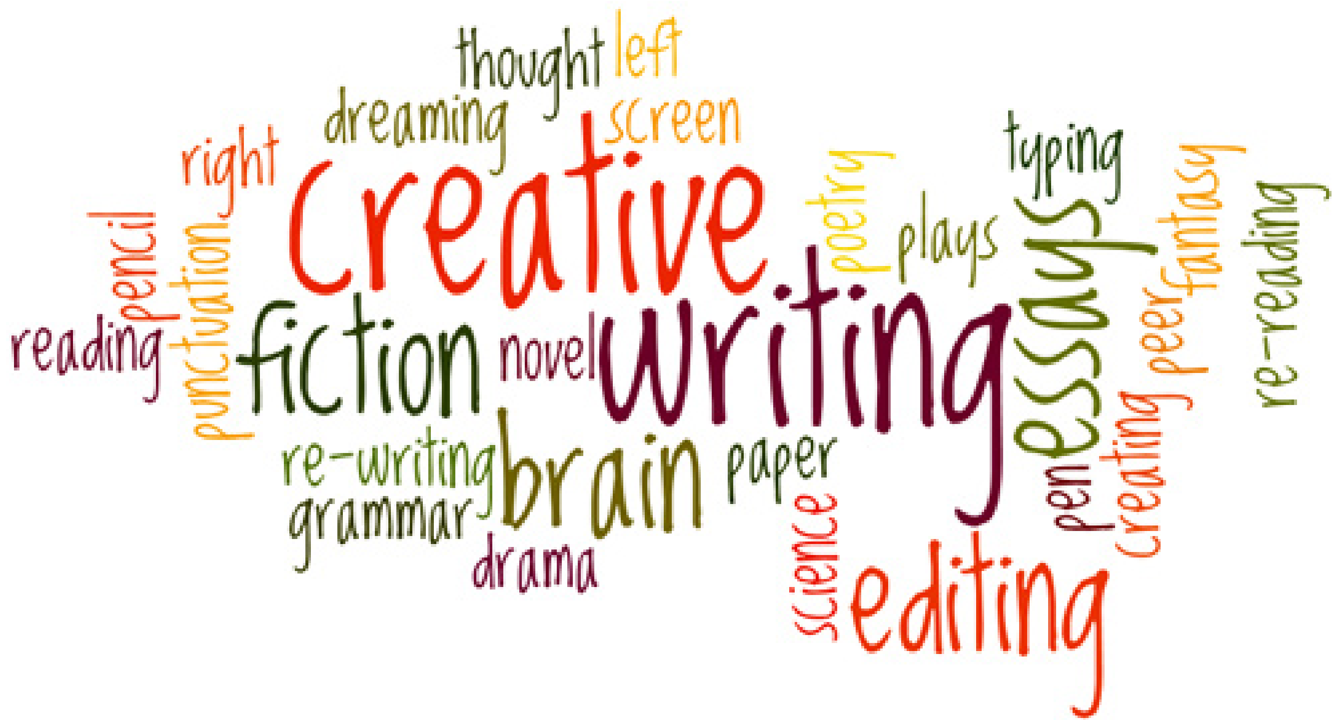

2017

John J. Frey III, MD

WRITING AWARDS

Writers see the world differently. Every voice we hear,
every face we see, every hand we touch
could become story fabric.
—*Buffy Andrews*

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Department of Family Medicine
and Community Health
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH

John J. Frey III, MD Writing Awards

Purpose:

To recognize and honor creative writing by faculty, residents, fellows, FMIG students, and staff in the UW SMPH DFMCH, UWMF managed family medicine clinics, Aspirus (Wausau) and Aurora/St. Luke's (Milwaukee).

Selection Criteria:

The **John J. Frey III, MD Writing Awards** recognize outstanding contributions of writing in any genre. This includes, but is not limited to, editorials, essays, short stories, commentaries, poetry, and narratives. Writings need not have been published. Research articles, instructional materials, and novels are excluded from consideration.

Eligibility:

- All faculty, residents, fellows, project, classified, and academic staff currently employed by the UW SMPH DFMCH.
- Faculty and staff currently employed by the UW Medical Foundation (UWMF) whose position is dedicated exclusively for work in the UW SMPH DFMCH and UWMF managed Family Medicine Clinics. (Excludes students, LTE's, and UWMF faculty and staff not working in family medicine clinics.)
- Aspirus and Aurora/St. Luke's family medicine faculty, residents and staff.
- UW Medical Student members of the Family Medicine Interest Group (FMIG).

Number of Awards Presented:

Will be determined annually by the selection committee.

Process:

- **Submissions:** There are no limitations on who can submit materials for review, and self-submissions are encouraged with a maximum of two submissions per person. Submissions will be solicited through department reminders and website announcements. Anonymous submissions will not be accepted. Previous submissions will not be accepted. Submissions should be sent to: suzanne.mcguire@fammed.wisc.edu
- **Materials:** Manuscripts should be submitted in an electronic format.
- **Deadline:** For 2017, the deadline is **August 25, 2017**.
- **Selection:** Readings will be available to members of the UW DFM on the internal website. Previously published materials must include written permission from the publisher to post on the DFM internal website or a web link to a public version of the materials. Award recipients are selected by a committee selected by the UW DFM Awards Committee. All submissions are anonymous during the selection process.
- Winning submissions may be shared with UW Health Public Affairs and/or other UW entities for publicity purposes

Presented At:

Recipients will receive their award at the annual Farley/Frey Awards Event on September 13, 2017 from 5:30-7:30 PM at the Pyle Center, Madison, WI.

Approved by DFM Awards Committee on 6/10/14

“A Large Slice of Humble Pie” by David Deci, MD

“I know by the ring of the phone that it is Betty calling for the ***10th time*** today!” Exasperated, my front office receptionist came storming into my office to sternly warn me that I needed to do something.

I had been in small town private practice for several years. Betty and her husband Joe (not their real names) certainly ranked up there as my most difficult patients. Just seeing their names on the schedule would engender in me a sense of dread and frustration. Perhaps, not so unconsciously, this same attitude had permeated my staff.

Joe was 65 going on 80 with a body ravaged by a heroic history of smoking. His clunky oxygen tank always foretold his arrival in the examining room. His wife Betty was 20 years his junior, but plagued with both real and imagined ailments, all magnified by “bad nerves”. They both had low health literacy and, despite repeated efforts on my part, never seemed to grasp even the basics of self-care.

I would often drive past their home on my way to the hospital. It was a ramshackle, unpainted house raised up on concrete blocks with an outhouse and a huge pile of firewood (great heating source for someone with end stage COPD!). I knew that they were poor, but I felt that wasn’t necessarily an excuse for wearing my nerves thin with repeated trivial requests and too frequent office visits.

