devil couldn't come in. I knew I needed to go to the hospital – the psych unit. My husband still had times he didn't think clearly. He wasn't sure what I should do. Because of his age and COVID, he was not going to be allowed into the hospital to visit. He had to drop me off at the emergency department (ED). I had to go to the ED to get medical clearance before I could be admitted to the psych unit. I did have low potassium, that was all. Nurses there (in the ED) made it clear they would rather take care of sick people (those with physical illnesses or injuries). The caseworker seemed to have doubts, asking if I was sure I wanted to do this, be admitted to the psych. Unit. The medical residents did keep checking on me, they would at least talk to me.

Ann was admitted to the geriatric-psychiatric inpatient unit on April 8, 2020, for a six-day stay. Following the process for medical clearance, she underwent a thorough psychiatric evaluation with attention to her recent history. In addition to her regularly prescribed medications, she was given Ativan, Remeron, Latuda, Periactin, and Gabapentin. Ann described her hospital stay in positive terms overall:

I was determined to get better. I knew I had to. The staff would launder my clothes for me, they were glad I was there because the census on the unit was low, and I added to the number of patients, so that meant the staff was not furloughed. I didn't really participate in groups and activities that much, I slept mostly. The meds knocked me out and I finally was able to sleep. I forced myself to eat. I still had problems with taste, but I knew I had no choice, I had to eat.

Ann was discharged from the hospital on April 14. The diagnosis given was mood disorder due to a medical condition (stroke). Ann reportedly found this amusing since there was no evidence of her having suffered a stroke. Additionally, her diagnoses included major depressive disorder, first episode, insomnia unspecified, and anorexia. She was discharged with instructions to continue the medications and given follow-up appointments with the psychiatrist who had taken care of her in the hospital, and an appointment with a psychologist for psychological testing. A consult with a neurologist related to the history of neuropathy and the metallic taste was also arranged.

The first follow-up appointment was on April 16 with the psychologist. Testing showed slight short-term memory impairment, and the psychologist did raise a question about the possibility that Ann had experienced a conversion disorder. The pathophysiology of conversion disorder, also known as a functional neurological disorder, is not well understood (Conejero et al., 2018). No further appointments with the psychologist were indicated.

On April 21, 2020, Ann had her appointment with the neurologist. Ann did indicate she believed Gabapentin was somewhat helpful for her neuropathy. The neurologist confirmed, there was no evidence of a stroke. He was the first to actively attend to the complaint of the metallic taste. He referred Ann to an otolaryngologist whom she saw on April 28, 2020. The otolaryngologist had provided treatment for four generations of Ann's family. After he reviewed Ann's records and had an extensive conversation with her about mental health as well as the taste and smell symptoms, he insisted that there was no way the symptoms she was having related to mental illness. He ordered two different COVID-19 antibody tests. Both were negative. Once he confirmed the altered sense of taste and smell was not due to COVID-19, he prescribed Clotrimazole lozenges, for what he determined was a yeast infection in Ann's oral cavity. By Ann's report the lozenges were helpful, the otolaryngologist discontinued the Periactin, prescribed as an appetite stimulant.

With the discontinuation of the Periactin, Ann began to consider her other medications as she began to feel somewhat better overall. Her appointment with the psychiatrist, originally set for May 16, 2020, was rescheduled to July 2020, in part, due to the impact of COVID-19 on physicians' change in practice to decrease risk:

I really had trouble functioning with the medications. I knew I shouldn't drive with the Ativan. I was concerned a little about addiction, so that was the first one I tapered. I saw no sense in being on Latuda. Once I had myself off Ativan, I withdrew myself from Latuda. As a psych nurse, I knew how to manage this safely. Then there was Remeron. That was last. It really did help me sleep, but I didn't want to have to take a drug to make myself sleep. It took me about six weeks total to get myself off the medications I didn't want to take.

By early May 2020, Ann was able to return to her work. She had been on family medical leave for months. Lost productivity at work is yet another dimension to Ann's story, one she focused on very little during interviews, but still a consideration.

Ann reported her taste had returned to normal, she had gained 20 pounds and was feeling great. She had her annual physical with her primary care provider in June 2020. Ann described a conversation with her PCP where he indicated, in retrospect, he could recognize there may have

been an emotional or psychological component, but he still would not know what to do about that, or how to proceed with treatment.

### John reflected:

COVID-19 at one point did create delays, but it (Ann's symptoms) should have been addressed better and sooner. I still keep an eye on Ann's eating and sleeping. She has always been the strength for our whole family – I mean everyone. I am more sensitive to the demands on her. Ultimately, I understand better now, the art and science of health care. There was always data, but it has to be interpreted, not just seen as normal ranges, or nothing wrong, but taken into context. The data mean something. Even normal or no findings mean something when you consider Ann was losing weight, couldn't sleep, she was not functioning. That all means something too. That is data. Maybe Ann did have a conversion reaction, that actually makes sense in hindsight. She had so much stress, my stuff, her work situation was really stressful, losing her friend the way she did, Ann was right there with her (Ann was called to her neighbor and friend when she collapsed and subsequently died). I was so frustrated with the care she was given. All the referrals! It just seemed they were dismissive, almost like they wanted to prove there was nothing wrong. I could look at her and know! I should have picked up sooner. I also think about when she was in the psych unit. It was hard for me to let anyone at work know that. I question myself. If she was in the regular hospital, I had no trouble sharing that, but psych. Pause. There is a stigma, and I never wanted to admit that.

In December of 2020, Ann had symptoms of a urinary tract infection. Immediately, she wondered if this was a relapse:

I worry that I could have this all happen again. I am hypervigilant. I am making more self-rules, that is I am being more self-compassionate. I never did get a definitive diagnosis. Maybe I did have a conversion disorder. I do worry about a relapse. I don't think I have any real issues with cognition or memory, at least not beyond what would be expected for my age.

As of September 2021, Ann was still finding Gabapentin to be helpful, her back pain was back to what it had been prior to October 2019. Walking is once again a source of pain relief. She reports being mindful about eating and drinking. She has continued her medications for hypertension. In final reflections, Ann shared:

I do think there is and was stigma about mental health. I also think there was gender bias, a dismissiveness. Even with the oral yeast infection, my primary care provider dismissed that, telling me there was nothing wrong. I know the lozenges made a difference. When I brought up, in hindsight, the recognition that stress had played a big part in my struggles he (the primary care provider) just reminded me the psychiatrist had cut me loose. He implied, there was nothing psychologically wrong. I wanted to have a conversation about preventing relapse. I am seeing my primary care provider does not have insight about preventing relapse. I will be sensitive to my stress levels and watch out for signs. It could present differently, but I want to recognize the connections between my stress and mental health and physical symptoms.

I've developed a toolbox for my own mental health. I taught nursing students and patients for years about taking care of their own mental health. I have told students over and over again;

they can't take care of patients unless they were taking care of themselves. I'm finally practicing what I've been preaching.

Fortunately, this journey made me aware of my own feelings about mental health and stigma and the stigma I believe I experienced from healthcare professionals. Those six months felt like six years. It was traumatic. Even during a discharge planning session with my psychiatrist, he seemed relieved to think I probably had a stroke and that is what caused this episode. I thought gosh, even my psychiatrist has feelings of stigma toward mental health. This was the catalyst for me wanting to share my story. My psychiatrist, who has been in practice for decades and is known for being a huge mental health advocate wanted me to have a physical diagnosis to explain my symptoms.

In the last interview with Ann, she referred to her ongoing journey, believing stigma interfered with thorough, accurate, timely diagnostic procedures and treatment. She did not recognize, nor did her primary care provider, the possible connection between the physical symptoms and behavioral health concerns, even though the primary care provider offered a prescription for Xanax at the time of John's surgery in December 2019 to assist with the situational stress and anxiety, it was prescribed over the phone without a documented assessment.

Ann reflected and summarized her story. Her chronic back pain worsened about the time John received his diagnosis. She developed a sleep disturbance and experienced an ongoing metallic taste in her mouth which interfered with her ability to eat or drink resulting in an alarming weight loss over a three-month period. During this same time frame, she was referred to an orthopedist who, after finding nothing significant, referred Ann to a rheumatologist for possible fibromyalgia. Ann did not follow up with that referral. By the end of January 2020, she was hospitalized briefly for possible TIA, confirmation not clearly documented.

In February 2020, Ann was transported by ambulance to the Emergency Department (ED) after fainting and falling in the shower. In the ED she was diagnosed with a UTI, and antibiotics were prescribed. At an appointment with her primary care provider in March, Trazadone was prescribed for Ann's complaint of insomnia. This prescription was not filled. By this point, John's concerns had escalated, and he was insistent that something more be done. While the primary care provider did recommend seeing a psychiatrist, it was left to Ann to arrange. Her husband took charge and repeatedly attempted to make an appointment, without success.

In early April 2020, Ann made the decision, she needed to be hospitalized. She had thought of dying, there was no actual suicide plan, but she was at a point of no longer being able to tolerate her overall state. Ann went to the ED for medical clearance in preparation for admission to an inpatient psychiatric unit where she spent six days. With medication and determination, Ann was able to sleep and resumed eating, even though the metallic taste persisted. At discharge, Ann was sent to a psychologist for testing and to a neurologist. Results of psychological testing revealed a slight short-term memory impairment, and a question was raised about the possibility of a conversion disorder. Conversion Disorder was a consideration but never indicated as an actual diagnosis. The neurologist confirmed there was no evidence of a stroke. He paid attention to the complaint of having a metallic taste in her mouth and referred Ann to an otolaryngologist who prescribe clotrimazole lozenges for a yeast infection in the oral cavity. This proved helpful at diminishing the metallic taste. Ultimately, Ann's sense of smell returned.

By May 2020, Ann was able to return to her university faculty position after more than four months of family medical leave, initially given to her so she could provide support and care to her husband. While Ann described feeling herself again by May, fears and doubts remained, as of the last interview still remained. What if she has relapsed?

From her primary care provider and various health care specialists including the psychiatrist, there seemed an inability to consider Ann holistically. When symptoms could not be explained by tests and diagnostic procedures and continued to worsen, Ann believes stigma prevented her healthcare providers from objectively considering all possibilities for months. It is her hope, sharing her story will resonate with providers and allow for their own self-reflection.

#### Discussion

The issue of stigma toward people with behavioral health issues by healthcare professionals is complex. Healthcare systems are key areas where people with BH issues experience stigma. Behavioral health and physical health are intricately linked, yet healthcare professionals continue to be entrenched in dualistic thinking of either physical or mental health (Rivera-Segarra et at. 2019; Shim & Rust, 2013). These artificial separations can involve stigma, stereotyping, judgmental attitudes with labeling, and impact the care provided. Ann's story from her experiences, using her own words, is intended to illustrate how detrimental it can be to continue dualistic thinking. (Al Saif et al., 2019).

Ann's experiences are not unique. Presenting her story is intended to resonate with readers more than data from a medical record review ever could. Baker and Naidu (2021) described challenges faced by individuals with behavioral health issues seeking primary care. The participants in their study, much like Ann, described feeling disrespected and found it stressful and frustrating to go to a primary care provider. In addition to having stigma toward people with behavioral health issues, primary care providers perceive themselves as having a knowledge and skills deficit for addressing behavioral health issues (Rivera-Segarra et al., 2019; Wakida et al., 2018). Motivation to make changes was another issue in the context of a scarcity of available resources for behavioral health treatment.

# **Opportunities for Change**

The National Academies of Sciences, Engineering, and Medicine's (NASEM) Forum on Mental Health held three webinars in 2020 to address and better understand the challenges as well as opportunities for integrating BH in primary care. Stigma was identified as one of the primary barriers to integration. The lack of financial incentive to incorporate behavioral health with primary care was another barrier identified as was the shortage of behavioral healthcare providers and the need for policy revisions (NAMSEM, 2020).

# Stigma Reduction

Interventions and training to reduce stigma can succeed (Aydogmus, 2020). The interventions and training need to focus on the negative beliefs, challenge myths, and increase empathy and understanding to foster the development of positive emotions and the capacity to see a person in his or her entirety. Reducing stigma is only the beginning.

There are those who believe combating stigma in healthcare may need to go back to the way individuals are admitted into educational programs for healthcare professionals, first screening out those who may harbor discriminatory attitudes toward those with behavioral health issues. Along with this line of thinking is the idea that anti-stigma training needs to occur early in the education of those entering healthcare professions, acknowledging attitudes are often ingrained early and can be hard to reverse (NAMSEM, 2020).

## Interprofessional Education

Caldwell et al., 2021 called for a paradigm shift in academia. They used interprofessional constructs within a competency framework aimed at the unification of various disciplines while understanding each profession or discipline has its own methods and standards for clinical practice. Other models for interprofessional education are growing across the country.

The education model described by Cortes (2019) represented a shift from each profession functioning as a uni-profession to valuing the contributions each profession could make in meeting the diverse range of needs patients present with. It is clear, interprofessional collaborative education and practice models are essential in the current complex healthcare climate. The Health Resources and Services Administration (HRSA) provides training grants to promote course work that supports integrated care (Putney et al., 2017). Putney et al., (2017), as well as Friedrich et al., (2021), described interprofessional education models that expand to include the experiential placement environment and collaboration with community partners. The curriculum development aimed at preparing graduating healthcare professionals in a variety of professions with new skills and knowledge and being prepared as team-work ready is encouraging.

## Health Care Settings

It is important to recognize, primary care settings are at different stages of integration of behavioral health. From no integration to full collaboration. In a systematic review, Mulvaney-Day et al., (2017) provided information that primary care providers can use to select appropriate screening tools to identify those who should have further behavioral health assessments. The tools include the Patient Health Questionnaire (PHQ) and others. The target conditions, reliability, and practical considerations, such as ease and time for administration are included. Integrating a tool or tools into primary care does not have to be a barrier to potentially lifesaving screening. Once an individual does screen positive, another challenge emerges.

Screening tools alone are only one step. More is needed. For those already in practice, training to develop the workforce is indicated. Training related to behavioral health issues could be effective (NAMSEM, 2020). Federally Qualified Health Centers (FQHCs), community-based clinics, providing primary care in underserved areas, use models of providing care to patients with complex needs, including behavioral health issues. FQHCs have demonstrated the effectiveness of training. Staff at FQHCs have received training using webinars and online courses to maintain a workforce prepared to meet the diverse demands of their patients.

The training model used specifically by FQHCs in Massachusetts has great potential to serve as a template for others. Their training has included how to treat patients remotely due to the COVID-19 pandemic. The use of technology for training and for treatment is opening a wide range of opportunities (NASME, 2020). This is of particular importance, given the lack of behavioral health providers in many areas of the country.

The Center of Excellence for Integrated Health Solutions (2021), funded by Substance Abuse and Mental Health Services Administration (SAMHSA) and operated by the National Council for Mental Wellbeing is another resource for individual practices and clinics. This organization can help customize approaches to achieve integrated care.

In one rural area of Texas, there is a collaborative arrangement between a FQHC and a community mental health center. They have partnered for nearly a decade. Both receive state and federal funds. They are not co-located but work closely to ensure the holistic care needs of their patients are met. Screening is a routine part of every primary care appointment. Providers are prepared to follow up with further behavioral health assessments as part of their overall care to individuals. They readily refer to their community mental health partner. Most individuals who receive mental health care at the community center have a primary care provider at the FQHC. Communication between the two agencies has become nearly seamless, enhancing continuity of care. One identified and ongoing limitation is the limited number of behavioral healthcare providers. Recruitment efforts are ongoing. (N. Vela, personal communication, November 22, 2021).

Two FQHCs in New Jersey opted to embed behavioral health care consultants into the primary healthcare delivery team. The behavioral health consultants were readily available as a member of the primary care team to provide services ranging from assessments to psychoeducational interventions and therapy. The assessments and initial interventions by the behavioral health consultant typically occurred the same day as the primary care visits. If additional therapy appointments were needed, those were arranged separately (Budde et al., 2017).

The work in both New Jersey FQHCs was reconceptualized to be more holistic. Training was provided for the entire, integrated team. The team participated together in training. Ultimately, the workflow was adjusted so universal screening could be incorporated. Budde et al. (2017) described how the behavioral health consultant participated in the brief, daily meeting, where staff reviewed the patients scheduled for that day, anticipating those who might require a behavioral health evaluation. Budde et al., (2017) further describe the behavioral health consultant's brief assessment and actionable steps. The steps are simple, individualized coping actions and strategies that an individual can implement prior to their scheduled follow-up appointment. The Consultant is in a position to recommend what type and level of care would be most appropriate.

It is easy to envision how the integrated team approach with successful patient outcomes in both New Jersey locations removed any possible remaining hint of stigma. The model used in the two New Jersey locations demonstrated how behavioral health could be incorporated as a routine part of primary care allowing for early intervention and good outcomes for patients. Overall, the model also reduced costs (Budde et al., 2017).

As indicated, maintaining a dualistic approach to healthcare is not optimal and at times, dangerous to patients. With every somatic complaint, elements of behavioral health need considered. Conversely, with behavioral health, there are somatic implications. The Menninger Clinic, a leader in psychiatric care since it was founded over 95 years ago and ranked nationally as a leader in psychiatry for 31 consecutive years, exemplifies the integration of primary care with the delivery of behavioral healthcare. Their biopsychosocial model of care is unique. Every patient has their own individualized treatment team, comprised of a psychiatrist, psychologist,

social worker, psychiatric nurse, psychiatric rehabilitation specialist, and if indicated, a licensed chemical dependency counselor, dietician, and chaplain. A pharmacist consults with the teams and directly educates patients. There is a full internal medicine staff to address the somatic needs of each patient. Many patients have co-existing conditions such as diabetes, depression, and anxiety. Each needs addressed simultaneously. Menninger outcomes data demonstrate the effectiveness of their model of care (Menninger 2022).

## Challenges

Integrated care models have been effective in clinical trials; however, they are not actually widely implemented outside of grant funding situations. Without funding assistance, implementation costs can be cost-prohibitive (McGinity and Daumit, 2020). There are policy barriers that create inadequate mechanisms to manage finances. Payment policy initiatives to date have been inadequate. Billing and technology for consultation are two areas where barriers emerge.

In addition to grants, what funding options are there? Experts have indicated jails and prisons are now our nation's largest provider of psychiatric care (Zesima, 2020). In 2017, the U.S. Government spent 80 billion dollars on incarcerated people with serious mental illness. That same year, the states spent an additional 71 billion dollars. Zesima (2020) went on to describe the success of Miami-Dade County's three-pronged alternative and community-based treatment program, Criminal Mental Health Project, under the leadership of Judge Steve Leifman. This project was established ten years ago to divert nonviolent misdemeanant defendants with serious mental illness and/or substance abuse disorders from the criminal justice system into community-based treatment and support services. This is an example of a problem identified as a community problem for which a community solution was devised. Initially, there was an investment, an investment that paid off, eliminating gaps in services and by creating relationships among stakeholders. After the first two years, there were substantive tax dollar savings. This model can serve as a guide for other communities (Gerstein, 2022)

#### Conclusion

Research has shown the benefits of integrated care. The integration of behavioral health care into primary care improves patient outcomes, increases employee productivity, and can, over time decrease healthcare costs (Buche et al., 2017). Even though the evidence supporting the integration of behavioral healthcare is strong and there are those who have embraced this model of care, the process of making the shift to integration is slow at best, resulting in less-than-optimal patient care and ongoing preventable suffering by individuals struggling with behavioral health issues and their families.

Opportunities and challenges for integration go hand-in-hand. Stigma in healthcare remains problematic. Once recognized, training can be useful to reduce stigma, resulting in better understanding and ultimately leading to additional steps such as routine behavioral health screening and the use of more holistic healthcare practices.

Storytelling was used to give voice to the experiences of one woman--Ann, who from her and her husband's perspective nearly lost her life because she was seen as a range of unexplained symptoms rather than a whole, indivisible human being. The use of Ann's story conveyed prolonged suffering and anxiety when her diagnostic assessments and treatment attempts were

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limited to her physical symptoms. Sharing Ann's story was intended to help others see the impact of what can happen when behavioral health is left out of the healthcare process.

Screening tools for behavioral health conditions are readily available, reliable, effective, and efficient, but only if used and used properly. Screening tools are only one step toward integrating behavioral healthcare after reducing stigma found in primary care. Preparation of the next-generation workforce is underway. The use of interprofessional education is recognized, endorsed, and supported by federal funding. Models are published and made available, yet not universally implemented.

Models for integrating behavioral health with primary care are available, admittedly challenging to fully implement and maintain (NASEM, 2020). There are numerous barriers to full implementation from billing to having access to mental healthcare providers along with the overall cost of implementation that includes training.

Substantive changes are needed in the healthcare system. It is not a one-size fits all situation. Optimal mental health was described as foundational to optimal health (NASME, 2020). Leaders from across the country who participated in the NASME (2020) workshop closed their meeting with optimism and indicated a shared belief that by working collaboratively, through differences, and across professional disciplines it is possible and necessary to move from hopes and vision to taking action and transform healthcare in the United States.

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# New Pathways for Assisted Psychotherapy: Do Psychedelics Bring Panic or Panacea?

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#### **Author Note**

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#### **Abstract**

The U.S. Controlled Substances Act of 1970 not only made psychedelic drugs illegal but also ended research about their therapeutic potential. Recently, several randomized controlled trials of psychedelic drugs have shown promise in the treatment of difficult to treat diseases such as depression, addiction, and post-traumatic stress disorder (PTSD). The Food and Drug Administration (FDA), once strongly opposed to psychedelic assisted therapy, has recently licensed ketamine for treatment of depression and designated psilocybin (magic mushrooms) and MDMA (Ecstasy) as Breakthrough Drugs for the treatment of depression and PTSD, respectively. Although it is expected that some of these still illegal medications will be licensed in the near future, effective use will require the acceptance of new psychological treatment paradigms.

*Keywords:* addiction, ayahuasca, ecstasy, depression, ketamine, LSD, magic mushrooms, MDMA, Psilocybin, PTSD, psychedelic, psychotherapy

#### Introduction

Readers who came of age during the 1960s and 1970s may be surprised to learn that the vilified drugs of their youth are currently extolled as breakthrough treatments for the world's mental health problems. LSD, ayahuasca, ketamine, MDMA (ecstasy), and psilocybin (magic mushrooms) have now been shown to have significant and sustained beneficial effects on patients with such diverse problems as addiction, depression, and PTSD. Because of these results, medical scientists and federal regulators are engaged in clinical trials that may well result in FDA approval of these medications in the near future. This article will trace the history of psychedelic drug research followed by a discussion of five drugs with therapeutic potential and the research supporting their clinical efficacy.

## The History of Psychedelic Medicine Research

Although plants containing psychedelic chemicals have been used by humans for thousands of years, the modern era of psychedelic medicine research did not begin until the 1920s when French and German psychiatrists proposed that mescaline from the peyote cactus created temporary mental changes similar to those seen in psychosis (Langlitz, 2013). In 1938, Albert Hofmann, a Swiss pharmaceutical chemist, synthesized LSD from ergot but did not realize its psychedelic nature until 1943 when he ingested some in a laboratory accident. Early researchers were divided in their opinions about the nature of LSD drug-induced experiences. Some believed that LSD was a model of psychosis while others believed that it gave patients new insights into their problems. Nevertheless, psychiatric use blossomed with over 40,000 patients treated between 1950 and 1965 for such diverse conditions as alcoholism, schizophrenia, autism, and neurosis. Researchers published over 1,000 studies during this period and LSD gained celebrity status as the next breakthrough both in psychiatry and adventurous behavior (Costandi, 2014).

In 1960, Albert Hofmann synthesized psilocybin, the psychedelic chemical in "magic mushrooms." Shortly thereafter, Harvard psychologists Timothy Leary and Richard Alpert (later known as Ram Dass) began an experimental study with psilocybin and allegedly offered the drug to undergraduate students and took it themselves. This led to a college scandal that ended their academic careers and caused others to question the scientific legitimacy of research that was increasingly identified with the hippie counterculture.

However, there were more serious minds at work. Humphrey Osmond, a Canadian psychiatrist, and Aldous Huxley, an English philosopher, took a different approach. They proposed that the drug- induced experiences were not hallucinations but visions providing deep psychological insight that might be of great therapeutic value. Osmond and Huxley coined a new term psychedelic, meaning mind-manifesting, to replace the older term hallucinogenic (Langlitz, n.d.).

