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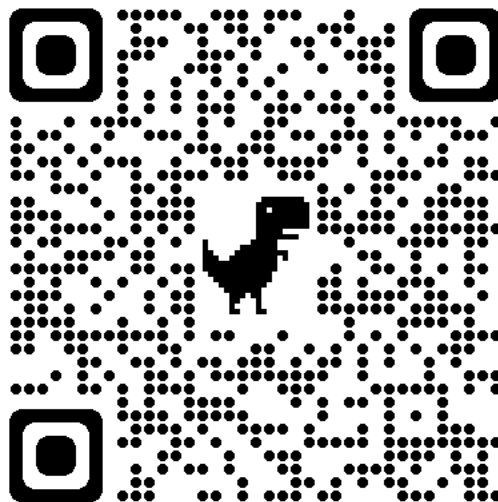
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CURRENT EVENTS

Written works that describe a situation in modern medicine and its overall impact on the Texan population.

Lost in Translation

Trevor Murphy, Jeff Bowcutt

The University of Texas Medical Branch—John Sealy School of Medicine

“Listen to your patient, he is telling you the diagnosis.”

These words, spoken over 100 years ago by William Osler, show the integral role that communication plays in the role of a physician. Osler is widely regarded as the father of modern medicine and known to have been a master diagnostician. In 1975 Hampton et. al. showed that 83% of diagnoses were made based on the patient history. This gave tangible validation to the words Osler spoke almost a century before and shows the invaluable role that the patient’s story has in uncovering their underlying diagnosis.

Medicine, however, has dramatically changed since Hampton’s findings. Gone are the days of the stethoscope being a physician’s sole diagnostic tool. We live in an era where physicians have access to a seemingly endless quantity of information from X-rays, MRIs, CT & PET scans, ultrasound, laboratory tests, ECGs, pharmacogenetics, etc. In a medical world so vastly different from that of Osler’s, do his words still ring true?

Current medical research responds to that question with a resounding “Yes.”

The patient history holds a unique place in the medical professional’s toolbelt. Unlike a lab or imaging study, the usefulness of a patient history is directly related to their ability to elicit valuable information through effective communication.

Thus, communication is at the heart of the role of health care professionals. As medicine continues its path toward a patient-centered care model, a physician’s ability to understand their patients and appropriately convey information to them is becoming increasingly important.

Effective patient-physician communication, however, is no simple task. It requires the interplay of non-verbal communication, word choice, and a mutual understanding of the connotations of words, phrases, and even diseases. Most of the interpersonal communication training that medical professionals receive focuses on non-verbal communication and word choice. Leaving cultural understanding as a side note that is scarcely, if ever, mentioned. This is astonishing because research has shown time and time again that cultural humility and interpersonal communication are not separate ideas (Lekas et al., 2020; Prasad, e. al., 2016). Rather, they are inextricably connected concepts that lead to increased empathy and connection with patients.

--

"Your blood pressure looks high again this time, Mr. Nguyen. It's high enough now that you fall into the range of hypertension. I'd like to start you on a medication to help control your hypertension. Does that sound okay with you?"

--

Physicians can plan on having conversations like the one above with patients many times in their career. As of 2020, 1 in every 2 Americans over the age of 20 have hypertension. It is a common and straightforward diagnosis based on the criteria set out by the ACC/AHA. If a patient's blood pressure is over 130/80, then they have hypertension (Whelton et al., 2018). Ask any physician, PA, nurse, or medical student what it means for a patient to have hypertension, and they would say "they have a high blood pressure." Even many patients themselves understand what hypertension is. Or at least they say they do.

--

"Thanks Doc, lots of people in my family have hypertension, must run in the family. I'm happy to start taking the meds if you think they'll help me feel better. Work has been really stressful lately; I really should start looking into retirement."

--

Both the doctor and the patient walk away from this encounter feeling like the other understands what they were trying to say. But do they really?

A research group interviewed one hundred and seventeen patients with hypertension in order to gain insight into what they understood about their diagnosis (Blumhagen, 1980). The results? 72% of the patients said that hypertension was best described as "a physical illness characterized by excessive nervousness caused by untoward social stress." They went on to give accounts of how being in this hyper-tense state led to social anxiety and problems at work. To these patients, hypertension was a catch-all term for an ambiguous amalgamation of physical, emotional, and social symptoms. The patients' understanding of hypertension varied based on age, ethnicity, and socioeconomic status. The rift between the words a physician speaks and what they mean to a patient can be shocking.

The Hippocratic Oath systemized physicians' duty to "apply, for the benefit of the sick, all measures that are required." One of the most important measures for the benefit of the sick is ensuring there is open and clear communication with patients. Physicians bear the responsibility of ensuring that their patients accurately understand their medical diagnoses and treatment plans. This ethical commitment emphasizes the significance of tailoring information to the patient's level of understanding, involving them in decision-making, and addressing any concerns they may have.

In a world where we have access to limitless tests, labs, imaging, and scans, let us not forget the words of Osler. Let us properly elicit, engage with, and listen to our patients' stories. Let us work to understand where our patients are coming from. Let us respect and protect the uniqueness of the human family. Let us do all this so that when they tell us their diagnosis, their words fall on ears ready to understand, treat, and heal.

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STUDENT LED RESEARCH

A collection of research submitted by healthcare students. Each research submission has been edited by local experts.

A 44-Year-Old Man with a Sore Throat and Vesicular Rash

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Abstract

Mpox (formerly known as monkeypox) is a rare viral disease with a presentation similar to smallpox, caused by the mpox virus (MPXV). Mpox outbreaks have been reported in Africa, and there have been sporadic cases in other parts of the world, including the United States. Immunocompromised individuals, including those with HIV, are at greater risk for more severe disease. Here we present a case of a 44-year-old HIV-positive male with a recent history of sexual activity with other men, who presented with tonsillitis and a vesicular rash. The presentation was highly concerning for mpox, and a PCR test ultimately returned positive for the mpox virus. The patient was started on supportive care, antibiotics, and antiviral therapy.

Introduction

Mpox is a rare viral disease caused by the monkeypox virus (MPXV), a member of the orthopoxvirus genus, which also includes the variola virus (the causative agent of smallpox) and vaccinia virus (the virus used in the smallpox vaccine).¹ Mpox is endemic to Central and West Africa, where sporadic outbreaks occur.² In 2022, the virus caused outbreaks in non-endemic countries including the United States.^{3,4} Mpox can present with symptoms similar to smallpox, including fever, rash, and vesicles. The disease can also present in immunocompromised individuals, including those with HIV, who are more susceptible to severe disease.⁴ Between May 17 and July 22 of 2022, eight health departments in the United States reported to the Centers for Disease Control and Prevention (CDC) a total of 1,969 individuals with mpox, of which 38% had previously been infected with HIV. Many of these individuals were found to have prior sexually transmitted infections.³ Complications of mpox can include sepsis, encephalitis, bronchopneumonia, myopericarditis, complications associated with mucosal lesions, and infection of the cornea resulting in possible vision loss.²

Diagnosis of mpox can be challenging, as it presents similarly to other viral illnesses such as chickenpox and herpes simplex.⁵ However, early recognition and prompt isolation of suspected cases can help prevent the spread of this disease.¹ Treatment is primarily supportive management of symptoms and prevention of secondary bacterial infections.^{5,6,7} Antiviral therapies tecovirimat, cidofovir, and brincidofovir have also been used with some success in treating severe cases.⁸

More recently, in Feb of 2023, the CDC released and updated its guidelines regarding treatment of mpox.⁸ Prior to the 2022 outbreak, there was little information known about the efficacy of some newer mpox vaccines, although there was a general understanding that prior existing smallpox vaccines would have some vaccine efficacy for mpox.⁹ Overall, clinicians must maintain a high level of suspicion for mpox, as it can have significant public health implications.³

Case Presentation

A 44-year-old male with a past medical history of HIV, who had been off antiretroviral therapy for one month with a CD4 count of 269, presented to the emergency department with a chief complaint of a sore throat. The patient reported that the sore throat had begun five days prior to admission and had steadily worsened to the point where he was unable to tolerate food or liquids due to severe pain with swallowing. Around the same time, the patient also developed a diffuse non-pruritic non-painful vesicular rash which was located on all his extremities, his groin, his abdomen, and throughout his face (Figure 2). About two days prior to admission, the patient developed subjective fevers and painful lymphadenopathy in his neck. The patient had two sexual encounters consisting of receptive oral and anal intercourse with other men in the month prior to symptom onset.