I was out of the office for a week following the birth of my second child. When I returned, my first day’s schedule included Betty and Joe. “Oh great!” I thought as I steeled myself for what I anticipated would be a challenging visit. When I entered the room, they were both smiling broadly and Betty proudly offered me a gift-wrapped box.

“Here, this is for your new baby boy.”

As I unwrapped the gift of baby clothing, tears came to my eyes. Despite great poverty and what I thought was a rocky relationship was a gift from the heart. They had generously given from their nothingness and had invested in me.

Surely, I could invest in them.

My perspective and attitude for Betty and Joe was forever changed. I learned to look at my patients in a different way. I began to search for the common humanity hidden behind the difficult behaviors. I grew to realize that the physician relationship is a powerful tool that has the potential to heal both the body and the soul. I learned that humility is the true gift that transforms not just the patient, but the physician as well.

Truly, humble pie was served that day…

<u>Disclaimer</u>: current policy prohibits physicians from accepting gifts from patients. This incident occurred in a faraway place a long time ago. *But, I would still do it again!*

“Reducing isolation in the city that never sleeps: using smartphones to combat addiction” by Andrew Quanbeck, PhD

Caption: Bronx cityscape.

The date reads February 24, 2016 as the digital clock on Janice’s smartphone inches towards midnight. Janice is sitting at her kitchen table in an apartment in the Bronx, intently watching her screen.

Outside, a late winter storm is raging. In fact, the storm is so intense that the Weather Service has officially categorized it as a “gale.” Horizontal sheets of rain are keeping most residents of the Bronx off the streets tonight. But Janice had already decided to stay inside, as she does most every night. The streets in her neighborhood can be dangerous. “I go to 12-step meetings and appointments at the health clinic during the day. I need that support to stay clean and sober. But I’m not going to risk going out at night to a 12-step meeting or for anything else.” Staying home at night keeps Janice from becoming a victim of street crime. More importantly, it eliminates the triggers that might lead her to use drugs again, a problem that has plagued her for most of her life. But staying inside night after night can be lonely. For the last year, Janice has been using a smartphone-based system for addiction named “Seva” that has been provided by the Institute for Family Health (IFH), the organization where she receives healthcare services. The word *Seva* comes from Sanskrit and means “selfless service.” Janice is one of about 70 patients from the Walton Family Health Center (an IFH clinic in the Bronx) who are using Seva. Janice has been using Seva consistently since she was introduced to it in March of 2015.

Seva is being tested with nearly 300 patients at 3 federally qualified health centers around the U.S. (Federally qualified health centers are primary care clinics that treat patients regardless of their ability to pay.) The study is funded by the National Institute on Drug Abuse, which is part of the National Institutes of Health. The goal of the study is to understand how mobile technology can help patients with addiction. Seva has proven effective in tightly controlled randomized clinical trials. But promising research findings usually don’t end up being used in the real world of healthcare. In fact, a new branch of research—implementation science—has emerged in recent years to study (and ultimately, to close) the significant gap between what research indicates should be done to treat disease and the care that is actually delivered in the healthcare system.

Outside Janice’s apartment, the rain and wind continue into the early morning hours. After finishing a video game on her smartphone, Janice watches a video about someone else in recovery. “I listen to stories like this and I realize that I don’t have to beat myself up. Because you know what? I’m not unique. People have this disease, but they can survive and live their lives, regardless of the errors in their past.” When the video ends, Janice turns out the light and goes to sleep.

Through Seva, Janice has connected with other Walton clinic patients who are struggling with addiction. The mix of patients using Seva reflects the racial and ethnic makeup of the Walton St. neighborhood. According to Seva patient Sam, “Unfortunately for a lot of us, we don’t have anyone to turn to; we don’t have family; we don’t have friends.”

Seva patient (codename "Sam")

Collectively, the group of Seva patients receiving care at the Walton St. clinic have taken to calling themselves the "Seva family." Charles is another Seva patient. Charles is a soft-spoken man, but he speaks enthusiastically about Seva and the kinship he now feels through the peer support system Seva has created: "I feel like I've got a 24/7 clinic in my pocket. It feels great."

Drug and alcohol treatment is known for advocating the principle that people with addiction need to hit bottom before they will get better. Treatment often involves rigid rules and expectations for patients—rules that would not be expected for patients suffering from other chronic diseases, like diabetes. In contrast, Seva promotes autonomy among its members and openness about failure. "I like the fact that this is not something I'm forced to do," says Janice. "I can do it when I want to. This is my option. If I don't feel like listening, I don't listen!"

While patients such as Janice, Sam, and Charles report benefits from using Seva, the system works best if it's part of the clinic. Tom McCarry is a mental health and addiction counselor at Walton Family Health. In many ways, he is the glue that holds the Seva family together. He has identified, recruited, and trained all of the Seva participants. He actively monitors participants' use of the system, answers questions, and posts positive messages. "Having someone in that role is critical. We make sure to set aside time so that he can play that role," says Vicki Ward, who manages the behavioral health department at the Walton Family Health Clinic. Vickin and Tom have provided the driving force behind implementation of Seva.

Mr. McCarry is getting ready to host a session to train 4 new patients on Seva. He gathers the new patients around a table, a new smartphone marking each place. He asks each patient to introduce himself (all 4 are men) and asks the men to talk a bit about their familiarity with smartphones. A couple of the younger participants start using their phones right away, snapping "selfies" for their Seva profiles. An older gentleman says that he has never used a smartphone before. Mr. McCarry pays special attention to him, walking him through every button press and keystroke. By the end of the hour-long session, the older man has learned how to swipe the phone's screen, convert voice to text, take a picture, and post a message.

Caption: Tom McCarry leads a training session for new Seva recruits.

Mr. McCarry has seen firsthand the effect of Seva on patients. But figuring out the best way to embed Seva in the clinic's operations is a challenge. IFH's resources are stretched extremely thin. According to Pik Sai Yung, a psychiatrist who treats patients who have both mental health illnesses and addiction disorders, IFH is pushing clinicians to get more deeply involved in treating addiction. But Dr. Yung often doesn't know what factors in her patients' lives are getting in the way of successful addiction treatment. "I've got 20 minutes with each patient every 6 weeks, if they show up, that is. If you're my patient and you're not getting better, I want to know what is going on in your life. Are you not taking the medications I've prescribed? Are you using alcohol or other drugs? Are you having trouble with your family? Are you not sleeping? What's going on?"