The leakage of psychedelic drugs from the clinics to the street led to a clash between the counterculture and establishment. Medical leaders saw the new drugs as a public health crisis, church leaders saw the new drugs as a spiritual crisis, and, more importantly, psychedelic drugs seemed to challenge the legitimacy of political power brokers. Timothy Leary proclaimed the advent of a neurological revolution, declaring that if every person took LSD all political problems such as war, racism, and economic inequality would be solved. This led Richard Nixon to call him "the most dangerous man in America." It has been argued that this incident began the War on Drugs. (Langlitz, n.d., Minutaglio & Davis, 2018).

The ensuing controversy ignited a media storm, simultaneously popularizing psychedelic drugs and demonizing them. A review of tabloid headlines from the early 1970s tells the story: "LSD made me a Prostitute", "LSD and Sex Madness", "LSD Sin Club", and "Girl Gives Birth to a Frog – Doctors blame LSD" (Psytech Ed., n.d.).

The Nixon administration did not take this perceived threat to their agenda lightly and in 1970 Congress passed the U.S. Controlled Substances Act, which designated LSD, psilocybin, ayahuasca, and mescaline as Schedule I Substances. Schedule I substances are those without any medical use and have a high potential for abuse (Gabay, 2013). Note that some psychedelic

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drugs had already been shown to have therapeutic use in scientific studies, although these studies were less rigorous than those done today. Moreover, there was no evidence that these drugs were addictive or being systematically abused. Nevertheless, under pressure from the Nixon administration, the United Nations Convention on Psychotropic Substances followed shortly thereafter, and the controlled drug scheduling concept was adopted for member states (United Nations, 1971). These actions not only made the use of psychedelic drugs illegal but largely ended research into their efficacy.

One might wonder that any psychedelic medicine research continued in the new atmosphere of governmental hostility, academic disfavor, and lack of funding. Strangely, while institutional sponsored academic research dried up, underground research flourished.

In 1976, Alexander Shulgrin, a chemist who had studied psychedelic drugs since the 1960s, developed MDMA (3,4-methylenedioxymethamphetamine) and shared it with psychotherapist Leo Zeff, who used it to treat thousands of mental health patients. MDMA was not illegal because it was a newly synthesized drug and the FDA had never heard of it. The researchers were able to continue their studies for almost a decade by using codenames for the drug to conceal its identity from the authorities. When MDMA was rebranded as Ecstasy the secret was revealed, and the drug became popular at Rave Parties. The FDA moved quickly to classify it as a Schedule I drug in 1985 over the protests of the research community (Sessa, Higbed, & Nutt, 2019; Psytech Ed., n.d.).

However, the story of MDMA was far from over and in many ways typifies the curious history of psychedelic medicine research. Convinced that the opprobrium attached to psychedelic drugs was not science based but due to their counter-culture association, Rick Doblin founded the Multidisciplinary Association for Psychedelic Studies (MAPS) in 1986 (maps.org). Doblin was a graduate of the Kennedy School of Government and had completed an internship at the FDA, so he was familiar with bureaucratic control of pharmaceuticals. He decided that his new organization would focus on MDMA, no doubt because it did not have the stigma accrued by LSD, and chose its application to treat PTSD, a condition that would interest the police and military (Langlitz, n.d., Psytech Ed., n.d.).

Between 1986 and 1988 five separate MDMA research proposals were submitted to the FDA but were put on hold by the agency (Psytech Ed., n.d.). Finally, Dr. Charles Grob received FDA approval to conduct a Phase I study (safety) in humans in 1994 and the bureaucratic research environment became less restrictive after Spain approved a human MDMA trial for PTSD in 2000 (Grob et al., 1996). Several successful human trials followed, and in 2017 the FDA designated MDMA a "Breakthrough Drug" for PTSD, meaning that the drug was not only safe for human use but that the FDA "has agreed that this treatment may have a meaningful advantage and greater compliance over available medications for PTSD" (Burns, 2017). Phase III trials (pre-approval) began in 2018 and it is anticipated that they will be completed in 2022 with commercialization in 2023 (maps.org, 2022, Sessa et al., 2019). In anticipation of FDA approval, Naropa University (Boulder, CO) has launched a "Psychedelic Assisted Therapies Certificate" program that emphasizes MDMA therapy (Naropa Univ., 2022).

Similar progress has been made in destigmatizing other psychedelic drugs. In 2000, Johns Hopkins researchers received FDA approval to resume psilocybin trials in healthy volunteers. Later studies by this institution demonstrated psilocybin efficacy in combating tobacco

addiction (2014), easing end-of-life anxiety in cancer patients (2016), and relieving major depression (2020) (Johns Hopkins Medicine, 2022). In 2019 the FDA designated psilocybin a "Breakthrough Drug" in treating major depression.

Although much progress has been made in de-stigmatizing psychedelic therapy, there is still much to do. Note that both MDMA and psilocybin are still classified as Schedule I substances (no therapeutic use) even though they have been designated as "Breakthrough Drugs" by the FDA.

# **Psychedelic Drugs with Therapeutic Promise**

#### Ketamine

Ketamine is a short-acting anesthetic and analgesic. First synthesized in 1962, it was initially used as a veterinary anesthetic and subsequently approved for human use by the FDA in 1970. Although it became a club drug known as "Special K" in the 1980s, it was never designated as a Schedule I substance and therefore never became illegal (Psytech Ed, n.d.).

Ketamine is a dissociative anesthetic, meaning that it can make patients feel detached from their bodies. It is also a rapid acting antidepressant. Ketamine's action on the nervous system is incompletely understood but some things are known. In high doses ketamine blocks a receptor for glutamate, the brain's primary excitatory neurotransmitter. This explains its anesthetic and analgesic effect. However, in lower doses ketamine may stimulate other glutamate receptors, leading to activation of multiple neurological signaling pathways. It has been suggested that low dose ketamine may create new connections in parts of the brain that regulate stress and mood (Hashimoto, 2019).

Ketamine can be administered by intravenous, intramuscular, sublingual, or intranasal dosing. The dose depends on the route of administration and can be titrated for individual patients. Patients report that their peak experience lasts 25-60 minutes and is over in two hours. Ketamine's antidepressant effect can take place in a few hours and last for two weeks after a single dose.

# Ayahuasca / DMT

Ayahuasca is an Amazonian biological mixture with no fixed chemical composition. It is usually prepared by boiling pulped vine (Banisteriopsis caapi) with leaves from other plants, typically either *Psychotria viridis* or *Diplopterys cabrerana*. However, practitioners sometimes add other plants to the mixture. The resulting liquor is swallowed, often causing vomiting, and produces vivid hallucinations in about an hour.

The leaves in the mixture contain dimethyltryptamine (DMT), also known as the "spirit molecule." DMT is an agonist at the serotonin receptor and, like antidepressants, increases the amount of serotonin in the brain. However, ingested DMT is rapidly degraded by the stomach enzyme monoamine oxidase (MAO). Ayahuasca practitioners solve this problem by adding pulped vine containing monoamine oxidase inhibitors (de Araujo, n.d.).

Early researchers thought that the effects of ayahuasca were solely due to DMT, but newer brain imaging studies reveal a more complex picture. Ayahuasca appears to inhibit the Default

Mode Network, that unconscious part of the brain that consolidates experiences and prepares to react to environmental stimuli. Michael Pollan famously described this effect as "firing the conductor and letting the orchestra play" (Pollan, 2019).

Ayahuasca has also been shown to increase neuroplasticity and regenerate neurons, sometimes referred to as "rewiring the brain." Perhaps this explains the observation that ayahuasca appears to decrease violent behavior, substance abuse, anxiety, and depression. The visions that users report and the subsequent effects on their behavior have led to the founding of several "ayahuasca religions," in which the mixture is used as a sacrament.

### **MDMA**

MDMA (methylenedioxymethamphetamine) was first synthesized around 1912 but remained almost unknown until Alexander Shulgrin introduced it to Leo Zeff, who used it to treat thousands of mental health patients. MDMA is an Entactogen, a distinct class of drugs having characteristics of both the hallucinogens and amphetamines. Like the classic psychedelics, it binds to serotonin receptors but also releases serotonin, increases dopamine and norepinephrine, and releases oxytocin (drug science, n.d.).

Users report feelings of euphoria, empathy, introspection, and decreased anxiety. MDMA has shown promise as a treatment for such diverse conditions as PTSD, substance use disorder, and social anxiety. It is orally bioavailable and usually administered as a capsule. Typical doses range from 75-125 mg and the psychedelic effect lasts 4-8 hours.

The FDA designated MDMA a "Breakthrough Drug" for PTSD in 2017 and Phase III trials are underway.

# Psilocybin

Psilocybin is a naturally occurring psychedelic found in over 200 varieties of mushrooms and has been used for millennia in various cultures throughout the world. It came to scientific attention in 1953 when two mycologists attended a mushroom ceremony in Mexico and later brought back spores. Albert Hofmann, discoverer of LSD, was able to isolate and synthesize psilocybin in 1959 (Psytech Ed., n.d.).

Psilocybin binds to serotonin receptors as do the other classic psychedelics although the length of effect is shorter. One interesting feature of psilocybin is that the perceived effects vary greatly with the dose. There has been recent interest in micro-dosing (0.1-0.3 g) using subtherapeutic doses to increase creativity, energy, and mood. At much higher doses (5+ g) strange effects have been reported such as synesthesia (e.g., hearing colors) and ego death (Third Wave, 2022).

Psilocybin has shown promise in the treatment of major depression, addiction, existential distress, and eating disorders. It is one of the safest psychedelics. It is non-addictive and there is no known lethal dose. In 2019 the FDA designated psilocybin a "Breakthrough Drug" for treatment of depression and Phase II trials are underway.

#### LSD

Although LSD (lysergic acid diethylamide) was not the earliest psychedelic substance, it is certainly the one most notorious and the most associated with the establishment-counterculture clash. For that reason, it is very difficult to gain approval for human studies and less is known about its neuropharmacology.

Like many other psychedelic drugs LSD binds to serotonin receptors but also affects dopamine and norepinephrine receptors. Advanced brain imaging studies showed that, under the influence of LSD, brains became desegregated, that is, regions that do not usually communicate with each other do when freed from the control of the brain's conductor, the Default Mode Network. The researchers suggested that this might explain the therapeutic effect of LSD in patients with "locked-in brains," such as occurs in depression and alcoholism (Cormier, 2016; Carhart-Harris, et al., 2016).

LSD appears to produce a dream-like state of consciousness dominated by increased reaction to inner stimuli. Stan Grof, a Czech psychiatrist who treated thousands of patients with LSD, believed that LSD gives patients access to their unconscious thoughts, feelings, and memories (Grof, 1975).

LSD assisted therapy has been proposed for such diverse conditions as addiction, depression, end of life anxiety, pain, and cluster headaches. LSD is much safer than generally thought. Although anxiety and paranoia may occur, they are uncommon in a controlled setting. LSD is extremely potent and patients in clinical studies were dosed between 100 – 200 micrograms.

# Depression, Addiction and PTSD

Depression, addiction, and post-traumatic stress disorder are major public health challenges. Despite the existence of multiple therapeutic regimens, many patients with these conditions are refractory to treatment, yet research studies have shown that all of them are responsive to psychedelic assisted therapy.

# Depression

The World Health Organization (WHO) estimates that about 280 million of the world's people are depressed, making it the most common mental illness and a major contributor to the overall burden of disease. Depression is a major cause of disability and the leading cause of suicide (WHO, 2021a). Depression is closely associated with other major illnesses including chronic pain, heart disease, diabetes, and cancer.

Treatments for depression include various types of psychotherapy, electroconvulsive therapy, transcranial magnetic stimulation, and antidepressant medications. However, the outlook is far from optimistic. It is estimated that 75% of lower- and middle-class patients get no treatment. Psychotherapy requires a long-term commitment with a skilled therapist. Current antidepressants require weeks to months to take effect and many have undesirable side effects, making compliance difficult. Some popular antidepressants are only marginally better than placebos. In fact, over 30% of depressed patients do not respond to current therapy. Psychedelic assisted psychotherapy may offer an alternative to current therapy (PsyTech, n.d.).

#### Ketamine

The use of ketamine for major depressive disorder has been researched since the 1990s and the drug received FDA approval in 2019 (Corriger & Pickering, 2019). Ketamine clinics are springing up all over the country and there is even a Ketamine Academy to instruct medical entrepreneurs about starting their own clinics. One of the advantages of ketamine is that it can relieve depressive symptoms within hours compared with weeks to months for current antidepressants. The drug (esketamine) is delivered via a nasal spray given at the provider's office. Patents receive either 56 mg or 84 mg of ketamine per treatment, depending on their symptoms (Spravato\*, 2022).

### Ayahuasca

One randomized controlled trial has been completed comparing Ayahuasca to placebo in the treatment of depression. Patients treated with Ayahuasca had significantly lower depression scores at one and seven days than those treated with placebo (PsyTech Ed., n.d.).

### Psilocybin

Numerous studies have shown that psilocybin assisted therapy for depression is safe and efficacious. In an especially interesting study Carhart-Harris and colleagues used psilocybin to treat 12 patients with depression who were unresponsive to standard therapy. Each patient received two psilocybin therapy sessions in addition to preparatory and integrative psychotherapy. All patients experienced immediate improvement in their depressive symptoms and 8 of the 12 patients achieved complete remission after a week. A recent randomized trial of psilocybin by the Johns Hopkins group showed that psilocybin was more than twice as effective as psychotherapy in relieving symptoms of major depression and four times as effective as pharmacologic therapy (Davis et al., 2021).

### Addiction

Drug abuse and addiction have become an almost unfathomable problem in our world. The United Nations reports that about 62 million people use opioids for non-medical purposes, 27 million use amphetamines, and 20 million use cocaine (United Nations, 2021). About 1.3 billion people use tobacco, which kills an astounding eight million a year (World Health Organization, 2021b). Alcohol consumption kills about 3 million people a year (WHO, 2022). The health consequences of addiction and misuse of drugs and alcohol make up a substantial portion of the world's total disease burden.

In discussions of addiction, most authorities focus on behavior and outcome rather than cause. For example, the National Institute on Drug Abuse defines addiction as "... a chronic, relapsing disorder characterized by compulsive drug seeking, continued use despite harmful consequences, and long-lasting changes in the brain" (NIDA, 2018). In a similar way, the American Psychiatric Association substitutes the term "substance use disorder" for addiction, again focusing on behavior rather than cause (Am Psych Assoc, 2013).

While causes of addiction are still not well understood, Matthew Johnson, Professor of Psychiatry at John Hopkins University, has this to say: "When you talk to someone who

has managed to overcome addiction, they often talk about how they had to answer big picture questions that connect to what's important in life. Psychedelics prompt those kinds of questions. Even though we have a lot more to explore, I think it's likely that it's the intense nature of the drug's psychological experience that's underlying its high success rates" (Psytech Ed, n.d.).

Current pharmacologic therapy for addiction consists of medications aimed at the physiology of drug abuse, either by replacing the desired substance, reducing cravings, or making the use of the drug unpleasant. These include nicotine gum and patches, disulfiram (Antabuse), methadone, and buprenorphine (Suboxone).

Current psychotherapy is similarly focused on behavior. Motivational Enhancement Therapy and Cognitive Behavioral Therapy teach patients to see they have a substance abuse problem and deal with relapse-provoking situations. Alcoholics Anonymous and Narcotics Anonymous are exceptions to this trend, in that they are spiritually based and surround members with a supportive peer group.

None of these therapies have been particularly successful. U.S. rehab centers report that 70% of those who enter treatment drop out in 3-6 months. Of those who complete the program only 30% remain drug-free long-term (Am Addict Centers, 2022). Psychedelic drugs may offer an alternative.

#### Ketamine

Beginning in the 1980s Dr. Evgeny Krupitsky successfully used ketamine assisted therapy to treat thousands of alcohol dependent patients in Russia. In 2007 Krupitsky published a small study of Ketamine assisted psychotherapy for heroin addiction. Half of those subjects who received three ketamine assisted psychotherapy sessions were still abstinent at one year follow-up (Krupitsky, 2007). This is a much more successful result than has been shown for any current therapy.

#### LSD

The use of LSD in the treatment of addiction disorders was one of the goals of the early psychedelic researchers. Dr. Humphrey Osmond, a psychiatrist at Weyburn Mental Hospital in Saskatchewan, Canada, used LSD to treat thousands of patients with alcoholism in the 1950s, but since these studies were not conducted in randomized controlled trials they were largely ignored (Dyck, 2019). More recently, Fuentes et al. conducted a systematic review of randomized controlled trials using LSD (Fuentes et al., 2020). They found that, despite the differences in treatment approach and experimental setting, LSD invariably led to some short-term improvement in alcoholic symptoms.

#### Post-Traumatic Stress Disorder

PTSD is a condition marked by changes in mood and behavior after experiencing a traumatic event. It is characterized by intrusive thoughts, alterations in cognition and mood, and avoidance of situations that may trigger disturbing memories. Individuals with PTSD may have angry outbursts or be hypervigilant (Am Psych Assoc, 2020). The National Institute for Mental Health estimates the lifetime prevalence of PTSD to be about 6.8%. That prevalence, applied to the U.S. population of 329,500,000 (2020) yields a staggering 22 million afflicted people.

Current therapy for PTSD includes various forms of psychotherapy, eye movement desensitization and reprocessing therapy, antidepressants, and medical cannabis. Cannabis is interesting because it acts on the body's endocannabinoid system that controls sleep, appetite, stress, and memory. Despite extensive research and a plethora of therapies 25-50% of patients with PTSD do not respond to them (PsyTech Ed, n.d.).

#### **MDMA**

Although there were many anecdotal reports of successful PTSD treatment with MDMA, the breakthrough came in 2011 with publication of Michael Mithoefer's FDA approved Phase II study comparing two MDMA assisted sessions against placebo (Mithoefer, 2011). All study subjects were refractory to both psychotherapy and psychiatric medication. The researchers used a clever study design that allowed subjects randomized to the placebo group to receive MDMA after two months. Subjects receiving MDMA were much more likely to have clinical improvement in their PTSD symptoms compared to those who received placebo (83% vs 25%). When the study was unblinded and the placebo group given MDMA they experienced similar improvement. Incredibly, 88% of those who completed follow-up had sustained clinical improvement (average 3.5 years).

This landmark research was followed by five similar Phase II studies conducted in the U.S., Switzerland, Canada, and Israel. All studies showed similar improvement in PTSD symptoms. A later analysis of these six trials by Mithoefer and his colleagues showed that, overall, 82% of patients improved and, after one year, 67% no longer met the diagnostic criteria for PTSD (Mithoefer, 2019). The success of these studies led the FDA to declare MDMA a Breakthrough Drug for PTSD in 2017.

### Ketamine

Because ketamine causes rapid improvements in depression and anxiety it was thought to be a good candidate medication to treat PTSD patients. In one randomized controlled trial researchers paired a single sub-psychedelic dose of intravenous ketamine with psychotherapy (Feder, 2014). Improvement in PTSD symptoms lasted twice as long in ketamine recipients as in controls.

### **Discussion**

The research on psychedelic assisted therapy indicates that these medications, previously proscribed for ideological rather than scientific reasons, hold significant promise for the treatment of mental health problems refractory to standard therapy. However, it would be wrong to conclude that they are one-shot solutions.

First, even though psychedelic drugs are not addictive and do not have the potential for abuse that their Schedule I assignment suggests, they are not innocuous drugs. Psychedelic drugs can cause paranoia, anxiety, and delusions. Although these symptoms will subside in a few hours and may be therapeutically helpful they can be very unpleasant. Many psychedelics interact with tricyclic antidepressants and lithium and may cause seizures. MDMA can cause hyperthermia and ketamine can suppress the drive to breathe. Ayahuasca is contraindicated for those with

hypertension and heart disease. Psychedelics should not be given to patients with a strong family history of schizophrenia and bipolar disorder because of their hallucinatory effects.

The second issue to consider is that of setting. The effects of a psychedelic drug cannot be divorced from the setting in which it is administered. For example, some psychedelics are used as religious sacraments. These include the use of peyote (mescaline) by the Native American Church and the use of ayahuasca by Santo Daime and União do Vegetal. The effect of a drug given as a ritual sacrament will be different from the effect of the same drug given in a therapeutic setting. Likewise, the effect of a psychedelic in a recreational context will be still different.

Optimal dosing is also important. Some medications, like psilocybin, are only psychedelic at higher doses. It may seem attractive to use very low doses therapeutically and thereby avoid the hallucinatory experiences that are so problematic with regulators. However, clinical efficacy appears to be linked to the psychedelic experience in which patients confront repressed memories and other unconscious material.

The final issue concerns the presence and effect of supportive therapy. Current researchers label their studies psychedelic assisted psychotherapy. That is, the drug is an adjunct to the psychotherapy; it does not stand alone. For example, psilocybin-assisted therapy for depression typically includes preparatory psychotherapy before ingesting psilocybin and follow-up psychotherapy sessions to assist subjects in integrating their psychedelic experiences. However, such integrated therapy is both expensive and time intensive. Given current clinical practice in the U.S., it will be tempting to omit the psychotherapy and rely on psychedelic medications alone. In other words, "skip the talk and pass out the pills." However, healthcare is human care and pills alone are not care. If this happens psychedelic therapy will not fulfill the clinical goals that research studies have shown are possible.

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# The School-to-Prison Pipeline

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### **Author Note**

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### **Abstract**

In the last few decades, public schools have funneled misbehaving children into the juvenile justice system. This trend, known as the school-to-prison pipeline, is the result of the Gun-Free School Act, Zero-tolerance policies, and the placement of police in schools. These policies and the resultant punitive actions have unfairly targeted minority students and those with disabilities. These punitive policies have raised an outcry from parents and caregivers to the U. S. Department of Education and the Office of Civil Rights about the disproportionate number of students thrust into the criminal justice system. The effects of the zero and no-tolerance policies can be lifelong for students and their families. The public education system is often the only chance that many students have to prepare for their future. This article explores the legislative background underlying, the school-to-prison pipeline, its effect on students, and propose solutions to this education crisis.

Keywords: discipline, intersectionality, students, disabilities, minorities, special education, public education, prison, juvenile justice, equity, exclusion, implicit bias

"Like many of you, I believe that education is the single most important civil-rights issue that we face today." — Michelle Obama

### Introduction

The term *school-to-prison pipeline* refers to school disciplinary practices that directly and indirectly push school-age children, especially the most at-risk children, out of classrooms and into the juvenile and criminal justice systems and on a pathway to prison. This process has become a national trend and is sometimes labeled the "funneling of students." The problem has escalated to the political level, with multiple legislators petitioning President Joe Biden to take action. Unruly childhood behavior was previously dealt with by teachers in the classroom or in conjunction with parents. With the increase in school policing and zero-tolerance policies,

school resource officers (SROs) have become more involved in the primary discipline of schoolage children.

The American Bar Association has summarized the problem succinctly:

The school-to-prison pipeline is a relatively new term for a problem that has been plaguing America for years. It describes failures in the education system where certain groups of students--students of color, with disabilities, or LGBTQ--are disproportionately disciplined more harshly, including referral to law enforcement for minimal misbehavior; achieve at lower levels, and eventually, drop or are pushed out of school, often into juvenile justice facilities and prison (American Bar Association, February 16, 2020).

What is the magnitude of this problem? In a sample of 8,000 schools, nearly 70,000 students were arrested during 2013-2014 (Turner, 2017). If this were not bad enough, there is evidence that minorities and students with disabilities are being targeted.

Senators Michael Bennet, Tammy Duckworth, and Chris Murphy have written to President Biden, urging that the discriminatory and punitive school discipline policies be addressed. Minority students, LGBTQ students, and students with disabilities have experienced a disproportionate number of suspensions and expulsions as a result of harsh discipline policies (Bennett, 2021).

For teachers and administrators across the United States, balancing appropriate discipline with school safety, classroom effectiveness, and positive behavior is a difficult task. Many schools use exclusionary discipline--removing kids from the classroom--for minor violations by suspending or expelling them. The long-term consequences of "zero tolerance" have become clear.

# **Impact**

Who are the school-to-prison pipeline's children and youth? What effect do these suspensions and expulsions have on students? This article shows that minority students and those with disabilities are often targeted by these policies. Exclusionary discipline has a significant impact on the pupils who are subjected to it. Isolated students may experience a variety of problems as a result of their isolation. Students who dislike school are more likely to quit school altogether.