The patient was alert, oriented to person, place, and time, and was afebrile throughout the entire admission. Examination of his pharynx revealed the presence of bilateral inflamed tonsillar exudates (Figure 1). An examination of his neck showed tender lymphadenopathy. Examination of his skin showed a diffuse vesiculopustular rash in various stages of healing located on his extremities, his groin region, and his face.

CT imaging of his neck was performed which showed significant bilateral tonsillar edema concerning for a pharyngeal abscess and bilateral jugular chain lymphadenopathy (Figure 3). The initial complete blood cell count revealed an elevated white blood cell count of 15.8 WBC's/microliter (reference range: 4.5-11.0 x 10⁹/L) with atypical lymphocytosis of 18.0%. The WBC trend is shown in Table 1. Subsequent peripheral blood smear showed mild leukocytosis with an increased number of neutrophils and few variant lymphocytes favoring a reactive picture. It also showed macrocytic anemia.

Given these findings of tonsillitis and a vesicular rash, the patient's differential diagnosis included infectious mononucleosis, group A streptococcal pharyngitis, gonococcal tonsillitis with the possibility of disseminated infection, mpox, herpes simplex virus infection, and varicella-zoster virus infection.

Supportive care with intravenous fluids, topical throat analgesics, antibiotics, and antiemetics was the mainstay of the patient's treatment. On the first day of admission, the patient was started on ceftriaxone to treat for potential bacterial versus gonorrhea/chlamydia cause of tonsillitis. Throat culture was negative for group A streptococcus, and urine nucleic acid amplification test (NAAT) was negative for chlamydia and gonorrhea. However, no oropharyngeal or rectal swabs testing for gonorrhea/chlamydia were taken. The patient was also not tested for syphilis at this time.

Treatment for HIV was restarted. The patient was given two days of methylprednisolone to reduce inflammation in his pharynx. He was not treated with additional antiviral medications such as cidofovir or brincidofovir due to the low concern of severe complications in his case. As this patient presented in August off 2022, CDC recommendations for antivirals were not yet solidified, and obtaining tecovirimat for the patient proved difficult. The patient's odynophagia had begun to improve and the day after the patient was discharged, the mpox PCR swab from the patient's oropharynx was obtained in the emergency department returned positive. Unfortunately, little is known about the long-term outcome of this patient as the patient was lost to follow-up.

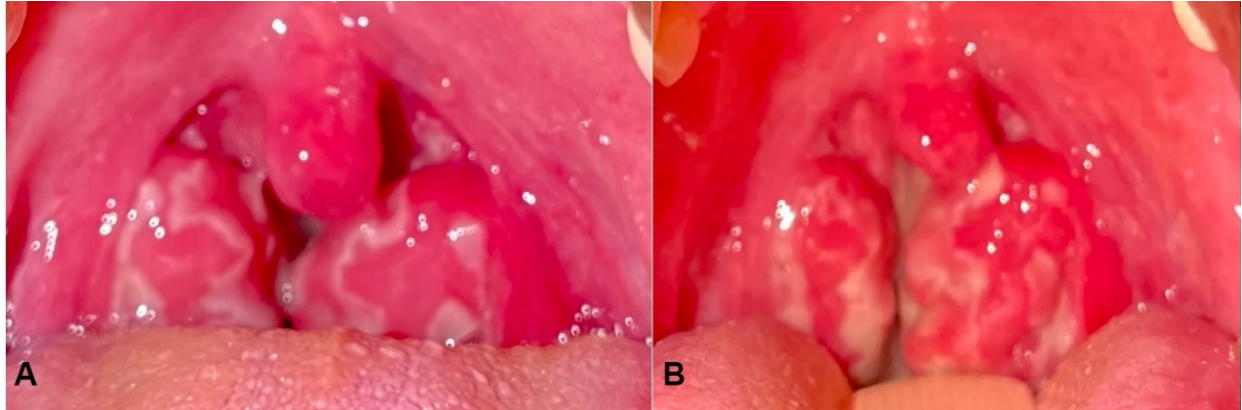


Figure 1. The appearance of tonsils on Day 1(A) and Day 2(B) of admission.



Figure 2. Mpox skin lesions on chest, arm, hands, back, thigh, and knees. Discrete nodules on an erythematous base.

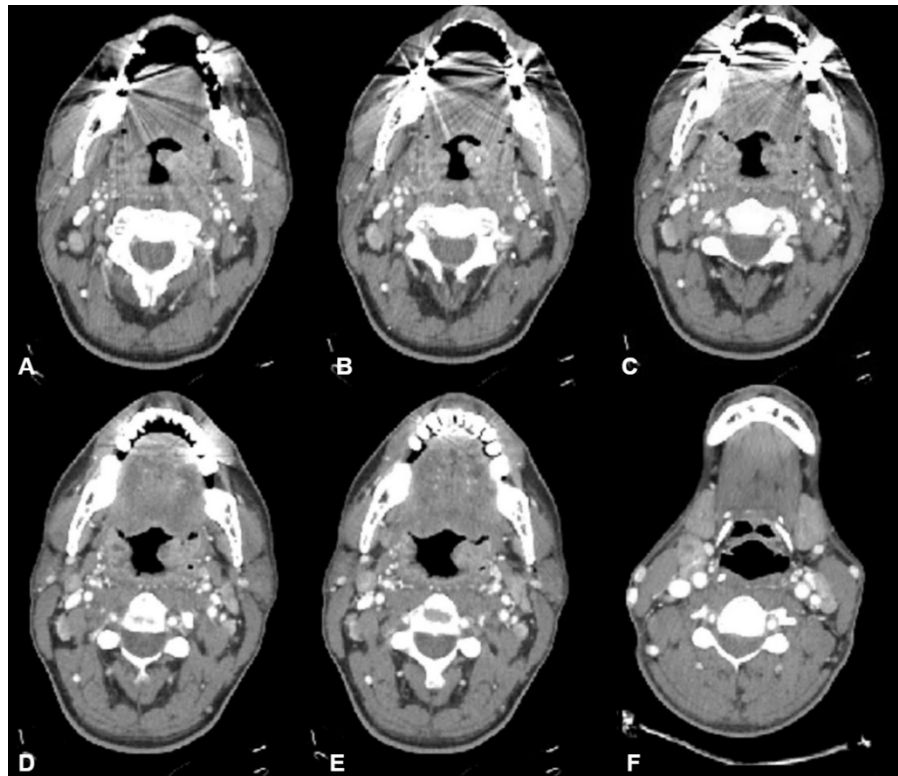


Figure 3. Superior to inferior axial sections of computed tomography of neck with contrast. Mild increased swelling of the left tonsil compared to the right (A - E). Similar heterogeneous appearance of both tonsils suggesting inflammation/microabscesses. No fluid collection amenable to drainage. Bilateral jugular chain lymphadenopathy (F).

Admission Day	1	2	3	4	5
WBC	15.8	13.5	12.9	10.4	8.5

Table 1. White blood cell (WBC) count trend.

Discussion

This case report presents a unique and rare instance of tonsillitis secondary to the Monkeypox virus, with detailed images documenting the clinical presentation. To our knowledge, this is the only published case report in the PubMed database that includes visual evidence of tonsillitis caused by the monkeypox virus, emphasizing the scarcity of this symptom in affected patients. While two other published case reports have mentioned tonsillitis as an early symptom of mpox, neither provided supporting images of the tonsillitis as seen in this case.^{10,11} The addition of these images serves to enhance the medical community's understanding of mpox's diverse presentation and contributes to our collective knowledge of the various ways the virus can manifest.