A system like Seva might be able to answer such questions. Mr. McCarry and Dr. Yung are getting ready to test how they might use Seva to do this. Mr. McCarry will email Dr. Yung weekly reports, based on the weekly surveys patients complete in Seva. In addition, Dr. Yung will receive an automated alert whenever Seva data indicate that a patient is at high risk of relapsing. This system may allow Dr. Yung to intervene before things get out of control. At the least, information patients enter into Seva could help Dr. Yung get a picture of what is going on in her patients' lives before they walk into the exam room, prompting her to ask the right questions in the extremely limited time she has with each patient. It's a balancing act. If Seva provides too much data, or data that isn't useful, Seva could add to Dr. Yung's information overload and be ignored. Dr. Yung and Mr. McCarry have learned that the best way to integrate Seva into treatment is by trying things on a small scale. They'll check in with each other a few times over the next month to see how the pilot test is working, and what adjustments they should make to fine-tune the system.

IFH is a mission-driven non-profit organization that has been meeting the needs of NYC's underserved people since 1983. Maintaining sufficient funding to fulfill the organization's mission is a continual struggle. According to Virna Little, Vice President of

Behavioral Health for IFH, “If a program (like Seva) costs us money, on balance, it will be very hard for us to sustain it. If it saves the organization money, it has a chance.” IFH is one of many accountable care organizations nationwide governed by the Affordable Care Act. An accountable care organization is responsible for the total cost of care for each patient. If a mobile health system helps patients maintain healthy and stable lives—and avoid the costly emergency room visits, detoxification stays, and hospitalizations often associated with relapse—the system may be a good investment for the organization. The Seva study will look at health-related results as well as the financial impact of using Seva on the organization. Evidence from earlier research shows that Seva could save an organization money in the long run—for instance, a system used with alcoholic veterans in upstate New York showed a significant decrease in re-hospitalizations for chronic alcohol abuse.

A patient focus group revealed how Seva helped one participant get through a precarious situation. Joe was (by his own admission) on the brink of relapse. He decided to use Seva to reach out to one of the group’s monitors (a member of the research team). “If I didn’t have that phone, I don’t know what would’ve happened,” reports Joe. “Reaching out through Seva was the only thing that I could’ve done at that moment. I just needed someone to talk to; to listen to what was going on with me; to give me a push in the right direction.” Obviously, it was critical that someone was monitoring Seva on behalf of the clinic to be ready to respond to Joe’s call.

An exchange that occurred on the Seva Discussion board further illustrates how the system is helping patients like Janice reach out to support one another in their struggles with addiction. It is worth noting the time when the exchange began, as well as the time between responses:

From: Janice
Date: 03/11/2016 4:41 AM **Title:** Ruff time Thursday
once again I wanted to pick up Crack not to make light of it the name alone speaks for its self. broken , garbage, destroyed . I want to be whole not garbage. I fill really confused some times. the word commitment comes to my mind . I not willing. the true hurts. thank for listening, I needed to share. I didn't pick up.

From: Dennis 03/11/2016 5:51 AM
Morning Janice, You did the right thing by sharing. I've been having a lot of difficulty staying focused these past 9 months, but I always share with the SEVA family. One thing I like about this is that I can be anonymous, but I'm also human with feelings & I'll always get feedback whether I agree with it or not. I hope this helped a little. Ciao.

From: Janice 03/11/2016 5:53 AM
thank you

From: Dennis 03/11/2016 6:03 AM
I figured it works for me, it help you when it gets tough.

From: Josie 03/11/2016 6:03 AM
you are on the right path Janice. one step at a time. confidence within you will help you conquer the urges. good luck and blessings

From: Dennis 03/11/2016 6:13 AM
That's right, stay focused. It's not easy, but if nothing else, you have the SEVA family, so please take full advantage of it as often as necessary. Ciao.

From: Mary 03/11/2016 6:25 AM
janice I'm glad you shared that with us, and happy you didn't pick up, our higher power was standing besides you, and he was not going to allow for you to pick up. try to.make a meeting today, that will work, God bless you. remember One Day At A Time.

From: Trent 03/11/2016 6:27 AM
You are not alone. This disease is a everyday battle. It's not kind, prejudice or unforgiving. It's objective is to kill, destroy and keep us in a state of confusion. It doesn't have a schedule to attack. It just comes for you without warning. Be prepared. Our weapons : meetings, literature, groups, prayer and contacts. I don't know how long SEVA has existed. To me it's inovated and something new. You used it, reached out to others and didn't pick up. I'd say you were prepared. Never give up or in. The disease of addiction doesn't. Have a nice day and enjoy life as it was meant to be.

From: Dennis 03/11/2016 6:31 AM
What did I tell you Janice? See the responses you got with just 1 post? This does work. Have a nice day. Ciao

The goal of the Seva implementation project has been to put technology in the hands of people who may find it useful in their day-to-day lives. Sam reflects on his experience over the past 12 months and his hopes for the future. “In the end, we’re all human. No judgment, man. We are all connected as human beings. To have each other’s back, to lift each other up . . . that’s the best we can do as human beings, you know?

“Finish to Start” by Edmond Ramly, PhD

It somehow seems to you now

That you did misremember

What the world

Had been sending

At the doors of December

But every beginning

Comes after an ending

Remember what endings allow

And when at last

Your self was bare

No mirrors or protection

Swimming

Through air

You became your

Own reflection

And each day in the past

Was once a future day

And you are then and now

The three acts of a play

With you the crew and cast

“Getting Drunk on Kefir and Other Ridiculous Ideas” by Cassandra Sundaram

Once, when I was working at a barely trafficked art gallery at my college, I slurped down an entire jug of strawberry banana kefir. Right there. In front of the security guard and the middle aged receptionist who always wore oversized cat earrings. At 8 AM. It was wild. I felt wild. In about 5 minutes I started texting all my friends, telling them I was getting buzzed off the probiotics. I started wandering around the gallery, pretending to be inspecting placards, but really I was just passing from one line drawing of a neuron to another, to another--a series of two hundred.

I was literally a human action potential, jumping along down from myelinated sheath to myelinated sheath down the long axon of drawings, each to the next, until I ended back up where I started. At this point I discovered I had enough clarity to think to myself "this would have been a cool idea for performance art." Then I thought, "That was some cool performance art that I just did."

Is it still art if no one sees it? Is it ridiculous if it's cool?

That night I got drunk on something else (kefir content: 0%) at a club tennis party and started re-creating the line drawings from the gallery on someone's old chem exam. I tore out the pieces and walked around handing them to people. I kept telling people I was trying to "create links" and "cross the threshold." I was only a month in to physiology.

This was not the most ridiculous thing I ever did.

The next morning I got breakfast with my sister and her friends, who aren't that much older but grew up in a different cultural generation. I wanted to get avocado toast but I didn't because I had read an article on buzzfeed the day before telling me that I was killing everything by eating avocado toast. I don't want to kill things. I don't want people to think that I kill things. I wanted to be the exception to the "millennials are killing everything" theory. So I got two eggs over easy and a side of bacon.