Many pupils will not finish the school year because they were expelled or suspended for poor behavior or for breaking a school rule or policy. The most recent numbers available come from a U.S. Department of Education study done in 2011-2012, which indicated that over 8,000 public *preschool* students (ages 3-5 years) out of 1,343,930 children enrolled in US preschool (Rutgers, 2016) were suspended at least once, with nearly half those students being suspended multiple times (Levin & Jones, 2016).

"Exclusionary school policies do not work; they impede student success, with research showing that strict school discipline inhibits a student's chance of attending an institution of higher education," the Senators wrote (Bennet, 2021). Unfortunately, these policies have led to sharp increases in school expulsions and suspensions. Black and Hispanic students, American

Indian and Alaska Native students, LGBTQ students, students with disabilities, and English learners experience the brunt of the consequences, shuffling them into the school-to-prison pipeline, denying them an education, and limiting their future opportunities (ibid.).

One might think that the situation in parochial schools would be different but, according to the current findings in one sample, Catholic schools rely on punitive, exclusionary tactics with limited positive-oriented practices. Despite the precautions, this approach to punishment and exclusionary methods reflects the measures done by public schools in the past, which have focused heavily on punitive and discriminatory methods at the expense of excellent or constructive approaches (Philippe, 2017).

School suspensions are a short-term discipline action or temporary removal of a student from their daily educational setting for a violation of school policies or rules. A principal or assistant principal may suspend a student for a certain behavior or violation of "School Policy." The Individuals with Disabilities Education Act (IDEA) gives extra protections to students with disabilities including manifestation determination review to determine if the violation was caused by the student's disability or was caused by the schools' failure to implement the students Individualized Education Program (IEP) with fidelity. Suspension may be in school, where the student goes to a designated room and is supervised, or to an interim alternative educational environment.

School expulsion refers to the permanent removal of a student from their educational setting due to a violation of serious school rules or policies. The county superintendent, upon recommendation by the principal, may recommend that a county board of education expel a student from school if the student's conduct is determined to be destructive to the progress and safety of the school. An expulsion can last a year or longer. Before a student can be expelled, a school board will hold a formal hearing to decide whether a student should be expelled for their violation. In all cases involving expulsion, the student is entitled to formal due process procedures if the county board of education agrees to act upon recommendations to expel a student from school. Expulsion by the board of education is final. However, if a student or parent/guardian believes that the student was not given procedural due process, they may appeal to the state superintendent of schools. If the state superintendent finds that the board's decision to expel the student was properly made, then the expulsion will stand unless overturned by a court.

Suspension or expulsion can have serious consequences on a student's academic performance. Suspended students are twice as likely to repeat a grade as other students. Suspension doubles a student's dropout rate from 16 percent to 32 percent, compared to 16 percent for students who are not suspended. Lower graduation rates are associated with high discipline rates (ACLU, 2019).

Students who do not complete high school earn less money, which negatively affects their families and communities. According to data from the Bureau of Labor Statistics' 2015 Population Survey, those over 25 without a high school diploma earn the least in their communities and experience the highest unemployment rates. Children and teenagers who are not in school are more likely to engage in dangerous behaviors. They may not have adult supervision and may join the wrong clique or gang. Suspended students are more likely to be entangled in the criminal justice system. Students who drop out of school are three times more

likely to be arrested as adults. Students who have been suspended are less likely to be involved in their community. Suspensions and expulsions are costly options available to school districts and families to prevent disruptive behavior (ACLU, 2019).

Many families consider school to be the second most essential and formative venue for their children's socialization. While being trained to prepare for post-secondary education or career-readiness abilities, students learn expected behavior from their classmates, receive direction from teachers, develop friends, and learn social norms. Students who are suspended or expelled from school are subjected to isolation, fear, and some students may face hunger. Some students rely on the school to provide them with food and a safe atmosphere. Because of the trauma they endure daily at home, students who come to school from abusive homes may act out in school. Even if students struggle to study and do not make good progress in school, they may discover that the school atmosphere serves as a safety net. However, problems persist when children do not perform well academically or do not fit the mold imposed on them.

### **Minorities Targeted**

In the most recent review of public-school disciplinary actions by the Civil Rights Data Collection (CRDC) of the Office of Civil Rights (OCR) from the 2017-18 school year, CRDC found striking racial disparities in discipline. Students of color, in particular, were disproportionately subjected to disciplinary actions when compared to their White peers. According to CRDC data, Black students made up 15% of total student enrollment. However, they accounted for 29% of all students referred to law enforcement. White students, on the other hand, are more likely to be involved in extracurricular activities and were subjected to less discipline. White students accounted for 47% of overall student enrolment but only 38% of law enforcement referrals.

Disparities in referrals to law enforcement can also be seen among students with disabilities. In 2017-2018, children meeting the Individuals with Disabilities Education Act (IDEA) criteria accounted for 13% of overall enrollment, but 27% of these students were referred to law enforcement by the SROs.

In addition to referrals to law enforcement, minority students are more likely to be suspended or expelled from school. Black students made up 38% of students who received one or more out-of-school suspensions, which is more than twice their share of overall student enrollment (15%). Black students accounted for 36% of all expulsions and 33% of expelled students. Furthermore, Black students who were expelled rarely received any further educational services. In contrast, White students, who made up 47% of total student enrollment, were expelled at a lower rate: 36% of all expulsions and 41% expelled students without receiving educational services. Expulsion rates for American Indian and Alaska Native students were slightly higher (1.1% and 1.8%, respectively) than their share of total pupils (Federal Register, 2021).

Minority pupils and students with disabilities are disproportionately affected by the school-to-prison pipeline. Seventy percent of pupils arrested in school are African-American or Hispanic. For the same behavior or misconduct, black students are 3.5 times more likely than white students to be suspended or expelled. Although black pupils make up only 18% of all students in the United States, they account for 46% of suspensions. Furthermore, whereas

students with disabilities make up only 8.6% of the student population in the United States, they account for 36% of jailed students (Soliz, 2021).

LGBTQ students are also disproportionately punished under school-based Zero-Tolerance Policies and often funneled into the criminal justice system. This occurs because LGBTQ students are subjected to increased discrimination, bullying, and harassment from other students. Out4MentalHealth, an agency of Santa Clara, CA, claims that LGBTQ students "... are often punished for their own victimization or for their attempts to defend themselves in a hostile school climate." In addition, LGBTQ students are often unfairly punished for violating school sexual and gender norms (Out4MentalHealth, n.d.).

### How Did the School-to-Prison Pipeline Begin?

The War on Drugs, with its "three strikes" policy and mandatory punishment, created a new context of thinking which led to the zero-tolerance policies and harsh discipline in the schools. These policies did not address the needs of students with disabilities whose behaviors are a manifestation of their disability. The needs and behaviors of these students should have been addressed through the Individuals with Disability Education Act (IDEA) or Section 504 of the Rehabilitation Act.

The school-to-prison pipeline developed as a result of the Zero-Tolerance policies, the placement of SROs in the schools, and general intolerance of childish behavior. Schools feared juvenile violence such as school shootings, guns, and drugs being brought into schools when zero-tolerance rules were first implemented. The media frenzy did little to calm the anxiety of families and professionals. Schools and districts employed SROs, often ex-policemen, to have a regular presence in their buildings. SROs are law enforcement officers who are responsible for the safety of students and educational personnel. In theory, they are concerned with crime prevention, and their presence may stop pupils from engaging in inappropriate behavior. Many SROs lack formal training in student work, diversity, or disability awareness. Parents and students are frequently unaware that the SROs have the authority to arrest, handcuff, and refer their children and youth to the juvenile or adult court systems. Other school security methods include video cameras, metal detectors, random contraband searches, and unarmed guards. Students do not have the same rights in public schools as they do at home under the Fourth Amendment, which prohibits excessive search and seizure. SROs or police officers bringing in drug dogs for a contraband search do not open backpacks or rummage through students' belongings until the drug-sniffing dogs identify contraband (Findlaw, n.d.). Although, these methods are legal because students do not have a reasonable expectation of privacy, this is hardly conducive to a nurturing educational environment.

Zero-tolerance policies were inserted into school handbooks and policies in the 1990s, to deter the entry of weapons into schools. These policies originated in the adoption of the "broken windows" theory and the Gun-Free Schools Act, enacted on March 31, 2004. "The 'broken windows' theory, proposed by James Q. Wilson and George Kelling, claim that crime is a disorder that, if not eliminated or controlled early on, increases the likelihood of committing a more serious crime later in life." (Maxime, 2018). Unfortunately, these zero-tolerance policies rarely contain any rehabilitative plan or support to teach students the desired behavior using positive behavior intervention. Because these policies are inflexible they often

have the effect of expelling students or pushing them into the criminal justice system for minor infractions (ibid.).

Kimberlé Crenshaw, a law professor at Columbia and UCLA, coined the term *intersectionality* to describe how people's social identities can overlap. "If you see inequality as a 'them' problem or 'unfortunate other' problem, that is a problem. Being able to attend to not just unfair exclusion but also, frankly, unearned inclusion is part of the equality gambit. We've got to be open to looking at all of the ways our systems reproduce these inequalities, and that includes the privileges as well as the harms" (Steinmetz, 2020). Simultaneously, social identities, advantages or disadvantages, race, disability, gender, sexual orientation, and socioeconomic class may increase the bias toward certain students and cause them to be receive unfair disciplinary actions (ibid.).

"The interconnected nature of social categorizations such as race, class, and gender, regarded as creating overlapping and interdependent systems of discrimination or disadvantage, a theoretical approach based on such a premise" (Mayhew, 2015). Intersectionality can be seen in the prison-to-school pipeline, where minority students or students with disabilities are funneled. As a student's particular identities or risk factors grow, so does his or her likelihood of entering the pipeline (ibid.).

### **Eliminating the School-to-Prison Pipeline**

The U.S. Department of Education intends to look into school discipline fairness, reigniting one of the most controversial education civil rights battles in recent years.

The agency announced that it will seek public input on school climate and punishment, as well as "how best to assist and strengthen schools' capacity to provide healthy, inclusive, safe, and supportive school climates in a nondiscriminatory manner." According to a release from the agency, the assessment would look into what "policy guidance, technical support, or other resources" schools require to ensure equitable treatment. This is a reaction to President Biden's executive order on January 20, 2021, directing government agencies to assess how their policies address and promote racial justice and equity (Blad, 2021).

It may be time to either remove SROs from the schools or limit their funding. An SRO typically serves as an on-site law enforcement officer and as a liaison with the local police or sheriff's department. They can and do arrest students. Data show that the presence of SROs in schools does not measurably increase school safety or improve academic outcomes (Pulrang, 2021). A *Dear Colleagues' Letter* on Key Policy from the USDE archives, signed by John B. King, Jr., 2016, provided recommendations and support for schools setting policy guidelines and supporting training for the SROs in the education environment. The goal was to decrease the arrests of students and use of other programs and interventions to avoid suspension, expulsion and punitive outcomes and to keep students in their schools and respective communities. (King, 2016).

Listening to and speaking with all children at a local level, as well as teachers, parents, and principals, is one of the first steps toward dismantling the school-to-prison pipeline. By talking at children instead of with them, educators, SROs, and parents cannot begin to reach and help

them. Students must be heard and encouraged to participate. In tense conversations, students are unable to process what is spoken to them. They only see the grownups in their lives' faces when they are angry or disappointed. First, adults must get on the child's level to understand their needs and the resources they need for success. Minor conduct problems and the teaching of appropriate behavior must begin at the local level. The school climate must be inclusive for all students, including those with disabilities, minorities and areas of intersectionality for them to feel safe and supported in their academic pursuits. Teachers and parents must set high expectations for all students and do so without bias.

Many schools across the United States have no mental health services for students. There are not enough counselors, social workers, psychologists, or nurses to handle students' individual needs. Students who need mental or behavioral support may end up in the school-to-prison pipeline. The U.S. Department of Education mandated that public schools keep track of the number of social workers, nurses, and psychologists hired. Although the Department of Education previously required information on school counselors, the ACLU study is the first to compare staff-to-student ratios at state levels. This mandate also includes mental health employees and school counselors (ACLU, n.d.).

School counselors, nurses, social workers, and psychologists are often the first to notice children who are unwell, worried, traumatized, acting out, or threatening to harm themselves or others. This is especially true in low-income areas with few alternative resources. Students are 21 times more likely to seek care at school-based health services than they are elsewhere. Schools with more school-based mental health practitioners had better attendance, fewer suspensions and other disciplinary issues, fewer expulsions, better academic accomplishment and career readiness skills, and higher graduation rates.

These data below show that millions of students attend schools with police but no counselors or mental health staff.

- 1.7 million students are in schools with police but no counselors.
- 3 million students are in schools with police but no nurses.
- 6 million students are in schools with police but no school psychologists.
- 10 million students are in schools with police but no social workers.
- 14 million students are in schools with police but no counselor, nurse, psychologist, or social worker. (ACLU, Cops and no counselors, Pg.4, n.d.)

Counseling, Social-Emotional skills, managing anger, restitution, and skills coaching are alternatives to suspension, but these methods require training and funding. The data above suggest that school systems put more money into funding SRO's than professionals to meet the students need to correct their behavior and remain in school.

Despite the fact that COVID-19 has taken students out of classrooms and away from SROs, the school-to-prison pipeline has not vanished. A 15-year-old Michigan student was arrested and sentenced to a juvenile detention center in May 2020 after failing to finish her online coursework, which was a violation of her probation. In August 2020, police were dispatched to the home of a 12-year-old pupil in Colorado after the student was caught playing

### **Articles**

with a fake gun during his virtual painting session. When his teacher observed a BB gun in the background during virtual learning in October 2020, a 9-year-old Louisiana fourth grader was suspended for six days. Recognizing that COVID-19 has an impact on how schools discipline children and youth, the Counseling Not Criminalization in Schools Act was sponsored in July 2020 by both the Senate and the House of Representatives. The Act would make it illegal for federal funding to be used to pay for law enforcement officers in preschools, elementary schools, and secondary schools (Soliz, n.d.).

Below are the three bills placed before Congress in 2021 to protect all students.

Counseling Not Criminalization in Schools Act of 2021 (CNC-HR 4011/S.2125) to expand the federal investment in trained school personnel who can support the academic, social, emotional, and behavioral needs of students, by diverting funding from the U.S. Department of Justice (DOJ) programs that place law enforcement and other measures that criminalize children in schools and put them into evidence-supported programs designed to hire counselors, nurses, school psychologists, and provide other non-penal and trauma-informed student supports.

**Protecting Our Students in Schools Act (POSSA - HR 3836/S.2029)** to prohibit schools who receive federal funding from beating, paddling, or using other forms of corporal punishment in schools, and to provide grants to train school teams to support the academic and behavioral needs of students.

*Keeping All Students Safe Act (KASSA - HR 3474/8.1858)* to prohibit the use of prison like seclusion rooms, as well as chemical, prone, and supine physical restraint of children and teens; to prevent and reduce the use of physical restraint; and to provide training to school personnel in the use of safe and effective practices to support school-appropriate behavior (Fed SDC).

The emphasis of most of the debate around these measures is on students of color and students with disabilities. This is because minority students and those with disabilities are disproportionately affected by unjust, harsh, and detrimental disciplinary methods. Disabled students of color are among the most often and harmfully affected students. LGBTQ+ students, as well as students who are socially stigmatized and discriminated against in other ways, such as socioeconomic status, are particularly affected by this issue. "However, there are two more major concerns that are commonly misunderstood. The instant physical and emotional harm caused by institutionally sponsored disciplinary tactics is one example. The other is long-term criminalization of students with disabilities, which typically begins in schools and has long-term consequences for them" (Pulrang, 2021).

In the plains of the Arizona desert, a network of women, many of whom are public school teachers, has established a network of new schools that is attracting attention from across the state and the country. The women were dissatisfied with the public education system's inability to provide a good education system and a nurturing environment for Black students, who have the largest proportion of students in the school-to-prison pipeline.

According to Debora Colbert, executive director of the Black Mothers Forum, a parent advocacy group, the women could have continued to work through the public education system but chose to invest their energy and expertise and teach the children themselves. Students are taught at their academic level and learning pace with two educators. A proactive strategy that allows the students to develop the coping skills in difficult situation and supported in restorative circles, instead of punishment.

Arizona's Governor Doug Ducey is watching closely the success of these microschools. With Arizona graduation rates lower than the national rates by 8% and less than 50% of the students pursue post-secondary education. Governor Ducey has devoted nearly \$4 million in the past year to increase the seven microschools to a network of 50 schools (McMurdock, 2022).

### Reflection

The school-to-prison pipeline affects children and youth across the United States in every community. These punitive disciplinary practices disproportionately affect students with disabilities and minority students.

Working as an advocate for families with a Masters of Education and the mother of a son with multiple disabilities, I find the schools' criminalization of children shocking. I have feared for my own child for most of his school years. Parents send their children to school thinking the school personnel will protect, teach, and support them while in the education environment. Yet, teachers are often complicit in funneling children into the juvenile justice system.

I work with parents and caregivers daily whose children have found themselves in the school-to-prison pipeline, many for typical childish behaviors that could be resolved between the classroom teacher and the family. Out-of-school suspension is a common punishment that removes students from their home schools and forces them on the street. Many families face socio-economic stressors and both parents must work to survive, and that stress is escalated for single parents and grandparents' homes. These punishments put the child on their own with no supervision or educational services, and sometimes remove vital sources of food.

Now is the time for parents, legislators, and school officials to join together in dismantling the school-to-prison pipeline. We must build and restore social justice education.

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# A Prince Hall Masonic Tradition: Leader and Character Development

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### Special Editorial Notation

This article provides uniquely deep and important perspectives that are critically needed for the development of leadership and character formation at this time in history. In this regard, it has special meaning for leadership and service in healthcare. The article was developed from the author's doctoral dissertation and original research. For further information regarding the concepts and developments discussed in this article, readers should contact the author directly.

### **Author Note**

This article is based primarily on the author's doctoral program research. The contents of this manuscript do not reflect the policy or opinions of the author's university or the agencies which the author serves. The author has no financial conflicts of interest.

### **Abstract**

This article investigates the historical context and presence of leader and leadership development processes in the annual proceedings of the Most Worshipful Prince Hall Grand Lodge of Ohio (MWPHGLO). In terms of the historical context, the article will ground the MWPHGLO within the larger Prince Hall Masonic Tradition. This critical grounding positions the Prince Hall Masonic Order as the oldest continuing institution in the African American community and contextualizes the energy and focus to build the character of the organization and its members. Moreover, the article culls from the research effort critical elements of leader and character development as elemental to the practices within the Prince Hall Masonic Tradition. Specifically, a focus on identity, justice, and community uplift represents additional characteristics lesser annunciated in contemporary models of leader development. The methodological approach is historiometric and integrates textual narrative analysis and statistical quantification. The process produced thousands of themes linked to conceptualizations of leadership development. A coding model was developed to identify the leader and leadership development constructs as outlined by Van Velsor, McCauley, Ruderman (2010). The project represents an interdisciplinary effort and features African centered analytical and interpretive lenses to fortify perspective.

*Keywords:* leader development, leadership development, Prince Hall Masonic Tradition, African Centered, interdisciplinarity

### **General Introduction**

Prince Hall Masonry has a long and consistent tradition of leadership and community development. Further, this tradition grew steadily and prospered in spite of tremendous oppositional societal forces. The idealism of Masonic principles, similar to the idealism of the American creed, helped to buoy the faith and optimism of the African American community, in spite of overwhelming domestic drag. The Masonic lexicon provided both a common language and reflection point for Prince Hall and subsequent leaders as it relates to the broader American society.

Prince Hall Masonry offers a rich tradition to discern patterns of leadership development and institutional development. This article brings forward the review of the history of this venerable tradition to its contemporary setting. Because most of the early historical scholarship on the Prince Hall Masonic Tradition (PHMT) is aimed at dispatching the question of the legitimacy of the Order, less attention was paid to historical analysis and the hermeneutical lens—that is an empowering or autonomous oriented analysis. Philosophically, this autonomy or self-determination is rooted in a long tradition grounded in success and virtue (Lambropoulos (1993)). As noted later, more recent Prince Hall Masonic scholars focus on building this autonomous analysis.

### Tradition

The Masonic tradition in the African American experience has a foundation as old as the United States and is rooted in pre-revolutionary British colonial activity. For a great deal of its existence, Prince Hall Masonry was seen as an illegitimate expression of Masonic tradition by domestic white Masonic institutions despite recognition of the Prince Hall Grand Lodge as a legitimate and duly authorized Masonic institution by a multitude of international Masonic bodies. Justin Holland was a member of the Most Worshipful Prince Hall Grand Lodge of Ohio; and he is illustrative of the visions and resources dedicated by the Grand Lodge to secure international recognition for the Order. Wesley (1961), a Prince Hall Masonic historian, notes Justin Holland's contribution as follows:

...his most distinguished service was rendered in the development of the foreign relations of the Grand Lodge from 1871 to 1883.... There were six grand lodges in foreign countries which established recognition and fraternal relations with the Grand Lodge of the State of Ohio (Wesley, 1961, p. 73).

This international recognition served as a bulwark against the domestic assertion of illegitimacy. It also served as a glimmer of optimism that the white American attitudes toward African Americans generally and Prince Hall Masonry specifically, were not global. Many of the fundamental reasons for this lack of recognition are rooted in the systematic racism which significantly impacted traditional social, political, and religious ethos in America. Moreover, from its genesis, the literature documents that Prince Hall and his contemporaries sought to build a tradition linked to the formal pathways for Masonic communication.

Prince Hall was born in approximately 1735. It is not clear if Hall was born a freeman or was freed by manumission. This older term, freeman, is an important point from a Masonic perspective, as no slaves could be initiated into the order, a point expounded upon by Révauger

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and Graham (2016) citing the British mitigation of this idea. The investigation of the PHMT identified fertile fields of research to cultivate related to community self-conscious expression and the development of self-concept. Moreover, the development of a philosophical and practical means of resistance and coping mechanisms that link that self-concept, must, of necessity, be a deep source of inquiry and insight. The Prince Hall Masonic tradition developed these mechanisms to survive and thrive against structures of subjugation, violence, and discrimination.

Boston, Massachusetts, was the backdrop both for the genesis of the nation and Prince Hall Masonry. Hall is a citizen of Boston by around 1765, according to Wesley (1961). There was a great deal of controversy surrounding the early account of Hall's lineage, as a result of the Grimshaw (1903) publication. Numerous errors were identified in his work. In a subsequent publication Wesley (1983) reframes and attempts to separate fact from fiction. The fundamental point is that there is no historical documentation for Hall's birth and it is deduced from his death certificate as a matter of convention. What is not in dispute is that he was a distinguished citizen of Boston by approximately 1765. His arrival date in Boston is 11 years before the Declaration of Independence. Boston was a very small town. In 1896, DuBois articulated the state of the slave trade in prerevolutionary Massachusetts as a mixture of tolerance and open engagement. The religious moral dichotomy espoused by the colonials (Puritan, etc.) somehow mitigated the full impact of the slave trade as experienced in southern and middle colonies (e.g., South Carolina, and other areas outside New England). It is informative to give a sense of the societal climate young Prince Hall was exposed to in Massachusetts. DuBois (1896) gives a view of the environment in early Boston prior to and contemporary with Hall's arrival.

Hall was a leather worker and soap maker-a fact not lost on this author as a soap maker for Procter & Gamble for 15 years. In addition to the aforementioned skills, Hall was a Methodist minister. He was a recognized leader in the Boston community by both blacks and whites. White (1973), an educator from the University of Florida, described Hall and his associates as follows:

During the revolutionary era, Prince Hall strove to free his people from a degraded status by organizing a leadership class among the residents .... The men around Hall had experienced relations with white benefactors uniquely enabling them to acquire the skills and values necessary for mobility. They achieved elite status by exemplifying Puritan ethics, attaining relative economic affluence and forming social institutions, schools, churches and fraternal organizations, based on those that held legitimate authority in the larger community (White, 1973, pp. 42).

Charles Wesley is instructive and relates Hall to the birth of America. Wesley writes, "Prince Hall urged Hancock and Warren, members of the Committee of Safety in 1775, to enlist Negroes in the Colonial Army. Later he served also as chairman of a delegation which conferred with General Washington on the same purpose (Wesley, 1961, pp. 4)."

