This year marks a milestone in the 134-year history of the American Medical Association. After several years of research and analysis, the AMA is rolling out a series of action programs that will be more responsive to what physicians tell us they need.

Building a more member-centric AMA is both long overdue and well under way. While public approval ratings of the AMA remain high, we are working aggressively to reconnect with America's physicians. The AMA has taken a comprehensive look at its programs, its objectives, and its future to develop a strategy that we believe will best serve America's physicians, as well as the future of organized medicine. Guided by management consulting firm McKinsey and Company, AMA leaders prioritized the association's activities around the following major goals.

1. Greater physician involvement in AMA decisions and actions. The AMA is holding a series of open-forum roundtable discussions in major U.S. cities; it developed a Member Connect survey research program to help it to set its agenda and identify emerging issues for study; and it has expanded its grassroots advocacy efforts to help AMA members to work on important legislation and regulatory actions.

2. More focused advocacy. The AMA's 2005 Health Care Advocacy Agenda addresses these symptoms of an ailing health care system:
   - Medical liability reform—President Bush and leading members of Congress have declared this a national priority. The AMA is aggressively campaigning for reform at both the national and state levels. Texas, Nevada, and Florida have revised their state laws to begin the control of runaway jury awards in tort cases.
   - Improving public health by promoting healthy lifestyles, and eliminating health disparities—The AMA's success in battling Big Tobacco is a matter of record. We are committed to waging equally aggressive campaigns against other public health problems that rob patients of their health and escalate health care costs. At the same time, the AMA is working to improve outcomes for minorities, and educate physicians about what they can do to minimize or eliminate minority health disparities. Disparities in the provision of medical care are now on the national agenda.
   - Regulatory relief—The AMA is vigorously involved

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Edward L. Langston (MD, Indiana University, 1975) is a trustee of the AMA.

Nancy H. Nielsen (MD, University of Buffalo, 1976) is a speaker of the House of Delegates of the AMA.

Donald J. Palmisano (MD, Tulane University, 2003) is the immediate past president of the AMA.
in the never-ending crusade to slash red tape and create physician- and patient-friendly rules and regulations. We are committed to clearing the logjam of unnecessary and sometimes harmful bureaucracy that hinders the practice of medicine and patient care.

- Managed care reform—Current antitrust regulations prohibit independent physicians from negotiating with huge managed care organizations. The AMA is working to change those regulations so that physicians have the same bargaining power other professionals enjoy. The AMA also continues its energetic campaigns to block mega-mergers of managed care behemoths, because we believe that patients stand to suffer from over-concentration of economic power.

3. Improved communication. Today’s AMA must be a critical and far-reaching voice in American health care. Its members therefore want timely, focused, and easy-to-read briefings on the progress of the AMA’s national health care agenda. Such briefings should include breaking news and an annual advocacy “scorecard” on the past year’s achievements. Through these briefings, we hope to better inform and connect with physicians and our members. Research indicates that more than 50 percent of all physicians and 70 percent of current AMA members strongly support the role medical societies can play in improving the profession and general health care. Health care activists welcome opportunities to help shape and influence health care in this country, and we want to connect with them and urge them to share their activism and efforts for advocacy with our 250,000 members. Improving communication among doctors, particularly those working directly for change, is vital to clarify and coordinate physicians’ advocacy efforts, and we want to enlist more physicians to work together with us in addressing these critical issues. The AMA can unite physicians to tackle the tough issues about medicine and health care in this country.

During 2005, the AMA will expand and enhance its coordinated efforts to address each of these critical issues. Our challenge remains to communicate our progress to physicians and the public. America’s physicians agree with us that together we are stronger—only together can we truly play an active role in shaping the future of medicine.

As part of this effort to work stronger together, in 2005 we will unveil an entirely new look to the AMA, designed to capture the essence of the organization’s ultimate goal, that of being the most influential advocate for U.S. health care. The new brand and our rejuvenated strategic direction will both embrace the AMA’s traditional programs and interests and more clearly communicate our focus, and will bring all aspects of organized medicine together to address these.

The AMA historically has used its unique position to unite physicians, leveraging the extraordinary diversity of our profession toward one straightforward, uncompromis-
Sunday morning rounds when the Baptist Church Choir came through

Richard I. Haddy, M.D., and Theresa B. Haddy, M.D.

Dr. Richard Haddy is a professor in the Department of Family and Geriatric Medicine at the University of Louisville School of Medicine, and the immediate past vice-chair for Academic Affairs there. Dr. Theresa Haddy is an academic advisory staff member at the Children's National Medical Center in Washington, DC. The incident described below really happened, and the patient made a good recovery.

