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Requests for reprints of individual articles should be forwarded directly to the authors.

The Pharos of Alpha Omega Alpha Honor Medical Society (ISSN 0031-7179) is published quarterly by Alpha Omega Alpha Honor Medical Society, 525 Middlefield Road, Suite 130, Menlo Park, California 94025, and printed by The Ovid Bell Press, Inc., Fulton, Missouri 65251. Periodicals postage paid at the post office at Menlo Park, California, and at additional mailing offices. Copyright © 2009 by Alpha Omega Alpha Honor Medical Society. The contents of The Pharos can only be reproduced with the written permission of the editor. (ISSN 0031-7179)

Circulation information: The Pharos is sent to all dues-paying members of Alpha Omega Alpha at no additional cost. All correspondence relating to circulation should be directed to Ms. Mara Celebi, Webmaster, 525 Middlefield Road, Suite 130, Menlo Park, California 94025. E-mail: m.celebi@alphaomegaalpha.org

POSTMASTER: Change service requested: Alpha Omega Alpha Honor Medical Society, Post Office Box 2147, Menlo Park, CA 94026.
During this 150th anniversary year of the birth of Charles Darwin, I have been musing about the possibility that the combination of scientific advances in medicine and the desire of human beings to improve themselves as individuals will, slowly but surely, effect an accelerated evolution of our species.

These changes in human beings that the evolution of medical science has generated are much more rapid than the physical ones other living organisms undergo by variation, inheritance, and selection over a million or so years. A clear example is the increase in life expectancy of the average person in developed countries over the past century. This could not have occurred without direct intervention of humans upon themselves. Public health policies providing clean water and in developed countries over the past century. This could not have occurred without direct intervention of humans upon themselves. Public health policies providing clean water and effective waste disposal, as well as, more recently, effective dissemination of data showing that smoking cigarettes can lead to early death, the discovery and development of antibiotics that cure bacterial infections, and anti-hypertensive drugs that diminish the incidence of cardiovascular catastrophes, are remarkable achievements. In addition, a good statistician could make a good case for synergy when technological advances, starting with dialysis and multi-organ transplantation, the imaging revolution, and effective cancer therapy, are blended with man's quest for longevity. Imagine the excitement among archaeologists if one of them unearthed evidence that a species of mammals during the period of 1000 to 1070 BC showed an increase in longevity from thirty years to forty-five. The race to find the environmental factors that brought this about would have stimulated all the sciences. These factors would not be the slow changes of gene modification. We, as a "highly evolved" species, however, take our increased chances of living to eighty years as a mere starting point.

Where is it all leading? Unsatisfied with having just a longer life, humans are focusing upon having a better life, striving for "compression of morbidity." That means having a long life marked by continued health and productivity, ended by a rapid decline and death at an old age from the inevitable combination of multiple organ failure. One of the elements of this goal is our quest to at least maintain and, at best, increase our mental acuity. One of the "gifts" for donating $12 a month to support local public radio, for example, is the "Brain Fitness" computer-driven program. The contributor can then spend an hour each day for forty days trying to achieve better memory and comprehension.

A relatively recent extension of this effort to improve our brain function is the use of neuroenhancement drugs. A lot of effort in the pharmaceutical industry is devoted to giving us the ability to tinker with our brain function. Margaret Talbot writes about this "Brain Gain" in a recent issue of The New Yorker. It is ironic that for centuries, we have been drinking coffee and alcohol, having sex, exercising, even skydiving to give ourselves those "highs" that make living more interesting. Many of us have become addicted to one or more of these hobbies. It is a recognition that life may well be, by and large, a quest to feel good. One way to feel good is to feel "smarter," forcing evolution by using neuroenhancement. At one small college in 2002, for example, more than thirty-five percent of students used "cosmetic neurology" to strengthen ordinary cognition. Everyone in our "developed societies" wants to be recognized as being "above average." Support for the moral and ethical acceptability of neuroenhancement comes from many directions. Across the country, it is estimated that seven percent of American college students buy and use Ritalin, Adderall (a mix of amphetamine derivatives), and/or Provigil to study harder with less sleep and get better grades. The pharmaceutical industry is hard at work developing more drugs like them that have better efficacy and fewer unwanted side effects. In the lay press as well as in peer-reviewed journals, there are many reasoned and intellectual treatises supporting this "hot-house" evolution of our species. How many parents would not want their children to achieve higher scores on exams if "safe" cosmetic neurology was available to help them attain this?

