



SETH GS MEDICAL COLLEGE AND KEM HOSPITAL
WITH
DR.M V L KOTHARI CHAIR OF MEDICAL HUMANITIES
AND DIVISION OF MEDICAL HUMANITIES
PRESENTS



Picture Courtesy Of : Luke Fildes

Doctor इसीका नाम है।

**DARE TO BE DIFFERENT,
DARE TO STEP ABOVE..**

ASCENSION
STEP ABOVE



*Peep In To Know
What Is Actually Happening In The Picture Above..*



*Seth GS Medical College And KEM Hospital,
Acharya Dhonde Marg, Parel, Mumbai - 400012*

**24TH JULY
2017**



Supported by GOSUMAC ALUMNI ASSOCIATION

ASCENSION JULY 24, 2017



SETH G S MEDICAL COLLEGE & KEMH

DR M. V. L. KOTHARI CHAIR OF MEDICAL HUMANITIES

AND

DIVISION OF MEDICAL HUMANITIES



Dean's Message



It is indeed a proud privilege to write on the booklet being printed on the occasion of first ever conference “Ascension-step above” on medical humanities being organized by students so enthusiastically under the umbrella of Dr.Manu V.L.Kothari Chair of Medical Humanities and Division of Medical Humanities at these twin institutions – Seth Gordhandas Sundardas Medical College & King Edward Memorial Hospital. Several thousand graduates and specialists have been qualified from these institutions and many have made their mark in the medical profession. Music, photography etc. are human endeavors that effect our emotions and our spirit which are required in medical system as it is becoming increasingly mechanized. I am more delighted to see this awareness in present generation to focus more on meaning making than on scientific measurement, developing their own unique value system.

Humanities in medicine courses, meant to develop understanding of the human side of health care are increasingly found necessary in our medical education programs. We are all currently in the midst of a high tide of concern and clamor for taking urgent action to improve the standards of the medical education in the country. In this context, there have been some refreshing initiatives in the country through curricular reforms and faculty development programs that essentially reflect a shift from the predominantly knowledge-based education towards a competency-based education (CBE) to ensure a graduate, who is skilled and motivated and ready to meet the health care needs of the country.

In addition to these initiatives, there is also a need to sensitize faculty, academic leaders, and policy/decision makers that we need to move from quality-attainment to quality-improvement by producing competent doctor with required knowledge, skills, attitudes, and professional attributes to meet the needs of the people. The present conference is nothing but an assessment driven learning. Such conferences will be prove path maker as what gets valued gets the focus of attention. I appreciate the efforts of organizers in arranging such first ever conference and wish

them all the best.

350 Fifth Avenue, 34th Floor
New York, NY 10118-3299
Tel: +1-212-290-4700
Fax: +1-212-736-1300; 917-591-3452

Kenneth Rot h, Executive Director

Deputy Executive Directors

Michele Alexander, Development and Global Initiatives
Nicholas Dawes, Media
Iain Levine, Program
Chuck Lustig, Operations
Bruno Stag no Ugarte, Advocacy

Emma Daly, Communications Director
Dinah PoKempner, General Counsel
James Ross, Legal and Policy Director

Division and Program Directors

Brad Adams, Asia
Daniel Bekele, Africa
Maria McFarland - Sanchez - Moreno, United States
Alison Parker, United States
José Miguel Vivanco, Americas
Sarah Leah Whitson, Middle East and North Africa
Hugh Williamson, Europe and Central Asia

Shantha Rau Barriga, Disability Rights
Peter Bouckaert, Emergencies
Zama Neff, Children's Rights
Richard Dicker, International Justice
Bill Frelick, Refugees' Rights
Arvind Ganesan, Business and Human Rights
Lesli Gentholtz, Women's Rights
Steve Goose, Arms
Diederik Lohman, Acting, Health and Human Rights
Marcos Orellana, Environment and Human Rights
Graeme Reid, Lesbian, Gay, Bisexual, and Transgender Rights

Advocacy Directors

Maria Laura Canineu, Brazil
Louis Charbonneau, United Nations, New York
Kanako Doi, Japan
John Foster, United Nations, Geneva
Meenakshi Ganguly, South Asia
Bénédicte Jeanmmeod, France
Lotte Leicht, European Union
Sarah Margon, Washington, DC
David Mepham, United Kingdom
Wenzel Michaelis, Germany
Elaine Pearson, Australia

Board of Directors

Hassan Elmasy, Co-Chair
Robert Kissane, Co-Chair
Michael Fisch, Vice-Chair
Oki Matsumoto, Vice-Chair
Amy Rao, Vice-Chair
Amy Towers, Vice-Chair
Catherine Zernitson, Vice-Chair
Michael Fisch, Treasurer
Bruce Rabb, Secretary
Karen Herskovitz Ackman
Akwas Aidoo
Jorge Castañeda
Michael E. Gelfert
Leslie Gilbert - Lurie
Paul Gray
Betsy Karel
David Lakshmi
Kimberly Marteau Emerson
Alicia Mirfana
Joan R. Platt
Neil Rimer
Shelley Frost Rubin
Ambassador Robin Sanders
Jean-Louis Servan - Schreiber
Sidney Sheinberg
Bruce Simpson
Joseph Skrzynecki
Domènec Stagliani
Siri Stolt - Nielsen
Darian W. Swig
Mako Takano
Marie Warburg
Jan Weidner

July 18, 2017

To :

The Students' Committee - *Ascensi on*
Set h G. S. M edica l College and K. E. M . Hospital
M um bai, India

Dear Team ,

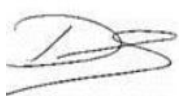
I am happy to learn that you, as medical students, have organized '*Ascensi on*' to celebrate Human Rights in medicine with a full day programme on related themes, including medical ethics and the history of medicine.

In our work on health and human rights, we see the many disparities that exist in health care access in countries around the world due to poverty and inequality, including in India .

Your programme looks fascinating : talks about illustrious doctors who have done remarkable work in your region on improving access to health care for tribal populations and medical education for aspiring doctors. Studying the lives and work of such pioneers will hopefully enrich and inspire you .

I wish you much success , and I hope that the programme will motivate students to join the fight for the realization of the right to health for all.

Sincerely,



Diederik Lohman
Director
Health and Human Rights Division
Human Rights Watch



HRW.org

AMSTERDAM · BEIRUT · BERLIN · BRUSSELS · CHICAGO · GENEVA · GOMA · JOHANNESBURG · KIEV · KINSHASA · LONDON · LOS ANGELES · MOSCOW
· NAIROBI ·
NEW YORK · PARIS · SAN FRANCISCO · SÃO PAULO · SILICON VALLEY · STOCKHOLM · SYDNEY · TOKYO · TORONTO · WASHINGTON · ZÜRICH

ASCENSION

PRELUNCH

- 9:00-9:30 am - Inauguration
- 9:30-10:30 am - Speech by Dr. Mario Vaz on
"Medical Students, Residents: Art and Humanities
- The St John's experience".
- 10:30-1:00 pm - Timeline
- Dr Dhruv Mehta - "Life and work of Dr Albert Schweitzer"
Dr Ashok Vaidya - "Life and work of Dr. Navnit Fozdar" A GOSUMEC,
AN INDIAN SCHWEITZER
Dr Sunil Pandya - "Dr. Charles Morehead"
Dr Samir Dalvie - "The 3 Cs : Communication, Compassion and Cash"
- 1:00-2:00 pm - Lunch

POST-LUNCH

- 2:00-3:00 pm - Debate

Debate: Theme: "Commodification of Health Care Makes an Unhealthy Society."

Topics for eliminations -

1. Innovative technology is a definite enhancer of patient care
2. We need more generalists than specialists in society today.

Chairperson – Dr. Mrs. Nandini Vallath

- 3:00 - 4:30 pm - Panel discussion

The panel discussion: Topic: "Entrance exams & MCQs: spoilers or levellers?"