In March 1775, Prince Hall and 14 other men were initiated into the order by the British Military Lodge No. 441. The intention here is to limit the discussion to the facts of the genesis of the order. No attempt will be made to argue points of legitimacy. Suffice it to say that there are several official documents from the Grand Lodge of England in 1784 and 1791

formally establishing both the African Lodge No. 459 and the Prince Hall Grand Lodge in North America. The point is closed by sharing Wesley's observations from the Grand Lodge of Massachusetts, a white American Masonic affiliate, acknowledging a common origin viz PHMT, as follows:

Grand Master Samuel H. Ragg of Massachusetts appointed a special committee on March 22, 1946, ... Thus for 170 years, African Lodge and its successors have been functioning in Massachusetts in good faith and with the justifiable belief that their origin and procedure was as regular and legitimate as we have thought ours to be (Wesley, pp319-320).

The following quote supports the assertion that one of the fundamental objectives of the efforts of the early Prince Hall Masonic historians was defense of the Order against enemies both foreign and domestic. There are older works that engage the question of the legitimate right of African Americans to even conceptualize an affiliation with the universal Masonic heritage. Arguments by Prince Hall himself and John Marrant in the 18<sup>th</sup> century preceded assertions by Robert Alexander Young, David Walker and later Martin R. Delany in the 19<sup>th</sup> century, all relate a range of references from a biblical linkage to Hamitic or Ethiopian heredity, a cultural and geographical linkage to Egypt and Africa and/or a common human heritage based on Masonic literature and principle; or a combination of all the aforementioned in one degree or another. Joanna Brook (2000) offers this supporting perspective:

Three lately republished and repopularized eighteenth-century speeches-John Marrant's Sermon to the African Lodge of the Honourable Society of Free and Accepted Masons (1789) and Prince Hall's Charges to the Lodge at Charlestown (1792) and Menotomy (1797)-suggest a more extensive and complex history for Ethiopianism. Prince Hall established the African Lodge of Freemasons in Boston in the 1780s and invited celebrity evangelist John Marrant to serve as its chaplain. In the Sermon and the Charges, Marrant and Hall expostulated a vital and portentous genealogy of African America. Their public claims to a common Black history and destiny-to the legacy of Ancient Egypt and the prophetic future of Ethiopia-prefigure and precede similar claims by David Walker and Robert Alexander Young. These three speeches document an early and little understood chapter in Black intellectual history, and they posit a much earlier point of inception for literary Ethiopianism than that generally agreed upon by scholars of the discourse (Brooks, 2000, p. 198).

Several Prince Hall Masonic historians frame a triadic of countermeasures focused against the extremely negative social environment surrounding the organization: 1) to rebut the accusations of illegitimacy with facts and supporting documentation; 2) to articulate the many facts related to the advancement of the African American community since the 18th century and, 3) to use writings and scholarship to inspire the youth in the community. These motivations are a common refrain in the literature created by Prince Hall Masonic scholars.

As with the African American experience more broadly, the nature and dynamic of family life and work life consume the vast majority of focus. The scholarship demonstrates that the Prince Hall Masonic tradition, from its beginnings, sought to undergird and protect the nature and dynamic of family life and work life against the forces that sought to diminish both. The next section will delineate the progression of the Prince Hall Masonic tradition from its beginnings

in Massachusetts to its nationwide and international reach. Importantly, there are constant and deliberate themes supporting leadership development and competencies, community development and self-help, resistance and mitigation strategies designed to foster internal growth and development and ameliorate the negative influences of a hostile external environment.

### Foundation and Expansion

The ensuing comments highlight the foundation pillars laid down by Prince Hall and his contemporaries. These pillars, diligently sought and secured, still support the structure of the institution and distinguish it from other Masonic bodies without such a pedigree. Like the Egyptian pillars standing at Abu Simbel, these pillars have proven timeless and unassailable. Like the monuments in Egypt, though silent, they trumpet the testimony of African heritage, impact, influence, and autonomy. The objective here is to document the purposeful and direct strategy of the founders of Prince Hall Masonry to build an institution that would frame a common platform of humanity. From this platform they intended to advocate for justice, build edifices to religious practice and education, and to foster self-reliance and economic prosperity. Masonry, in a very unique way, provided a basis for mutual aid in an ostensibly nonsectarian yet ontologically diplomatic way as well as in a practical manner. There is a persuasive argument to be made that for more than two centuries, the institution has fared better than the vast majority of institutions contemporary with its genesis.

Further, it has spawned replicas across the country focused on parallel objectives. The cohesive property of a common source of pain and suffering, life-threatening at worst and disrespectful and discriminatory at best, cannot be diminished. This cohesive property is analogous to covalent chemical bonds in that people are sharing common mechanisms that create holistic or more complete relationships at multiple levels, from micro- to macro. This is a critical component that fosters the foundations for longevity and consistency of the Prince Hall Masonic tradition--institutionalism.

After Prince Hall and his contemporaries were granted the right to conduct the nominal Masonic practices of a Lodge by the Grand Lodge of England, they sought more autonomy and authority within the construct of prevailing Masonic doctrine and practice. There was a great deal of communication with the Grand Lodge of England. Given the travel times and modes of communication, Prince Hall and his Lodge showed great patience and diligence. From 1775, the initiation of Prince Hall and 14 others in Boston, to 1787 with the issuance of a warrant from the Grand Lodge of England, to the installation of Prince Hall and others as Grand Lodge Officers by St. Andrew's Lodge (white) in 1791, 16 years had elapsed. The social networks in play were impressive. The odyssey for Hall began with an original request and an apparent follow-up request some four months later. The first letter is the generally accepted documentation substantiating the relationship with English Masonry. The following summary from a journal article entitled "Documents Relating to Negro Masonry in America," by Hall, et al., (1936) explains:

This further substantiates the organization and existence of the first lodge. William Moody was Master of a lodge in London, and Hall requested him to present the application to the Grand Lodge. This letter is signed "Prince Hall" and is the version of the application generally accepted (Hall, et al., 1936, pp. 414).

If one takes into consideration the social environment and pressures on the African American community, it is indeed remarkable to maintain such focus on establishing the Lodge. He persisted in this endeavor, however. Additionally, two members of the African Lodge were present in overlapping sojourns in London. These two members, William Gregory and Prince Spooner, were in London and in correspondence with Hall who was in Boston. Hall sent the required funds via a ship steward named Mr. Hartfield. Moody, the Lodge officer from England whom Hall petitioned, wrote a note expressing concern. Hall responded to this note indicating that Spooner would remit any difference in fees upon receipt of fund sent via the steward. Finally, Hall, Moody and a ship captain named Scott completed the transaction.

The Prince Hall Grand Lodge was founded in Boston, June 24, 1791. Prince Hall died on December 7, 1807, but the work of the Grand Lodge continued uninterrupted. The Lodge was renamed Prince Hall Grand Lodge, changing from the African Grand Lodge. Nero Prince succeeded Prince Hall. In the period from 1807 to 1826, more than 80 candidates were initiated. One of the marks of a sound institution is the orderly transition of leadership and the continuance of its work and mission.

The succession of state Grand Lodges owing direct dependency from Massachusetts Prince Hall Grand Lodge are: The First African Independent Grand Lodge of Free & Accepted Masons of North America for the State of Pennsylvania; the next state being Rhode Island; then New York, Washington, DC, Maryland, Delaware, New Jersey, Virginia, and Ohio.

The Most Worshipful Prince Hall Grand Lodge of Ohio began in 1849 in Cincinnati, Ohio. They picked up the precepts, principles, and torch of the founding organization via Pennsylvania and expanded the legacy of Prince Hall. According to Charles Wesley, Prince Hall Masonry in Ohio is linked to the migration of fugitive slaves from southern states. Wesley notes the following relative to the social interests of the African American population:

The organizational life of the colored population in Ohio included not only churches and school activities, but also fraternal ones. Following the lead of Pennsylvania, they took the first steps in Ohio toward the membership requirements of masonry. A large number of them had acquired education property and personal culture, which were the basis for fellowship among themselves with others (Wesley, 1961, pp. 30).

The last comments outline contemporary perspectives by reviewing the work of two scholars, P. L. Dunbar and C. D. B. Walker, respectively. As noted, the majority of Prince Hall Masonic scholars up to Wesley focus on historical facts and documentation that act as fortification for the basic triadic articulated by Grimshaw. Reviewing recent scholarship, a more analytical lens is evident, relating the implications and results of the historical activity. In his introduction, Dunbar (2006) asserts:

... the black church and Prince Hall Freemasonry both played important roles in the black experience in America. Some argue that the story of black America cannot be accurately and completely told without recording the impact these organizations have had in the black community... Rather than the church and Freemasonry embodying two separate and distinct means of social protest... those organizations complemented each other and have

played important interrelated roles in the way the black community address social, political and economic problems (Dunbar, 2006, pp. 2).

The thesis argued herein is consistent with this basic premise articulated by Dunbar. The Prince Hall Masonic tradition is also recognized by Booker T. Washington and W.E.B. DuBois and they assessed that it provided critical support mechanisms for the African American community (Washington (1911) and DuBois (1903).

Writing in 2001, Corey D. B. Walker wrote a doctoral thesis entitled, *The Freemasonry of The Race: The Cultural Political Ritual, Race and Place in Post-Emancipation Virginia.*Walker offers a tremendous insight into the utility of the Masonic institution in post-Civil War Virginia. He illustrates the delicate balance the community strikes in managing the internal and external dynamics of existence and survival (if not a measure of prosperity). The author carefully links primary and secondary source materials to "highlight an intricate process in and through which African American Freemasons utilized a fraternal form to navigate post-emancipation society (Walker, 2001, pp. 25).

The last comment from Walker frames a continuity of themes highlighted in the contemporary literature. He and others, working from the foundation laid by their predecessors, frame the interpretation and meaning of the facts of Prince Hall Masonic existence. As Walker asserts:

In the end, African American men would lay claim to the culture and institution of Freemasonry not only as a model for labor organizing, but as a viable fraternal form commensurate with their goals, aims, and ambitions for the fraternal order and the social, political, and economic order. The cultural practices of African American Freemasons were often locked within the competing framework of citizenship and self-determination. In the post-emancipation era, the members of Jefferson Lodge, along with their Masonic colleagues in Virginia and throughout the United States, utilize the fraternity to articulate their conception of what it meant to be a (black) man, a citizen, and human in an antiblack racialist and racist society. Their actions reveal the interesting territories where even in the midst of an antagonistic society and cultural form, they were able to (re) construct a fraternity in their own image whereby the oppositions and contradictions of fraternity and society could be the generative material for fascinating possibilities for social, political, economic and cultural flourishing (Walker, 2001, pp. 356).

Lastly, the exegesis outlined by P. L. Dunbar and C. D. B. Walker evince a contemporary perspective. These two dissertations, in whole or in part, expand the foundational historiography linked to Prince Hall Masonry. Their works are demonstrative of the shift away from validation to interpretation and analysis.

### **Research Foundation and Context**

Various researchers in a wide range of academic and professional disciplines point to the need for greater scholarly investigation of leader development processes, particularly compared to leadership studies generally. As contemporary challenges, such as globalization, continue to expand and demographic diversity increases in this country, developing leader's efficacy across a multitude

of human dynamics looms critical. There are two questions posed and investigated in this review. What have been the leader and leadership development practices and principles utilized by the Most Worshipful Prince Hall Grand Lodge of Ohio--its officers, appointed leaders, and committee chairs--as well as the principal officers of the subordinate lodges in the state? Primarily, how are these practices and principles applicable to contemporary and future challenges related to developing creative and enlightened leaders in the African American community?

Leader and leadership attributes, at the macro level, are encapsulated by the terms assessment, challenge, and support which were found in the MWPHGLO in both time sequences studied as well as traced to the broader Prince Hall Masonic Tradition. The basic constructs for the leader and leadership development model follow from the concept provided by Van Velsor, McCauley, and Ruderman (2010). As they outline this concept, leader development takes place in a leadership context. The three key elements they conceptualize are assessment, challenge, and support. They define assessment as follows:

Assessment gives people an understanding of where they are now: their current strengths, the level of their current performance or leader effectiveness, and their primary development needs. ... stimulating people to evaluate themselves, .... points to gaps between a person's current capabilities and performance and some desired or ideal state (p. 7).

The results of the textual analysis of historical materials from the MWPHGLO highlighted numerous examples of assessment. These assessments were effected at the level of the individual leader and in the context of broader organizational leadership.

The idea of challenge expands on the premise that growth comes from overcoming or meeting problems and opportunities that seem to be beyond a person's or organization's current capability. Van Velsor, McCauley, and Ruderman (2010) conceptualize challenge as:

Challenging experiences force people out of their comfort zone. They create disequilibrium, causing people to question the adequacy of their skills, frameworks, and approach. ... [The sources of challenge] Mainly they are novelty, difficult goals, conflict, and dealing with adversity (p. 9).

Examples of challenge experiences represent an inherent characteristic of the Masonic enterprise itself. The concept of challenge manifests at every level in the organization. People get challenged to grow the organization by setting up lodges, by engaging other jurisdictions, by deploying programs, by launching quasi-business enterprises, and by attempting to provide community uplift. Character formation then is facilitated through challenge.

Support, the final element in the trilateral conceptual framework, facilitates the successful integration of assessment and challenge for the individual. Finally, Van Velsor, McCauley, and Ruderman (2010) note the following characteristics of support:

Support helps the people handle the struggle and pain of developing. It helps them bear the weight of the experience and maintain a positive view of themselves as capable, working, valuable people [or organization] who can learn and thereby grow.... The most important

source of support is other people: bosses, coworkers, family, friends... People who can listen to the stories of struggle, identify with challenges, suggest strategies for coping... (p. 12).

Support mechanisms are replete in the textual analysis. Abundant examples represented by workshops, one-on-one visits, networking occasions and events, as well as visitations, all comprise the notion of support in the context of the MWPHGLO.

In a recent journal article, Day, Fleenor, Atwater, Sturm, and McKee (2014) define leader and leadership development as follows:

Leader development focuses on developing individual leaders whereas leadership development focuses on a process of development that inherently involves multiple individuals (e.g., leaders and followers or among peers in a self-managed work team) (Day, Fleenor, Atwater, Sturm, and McKee, 2014, p. 64).

The authors go on to articulate the complexity of leader development which is linked to adult learning dynamics. This frames the impetus for the research question herein. That question focusing on the developmental processes rather than leadership attributes. The golden nugget resides in creating ethical and innovative leaders.

Given that individual leader development occurs in the context of ongoing adult development (Day, Harrison, & Halpin, 2009), we need to focus on development as much as leadership to shed light on how this process unfolds (Day, Fleenor, Atwater, Sturm, and McKee, 2014, p. 64).

The research effort maps typologies for these developmental processes as they may appear in the annual reports of the Grand Lodge. A second objective seeks to illuminate any unique characterizations of the leader and leadership development processes identified as they relate to fortifying efforts to develop leaders in marginalized or underrepresented people in the United States and globally. Further, an interdisciplinary research and analytical lens, coupled with an African centered hermeneutical lens, fully positions the Prince Hall leader and leader development tradition in the universe of leadership traditions. The Most Worshipful Prince Hall Grand Lodge of Ohio (MWPHGLO) is the specific unit of analysis, and the organization is representative of the broader Prince Hall Masonic Tradition (PHMT).

# Cultural Sensitivity and Context

McDougal (2014) outlines the criticality of African centered analysis, linking the effort to accurate interpretive assessment, balanced, and empowered. This text reflects a similar focus as Robson (2011) in that McDougal (2014) seeks to frame the characteristics of fundamental techniques to construe the validity, reliability, and generalizability of research of, for, and about people of African descent. Ineffective translation of a cultural phenomenal meaning between cultural groups remains prevalent. The study of Prince Hall Masonry is subject to this issue. McDougal (2014) describes the issue as "mistakes in racial/cultural reasoning" and he comments about this as noted below:

Because so much of the history of social science has been the study of the powerless by the powerful, researchers must be cautious of engaging in scientific colonialism, which occurs

when the center of gravity for the acquisition of knowledge about a people is located outside of that people's lived reality (Galtung, 1967). Nobles (2006) explains that scientific colonialism can leave a researcher conceptually incarcerated or capable of only using non-African concepts, ideas, and perspectives to study people of African descent (McDougal, 2014, p. 15).

Prince Hall and his contemporaries purposefully chose to link themselves to Africa. Brooks (2000) comments after quoting H. A. Williamson who links Masonry and Egypt, "Through elective identification and conscious study, black Freemasons built a genealogical tradition for themselves, articulating and re-articulating the line of descent through which the wisdom of the ancients passed on to American Blacks." (Brooks, 2000, p. 201).

A review of the PHMT demonstrates that at its founding and through significant periods of its development, the founder and members noted a critical link between Africa and the Prince Hall Masonic order. This link continues with the work of Absalom Jones and Richard Allen in Philadelphia. Their association with the African Society and the African Methodist Episcopal church are testament to this enduring linkage. At a practical if not psychological level, the link to Africa is not theoretical but genealogical. This means that families, clan, and ethnic groups can tie their cultural practice, however veiled by a Western veneer, to Africa. The DNA thread of colloquial Masonry in the form of West African secret societies is manifested in Prince Hall Masonic consciousness and practice.

Tenure alone constitutes a prima facia case for effective leader and leadership development processes in the context of PHMT. Hinks (2007) writes the following affirmation in an article in the *William and Mary Quarterly*, "Historians often fail to recognize that the Prince Hall Masons makeup the oldest enduring black institution in America." (p. 106). In the same context, the MWPHGLO celebrated its sesquicentennial in 1999 and is likewise a significantly tenured institution. Over the last few years, the impact of Masonry has been given more attention by historians and academics. Hackett (2014) highlights the recognition that the study of Freemasonry across multifarious expressions in America constitutes an underappreciated influence on American life.

#### Method Overview

In conducting historiometric analysis, narrative analysis presented a critical step in terms of both framing the coding structure and quantification of frequency of themes for comparative purposes. Lawler (2014), Elliott (2005), and Ligon, Harris, Hunter (2012) provided a fundamental polemic for the importance of narrative analysis regarding both meaning and context. Narrative and content analysis are framed very well in Creswell (2013), Birks, and Mills (2011) and Saldana (2016). In both methodological approaches, significant levels of coding are involved throughout the methodological process. The scope of this discourse focuses primarily on the basic elements of the approaches not to provide an exhaustive review of the intricate detail of application.

The research methodology provided the potential to build a theoretical construct from the rich primary textual source material-the MWPHGLO annual proceedings, a historian's dream. The present interest, however, sought to test the thesis that contemporary conceptualizations of leader and leadership development are deeply situated in the Prince Hall Masonic Tradition.

Narrative analysis leveraged to a study of the proceedings for synonyms linked to these conceptualizations represented an appealing approach to the research question. Narrative analysis, textual analysis, or discourse analysis constituted variations on the same theme.

The MWPHGLO annual proceedings constituted the narrative to be examined. The present project assessed the various constituent components of the document (i.e. Grand Master's allocution, various line officer reports, and committee reports, etc.) for elements of leader and leadership development. What manifested as unique and innovative in terms of scholarly contribution and an important insight to both leader and leadership development originated from the fact that these documents represented primary source materials (historical evidence).

#### Results

The results of the textual analysis demonstrate that both leader and leadership development elements existed consistently in both the 19th and 20th century analysis of the annual proceedings of the MWPHGLO. The vast majority of the data focused on the organizational role associated with leader development processes-recall leader development themes link to individual aspects of development and leadership development link to organizational aspects. To a lesser extent, themes were also linked to environmental context, identity, conflict resolution, and networking for investigation were highlighted.

The data, distributed in two time sequences, provides a context for statistical comparison. The two-time sequences outline a generation for leader and leadership practice to take root given the origin of the institution and in this case, its centennial. The primary source material for the themes emerged from the Grand Lodge elected and appointed officers engaged in driving the organizational agenda, mission and purpose (e.g. Grand Master, Deputy Grand Master, Grand Lecturer, etc.). As such, the Treasurer, Secretary, and other similar reports constituted more or less transactional rather than directive activities. Directive activities refer to the nominal leadership functions—in terms of creating, driving, and realizing the mission and vision for the organization.

# MWPHGLO 19th Century Thematic Results

The themes that emerged spell out a robust energy to fortify an emerging institution with high quality members (good men, not fundamentally defined by economic class or academic accomplishment but character and values). Additionally, the leadership of the Grand Lodge believed that these good men would enliven masonic principle and tradition in the African American community. This approach in turn would exemplify to the global masonic network the notion of the equal humanity of an otherwise subjugated community. Importantly, the institution viewed through the eyes of these leaders represented a mechanism for uplift.

As noted earlier, the MWPHGLO was founded in 1849. The year 1865 represents a generation of activity by which the membership and leadership labored to establish a foundation for the long term. Themes associated with assessment link to four sub-categories (assessment against individual behavior, against the mission or purpose of the organization, against organizational performance, against more or less tactical goals and a general assessment). Themes associated with challenge link to four sub-categories (coaching in terms of personal feedback, organizational feedback, a general challenge, and against creating job assignments).

Lastly, those themes associated with support link to three sub-categories (mentoring or advice, networking, and general support/encouragement).

### MWPHGLO 20th Century Thematic Results

The analysis follows the flow articulated earlier in the section. The distribution of data demonstrates themes linked to support and networking are the most prominent. Challenge themes are close in prominence to support and the themes linked to assessment last (an order of magnitude smaller).

The membership population (MWPHGLO) in the 19<sup>th</sup> century was between 400 and 500. The membership in 1964 was approximately 6,000 and distributed among about 74 lodges in the state. This shift in demographics is significant and represents more than a four-fold increase in the number of subordinate lodges under the authority of the MWPHGLO versus the profile in the 19<sup>th</sup> century. The shift in leadership development focus relates to the shift from concerns about establishment and foundational questions of the institution to concern about effective operations and issues of relevance to advancing the African American community.

### Implications for Leader and Character Development

The *Standard Masonic Monitor* codifies the spirit and letter of a leadership ideal announced in the public installation ceremonies related to the Worshipful Master-leader of a local lodge. The following frame the duties:

Worshipful Master, having been chosen to preside over this Lodge, you cannot be insensible to the obligations which devolve to you. The honor, reputation and usefulness of your Lodge will materially depend upon the skill and ability with which you manage [lead] its concerns. As Master of this Lodge it will be your especial duty to attend to the administration of its ceremonies, preserve the ancient landmarks of the Order, now committed to your care, and permit no innovation in the principles or rites of the Order. ...The leading objects of our institution [rituals, ceremonies, teachings] are to inculcate sound morality; to make men honest and upright, true to their God and faithful to their country, and to unite them by the strong bonds of charity, friendship, and brotherly love. ... [as WM, you have a duty to] The mysteries of the Order must be unfolded, and the moral duties inculcated. The minds of the brethren must be enlarged and informed....Thus taught and thus acting, they will convince mankind of the value of the institution (Simons and Macoy, 1984, p. 148).

In this quote, several critical attributes of the leadership development themes within the Order are outlined that the MWPHGLO's leadership return to constantly. The idea that a leader demonstrates generosity (charity), amicable interpersonal skills (friendship), and care for the constituents (brotherly love), speak to critical leadership skills that either must be developed, maintained, or improved upon. Additionally, a high level of moral grounding and application must be demonstrated by leadership. The teaching and rehearsal of ritual and allegory represent vehicles to accomplish these leadership skills, perhaps unique among organizations.

The textual analysis reveals a pervasive focus on good order and character as well as diligence in terms of self-improvement. The developmental culture created within the context

of the MWPHGLO revolve around some critical African-centered principles that necessarily integrate with Masonic ideals and broad history. The argument here is not that these African-centered principles were always overtly articulated or referred to, but throughout its connected heritage, the MWPHGLO adopted these precepts. There are numerous positive associations of the membership both with its African heritage and contemporaneous linkages to the Grand Lodge in Liberia. One of the Masonic leaders instrumental in the creation of the MWPHGLO was Martin R. Delany, a well-known proponent of Kemet (also known as Egypt) as a classical African civilization and the connection of Masonry, in particular the Prince Hall Masonic Tradition, to it. Walkes (1979) provides a view of Delany's scholarship:

Masonically, Bro. Martin R. Delany is better known for his Treatise, *Origin and Objects of Ancient Freemasonry: Its Introduction into the United States, and Legitimacy Among Colored Men*, which he delivered before St Cyprian Lodge No. 13, June 24<sup>th</sup>, 1853, in Pittsburgh and which is the earliest printed work on Prince Hall Freemasonry. It is here that the Black nationalist philosophy of Martin R. Delany is best seen. He writes that the Ethiopians are the leading race of mankind, with the Egyptians as a branch of that race, and further suggests the Black origin of Freemasonry (p.119).