As an aside, it is also ironic that while cognitive enhancement is gaining acceptance, use of performance-enhancing drugs among athletes is deplored, and for good reasons. Unless serious long-term side effects of neuroenhancers are found, it is unlikely that there would be penalties for students taking Adderall to match Manny Ramirez's fifty-game suspension from major league baseball for allegedly taking human chorionic gonadotropin to revitalize his endocrine production of testosterone after taking that hormone for a sustained period of time.

Each of these available routes to accelerating evolution of our species will confront every medical student and young physician in ways never contemplated by older generations of physicians. Good arguments can be made for medical schools and medical societies making a strong effort to be sure that these younger doctors are firmly based in the institution of medicine, its scientific, humanistic, and ethical bases, at a time when more and more medical students appear to see their careers as a business rather than a profession.

How can we impress this on them when they are bombarded with so many different stimuli? Among the facts they must learn, the evidence-based medicine they will practice, the restrictions on hours that they can work during training, the debts they must repay, the specialty they must choose that is often determined by their debt, how much time and attention is left?

Reference

1. Talbot M. Brain Gain: The underground world of "neuroenhancing" drugs. The New Yorker 2009 Apr 27: 32–43.
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Ms. P: Case summary

Ms. P is a fifty-year-old woman with a history of hypertension who presented to the hospital with a severe allergic reaction to over-the-counter pain medications. During her hospitalization, Ms. P admitted to the intern that she had experienced the same allergic reaction before and felt ashamed that it had occurred again. In discussing how Ms. P organizes her medications, she also admitted that she only intermittently takes her blood pressure medications. She revealed that she is a busy caregiver for her mother and son, both of whom live with Ms. P and have complex medical problems of their own. The intern, consulting with her resident and attending, wondered how she can best help Ms. P return home safely and avoid future problems with her medications.

Sir William Osler, if reincarnated and the attending for Ms. P, would have taken this opportunity to teach his residents the importance of knowing her as a person, for it was he who famously observed, “It is much more important to know what sort of a patient has a disease than what sort of a..."
Teaching residents to know their patients as individuals

Despite increasing evidence that knowing the patient as an individual improves patient outcomes, graduate medical education (GME) pays little attention to affording residents the opportunity to know their patients well. If you ask the members of an inpatient ward team what keeps them from knowing their patients, most—from students to residents to attendings—say, “We don’t have enough time.” Medical historian Kenneth Ludmerer laments the recent focus of residency training on service over education, with residents caring for greater numbers of patients for shorter periods of time. He argues that a fundamental educational principle of traditional medical education requires that residents learn deeply from and about fewer patients, citing the landmark report by Abraham Flexner: “Men become educated by steeping themselves thoroughly in a few subjects, not by nibbling at many.”

Hippocrates wrote, “Healing is a matter of time, but it is sometimes also a matter of opportunity.” At Johns Hopkins Bayview Medical Center, we are seizing the opportunity to give residents the gift of time to allow them to become healers and know their patients in the way Osler recommended. The Aliki Initiative—a new educational program named for philanthropist Mrs. Aliki Perroti, who supports our efforts—reduces residents’ workloads and creates new opportunities for residents to know their patients more fully both inside and outside the hospital. The program provides residents the time both to get to know their patients and to learn from and reflect with their teachers.

The importance of patients’ narratives

The opportunity to know patients as individuals is one of the greatest rewards in medicine. The narratives of our patients’ lives fuel our passion for this work and keep us grounded in the art and humanity of medicine. By allowing us into their lives—whether through a single, brief interaction in the hospital or an enduring relationship over decades—patients bestow on us a special privilege.