1. Dr. Sanjay Nagral- **Moderator**
2. Dr. Avinash Supe
3. Dr. Sunil Pandya
4. Dr. Mario Vaz
5. Dr. Ravi Ramakant
6. Dr. Kiran Kumbhar
7. Dr. Mrs. Urmila Thatte

Online Competition

Photography : Humanity – Gulserene Dastur, Dr. Supe

Sketch the Medical Condition – Dr. Munira Hirkani

Cartoon : Humour in Medicine – Dr. H. Morpariya

Essay Writing – Dr. Nithya Gogtay

- Being Human
- Medicine and the end of life
- Physician assisted death
- The medicalization of society has seen a shift of medicine into the lives of the healthy

Speaker's



Dr. Sunilkumar Pandya

Completed his Under-Graduation and Post-Graduation from Grant Medical College and Sir J. J. Group of Hospitals and completed his further training at Institute of Neurology, London. He was Professor of Neurosurgery at our very own Seth GS Medical College and KEM Hospital and is currently attached with Jaslok Hospital & Research Centre. He is also the Chairperson of Dr MVLK Chair of Medical Humanities at our institution. He has had various publications on Neurosurgery, History of Medicine, Medical Ethics for the medical profession in journals, text books and Neurosurgery, Medical Ethics and Medicine in general for the lay public.

Dr. Mario Vaz

He received his medical education (MBBS) at St. John's Medical College, in Bangalore and then worked as a medical officer and field worker in leprosy and tuberculosis at the Emmaus-Swiss Leprosy Project in Andhra Pradesh for 3 years. He completed his MD in Physiology at St. John's Medical College in 1992 and followed this with a fellowship at the Baker Medical Research Institute in Melbourne, Australia where he worked for 2 ½ years.

His primary appointment is in the Department of Physiology, St. John's Medical College. He also heads the Department of History of Medicine and the Division of Health and Humanities.





**Ashok D.B. Vaidya MD, PhD, FAIM
Research Director**
Kasturba Health Society-Medical Research
Centre

Director
Clinical Pharmacology, BSES & Global (BK)
Hospital

Adjunct Professor,
Saurashtra University, Rajkot,
Drexel University, Philadelphia,
Transdisciplinary University, Bengaluru.
Gujarat Vidyapeeth, Ahmedabad.

**Former
Regional Medical Director (South Asia)**
Ciba-Geigy (Now Novartis)

V. Asst. Prof. & Merck Fellow
Clinical pharmacology, Yale Medical School

Senior Scientific Officer
CSIR, Clinical Drug Trials Unit,
Seth G.,S. Medial College & KEM Hospital

Dr. Samir S. Dalvie

He is a leading Spine Surgeon currently attached with PD Hinduja Hospital and Reseach Centre as a Consultant, apart form Laud Clinic Multi-speciality Hospital and Breach Candy Hospital. He completed his Under-Graduation and Post-Graduation in Surgery at our very own Seth GS Medical College and KEM Hospital. He also is a Fellow of College of



Physicians and Surgeons and holds a Diploma of the National Board of Education. He has also been attached previously with Seth GS Medical College and KEM Hospital as Senior Lecturer and Associate Professor and has been a recipient of various Scholarships and Awards like Essar Sholarship and Young Achiever Award at Indo-American Society. He has had various publiations in peer reviewed journals and presentations in National and International conferences.



Dr. Dhruv Mehta

Educational Qualifications:

- B.Sc (Physical Therapy) June 1981.
- M.Sc (Physical Therapy) May 1985.
- Both Bombay University (Seth.G.S.Medical College and K.E.M.Hospital).
- Dr.P.N.Berry's Scholarship for United kingdom 1994.
- (Did the Bobath Neuro developmental Course), Visited Stoke Mandeville Hospital for spinal cord injuries & other Hospitals for Paediatric and Adult Neuro Rehab

Experience:

- Over 30 years of experience of working with children & adults with Neurological conditions.
- Asha sadan, Missionaries of charities Borivali, Byculla, Brahma Chaitanya Rugnalaya – Gondhavl, Hi-Five Child Development Center.
- Worked at Children's Orthopedic hospital for 21 Years and was head of physiotherapy department for a decade.

Research & Current Projects :

- Engaged in projects particularly for Cerebral Palsy, Developmental Disorders, Spinal Cord Injuries

Dr. Nandini Vallath

QUALIFICATIONS

Bachelor of Medicine and Surgery (MBBS) (1987)	Mumbai University, India
Diploma in Anaesthesiology (1988)	Mumbai University, India
Doctor of Medicine (MD) Anaesthesiology (1990)	Mumbai University, India
Diplomat, National Board, Anaesthesiology (1996)	National Board of Examinations, New Delhi
Post Graduate Diploma in Palliative Medicine (2010)	Cardiff University, UK
Post Graduate Diploma in Family Medicine (2012)	Christian Medical College Vellore, India
Foundation Course in Pain and Palliative Care(2000)	Global Cancer Concern and Pain and Palliative Care Society, Calicut, India



Certificate Courses

Community change in Public Health (2015)	Johns Hopkins University (Online)
Epidemiology - The Basic Science of Public Health (2015)	University of North Carolina (Online)
Community based approach for the prevention of Chronic Kidney disorders	Kidney Help Trust, Chennai, India
Yoga Teachers Training Course (2007)	Bihar School of Yoga, Bihar, India
Basic Vedanta course (2006)	Chinmaya International Foundation, India
Yoga Instructors Certificate Course (2004)	Swami Vivekananda Yoga Anusandhana Samsthana, Bangalore, India
ECHO-Immersion Training - Education for Community Health Outcomes	Project ECHO, University of New Mexico
Palliative Care Always	Albuquerque, USA Stanford University, USA

AWARD

AWARD FOR EXCELLENCE AND LEADERSHIP IN PALLIATIVE CARE BY THE CANCER AID SOCIETY FOR THE SAARC COUNTRIES – 2014 - 2015



Dr. Avinash Supe

He is the Director(Medical Education & Major Hospitals) and Dean of Seth G.S.Medical College & KEM Hospital. He is also Professor of Surgical Gastroenterology & was Past President of Indian Chapter of Indian Association of Hepatobiliary Pancreatic Association;

He has been a recipient of over 26 national and international awards and medals and has done prestigious orations like Dr GM Phadke, and AMASI, WIRDC Dr.Dholakia, Network

He has over 240 publications in National and International journals and has authored 4 books.

He is also a wild life, nature and medical photography enthusiast and a honorary member of Photographic Society of India. He also has written the Marathi Book – Arogya Sampada and regularly contributes articles in Lokprabha

Dr Sanjay Nagral

He is a surgeon with specialisation in Hepato-pancreatobiliary Surgery & Liver Transplantation, working as a Consultant Surgeon & Coordinator of the Department of Surgical Gastroenterology at Jaslok Hospital & also Heads the Department of General Surgery at the KB Bhabha Municipal General Hospital.

He was involved in the first successful liver transplant program in Western India & has 80 publications in peer reviewed medical journals to his credit.

He is the joint secretary of the Zonal Transplant Coordination Committee based in Mumbai, which regulates cadaveric transplant activity in Mumbai & the chairperson of its ethics committee.

He is the publisher & member of the editorial board of the Indian Journal of Medical Ethics & chairperson of the Forum for Medical Ethics

Dr Sanjay Nagral regularly writes on issues related to public health, medical ethics & organ transplantation





Dr Ravi Ramakantan

With over 37 years of experience, Dr. Ramakantan was also Professor and Head Department of Radiology, KEM Hospital, Mumbai and Visiting Professor, Brigham's and Women's Hospital, Harvard Medical School. He was the First International Visiting Scholar, Radiological Society of North America and the Founding President Indian Society of Neuroradiology. He

has received the Best Medical Teacher Award, University of Mumbai and Karmayogi Award, Bombay Medical Aid Foundation. He has above 60 research papers in Indexed Journals and over 20 orations to his credit.

Dr Urmila Thatte

“Nothing will sustain you more potently than the power to recognize in your humdrum routine, as perhaps it may be thought, the true poetry of life – the poetry of the commonplace, of the plain, toil-worn woman, with their loves and their joys, their sorrows and their griefs.”

– William Osler, from *The Student Life*, in *Aequanimitas*.



“To most physicians, my illness is a routine incident in their rounds, while for me it's the crisis of my life. I would feel better if I had a doctor who at least perceived this incongruity”

– Anatole Broyard (Former New York Times critic) (1).

Dr Kiran Kumbhar

He completed his undergraduation at BJMC and Sasoon General Hospital, Pune and went on to achieve his Master of Public Health (MPH) in Health Policy, at Harvard School of Public Health. Currently a Doctoral student in History of Science at Harvard University Graduate School of Arts and Sciences, he is a Recipient of the Govt of India Fellowship in Honor of Amartya Sen for 2016-17, Harvard University.



