

Footprints

“Dr. Cohen?”

The summons broke my trance. I was busy staring at my 62-year-old patient’s feet. Or more precisely, his shoes. He was wearing Rockport sneakers, which should have been retired a long, long time ago. The laces, once white, were overripe and withered. The rest of his appearance was not much better. He had frosty, uncombed hair and was wearing a pair of slightly discolored green pants and a soiled workman’s coat.

“Yes,” I replied as doctorly as possible, though caught off-guard by the honorary degree prematurely bestowed on me.

I was a first-year medical student visiting a local urgent care center. I knew from having reviewed my patient’s chart with my physician mentor that Mr. Tomero* had come in complaining of foot pain, having stubbed his large toe a few nights before. He thought it might be broken and had requested an x-ray.

“Where are you from?” Mr. Tomero asked.

“Upstate New York.”

“Oh, I could have guessed,” he said. “We New Yorkers never lose the sense for a fellow ‘lontzman.’”

Though I’d never heard the Yiddish expression for “countryman” before, I understood its meaning. And I appreciated the personal interaction with my patient. It was a far cry from the way I usually spent my time, listening to a monologue on lipoprotein metabolism or studying in the deafening silence of the school’s library.

* Not the patient’s real name.

My mentor was called to another room and I was left alone with Mr. Tomero. In a thick accent, he described his childhood bout with typhoid fever and an emergency appendectomy. He told me that his familial hyperlipidemia, which had been at 330 for over 30 years, had miraculously left him with the “arteries of a 10-year-old.”

I learned he was an Egyptian-born Italian Jew who grew up in Brooklyn not far from where my mother was raised. My eyes turned again to his dilapidated Rockport shoes, prompting me to jump to conclusions about the kind of life he’d likely led. A simple life. An unremarkable one.

But he interrupted my thoughts again. This time to tell me of his decision, early in life, to leave the field of mechanical engineering to pursue art. After all, he’d gotten the degree to appease his parents. It was time, he said, to find his own way.

He spoke with religious fervor about the sacredness of creativity in life and medicine. “One cannot achieve true greatness as a physician without creative aspirations.”

I was hypnotized by his unwavering eye contact and passion. I told him that I had come back to medical school after having been a professional singer/songwriter and how I’d struggled with a lack of creativity in my training. He told me of his desire to leave a footprint in the sand and said he could sense the same in me. I was amazed at how perceptive he was. All this from a man I thought I’d pigeonholed 5 minutes earlier.

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FAST TRACK

“One cannot achieve true greatness as a physician without creative aspirations”

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He reached into his worn pocket and handed me his business card. It was a beautifully handcrafted pewter card with the words, "EDMUND TOMERO," inscribed in relief. Below his name were the letters "CEO."

Seeing the disbelief on my face, he explained that he'd always wanted to make fine jewelry but was not able to do it full time, until a letter arrived one day from the Vatican. He had written to Pope John Paul II some years ago respectfully criticizing the Catholic Church for its silence after the bombing of a synagogue in Turkey. Astonishingly, he received an invitation to be the Pope's guest for a week. He crafted a gilded jewelry box for Pope John Paul II. The gift was so well received that he had since been commissioned to create pieces for the Vatican and the White House.

As my patient was finishing his story, my mentor returned with the results of the x-ray: hairline fracture of the right large toe. In awe of this gentleman's life, I could hardly focus on the diagnosis. But with my mentor present, Mr Tomero fell silent and I knew I wouldn't hear the end of his story.

As he prepared to leave, I shook his hand and told him what a pleasure it was to meet him. He nodded tersely and wished me the best. My fingers ran up and down the smooth card in my pocket as I watched him limp out of the office.

Mr Tomero taught me a great deal about judging our patients based on their appearance. Though we try not to jump to conclusions, we do so anyway—in the blink of an introduction. While I'm not sure if I will ever be able to completely control this conditioned response, I'm certain I will process these prejudices differently. I'm learning it takes patience, respect, and compassion to look beyond a tired pair of Rockports to the sterling person within. ■

FAST TRACK

"Though we try not to jump to conclusions, we do so anyway—in the blink of an introduction"

THE JOURNAL OF FAMILY PRACTICE

Evidence-based medicine ratings

THE JOURNAL OF FAMILY PRACTICE uses a simplified rating system called the Strength of Recommendation Taxonomy (SORT). More detailed information can be found in the February 2003 issue, "Simplifying the language of patient care," pages 111–120.

Strength of Recommendation (SOR) ratings are given for key recommendations for readers. SORs should be based on the highest-quality evidence available.

- A Recommendation based on consistent and good-quality patient-oriented evidence.
- B Recommendation based on inconsistent or limited-quality patient-oriented evidence.
- C Recommendation based on consensus, usual practice, opinion, disease-oriented evidence, or case series for studies of diagnosis, treatment, prevention, or screening

Levels of evidence determine whether a study measuring patient-oriented outcomes is of good or limited quality, and whether the results are consistent or inconsistent between studies.

STUDY QUALITY

- 1—Good-quality, patient-oriented evidence (eg, validated clinical decision rules, systematic reviews and meta-analyses of randomized controlled trials [RCTs] with consistent results, high-quality RCTs, or diagnostic cohort studies)
- 2—Lower-quality patient-oriented evidence (eg, unvalidated clinical decision rules, lower-quality clinical trials, retrospective cohort studies, case control studies, case series)
- 3—Other evidence (eg, consensus guidelines, usual practice, opinion, case series for studies of diagnosis, treatment, prevention, or screening)

Consistency across studies

Consistent—Most studies found similar or at least coherent conclusions (coherence means that differences are explainable); or If high-quality and up-to-date systematic reviews or meta-analyses exist, they support the recommendation

Inconsistent—Considerable variation among study findings and lack of coherence; or If high-quality and up-to-date systematic reviews or meta-analyses exist, they do not find consistent evidence in favor of the recommendation