Taxonomy and Virology

The mpox virus is a double-stranded DNA virus belonging to the orthopoxvirus genus, a group that also includes the agents of smallpox (variola virus) and cowpox (vaccinia virus).^{12,13,14} Electron microscopy and genomic analysis led to two distinct clades of monkeypox virus: the Central African and West African clades, with the former being associated with more severe disease in humans, including higher case-fatality rates and increased lesion counts.^{14,15,16}

Epidemiology

The disease is primarily found in Central and West Africa, with sporadic outbreaks occurring in remote forested areas of countries like the Democratic Republic of Congo (DRC), Nigeria, the Republic of Congo, and the Central African Republic.¹⁵ Recent data suggest that the incidence of mpox is increasing in certain areas, possibly due to waning smallpox vaccination-induced immunity in the population, as the vaccination campaign concluded during the 1970's.¹⁷

Mode of Transmission

The primary reservoirs of the virus are believed to be rodents, particularly rope squirrels and dormice, and non-human primates.¹ Human-to-human transmission is also possible, primarily via respiratory droplets and direct contact with skin lesions, fomites, or contaminated materials, such as bedding and clothing.² More recently, there have been emerging reports of sexual transmission of mpox. Another case report in Nigeria described a similar scenario where a man transmitted the virus to his wife via sexual contact after having recovered from mpox two weeks prior.¹⁸ Physicians should be aware of this mode of transmission when evaluating patients with potential exposure, counsel them on the importance of abstaining from sexual contact until complete healing, and promote safe sex practices, such as consistent condom use.

Clinical Presentation

Patients with mpox often present with fever, headache, myalgia, and a characteristic vesicular rash.² In some cases, tonsillitis could be an initial presentation, which could complicate the differential diagnosis, as infections like streptococcal pharyngitis, infectious mononucleosis (caused by Epstein-Barr virus or cytomegalovirus), or herpangina (caused by Coxsackie A virus) may present similarly.¹⁹ Physicians should include mpox in the differential diagnosis for tonsillitis when assessing patients with compatible epidemiological and clinical features.

Treatment

Currently, for milder cases, there are no specific antiviral treatments that are recommended outside of clinical trials.^{8,20} The management of the disease involves supportive care, such as maintaining hydration, pain relief, and prevention of secondary bacterial infections.² For severe cases, the use of the antiviral medications tecovirimat, cidofovir, and brincidofovir may be recommended, with tecovirimat being considered the modern recommended treatment for the majority of severe cases.⁸ Physicians should be prepared to manage cases with supportive care, as well as consider use of antivirals and/or IV immunoglobulins for severe cases while monitoring for potential side effects.

Prevention

In 2018, the United States Centers for Disease Control and Prevention (CDC) recommended the use of a third-generation smallpox vaccine, Imvamune (JYNNEOS), for emergency use in the event of an outbreak in the United States. This vaccine, which is replication incompetent, has a better safety profile than replication-competent vaccine ACAM2000.²¹ We now know the two-dose series of Imvamune, a live-attenuated non-replicating vaccinia virus vaccine has a vaccine efficacy of approximately 86%, with peak immunity being provided fourteen days after the second dose.⁹ Public health measures, such as raising awareness about the disease, promoting safer sexual practices, promoting safe handling of animals and bushmeat, and implementing infection control practices during outbreaks, are crucial in preventing the spread of mpox.^{4,16} Physicians are encouraged to collaborate with public health authorities to implement appropriate preventive measures and contribute to the management of potential outbreaks.

Disclaimer

This research was supported (in whole or in part) by HCA Healthcare and/or an HCA Healthcare affiliated entity. The views expressed in this publication represent those of the author(s) and do not necessarily represent the official views of HCA Healthcare or any of its affiliated entities.

Consent Statement

The authors of this case study received consent from the patient for presentation of this information as well as the presentation of all images/photos provided.

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Erector Spinae Plane Block Utilizing Liposomal Bupivacaine in Pediatric Cardiac Surgery: A Case Report

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³ Baylor College of Medicine & Texas Children's Hospital

Abstract

Erector spinae plane blocks (ESPBs) have become more popular in cardiothoracic surgeries due to their safety, execution simplicity and efficient pain relief.¹ ESPBs utilizing the long-acting liposomal form of bupivacaine have shown promise in the reduction of prolonged pain and opioid use both during and after surgery.² Nonetheless, the use of liposomal bupivacaine in ESPBs in pediatric cardiothoracic surgeries remains minimally explored.³ In this case, an ESPB with liposomal bupivacaine was used on a pediatric patient undergoing coronary artery unroofing on cardiopulmonary bypass with the goal to reduce postoperative opioid requirements and pain scores.

Methods

A seven-year-old male with a history of an anomalous left coronary artery arising from the right sinus of Valsalva underwent coronary artery unroofing on cardiopulmonary bypass. Before surgery, bilateral ESPBs utilizing 1.3% liposomal bupivacaine (3 mg/kg or 108 mg) and 0.25% plain bupivacaine (2 mg/kg or 73 mg) were performed at the 5th thoracic vertebrae with the guidance of ultrasound (Figure 1). After the operation was completed, a field block, using a combination of 0.25% plain bupivacaine (0.25 mg/kg or 9 mg) and 1.3% liposomal bupivacaine (1 mg/kg or 36 mg), was performed at the chest tube site. Post-operative pain scores, along with intraoperative and postoperative opioid consumption, were recorded within the first 48 hours.

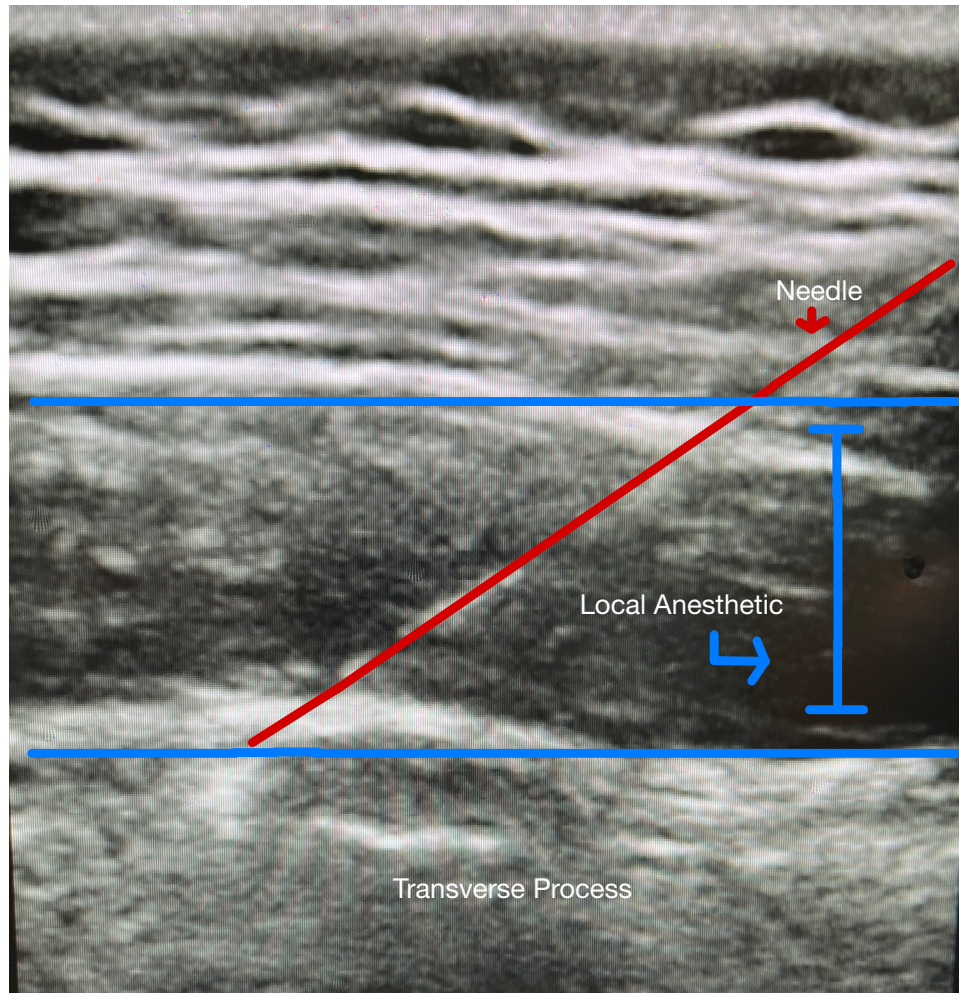


Figure 1. ultrasound-guided ESPB block.