He has Six years of Experience in medical and public health work including writing on health policy He has been a Research Associate at Sitaram Bhartia Institute of Science and Research (Delhi) and a Research Fellow , Public Health Foundation of India, Gurgaon (Delhi)

Thought Provoking Essays

A positive visit with a patient with chronic pain

DANIELLE OFRI, MD, PHD | PHYSICIAN | FEBRUARY 20, 2017

We have two ears and one mouth so we can listen twice as much as we speak,” said Epictetus. It's clear that the Greek philosopher wasn't a physician in 21st century America. If you watch doctors — and many researchers do — they speak more than listen.

Studies have shown that doctors interrupt or redirect patients within the first half minute of talking. I'm just as guilty. I fear that if I don't quickly home in on the top priorities, the patient will ramble on ad infinitum.

How long, I've sometimes wondered, would my patients actually talk if I didn't say anything at all? According to a group of Swiss researchers, when doctors did not interrupt, the average duration of their patients' monologues [was 92 seconds](#). Not exactly the deluge of historic proportions that most physicians fear. But, well, you know the Swiss — reserved, diplomatic, precise. Maybe Swiss patients lack the American gene for self-referential gab.

The day after reading that study I tried it out in my clinic. For each patient I saw, I quietly clicked on a stopwatch after saying, “How can I help you today?” My first patient took 37 seconds, the second 32. But these were basically healthy individuals. The third had more issues: unresolved back pain, plus his glucose, cholesterol, and weight were all creeping up. He took two minutes.

But then came Josefina Garza. A teacher in her native Argentina, Ms. Garza (not her real name) was saddled with a vast array of insoluble pains compounded by anxiety, depression, and irritable bowel syndrome — plus a demanding mother to care for. Exactly the type of patient who can drown you with a list of complaints. I love her droll observations about New York City's pretensions of culture, which of course could never measure up to the sophistication of Buenos Aires, but they steer us away from crafting her care.

If I let Ms. Garza talk uninterrupted, I feared that the visit would unfurl like a Borges labyrinth. We'd tumble down a dizzying path of her symptoms that would encompass every organ system of her body, plus a list of her mother's medical woes and a stinging critique of the Metropolitan Opera's soulless production of “Turandot.”

But I had promised myself I'd let every single patient talk that day. If I eliminated the “difficult” patients, then my data — however informal — would be flawed.

I girded myself for battle and asked, “How can I help you today?” as I reluctantly clicked on the stopwatch.

“Every single thing hurts,” she said, “from my toes to my head.” There were shooting pains in her gums. Her scalp was painfully sensitive. Neck pain was radiating down her spine. Her mother had insomnia and was up complaining at all hours of the night.

Each time she paused I said, “Anything else?” And there always was.

“I’m only 45,” she said, “but I feel like I’m 85. Every step hurts, and my head feels swollen to five times its size. It’s like I’m walking through molasses.”

I scribbled a few notes on paper as she talked but maintained eye contact with her the entire time. “Let’s get everything out on the table,” I said bracingly, “every last symptom and then we’ll . . . then we’ll, uh, we’ll figure out where to go from there.”

I let her keep talking until she had fully, truly, absolutely come to the end of all that she had to say. In the silence that followed, I clicked off the stopwatch. I estimated that eight to 10 minutes had transpired, but in fact it had been just four minutes and seven seconds. And the Met had come out unscathed. I suppressed the urge to say “Wow!”

Instead, I turned back to Ms. Garza and said, “Is this everything?” She nodded, and I showed her the list I’d jotted down. When viewed on the page, it actually didn’t seem so overwhelming. It was long, but finite.

Ms. Garza had already had the million dollar workup, which was all negative. I explained to her that something was going on. “Medicine is very poor at explaining pain syndromes,” I said, “but that doesn’t mean we can’t go ahead and start treating your symptoms.”

We went down the list together, trying to identify which pains might be helped with ice packs, which might be helped with local heat and massage, which might best be treated with physical therapy, and which might respond to pain medications. We talked about how antidepressants could be helpful and that seeing a therapist could decrease her stress. We discussed how she might get help in caring for her elderly mother. We covered the critical role of exercise in treating chronic pain. And then we wrote up a plan.

At the end of the visit, which didn’t run overtime by too much, she said something I’d read about but never heard a patient say: “Just talking about all this has actually made me feel better.” I wanted to jump up and sing an aria (which, luckily for all parties involved, I refrained from doing) but I was in the process of realizing something else: Just talking it all out had made me feel better, too.

Like any doctor honest enough to admit it, I dread patients with chronic pain. Every visit is taxing and protracted. The patient is often dissatisfied, and so is the doctor. Patients like Ms. Garza are accustomed to having walls erected in front of them. Their clinical issues can be so daunting that doctors react — consciously or unconsciously — by attempting to turn off the spigot as expeditiously as possible.

Perhaps the mere act of getting every last bit on the table made it seem less overwhelming to Ms. Garza. It certainly felt that way to me. Maybe my less-pressured tone of voice lowered her adrenaline level. Maybe ignoring the computer and maintaining eye contact for the entire conversation made a difference. Maybe it was the sense of unlimited time. Or maybe it was simply admitting that passion and culture

in New York could never hold a candle to Buenos Aires and leaving it at that.

This was first time I'd ever felt good after a visit with a patient with chronic pain — I was actually doing something to help, rather than just rearranging deck chairs. It's a reminder that doctors sometimes need to zip it up and let the patient talk uninterrupted. Although it may feel like time is being wasted, it could actually make everything much more efficient.

Once patients feel confident they have been heard, there are fewer surprises later. And when all the data are on the table from the outset, there's a much better chance of getting the diagnosis right on the first go around. Most importantly, a few minutes of solid listening can form a crucial connection between doctor and patient — one of trust, respect, and confidence. The dividends of this connection can pay off for years.

“When people talk, listen completely,” Ernest Hemingway wrote. I can hardly imagine a better lesson in communication.

(Danielle Ofri is an internal medicine physician and editor-in-chief, [Bellevue Literary Review](#). She can be reached at her self-titled site, [Danielle Ofri](#). This essay was adapted from her new book, [What Patients Say, What Doctors Hear](#).)

The collapse of education is the collapse of the Nation

Discussion in '[Jukwaa la Elimu \(Education Forum\)](#)' started by [bittersweet](#), [Apr 7, 2017](#)

A University lecturer wrote an expressive message to his students at the doctorate, masters and bachelors level and placed it at the college entrance in the university in south Africa:

"Collapsing any Nation does not require use of Atomic bombs or the use of Long range missiles. But it requires lowering the quality of Education and allowing cheating in the exams by the students".*

The patient dies in the hands of the doctor who passed his exams through cheating. And the buildings collapse in the hands of an engineer who passed his exams through cheating.

And the money is lost in the hands of an accountant who passed his exams through cheating.

And humanity dies in the hands of a religious scholar who passed his exams through cheating.

And justice is lost in the hands of a judge who passed his exams through cheating. And ignorance is rampant in the minds of children who are under the care of a teacher who passed exams through cheating.

"The collapse of education is the collapse of the Nation"*

April 11, 2017

Barry Marshall, MD: *H pylori* 35 Years Later

[JenniferAbbasi](#)

JAMA. 2017;317(14):1400-1402. doi:10.1001/jama.2017.2629

Step into the right pub in Perth, Australia, on a Monday early in October—Nobel Prize announcement day—and you'll find 2 laureates catching up over fish and chips and couple of beers. It's an annual tradition that Barry J. Marshall, MD, and J. Robin Warren, MD, started even before they won the [Nobel Prize in Physiology or Medicine in 2005](#) for their discovery of the bacterium *Helicobacter pylori* and its causative role in gastritis and peptic ulcers.

This year marks a milestone anniversary for Marshall, who has devoted his career to researching the microbe and treating resistant infections. Thirty-five years ago, over Easter weekend in April of 1982, he [cultured](#) *H pylori* from patients with gastritis and ulcers for the first time, after Warren, a pathologist, [observed](#) the previously unknown spiral-shaped bug in stomach lining biopsies. Prior to their discovery, it was dogma that the stomach was a sterile environment and that stress caused ulcers.

The duo hypothesized that *H pylori* infection, not stress, caused gastritis and peptic ulcer disease. “I thought, well, this is great—people are going to be so excited about this new thing,” Marshall said.

It didn't work out that way. The idea that an infection could kick-start chronic disease was novel at the time, and it took a decade for Marshall and Warren's thinking to be widely accepted. Before the tide turned, Marshall resorted to [drinking a dose of *H pylori*](#) in 1984 to infect himself and prove their case. Ten years later, the National Institutes of Health [recommended](#) using antibiotics to treat ulcers in patients infected with *H pylori*. Now, stomach and duodenal ulcers caused by *H pylori* often can be cured with 1 or 2 short courses of therapy.