There I was on Sunday morning, with a group of residents outside the patient’s room in one of our affiliated hospitals, trying to read the patient’s chart and figure out how to tell the residents that the case had been mishandled and how to say it in way that wouldn’t hurt their feelings too badly. Trying to figure out, too, how I was going to explain this mistake to our chairman (this really scared me), when here came the Baptist Church Choir, all two dozen of them, resplendent in their Sunday-best attire.

Bless you, brothers and sisters! (Choir director’s hand gesture, blessing everyone.)

Me: Oh, yeah, hi! (Dismissive hand wave.)

Shall we gather at the river, where bright angel feet have trod, (Choir in full voice.)

Me: Now let’s go over this case again. You tell me that the bed, I mean the patient, is a 24-year-old man, a known drug abuser, who came in during the night with osteomyelitis of the left tibia. What makes you think he has osteomyelitis?

With its crystal tide forever, flowing by the throne of God,

Me: You say that the bone, I mean the patient, was clearly infected, as shown on X-ray and bone scan. Now, why did you start antibiotics right away?

Yes, we'll gather at the river, the beautiful, the beautiful river,

Me: You started antibiotics because you think he has an infection of the river, I mean the tibia? And it was important to get treatment started? But what did the cultures show? How did you know which antibiotics to use? What did the orthopedists say?

Gather with the saints at the river, that flows by the throne of God.

Me: O.K., guys and gals, here’s what we’ll do. We’ll stop the antibiotics for the time being and call in the saints, I mean the orthopedists, for a bone biopsy. Unfortunately, we’ll have to temporarily discharge the patient and delay the bone biopsy for two weeks, since antibiotics have already been started. Then we’ll restart the antibiotics and readjust them according to the cultures and sensitivities.

Bless you, brothers and sisters! (Choir director again blessing everyone.)

Me: Yeah, yeah!

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The Pharos

Problem solving: A story for medical educators

Bennett Lorber, M.D., D.Sc. (Hon)

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In my more-than-30-year career as a medical school teacher, I have been repeatedly stricken and dismayed by the following observation. Students coming to medical school are generally bright, filled with intellectual curiosity, and in pursuit of many other attributes important to professional competence, including problem-solving skills. We then put them in classrooms, lecture to them hour after hour, overwhelm them with information, and change them from creative, energized, idealistic go-getters into passive learners lacking the ability to solve even simple problems. When they later reach the clinical part of the curriculum, we must rekindle the flame of curiosity and help them to find anew the problem-solving bent they had when they arrived. The following true story illustrates this point, and serves as a reminder that we who teach in medical schools need to strive to support and foster the problem solving ability of those who arrive in our schools, and not breed it out of them.

On the first day of the medical school course in physical diagnosis, my task as preceptor was to perform a demonstration history and physical for the two second-year medical students assigned to me. I did that, but I wanted the students to be excited, to remember their first visit to the hospital for more than their first opportunity to wear their starched white coats and carry their new stethoscopes. I took them to the room of a man who had severe aortic stenosis, and who was to have an aortic valve replacement the next day. He had the loudest murmur I had ever heard. I prearranged the visit, and the patient was expecting us. At his bedside, I introduced the students to him and asked them to place their stethoscopes on his chest and listen for a moment. After some time, they raised their heads and looked at me expectantly.

I turned to the first student. “What did you hear?” I asked.

“I heard him breathing,” she said.

I turned to the second student. “And what did you hear?”

“I heard him breathing, too,” was his reply. Of course, the sound from the murmur was so loud that no breath sounds could be heard. I thought for a moment.

“Listen again,” I urged. Again they listened and then waited for my next instruction.

“Try to imitate the sound you heard with your mouth,” I said to one student. A look of panic spread over his face and he froze.

“O.K.,” I said, directing my comments to the other student.

“Can you make the noise?” The blood seemed to drain from her face, and she silently shook her head.

I smiled, tried to soften my voice, and spoke with as much support and encouragement as I could muster. “Don’t worry. Soon you’ll be able to do this with no effort. Try to forget what you’ve learned in school for a moment.”

Let’s pretend you are back in elementary school. If I had asked you then what was inside your chest, what would you have told me?

“The lungs,” said one student.

“Good,” I replied. “And what else?”

“The heart,” came the response from the other student.

“Right,” I said with a big smile. “Now, if you heard a noise and you couldn’t tell whether it was coming from the lungs or the heart, could you think of a way to tell one from the other?”

Panic returned to their faces. At this point I felt certain that if I asked for their names, they wouldn’t be able to respond. I turned to the patient who seemed to be getting a good deal of amusement out of the interchange and said, “Could you hold your breath, please?” And, in point of fact, these students listen again? He nodded affirmatively. I asked the students to listen once more while he held his breath. The lesson was clear, and they seemed a little sheepish. I spent a few more moments describing the murmur, and then dismissed them, their obvious relief. I didn’t really think anything about these events until a couple of hours later that evening.