A preponderance of the principles of Masonry have their grounding and origin in Kemet, as acknowledged by Prince Hall and white American Masons alike. Washington (2015) provides substantial grounding in terms of this assertion. Certainly, Masonry bases its rituals and principles in the context of an effort to improve the moral character of its patrons. A key anchor of these principles is the concept of Maat which is a Kemetic conceptualization linked to ethical comportment among other ideas. The Maatian frame of reference predates the notion of cardinal virtues, yet its attributes are comparative and foundational to the idea. The African American leadership tradition is replete with references to and expectation of its leaders to have sound moral character. Many contemporary African American scholars from a broad range of academic disciplines articulate the relevance and connection of African American leadership traditions to the idea of Maatian ethical practice. Similarly, to the ideas outlined in contemporary leadership literature, ethics and leadership are fundamental. Stephen Covey (1990) coined a term, "principle centered leadership," a concept that advocates for time honored ethical precepts to be adopted and applied to leadership. This idea is congruent with Masonic tradition.

Maat represents the seed of natural laws and governing social values that have propagated through the Western experience. Ultimately, Maat is represented in Masonic Tradition and frames a superstructure for leadership in that context and society broadly as an ethical ideal. As alluded to earlier, the broader Masonic tradition articulates a powerful link to Kemetic origins. Many researchers have made the case for this assertion (Mackey (1898), Butt-Thompson (1929), Bernal (1987)). Washington (2015) notes as follows regarding the continuity in connection of Masonry to African roots:

It is clear that both white and African American Masonic tradition recognize the profound impact of African philosophy and ideals in shaping the principles and precepts of Masonry. Albert Mackey, William R. Singleton, and William James Hughan wrote a multiple volume work chronicling the development of the Masonic tradition, in a universal context (p.34).

The connection of Masonic tradition to Kemet being articulated, it becomes critical to outline the Kemetic principle of Maat to the African American leadership tradition generally.

The maintenance of Maat, the cosmic order, is at the core of Kemetic (ancient Egyptian) spiritual and practiced ethos. Here we begin by exploring one of the most developed articulations of this idea, framed by Karenga (2004).

Maat comes from Kemetic cosmology and is rooted in Kemetic text associated with the afterlife. Karenga (2004) provides an exhaustive review of Maat as an ethical and moral ideal grounded in Kemet. Karenga provides the following definition of Maat:

... in its essential meaning, Maat is rightness in the spiritual and moral sense in three realms: the Divine, the natural and the social. In its expansive sense, Maat is an interrelated order of rightness which requires and is the result of right relations with and right behavior towards the Divine, nature and other humans. As a moral thought and practice, Maat is a way of rightness defined especially by the practice of the seven Cardinal virtues of truth, justice, propriety, harmony, balance, reciprocity and order (p. 10).

In commentary made in 1892 in an annual report, the Grand Master articulates this Maatian focus on truth, right action, and invokes its relationship to the heart. In Kemetic practice, the heart of the individual is weighted against the feather of Maat to assess fidelity of actions to Maatian principles. Grand Master J. A. Brown articulates this concept as follows:

I desire at this time to read you and extract from the pen of our M. W. friend and Bro. Dr. E. A. Williams, the Grand Master of Masons of Eureka Grand Lodge for the state of Louisiana....we are told that the sand hardens into rock under the immense super incumbent pressure of the ocean, aided sometimes by the irresistible energy of fire. When we of an Order become such by pressure of immorality, we are like the sands of the seahardened. We insist that we should be otherwise than this is a force. It is the magnetic attraction of the heart towards truth and virtue. (Brown and Buchner, 1892, p. 19).

Finally, the MWPHGLO articulates a view of the teachability of its members and leaders in terms of the capacity to grow and develop both as individuals and in the context of the propagation of the institution. While this view is changing, in my corporate experience and generically, aspects of the "Great Man theory" still impact eligibility for leadership. This phenomenon means that the template for leadership is still dominated by white patriarchal form. This idea of the teachability of humanity was a practical axiological construct of the Order. It links to what Karenga (2004) articulates as the five anthropological attributes of Maat.

The developmental potential of humans represents a continual and repetitive refrain throughout the textual analysis. It is a demonstrated principle that posits that all people can learn and therefore develop. Paraphrasing Martin Luther King Jr., all people can serve; therefore, all people can lead. This concept stands as a hallmark of the Prince Hall Masonic tradition.

# **Concluding Personal Reflection**

Northouse (2013) reinforces the need for competence in multicultural or global leadership competency as articulated by Shriberg, Shriberg, and Kumari (2005) in a discussion of the relationship of globalization and leadership. Even today, the Order has vibrant international relationships. In my professional experience, I traveled to Brazil on one of my latest job

### **Articles**

assignments as an operational excellence expert. I met a southern Brazilian chemical engineer of German heritage, Getulio. As he and I exchanged background conversation, I was surprised to realize two important commonalities. The first was that he was quite familiar with the work of Cheikh Anta Diop and conversant in the Kemetic heritage link to Africa. The second commonality was the mutual membership in our respective Grand Lodge jurisdictions and as practicing speculative Masons. Our professional relationship lasted five years; our personal friendship is vibrant even today. This experience bears witness to the contemporary power and relevance of the Prince Hall Masonic Tradition.

In referencing the global project, Northouse discusses a summary of leadership behaviors "universally" outlined as desirable. The PHMT routinely advocates for universal principles that subsume the basic attributes outlined by Northouse. Some of the key overlapping "universally desirable leadership attributes," in common with practices found in this research are: excellence orientation, honesty, justice, and being administratively skilled. The data points to a propensity of evidence supporting the MWPHGLO advocating and facilitating the practice of ritual and administrative excellence, working for justice, and demonstrating an appreciation for international networking.

The PHMT intertwines with the Kemetic ethical construct of Maat and thus aligns with the ideas advocated by Covey (1990) and Kofman (2006). Specifically, Covey (1990) and Kofman (2006) advocate the application of integrity and adherence to time honored principles to the practice and development of leaders. Perhaps most uniquely among institutions, the opportunity for building competent and fluent multicultural leaders rests particularly in the Prince Hall Masonic Tradition and the global Masonic tradition broadly. The cultural fluency and dexterity of the leadership of the MWPHGLO manifest most prolifically in the numerous international engagements in the 19th century. They matriculated among a range of European and South American Grand Lodge bodies to secure recognition and masonic social intercourse. Their efforts to provide a polemic for masonic recognition were articulated across language and cultural diversities represented by the aforementioned geographies. This action frames a testament to multicultural efficacy.

Today, the United States finds itself wrestling with a divided citizenry. Many of the leaders, political or otherwise, seem to focus on tribal affiliation and interest rather than the common good. There appears to be less focus on Cardinal Virtue, reflective consideration, humility and respect. The principles espoused within the context of the Prince Hall Masonic Tradition, as they relate to leader development, might inform a renewed appreciation for leadership grounded in common principles revered through the ages and across the globe.

Maat, that is balance, harmony, order, truth, justice, etc., an ancient African and Masonic concept, reminds us that character is measured against a standard. This ancient standard has contemporary importance and must be recognized in modernity.

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## **Academic Commentary**

## Palliation: A Parabolic Pathway

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## Special Editorial Notation

This article was originally published in a previous edition of the Journal. It is being republished, with minor updates, to underscore the current edition's special promotion of the primordial nature of healthcare as human care.

#### **Author Note**

This article was developed originally from an academic position paper made by the author in 2009 in his previous executive role as Ethicist to the Surgeon General of the United States Navy. The opinions reflected in this article are those of the author and do not reflect the official policy of any institutions the author has served or currently assists. The author has no conflicts of interest. The photograph at the conclusion of this article is from the United States Air Force and is therefore in the public domain.

#### **Abstract**

Sickness and healing are central to the human experience. From the dawn of time, individuals and communities have struggled with the stark realities of our human finitude and how we best can cope with the same. Over the course of centuries in an unending myriad of ways from culture to culture, the human genius has developed an unending series of approaches that we have come to call "healthcare." In our modern era, social criticism has advanced concerning the inroads of the business model that seems to lead at times to the depersonalization of the healthcare experience. Critics point out that this depersonalization is inherently contradictory to the very nature of healthcare as the experience of healing that the human person needs and which is being appreciated today more and more as an ultimate right. Into this important boiling reality, there is a need for a pathway that can move the human imagination to understand, appreciate, reform, and renew systems of healthcare precisely as human care. Such a pathway, like parabolic images and stories of old, must have a deep and penetrating effect to change not just surface behaviors but also interior and subconscious beliefs, values and life stances. This article explores palliation as that needed parabolic reality as a type of nova-

paradigm. In the modality of a reflective academic commentary, the article discusses a number of important historical background points, the fundamental foundations of healthcare as palliative, the establishment of palliation as a parabolic paradigm, and some practical pathways. The article concludes with a series of reflective points to be considered for the future potential of this parabolic pathway for the continuing enrichment of health as a human experience, and healthcare as a human right.

Keywords: Palliative care, palliation, healthcare, systems of care, patient-centered, paradigm, medicalization, quality of life

## Introduction: Historical Reflections

The human tribe has always been obliged to care for the indigent, poor, sick, and dying. Time honored codes in various and very diverse cultures give clear evidence that the care of the sick is a firm ethical obligation for preserving human dignity and personal value. This ethos is more fundamental than any agenda, civic obligation, precept, or sentiment. It arises from the essential nature and core experience of human life, human community and good social order.

In the West at the end of the Roman Empire and the beginning of the medieval period, the care of the sick often was taken up within the charism of hospitality of monasteries and abbeys. As an extension of the monastic infirmary for sick members of the religious community, the civilian sick would be offered comfort, care and health as part of the mission of the religious body to the wider world. This mission also included welcome for the stranger and the pilgrim in an age of political fluidity and potential violence toward travelers, serfs and all those outside the ruling class, and vulnerable others. The hospitality of medieval religious houses was the context out of which the later concept of the hospital institution eventually developed.

Resulting from educational and intellectual shifts arising from scientific thought and discovery, the provision of healthcare over the centuries took on a particular identifying character that might be termed "medicalization," namely the provision of scientific cure by a licensed and certified profession with an assigned or recognized social status. With the coming of the Industrial and Nuclear Ages, the Information and Knowledge Management Explosion and skyrocketing costs, the need for efficient business modeling, and the advent of the hospital as a civic institution, the experience of healthcare has been modeled beyond medicalization even further into an organizational system of effective service delivery.

While respecting the need for increasing efficiencies and reducing unnecessary costs, industrial or business modeling has changed slowly and dramatically what might be termed the original "fundamentum in re" and experience of healthcare as an act of human solidarity. While understandable, this shift has also had unforeseen and undesirable consequences. In some cases, the provision of healthcare has been used for politicization. Examples of this include acts of violence against healers and healthcare professionals such as violence against Doctors Without Borders.

Complicated by discriminatory issues of class, race, gender, sexual orientation, and other forms of social injustice, community leaders in diverse cultures have, in various historical periods, reacted to such paradigm shifts or modeling changes in healthcare. In various decades,

social critics and studied commentators have sought to promote a corrective re-balancing of effective institutional medical delivery with the core character of healthcare as a personalized and humanistic service. Such has been the case beginning in the 17<sup>th</sup> century in Europe to the present in the United States with the rise of new associations providing patients with the human comfort and care reminiscent of medieval hospitality toward the sick and dying.

One historical example of this was the work of Catherine Macauley, Frances Xavier Warde and company who left the traditional place of women in the home to venture into the alleys and streets of 19<sup>th</sup> century Dublin to care for cholera victims and those left to die alone and abandoned. Frances Warde brought this culturally stretching experience to the United States in a series of founding-ventures that eventually developed into what would become one of the larger hospital systems in America. The *fundamentum in re* of the Macauley/Warde system was the retrieval and re-imagining of the medieval experience of hospitality---however no longer at society's peripheral vision but directly within the eyesight of the urban experience. This was a powerful phenomenon in a time of unbending and calcified class distinctions. The reaction against Macauley, Warde and company was strong, yet did not thwart their work.

In this same spirit, in 1967 Dame Cicely Saunders gave new expression to patient-centered healthcare at St. Christopher's Hospice in London. Notably for this discussion, this was care for the dying. There followed the founding of similar institutions in Canada and the United States. The founding of St. Christopher's is looked upon as the modern origins of palliative care, though underscoring here again that this was focused at that time as care for the dying. Under the rubric of this seminal hospice concept and in a time when living with long-term conditions was only beginning to become more widely understood, palliative care was a means of providing a holistic approach to care for the total human person in a time when death seemed near. Such care included pain management, alternative therapies, human spirituality, counseling, pastoral care etc. However, the concept of palliative care itself has been rapidly evolving over the last 50 years beyond its original singular focus upon end-of-life issues and care for those nearing death.

#### Palliative Care

Though the popular imagination in some corners still, whether consciously or subconsciously, relegates palliative care to hospice care for the dying, palliative care has mutated over time into a beneficial approach for patients in any long term condition of need. Under this aegis, palliative care as a concept has acquired a more universal definition that is not necessarily tied only to the care for those in proximate danger of death. Its principles of holistic and interdisciplinary/interservice provision for the total healthcare needs of the sick quickly have come to be seen as an extraordinary benefit for those who have long-term care health requirements.

Today, palliative care includes a wide and diverse pallet of services, concepts, and perspectives: medical practice, nursing care, medical and healthcare research, pastoral care, counseling and psychological services, social welfare and advocacy, family service, healthcare mediation, law, the role of the medical arts and humanities etc. These and other related areas have become enfolded into palliative care as a result of what is a long and evolving definition that is still in process. The multidimensional expanse of palliative services in society can be observed within the WHO definition retrieved in 2009 that follows. It is to be noted, however, that the underlying approach in the text still focuses largely on end-of-life issues.

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care: provides relief from pain and other distressing symptoms; affirms life and regards dying as a normal process; intends neither to hasten or postpone death; integrates the psychological and spiritual aspects of patient care; offers a support system to help patients live as actively as possible until death; offers a support system to help the family cope during the patients illness and in their own bereavement; uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated; will enhance quality of life, and may also positively influence the course of illness; is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Within the United States specifically, the Third Edition of the National Consensus Project (NCP) in its *Guidelines for Quality Palliative Care* incorporates and expands many of the same aspects of the WHO definition. The document is a comprehensive discussion of the nature of palliative care, its interdisciplinary emphases, the synergistic approach that must be taken to palliative care, and the ability of the concept to be applied to a wide variety of patient conditions and circumstances. As would be expected, the document discusses palliative care and its applicability to the dying or those with life-long or life-threatening conditions.

However, when the document discusses palliative care as a general approach to healthcare even in the primary care setting, one can sense the beginning of an applicability of palliative care to the fundamental nature of healthcare itself. When read from a more studied and objective perspective, the eight domains of palliative care that NCP addresses may well be applied to all forms of healthcare not previously thought of as applicable under the rubric of palliative care. For the sake of completeness here, the NCP eight domains are:

- Structure and Processes
- Physical Aspects of Care
- Psychosocial and Psychiatric Aspects of Care
- Social Aspects of Care
- Spiritual, Religious and Existential Aspects of Care
- Cultural Aspects of Care
- Care of the Patient at the End of Life
- Ethical and Legal Aspects of Care

There is yet another social or cultural perspective influencing the developmental nature of palliative care today. While accepting the real benefits of efficiency models, a cultural reaction is occurring within the healthcare community across the globe. To understand this reaction, the following reflection may be helpful.

Linguistics teaches us that "language talks." In other words, the terms humans use reveal deep patterns of internal systems of valuation and meaning. This is true for individuals as

it is for groups, including individual societies and cultures. Those who traditionally have been "patients" have become known in modern parlance successively as "clients, customers, consumers, and generators of metrics of productivity for electronic medical records." Though these alternative terms have their utility, there are prudent commentators who see in this system of nomenclature a progression that, unless balanced, promotes depersonalization and obscures, if not entirely contradicts, the core experience of healthcare as human care.

These contemporary and thoughtful commentators seek a qualitative balance to quantitative methods of outcome assessment and performance measurement. In addition, an increasing over-medicalization and hyper-professionalization of healthcare has, consistent with the characteristics of all institutions, inadvertently allowed the creation of silo-effects between diverse departments and services within hospitals and care centers. These silo-effects create compartmentalization and can erode the full effectiveness of even the most robust programs of existing patient-centered services such as social services, pastoral care, counseling etc. Greater impact is lost when departments are not connected and providers do not work as actual team members for holistic treatment of persons who are ill.

Against this backdrop and consistent with the overarching NCP approach above, an appreciation of palliative care as a human-centered paradigm for healthcare as a whole can be observed in the 2008 report of Wolfgang Wodard to the Parliamentary Assembly of the Council of Europe. Several passages of the opening summary follow:

The importance of palliative care as a comprehensive approach, with the potential to complete and improve existing care programmes, is now recognised in many of the Council of Europe' member states. Palliative care is a substantial and socially innovative addition to curative, highly scientific medicine, where subjective wellbeing of the patient comes after the goal of curing an illness and which involves therapy-related restrictions and sometimes massive side-effects. The report endeavours to highlight the central problem of the highly sophisticated and costly healthcare provided particularly in Western Europe, which, at ever shorter intervals, produces new medical techniques and medicines, raising high public expectations of curative success. At the same time, however, this type of healthcare is increasingly - and obviously - failing to meet the basic needs of people suffering from chronic or rare diseases. The rapporteur considers palliative care as a model for innovative health and social policies. Palliative care does not simply meet a cultural and humanitarian need of the most pressing kind. It also provides an innovative structure which, if intelligently developed, will not only produce sustainable change in the health sector, but may also serve as a recipe for success in other policy areas with serious, systemic and recurrent problems (eg drug prevention). The rapporteur therefore regards palliative care as an essential component of appropriate health care based on a humane concept of human dignity, autonomy, human rights, patient rights and a generally acknowledged perception of solidarity and social cohesion.

## Palliation as a Parabolic Paradigm

From all of the above, it can be posited that underneath palliative care there exists a paradigm that can be termed, "palliation." Phenomenologically, palliation operates as the essential foundation for healthcare itself. It serves as a type of universal against which are best understood the subsets of specific clinical services. Without the universal of a paradigmatic

concept such as palliation, individual clinical acts can be easily misperceived or caricatured in the contemporary mindset as assembly line activities. Palliation is a holistic and synergistic paradigm. In fact, it serves powerfully as a type of parabolic entity. Like parables and parabolas, the word and image indirectly but powerfully can lead us to understanding something that is far deeper than initially imagined. Palliation requires that the care of the sick and suffering integrate both scientific/medical cure and humane/humanistic care, medicine and human services, to create an ever-developmental, interdisciplinary, patient-centered approach to individuals, to their families, and the cultural communities in which they live.

To coin a new phrase, effective palliative healthcare is a *de novo* intentional approach to treatment team design and operations. It requires that sickness and health not be viewed as isolated phenomena in individual patients inhabiting individual beds. Palliative healthcare is a relational construct that touches the relational dimension of any sickness and disease as these are experienced within the condition of human beings who are themselves relational by nature. Academics and social scientists clearly attest that, underneath symptoms and diseases, patients suffer a more fundamental illness, namely alienation. Disease creates in patients both psychosomatic or somatic pain, as well as existential angst. Palliation/palliative healthcare might be the best underlying parabolic paradigm for contemporary healthcare delivery. It challenges providers and institutions to bring together and integrate medical/scientific cure and full humanistic care in the most robust fashion possible but in new and unprecedented ways.

The impact and importance of palliation is highlighted when we reflect upon the dimensions of the human experience itself. Traditionally, we are often taught that the human person is a creative combination of body, mind and spirit. While an easy vehicle for beginning to teach our young about what it means to be human, this tripartite image needs expansion and even deeper wording. This author suggests that, we as human persons, are constituted by matter, mind, motion and meaning. These "4Ms" lead us to understand that, while we are made up of the physical and mental, we are deeply joined within ourselves and with others through those inner realities we call emotion and movement. And ultimately, our entire being is both joined together but also quantum leapt by one's moral meaning as a unique human person or as a unique human community and culture. Our experiences, including those of sickness, woundedness, and death, touch us deeply in all four substantial modes. Thus, even new health and illness understandings such as "moral injury" need to be reimagined on these deeper levels as realities that can be experienced by any of us in this life. Ultimately, this 4M image or metaphor is a critically important horizon that calls us to understand the immediate need for healthcare as human care, for healthcare as palliation---something far deeper than what modern society seems to embrace.

Of immediate historical importance is the contemporary drive in the United States to some form of nationalized healthcare such as is found in other democratic nations. Reactions to this national drive are plentiful and broadly diverse. Often, they are also divisive. One set of critiques questions whether any form of nationalized healthcare will be responsive to the total human needs of patients, their families, and communities. Models and approaches are needed to give flesh to the palliation paradigm. In this way, the existential disease of "alienation" can be met by a cure/care dynamic of "integration" bringing together in a unified way diverse services, approaches, analyses, resources, and outcomes. Such an approach will require careful delineation of new institutional doctrine as well as education/training to assist providers with new critical thinking skills and worldviews so that they might act more as healers and as team members serving the needs of patients who themselves are not isolated persons but relational beings.

## **Articles**

Parenthetically, this author is reminded at this juncture of his experience as a hospital chaplain in the early 1980's assisting patients in a burn unit. There was no touch, no ability to express care through simple human contact. A plastic sheet separated the patient so there could be no contamination. There also was no means of conveying the simplest form of human communion via touch. While the medical need was clear that physical separation was needed, the existential disconnection was powerful and endures to this day as a profound memory of stinging wonderment.

In current discussions regarding potential national programs of healthcare, the Military Health System and Veterans Administration System (MHS-VA) is critically central. MHS-VA are themselves the original "socialized medicine" in the American experience. Despite surges and gaps over time, they remain as a context in which key elements of palliation/palliative healthcare are experienced and emergent. It is in the MHS-VA context that palliative healthcare can lead the nation's progress.

## **Potential Practical Pathways**

- Based upon the previous reflections, it would be strongly recommended that executive healthcare leaders establish in their institutions Executive Task Forces (ETF) on Palliation and Palliative Healthcare Initiatives.
- These ETFs should explore the full nature of palliation as a cultural-metaphor, and
  palliative healthcare as the basic strategic doctrine for all healthcare delivery within the
  system and institution. ETFs should explore tactical implementation of the doctrine
  especially for the education of healer/providers to "think and act palliatively." These
  ETFs should explore methods by which the institution/system effectively can integrate
  departments, resources, and capacities for patient-centered, holistic, and communitycontextualized healthcare delivery.
- The ETFs should undertake a comprehensive review of contemporary literature and
  specifically analyze the NCP definition of quality palliative care for incorporation
  into the self-understanding of the community's mission. The ETFs should analyze and
  determine the best applicability in the institution's overall healthcare delivery systems
  and operations of the eight domains of palliative care as found in the NCP Clinical
  Practice Guidelines for Quality Palliative Care.
- ETF results should be used to augment long-term development for strategic planning and mission for the next decade. This aspect of the institution's mission should be used to address wider, emerging needs of national programs of healthcare.
- ETF membership should include a wider representation of leaders and healing providers
  whose diverse services are part of the expanse of palliative healthcare in contemporary
  society. Of particular importance will be those who have a strong background in the
  medical humanities. Of equal importance would be those who lead the local Healthcare
  Ethics Committees.

## **Concluding Reflections**

Within the metaphor of "palliation" and the development of palliative healthcare there is nuclear cultural power for the advancement of model healthcare systems for the nation's future. Yet, how might one understand this power? A creative reflection upon the linguistic/etymological origins of the term "palliative care" will prove intriguing, challenging, and fruitful.