Marshall developed 2 *H pylori* diagnostic tests, the rapid urease test and the breath test, that are still used today. As knowledge about the bacterium has evolved, so has the understanding of its role in other diseases and conditions, including stomach cancer, mucosa-associated lymphoid tissue (MALT) lymphoma, and idiopathic thrombocytopenic purpura.

Today, Marshall is director of the Marshall Centre for Infectious Diseases Research and Training at the University of Western Australia. He recently spoke with JAMA about his historic discovery, how he plans to use H pylori to prevent disease, and the greatest rewards from his life's work. The following is an edited version of the interview.

JAMA: Before your discovery, why did physicians think stress caused peptic ulcers?

Dr Marshall: People with duodenal ulcers tended to be at the high end of the normal distribution of acid secretion. No one really knew what the cause of that was. And so the idea that stress caused ulcers was easy to accept and nobody really challenged it. That had been the assumed cause for about at least 50, probably 100 years. It was a great explanation, because people really didn't have the tools necessary to look at the cellular physiology very well.

JAMA: So the idea was that stress somehow increased acid in the stomach and led to ulcers?

Dr Marshall: That's true. There were some studies around, which seemed to support it. There was probably also an incredible publication bias. So that if you had something that supported the stress idea, you could get it published. Whereas, if you had something that really came out with a negative result, it would never see daylight.

JAMA: Back then, how were ulcers being treated?

Dr Marshall: Prior to 1977, ulcers were treated [in the United States] with antacids and anticholinergics. They could perhaps take the edge off some of the acid secretion, but there were a lot of side effects. Ulcers were also being treated then with H2 blockers [which reduce acid production by cells in the stomach lining]. You could show that you could heal ulcers with acid reduction, so that was fantastic for ulcer patients who had really suffered a lot and were always facing surgery. But the enthusiasm was waning a bit, because it was found that as soon as you stopped taking H2 blockers, your ulcer would nearly always come back. All the patients who started on H2 blockers, say in the late '70s, were now heading towards the surgeon. Some of those people really ended up having a miserable existence with no appetite and all kinds of GI [gastrointestinal] problems related to the removal of parts of their stomach.

JAMA: You famously drank a brew of *H pylori* cultured from a patient. What drove you to do this?

Dr Marshall: The great majority of people connected with ulcer treatment—gastroenterologists and surgeons—ignored the observation of the bacteria in the stomach. It seemed obvious that we needed to have a human volunteer, and I chose to do it myself at that point. It sounds a bit extreme. And I was actually quite embarrassed by it, because you don't normally experiment on yourself. I drank the bacteria, and then I had this illness, which surprised me. I never saw a person with acute *Helicobacter* infection, and nobody who had an ulcer could remember when they caught the *Helicobacter*. I was thinking that it must be asymptomatic. My original thoughts were wrong. I had a vomiting illness lasting several days in the second week after taking the bacteria. Biopsies showed that I was significantly infected with *Helicobacter*. And I had severe inflammation to the stomach, exactly as what we were seeing in the worst cases of peptic ulcer disease, although I did not develop an ulcer. I put together a hypothesis that the natural history of peptic ulcer disease was like every infectious disease. You catch it when you're a very small child. But unlike most diseases, it stays with you and slowly damages the wall of the stomach and affects your acid secretion. And eventually, probably when you're an adult sometime, the damage becomes sufficient to cause acid breakthrough, and then you get a peptic ulcer. So that was the hypothesis I developed, and it was largely correct. It took about 10 years before people accepted it.

JAMA: What turned that around?

Dr Marshall: There was an experience in the [United States] in the '80s with a new thing, which was large, double-blind clinical trials. That was really driven by the FDA [US Food and Drug Administration]. And so there was experimentation on different treatments. One of the treatments that came up was Pepto-Bismol. I had found that bismuth had been used for a couple of hundred years for treating ulcers. Everybody thought it was just a fancy antacid. But, in fact, it suppressed *H pylori* so much while you were taking it you could go into remission. There were double-blind studies, particularly in Houston with Dr David Graham and his group, [in which] they were seeing this miraculous change when they treated people with the antibiotic-bismuth combinations. And things started taking off then.

JAMA: So today, do we think that stress has anything to do with ulcers?

Dr Marshall: I think it's very minimal. Maybe it affects compliance with treatment. I

did a double-blind study, and I particularly sought out people who said they were totally stressed—people who had given up their careers and retired early. People who were smokers. Really typical “ulcer personalities.” These people did brilliantly when you treated them for *Helicobacter* and eradicated the bacteria. So I've never given stress any credence. I don't know of any good double-blind study that showed stress was important.

JAMA: Have you seen the updated American College of Gastroenterology [ACG] [clinical guidelines](#) for H pylori treatment?

Dr Marshall: Yes. And I was reassured. I think I agree with pretty much everything there.

JAMA: How has treatment for peptic ulcers evolved since the days of the stress hypothesis?

Dr Marshall: [Back then] it was focused on lowering acid, and also treating stress in difficult cases. Some people were even put on antidepressants and modified their lifestyle. Nowadays, we would decide whether the patient has a cancer risk. If the patient's a US-born person below the age of 50, a cancer risk would be rather low. You would go ahead and test the patient for *Helicobacter* with a serology or a breath test and give the patient a 10-day course of antibiotics.

JAMA: Antibiotics combined with a proton pump inhibitor (PPI)?

Dr Marshall: Yes. Around 1990, AstraZeneca was rolling out [the PPI] omeprazole. People started thinking, “Why is the treatment for *Helicobacter* so difficult?” Most of the antibiotics were really designed to get into only slightly acidic areas like urine, kidney, lung. Nobody had ever designed antibiotics to be active in the stomach. Somebody in Sweden said, why don't we use this new PPI—omeprazole—and combine it with amoxicillin? That immediately bumped the cure rate up to about 50%, just with the two drugs. Clarithromycin, amoxicillin, and a PPI were rolled out in the late '90s as the top treatment. You would have an 80% to 90% cure rate. So it was pretty magical by the end of the '90s. All of a sudden, all the severe, chronic cases were treated very quickly in a few years. Treatment now has changed a little bit. Those combinations [that] were locked in about the year 2000 are still being used, but they're not as effective. The cure rate might have dropped now to 75% to 85% with the 3-drug combinations. So some of the older treatments have been resurrected in different

ways. [The ACG] paper says if you've used one combination and the patient's still positive for *Helicobacter*, you wouldn't use the same drugs. You would switch over to some other antibiotics. And you might even switch away from the amoxicillin and replace that, say, with bismuth, and even combinations of tetracycline. Even if they have a resistant organism, the second line of treatments also have very high cure rates. It's unusual for us to actually have a patient in whom we cannot eradicate *H pylori*.

JAMA: In February, the World Health Organization included *H pylori* on its list of antibiotic-resistant priority pathogens for which new antibiotics are needed. Are you concerned about the rise of antibiotic-resistant *H pylori*?

Dr Marshall: My practice has really been the treatment of antibiotic-resistant *H pylori* in failed patients for the past 20 years now. So I'm not concerned about it, because I know it can be dealt with. But I know people who don't have access to a more specialized treatment process. In each, say, state you need one or two experts who can offer that service if the family doctor doesn't have success with one or two treatments. Certainly with two failed treatments, it's time to send the patient on. They would come in and have an endoscopy, and have some biopsies, have some cultures. And then have a personalized, precision medicine-type therapy, using exactly the antibiotics and combinations that we know are going to work on that organism. With a proper follow-up, you end up with about a 99% cure rate.

JAMA: You developed two widely used diagnostic tests for *H pylori*. What are you working on these days?

Dr Marshall: About 10 years ago, studies showed that children with *Helicobacter* were less susceptible to allergic disease such as asthma. It cut down the amount of asthma by 40%, at least. We are going ahead with the development of a sort of a prebiotic- or probiotic-type product based on *Helicobacter*, which could potentially be something to give to small children in very allergic families. I'm quite excited about it. I think that probably 3 years from now, we'll see some significant data coming out from clinical trials.

JAMA: Chinese researchers recently [reported](#) on an experimental vaccine with 72% efficacy against *H pylori* infection in children. Are you enthusiastic that a vaccine is possible?

