# Reflections

## *Shabbos goy*

Frank J. Bia, MD, MPH (ΑΩΑ, Cornell University Medical College, 1971) is Professor Emeritus, Department of Internal Medicine, Infectious Diseases, Yale School of Medicine, New Haven, CT.

In late December of 1945, I was born at The Bronx Maternity Hospital during a heavy snow fall—the first grandson of four early 20th century Italian immigrants. The Bronx was approximately 50 percent Jewish at that time, and many survivors of the Holocaust would follow. There were more than 200 active synagogues in the south Bronx, and the *lingua franca* for much of the borough was Yiddish.

I am told that, at age six, I repeatedly asked my mother why Abe, the owner of our local delicatessen, had five numbers tattooed across his forearm. This was immediately following the Nuremberg trials of Nazi war criminals in Germany. She told me he had been "in prison."

I persisted, asking, "Why had he been there? What did he do wrong? She was unusually flustered, and simply promised several times that she would tell me the entire story when I was older. She did.

Yiddish is the historical language of Jews in Europe. It originated during the ninth century in central Europe and provided Jewish communities with a German-based vernacular language combined with many other elements taken from Hebrew, Aramaic, Slavic, and Romance languages. Hebrew, like Latin, was no longer a conversational language, but gradually re-emerged over the 19th century until its adoption with the formation of the State of Israel in 1948.

The descendants of Irish, German, Greek and Italian immigrants made up most of the remaining Bronx population. However, the children of Italian immigrants were not encouraged to speak their native language. Better to become a "real" American and leave the old dialects behind. Besides, Italy's distinct regional dialects were often mutually incomprehensible, unlike Yiddish which was a binding force for Jews of many different cultures and ethnicities.

As a teenager, I worked for five dollars a night with my Uncle Pete on his Whitestone Farms milk truck. At 5 a.m. our delivery route coursed along the central Grand Concourse of the Bronx, where many of our customers spoke Yiddish. Often, I collected on their milk bill balances in the early hours of the morning. Family members would speak to each other in Yiddish, and I would casually comment in somewhat fractured German/Yiddish. I know they were thinking, "*Was ist mit dieser goyishe sheygets*? (What is it with this non-Jewish kid?)"

I was encouraged by constant exposure to Yiddish, and by taking the German language seriously during high school and college at Fordham University. German is not the most musical of languages, although Mozart might disagree, but I greatly enjoyed learning it. Another benefit of speaking German is that I could make a few extra dollars on Saturdays working as a *Shabbos goy*.

Judaism does not allow Jews to do various forms of work, known as *melakha*, on the Sabbath. A non-Jew may perform certain tasks which are helpful and beneficial to Jews, but with certain restrictions. The phrase is a combination of the word *Shabbos* meaning the Sabbath and *goy*, or non-Jew. It is said that Mario Cuomo, former governor of New York, performed similar work in Queens as a youth, as did the noted film director, Martin Scorsese, who graduated three years before me from Cardinal Hayes High School in the Bronx.

While riding the Bronx buses and subways to school, I often read and re-read Paul Henry de Kruif's *Microbe Hunters*, first published in 1926 with scores of re-editions. It recounts the history of renowned physicians and scientists during the "Heroic Age," including Spallanzani, Koch, Pasteur, and Ross. It details their discoveries in bacteriology and infectious diseases. This book, gifted to me by my Sicilian mother, became a major influence on my own choice of medicine, including the study of infectious and tropical diseases.

The actual practice of clinical infectious diseases often requires some very broad diagnostic considerations. What is the microbial flora to which patients have potentially been exposed? Who are these infected patients, and what is their immune status? How are their immune defenses

holding up under attack? What are the pathogenic mechanisms at work, be it in tuberculosis, leprosy, endocarditis, plague, or malaria?

At Yale I experienced one of those consulting days that infectious disease practitioners relish. I was asked to see Sol, a spry, elderly man with bilateral fiery cellulitis on both of his legs. He had blisters the size of a Buick. He was not responding to an intensive course of therapy, including parenteral beta-lactam antibiotics. We talked extensively about what might have happened.

Sol lived on the Rockaway Peninsula of southern New York City, looking out over the Atlantic Ocean. Although in his late eighties, he swam in the ocean nearly every day. He recalled cutting himself on sharp sea shells while walking the Rockaway Beach. Aspirating one of the bullae with a tuberculin syringe, I carried the fluid sample directly to clinical microbiology. I knew that the cultures would show *Vibrio vulnificus*, a particularly virulent halophilic, or salt loving, gram-negative bacterium. Treatment would require a completely different antibiotic regimen. We made adjustments, and he responded within two days. His wife, Miriam, took notice.