The word "palliative" has its origins in the Latin "palliare," meaning to cover or cloak. Using this as a rich metaphor, the monastic practice of hospitality toward the sick was an act of extending the monastic habit or cloak to wrap up and enfold the suffering from the doorway or porter's guard gate into the care of the religious community in fulfillment of the mandate of compassion central to the Western spiritual tradition. The care of the sick and suffering, not just the dying or long-term ill, is captured powerfully within this metaphor. While religious communities were the *loci* of pharmacology and medicinal care during the Middle Ages, they contextualized the offering of curative therapy as part of and within the healing event of human welcome. For them, the former made no sense without the latter. This is a powerful metaphor. However, all metaphors are symbols, and therefore are tensive or polyvalent. They are many meaning-ed. They can conjoin disparate even contradictory meanings. The following exemplifies this point.

"To enfold" is only one of the functions of a cloak. It also can conceal, hide or disguise. In children's stories and mythology, cloaks can be magical pieces of clothing allowing the wearer to disappear completely. Early medieval monasteries and abbeys often were located at the fringe of villages prior to the rise of the cities in the 13<sup>th</sup> century. They were relegated outside the normal civic population, partly to meet the theory of the time that a vowed celibate life was to be a "flight from the world" (*fuga mundi*). In a certain respect, they were a "hidden life" cloaked from regular daily view. Even after the 13<sup>th</sup> century when it became more common for monasteries, canonries, friaries, and convents to be located within city walls, religious houses were ordinarily still separated from the streets by a strict cloistered life. Religious life struggled then, as it sometimes still does now, with being something "hidden" despite its powerful social witness in every century.

Within this context, the care of the infirm, the poor and the sick became cloaked, compartmentalized, even hidden, from the sight of society. Sickness and human dying were realities that could be forgotten, or treated as the unmentionables. They could be, and many times were, gladly ignored. Infection control, popular misconceptions, ignorance, and superstition contributed to a gradual, historical pushing of sickness to the fringes of perception. In other words, what developed in culture was a "denial" of sickness and dying.

In our own time, the analytic work of Ernest Becker and Elizabeth Kubler-Ross powerfully has underscored much of this tendency, namely a fear and denigration of aging and the human experience of finitude as experienced in a society where humans live longer and where we are commercially bombarded to take every measure to counter the aging process and the inevitability of death. In other words, building upon the poetry of Dylan Thomas, while we may never wish to go gently in that good night, it is another matter entirely to deny that the night exists in the first place.

## **Articles**

Yet into this discussion it must also be recalled that from the Latin "palliare," another term evolved, namely pallium. The pallium is an ecclesiastical vestment in the Western church that has its origins in Greco-Roman garb. In the Western liturgy, it is a decorative stole worn around the neck given by the Roman pontiff to archbishops under his jurisdiction. The pallium signifies the induction of the individual archbishop into a close-knit circle of the highest-ranking leaders. It is a symbol of the highest form of cultural visibility. Interesting; in fact, very interesting. What might this curiously pose for understanding the power of palliation in culture today?

As Charles Gusmer discusses, the experience of human illness is revelatory of a deeper experience of alienation and identity-disintegration. The human animal in sickness experiences a crisis of communication and relationship with the other that is the physical world, the others with whom we share the world, the other that is the self, and the utterly other that is our ideal self or the self within us that gives us meaning. It is an experience of disruption and loss of control. One's time is no longer one's own. Space and the freedom to utilize it are ruptured. One's sense of being an active "agent" gives rise to a diffuse ambiguity between bodily or psychological pain and existential anxiety or meaninglessness. Perhaps it is precisely this internal chaos that makes sickness/death denial attractive. Much like the caricature of young adults in the 1970's film "Logan's Run," society seeks to terminate from its visual field anything that reminds us of our finitude, our inability to extinguish death. From a philosophical perspective, it is possible to consider that this fear of death and finitude is the ultimate disease that exacerbates our fear.

Into this volatile mix, the symbol of the pallium reminds us of some classical academic perspectives in the medical humanities arguing for an honored role of the sick and the suffering in society: that the sick and the suffering have as much a mission or service to society and community, as do society and community to them. With this as a reflective backdrop, it is then an interesting invitation to consider that palliation and palliative healthcare are systemic means by which we make acutely---even uncomfortably---visible within our worldview the sobering experiences of sickness and death.

While covering the ill and the suffering with care and compassion, palliative healthcare challenges us not to disguise or deny them, and how they carry in their bodies the universal human realities of disease and our inevitable finitude. Palliative healthcare may be itself the cure in this age for our blinding fear, urging us to face squarely, accept, and finally integrate within the individual and social psyche the age old problem of suffering that Western philosophy sees as part of what it calls "theodicy."

We humans are truly courageous. We have explored the expanse of the cosmos and plunge into the limits of the seas. We delve deeply into concept and configuration. But perhaps the journey that is most needed is the one we resist with the greatest energy and fear: the journey into the deepest shadow of our human existence --- a shadow that envelops the shades of sickness, but also is the necessary prelude to the glint that is our hoping.

I wonder, are we ready for such a journey?



As part of a 2011 health care rescue initiative in Afghanistan, an Air Force medic sergeant examines a child's injured knee during a neighborhood patrol. Staff Sgt Ryan Crane photograph. https://www.flickr.com/photos/usairforce/6130943780.

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# A Medical Student's Reflection on Implicit Bias and Microaggression in the Hidden Curriculum

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#### **Author Note**

This article is an original commentary of a third-year medical student's experience with implicit bias and microaggressions in the hidden curriculum. It is also a plea for more effective training during the pre-clinical years to better prepare medical students to address and manage the many forms of implicit bias and microaggressions present in healthcare. The author is solely responsible for the contents of this article. This article does not necessarily reflect the position of any of the institutions the author serves. The author has no financial conflicts of interest.

Biases are nature's algorithm for the preservation of life, but unlike mechanical algorithms, nature's algorithm in human neuroanatomy is accompanied by the capacity to defy that predominant algorithm and write new ones with acts of self-regulation.

— Abhijit Naskar, 2021

## Introduction

Explicit bias and macroaggressions are easily recognized since they are blatant and obvious, and the perpetrators of such acts typically are quite clear about how they feel about certain groups of people who are different from them. Implicit bias and microaggression are often more subtle and not as easily recognized. Malcolm Gladwell in his book, *Blink: The Power of Thinking Without Thinking*, does an excellent job at differentiating the two categories and explaining how Harvard's Implicit Association Test can be used to identify one's own implicit biases. As he says:

[O]ur attitudes towards things like race or gender operate on two levels. First of all, we have our conscious attitudes. This is what we choose to believe. These are our stated values, which we use to direct our behavior deliberately . . . But the IAT [Implicit Association Test] measures something else. It measures our second level of attitude, our racial attitude on an unconscious level – the immediate, automatic associations that tumble out before we've even had time to think. We don't deliberately choose our unconscious attitudes. And . . . we may not even be aware of them. The giant computer that is our unconscious silently crunches all the data it can from the experiences we've had, the people we've met, the lessons we've learned, the books we've read, the movies we've seen, and so on, and it forms an opinion (Gladwell, p. 84-85).

## **The Open Forum**

Thus, when thinking about the differences between explicit bias and implicit bias, we understand explicit bias to be equivalent to one's *conscious* attitudes and implicit bias to represent one's *unconscious* attitudes. Likewise, macroagressions are an expression of overt and conscious attitudes of discrimination and racism, while microaggressions can be both conscious and subconscious. Attitudes that have been so engrained and entrenched into our psyche by various messages given to us by society, that we may not even recognize them, unless we do the active and important work of identifying and unlearning those biases, while actively minimizing the impact one's implicit bias can have in our daily and clinical lives.

## We are not prepared...

Before matriculating into medical school, I worked as a medical scribe in an urgent care setting. To my dismay, I was written up for asking a co-worker for a tampon and not smiling enough. I was not prepared for this sexism.

When I was applying to medical school, I was told "Don't worry, you're going to get in because you don't look white, it's not as competitive for *you* people." I was not prepared for this racism.

When I was beginning my clinical rotations in the hospitals, I watched in disbelief as a physician diagnosed a Black woman, after spending just 15 minutes with her, with bipolar disorder and placed her on antipsychotic medication. He indicated that she was "depressed and erratic." He did this even though, according to my understanding of psychiatry, it takes more than 15 minutes to accurately diagnosis anyone with a mental illness. I was not prepared for this intersectionality of racism and sexism.

Although I was not prepared, I was not surprised. Many articles have been published to examine the prevalence of implicit bias and microaggressions within the healthcare field and their impact on patients' level of care. William Hall and colleagues did a systematic review of 15 publications, in a study titled "Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review" and found that 14 out of the 15 studies they reviewed showed evidence that a majority of physicians included in the study (43-100%) had low to moderate levels of racism. In a field that is dedicated to helping vulnerable people and saving lives, any level of bias is too much. As a physician in training, I believe it is imperative that we are teaching the next generation of doctors to recognize and eliminate bias to provide the best care to our patients. As medical students who are learning how to take care of people in need, it is time to ensure our training is anti-racist, so instead of adding to or tolerating this bias, we should be trained on how to eliminate it.

#### Sexism in Medicine

"You," the patient's husband said, pointing at the one white male on our medical team, "I want that doctor to solve this problem for my wife." Our entire team was taken aback but as professionals, and more importantly women professionals, we resisted the urge to point out the display of sexism that was embedded in this patient's husband's request. Instead, the attending physician politely informed the patient's husband that the White male on our team was not a doctor yet, but rather a fourth-year medical student. As we left the room, I could not help

but wonder why the male student was singled out, among a team of professionals to solve the patient's problem. Was it his gender or his race that made him seem more capable than the actual doctors in the room? Or maybe it was a combination of both and the shared identity he had with the patient's husband as another White male. Veronica Gerace conducted a study done in 1997 entitled "Perceptions of Physician Credibility and Patient Credibility and Patient Communication Satisfaction as Affected by Race and Sex of the Physician," which found a significant difference between patient perceived credibility and anticipated communication satisfaction when accounting for race and gender. The study found White male doctors were rated the highest in credibility and successful communication, whereas Black women were rated lowest. However, more recent studies have shown mixed findings, with a study completed by Rachel Solnick and colleagues titled "Effect of Physician Gender and Race on Simulated Patients' Ratings and Confidence in Their Physicians: A Randomized Trial." The researchers found no significant difference between female or Black physicians when compared to White male physicians.

Numerous studies have shown that patients now recognize the hours of training it takes to become a physician. Nonetheless, many patients still do not trust physicians of color or women. In fact, many doctors must spend valuable clinic or ward time convincing patients that they are in fact doctors. Lauren Vogel published an article in 2019 titled "When people hear 'doctor,' most still picture a man" that found that only 5% of people presume a doctor will be female, and in people over the age of 55, that figure fell to just 2%. These numbers would drop even further if the female physician were to skip her white coat and wear professional attire alone. Christopher Petrilli and his colleagues' research titled "Understanding Patient Preference for Physician Attire: A Cross-sectional Observational Study of 10 Academic Medical Centers in the USA" published in the British Medical Journal, found that patients perceive physicians in white coats more trustworthy, professional, and knowledgeable.

But not even my white coat could protect me. Protect me from patients feeling it was appropriate to stare and comment on my body and looks. Protect me from patients leaving me their phone numbers and asking me to call them after work. Protect me from residents calling me thick or asking me if they could see me again, outside of work. And why would my white coat protect me? The Association of American Medical Colleges Graduation Questionnaire in 2011 showed that one in six medical students would experience sexual discrimination or harassment by the end of their fourth year. Furthermore, in a meta-analysis which included 28 studies looking at harassment and discrimination in medical training, Fnais and colleagues found that 68% of medical trainees had experienced verbal sexual abuse.

Although we have made amazing progress in the last 40 years, increasing the number of women represented in medical school, from 25% to 50%, we still have a lot of work to do to make this once male dominated field more accepting of and comfortable for women providers. Increasing access to the field is not enough, when women are still being subjected to sexism in their professional lives. Training in how to handle sexism and gender bias from our patients and our colleagues, and training on how to recognize and eliminate one's own sexist and gender bias is needed to create a welcoming work environment. Restructuring of policies that favor a male dominated workplace is needed to ensure equal opportunities for career progression equivalent to that of men. As a woman in medicine, I am thankful to be here, but I recognize that more needs to be done to ensure that sexism and gender bias are not factors that contribute to physician burnout, so that we are here to stay.

## Racism in Medicine

"That's it, SEDATE HIM! And someone put restraints on this man." As four police officers walked over with restraints in hand, and a nurse with intravenous haloperidol drawn up, my heart broke. This man was not physically threatening anyone, nor was he a risk to myself and the other team members. It was the perception of him being loud and verbally insulting to the doctor in charge, that resulted in him being placed in physical and chemical restraints. I looked over at my chief resident, who looked just as distressed as I was, and in a low voice she said to me, "I could have verbally deescalated the situation, this was not called for." The attending of the ER, however, did not even try. As a third-year medical student with no obvious power or authority, who was I to point out that this was not the protocol for dealing with this patient, regardless of the perceived "aggressiveness." All I could do was stand in the corner and wonder would things be different if our patient was White and thin, rather than large and Black? Would the same behaviors be interpreted differently because this patient was perceived as less threatening? Sadly, there is clear evidence in the medical literature that indicates that the answer is yes. Simply being a Black man in America puts you at an increased risk of getting physically and/or chemically restrained in our emergency rooms, as discussed in Ambrose Wong and her colleagues' study "Association of Race/Ethnicity and Other Demographic Characteristics With Use of Physical Restraints in the Emergency Department."

"Can you translate for me?" the resident asked me before we walked into the room of a Spanish speaking patient. "No, but I can get the Interpreter for you," was my response. In making this on-the-spot decision, I felt I may be jeopardizing my grade on the clinical rotation. However, I was not trained as a medical interpreter and did not want to jeopardize the care of the patient, whom I felt should be treated with dignity. The resident declined saying it will take too long and then proceeded to ask the patient questions using his rather limited understanding of the Spanish language. I stood there, shocked and disgusted by the disconnect between what we are taught in medical school and the hidden curriculum in the hospitals. How much time is really wasted, if the end result is better patient care and patient understanding of their illness through increased health literacy? Am I naïve to believe that a five-minute "inconvenience" now, could potentially improve the health literacy of a patient? Or increase their ability to provide their other providers with more accurate information regarding their medical condition and treatment during their hospital stay? Even with legislation passed requiring all providers to utilize medical translation services to those with low level English proficiency, the rates of usage only increased by 3% in Massachusetts, as found in Breena Taira's and her colleagues' study titled "Hospital and Health System-Level Interventions to Improve Care for Limited English Proficiency Patients: A Systematic Review."

#### A Reflective Conclusion

As a third-year medical student who has completed one semester of clinical clerkships, I found it important to take time and reflect on the biases and microaggressions I have witnessed thus far in my medical education. Not only are we in need of more robust anti-bias training across all levels of medical education, but also, we need a complete re-structuring of the healthcare system to eliminate racism and bias from how we practice medicine. The impact of leaving out anti-racist/implicit bias training from medical education will contribute to the

widening gap in healthcare disparities ranging from lack of access, maternal and infant mortality rates affecting Black women and babies at rates two to six times more than those of White women and babies, misconceptions of pain tolerance and need for analgesics in Black patients, and the continued underrepresentation of Black and Brown medical providers, to name a few.

While interviewing for obstetrics and gynecology residency, Shakkaura Kemet was told by an attending physician that racism does not exist in the field of medicine. The fact that she had to go on the defense during her interviews to educate someone who is supposed to be her future supervisor or attending physician, makes clear the urgency of providing anti-racist/implicit bias training broadly to all who interact with students, residents, and patients. This attending physician and other physicians should have received this training far in advance of meeting with this applicant.

Kemet went on to outline the experience that many "anti-racist warriors" face in trying to balance the desire to close the gap in health disparities caused by racism with the fear of triggering "White fragility" in the people holding the power over our futures in her article "I Can't Breathe during interviews—The Incomplete Penetrance of Anti-racism." Like myself, she understands the need for longitudinal anti-racist training among practicing physicians and those in charge of selecting the next generation of physicians.

However, the impact the lack of anti-racist/implicit bias training has is not only seen during the clinical years of our education, but also during our pre-clinical training. LaShyra Nolen shares her experience of her pre-clinical training in her article "How Medical Education Is Missing the Bull's-eye," where she discusses the effects lack of representation of Black skin and bodies in medical education has on patient's outcomes. When comparing my own education to the one she received, I see many similarities. Neither of us were taught how to perform CPR on women or pregnant women or taught how to recognize and thus diagnosis skin pathology, such as early stages of Lyme disease in Black and Brown patients. This clear deficiency that is present in medical schools around the country makes us woefully unprepared to make early diagnoses in some of the most vulnerable patients in our communities. Suffice it to say, medical education in the United States may be unintentionally and indirectly contributing to the continuing health disparities that remain ever present in our society.

The time to act is now, because the consequence of inaction will be more lives lost and more harm to patients and learners, due to unconscious biases and microaggressions we have not been taught to identify and address. Although I was not prepared, I want to ensure that future medical students are prepared. I want to be; we need to be; you need to be prepared.

#### Attribution

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## Guest of the Emperor: Rear Admiral Ferdinand V. Berley, MC, USN (ret.)

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## **Navy Surgeon**

Seventy-seven years after the end of World War II, veterans of that global conflict are becoming few and far between. As of 2020, which was the last time the Department of Veterans Affairs released these statistics, 325,574 of the 16 million Americans who served in World War II were still among us, with an estimated 296 dying each day. Included in those members of the "greatest generation" was a subset of veterans who have vanished at a far greater rate: prisoners of war held captive by the Japanese.

In my long career as the Navy's Chief Medical Historian, I conducted oral histories with veterans of many conflicts. But the bulk of those interviews focused on physicians, nurses, dentists, and hospital corpsmen serving during the Second World War. Some individuals stand out, however, not for their heroism on the battlefield but for their selfless devotion in practicing medicine in unimaginable circumstances. One such veteran was Dr. Ferdinand Berley, a Navy surgeon taken captive on the island of Corregidor by the Japanese in May 1942. For the next 3 ½ years, Berley spent the war as a POW in prison camps in both the Philippines and Japan. What this physician witnessed in his early 30s in those camps were atrocities unparalleled in their singularity: brutal beatings, the "water cure" (an extreme form of waterboarding), electric shock, vivisection, and random shootings and beheadings. Starvation and disease were considered "normal" everyday occurrences.

I met Dr. Berley in 1995 when I conducted the first of numerous interviews with him stretched out over many years. We remained good friends for the rest of his life. Surviving starvation and brutality at the hands of his captors is just part of his story. The countless lives he saved, often without medicine or proper instruments, is an extraordinary account of heroism and resilience worth telling.

Born in Chicago, Ferdinand Berley joined the Navy as an ensign right out of college in 1934. Yet his true ambition was to become a Navy physician. The Great Depression was at its height, and the few Navy doctors on active duty were kept busy caring for young men at Civilian Conservation Corps (CCC) camps scattered around the country. In 1937, the year he graduated from Northwestern Medical School, the Navy had very few openings for new physicians. Nevertheless, after taking the examination, Berley made the cut and transferred to the Navy Medical Corps.

After a surgical internship at the San Diego Naval Hospital, he volunteered for duty with the Asiatic Fleet. He was first assigned as medical officer of a destroyer division, a group of destroyers patrolling the China coast, and then he served with the 4th Marines in Shanghai. With the threat of war with Japan on the horizon, the Marines departed that city in September 1939.

## **Profiles in Courage**

Lieutenant Berley next served at the Cavite Navy Yard dispensary in the Philippines. He learned the war had begun when a colleague shook him awake at 5:30 in the morning declaring, "Fred, we just got word. The Japs bombed Pearl Harbor."

Fred responded. "Good! Now we can lick the sons of bitches." He then turned over and went back to sleep.

Such bravado was short-lived. On December 10, 1941, the young doctor witnessed the violent destruction of the Cavite Navy Yard by Japanese bombers, as well as the death and wounding of hundreds of the yard's civilian employees and Navy personnel. For the next several days, he and his colleagues treated the injured. As he shared: "We wore surgical gowns but never changed them. They were soaked through with blood. And then came the next patient. You'd amputate a leg; you'd amputate an arm. Someone would die on the table. It was just a nightmare when I think back on it."

Just days later, Dr. Berley and his comrades evacuated Cavite. When General Douglas MacArthur declared Manila an "open city," the Americans began a harrowing retreat down the Bataan Peninsula toward the port of Mariveles. On the night of December 29, 1941, Berley and his 4th Marines sailed the short distance across Manila Bay to Corregidor by barge. Seeing an uncertain refuge on "The Rock," nicknamed for Corregidor's rocky terrain and defenses, he and his comrades would make their last stand.

Within hours, Berley witnessed his first air raid. "The first string of bombs came across, the third string hit the barracks about a hundred feet to my left. It went through the roof, through all three decks, and landed in the dining room, blowing the walls apart in the room I was in. Talk about being shell-shocked! I could hear these bombs coming down, and every one sounded like it was aimed for the back of my neck."

From the day he arrived on Corregidor, Berley endured constant shelling and bomb attacks, often taking shelter in a maze of tunnels dug into the hillsides. But finally, after many weeks of bombardment, exhaustion, mounting disease, and near starvation, the landing of Japanese troops on the island spelled the end for these valiant troops. The Americans were forced to surrender. Dr. Berley stashed his Model 1911 pistol in his latest tunnel shelter and waved a white bed sheet. He then walked down to the Malinta Tunnel, a bomb-proof personnel bunker, also equipped as a 1,000-bed hospital complex. The real ordeal had just begun.

#### Prisoner of War

Ferdinand Berley endured unspeakable prison experiences. His odyssey took him first to Bilibid prison, a hellish place within Intramuros, the old walled city of Manila. Bilibid had been built by the Spanish in 1865 but, by 1938, Filipino authorities condemned it as unfit for prisoners. Nevertheless, in 1942, when Berley and his comrades arrived, it housed thousands of American, British, and Dutch prisoners of war. From Bilibid, Berley went on to the forced labor farm camp of Cabanatuan. The last phase of his POW ordeal was in Japan itself where he worked in the prison hospital at Tsumori Camp in Osaka caring for POWs.

All these camps had a common denominator--suffering beyond imagination. Malaria, dysentery, tuberculosis, and dengue fever raced through most Japanese prison camps. Malnutrition caused countless cases of beriberi, scurvy, and optic neuritis, a condition which often led to partial or total blindness. Berley encountered all these diseases, and despite the lack of medicine and even the simplest of surgical instruments, he did his best to save as many POWs as he could.

The diet during his captivity varied little and was barely enough to sustain life. "The food was absolutely atrocious. It was nothing but a watery rice they called 'lugao.' The rice we had at that time was nothing more than just the sweepings off the floor. It contained pebbles, rat turds, and things like that. It was moldy and tasted awful."

After the prison hospital at Tsumori Camp, his captors sent him to Ichioka, a nearby hovel masquerading as a hospital. While at Ichioka, he established a relationship with the Japanese hospital commander, a man named Ohashi, who had been a prominent surgeon in civilian life. Ohashi's sense of fairness and compassion contrasted sharply with the inhumane treatment the prisoners had become accustomed to. "Ohashi proved to be a very fine person, very much a gentleman, very much a doctor. He was not a military man; he had been drafted like many of the people had. And he treated us as fellow physicians." After meeting Ohashi, Berley decided to learn Japanese. "Prior to that, I thought anyone who learned how to speak Japanese was a traitor and I wouldn't do it. But now the idea seemed to be a good one."



Dr. Berley (1st person seated from the left) with fellow POWs and Japanese captors, 1945. Dr. Ohashi ( $2^{nd}$  person seated from the right).

## **Profiles in Courage**

Dr. Berley described his new so-called "medical" workplace. "I shouldn't even call Ichioka a "hospital." A long passageway divided the place in two and was about six feet wide and on either side were wooden platforms about one and a half feet high. These were divided by partitions which formed bays about twelve feet square. The patients lay on their straw mattresses in these bays with their feet toward the center. The ceiling slanted down so that on the right side you couldn't stand up. There was no ventilation, no windows." His patients were too weak to bathe and some were covered with lice. He added, "There was nothing but a bunch of scarecrows-horribly diseased, sick men."

Berley quickly learned a hard lesson when he found the Japanese guards stealing a once-amonth fish ration meant for the prisoners. When no fish appeared in the promised meal, Berley made sure that Ohashi, the Japanese prison doctor, learned about what had occurred. That night, the guards who had stolen the fish took their revenge. "They had long leather belts and they beat the daylights out of all of us. They even went to where the sick guys were lying on their straw mats and, yelling and screaming, they beat them. Then they warned me, 'Don't you say anything to Ohashi.' It was the fish protest that caused all this."