Dr Marshall: That vaccine would go a long way to helping eradicate *H pylori* more

quickly in areas where it's endemic, including parts of China. There's a caveat to this, though: You're never totally immune to [H pylori], even when you have very high antibody levels. So it's going to be hard work to make a really effective Helicobacter vaccine. The strategy at the current time is just to try to improve the level of hygiene and the standard of living in places where there's a lot of Helicobacter.

JAMA: Shifting subjects a bit, how did winning a Nobel Prize change things for you?

Dr Marshall: Winning the Nobel Prize means that you are vindicated if you have a controversial [idea]. And it also means that you can become a spokesperson for science and medicine, and hopefully continue to publicize the area that you're doing the research in. [But] the most exciting thing about winning a Nobel Prize is making the discovery, and being able to cure people who have had a lifelong, chronic disease. Every doctor would aspire to that. Connecting up with Helicobacter and developing diagnostic tests and treatments for it, I could see that I was amplifying my capacity to be curing thousands, and ultimately millions of people, and changing their lives. That's far more satisfying, probably, in the long-term, than just winning the Nobel Prize. I'd already had the rewards, as far as I was concerned.

Saving Private Ryan

Gregory Rutecki

The late Eighties was the worst of times in medical education--the era when doctors in training worked a virtually unlimited number of hours each week. This unceasing and inhumane workload led residents, understandably, to view patients purely as collections of physical ailments.

Back then, I was an attending physician at a community teaching hospital. One day, as usual, I was preparing to make morning rounds and, simultaneously, to do my best to teach my team of internal-medicine residents.

Fourteen patients awaited us, every one of them quite sick. As my team and I proceeded from one bedside to the next, struggling to cram the patient interviews into ever-dwindling snippets of time, I felt a familiar sense of growing pressure; it was a struggle to focus fully on each patient.

Despite this, our last patient's chart notes grabbed my complete attention.

Mr. Ryan, age seventy-six, was sicker than most of our patients--and he was a

veteran. He'd been sent to our hospital after being deemed unfit to travel to the nearest VA facility. All of my first-degree male relatives served in the military during WWII, and I pride myself on being a WWII buff.

Scanning Mr. Ryan's problem list, I knew we were in for a long haul. Like so many veterans of the Greatest Generation, he had the usual diseases that accompany sixty years of cigarette smoking--chronic lung disease, atherosclerosis and heart failure. I noted that the last problem on his lengthy list was "blind oculus sinister."

"How did he lose the sight in his left eye?" I asked my residents. "Was it glaucoma, a blood clot or macular disease?"

After a moment's hesitation, one answered, "We didn't ask about his eye...His other problems were so urgent, we thought it was more important to address them first."

When we entered Mr. Ryan's room, I studied him for a moment. He seemed comfortable, no longer short of breath. But when I introduced myself, he didn't look at me or reach out to shake my extended hand.

I decided on a different approach.

"Before we do anything else, I want to thank you for your service to the country," I said. "What branch of the military did you serve in?"

"In the Army," he replied tersely.

"What years did you serve?"

"Nineteen forty-two to nineteen forty-five."

"Where did they send you?"

His expression brightened, and he looked me in the eye.

"Europe was my destination," he said. "And it wasn't a vacation."

"Where did you see the most action?"

"I landed Utah Beach* on D-Day," he answered briskly.

"I heard you guys missed your landing zone, so you took fewer casualties than the guys at Omaha."

"Maybe so, Doc, but I lost a lot of friends."

The residents may be right about his left eye's significance in the greater scheme of things, I reflected, but I'm still in charge of "teachable moments." And I was on a roll. I decided to push my luck.

"What happened to your left eye?"

"Caught shrapnel at Utah and finished the war as a one-eyed rifleman," he said. "I didn't want to leave my men."

So much for fewer casualties and missed landing zones, I thought.

By the time we got to the physical exam, Mr. Ryan had become so talkative that I couldn't hear his heart or lungs for the flood of words. A widower whose children and grandchildren lived too far away for a visit, he now had a captive audience. Knowing that I was fascinated, he rattled off battlefield vignettes at a superhuman clip, and I drank it all in.

As for the medical portion of his story, it was straightforward. The residents had already prescribed a diuretic, inhalers and antibiotics for his diseased, waterlogged lungs, and beta blockers for his heart. When I asked them for his echocardiogram and lab results, they answered without a moment's hesitation.

Leaving the room after I'd bid Mr. Ryan a reluctant goodbye, I found myself wondering what the residents had made of our encounter.

Did they notice how quickly he was transformed from a silent invalid into a living, breathing WWII historian? In our short time together, he completely forgot his nagging chronic illnesses. He was lonely and sick, but reliving his finest hours invigorated him.

"How many of you saw Saving Private Ryan?" I asked the team. Everyone raised their hands.

"Do you think maybe you missed something by not asking Mr. Ryan about his eye?" I went on.

They gazed at me, their faces radiating nonchalant confidence.

"It was the key to what he most valued among his life accomplishments," I pointed out. "He feels defined by his trial by fire at Utah Beach. You may not agree, but I believe that giving him a chance to share his experiences with us was more therapeutic than any other aspect of his medical care."

Their expressions didn't change.

The next day, before rounding, I overheard the residents chatting.

"Wasn't yesterday strange?" said one. "Dr. Rutecki seemed so excited about that veteran's story, even though it had nothing to do with the reason he was admitted."

I felt let down; the teachable moment hadn't connected as I'd hoped.

It seemed clear that we all had a lot to learn. I resolved to read more about Utah Beach. And I hoped that my residents would somehow make time to reflect on this encounter from our own personal Private Ryan.

I wanted them to see that, in terms of healing power, listening to a patient's WWII stories might transcend even the best treatment guidelines. Our veteran knew that his diseased lungs and heart would be the victors in his final battle; he wanted to tell his story before he vanished with the rest of his generation. I hoped the residents would see how the act of sharing his story with me had created a strong, intimate doctor-patient connection that was ultimately more therapeutic--for both of us--than antibiotics or steroids could ever be.

Not long after that day, medical educators grasped the folly of expecting residents to work seven days a week, with no time off. Legislation was enacted to cap residents' work hours and allow them "time to heal," as advocated by medical historian Kenneth Ludmerer in his book of that title.

This was a much-needed improvement--but, I've realized, it was still only half of the equation. My encounter with a real Private Ryan was possible because of the serendipitous overlap between his life story and my personal interests--and because I was willing to devote the time needed to explore our common ground.

I worry that, unless I can somehow teach my residents a willingness to open up and listen, and to care for the patient on every level, they will overlook their own

Private Ryans--and miss the chance to give and receive the deepest kind of healing.

*"Historians generally overlook the Utah Beach invasion in favor of the much larger and costlier Omaha assault...Indeed, when one adds the 82nd and 101st Airborne components to the troops who landed on Utah, the Omaha and Utah invasions were comparable in size...Furthermore, when the casualties suffered by airborne units on D-Day are added to those suffered by VII Corps on Utah Beach...the two major American contributions to the D-Day invasion, Omaha and Utah, were similar in both size and cost." --J. Balkoski, *Utah Beach: The Amphibious Landing and Airborne Operations on D-Day, June 6, 1944* (Stackpole Books, 2006), p. xiv.

About the author:

Greg Rutecki practices general internal medicine at the Cleveland Clinic. After graduating in 1974 from the University of Illinois Medical School in Chicago, he trained as an internist at Ohio State University and then completed nephrology training at the University of Minnesota. Since then, he has practiced nephrology and has been a teacher. Over the last ten years, he has written medical-humanities pieces on topics such as the impact of composer Gustav Mahler's endocarditis on his Ninth Symphony, and the use of radium to treat opera composer Giacomo Puccini's laryngeal cancer.

Do we, as doctors, need to imbibe this and act on it?

Sunil Pandya <shunil3@gmail.com> Apr 9

Listening to, understanding and loving our patients:

Philosopher and psychologist **Erich Fromm** (March 23, 1900–March 18, 1980) explored *The Art of Listening* in a 1974 seminar in Switzerland. It developed further into the 400-page text was eventually published posthumously

Listening, Fromm argues, is “is an art like the understanding of poetry” and, like any art, has its own rules and norms. Drawing on his half-century practice as a therapist, Fromm offers six such guidelines for mastering the art of unselfish understanding:

1. The basic rule for practicing this art is the complete concentration of the listener.
2. Nothing of importance must be on his mind, he must be optimally free from anxiety as well as from greed.

3. He must possess a freely-working imagination which is sufficiently concrete to be expressed in words.
4. He must be endowed with a capacity for empathy with another person and strong enough to feel the experience of the other as if it were his own.
5. The condition for such empathy is a crucial facet of the capacity for love. To understand another means to love him — in the sense of reaching out to him.
6. Understanding and loving are inseparable. If they are separate, it is a cerebral process and the door to essential understanding remains closed.