My family and I were just finishing our evening meal when the phone rang. It was my grandmother. She asked if I could do her a favor. It seemed that my grandfather had not eaten his evening meal with his usual relish, and she was concerned.

“Could you come check out your grandfather?”

“Sure,” I said. “I’ll be there in a little while.” I turned to my eight-year-old son, Sam, and asked if he would like to accompany me on a little house call to see his great-grandparents.

When we arrived at their apartment, we were greeted at the door by my grandfather who looked well and was clearly pleased that my grandmother had called me. I asked him some questions, watched him walk, took his blood pressure, felt his pulse, listened to his lungs and heart, and felt his abdomen. All was well. He did have a heart murmur that had been present for years.

When I finished, I handed the stethoscope to my son. “Here, Sam,” I said, “check out your great-grandpa.” He put the stethoscope earpieces in his ears and placed the diaphragm on my grandfather’s chest. Sam closed his eyes and scrutinized up his face the way he did when engaged in serious activity. After a few seconds he began nodding his head up and down, and, after a few more moments, he removed the stethoscope from his ears and handed it back to me. “What did you hear, Sam?” I asked.

He looked at me and answered, “His heart was making a noise like this.” He then made a shushing sound with his mouth, imitating the sound of a heart, or the heart, could you think of a way to tell one from the other? Just then, his face changed to one of amusement out of the interchange and said, “Could you hold your breath, please?” I turned then to my next instruction.

It was going to slow to be his breathing, so I figured the noise must be from his heart.

“Sure,” I said. “How would you like to teach physical diagnosis to second-year students?”

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Perspectives

Sports physicals

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The first question I asked Mrs. Carter, who had brought her three children to the Pediatric Infectious Diseases Clinic, was, “Do you know why you are here today?” Mrs. Carter smiled, nodded yes, and suggested that she and I talk in another room while the kids giggled and played with the blood pressure cuff.

Three months ago, Mrs. Carter had undergone an evaluation as she was updating her life insurance. Her HIV serology had turned up positive. She was told that there are many reasons for false positive HIV antibody assays. Did she have cross-reacting antibodies? Perhaps she had an autoimmune disorder? The HIV serology was repeated, and was again positive. A month later, she came down with a fever and a cough, ending up in the ICU with Pneumocystis pneumonia. HIV infection was confirmed.

Mrs. Carter started antiretroviral therapy. She took a leave of absence from her work at the beauty shop. Her husband changed jobs so he could help with the children. Instead of being out of town for weeks at a time, he now commuted four hours a day. And there was this enlarged cervical node, sched-
uled for biopsy tomorrow. Could be lymphoma, she was told.

Mrs. Carter thought she had acquired HIV from her first husband, who she described as having risk factors. Her current husband of eight years tested negative for HIV. She was horrified to think that she might have infected her children.

Mrs. Carter lived in a small rural town. Everyone knew everyone else. She was not sure how others would react to her diagnosis, was afraid her family would be ostracized. She hadn't figured out how or what to tell the kids yet. Their visit to our University clinic today, several hours' drive from home, was for “special sports physicals.”

We returned to the exam room. I started with Keith, a nine-year-old boy. He had no unusual or frequent illnesses, was doing well in school, growing well. His exam was normal.

Next, I took a look at Donna, a seven-year-old girl. She was also healthy, Mrs. Carter said. She had had lots of ear infections as a kid, even requiring tubes, but plenty of children had that. The tubes fell out, and she still has a draining ear. Otherwise she's fine, doing well in school, active. Her height and weight were fifth percentile for age. Donna scratched her arm, and I asked about the bumpy excoriated rash. Mrs. Carter said Donna was diagnosed with “something contagious” a few years ago, and they were waiting for it to go away. Indeed, it looked like molluscum contagiosum; it went from her elbow to her axilla. I tried to change my thoughts. I palpated axillary nodes bilaterally. My heart sank. I felt her spleen. I was cold and sweaty and lightheaded. I wanted to be alone, to curl up into a ball.

I smiled and looked at Gene, five years old. His grin went from ear to ear. Hardly ever sick, starting kindergarten soon, growing like a weed, developing well. His exam was normal.

The perinatal HIV transmission rate is about 30 percent in the absence of antiretroviral therapy/prophylaxis. One out of the three children's HIV serologies was positive. Combination antiretroviral therapy can reduce the perinatal transmission rate to less than two percent.

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Supplemental oxygen

He fusses while he fiddles with his cannula, 2 liters per minute unless he needs a pick-me-up.

He can dial up to 6 and does, although I’ve told him don’t.

I tell him slow to clot won’t make you cold,

He takes blood thinners and knows that’s why he chills so easy.

He doesn’t breathe as much as exasperate.

Whatever, the electric bill has doubled.

I counter with a lurid story.

The pump humming like religion

A little knowledge is a dangerous thing

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