Two of my sister's friends got avocado toast. And they did it without any guilt at all. I guess that's the price you pay for being born in the 90s and having friends who buy Days Inn baseball hats from Urban Outfitters for $35.99.

It sounds ridiculous, right?

I once overheard a millennial couple in a tea house (I know what you're thinking, what did I expect from going to a tea house):

"There's a professor I'm trying to work with who has done some really important work in linguistics--all about how Americans promote nationalistic tendencies in society by being ignorant of cultural linguistic traditions."

"Wow! That does sound like important work. We need to educate people."

"I mean, there are many pitfalls of the American educational system, but think about it. Hardly anyone knows what a ditransitive verb is, let alone how to use it."

"Well, when I lived abroad in Tokyo for two weeks....." etc.

shaking heads, chuckling, sipping macha $8 macha shots

Maybe they're not wrong about us killing everything.

But me, I guess you could call me old-fashioned. I still buy CDs. Haven't yet made the switch to vinyl.

I once live tweeted my experience accidentally locking myself in a bathroom. That was verging on ridiculous.

What comes closer to truly head-shaking is the 8 hours I spent chronicling every single song on John Mayer's past three albums, a one-woman mission to change hearts and minds about the extent of his douchebaggery and the pushing of the argument that society may need to judge an artist's work separately from his or her portrayal in the media.

I mean, he's still a d-bag, but he plays guitar really well. I bought tickets last week. I'm going by myself. The spreadsheet had minimal success within my friend circle. I'm confident it just needs more exposure.

In the winter of my senior year of college I tried to get into coffee. I remember exactly where I was when I downed a peppermint mocha at 1pm on December 2nd in the midst of the polar vortex with only a half a banana in my belly. The next 80 minutes of an oceanography lecture were spent trying to stop excessively sweating and twitching, looking awkwardly behind me every 5 seconds to make sure people weren't staring at me.

I never had a peppermint mocha again. I turn my back when my roommate makes espresso. I don't know for sure, but it seems like this is something they maybe they should share in D.A.R.E.

PSA:
Caffeine is a drug. It might be better than Admiral Nelson, but it's for sure worse for you than kefir.

I guess my point is, getting drunk on kefir is not the most ridiculous thing a millennial could do. It's as normal for us as kombucha, IPAs and instagramming brunch.   So ridicule us if you want, but we'll be out here, continuously giving the world things to lovingly despise. And that's what the world needs more of. Some wholesome, unimportant things to despise. Think fidget spinners.

#5

Health Care Professionals: Opportunities to Address Social Determinants of Health

Geoffrey R. Swain, MD, MPH; Katarina M. Grande, MPH; Carlyn M. Hood, MPA, MPH; Paula Tran Inzeo, MPH

Nearly all of the health-related investments in the United States are focused on health care. While access to and quality of health care is important, health is influenced far more strongly by social and economic factors such as employment, income, and education. These factors drive not only health outcomes, but also the significant health inequities experienced by many of our communities. Therefore, it is essential that professionals dedicated to improving health increase their effectiveness by addressing the "upstream" causes of health in the community and by engaging in ways to change the broad policies, systems, and environments that shape the social and economic conditions that, in turn, so strongly influence health.

The World Health Organization (WHO) has broadly defined the social determinants of health as "the conditions in which people are born, grow, live, work, and age."[1] They include an individual's socioeconomic status (SES)—including income, employment, and education—as well as multiple other factors such as social cohesion, social support, community safety, affordable housing, and food security.

Research shows strong and consistent associations between these socioeconomic factors and health outcomes.[2,3] The Milwaukee Health Report illustrates this pattern well, showing a consistent gradient on nearly every health measure, with higher education and income strongly associated with better health outcomes.[4] Further, communities with greater differences between the highest and the lowest incomes not only experience poorer health down the income gradient, but also overall poorer health than communities with incomes more equally distributed.[5]

These relationships are documented not only in research data; there are solid, plausible mechanisms proposed for why socioeconomic factors drive health outcomes.[6] In short, social determinants (a) affect people's access to health care, (b) support or constrain people's ability to practice healthy behaviors, and (c) directly affect people's physiology through chronic elevations of stress hormones, epigenetic changes, and other biologic mechanisms across the life course that can have lasting impacts across generations.[7]

The effects of socioeconomic factors on health are surprisingly strong. The County Health Rankings model (Figure), developed at the University of Wisconsin Population Health Institute (UWPHI), indicates that only 20% of the modifiable factors that influence health relate to access to quality health care, while 40% of the factors that influence health are social and economic.

While the influence of social determinants of health in driving health outcomes is clear, actions to address social determinants—particularly by physicians, other health professionals, and health care systems—have been less well explored. How can professionals dedicated to improving health continue our traditional roles of promoting healthy behaviors and delivering quality health care and also balance our repertoire by adding the skills, competencies, tools, and methods to address the socioeconomic policies, systems, and environments that so strongly influence health?

Here we discuss 2 concrete and well-studied examples of social determinants of health: income/employment and education. We then describe evidence-based examples of clinical and policy-level practices to address these determinants.[8] Finally, we offer suggestions and resources for specific actions readers can take to address not only these specific determinants, but also any of the many other social and economic factors that drive health outcomes.

DETERMINANT: INCOME/EMPLOYMENT

There is a clear relationship between health and employment/income: people in high-income groups can live up to 6 years longer than their low-income counterparts.[2] Not only are high-income individuals more likely to have insurance and access to medical care, but they also have better access to nutritious food, more oppor-

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tunities to be physically active, and increased ability to live in safe homes and neighborhoods.[9] For most people, income is driven by employment, yet employment opportunities vary widely among communities. For example, the rate of employment for the white population of Milwaukee is 77.4%, while the rate of employment for Milwaukee's African Americans is only 44.7%.[10] Increasing employment rates and income levels typically requires systemic policy changes, and although income- and employment-based policies often do not have health improvement as a primary goal, research has shown that many such social policies play a key role in improving health outcomes.[5]