(I found the term 'unselfish understanding' thought-provoking. SKP)

What medical school fails to teach

CAROLINE HUMPHREYS | EDUCATION | APRIL 28, 2017

[HTTP://WWW.KEVINMD.COM/BLOG/2017/04/MEDICAL-SCHOOL-FAILS-TEACH.HTML](http://www.kevinmd.com/blog/2017/04/medical-school-fails-teach.html)

This May, I will graduate from medical school. I will also be part of the first group of medical students to graduate from its new Literature and Medicine track. To me and the other participants, this has been one of the most important components of our medical education. In many ways, it has kept us grounded, serving as a constant reminder that there are experiences different from our own.

We know that in order to be a competent and caring clinician, physicians must do more than master facts: they must also become expert communicators. The crux of the clinical encounter — why are you here today — may seem simple, but it is deceptively complicated. Patients do not tell you a diagnosis; they tell you a story.

Learning to unpack these stories — understanding why your patient is actually here today — is one of the most important steps in becoming a physician. Yet the medical education system fails to adequately cultivate this skill. As medical students, we spend years memorizing physiology, pharmacology, and pathology, among other subjects. The body, we learn, can be reduced to a series of tiny processes, and this approach is often extended to all facets of medicine. Alongside biochemistry, we are taught a step-by-step process of how to talk to another person. Human interaction is reduced to a series of prescribed talking points designed to most effectively elicit necessary information.

After all, we get to medical school by being exceptionally skilled at following directions. These lessons in human interaction would be laughable were they not necessary for so many of us. The difference between obtaining data and

understanding the story shared by the person in front of us is vast, and beyond the scope of even the most refined communication course. To do so requires empathy. But becoming empathic is no simple task.

Gaining that skill is particularly difficult in today's climate of social unrest, in which society defaults to suspicion and mistrust. At the same time, bias, both implicit and explicit, remains prevalent among clinicians, and it continues to adversely affect patient-physician interactions. A 2015 review of 15 studies examining the extent of health care professionals' implicit racial and ethnic biases demonstrated that health care professionals displayed “low to moderate levels of implicit racial/ethnic bias.” Although this is comparable to the general population, the study also revealed important relationships between these biases and health care disparities. Provider bias was associated with poorer patient-provider interactions, discrepancies in treatment recommendations, and worse psychosocial health outcomes such as decreased satisfaction with life and higher rates of depression.

The question, of course, is how to overcome these issues. A 2011 [study](#) found that perspective-taking strategies, which facilitated “active contemplation of other's psychological perspectives,” resulted in improved interracial and interpersonal behaviors, both in terms of participants' inherent tendencies and actual behaviors. In other words, these exercises increased participant empathy. Although the idea of empathy has become a touchstone of modern medical education, it remains a fundamentally limited concept. After all, it is difficult to empathize with those things you have never experienced or imagined; the only world we know is our own.

But empathy, like any skill, can be practiced. Each time we listen to someone's story, we broaden our understanding of countless possible worlds, giving ourselves a wider range of experiences upon which we can draw to better understand the next person. This understanding requires practice and repetition: Each new story makes you better at hearing the next. But there are only so many worlds to which we are given access.

This is where reading fiction comes in. Books open our eyes to new worlds; they elevate our understanding of what it means to be human, to be someone else. Fiction, with its vast and far-reaching scope, broadens our horizons and forces us to consider novel possibilities. Reading the first-person narrative gives us insights into the interior thoughts and feelings of others that we can get no other way.

I advocate for endeavors like our Literature and Medicine Track because they function as a continuous reminder of the person at the heart of the patient-physician interaction. Teaching science is an art in medical school, but teaching empathy has historically been left by the wayside. Folding literature into the curriculum nurtures the idea that every single person who sits in the examination room bears the weight of their own story. Reading fiction makes us better students of those patients' stories.

Caroline Humphreys is a medical student.

When Doctors Stop 'Seeing' Patients

ABRAHAM M. NUSSBAUM

May 8, 2016 <http://www.wsj.com/articles/when-doctors-stop-seeing-patients-1462738682>

Physicians aptly speak of “seeing” patients. After all, medical training is a series of vision lessons. Students look closely at a nameless cadaver and disassemble it until it resembles the pictures in an anatomy text. They watch lectures in which interrelated organ systems are displayed as simple machines.

Often, however, doctors' vision narrows too far. We begin to see the body as a collection of parts and lose sight of the person before us. Early in my medical training, this way of seeing began intruding on the rest of my life. During movies I imagined the best surgical approach for the actress. I saw friends' physical imperfections as signs of syndromes.

So I took a leave of absence from med school to study history, literature and theology. The humanities taught me that the questions I was wrestling with are foundational to the history of medicine. In Platonic medicine, a physician sought to diagnose disease as a concrete fact. Hippocrates, who lived around 400 B.C., reoriented doctors toward seeking to understand the beneficial and deleterious forces in a patient's life and then helping rebalance them in favor of health.

For the past two centuries, physicians have been counseled to pursue something akin to Platonic medicine, to act like scientists. Remarkable technologies — antibiotics, anesthesia, antiseptics — resulted. But physicians also shifted away from the Hippocratic pursuit of understanding patients. Today's clinics are often alienating, as when a physician spends a checkup gazing into a computer screen. Half of doctors [report](#) feeling burned out, and a majority [would advise](#) against a medical career.

Physicians are trained to speak in numbers: prevalence rates, survival odds and remission statistics. They talk to administrators about days of uncompensated care and billing variances. But numbers are, as the historian of science Theodore Porter says, “a technology of distance.” They require us to abstract and standardize. The patient becomes a case report, a billing code, a quality metric.

I wonder about renewing medicine through the kind of vision lessons I received when I took a break from med school. Sustained encounters with the humanities would be beneficial. So would recommitting to the Hippocratic ideal of seeking understanding of each particular patient.

My hope for medicine can be summed up by the last line of the Hippocratic Oath: “May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.” The finest traditions of the physician's calling are those moments when we look patients in the eyes, understand

their pain and anxiety, and help them resolve, relieve or endure it. If we pursue these moments, physicians and patients alike may be able to experience the joy of medicine again.

Dr. Nussbaum, the chief education officer at Denver Health, is the author of "The Finest Traditions of My Calling" (Yale University Press, 2016).

Image of the Day: Beautiful Bacteria

Artists paint with colorful microbes on agar palettes for the American Society for Microbiology's Agar Art Contest.

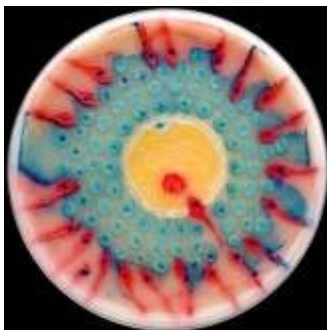
The Scientist Staff | May 23, 2017



"Dancing Microbes" by Ana Tsitsishvili, an undergraduate student at the Agricultural University of Georgia, earned third place.

AMERICAN SOCIETY FOR MICROBIOLOGY'S 3RD ANNUAL [AGAR ART CONTEST](#)

The artist, Ana Tsitsishvili from Tbilisi, Georgia, won third place with this arrangement of bacteria and fungi on brain-heart infusion agar. The common skin microbe, *Staphylococcus epidermidis*, is responsible for the white color; *Rhodotorula mucilaginosa*, common in milk, soil, and air, makes pink; *Micrococcus luteus*, frequently found in soil, water, air, and skin, is responsible for the lady's luscious yellow locks; *Xanthomonas axonopodis*, a pathogenic plant microbe, makes green. Combinations of these various microbes make up everything in between.



1st Place, "The First Race", Md Zohorul Islam, DVM

Fertilization is the first competitive event of plant and animal life. It is a process involving the fusion of male and female gametes to form a zygote. Millions of spermatozoa race and compete to be the first to penetrate the egg, but only one of them finally meets the egg and creates a zygote leading to the development of an embryo. In this artwork, I used four bacteria as paint and a selective agar medium as canvas. The red colored paint was *Staphylococcus aureus*, which is an opportunistic pathogen in both humans and animals. The green color was *Staphylococcus xylosus*, a commensal organism in human skin, the white was *Staphylococcus hyicus*, an animal pathogen responsible for grassy pig disease. The yellow colored organism was *Corynebacterium glutamicum*, a non-pathogenic but industrially important bacterium for production of amino acids such as L-glutamate and L-lysine. Other colors were from mixture of two or more of these four organisms.