Berley moved yet again to what the Japanese euphemistically called the "Kobe International Prisoner of War Hospital," where he was to be the senior medical officer in charge. The hospital occupied a former American school in the hills above the city. The new hospital, staffed by Australian, British, Dutch, and American personnel, was the Japanese response to international outrage over their treatment of POWs. Berley found an operating room set up with instruments, obsolete by American standards, but better than anything he had before. "They even gave us some optical instruments to work with, which were also antiquated."

The return of U.S. air dominance came to the Philippines and Japan in late 1944 and early 1945, and its show of power was graphic evidence even to the prisoners that the war was going badly for Japan. From their vantage point, Berley and his comrades watched the war come to them in February 1945 as American bombers arrived. Their hope that freedom was not far off was tempered by fear that bombs dropped on Japan by their own countrymen might also end their own lives--friendly fire from 9,000 feet.

B-29s hit military shipyards and other military targets in and around the city. Unfortunately, the Kobe International Prisoner of War Hospital was in the line of fire.

On the morning of June 5, 1945, Berley and the others heard the alarms. "I went running around through the halls yelling, 'This is it. This is the big one!' We looked up into the sky, but by that time you couldn't even see the sun, which was pretty well blotted out by the smoke from below. By then the planes were flying directly over us. Pieces of tin, bullets, and wreckage were floating down and hitting the compound. Later I counted about 10 large oil bombs that hit our compound. When the bombs hit, they exploded with a great big whoosh and a tremendous flame. One hit right in the room where we had taken one of our patients. I was about 15 feet away."

The fires became so intense that patients and staff had to abandon the compound. Lining the road near the burning compound, they found many Japanese civilians. "Some were lying there, some were sitting. Some were moaning and crying. With our emergency kits we administered aid to them, too. Although we didn't have much to treat them with, we had plenty

of morphine which we administered for pain." Afterward, Berley found practically all the food, which they had stored away had been burned. "I think we had 70 sulfanilamide pills and some bandages, but not very many, certainly not enough to take care of the injured. But we did the best we could."

After the destruction of the International Prisoner of War Hospital, the POWs were forced to abandon it and move to another camp nearby called "Maruyama." As the months dragged on, food became even more scarce and the inmates had to make do with millet seed, squash, and a very thin soup once a day for about 129 patients and staff. One day a cat came over the fence--but never made it out of the camp. The desperate prisoners caught and cooked it. Berley couldn't force himself to drink the soup, adding "But I did enjoy the meat." In front of the guardhouse, the Japanese sentries had been growing some corn. Berley set his eyes on one ear, determined to steal it when the coast was clear. "We cooked that darn piece of corn and ate it cob and all."

One day in mid-August 1945, the day had begun as most other days. Inside a nearby guard tower, a radio blared. Suddenly a high-pitched voice interrupted the program. Although Dr. Berley was now conversant in the language, the classical form of Japanese he was hearing was foreign to him and he understood only a few words. The voice trailed off and suddenly all was quiet. He noted the guards inside with their heads bowed. After a few moments, the two men came down from the tower appearing dejected and sullen. Emperor Hirohito had just announced that Japan had accepted the Allied terms. History's most destructive war was over.

Beatings and work details abruptly stopped. Guards became overly friendly and solicitous, offering food and favors. Yet conditions in the camp had deteriorated so much that hundreds of prisoners were dying every week. Berley feared that humanitarian assistance would not arrive soon enough to save his sick and starving patients. He and two of his comrades took matters into their own hands. With a list of all the patients and their addresses, they headed to Tokyo, hopefully to meet the American fleet, rumored to be there shortly. With little in the way of clothes, Berley borrowed a hat from another physician and found a khaki shirt with a Marine Corps insignia. "We had our wallets, we had money, and we went to the Kobe station and bought tickets to Tokyo."

After an adventurous ride on two trains, the trio found themselves in an almost totally leveled capital. Months of American bombing left few structures intact, one of them being the famous Imperial Hotel where Berley had once stayed before the war. The ragged companions walked to the front desk and asked for three rooms. The desk clerk was so incredulous that he called his supervisor who told the three men only two rooms in the basement were available.

After settling in, two Kempetai--Japanese secret police--arrived and began interrogating them. Who were they? Where did they come from? How had they gotten to Tokyo? They answered the questions, but, as Berley recalled, the "Kempe didn't accept our explanations, and the man in charge grew more nasty and dismissive. One of the police then asked, "Who knows you are here?"

Thinking quickly, Berley answered, "Everyone knows we're here. We told everyone we were coming to Tokyo."

## **Profiles in Courage**

The interrogation continued. Dr. Murray Glusman, who stood well over six feet tall, had heard enough. Towering over the two Kempetai agents, and gesturing menacingly, he declared, "Look, you are no longer the victor, you are the defeated. You do not talk to us in that tone of voice anymore. We will have you shot." Outside, Navy planes flew over almost at treetop level, punctuating Glusman's threat. The two Kempe abruptly left the room.

After delivering their list of patients to the nearby Swiss Embassy, the three Navy doctors returned to Osaka. "The place was bustling! There was so much activity, such excitement." When they got a ride to Maruyama camp, they found the site empty. The patients had been moved by ambulance to the Osaka Red Cross Hospital, which was still standing. They now had *Life* magazines, food, all sorts of things. All the patients were in beds being tended to by Japanese nurses.

While Berley and his two colleagues were in Tokyo, B-29s had returned. But this time, from their bomb bays, bundles--not bombs--were now dropped, slung beneath brightly colored parachutes. The bundles contained steaks, candy, cigarettes, canned meat, sugar, newspapers, and medical supplies.

The homecoming for Fred Berley and the other POWs was not without issues. During his imprisonment, he dropped from 160 pounds to 112 pounds. He ended up on a tank landing ship (LST) for a month-long trip back to California. "I had such a big chip on my shoulder. I even got angry in the wardroom because they served us rice. Rice of all things! I vowed I would not turn down any speaking requests to tell people what had happened. But after a while, I found that you just couldn't dwell on all that stuff. But it took me a long time."

## Return to the Philippines

In 2004, when producing the documentary "Navy Medicine at War," I invited Dr. Berley and his son to accompany my production crew and me to the Philippines. I wanted to interview him on camera and get his perspective as an eyewitness to history. Our first stop was Corregidor, the tadpole-shaped island in Manila Bay. With the Malinta Tunnel as a backdrop, Dr. Berley recounted the siege, the constant shelling, short rations, the humiliation of surrender to overwhelming forces, and the brutal aftermath.

Our next stop, Bilibid Prison, proved even more emotional for the former POW. In fact, it was surprising that Bilibid, which Filipino authorities had condemned even before World War II, was still serving as Manila's municipal prison. We drove through the gates of the infamous lockup in our rented van after showing two submachine-toting guards our papers. Multistranded razor wire stretched atop Bilibid's walls. As my cameraman and I alighted from the van to meet with the prison warden, we were accosted by curious inmates uncomfortably crowding around us and almost in our faces. Many were rough-looking, tattooed men dressed in grimy undershirts and rubber sandals cut from old tires. We were puzzled by seeing many women, children, and a menagerie of animals, mostly chickens and a few goats.

Upon meeting with the warden, I asked her why the inmates weren't confined to cells. She pointed out that the high walls and razor wire were the only deterrents required. "So these then are petty criminals--pickpockets and petty thieves," I deduced out loud.

The warden corrected me. "Oh, no. They are rapists and murderers." And in answer to my next question about the women and children, she said that they were inmates' wives, children, or girlfriends who set up housekeeping within the prison walls.

Having considered the crowded circumstances and general chaos, I inquired as to where we might set up our camera and conduct the interview with Dr. Berley. "Up on the deck next to the guard tower," she replied, and directed her assistant to escort us. Noting a semi-automatic pistol jammed into his waistband, I assumed that holsters were not a common uniform item in Bilibid.

From our location atop the observation deck, we had a bird's-eye view of the prison yard and its surroundings. It was a sight I shall never forget. Beside barracks buildings covered with graffiti, prisoners milled about aimlessly. A 10-piece band played in one corner while a few feet away, an impromptu religious service was in progress. In the near distance, a prisoner was urinating against the prison wall.

I asked, "Dr. Berley, do you recognize anything that may have been here during the war?"

At first, the 92-year-old man appeared confused and unresponsive. Finally, he pointed to a building he identified as a barracks he recognized. And then again, he fell silent, shaking his head from side to side. I then detected the color rising in his neck and suddenly, in an outburst of anger, he shouted, "This prison is a disgrace! They have ruined a perfectly good prison!"

Dumbfounded by this incomprehensible outburst, I replied, "Dr. Berley, how is that possible? This was a terrible place back in 1942 when you were here. Thousands of men died of starvation and disease."

"You don't understand," he replied. "When we were here, we cleaned it up, got the plumbing to work, and even planted trees over there," he gestured. "We made a naval hospital in this place and took care of patients. And we were proud of what we accomplished, despite the Japanese."

The psychological wounds would indeed be long lasting. Dr. Berley came home later in 1945. He was bitter about the horrors he'd witnessed and angry at the captors who had beaten him almost senseless after he complained about guards stealing food meant for his patients. But eventually he forgave the Japanese. He and his family even hosted a Japanese exchange student, a young woman whom the Berleys treated as a member of their family.

After retiring from the Navy in 1959 as a rear admiral, Ferdinand Berley practiced thoracic surgery in Jacksonville, Florida, until he retired in 1990. He died in 2013, just shy of his 101st birthday. During our many conversations, he admitted that his POW experience never left him. "I always said the seagulls would have a tough time around our place because no food was ever thrown out. To this day, nothing is thrown away."

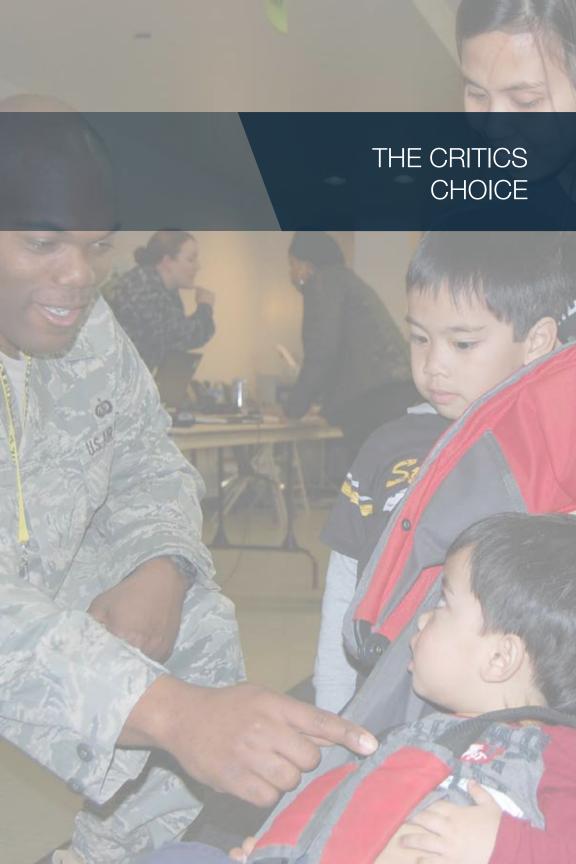
## **Profiles in Courage**



Shigeko Ohmori, who formerly lived with the Berleys as a student, honoring them at their anniversary celebration. Photo courtesy of the Berley Family.

## **Author Note**

The opinions expressed in the article are those of the author alone. The author has no financial conflicts of interest. The first two photographs in the article are from the Navy Bureau of Medicine and Surgery Archives and are therefore in the public domain. The photograph at the conclusion of the article was provided, as indicated, courtesy of the Berley Family.





### Film Review

# RBG A Film by Betsy West and Julie Cohen Released May 4, 2018

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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 the institutions the author serves. The author has no conflicts of interest.

# Introduction and Biographical Background

On a bright January morning in 2018, U.S. Supreme Court Justice Ruth Bader Ginsburg appeared at the Sundance Film Festival alongside the premiere showing of the documentary RBG, which chronicled her life and accomplishments. Aptly nicknamed "Notorious RBG," Justice Ginsburg became an American cultural icon and celebrity primarily in the last decade of her life. This, in itself, is iconoclastic within a culture that often affords celebrity status to energetic youth over older and wiser citizens. However, RBG was notorious, in part, for breaking stereotypes. In 1993, she was appointed as the 107th U.S. Supreme Court Justice, and the second woman in United States history to serve on the Court after a confirmation vote in her favor of 93 to 3. From the onset, she was a formidable and widely-respected consensus-building force. After her confirmation, RBG remained in this role until she died, overcoming two fights against cancer without missing a single day on the bench. Upon reflection, she notes that these times of illness gave her, "an enhanced appreciation of the joys of being alive."

However, before RBG became notorious, she was normal. Born and raised in a Brooklyn New York low-income family, Joan Ruth Bader was a first-generation American on her father's side and barely a second generation on her mother's. She had a particularly close relationship with her mother who tragically died of cancer the day before RBG's high school graduation. After high school, RBG attended Cornell for her undergraduate education from 1950 to 1954, where she graduated at the top of her class with a bachelor's degree in government and married her life partner, Martin (Marty) Ginsburg. Marty was subsequently drafted for two years into military service and upon his honorable discharge, they both enrolled to study law at Harvard University.

At Harvard, RBG excelled in an environment that was almost exclusively hostile to her doing so. She was one of nine women enrolled in a class of 500 men, barred from entrance to the

library many times, and questioned by the dean about her place at the school. Nevertheless, she became the first woman to serve on the prestigious *Harvard Law Review*. In 1956, her husband contracted cancer, which challenged her ability to balance their young child, her husband's treatment, and both of their commitments to success in their ongoing education. With her tireless support and diligence, Marty graduated from Harvard and began working as a lawyer in New York shortly thereafter.

Undeterred from her dreams and with the full support of her spouse, RBG transferred to Columbia Law School where she continued to excel, graduating first in her class in 1959. Despite her significant accomplishments and intellect, however, she encountered difficulty seeking employment as a woman lawyer in the 1960's. After a two-year clerkship, RBG became a professor: first at Rutgers Law School and then at Columbia. Against the backdrop of the women's rights movement in the 1970's, she directed the American Civil Liberties Union's (ACLU's) Women's Rights Project. In this role, she argued six cases on gender equality before the U.S. Supreme Court, winning five.

In 1980, President Carter appointed RBG to the U.S. Court of Appeals for the District of Columbia, where she served until she was appointed to the U.S. Supreme Court in 1993 by President Clinton. She continued serving in this position until she died on September 18, 2020.

#### **Film Summary**

RBG opens with Rossini's iconic *Il Barbiere di Siviglia*: an overture which mirrors Justice Ginsburg's infamy and foreshadows her love for opera from the start. These bright notes are quickly juxtaposed against the sound of male voices disparaging Justice Ginsburg with comments such as, "this witch, this monster, this evildoer... she is anti-American...she is wicked." As the music fades, Justice Ginsburg's familiar voice quotes Sarah Moore Grimke in a measured tone, "I ask no favor for my sex, all I ask of our brethren is that they take their feet off of our necks." This quote was endemic of themes in Justice Ginsburg's life, particularly because she used it in the first argument that she made before the U.S. Supreme Court, and she won. There is a beat of silence before the next song by Dessa begins, "Forget the bull in the china shop, there's a china doll in the bullpen." The transition to a modern feminist pop song signals the ultimate adoration and celebrity status Justice Ginsburg acquired at the end of her life, in addition to the way her life would continue to inspire the future of equal rights in American youth.

The film then moves to original footage of Justice Ginsburg in 1993 at her confirmation hearing for the U.S. Supreme Court. She introduces herself and her family background with the assertion that her story would only be possible in America. She affirms both her father's Jewish heritage and her lasting adoration for her mother who taught her two lessons above all: (1) to be a lady and (2) to be independent. Throughout the film and her life, Justice Ginsburg returns to these themes of wisdom and humility.

During her confirmation hearing, Justice Ginsburg openly announces her desire for many more women to serve on the Supreme Court with different complexions. From the beginning, she centers the fight for women's rights as inherently intersectional. She also speaks to the influence and support of her life partner, Marty, who from the time they met affirmed her work as equally important to his own. He supported her decision to pursue law "unreservedly." Ruth and Marty's love story is interwoven throughout the film, as it was

interwoven throughout their lives. Beginning at Cornell, Marty was the only "repeat date" that Justice Ginsburg went on because he affirmed and engaged her intellect. The film details how, throughout their lives, Justice Ginsburg and Marty took turns prioritizing careers, family, and education. The film shares quotes from a book of letters that Marty gifted to Justice Ginsburg. Ultimately, he sums up their love story when he writes, "I hope you will support where I come out, but if you don't, I will not love you a jot less." Justice Ginsburg reads this quote from one of his final letters in the film. It is the only time the audience can hear her voice crack with emotion.

The film captures many facets of Justice Ginsburg's humanity by including moments and perspectives from her family, such as her granddaughter, who affectionately calls her "bubby." Justice Ginsburg's daughter and granddaughter chose to complete law school at Harvard University as well, which segues into a reflection on the significant discrimination that Justice Ginsburg faced while in attendance there. In the film, she describes not only the mechanisms of discrimination she faced, but also what it felt like for her emotionally. She credits her success at law school, and her accomplishment as the first woman to make the prestigious *Harvard Law Review*, to having a family that she prioritized in the evening time. Although she was caring for an ill husband, raising a young child, and studying law, she points out the ways that her roles as a wife and mother fueled her success instead of detracting from it. In this way, she models why sex discrimination is harmful, insidious, and based on inaccurate assumptions.

The film follows Justice Ginsburg's transition from Harvard to Columbia and, eventually, into the workforce. Despite graduating first in her class from Columbia and the recommendation of multiple highly respected attorneys in New York, she was denied employment as a lawyer because of her gender. Justice Ginsburg, after a brief clerkship, becomes a law professor and, fueled by the discrimination in her own life and the lives of her students, she begins to leverage her skillset to erode discriminatory laws within the United States. The film goes on to recount many of the landmark cases she argued to the U.S. Supreme Court before she sat on it.

These cases are presented in the film with varying degrees of detail. The first case, Frontiero vs. Richardson, centers on a lieutenant in the Air Force who was denied a housing allowance because she was a woman. When this lieutenant attempted to correct the mistake, the military pay office asserted that she was lucky to be able to serve her country at all and that she was not entitled to the same housing allowance as her male counterparts by law. Justice Ginsburg took over the case and presented orally for the first time in front of the Supreme Court. Original audio of a young, formidable Ruth Ginsburg plays, her words scrawling across the screen in text. Justice Ginsburg then reflects on her lived experience of that day and the verdict delivered. Although she won the case for that lieutenant and changed military law, she lost the greater argument she was making by a single vote. Undeterred, she affirms that she felt her role was to educate the men on the Court in front of her and that the change she was dedicated to fostering would likely take a very long time.

The film then showcases the case of Weinberger vs. Wiesenfeld, which demonstrates how Justice Ginsburg fought for gender equality on all sides. In this case, a young man's wife dies in childbirth and he is left to raise his newborn son alone. When he seeks a social security benefit in order to devote his time to caregiving for the child instead of employment, he was denied because it was considered a "mother's benefit." Justice Ginsburg argued the case before the U.S. Supreme Court in 1975, which yielded a unanimous judgement in his favor.

The film briefly summarizes several other cases that Justice Ginsburg argued, highlighting these accomplishments and the wisdom that she gained in the pursuit of them. The film captures Justice Ginsburg's strategy as a lawyer, but also her resolute character and the continued discrimination that she faced personally in the pursuit of equal rights under the law. Her quiet magnetism, concise communication, and intellectual prowess shine through the screen. The film details the way that Justice Ginsburg was dedicated to important work, regardless of whether or not she was seen and applauded for it.

The story then moves to the latter part of Justice Ginsburg's life, in which she became a judge and was ultimately nominated by President Clinton for the U.S. Supreme Court. The audience also witnesses the incredible role that Marty played in helping Justice Ginsburg as a judge: calling her on late evenings to come home, taking care of their children and household tasks, and ultimately, leveraging his extensive law network in order to ensure she was visible to President Clinton for nomination. She is ultimately sworn in with Marty at her side in 1993.

The remainder of the film focuses on Justice Ginsburg in her role on the U.S. Supreme Court. It details her remarkable friendship with Justice Antonin Scalia and her political trajectory across time. As the political landscape shifted on the Court, so did the role that Justice Ginsburg felt she needed to play. When it was balanced, she was able to act as a consensusbuilder and moderator. However, as she got older, and the court shifted more conservatively, she exercised her voice in dissenting more often. The film demonstrates how she never stopped fighting for equal rights, showcasing her majority and dissenting opinions over time toward this cause. In one such instance, Ledbetter vs. Goodyear Tire & Rubber Co., federal law was changed in Congress because of the dissenting opinion that Justice Ginsburg offered.

The film closes with Justice Ginsburg affirming her continued capacity on the U.S. Supreme Court and investing time in speaking with the younger generation ahead of her. She offers a quote by Judge Learned Hand, disclosing that she keeps it in the front of her mind during her judicial service: "The spirit of liberty which imbues our constitution must lie first and foremost in the hearts of the men and women who compose this great nation--a community where the least shall be heard and considered side by side with the greatest."

The film ends with an image of the Supreme Court building on a clear blue day.

#### Reflection

Uniquely, this documentary allows us to view Justice Ginsburg not solely as the familiar "Notorious RBG" with formal authority, notoriety, and power, but rather, to see images of her before she became a household name. Here, we glimpse Ruth as she was and how she got here: Ruth, as a young mother, a striving student, and diligent wife; Ruth, exhausted but yet steadfast; Ruth, committed and unshakeable; Ruth, powerfully and quietly incredible from the start.

Throughout the film, Ruth offers insights in her own voice about what made her life whole. This begins with an undeniable love for the arts. She reflects on opera as a conduit to full presence--a space where she cannot think about next week or even tomorrow, but only about the electric current of the human voice coursing through her in that moment. Never content to be just an observer, she modeled what it is to show up with the fullness of our humanity when

she took the stage herself. Notably, she wrote her own lines for a cameo in *The Daughter of the Regiment* and stated boldly to the audience, "The best of the house of Krakenthorp have open but not empty minds. The best are willing to listen and learn. No surprise, then, that the most valorous Krackenthorpians have been women." She thoughtfully and authentically utilized the opportunities and platforms that made her most come alive. Afterwards, she often went home and worked until the early hours of the morning on the causes that gave those without such opportunities the best chance to come alive, too.

Throughout her life, Ruth affirmed the value in spending time with those who are different from us. A reclusive, deep-thinking introvert, she chose a lifelong partnership with a funny, gregarious, life of the party. Similarly, she became dear friends with Justice Scalia, who held diametrically opposing political and legal viewpoints from her own. Despite these stark differences, Ruth affirmed their deep connection through opera, adventure, and love for the law. When she was titled "Notorious RBG" she reflected that it was fitting because she had much in common with The Notorious B.I.G. Ruth was able to build consensus among disparate groups because she proactively stood on common ground whenever possible, as her mother taught her to do. She unwaveringly honored the dignity in all people, regardless of their individual backgrounds, opinions, or beliefs. Ruth affirmed and wielded the capacity to both wholly disagree and wholly value the person sitting across the room from her. She was truly a woman of Krakenthorp, "willing to listen and learn."

Ruth's unmatched work ethic and dedication to gender equality was a hard road to walk, but she rarely complained about blisters along the way. She showed up ready to pay the steep price of admission for the best vision of this nation that she believed was possible. During the first case that Ruth brought before the U.S. Supreme Court, she broadly argued that sex discrimination should be treated similarly to race discrimination and she lost by one vote. Unphased, she acknowledged that she would repeat this kind of argument over and over again until she won it. More incredible than her insight was her steadfast willingness to stay the



course in doing so. She stated, "Real change--enduring change--happens one step at a time." Beyond legal strategy, Ruth offers us all an invitation to first look inward to what makes us come most alive, and then look outward and ask: What one step can I take, with the skills that I have, to create a nation with true liberty and justice for all?