Results

A total of 175 μg fentanyl ($4.9 \mu\text{g}/\text{kg}$) was administered throughout the operation. Additionally, the patient received a rescue dose from the Nursing Controlled Analgesia (NCA) pump at the 3rd postoperative hour and a total of 5 doses until the 20th postoperative hour. After discontinuing the NCA pump, the patient required a single 1.82 mg dose of morphine at the 23rd postoperative hour. No other opioids were required thereafter. Post-operative pain scores ranged from 0 to 5, with an average of 1.0/10 (maximum pain score of 5) on day 1 and 0.7/10 (maximum pain score of 4) on day 2, as shown in Figure 2. In general, NCA doses were administered whenever pain scores showed an increase.

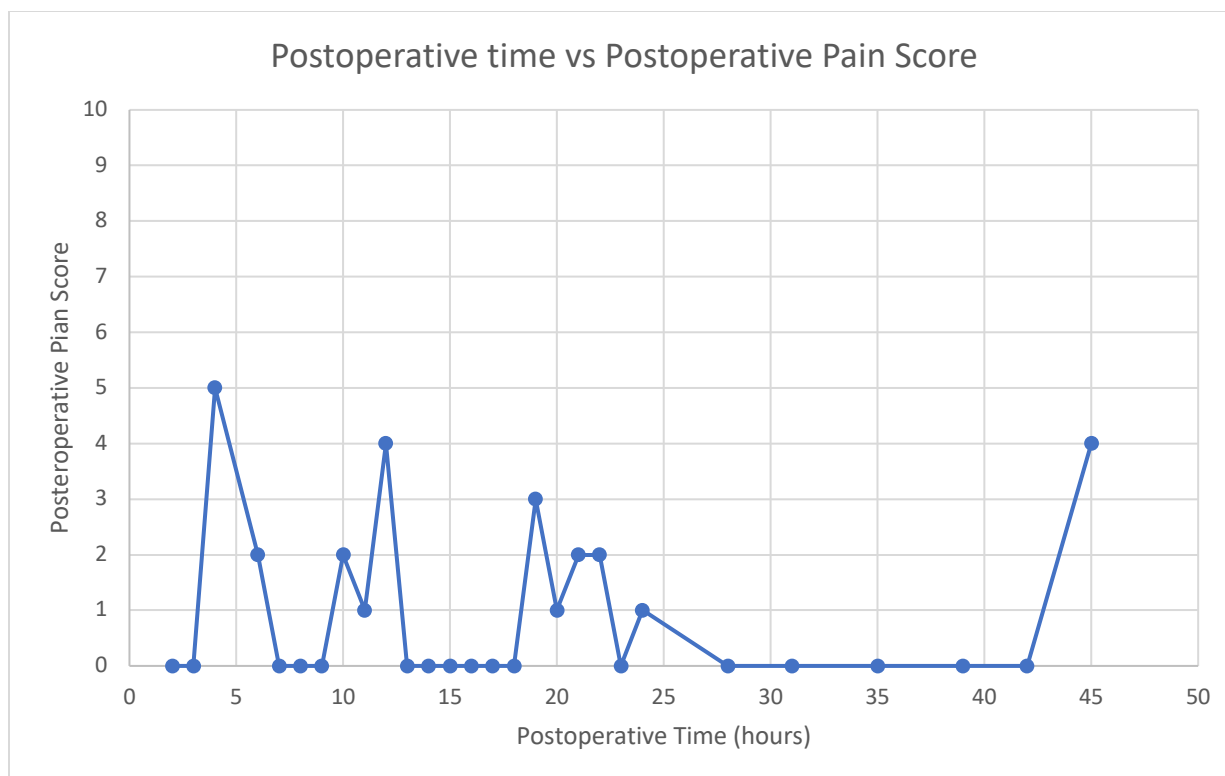


Figure 2. postoperative time vs. postoperative pain score chart for our patient.

Conclusion

In the realm of pediatric heart surgeries, ESPBs are a relatively new form of regional anesthesia, especially when using liposomal bupivacaine. Historically, many patients have required high intraoperative opioid doses, often within the range of 10-30 $\mu\text{g/kg}$ of fentanyl.⁴ However, in this case study, the patient required less than 5 $\mu\text{g/kg}$. Postoperatively, the patient experienced consistently low pain scores during the first two postoperative days, with minimal need for rescue opioids. The case study also demonstrated the potential of ESPBs to enhance postoperative recovery and reduce opioid-related side effects in pediatric heart surgery patients. Furthermore, as we learn more about this unique strategy it becomes clear that additional outcomes need to be evaluated. One aspect that could use unique investigation is measuring length of stay (LOS). Understanding how ESPBs with liposomal bupivacaine impact LOS compared to traditional opioid-based pain management could provide insight into potential economical and logistical advantages. Additional research is needed to gain a comprehensive understanding of the benefits and potential side effects of these blocks in this unique patient population.

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Brain Drain Within the Field of Academic Anesthesiology in Texas

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Abstract

Brain drain describes the emigration of highly educated professionals from resource deficient countries to wealthier ones.¹ This phenomenon profoundly impacts healthcare on a global scale, providing much-needed physician workforce to certain locations while depleting healthcare personnel in resource-limited regions.² Our study investigates the effects of this phenomenon on the field of academic anesthesiology in Texas. We hypothesize that the anesthesiology faculties of the state of Texas rely on the work of anesthesiologists that are foreign-trained international medical graduates (IMGs).

Methods

We compiled a list of anesthesiology residency programs in Texas, and identified the locations (countries, nations, and/or states) of faculty anesthesiologists' medical schools and residency programs. The number and residency locations of faculty anesthesiologists who had immigrated to the United States following their medical education abroad was recorded.

Results

Out of 289 faculty anesthesiologists included in the study's sample, 31 physicians (10.7%), are IMGs (Table 1). Asia contributed the largest number of physician faculty members, with 15 individuals (5.2% of total faculty). Of those faculty who attended medical school outside of the US, 23 (74.2%) completed residency outside of Texas (Table 2).³

Conclusion

This study supports the hypothesis that a considerable proportion of the anesthesiology faculty in the state of Texas qualify as international medical graduates. In addition to the experience they bring with them from their nations of origin, they possess diverse training backgrounds from across the United States. These clinicians play a vital role, not only in providing care to patients, but in educating future physician anesthesiologists. Moreover, it must be acknowledged that their contribution to our system comes at the expense of the many nations from which they hail, exacerbating the system of brain drain that further worsens global health inequality.

Country/Region (19)	
Asia	15
Azerbaijan	1
China	3
India	5
Jordan	1
Israel	1
Russia	1
Pakistan	3
Africa	3
South Africa	1
Egypt	1
Nigeria	1
North America	2
Mexico	2
South America	5
Peru	1
Argentina	1
Uruguay	1
Colombia	2
Europe	3
Belgium	1
Greece	2
Caribbean	3
Grenada	2
Sint Maarten	1
total	31
*3 International Medical Graduates were excluded because no information on their medical school was found	

Table 1. Distribution of IMG faculty anesthesiologists

Residency By State	27
New York	3
Louisiana	2
Ohio	3
DC*	1
Massachusetts	1
Florida	2
Arkansas	1
Virginia	1
Missouri	1
Pennsylvania	1
New Jersey	1
Georgia	1
Texas	8
Illinois	1
Residency By Country (2)	2
India	1
UK	1
total	29
*District of Columbia, included as equivalent to a state	
**5 doctors were excluded because no information on their residency was found	

Table 2. Residency distribution of IMG anesthesia faculty physicians

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CULTURE AND ART IN MEDICINE

Authors' full creative energy in the format of narrative medicine, opinion pieces, or poetry.