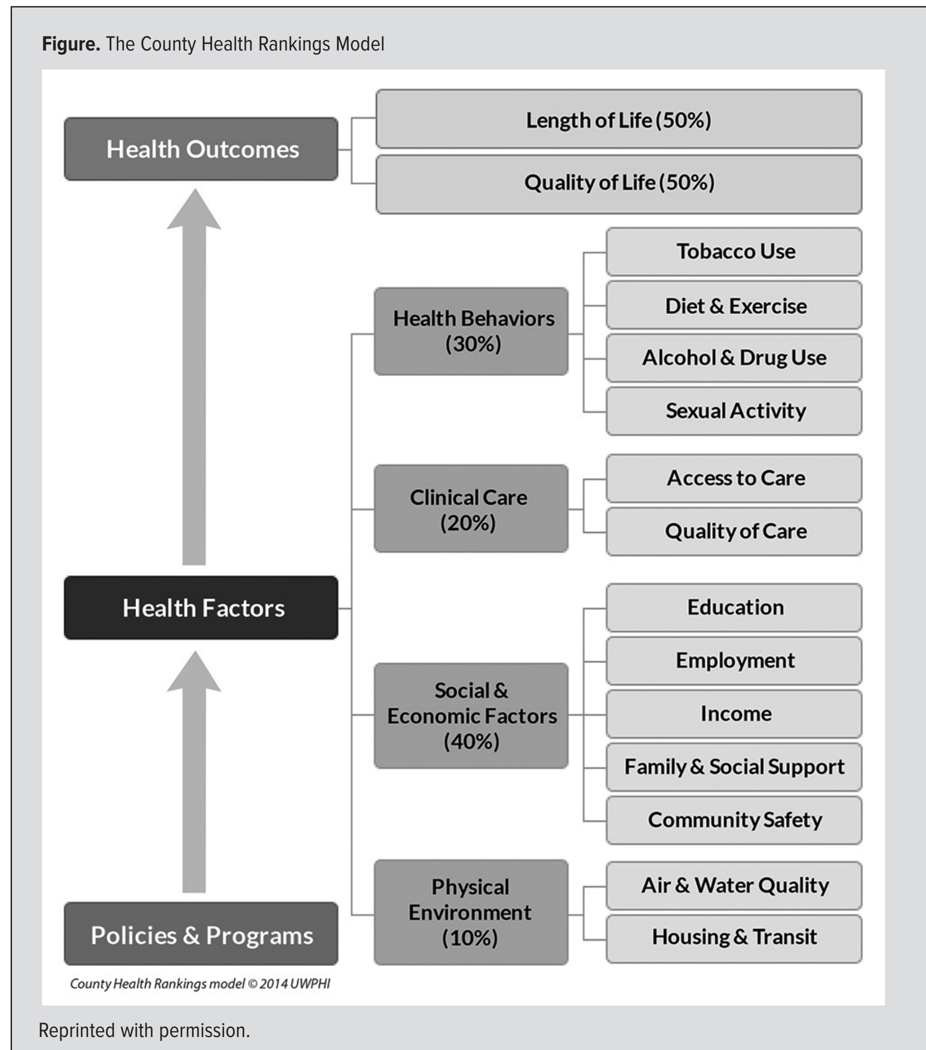
Existing antipoverty programs such as Social Security have already reduced poverty by about 80% among seniors.[11] But with poverty rates in Wisconsin hovering in the low double digits overall, and closer to 25% in some urban areas (including a child poverty rate of over 40% in Milwaukee),[12] more policy interventions are needed.

Policy Case Example
Addressing income and employment to greatly reduce poverty

A rigorous analysis by the Urban Institute and Milwaukee's Community Advocates Public Policy Institute has shown that a 4-component policy package would reduce poverty in Wisconsin by more than 50% for all age groups and all racial and ethnic groups.[8] This policy package includes: (1) expanding transitional jobs programs, (2) increasing the minimum wage and indexing it for inflation, (3) expanding the Earned Income Tax Credit (EITC) so that all low-income workers—regardless of marital status or number of children—would qualify, and (4) providing a tax credit for adults who cannot work and who receive disability income or Social Security income.

The components of this policy package have proven health benefits as well. In the case of EITC, an increase of $1000 in the tax credit income is associated with a 6.7% to 10.8% reduction in low birth weight rates for single mothers with less than a high school diploma, and an even larger impact for births to African American mothers.[13] In the case of transitional jobs (TJs), a Health Impact Assessment (HIA) conducted by UW–Madison's Population Health Institute found a host of positive health impacts of relating to expanding TJs.[14] In fact, the study found that the absence of such programs increases poor health outcomes, and that many of employment's positive effects on stress, children's physical and mental health, and family cohesion are undermined or even reversed when employment is unstable (and income inadequate). Another HIA on minimum wage policy conducted at the University of California Los Angeles (UCLA) showed that improvements in minimum wage policy could reduce mortality on the order of 1.4 deaths per 10,000 workers per year over the long term.[15]

Figure. The County Health Rankings Model



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DETERMINANT: EDUCATION

Education and poverty are closely linked—as one's educational background improves, typically so do opportunities for higher incomes, better employment opportunities, and improved living conditions.[16] As with income/employment, educational outcomes can vary widely among communities. For example, Wisconsin's 4-year graduation rate (87.5% in 2011-2012)[15] is among the best in the nation. In Milwaukee, however, the graduation rate is 61.1%; among Milwaukee students who are economically disadvantaged, graduation rates are even lower.[17] As with income, there are many policy levers by which to improve educational outcomes (and thereby improve health);[6] we will highlight only 1 example here.

Policy Case Example
Early Childhood Education Programs

WHO's Commission on Social Determinants of Health has identified early childhood education as a priority area, urging governments

Box. Examples of Social Determinants-focused Individual and Population Level Strategies

Clinical Level

Screen for socioeconomic issues in clinical interactions.
Screening for access to basic needs (food, employment, benefits, education) increases physician referrals and family contact with community resources. Screening tools such as the mnemonic IHELLP for Income, Housing Education, Legal Status, Literacy, and Personal Safety (Table) are intended to facilitate care by connecting a patient's biomedical situation to the context of his or her life.[30]

If no one on the health care team asks and providers remain ignorant of patients' social and economic realities, factors like prescription unaffordability and poor neighborhood composition will continue to adversely influence health. Conversely, screening for patient's socioeconomic issues could broadly augment clinical care over a number of clinical visits or could be leveraged in a focused way should an area be identified as a significant contributor to poor health,[31] such as altering traditional clinical prescribing practices to better fit within a patient's life conditions or providing more coordinated services overall.

Coordinate services for individual patients by partnering with social workers, health advocates, community health workers, and similar professionals.
One California-based organization, Health Leads, leverages college students to connect patients with the basic resources they need to be healthy. Information from socioeconomic screening questions results in more effective prescriptions for food, heat, and aptly targeted diet and exercise-related interventions. Through this model, students act as navigators to expand clinics' capacity to address basic resource needs often at the root of poor health and implement a net of social support within health-care settings.[32]

Population Level

Advocate for pro-health social and economic policies.
Due to their position and influence in society, health care professionals in general and physicians in particular can use their expertise, access to evidence, and credibility to help decision-makers better understand the health impact of policies far beyond those focused on clinical care quality or access. With their power, physicians can advocate for pro-health social policies such as income maintenance policies (eg, unemployment and disability insurance), education policies (eg, Head Start, universal pre-K), employment policies (eg, transitional jobs), compensation policies (eg, minimum wage/living wage), and tax policies (eg, Earned Income Tax Credit).