2nd Place, "This is not a beer!," Mariarosaria Marinaro, PhD, Erika Grandolfo, Cristiana Catella, PhD, Livia Bodnar

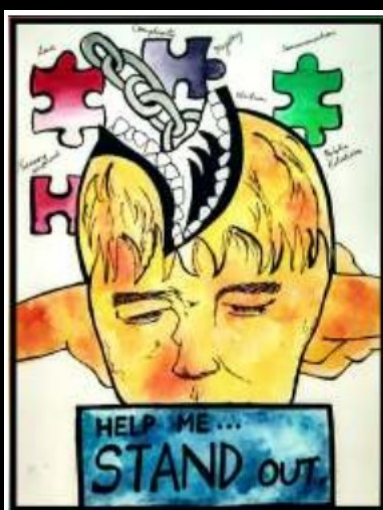
Some *Staphylococcus aureus* bacteria are referred to as MRSA since they are resistant to methicillin and other antibiotics. These "superbugs" are real threats to human and animal health. *Staphylococci* possess an enzyme, called catalase, which converts hydrogen peroxide into water and oxygen. In particular, the MRSA isolated in our lab was grown on agar and then treated with hydrogen peroxide to produce a foam (i.e., oxygen production). The catalase-positive MRSA was therefore used to evoke a beer through its image. Our piece of Agar Art took inspiration from the scientist and philosopher Alfred Korzybski ("The map is not the territory it represents," 1931) and from the surrealist painter René Magritte who drew a pipe with the caption *Ceci n'est pas une pipe* meaning that the image of the pipe is not a pipe (The Treachery of Images, 1928-1929). The work presented here stems from a simple catalase reaction; nonetheless it expands Korzybski's and Magritte's work to the bacterial world. It also represents our attempt to reach a synthesis between Science and Abstraction, Metalanguage and Microbiology. The Agar Art plate was prepared during a Microbiology Class addressed to High School Students from Liceo Enrico Fermi and Liceo Gaetano Salvemini, Bari, Italy.



People's Choice, "Bacterial Shadow of Wolf," Barış Halaç, DVM, Sevgin Can

Bacteria can produce biofilm formation when they are under threat, like hostile immune system, in order to protect themselves from harmful conditions. When it happens, a differentiation of the gene regulation reflects as a change in behaviour. To this end, individuals must behave not only for their but also the group's benefits. Some members of the company don't make an effort for the construction of biofilm but they still bask protection of it. This strategy is seen in wolves that hunt together. When the game begins, some wolves are more active to get the prey and take more risks, whereas the others spend less energy, but at the end, all members of the pack share the food.

Some of the Online Competition Entries



Some of the Online Competition Entries



DIVISION OF MEDICAL HUMANITIES

DR. Manu V. L. KOTHARI CHAIR OF MEDICAL HUMANITIES

Summary of activities in 2017

First Anniversary Program-January 24th,2017

The first Annual Day was celebrated on Tuesday, 24th January 2017 with a Poetry Program – “Reading and understanding poetry” by Dr. Gieve Patel, Poet, Playwright, Painter as well as a practicing physician. The session was Chaired by Dr. Farokh Udwadia, an eminent physician from Breach Candy Hospital.

The Annual Report of the activities of Dr. Manu V.L. Kothari Chair of Medical Humanities and Division was released in a booklet form*. An audio visual projection of our activities was prepared by Ms. Pallavi Sutar (II/I year student) and was presented by Dr. Padmaja Samant.

Dr. Smrati Bajpai introduced Chairperson Dr. Farokh Udwadia and Guest Speaker Dr. Gieve Patel. They were welcomed with flowers.

The program started with introductory speech of Dr. Farokh Udwadia describing the importance of arts in the making of a complete human and physician. Dr. Gieve Patel then read out poems from different cultures in the 20th Century.

The poems had been e-mailed to members of the audience in advance. We had an enthusiastic audience of teachers, students and friends of Medical Humanities. They actively participated in discussion. At Dr. Udwadia's suggestion, Dr. Patel read out each poem and followed it by his commentary and discussion by the audience before proceeding to the next poem. This enabled adequate discussion with the poem still fresh in the minds of the listeners.

Dr. Gieve Patel complimented the students on their rapt attention and concentration during his recitation of each poem and his subsequent commentary.

Dr. Udwadia recited parts of T S Eliot's The Wasteland from memory. The final poem depicting the soldier's sentiments was especially appreciated.

Poems read out by Dr. Patel are as follows:

“Heart of Ruin” and “The Butterfly” from Jejuri by Shri Arun Kolatkar. India. 20th Century

“Villon's Epitaph” Robert Lowell (translator) from the French. Author: Francois Villon. France. 14th Century

“Fear No Fall” by A. K. Ramanujan, India. 20th Century

“In the woods”. Poems from Anna Akhmatova. Russian 20th Century translated by Lynn Coffin

“The Literary Life” From 'Birthday Letters' (1998) By Ted Hughes Britain. 20th Century

In his concluding remarks Dr. Farokh Udwadia mentioned that Dr.Manu Kothari Chair of Medical Humanities aims at inculcating in undergraduate and post-graduate medical students humanity, ethics, a love for philosophy and the arts and, whilst enriching their lives, simultaneously help them treat their patients with empathy and kindness.

Dr. Sunil Pandya expressed a hope that in coming future the division will expand into a full-fledged department having full time staff members. It is likely that Medical Council of India (or its replacement) and Maharashtra University of Health Sciences are going to introduce Humanities in medical curriculum. Our endeavor should be to anticipate this.

The program concluded with vote of thanks by Dr. Nandini Dave. Dr. Supe, Dean (G&K) and Director (ME &MH) provided consistent support and encouragement.

*The booklet was handed over to the guests, invited audience and has also been sent to all the participants of Palliative Care Workshop, GAA, MH (give full forms) committee members and the donors to the Chair.

February 2017

The movie WIT was shown on 22nd Feb. 2017. Ms. Meherin, IInd/Ist student made the arrangements for this projection. Dr. Arnav Tongaonkar introduced the film to the audience. (Give the name here), Principal, Nursing School, along with her students in large number attended the program. Dr. Parkar summed up that doctors and nursing staff can be kind to patients without getting emotionally involved. Respecting sentiments of living person whilst attending to various aspects of medical treatment is important. We hope to show it once again for our medical students.

March 1st-4th Orientation program of interns

The movie WIT was projected as part of Orientation Program for new interns on 1st March at 1.00 p.m. in Theatre- 4. Dr. Arnav made extempore introduction why a medico should see the film and what he learnt from it. There was an extensive interactive session with interns. Dr. Sunil Pandya conducted the session.

On 5th March 2017 as part of Orientation program, a lecture of Dr. Nandini Vallath on “Palliative Care” was arranged under the aegis of Dr. Manu V. L. Kothari Chair of Medical Humanities. Dr. Tushar Shah with his wit introduced in a very lighter way dos and don'ts and how to do and not to do when they begin internship very next day. Dr. Nandini continued with her orientation to Palliative Care for chronically non-reversible illness of afflicted patients. This was held in S.M.Merchant Auditorium, Wadia Children Hospital from 9.30 a.m. to 12.30 p.m.

March 18th Lecture by Dr.Anand Nadkarni to 1st year students- (enclosed Power point presentation & Photographs) in MLT from 1.30 to 3.30 p.m.

Dr.Anand Nadkarni gave a talk on “CCD- college, campus and discovery” on 18th March 2017 to 1st year entrants. His talk brought out how to cope up with change in phase of their life as well as subsequently when they enter the world of medical practice. There was a question answer session after the talk.

March 30th Lecture by Dr.Nandini Vallath on “Graceful Ageing” to 1st year students in Physiology Lecture Theatre No.5,

From 9.30 a.m. to 10.30a.m. Dr.Bharat Patel, Assistant Professor of Physiology talked on Physiology of Ageing as part of Physiology curriculum to 1st MBBS students. In addition from 10.30 a.m. to 11.30a.m., as part of Humanity Program, Dr.Nandini Vallath continued on the topic of “Graceful Ageing”.