Raices en Medicina

Guillermo Saldana

University of Houston–Tilman J. Fertitta Family College of Medicine



A farm egg, aromatic herbs, and a sacred candle cleanse were my treatment that day—a practice in traditional Mexican medicine. Earlier, I was supposed to take my uncle some bean tacos for "strength" and a soda for "hydration" on my grandfather's donkey. On the way, the donkey was startled by a tarantula, and I fell to the ground. I had no injuries beyond a strained neck and nausea. Upon my return, my grandmother made me lie down on the patio, placed multiple candles around me, and rubbed my body with the egg and some herbs. I was to be cured of *susto* (fear). The egg was to absorb all the negative emotions, and the herbs were to rub evil spirits away, curing my nausea. My grandma also told me my neck pain was from *aire* (air) entering my tissues, and she prescribed me a warm shower and Mexican pomade. Within a couple of days, I felt better, but I was left with questions. How did "air" find its way inside my neck? How did this egg cure my nausea? This sparked my curiosity about the ability to heal.

Over a decade later I am grateful for my *gente*, my heritage, and the donkey who lit the fire inside of me to pursue medicine. There is no me without them, and no them without me; there is only us. *Vamos con todo menos con miedo.*

Slightly Less Silent

Navigating homophobia and transphobia in clinical settings

Maverick Graveworth
Medical Student at a Medical School in Texas

[Through the looking glass](#), I swam
Submerged in amniotic waters
Fed via the [umbilical vein](#) of medical dogma
Four years of studies and [servant leadership](#)

I have seen the growing pains of a root system that has forced cracks into my sidewalk
Medical Education shifting under my feet as I traverse the meaning of value and quality of life
A [root cause analysis](#) begs us to ask, “[why?](#)”
As was before so will be until we willingly leave comfort

I no longer wince at windshield-cracked skulls,
I can [approximate](#) borders of gashes and large holes with poise,
But I cannot close the systematic crevices that my patients fall between as I salvage
my energy to address the censorship of those perceived as weak

We survive in a system that calls people names that died long ago
[Residents](#), finding safety and power in the structures and systems where they reside;
In hospitals to [pimp](#) and be *pimped* at a [salary of 20 dollars an hour](#)
Earning the inheritance of quid pro quo education for captivity

Western Medicine bestows power through penance
We say we are going to change the face of medicine
To question a [hierarchy](#) as ancient as the hieroglyphs
So we masked our faces and walked straight into a wall

Built to separate us from the queer and those who speak different languages
Those who in their suffering ask, “why do you defend what is unholy?”
And in those moments, I hope we answer something other than “it was difficult to get here”
That we are so near to the title of “Doctor” that to risk truly being seen would be a liability

I fall back on my five senses, but most importantly my sixth:
“Will this best serve my patient?”
We are not police or juror
Thankfully, we only have ourselves to judge

So, before you mock the [queer](#):

Know that there is a generation of medicine coming that has nothing to lose

We have learned new languages and prefer a peaceful silence in the place of silent suffering

The first wail of a lion cub will waver

But even a novice poacher knows to fear its [bite](#)

Foot Soldiers of the Pandemic

Richard Hubbard, MD

Baylor College of Medicine and The Texas Children's Hospital

This war started as thunder
A slow rumble over the horizon
Punctuated by distant flashes of light

Then it came
A slow, creeping, unstoppable haze
More a figment of fantasy than reality
Moving ever closer

We stood in our trenches
Watching
Eyes Wide
Unknowing, Afraid
More for those at home than for ourselves

We scrounged what protection we could
Never enough
Always promised more
The first of many promises broken

And then we were in it
Fighting an enemy unseen
Surrounding us, enveloping us
Seeping into every crevice of life

Letters came from home
Full of praise and heroic words
But help remained elusive
Real sacrifice seemed too much for most, anathema to some

Courage gave way to fatigue
Fear was ground down to anger
Then rage
Then resignation
Then guilt

The war ebbed and flowed
Then flowed faster
It flows still

A war than did not have to be
Does not have to be
Yet remains

And what of us
The foot soldiers
We remain
Changed
But still willing

Loss and Clipboards

Christopher Richter
The University of Texas Medical Branch—John Sealy School of Medicine

snap

Upon the board are papers clipped.
A date, a name, a note, no time.
For ticks passed by are one less breath,
to save their life from grasps of death.

snap

Brought comfort though the pain is great.
New orders written, bottles filled.
More papers added to the fold,
as fate begins to grab ahold.

snap

Amidst the fight we lost ourselves.
Caregivers with less to give.
There's haunted visions of an empty bed.
A few last papers are the words unsaid.

snap

Bold colors fade to white and grey.
No fight is left, the struggle lost.
The heart done through without a tap.
Empty clipboard, I heard its snap.

Wondrous Abode

Adonai Paz

The University of Texas Medical Branch—John Sealy School of Medicine

Hills gleam in the distance,
Their majestic peaks
Adorn the barren lands.
It's another icy morning
For another clinic day
In rural West Texas.
While we tread for hours to each town,
There is nothing and no one,
But the remote and desolate mountains
Welcome us to the expanse.
Each day patients arrive
Seeking answers to their questions
cures for their ailments,
But most of all,
Curiosity for the strangers
Who've arrived from afar.
Each day we help as we can
Survivors in these isolated lands.
Here, medical care is a rare commodity.
As a medical student,
I fear I cannot help much,
But their "adios" and "gracias"
Express otherwise.
Smiles more often than not,
A product of mere conversations.
I learned so much and plan to return
As a physician one day
To the lands of these survivors.
A wondrous abode
of sepia plains and raging sierras.
Where dawn and dusk are announced
By the blushing sun concealed,
Behind colossal stones.

Worth It

Holly Hodge
Texas A&M University School of Medicine

A diagnosis missed
A slip of the hand
A heartbeat stopped
A human life gone too soon

Let me not be the reason
For a delay in diagnosis
For a wrong dosage
For a nicked nerve
For a lost loved one

Each and every day
We walk the thin line
Of harm and healing
Of life and death

Thousands and thousands
Of pages read
Wounds sutured and knots tied
Is it enough?

Thousands and thousands
Of patients seen
Histories taken
Diagnoses made

Let the years and years of practice
Of long days and nights
Let all the knowledge gleaned
Help me to be the reason for

An urgent diagnosis caught
A treatment plan made
A life touched
A patient saved
It was worth it

La Santa Muerte

Tristan A. Ibarra
Texas A&M University School of Medicine

Un panecito, un tequila
Y un puñito de monedas
Te traigo, mi flaquita,
En esta humilde ofrenda.
Te encomiendo mi ser,
La sangre de mis venas,
El pulso de mi corazón,
Para que me mantengas
A la lejanía del mar donde
Acaba el río de la vida
...

She is of a gentle caress,
A touch as soft as snow,
Wielding a silver instrument
And a long, hanging coat.
Her presence could be bad
Or the glinting sign of hope
Of a shimmering new day,
Namely, a healthy tomorrow.
But when she's there to endow,
On a more serious note,
Your possible conclusion,
Whether cinch or a throe,
You could always take refuge
in having already known:
She is of a gentle caress,
A touch as soft as snow.
...

Un panecito, un tequila
Y un puñito de monedas
Te traigo, mi flaquita,
En esta humilde ofrenda.

Brain Work

Jenny Li-Wang
Rice University

The door to Dr. Vaughn's office is open. Elaine peers out carefully from behind her new manager Caitlyn.

"Dr. Vaughn, this is Elaine," Caitlyn introduces, "our new medical assistant."

Dr. Vaughn immediately perks up from where she's scrunched around her computer.

"Oh, so nice to meet you!"

Elaine's first thought when she sees her is, *So this is the senior neurosurgeon that all the other surgeons get bullied by.* Her second thought: *Wow, she's so small.*

"It's nice to meet you too," Elaine murmurs reluctantly. She shakes her new boss's hand.

"Caitlyn says you're a stellar applicant. God knows we need competent people around here." Dr. Vaughn and Caitlyn share a look.

"Oh," Elaine says, unsure how to respond.

The doctor turns back to the screen and scrolls through her email. "Caitlyn tells me you want to go to medical school. Any particular specialty?"

"I think I'm interested in pediatric neurosurgery."

This isn't technically a lie. Elaine knows she wants to specialize in something surgical where she can work with kids. Neurosurgery is competitive, she knows, so she hopes to get ahead with clinical experience and, if this job goes well, the blessing of one of the most distinguished experts in the field.

Dr. Vaughn hums in approval. "This is the perfect place to learn. I'm not sure if Caitlyn told you, but our clinic is very high-volume. We get sent the most interesting cases in this hospital."