I saw Sol at a follow up appointment, accompanied by Miriam. He was recovering nicely. I learned they were both Holocaust survivors, nearing age 90, and were clearly devoted to one another. Miriam watched over Sol like the proverbial hawk. Since he was my final patient that afternoon we had ample time to converse.

Miriam had a lively sense of humor that flourished as Sol improved. Gradually they both learned of my Bronx origins and my stint as a *Shabbos goy.* Miriam clearly grew fond of teaching me Yiddish, or correcting words I mispronounced with an Italian accent. We never spoke of the Holocaust itself, only their own experiences in flight from the Nazi *Schutztaffel* or SS. This was the dreaded agent of security, surveillance, and terror within Germany and German-occupied Europe. The SS was out to annihilate them both, along with any other Jews they could find. They called it "The Final Solution."

Miriam was eventually admitted to the hospital herself; I stopped by, simply to say hello and trade a few stories once again. The hospital staff had paired Miriam with, Mrs. Liebovitz, an elderly but talkative roommate, who also spoke Yiddish. Suddenly Miriam interrupted our conversation and exclaimed, "Sol, come here, quickly! Your doctor is visiting me today—Dr. *Shabbos goy*."

If you grew up in a mixed ethnic urban neighborhood that included a significant Jewish population you certainly understand the reference, and the humor within it. If not, then consider this analogous to being referred to affectionately as "Dr. Non-Jewish Saturday Helper."

It is fortunate the side rails were up on Mrs. Liebovitz's bed, or she would have rolled out laughing. As people often said in the Bronx, "Such a laugh, you wouldn't believe." Miriam was indeed a very sharp operator, and her comic timing was impeccable.

Around that chaotic maelstrom, commonly known as the Italian dinner table, I reigned as the oldest grandson and self-appointed stand-up comedian. "Hey, shut upa you face," screamed my grandmother. "*Perche' e' siempre tu con gli scherzi*? (Why is it always you with the jokes?)" Never did I imagine that 50 years later I would be totally outclassed by a 90-year-old woman performing her own hospital comedy *schtick*.

And I am certain that somewhere, out there, floating near the edge of the universe, Mrs. Liebovitz resides, still laughing with delight.

The author's E-mail address is frank.bia@yale.edu.

## What Bernie Fisher taught me

H. Schipper BASC(Eng), MD, FRCPC (ΑΩΑ, University of Toronto Faculty of Medicine,1971) is Professor of Medicine, Adjunct Professor of Law, University of Toronto, Canada.

My friend, colleague, and mentor Dr. Bernard Fisher (ΑΩΑ, University of Pittsburgh School of Medicine, 1989, Alumnus) passed away in Pittsburgh, on October 16, 2019, at the age of 101. I was fortunate to have been part of his scientific, clinical, and social circles in my career as an oncologist. His passing has given me pause, as it has others, to reflect on the enormous contributions he made to the health and well-being of women with breast cancer, as well as the contributions and guidance he made to the lives and careers of oncologists who came after him. He was a powerful teacher, of the scientific community, and of the broader community of social, ethical, and public policymakers.

It was the late 1970s, and I was a young academic oncologist in Winnipeg, Canada. As all general oncologists, we were encouraged to develop one or two site specializations. At the suggestion of my colleague and dear friend David Bowman, I chose breast cancer. It was a common ailment, and, having worked with Bill Meakin in Toronto, I was fascinated by the protean nature of its history. Clearly it was not a tumour totally autonomous and unregulated by

its host. Moreover, there was this controversial Pittsburgh surgeon, Bernard Fisher, who was building a clinical trials organization, and I got to go to the meetings. That was the start of an odyssey of more than 20 years as a contributor to trial design, accrual and reporting, committee participant, member of the National Surgical Adjuvant Breast Program (NSABP) Executive Committee, and mentee, colleague, and friend of Dr. Fisher.

Great mentors like Dr. Fisher impart a way of thinking. It's not the small details, because often they are evanescent, even tangential. It's about the approach to a problem, and a philosophy of seeking answers and solutions. Here is what I learned from Dr. Fisher:

1. Respect dogma, and don't be constrained by it. Prevailing wisdom is based on something; find out what it is, and test it against your observation. Ask why?
2. Clinical trials do not provide eureka moments. Trials are but an essential part of a dispassionate confirmation of an insight, intuition, or belief. The insights that lead to landmark trials come from open-minded, deeply curious, even skeptical observation. Science is disciplined rigour applied to testing insight.
3. Great science needs a safe haven for new ideas. Science is not immune to dogma, and as we have painfully learned more than once, we remain prone to the juggernaut.
4. Patients count. Rose Kushner attended almost every NSABP meeting. She was a journalist and had had breast cancer. She thought that much of the practice of breast cancer medicine made little sense, and she marshalled her impressive communication skills to make her point. Long before she became the first lay member of the National Cancer Advisory Board, she found safe haven in NSABP.
5. Changing paradigms is not for the faint-hearted. NSABP conducted many trials. Some were paradigm shifting, none more so than B-06, which compared mastectomy with lumpectomy with or without radiation.[1,2] It is commonly described as a surgery trial, but it was actually a fundamental test of biological hypotheses. It questioned whether cancer spreads in a stepwise fashion outward from the primary site—dogma for more than 100 years—or is a systemic disease originating in the breast and disseminating from its earliest days.