In addition to developing relationships with and educating policy-makers directly (eg, participating in Doctor Day at the Wisconsin Capitol), physicians can exert their influence through media appearances (eg, television interviews, radio show call-ins, and writing op-eds and letters to the editor), by becoming involved in local policy leadership (eg, school board, board of health, city council, county board), by supporting educational and workplace initiatives, and by working in other venues to change public attitudes on various issues. Physicians and other health care professionals also can provide significant support to community efforts—via partnering with community and faith-based organizations with overlapping interests, education sector leaders, business leaders, and public health and safety officials—because of the content expertise as well as the credibility and standing in society that they bring to the table.

Work collectively with peers.
Clinicians can and should advocate within their group practice/hospital/HMO for a community/population health perspective emphasizing the importance of addressing the social determinants of health. As group practices and hospitals are increasingly held accountable for community health outcomes, effective interventions addressing "upstream" socioeconomic factors are crucial for success.

Work collectively with professional associations.
The more medical and other health professional groups become involved in addressing social determinants of health, the higher the impact on policy change and eventual improvement in health outcomes. The American Academy of Pediatrics (AAP), for example, has put poverty high on its advocacy agenda for 2013-2014, and has convened a workgroup to review current opportunities related to expanding access to basic needs such as food, housing and transportation, and promoting positive early brain and child development and school readiness and success.[33]

Be both patient and persistent.
Physicians and other health care professionals should view policy change as incremental and occurring at various windows of opportunity, not under any 1 political environment. Health care providers can help open these windows of opportunity by building policy and advocacy capacity within their organizations, creating and elevating the evidence-base for social policy, and educating their own organizations, policy-makers, and the public on these issues.

to invest in it.[14] Similarly, Wisconsin's State Health Plan—Healthiest Wisconsin 2020 (HW2020)—cites strong and consistent evidence for early childhood education's positive influence on health over the life course.[2] Children who attend high-quality early learning programs see gains later in life including improved graduation rates and earnings, as well as decreased rates of crime and teen pregnancy.[18] Additionally, randomized controlled preschool intervention trials have shown that early childhood education is associated with improved adult health status, lower behavioral risk factors, and lower criminal activity,[19,20] and that these early childhood programs are cost-effective.[21] The quality of these programs can be improved through interventions such as smaller teacher-child ratios, increasing the number of teachers with 4-year college degrees in early childhood education, increasing home visits with families, and more monitoring by government or accrediting agencies.[22] Expanding the reach and quality of early childhood education programs such as Head Start and Early Head Start, therefore, is a social determinants-based policy approach with potential for great impact on health outcomes.[23]

IMPLICATIONS FOR PRACTICE

Today, 4 in 5 physicians believe that unmet social needs are leading to worse health among Americans, yet the same percentage also feel unable to address health concerns caused by the unmet social needs of their patients.[24] The Affordable Care Act's new payment structures encourage physicians, hospitals and other health care professionals to form networks known as Accountable Care Organizations (ACOs) to increase the coordination and quality of care.[25] ACOs currently are thought of as focusing on individual-level quality care that matters (eg, improvement in health measures among clinical populations such as average hemoglobin A1c among all diabetics in a health care system). However, health care systems will see improved patient outcomes, and thus improved reimbursement, if they also become involved in addressing the upstream social determinants of health in the

communities where their patients live, work, and play.

Medical school curricula are beginning to emphasize the role of physicians as population health and social determinants policy advocates.[26] At least 9 medical schools now integrate population and community health coursework with traditional clinical science curricula.[27] Some also include the importance of advocacy and policy work for medical professionals. Both Wisconsin medical schools are innovating in this area; the University of Wisconsin School of Medicine and Public Health incorporates policy advocacy in its innovative Integrative Case Series for medical students in their first 2 years,[28] and the Medical College of Wisconsin features an Urban and Community Health Pathway whose core sessions include a focus on social determinants.[29]

In practice, physicians and other health care professionals can address the social determinants of health at both the individual and population levels. See Box for examples.

On the individual patient-care level, clinicians can implement broader and deeper screening for social determinants (Table). Elevating the importance of gathering information on a patient's socioeconomic context to that of conducting his or her physical examination or developing an evidence-based treatment plan will increase the effectiveness of individual level patient care. Clinicians also can partner with allied health professionals and community partners to address patients' socioeconomic needs.

On the continuum between the individual and population levels, physicians also can provide support to local community-based organizations whose mission focuses on addressing the social and economic needs of community members. Such physician support could range from providing volunteer clinical services (eg, sports physicals at Boys and Girls Clubs or YMCAs/YWCAs) to serving on the advisory boards of advocacy or social service organizations.

Physicians also might consider working with community coalitions. Coalitions are comprised of many partners such as community-based organizations, government agencies, and private sector partners who are collaborating on a common goal. Physician perspectives can bring added depth to coalition strategies, and such engagement can provide a platform for policy and systems change.

Table. The "IHELLP" Mnemonic

Examples of Potential Social History Questions (Using the "IHELLP" Mnemonic) to Address Basic Needs

Domain/Area	Examples of Questions
	Income
General	Do you ever have trouble making ends meet?
Food income	Do you ever have a time when you don't have enough food?
	Do you have WIC?[a]
	Do you have food stamps?
	Housing
Housing	Is your housing ever a problem for you?
Utilities	Do you ever have trouble paying your electric / heat / telephone bill?
	Education
Appropriate education placement	How is your child doing in school?
	Is he/she getting the help to learn what he/she needs?
Early childhood program	Is your child in Head Start, preschool, or other early childhood enrichment?
	Legal Status
Immigration	Do you have questions about your immigration status?
	Do you need help accessing benefits or services for your family?
	Literacy
Child literacy	Do you read to your child every night?
Parent literacy	How happy are you with how you read?
	Personal Safety
Domestic violence	Have you ever taken out a restraining order?
	Do you feel safe in your relationship?
General safety	Do you feel safe in your home?
	Is your neighborhood safe?

[a]WIC includes Supplemental Nutrition Assistance Program (SNAP) for Women, Infants, and Children.
Reproduced with permission from *Pediatrics,* Vol. 120, pages e734-738, copyright 2007 by the AAP.[30]

On the population level, health care professionals should advocate for pro-health socioeconomic policies, work collectively with peers and professional organizations, and be both patient and persistent in working to bring about policy change (Box).