Elaine knows this already. Out of a desire to make a good impression, she obsessively Googled the physician yesterday and could recite the year Dr. Anne Vaughn graduated medical school, the titles of her most widely-read research papers, and the name of her husband. Elaine's boyfriend David had commented that this seemed slightly more than the typical premed neuroticism, and Elaine immediately explained that Dr. Vaughn is one of only a handful of global experts in a certain rare brain cancer. Elaine had jumped through hoops to become acquainted with her scrub nurse, who introduced her to Dr. Vaughn's clinic manager Caitlyn, who interviewed her last week.

"You're not a nurse, so you'll have to work super hard to learn," Caitlyn had warned her during the interview. "We don't usually hire medical assistants. I run a tight ship here. Just so you know."

"It's not a problem," Elaine immediately responded. "I'll do anything for this job."

"I've seen Dr. Vaughn make grown surgeons cry over the smallest mistakes." Caitlyn sounds almost proud. "You up to the pressure?"

Elaine levels Caitlyn's gaze with her best impression of a high-power woman. "That just makes me respect her more. I'm here to learn from the best."

Caitlyn had smiled. "You'll start on Monday."

Elaine's first task as a trainee is to collect medical history on a new intake. The patient is an elderly man named Mr. Ellis with a consult for a glioblastoma. In the exam room, Elaine sits at the computer with Caitlyn hovering over her shoulder, making her neck prickle.

"Did you folks hear about the tornado the other day?" Elaine asks, making conversation while she enters the patient's long medication list.

"Oh, yes," Mrs. Ellis responds, "it touched down in our garden!"

"Your garden?" Elaine repeats, glancing up. "That sounds terrifying."

"You should've seen us," Mrs. Ellis laughs, looking at her husband. "We huddled in the hallway like this." She balls herself up as best as she can in her chair.

"Tore up all the roses," Mr. Ellis adds. He points at his wife. "She was upset."

"Of course I was!" she wails. "We worked all year tending that garden."

Elaine finds herself smiling. "I'm sorry about the roses. But thank goodness you two are alright."

"*You misspelled olmesartan,*" Caitlyn suddenly whispers in her ear, making Elaine jump. "*It's an "E" instead of an "O". Also, we try to keep these workups under ten minutes. Just so you know.*"

"Sorry," Elaine mumbles back. She finishes the rest of the visit quickly.

Three months later, Elaine has learned little about the brain but she has learned a lot about Caitlyn and Dr. Vaughn. For example, Caitlyn has worked with Dr. Vaughn for 11 years and senses their boss's mood like a hawk detects the slightest change in barometric pressure.

"She's in a terrible mood today," Caitlyn tells Elaine as they make coffee in the breakroom. "The OR has been giving her a hard time with some slip-ups that happened recently. Just as a warning."

Like a curse, the day progresses in the worst way possible. Elaine mixes up the pathology reports for two patients. She accidentally orders a CT instead of an MRI on someone with a pacemaker. In the afternoon, Elaine follows Dr. Vaughn into an exam room and is asked to pull up an MRI to show the patient—a task Elaine has done literally hundreds of times at this point. But the most recent scan isn't uploaded. Because the radiology team decides today is the day Elaine must suffer.

So, she can only watch as Dr. Vaughn's mouth pinches into a sharp line. When it opens again, Elaine is hit with a scoff and devastating words:

"*Can't you even do this? No, it's too much for you. Too much to ask.*"

Elaine returns home and slams the door.

David leans to peer at her from behind his dual monitors. "Well, hello to you too."

Elaine kicks off her shoes. Collapses onto the couch in her dirty scrubs, startling the cat from his nap. "Not. In the mood."

"I can get dinner started?" her boyfriend offers. "What do you want?"

"Ugh. Whatever. We should have stuff for pasta in the pantry."

David stands and touches her shoulder on his way to the kitchen. His touch is meant to be reassuring, but today it only makes her mood flare up, inflamed. Elaine narrows her eyes at David's desk, behind which he works from home for eight hours a day, with a generous boss who always seems satisfied with his work.

"What sauce do you want?" David calls from the kitchen.

"It's in the cabinet."

"Can't find it."

"The red sauce."

"It's not here."

Elaine groans, frustrated. "Oh my *god*. *Fine*, I'll just do it."

"You don't have to," David protests, but Elaine is already in the kitchen, glaring at the setup. He's using the wrong pot, with the wrong lid on it, on the wrong burner. Elaine is filled with a strange, great fury.

"*Can't you even do this one thing right?*" she seethes at him. "*Making pasta. Too much to ask.*"

The next day, Elaine shuffles into the breakroom and after a brief hesitation, sits next to Caitlyn.

"Do you ever feel like..." Elaine starts.

"Feel like...?" Caitlyn glances up at her coworker, undressed salad in her mouth.

"Do you ever feel like...this job is making you less kind?"

"Oh," Caitlyn swallows. "Yeah. 'Course it does."

Elaine blinks. "Isn't that...a bad thing?"

"Mmm. Not necessarily." Caitlyn's eyes dart to the clock, then back to Elaine. "We just have less tolerance for bullshit. The way I see it, Dr. Vaughn's energy is so valuable that she has zero time to waste on things that aren't important. That's what happens when you become such an expert that there are literally only eight other people in the country who can do your job."

"I guess that makes sense," Elaine concedes hollowly.

Caitlyn softens. "We do incredible work here. We're effective because we're tough. You know, like Machiavelli?"

"Sure," Elaine says. She does not point out that the comparison to Machiavelli does not inspire confidence in her regarding this particular situation. If competency means becoming a tyrant, Elaine is not sure she wants it.

After Caitlyn leaves, Elaine opens her lunchbox in the quiet breakroom. She's greeted by leftovers messily packed by David. Cracking open her Tupperware, she feels a twinge of affection, then guilt. This job has been making her unlike herself. She'll apologize to him properly later.

As she eats, pasta savory on her tongue, Elaine thinks about Mr. and Mrs. Ellis. The story they told her of the tornado touching down in their garden, tearing up their roses. How they huddled up together in their hallway—clinging to each other as chaos roared outside—and she thinks she'll never hear a more apt metaphor for illness and companionship. Their expertly tended garden, demolished. Their wisdom in knowing how to keep what is important closer.

To be a Sophomore in June

Johnny Dang

The University of Texas Medical Branch—John Sealy School of Medicine

June 26th, 2015. It was the summer right before my sophomore year of high school when the U.S. Supreme Court struck down state bans on same-sex marriage to legalize it in all 50 states, ensuring that same-sex marriage licenses from any state would be honored. In my lazy suburban home in Austin, I watched the national coverage and celebration of the historic and triumphant conclusion of *Obergefell v. Hodges* just before the end of Pride Month. Marriage was the farthest thing from my mind as a high school student on summer break, but I couldn't deny the uplifting and empowering impression the decision made on me as a queer young adult. Simply having the option of marriage available meant queer individuals had more control over their own representation in the eyes of institutions that recognize and have benefits for heteronormative spouses, and this is especially true for healthcare. Queer couples now had nationwide access to healthcare coverage options such as employer-sponsored health insurance, spousal dependent coverage, consolidated family deductibles, spousal Medicare/Medicaid eligibility, and joint Health Savings Accounts. More importantly, couples now also had legal recognition of medical decision making, bringing us closer to ensuring queer individuals would have the most control over their desired health outcomes. It also finally meant John James Arthur's final wish of being remembered and survived by his spouse, James Obergefell, could be reflected on a death certificate in their home state of Ohio (*Obergefell v. Hodges*, 2015).

June 20th, 2023. I am now preparing myself to enter the proverbial sophomore year again as a second-year medical student. As an adult on the verge of being responsible for my health insurance, I find myself pondering about the prospects of my own future healthcare decisions, who can be involved, and would my autonomy be respected. At the same time, I am reminded to think about what I can do as a future queer healthcare professional to empower the queer patients that may come under my care. These motivations inspired me to look towards the current LGBTQ+ legislation being discussed and debated nationwide and in Texas. Still, under the impression of the momentous victory for the LGBTQ+ community in 2015 with marriage equality, I expected there to be more pro-LGBTQ+ legislation almost a decade later. The reality of the situation couldn't be further from my hopes.