#### Attribution

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#### **Book Review**

# The Mole and the Violin The 2013 Original and the 2018 Part II

By George Brummell Xlibris Publishing Bloomington, IN 2013 and 2018

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#### **Author Note & Attribution**

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

Also note: SSG (ret) George Brummell provided the photographs for the collage at the end of this review. They are his photographs and are used with his permission. The photographs are of SSG (ret) Brummell himself as well as the covers of both books reviewed herein.

#### Introduction

The Mole and the Violin, both Part 1 and 2, can only be fully appreciated in the context of the amazing person who penned these whimsically delightful stories of Mikey and friends---George Brummell.

Author George Brummell, a retired U.S. Army veteran who was blinded in a mine explosion in Vietnam, and who later served as National Field Services Director for the Blinded Veterans, adds to his résumé the title of "author." His previously published Shades of Darkness (his memoir) is now followed by *The Mole and the Violin, Part 1 and Part 2.* 

His choice of a mole as the leading character in both books comes as no surprise. When asked in an interview why he chose a mole as the protagonist, Brummell shared that as a blind person he identifies with moles, burrowing animals who are virtually blind and disadvantaged when they are above ground. His interest in moles began during a visit to the Philadelphia Zoo's amazing mole exhibit. The exhibit inspired Brummell to further research the ethology of moles.

Moreover, he began to investigate the behaviors and environments of animals that would be cast as animal characters in developing the story. Brummel drew his inspiration from Emma, his violin playing granddaughter who, like Mikey, was hardworking and persistent in pursuit of her goal.

Brummell's love of children and his understanding of the power of children's stories in educating and motivating young people is undeniable. He has spent considerable time visiting schools and conducting workshops. He brings a wealth of detailed information about the various animals who are part of the story; and importantly, he educates and enriches the narrative by orchestrating references to beautiful classical music that Mikey and Shalonda experience during their magical journey.

# **Summary**

#### The Mole and the Violin 2013 Original

#### Introductory Note:

Part 1 of *The Mole and the Violin* (the original book), sets the stage for Part 2 which must be read as a sequel.

A delightful cast of wildlife critters take the stage in this imaginative and beautifully crafted story. The chief protagonist is Mikey, the dauntless mole who dreams of learning to play the violin and who never gives up on the dream even in the face of frustration and disapproval of others. The story begins when Mikey, a young and curious mole, ventures out to dig for worms. Against his mother's admonitions, the adventuresome Mikey tunnels and ventures far from the safety of his home to explore new and inviting surroundings.

Lured by an amazing sound, Mikey follows it to its source. Breaking through the surface, he finds himself at the feet of the sound maker, a tall figure whom he later learns is a human playing the violin. Her name is Emma. Mikey is enraptured by the beauty of the sound and the deep joy it brings to his little being. He fully expects his mole friends, Sammy and Frankie, to share his enthusiasm but instead, they dismiss his giddy exuberance with taunts about his ignorance. Gleefully, they inform him the sound he hears is that of a violin. A violin! "I want to learn how to do that," he tells his friends who continue to mock him. Dejected, he goes home to his mother who gently informs him that violins are for humans; violins are not for moles. Mikey is unconvinced. He knows he can learn to play the violin.

Refusing to accept his mother's discouraging comments, the determined mole sets out to find the girl and her magical violin, and ask her to teach him how to play. In short order, his hypersensitive ears lead him to the tunnel where he first heard the girl singing and playing the violin. He breaks through a molehill and finds himself at Emma's feet.

An unlikely friendship is born and Mikey's dream of learning to play the violin comes within reach. When Mikey asks if she can teach him to play, she hesitates. How is that possible? The obstacles for this little friend of hers are insurmountable. His smallish size and bent legs will never allow that. And where to find a tiny violin to accommodate a mole? She knows that

moles live in the dark, are blind, and learn about the world through hearing and touch. Mikey is undeterred by all the would-be obstacles, and insists that he can learn to play the violin. Emma, eager to help her new little friend, devises a plan to find a violin for Mikey. She will get him a violin and will teach him to play. Emma asks her grandfather to make a violin for one for her favorite dolls who is about Mikey's size. Emma's grandfather, George, who dotes on her, agrees and goes to work creating a violin for the doll.

With his new little instrument in hand, an excited and happy Mikey begins his dream of learning to play it. Initially, he is disheartened by difficulties he experiences mastering the violin, and by the discouraging comments from those around him. He refuses to relinquish his dream and with great determination, discipline, and bravado, the mole begins to make progress. Under the guidance of his new-found music teacher, his repertoire and musical knowledge begins to grow. He soon has the underground mole community rocking to his beat.

Emma is impressed with his mastery of the violin and tells Mikey that he is ready to perform. But first, he needs to see a great violinist in concert so he will know what to do. With Emma's help Mikey experiences his first concert, and it sets the stage for becoming a concert violinist.

Mikey's excursion to the concert hall is arranged by the inventive Emma who hides him inside her doll. It is a joyous occasion for the little mole who is transformed by the beautiful sounds coming from different instruments. The excitement of the afternoon ends when a tired Emma falls asleep in her home, forgetting her promise to see Mikey safely home. Desperate to get there, Mikey tries to wake Emma, and failing to do so, he roams the house to find a way out. His inexperience in the ways of human behaviors almost proves catastrophic when Mikey reaches for a tempting piece of cheese sitting on a mousetrap. The quick action of Shalonda, a little mouse, saves the day and Mikey is spared the mouse trap's deadly wire hammer. But he now faces another threat—the large house cat is in pursuit of the two fugitives. They exit the house, barely escaping the cat's clutches, but now face the twin dilemmas of getting Shalonda safely back into her house, and finding Mikey's mole hole

With a grasshopper's help, Mikey locates the hole to his home, but he is unable to get Shalonda back into her house. A frightened Shalonda is left with no choice but to accept Mikey's invitation to have her spend the night in his burrow. The mole senses her unease and calms her fears by playing the violin for her. The music soothes Shalonda who begins to sing in a lovely voice that quickly draws an audience of Mikey's family and uninvited worms.

The following morning, Mikey helps Shalonda back into her house, and the two tearfully say goodbye, believing they will not see each other again. Happily, Shalonda shows up during Mikey's violin lesson with Emma. At the musician mole's prompting, she accompanies Mikey on the violin. Shalonda's lovely voice astounds Emma who, seeing their talent and potential, encourages the budding musicians to pursue a career together. A musical duo is born.

#### The Mole and the Violin Part 2 2018

The saga of *The Mole and the Violin* continues in Part 2 at which point Mikey and Shalonda's musical concerts are gaining in popularity among the neighboring animal world. Mr. Bill, an older rabbit, a "handsome buck, looking like a professor of sorts, those glasses hanging low over his big nose," and a big fan of the two, urges Mikey and Shalonda to go on the road.

"Other animals can benefit by your performance," he comments. Mr. Bill offers transportation and suggests that concert clothing would be a nice touch for the two talented performers.

Mikey and Shalonda like the idea and decide to take the show on the road in a trial run. With Mr. Bill at the helm, Mikey and Shalonda climb on the rabbit's back for what turns out to be the adventure of their lives--a long and perilous ride. Notwithstanding a number of threats and obstacles, the trial run is not without success. Their concerts are drawing a large audience of squirrels, opossums, a family of deer, and a variety of birds who love their music. Mikey and Shalonda finally obtain concert clothes, courtesy of Ida the silkworm, and their popularity grows. But they are far from home and feel an urgency to return to their families.

The trip home for the furry musicians and their transportation—Mr. Bill--is another enormous challenge as they search for food, escape predators, and overcome human barriers. Time and time again, the little group is saved from the danger of predators through the friendship and assistance of a variety of animals.

The final leg of their journey finds the little group trapped in a window well outside a red brick house. Luckily, the homeowners who save them, place the trio in a box, and release them into the woods where new threats meet them at every turn. Although fraught with dangers, the three animals bump into friendly ducks and bunnies who share food, assure them that the water is safe to drink, and point them in the direction of home. Betty, a flirty girl bunny, joins the group, much to Mr. Bill's delight!

Home at last for the weary and happy-to-be-home friends! Mr. Bill perfectly sums up the shared escapade: "I know it's been a long hard trip--but look at it this way. You had an adventure you'll remember for the rest of your lives." And indeed, it was!

#### Reflection

Although these are children's books, *The Mole and the Violin*, parts 1 and 2 speak to a greater audience. Who can deny the appeal of Mikey's determination to achieve his goal to learn to master the violin against all odds. What child would not take heart, recognizing the value of persistence and hard work that Mikey teaches? He never gives up on his dream. The universal child in all of us often faces obstacles and impediments to achieve our goals and dreams. Mikey's challenges appear insurmountable, his diminutive size being but one of them. Yet through persistent determination, he conquers all that stands in his way.

The story also offers another valuable lesson--the importance of acceptance, tolerance, and friendship in our relationships. Mikey's alliance with Emma, despite their natural differences, illustrates the power of tolerance and acceptance. In this case, Mikey's friendship with Emma requires an openness to her otherness. Emma is a human, Mikey a mole, but the difference never stands in the way. Young children are innately accepting of differences and tend to make friends from far-reaching sources. Once assured that humans pose no danger, Mikey opens up completely to Emma; she, on the other hand, remains forbearing and engages Mikey in a most unlikely conversation. Mikey introduces himself: "My name is Mikey. What's yours? "My name is Emma, and I am very happy to meet you."

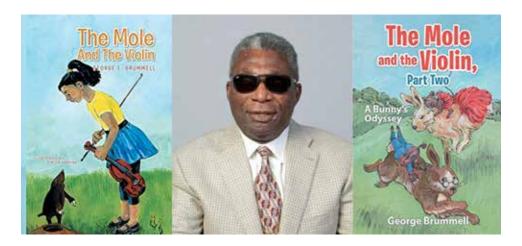
The same openness and acceptance of the "different other" is beautifully exemplified in Mikey and Shalonda's relationship. Mikey meets the mouse, Shalonda, during an escapade where he seeks a way out of Emma's house after becoming stuck there. Shalonda, the resident mouse, stops Mikey from falling victim to a mouse trap. Because of his poor vision Mikey is unaware of Shalonda's appearance but relies on his supercharged ears and sense of smell to help him "see" the other. After sniffing each other, they introduce themselves: "What are you?" the mouse inquires.

"I am a mole. What are you?"

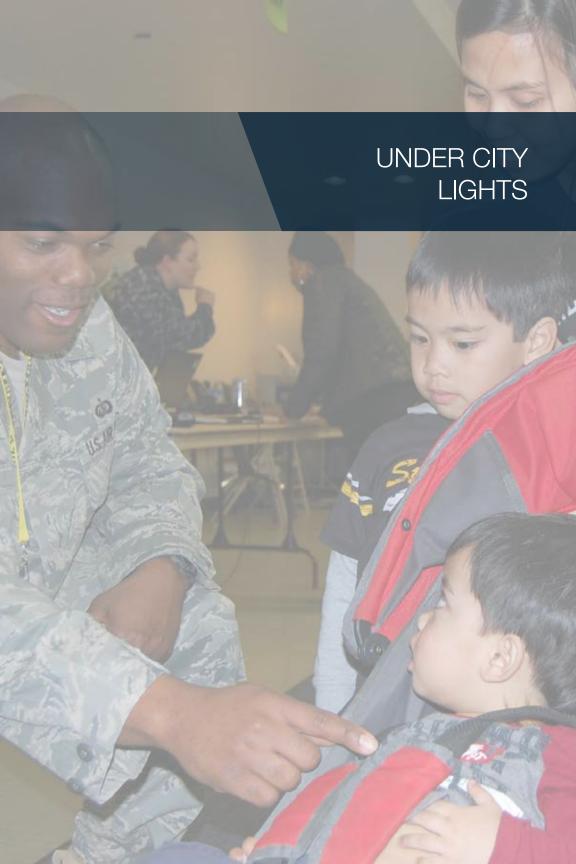
"I am a mouse, of course. My name is Shalonda."

The power and beauty of friendship is another underlying theme in the two-book series. The relationship between Mikey, Emma, Shalonda, and Mr. Bill are integral to the narrative. The adventure itself required that sense of individuality, each playing off the others. The nurturing support and loyalty they find in each other become a joyous celebration of friendship. Upon returning from a long adventurous journey, in an awkward moment Mikey bids goodbye with a simple, "See you tomorrow!"...because he couldn't imagine a day without his friend – and they went in opposite directions."

George Brummell is a master storyteller who brings to life the animal characters with the magic of a creative and imaginative mind. In an interview with the author, he was asked if we can expect to hear more about Mikey and friends--a series, perhaps? The good news is "Yes."









#### **Creative Reflection**

# Solidarity in Tragedy: A Reflection on the Human Spirit

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Over the 15 years I practiced as an emergency nurse, I compiled a mental collage of experiences that challenged me, informed me, and validated my love for the nursing profession. All of my experiences blend together without date or time stamps, except for one.....The day I experienced the unifying ability of the human spirit.

In the early dawn hours, I changed into scrubs and turned on the local news. A heartbreaking update. A baby boy who was rescued after falling into a nearby lake was just removed from life support at the hospital where I worked. My heart heavy, I kissed my sleeping children goodbye and started the commute to work. Our emergency department waiting room was already full when I arrived. An inner-city trauma center, we had our usual mix of patients. Harold was lying on several chairs pushed together and was yelling out in his drunken state. A young Somali couple sat quietly, appearing weary and apprehensive. A homeless woman was nervously rocking back and forth gripping her trash bag of possessions. An elderly man was holding pressure to a wound on his hand. And an anxious woman was biting her nails and working hard to ignore the middle-aged man nearby arguing with an unseen person.

Hearing that some of the patients in the waiting room were agitated by the long wait, I went to let them know we were working to get them a room. I listened as several patients collectively raised their voices at me, expressing frustration that others were being called back ahead of them. As I began to explain the triage process, something outside of the waiting room window caught my eye...a hearse. I noticed a sharp looking man dressed in a black suit open the back doors of the hearse and stand at attention facing an adjacent hospital entrance. My conversation trailed off as I leaned forward to take a longer look outside...four children...a young mom. I could not make sense of the situation at first and pondered: what was happening out there? A few minutes later, the father exited the hospital holding a lifeless body wrapped in white linen. I gasped and said under my breath, "the baby in the news." As the father began his slow and labored walk past his family towards the hearse...one by one, Harold, the anxious woman, the Somali couple, and all the other waiting patients rose from their chairs...and the waiting room became silent. We watched as the father gently laid his swaddled son on the gurney; and then one by one, in a choreographed manner, each sibling walked to the gurney. With a sweet tenderness, they each kissed their baby brother goodbye. The parents, overcome with grief, held each other and laid their hands on their baby boy, bowing in prayer. We joined them in prayer; and at that moment, the world came to a halt. There was peace and stillness in the waiting room and we were all connected, standing in solidarity with this family. The family was not aware of our presence, but we were there: They were not alone.

# **Under City Lights**

Still holding our breath, we watched the suited man gently load the gurney into the hearse and tenderly close the doors. The family, regaining their strength, clutched hands, and stood tall as they watched the hearse drive away. They took one last look toward the hospital and walked away. With a collective exhale, the patients in the waiting room quietly returned to their chairs-speechless, reflective, and changed. They remained calm from that moment on, as perhaps, their own needs were put into perspective.

Characteristic of an emergency nurse, I swallowed the lump in my throat, packed my emotions away, and returned to the fast-paced environment--resuscitating trauma patients, initiating rapid stroke protocols, and taking care of the psychological needs of the most vulnerable.

Thirteen hours later, I returned home, kissed my children goodnight--this time filled with emotion--and reflected on my experience from earlier in the day. I shared a moment with a group of strangers that I will never forget. Although we had many outward differences, and minutes prior I was the target of their anger, we were able to unite in honor of a young boy's life and lend strength to his family. We also supported each other as we witnessed this family's inconceivable loss.

As we live in times of deep political divisions amidst a global pandemic, we must think about how we can unite with others through shared foundational values, such as human dignity and respect. Connecting with others--our patients, coworkers, and leaders--on a spirit-level can dissolve defensiveness and help us to relate to each other and care for one another. This is vital, especially as the tension within workplaces throughout the country is high. Emergency departments are overwhelmed, hospitals are at full capacity, and staff are scarce. In these environments, when our focus shifts to carrying out tasks, it is easy to become defensive and emotionally withdrawn. But we can choose to use the brief interactions we have with others to connect, whether through words of reassurance or through nonverbal gestures like offering a hand or squeezing a shoulder. In turn, that connection can provide comfort, slow time even for a moment, and remind us that we are not alone.

#### **Author Note**

The insights and views expressed in this vignette are those of the author and do not necessarily represent the views of any of the health care organizations or agencies in which the author has served. The names used in this reflection are fictional to protect patient privacy. The author has no financial conflicts of interest. The author thanks Linda Garand, PhD, RN, GCNS-BC; Joan Such Lockhart, PhD, RN, CNE, ANEF, FAAN and Amanda Ramsden, MSN, RN for reviewing this essay.

# Special Attribution

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# **Upon Reflection**

# **Releasing The Inner Child**

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My day looks nothing like it did a few years ago. The hectic days of teaching bell to bell, hitting the gym and writing till midnight are gone. In place of the restrictive schedule is a flexible day that allows me to explore new opportunities to learn and to play. As I play more, I feel a distinct dance between playing and praying. Feel free to substitute "meditate" or "tune-in" for the word "pray."

Now that I'm unemployed and have more time than ever to play, I'm getting less accomplished, and I'm a bit confused by the conflict of not having enough time to do what I want, yet having more time than ever to do it.

I often feel unproductive and wonder where my ambition slithered off to. I intend to write, to clean, to exercise, and to energize my healing and life-coaching business. I do all these sporadically, thoroughly and in presence, enjoying the moment. But something is missing. My inner child feels as if she is watching everyone dance but can't attend the ball even if she were invited. She hasn't the right dress to wear. She has forgotten the unpracticed way of moving that is native to her innocent soul.

But to remember. What would it take to remember how to move with grace? To giggle and twirl without a care as to a missed step or a preoccupied audience that's too busy texting to notice how much joy is bouncing through the room? To feel a stirring of the soul in its raw, childlike state. The sort that jiggles the memories stored in our energy matrix. To let go of rigid goals and checked boxes on lists.



# **Under City Lights**

For me it takes prayer and play. Prayer isn't only something we do when someone's sick or there's a problem. Prayer is a form of meditation in which we open our hearts to sacred space and commune with the infinite source of all that is. Play is also a method of opening our hearts to potential and allowing our imaginations to mold the moment like a child who pretends flowers can dance and birds can talk. Both take us out of our mental minds and transport us to a liquid reality where anything is possible. One where we can coax new scenarios to come alive like a painter animating a canvas with strokes of playful genius. As David Curran states in *Our Subconscious Mind*, "I like to think of imagination like a factory that produces and transforms our ideas into existence."

In other words, by erasing what we think we know and not taking life so seriously that we squeeze the joy out, we allow an open dialogue between our inner and outer worlds. We can then manifest our wishes with ease and not a grinding away. The difference between work and play is attitude and a possible monetary element, but we can combine them into one through our perception. Work is play and play is a childlike form of prayer with imagination leading the way.

We possess the power to change our reality through imagination that is present in both prayer and play. Imagining guidance or a higher power doesn't mean it is not real. It means that we open the gate of possibilities. Through releasing what we think is impractical and not possible, we are able to imagine as a child would, in innocence and trust. This is where the magic of manifestation happens. Einstein said, "Imagination is everything. It is the preview of life's coming attractions."

The more flexible my schedule, the more I imagine the possibilities for my own desires. Something about traipsing through the park on a whim or pouring a salt bath midday frees my mind to imagine. It's as if I am dancing with freedom as my partner. I reevaluate my priorities and erase my to-do's like there's no tomorrow... and perhaps, there isn't.

Perhaps all that exists is the eternal now. An ever-flowing, glowing love connection of events and glances from strangers and friends in pain and tears washed by the rain. Maybe all we need to know is right under our nose or our feet, our dancing, happy feet, and all we have to do is breathe in fresh oxygen as if we were just plopped onto this mound of dirt rolling through the universe.

Maybe it doesn't matter if we believe time passes or that everything is happening at once on many levels of existence, or dimensions. What matters is what you decide matters. No meetings or trainings or schooling can tell you what matters. You must decide that for yourself.

I'm suggesting that play is a way to call in your own existential pattern, your own blueprint for happiness that activates when you permit your imagination to rove the way a child rolls down a grassy hill on a summer day. Just roll, trusting the ground to support you. Trusting the giggling on the way down to stimulate your innocent wonder. Trusting that the rolling, the laughter, doesn't matter a speck unless you decide it is important to let your inner child play so you can cultivate a child-like prayer of praise. A prayer that shouts to the heavens that all is well with your soul and that your creative garden is blooming with ideas to help the world be a better place.

Maybe the connection between the words "prayer" and "play" needs to be emphasized like the words Jesus of Nazareth said and as they are remembered in the Christian Tradition, "Suffer little children, and forbid them not to come unto Me, for of such is the Kingdom of Heaven." Maybe the kingdom is the internal fountain of endless potential we see and experience when we play like a child in the sand, not caring if the castle will be gobbled up by the tide. Just building and enjoying. Then admiring what we've built such as careers, relationships, and accepting that everything has a season.

God played in the dirt one day and, as a result of forming men and women, kings and queens were born. The child inside of us is a part of our inner royal family and must not only get invited to the ball, but have a place at the table. We can create our own gardens in which to dance. Our own desires for our lives manifest into reality. We must let the wind tingle on our skin until our cells remember how to pray through play.

Through prayer we ask for guidance. Through play we permit ourselves to explore possibilities our mental mind won't entertain. Both prayer and play are teachers. They teach us to drop limits and create imaginary audiences for the unwritten speeches of our soul.

Prayer means different things to different people but one commonality with this practice is the connection to an omniscient energy that sustains all life. Feel into this and extrapolate from this what helps you and discard the rest. What are you waiting for boys and girls—it's recess!

#### **Author Note**

The author is self-employed and has no conflicts of interest. The author has no ties to any organized religion. She writes from the perspective of her current spiritual practice and her original religious tradition.

# Special Attribution

The photograph of the children dancing with their mother is the artistry of Regina Zulauf and is freely available on Pixabay at: https://pixabay.com/photos/mama-children-to-dance-fun-family-5098862/. The photograph of a boy in a classroom that follows at the end of this creative reflection is used freely from Needpix per: https://www.needpix.com/photo/download/527577/boy-math-student-desk-elementary-school-child-education-classroom#google\_vignette



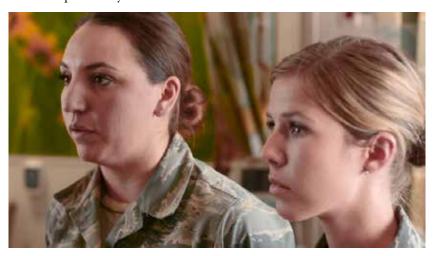
# Henry M. Jackson Foundation Special Military Health Film Series Continues...

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





#### **Special Notation**

The front cover photograph is the 2010 US Navy work of Mass Communication Specialist Seaman Brian A. Stone. It depicts Logistics Specialist Seaman Sergio Torres drawing pictures with a child at the Vladvistock children's cancer ward as part of a community outreach during a joint commemoration there for the 65th anniversary of Victory Day and the end of World War II. Website: https://commons.wikimedia.org/wiki/File:US\_Navy\_100507-N-9094S-375\_Logistics\_Specialist\_Seaman\_Sergio\_Torres\_draws\_pictures\_with\_a\_child\_at\_the\_Vladivostok\_children%27s\_cancer\_ward.jpg

The inside front cover photograph of St. Jude Hospital is in the public domain from Wikimedia Commons with permissible adaptations per: https://commons.wikimedia.org/wiki/File:St\_Judes\_grass.jpg.

The divider page photograph is an adaptation of a USN 2011 original by Melinda Larson. It depicts USAF Maj. Craig Dorn, operations officer for the 60th Support Squadron at Travis Air Force Base, greeting military dependents upon their arrival from Yokosuka, Japan. More than 700 military family members arrived at the Forward Joint Reception Coordination Center during Operation Pacific Passage, the Department of Defense mission to provide support for the voluntary return of family members from designated areas in Japan. The photograph is in the public domain per: https://commons.wikimedia.org/wiki/File:US\_Navy\_110323-N-4104L-023\_Maj,\_Craig\_Dorn\_greets\_dependents\_upon\_their\_arrival\_from\_Yokosuka,\_Japan.jpg