April 19th at 1.15 p.m. lecture by Dr.Nupur Kapur-Nerurkar in Anatomy Hall to 3rd year students on “Voice Matters”

Dr. Nupur Kapur-Nerurkar, Consultant Phonosurgeon of Bombay Hospital – addressed 3rd year students on the subject “your voice matters”. She explained that the term phonosurgery denotes restoration of voice by using various surgical techniques. Human voice acts as primary instrument to project our personalities in the society. She explained each aspect with example slides and made lecture interesting. Voice problems may arise from laryngeal or systemic disease or trauma or misuse. This surgery which includes phonomicrosurgery of the vocal folds done through an endoscope. It is highly specialized surgery to improve voice. She explained every aspect diagnosis, treatment and prevention. The lecture was very well received by students. This operation is required when the patient undergoes gender change to match the voice with the change in the external characters.

April 21st at 4.00 p.m. in MLT. Lecture by Mr.Azhar Tyabji on “Medicine in Art” for students.

Mr.Azhar Tyabji, anthropologist ..in the form of slide presentation of paintings sensitized the medical students to medical diseases as seen by some of the renowned artists of Europe to have humane approach to the patients.

May 2017- No programs due to vacation and exams.

June 2017- Movie ventilator was screened at MET Dome hall , college terrace on 28.6.17 at 1.30 pm, residents from clinical pharmacology , anesthesia, medicine , and

gynaecology attended it along with faculty. Dr Sujata Patwardhan Head of Urology dept. was invited for discussion. She gave an insight about the wrong portrayal of organ donation and brain death in the movie and she felt that such things have a negative impact on society at large so makers should have been careful about the same. Later other aspects like brain death, ICU issues, spiritual help , end of life decisions and respect for relatives privacy at time of grief were addressed. It was felt that such movie screenings followed by discussions are great medium of medical education and should be followed in future as well. Dr. Smrati Bajpai and Dr. Urmila Thatte organized the program. Photographs of program attached.

July 2017 – Conference “Ascension” – first ever conference on “Medical Humanities” organized enthusiastically by students and staff.

Forthcoming events - August 2017- 18th August 2017 – Performance Poetry by Dr. Tushar Shah

Sept. 2017 - Book review “Being mortal” and workshop on Geriatric Care by Dr. Shenavi, Dr. Salagre along with Dr. Nandini Vallath

10th Oct. 2017 – Manusmriti – Guest speaker -Dr.Shirish Sheth

Nov. 2017- Stroke Caretaker Workshop

Dec. 2017- Movie “Waiting”

Front Cover The Doctor : History of the painting

Painter: Sir Luke Fildes', Tate Gallery, London.

He is watching over an impoverished labourer's sick child; the bed is makeshift, two non-matching chairs pushed together; the cottage interior humble, befitting the labourer's status. The central figure is the imposing male doctor, gazing intently at his patient, while in the background the father looks on helplessly his hand on the shoulders of his tearful wife. The doctor is observing the 'crisis' of the child's illness, the critical stage in pre-antibiotic days when the patient is no longer overwhelmed by infection. The breaking light of dawn on the child's face suggests the crisis is over and that recovery is possible. Fildes' skilful use of light and perspective focuses the eye on the doctor, the patient, and the relationship between them. The child's parents are peripheral, almost irrelevant, the father is watchful but disempowered by the presence of the expert, and the mother, in a stereotypically female role, is collapsed but accepting succour from the hand of the more powerful male. 'The doctor broods, and in truth there was very little more he could do; he was almost as helpless as the parent only 6 feet and three or four social classes away'

**DR M. V. L. KOTHARI CHAIR OF MEDICAL HUMANITIES
AND DIVISION OF MEDICAL HUMANITIES
- CORE COMMITTEE -**



Dr Padmaja Samant

Ascension is a unique event where medical teachers, students and private practitioners will come together to explore contribution of arts and humanities to medical education and practice. It is an interesting blend of art and literature contributed by students, and deliberations on contributor of humanities to medicine by teachers.



Dr Urmila Thatte

"To most physicians, my illness is a routine incident in their rounds, while for me it's the crisis of my life. I would feel better if I had a doctor who at least perceived this incongruity"
– Anatole Broyard (Former New York Times critic)



Dr Santosh Salagre

"Medical education with blend of science, philosophy, literature, religion, art, music, history and language creates humane doctors."

Dr Santosh Salagre



Dr Smrati Bajpai Tiwari

"Cure sometimes, treat often, comfort / care always "

Hippocrates

Dr Smrati Bajpai Tiwari



Dr Nandani Dave

In an age of increasing emphasis on science, technology and evidence based medicine, I see medical humanities as a link, a reminder to the forgotten "art" of healing.



Dr Sandhya Kamat

"A good physician perceives the patients suffering as his own and strives to ease it compassionately."

Dr Sandhya Kamat



Dr Nandini Vallath

Humanity, thou art the mother of Medicine!

Dr Nandini Vallath



Dr. Mridula Solanki

Medical humanities in medical education & practice will help create compassionate doctors who will practice this profession understanding the health needs of their patients while respecting their dignity

Dr Mridula Solanki



Ms. Gulserene Dastur

"The aim of Medical Humanities is to enable practitioners to genuinely heal their patients (rather than just eliminating their symptoms) by arming themselves with the tool of respect: regard and understanding for mind and soul as well as the body."



Dr Ravi Ramkantan

"Care not just Cure"

Dr Ravi Ramkantan

Dr M V L Kothari Chair of Medical Humanities



Dr. Avinash Supe
Dean & Director



Dr. Sunil Pandya
Chairperson



Dr Ravi Ramkantan
Advisor



Dr Lopa Mehta
Advisor

Advisory Board	
Dr. Sunil Pandya–Chairperson	
Dr. Avinash Supe –Dean & Director	Dr. Lopa Mehta
Dr. Ashok Vaidya	Ms Gulserene Dastoor
Dr. Dinesh Daftary	Dr. Rajesh Parikh
Dr. Jyotiben Kothari	Dr. Vikram Kamdar
Dr. Vatsal Kothari	Dr. Nila Vora
Dr. Minal Kothari	

Dr.
Dr.
Dr.
Dr.
Dr.
Dr.
Dr. Mridula Solanki
Dr. Nandini Vallath
Ms. Gulserene Dastur

ittee
Dr.
Dr.
Dr.
RD

Student Organizing Committee Ascension 2017



Mehreen Mir



Nikit Kothale



Devi Bavishi



Devanshi Shah



Swastika Lamture

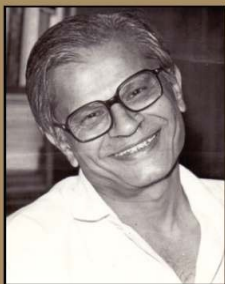


Manan Boob



Niladri Mishra

Cover page painting courtesy: Sir Luke Fildes (Tate Gallery)



A TRIBUTE TO DR. MANU V L KOTHARI

Dr. MVLK Chair Of Medical Humanities

Dr. Manu Kothari, a learned scholar, committed academician, most loved teacher by students, a medical philosopher, an author of many books (translated in many languages) and national and international publications on topics like Cancer, death, medical philosophy etc., worked for the institution from the day of joining the institution as a student till his last breath at the age of 79 on 16th October 2014. He was highly respected amongst students, teachers, medical fraternity – nationally and internationally. When he was a medical student, a clinical sign named after him appeared in Hamilton Bailey's highly respected Text Book of Surgery. Dr. Kothari served as the Chairman of the institutions' Ethics Committee for over 20 years till the year 2012. He was a friend, philosopher and guide for one and all – all categories of staff – teaching and non-teaching and students, undergraduates and postgraduates.

Dr. Manu Kothari has left behind countless students who treasure his thoughts and behaviour and their experiences of association with him. In the remembrance event held in honour of Dr. Manu Kothari, Ex-Head of Department of Anatomy at Seth G. S. Medical College held on Saturday, 18th October 2014 medical teachers from all over Mumbai decided to institute a Chair of Medical Philosophy/Humanities in the name of Dr. Manu V. L. Kothari as the best way to nurture his philosophy in these institutions. The suggestion was accepted unanimously. The medical fraternity present felt the need to bring the humanities back into the medical sciences. Although this subject is clearly mentioned in the syllabus of MCI, its implementation is less than desired. It is the necessity of the hour to revive this subject and sensitise our young doctors into implementing it in their medical practice.



SETH GORDHANDAS SUNDERDAS MEDICAL COLLEGE AND KING EDWARD MEMORIAL HOSPITAL
ESTD. 1926

ACHARYA DHONDE MARG, PAREL, MUMBAI - 400012

E MAIL : nostalgia@kem.edu
ascensiongsmc@gmail.com

WEBSITE : WWW.GOSUMEC.COM