By the time I left high school in 2018, there were 42 anti-LGBTQ+ legislative bills proposed across the nation: a little less than half being specifically anti-transgender, and the rest mostly related to discrimination of services to LGBTQ+ individuals based on religious beliefs (NBC News, 2022). Today, there are currently 492 anti-LGBTQ+ bills that are being debated, defeated, or passed in the 2023 legislative session, according to the tracker provided by the American Civil Liberties Union (ACLU, 2023). Of the anti-LGBTQ+ bills proposed in 2023 alone in 2023, over half are anti-transgender: from bills prohibiting transgender youth from receiving gender-affirming care (HB 648 in Louisiana and LB 574 in Nebraska) to bills banning transgender individuals from using the restrooms congruent with their gender identity (HB 1521 in Florida and SB 1040 in Arizona) (Human Rights Campaign, 2023). Some bills are anti-LGBTQ+ on a broader sweep, attempting to restrict or prohibit diversity, equity, and inclusion programs (SB 83 in Ohio, H. 3728 in South Carolina, and SB 17 in Texas, which was passed as I write, in June 2023) (Human Rights Campaign, 2023).

Texas itself takes up 53 of the 492 anti-LGBTQ+ bills this year, according to the ACLU. While most were defeated, enough were passed to significantly hinder transgender rights specifically. For example, the passing of Senate Bill 15 would now ban transgender university athletes from being able to compete on teams other than the ones reflecting their biological sex assigned at birth despite the National Collegiate Athletic Association having policies that monitor transgender athletes' testosterone levels (Nguyen, 2023). Most notably directly affecting LGBTQ+ healthcare in Texas was Senate Bill 14, which bans transition care for queer youth. Under this bill, physicians providing any form of transition care to anyone under 18 can have their medical licenses revoked. Hospitals that provide any type of transitioning care would also lose public funding. Finally, youths who are currently transitioning would have to slowly stop treatment, a point to which many healthcare professionals have warned it to be physically and psychologically stressful on transgender youth (Nguyen, 2023). This change is perhaps the most detrimental to trans youth, considering a Journal of the American Medical Association Network's prospective clinical cohort study from last year observed strong associations between denial of gender-affirming care and mental illness within a transgender nonbinary (TNB) youth population. TNB youths in the trial who were issued puberty blockers and gender-affirming hormones following the initial visit had 60% lower odds of moderate to severe depression and 73% lower odds of suicidal thoughts at their one year follow-up compared to those who did not receive gender-affirming care (Tordoff et al., 2022). For those in the trial who did not receive gender-affirming care following the initial visit, Tordoff et al. observed statistically significant increases in moderate to severe depression by the three month follow-up and significant increases in suicidal thoughts by the six month follow-up. Denying or revoking ongoing gender-affirming care could result in an increase in mental decline among TBN youth statewide, magnifying the mental health crisis among the LGBTQ+ community of Texas. SB 14 was passed into law on June 2nd, 2023, but its impact has yet to be seen as it faces lawsuits filed by families and health professionals citing the same deleterious effects on transgender care (*Loe v. State of Texas*, 2023).

While Texas and many other states have been drafting legislation directed toward transgender healthcare, we must recognize the potentially harmful effects of this recent rise in anti-LGBTQ+ legislation on the queer community's health and well-being as a whole. Senate Bills like SB 1076, which would have banned public and charter schools from teaching gender identity and sexual orientation up to 12th grade, could have negatively impacted the mental health of LGBTQ+ youth by eliminating school as an environment for informative discussion, demystifying misunderstandings, and stopping bullying (Nguyen, 2023). Schools have already been shown to be an inherently negative environment for trans children because there is a lack of policies in place providing protections for or information on gender identity and expressions, so more education and policies on LGBTQ+ sensitivity provide a better framework overall to cultivate a healthy learning environment (Cicero et al., 2017). The passing of SB 17 has already effectively banned public universities from establishing or maintaining a diversity, equity, and inclusion office (Texas Legislature, 2023). Without the presence of these offices to oversee diversity training, such as LGBTQ+ sensitivity, public LGBTQ+ university students now may become more vulnerable to on-campus discrimination. Even a senate bill directed towards business owners like SB 476, which sought to reclassify bars and any other commercial business that hosted drag shows as "sexually oriented businesses," could have affected the mental health of queer adults in Texas by straining historic queer safe spaces. Had SB 476 passed, many of the state's LGBTQ+ bars would have to operate under regulations that come with higher taxes and

fees if they were classified as a sexually oriented business (Nguyen, 2023). From small town closures to increases in expenses to keep up, the coping mechanisms of these spaces would have surely had a direct impact on the queer communities they served.

Each anti-LGBTQ+ legislative proposal that passes has its undeniable discriminatory consequences to follow. Each anti-LGBTQ+ legislative proposal that does not pass still serves as a harrowing glimpse into a reality that only serves to spur more anti-LGBTQ+ rhetoric: SB 476 did not pass but was scaled back only a few months later to give way to SB 12, the infamous bill that aimed to criminalize drag performances to children (Nguyen, 2023). We now also know that this ongoing rhetoric and even the mere act of passing anti-LGBTQ+ bills have direct negative impacts on the mental health of the constituents involved. A study by Raifman et al. in 2018 found a 46% increase in mental distress among LGBTQ+ adults in states that passed laws that allowed businesses to deny service to same-sex couples. Meanwhile, in 2002, a study by Parris et. al found that the number of texts to Crisis Text Hotline from LGBTQ+ youth increased one month after their respective states proposed anti-LGBTQ+ legislation.

It is only a matter of time before even more major legislation is proposed or is called back into question. The overturning of *Roe v. Wade* in June 2022 concurred with Justice Clarence Thomas's ominous suggestion of high court reconsideration of many other cases, including *Obergefell v. Hodges* (Stolberg, 2022). All the opportunities for same-sex couples granted over 8 years ago could come to hang in the balance once again, especially with the wave of anti-LGBTQ+ rhetoric in legislation. So with all of the sides of queer health, from mental health to healthcare accessibility, being targeted as a point of contention in Texas and beyond, what can healthcare professionals and aspiring healthcare professionals do? As Jackson et al. summarize in their abstract on the role of clinicians amidst anti-LGBTQ+ legislation, we must continue to use our "privilege to engage stakeholders and advocate for LGBTQ+ inclusive policies at the institutional, local, state, and national levels" (Jackson et. al., 2023). We can start small by just making sure our institution's clinics have gender-inclusive guidelines, ensuring demographic forms and electronic medical records that account for all gender-expansive identities, sexual orientations, and same-sex couples. Moving upwards to the local level can look like approaching school boards about their LGBTQ+ education and sports inclusion policies to see that they stay safe spaces for queer youth. The simple acts of voting or voicing opinions on national laws to pass The Equality Act or uphold *Obergefell v. Hodges* takes us to the last level. We can magnify the benefits to the queer community with LGBTQ+ affirming policy enacted through each level, but we must do so without losing focus on the dangers continuous anti-LGBTQ+ rhetoric and proposals bring.

The term 'sophomore' is a Greek portmanteau that combines the term '*sophos*', meaning 'wise', with the term '*moros*', meaning 'fool', to effectively translate to the oxymoron: a *wise fool*. *Wise* for us to recognize the magnitude of the situation; *foolish* of us to take it lying down.

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Using Our Powers for Good

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Growing up, doctors were my superheroes. I dreamed of being among them. They seemed to fly in with their training and knowledge, treat the toughest cases, and ease the worst pains. From super-human suturing to X-ray vision, they could handle anything. Not until my first brush with death did the realism of direct experience change my view.