To be effective change agents, physicians don't need to become policy experts on income/employment, education, or any other social determinants-related policy. What physicians and other health care professionals bring to the table is unparalleled credibility and expertise in the area of health. Thus, when physicians and their colleagues bring their health-related voices to the table, it strengthens the arguments of advocates who are already experts in policy fields related to the social determinants of health.

It would, of course, be extremely helpful for health professionals to partner with policy advocates. It would also be ideal for each group practice or hospital system to designate a specific person whose job is to advocate for pro-health social and economic policies.

In any case, clinicians' participation in the policy advocacy process makes such changes far more likely to succeed—all for the ultimate benefit of patients, communities, and population health.

CONCLUSION

The role of physicians and other health care professionals in both individual care provision and individual behavior change is crucial. However, social determinants of health make up a stronger percentage of the modifiable

drivers of health outcomes than either health care or health behaviors.

To be most effective at improving the health of families and communities and to ensure the greatest impact for investment of resources, health professionals need to expand their repertoire of skills and activities both with their individual patients and in the policy arena.

Medical education training programs focusing on physicians' clinical and policy-level responsibilities for addressing social determinants are emerging.[31,34] But currently-practicing physicians and other health professionals must also work both individually and collectively to address social determinants within their practices, their communities, their states, and beyond.

Acknowledgements: The authors are extremely grateful to Raisa Koltun, PharmD, MPH, for significant substantive contributions to this article. Dr Koltun was Associate Director of the Wisconsin Center for Health Equity at the time of this article's genesis. The authors also are grateful to the Wisconsin Partnership Program: Katarina Grande, Carly Hood, and Paula Tran Inzeo were UW Population Health Service Fellows during this article's development.

Funding/Support: The UW Population Health Service Fellowship is supported by funding from the Wisconsin Partnership Program.

Financial Disclosures: None declared.

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"history and physical" (in 55 words) by Jon Temte, MD PhD

our conversation unfolds…

pretty good for 92
born in '24?
yup
WWII?
yup
what did you do?
B-17
position?
gunner
my uncle, B-29, bombardier; my dad, PBY, navigator
smiling nod
which gun?
bottom
ball turret gunner?
yes
how tall are you?
5 foot 5
that explains all

my thoughts drift to Jarrell's five filigreed lines

[Note: The residents with whom I share late night call know my penchant for asking patients about their hometowns, their occupations, and other unimportant trivia. As time has gone on, I find myself as drawn to the arc of my patients' personal histories as to the symptoms and maladies that bring them to the hospital. This admission was of a 92 year old man, coming in with multiple fractures from a fall. My bonus find: he was a WWII B-17 ball turret gunner. For history buffs, the ball turret was an incredibly tight Plexiglas ball on the belly of a B-17 bomber (and also on B-24s). It was a position for the shortest, smallest, post-adolescent; most being under the 5' 5" frame of my patient. They usually entered the ball before takeoff and remained curled in a womblike pose for the duration of the flight. This information—and the fact that he returned from the war, married, ran a hardware store for 35 years, and raised 8 children—was absent from the residents' template-driven history and physical note. When I talked to them later and asked how tall they thought he was, they responded, "pretty tall, maybe 6 feet." Randall Jarrell (1914-1965) wrote the five-line (52-word) "Death of the Ball Turret Gunner" in 1945, a poem on the industrialization of violence… I write this in dissent of the industrialization of medicine.]

"Hospital Haircut" by Elizabeth Perry, MD

I did a horrible job.
Lets try to just even this out, I winced, scissors snapping
at what the neurosurgeons had left of her matted afro.
Craniotomy staples sparkled like silver tinsel on the left side,
but a half-shaved head made her look more uneven
than she really was.
When I was done,
it looked like a wayward goat had nibbled
half-heartedly at her before nurses chased him out.
She patted her head thoughtfully and grinned,
tying a do-rag over this and that, her mechanical heart valve
clicking audibly in her twice-cut chest.
Its better than it was, she said, which was kind of untrue.
I pulled the alarmingly white sheets up over her legs
while the sun wobbled into her sky, wry and intact.

“II Corinthians 9:12” by Ildi Martonffy, MD

Elderberry jam
Homemade and hand carried
Across 520 miles and a storm
To the bedside of a dying brother
At the request of his wife of 54 years.

Not for him.
[X] He failed his swallow study.

For us
His care team
It was sweet.

"Picture Book Bandhs" by Maureen Landsverk

We fumbled around in the dark, clumsy with sleep and lethargic in the heavy heat. We muttered incomprehensible phrases like 'toothpaste' and 'key' to each other, finally shuffling out of the humid hotel room. We tripped down the stairs to find our traveling companions waiting by the hotel gate. I've always wanted to say I 'escaped under the cloak of darkness,' but I now realize how romanticized that phrase is, especially when it involves early morning monsoon rains and emergency ponchos that transformed us into vibrant Teletubbies tottering down the river-street. It is 4am, and we're leaving Janakpur earlier than expected because of a Bandh (strike) that was announced late last night. In a few hours, anyone still on the road in Southern Nepal risks violent retribution, particularly drivers. Bandhs are usually called by members of the reigning political party in Nepal, often to prevent any event that threatens to weaken their power--in this case, a federal democratic election in Dhanusha. So instead of visiting the last school in the district for interviews and leaving at 11am as we had planned, we're sloshing through street puddles halfway to my knees, warm and muddy, hoping to make the early morning bus and escape Dhanusha before the strike officially starts. If we don't, Bandhs have been known to last for weeks, and that would put a serious wrench in our efforts to finish our fieldwork by next week.

The streets are eerily silent, and there are cows huddled under the tin eaves of shuttered shops on either side of us, avoiding the rain that is now pelting from the sky. It feels like someone above is angry at us for leaving this furnace of a city, but all I can think about is the bus that awaits us on the darkened, empty main road that is usually impossible to cross due to the traffic. I heave my duffel bag higher and question once again why I didn't bring a backpack instead. By the time we make it to the bus, the sun is beginning to brighten a world that is not quite ours yet; I can see the hints of warm pink on the horizon, a sight that would normally seem welcoming but is now foreboding. We pile into the minivan half-asleep, wait for a few straggling passengers, and watch the sunrise grow larger, redder. Finally, the driver begins to speed down the road toward Kathmandu, but mostly toward the northern border of Dhanusha past the strike zone. Despite the sleepless night, everyone seems alert, on edge, and it makes me anxious. We see men and women in blue uniforms marching along the road to their posts, where they will soon enforce the Bandh. I wonder who they are, what has inspired them to this cause; if this is entirely their choice, and how something that seems so ludicrously authoritarian can organize so freely in a country that established a federal multi-party republic nine years ago. I realize that timespan is not long in the grand scheme of political systems, but still, the blatant corruption here and the casual way in which it's discussed continues to baffle me.