The evolution of that trial taught a profound lesson about progress in medicine. When the trial was initiated, patient accrual was very slow. An innovative modification to the accrual process was introduced, including enlisting sites in Canada. Patients were pre-randomized, and consent was subsequently sought, because the profession was very skeptical of subjecting patients to a treatment approach so out of line with what was the accepted biological truth of the day.

Accrual increased rapidly, motivated by patients sensing the potential of a less disfiguring treatment. Toward the end of the enrollment period, it again became difficult to accrue patients, as surgeons and patients found little justification for extensive surgery when a lumpectomy might work.

However, there were no new data. Rather, public and professional belief shifted because of broad education on the issue, buttressed by the National Cancer Institute's (NCI) approval of the trial and all the communication that followed. Further, a functioning infrastructure had been developed linking diagnostics, surgery, and radiation.

Once the trial results were released,[3] the shift in treatment came almost overnight. It is a classic story of technology diffusion. It is also a story of how one person, Dr. Fisher, his strength of personality, and his dogged belief in the scientific data, changed the paradigm of breast cancer treatment.

B-06 brought recognition and notoriety to NSABP, and led to a U.S. Congressional investigation for data fraud, targeting Dr. Fisher directly. In the end, he was exonerated, but the personal toll was immense. Dr. Fisher learned that one Montreal investigator altered consent date data in a way that was clearly wrong. Although the numbers involved were small relative to the size of the trial, and exhaustive analyses showed that the scientific conclusions reached were in no way compromised, the damage had been done.

Much of the trial money came to Canada where accrual and leadership were strong. Some institutions distanced themselves out of political correctness, if not fear of guilt by association, and there was opportunism from other trial groups who could gain from the weakening, if not demise, of this large and heretofore influential trial group.

What hurt Dr. Fisher the most was the sense that women would lose confidence in the science and data that made for such enlightened progress in breast cancer.

There was a perception that Dr. Fisher was tough, and he was. Agents of change have to be. He was uncompromising in his commitment to science, and his concern

Dr. Fisher, and his wife Shirley, visit with the resident *shamas* at the Lubeck Synagogue in Hamburg, Germany.

for women with breast cancer. This was evident in his relationships with colleagues, reviewers, journal editors, and most dramatically in his encounter with Congress. However, to those of us who knew him, he was a warm man of immense curiosity, clarity of mind, integrity, and concern for humankind.

In 1990, Dr. Fisher and I were attending a cancer meeting in Hamburg, Germany. We had heard about a small synagogue in Lubeck, Germany, one of three that the Nazis somehow did not destroy. Lubeck was about an hour away by train, and we decided to make the pilgrimage. We found a small elegant building, set back on a quiet street. The ritual caretaker, the *shamas*, welcomed us. He shepherded us around, telling us the history of the place. My father had died within the year, and I thought to recite the memorial prayer, the *kaddish*, in his honour. Dr. Fisher looked at me and said, "I'll recite it too. For lots of people." At the end his face was moist with tears.

Does Dr. Fisher qualify as a giant of science? If the criterion is whether our knowledge changed in a profound way as a consequence of his work, the answer is yes. If the criterion is whether he left a coterie of leaders for the next generation, the answer is also yes. And, if the criterion is whether he shared his deep humanity for the benefit of humankind, the answer is a resounding yes.

While working with Dr. Fisher, the challenge was daunting, and as in true science, the specific outcome uncertain. But the goal was always clear: to advance medicine and makes lives better.

**References**

1. Schipper H. Shifting the cancer paradigm: must we kill to cure? J Clin Onc. 1995 May; 13(4): 801–7.

2. Fisher B, Bauer M, Margolese R, et al. Five-year results of a randomized clinical trial comparing total mastectomy and segmental mastectomy with or without radiation in the treatment of breast cancer. N Engl J Med. 1985 Mar; 312: 665–73.

3. Schipper H, Minden KP. Writing papers and changing minds. CMAJ. 1994 April; 150(7): 1075–8.

The author's E-mail address is harveyschipper@gmail.com.