Bright eyes shimmering with naivete, I remember approaching the bed. The patient lay surrendered in the sheets, a tangle of limbs and tubes and wires. Adorning a tag reading “EMT IN TRAINING” in capital letters, I hung back to watch a mass of healthcare workers rush into the room; EMTs, paramedics, nurses, and hospice workers crowd around the patient. We had been called to give her CPR, something I had only ever seen done in the movies then, as a college freshman. My simple task was to give her oxygen with a bag-valve mask. My own breath bated as I watched hers: chest slowly inflating, lungs laboriously expanding. Paramedics desperately pushed on her sternum. The sound of her ribs snapping cut through the beeping of the medical monitor, the tense commands between the team, and the beat of my own heart reverberating in my ears. I blink. Suddenly, the patient’s daughter is next to us yelling frantically for us to stop as her mother had a DNR, a request to pass without resuscitation. The hospice care had lost the physical copy and their online systems were down: a terrible misunderstanding. I could feel the air around us sink with the realization, as confusion flitted around the faces of the team. I could hear the mother’s agonizing breaths as she balanced on the edge of mortality. I felt a heavy feeling; my heart sank. A worker in the facility was able to find a copy of the DNR, so a new instruction was suspended above our heads: let her go. I eased her off the oxygen. Her eyes dimmed and her heart slowed to a stop. Her breaths, which I had once willed to continue, ceased entirely. Her body was now wrapped in sheets drenched in blood and feces. All in one day, I had assisted in her revival and then had to let her go again.

Five years later, my naïve eyes had grown a little dimmer as I approached the bed. The patient lay listlessly scrolling through TV channels. Now adorning a tag reading “MEDICAL STUDENT” in capital letters, I enter the room. I was volunteering as part of a social service program, inquiring about post-discharge needs of patients from marginalized socioeconomic backgrounds. He seemed to perk up a little as I neared him. As I methodically went through the questions, he kept offering me unprompted insight into his life. Did he need the hospital to provide a ride home? No, because his fiancée, the love of his life, the woman he had just proposed to—something he never thought could happen having grown up homeless and alone—was going to pick him up. Did he have access to a cellphone for a follow-up call? No, because he had worked on docks and ships all his life and he was to set sail soon with the company. His real dream, he interjected, was to someday buy his own sailboat, weathering storms and rough seas, as he traveled the world as captain. Could he afford his prescription medications? He could if he rationed them, weighing the worth of his pain to make ends meet. I felt that familiar heavy feeling; my heart sank. I provided him with some forms to fill out, scoured for some discounts, and wished him the best. We care about people, and we try our best, but we are not limitless.

I am learning every day that what makes a “superhero” is beyond public acclaim, promising statistics, or effective cures, and that it lies rather in the intimate, personal moments with patients that no one sees. Physicians are imperfect, just everyday people trying to make the best of desperate situations. They are mitigators between life and death, bargaining with their expertise to serve others. The real superpower is respecting vulnerability. We tend to see patients at their weakest, worst moments in life. We guide them and care without judgment or restriction. The medical field not only demands bravery from patients facing dangers to their health head-on, but also courage from physicians to help them through it with empathetic, logical poise. Disease and pain are unpredictable. The role of the physician is to be dependable, to steer that chaos to calm. With each new experience as a medical student, I learn a bit more about how to use the “powers” I have been given for good.

LOOKING INSIDE MEDICINE WITH HEALTHCARE PROFESSIONALS

Interviews with faculty, healthcare providers, or other inspirational professionals.

Physical Therapy, Magnified

An Interview with Rupal M. Patel, P.T., Ph.D.

Sarah Snyder, P.T., D.P.T.

University of Houston–Tilman J. Fertitta Family College of Medicine



Note from the author:

Dr. Patel is an Associate Professor at the School of Physical Therapy at Texas Woman's University located within the Texas Medical Center in Houston, Texas. I had the privilege of taking several classes from her. She was always a positive influence, upbeat and energetic, even when teaching the drier topics, such as Ethics and Health Policy. The reason I chose to interview her is because of her passion for advocating for the profession—embodying an awareness of what physical therapists provide to their patients. Although I am now in my fourth year of medical school, I frequently fall back upon my knowledge and the foundations of patient care that I learned while obtaining my clinical Doctor of Physical Therapy (D.P.T.) degree: where I learned to emphasize the patient's goals, the healing power of movement, and a foundational understanding that quality of life can be just as important as quantity of life.

The following questions were answered by Dr. Patel, using her own words:

How would you define physical therapy as a profession? What services do you feel we provide to patients and other healthcare workers?

As a profession, physical therapy is coming into its 2nd century. Relative to other professions such as theology, law, and medicine, we are still young! I define physical therapy as a service that is provided by a physical therapist where we focus on health promotion, prevention, protection, preservation, restoration, maintenance, and/or enhancement of a person's movement and physical abilities that are often impaired or limited by unhealthy behaviors, social determinants of health, a condition, injury, hospitalization, or disability.

I believe as physical therapists, the most valuable service we provide is to improve the human experience of our patients or clients. We do this by listening to our patients, by observing their movements, and by building a therapeutic alliance, so that we can optimize their movement for the activities and roles they want to fulfill in life.

What is one thing you wish other healthcare workers knew about physical therapists?

I wish every healthcare provider to know that physical therapists generally get to spend time with their patients that is often much more than other healthcare providers get to do. This precious privilege of time allows us to get to know our patients on a deeper level. This means we can sometimes pick up on things that get missed by others. Physical therapists are trained to screen and diagnose musculoskeletal conditions, and we have an excellent track record of referring to, collaborating with, and following up with other providers to help the patient or client achieve their goals.

I still remember you sharing with our class that your father-in-law had type II diabetes, and that this is quite a common illness among the Asian Indian American population. How has this impacted you personally? How has it impacted how you care for your patients and your understanding of the United States healthcare system?

Watching my father-in-law struggle with the complications and consequences of diabetes was heart-wrenching. I wanted to know more about how we could have prevented some of his complications early on. So, as part of my Ph.D. in health promotion and wellness, I created and administered a [randomized controlled trial] in a community setting to look at how effective culturally tailored group-based community lifestyle modification programs could be to help transform the lives of people that may be struggling to cope with lifestyle conditions such as type 2 diabetes. This has impacted the care I provide to patients or clients in indelible ways. I now look at every patient or client I engage with from the lens of a health promoter first. I assess their health habits, the type of physical and social environment that they live, work, learn, play, pray, and age in, so that I can better assess these determinants of health that may be compromising their movement and functional abilities.

Seeing my father-in-law's experience with trying to live a quality life with diabetes made me even more aware of how broken our US healthcare system is. Our system's focus on sick care versus health care is not helping. Our healthcare system needs to change. We need to put more effort [and] money "upstream" into health care by investing in health protection, promotion, and prevention, at the community level, so that "downstream," we won't have to spend as much on chronic or lifestyle conditions such as diabetes—and ultimately improve the quality and quantity of life of our population.

What would you say to individuals who are interested in becoming a physical therapist?

Physical Therapy is a great profession. Being a physical therapist is very rewarding because you get to be able to go to work each day and help people move more or move differently and do the things they want to do in life. For those interested in becoming a D.P.T., be ready to work hard during the professional training, which is typically three years post-baccalaureate. Know that you are entering a profession where you will have the privilege of helping people achieve their goals from "womb to tomb." That's because you get to work with women who are pregnant to neonates to adults and those that are nearing the end of life—and the practice settings that you can work in are as open as your imagination.

What is one way that you think Texas healthcare can improve in the next five years?

The one thing that I think we can improve upon in Texas is access to health insurance. We can do this by expanding Medicaid coverage for the nearly 20 million Texans who are uninsured—which is twice the national average!

What is one measure you take to ensure you are practicing appropriate work-life balance?

I am not sure I have ever found that perfect balance. I am striving towards it always. One thing I practice is deep breathing to help focus and center my energy, especially during busy chaotic days. I also like to get outside in nature and be intentional about experiencing it with all my senses. The Japanese call it "Shinrin-yoku" or "forest bathing." [I find it refreshing, and it helps me renew.]

How do you hope to see the profession of physical therapy grow within the next five years?

I hope that our profession will grow by increasing awareness among consumers, other healthcare providers, and policymakers about the great value that the services of a physical therapist can bring to every American's life. It is said that about 90% of the population could benefit from the services of a physical therapist, yet only about 20% of the population engage our services. I hope that the number changes in the next five years!

Any current projects or personal goals of yours?

Nah, nothing major. I love what I do as a physical therapist. I am an academician, researcher, clinician, servant leader, and a community health promoter. I have the privilege and honor to influence the next generation of physical therapists. What more can a gal ask for?