The navy-suited men and women we pass along the road give a face to this corruption; make it tangible, easy to point out. If political manipulation were condensed to a form of literature, Nepal would be a picture book, but the United States would be a dense, incomprehensible legal textbook that intimidates its readers and defies understanding. In many ways, the subtlety of political manipulation in our country is far more insidious. We may have been allowed to travel to the polls and cast our votes in November, but did everyone in our country feel safe to do so? Did everyone, regardless of nationality, income, creed, and race, have the same right to a voice, an opinion, and a stake in their future? I don't believe so. For that reason, our democracy, established over 240 years ago, is still a work in progress, continuing to evolve in ways I don't entirely understand or agree with. Now, living in a country where practical considerations like language and culture act as barriers to human connection and understanding, I realize how easy it is to stop trying. I realize how seldom I make a concerted effort to understand those in my own country who hold different beliefs; how easy it is to write them off as uneducated, crude, or simply wrong.

There are so many things that wall us off from each other, isolating us into groups defined by personal interest and fear, skewing our perceptions in favor of whatever it is we want to believe. Language might be one factor, but I believe education is just as powerful in terms of elevating, isolating, or uniting a society. I have seen how children here break down barriers that seem insurmountable to me--poverty, food shortages, child marriage--all in the interest of access to education and the chance at a better life. They don't just survive; they fight for what they want every day, they create spaces and dialogues for their beliefs and interests; their hopes and dreams.

Education and the promise of knowledge have the power to inspire individuals and subjugated classes, build bridges and understanding between those who might have otherwise been separated by differences. My fieldwork in Nepal may not involve hospitals or medicine, and it may not be the picture book version of public health. But I believe how we discuss differences and personal beliefs, how we think about ourselves and those around us, and ultimately, what we believe about everything from politics to nutrition to vaccine schedules, is influenced and informed by our education. That is why this fieldwork opportunity stood out to me, and why I feel it is so important to explore the intersection of education and individual and community health. They are so intertwined, influence flowing inexplicably in both directions; a model of cause and effect I am only beginning to grasp. I believe a better understanding of how these concepts are related will help us better understand each other, and how we might be able to unite in the face of challenges and differences that seek to divide us.

“Sail On” by Edmond Ramly, PhD

So sail on by

Drown into the rising sun

Keep on sailing

Keep the course

Your journey's never done

Through mist and fog and rain

Through dusk and morning dew

In every joy and pain

Discover something new

"The Bulls and the Bears" by Andrew McClintock, PhD

A black-capped chickadee chirps and squawks,
As an early morning fog forges over Wall St.
The wilting, adipic air drips with anticipation
And collects upon grand Corinthian columns.

The stairs become flooded:
An army of investors, brokers, and pundits
Reporting for duty, regaling common dreams.
But a tempestuous market awaits,
Replete with unforeseen twists and cryptic turns.

With gold in their eyes,
They place their bets, inherit their losses,
And amid the chaos,
Cling to elusive notions of meaning and control:
That they are the masters of the universe,
The architects of fate.

The defeated hang their heads,
Their ruminating thoughts race to dismay.
A complacent ascetic sits quietly and unassumingly,
Watching the day's unending moment unfold,
She admires a resilient ray of sunlight,
As it gracefully rests upon her shoulder.
She breathes, and that, is enough.

"Review: The Image of Blacks" by Susan Golz

This past week I was looking through a box of childhood memories and came across a Civics paper I wrote in September 1976. I was 12 years old at the time. The article was titled **The Image of Blacks** (see attached) . When I picked it up . I will admit my first response was a bit of panic. Before I read the words I did a gut check. What had my 12 year old self written? Was i about to read an article that would shake what I thought my inner core and ideals were based on? I looked closely at the spiral torn off pages with my name and date across the top. It was all written in cursive and a part of me traveled back in time to Wisconsin Dells Junior High School. Towering over the boys I was a tall , skinny , large plastic frame glasses wearing ,awkward adolescent . My father was the fair , well loved county sheriff and my mother the favorite high school home economics teacher and I had three wonderful siblings. We had a good life of honest means and a lot of love and family and friends.

Then I read the words I had written so many years ago. I wrote about the injustices and inequalities that black people faced . I wrote with 12 year old honesty , heart and run on sentences . I wrote of history books omissions ,stereotypes and mistreatment. As tears rolled down my face I reflected on the current world , my own brown children and grandchildren and the continued discrimination and hate that they and so many others face today. I called my Mom and told her about the paper and she wasn't surprised , she said from a young age I recognized the equalities and pain of others based solely on the color of their skin and often was vocal and confrontational about it . She said I always wanted to live or go outside the bubble of my small town and experience diversity and make things better for others.

It brings me now to the work we do, the people we care for , the importance of standing up for the injustices and inequalities that people face every day. I think of being a child growing up in the 70's, the freedoms I had and our simple but basic rules . I then thought of the specific lessons and rules I have taught my brown children solely based on safety and protecting themselves because of the color of their skin . The fear I have with every news story and every time my phone rings late at night. The current climate that seems to make it "okay to hate" and brings fear and uncertainty to all of us.

In the words of my 12 year old self, I think this mistreatness is wrong don't you?

last paragraph reads it came through light in copy: "John Churchill was the first leader of black power. He taught the children not what they were not but what they were. Black and beautiful Afro Americans not Negroes, that they were people not animals .I think this mistreatment was all very wrong don't you?"

Civics

Sept 30, 1976

Susan Goz

The Image of Blacks

The old white films cut down the blacks. The whites copied the blacks art. The whites used to not let blacks go to school. The blacks when mentioned, the word slavery usually comes to mind. When a test was taken by two average children, one black the other white. Each one drawing a tree and a self-potrait the white child drew a regular face and trees with lots of leaves and the body with arms, legs. The black child drew a body with no arms maybe meaning deformed rights or in another test taken one child didnt draw a face. What does it mean?

Where are they in history books?

Deadwood Dick was with the Jesse James gang but where was he in the history books.

Dan Williams performed the first sucessful open heart surgery where was he?

Blacks were in movies but that didnt make up for the history books. If I were them Iòde rather be in history books. In movies they potraied servents, bums or men being cowardly but not Shirley Temple

The black people tried to be like whites by dressing acting and having their hair cut like them.

John Churchill was the first leader of black power. He taught the children what they were

not what they were if
you were treated and
[illegible] of the [illegible]
not Negroes That they
were people not animals.
I think this mistreatness was
very wrong don't you?

Department of Family Medicine
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