Beyond this, however, our capacity to know patients as individuals allows us to translate the best evidence-based medicine into the highest quality, personalized care. In 1977, George Engel exhorted physicians to break free from the constraints of the biomedical model to understand “the patient as well as the illness” by uncovering the psychological and social aspects of patients’ lives and life views. This patient-centered framework of care is associated with improved patient outcomes, including better quality of life, improved adherence, pain reduction, and improved blood pressure control.

Despite its demonstrated benefits, the widespread failure of the health care system to provide individualized, patient-centered care is directly linked to suboptimal patient outcomes. A survey of 39,090 patients by Consumer Reports published in 2007 shows that fifty-eight percent of them feel their doctors do not know them as individuals. Another report in 2005 indicates that, on discharge from the hospital, fewer than half of patients can list or explain the purposes and side effects of their medications. A study by D. R. Calkins and colleagues published in 1997 shows that physicians, on the other hand, tend to overestimate the quality of their discharge instructions. A 2007 paper by Derjung Tarn and coworkers noted that physicians prescribing new medications only stated
the name of the medication seventy-four percent of the time and addressed adverse effects and duration of therapy about one-third of the time.\textsuperscript{13} This failure by physicians to communicate critical elements of medication use may contribute to failure by patients to take medications as directed. Similarly, Sunil Kripalani and colleagues in an article published in 2007 report that communication between hospital physicians and primary care physicians is often lacking or suboptimal in detail, affecting the quality of care in twenty-five percent of follow-up visits.\textsuperscript{14}

Patient centeredness—one of six core aims for improving the quality of health care in the United States

The Institute of Medicine (IOM) report Crossing the Quality Chasm highlights patient-centeredness as one of the six core aims for improving the U.S. health care system. The report defines patient-centeredness as: "Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."\textsuperscript{15,16} Toward that goal, the IOM in the follow-up report Health Professions Education: A Bridge to Quality proposes that skills in providing patient-centered care should be a central competency for health professionals.\textsuperscript{16}

Unfortunately, traditional GME is not prepared for this imperative. The goal of GME is not only to provide trainees with the knowledge and skills to care for patients like Ms. P, but also to inculcate in them the core values of the medical profession.\textsuperscript{17} GME today, however, is largely driven by the service needs of medical centers instead of thoughtful educational priorities.\textsuperscript{2} Residency graduates emerge from three years of stressful, demanding training ill-equipped to provide the type of patient-centered, quality care Ms. P deserves. Rather than learning to care for patients collaboratively across transitions and in the greater context of their lives, health care is both practiced and taught in "silos."\textsuperscript{18} At the same time, the structure and financing of GME elevates the business of medicine over the vocation of medicine, creating a hidden curriculum in which "the values of the profession are becoming increasingly difficult for learners to discern."\textsuperscript{19,20} of hours without adjusting the volume of work may lead some residents to make conscious decisions about how to spend their time, as voiced by one resident in a 2005 survey: "It is harder to have as much time to speak with and really get to know patients, which impacts the ability to have shared decisions and understand patient perspectives."\textsuperscript{21,22}

Finally, GME leaves little time for reflective learning. Reflection allows physicians-in-training to think about the meaning of their experiences with patients and how these experiences are influencing their own overall professional development.\textsuperscript{23,24} Although medical educators promote the potential value of self-reflection through activities like critical

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Teaching residents to know their patients as individuals

incident reports and portfolios, trainees’ capacity for reflection may decline with the workload and fatigue of residency training.25–27

Thus today’s young physicians-in-training may master the mechanics of delivering medical care, yet never have the opportunity to learn the art of healing.

Creative philanthropy—key to success of the Rockefeller Foundation

At the turn of the twentieth century, Frederick T. Gates advised John D. Rockefeller to establish an institute of medical research focused on medical education reform. Rockefeller’s $32 million endowment of the General Education Board comprised the largest gift to higher education up to that time.28 In 1905, Henry Pritchett of the Carnegie Foundation commissioned Abraham Flexner to study the state of medical education in North America and to make recommendations to improve it.28 This effort resulted in the publication of the Flexner Report, perhaps the most influential document in the history of American medical education.29 These achievements a century ago represent striking examples of the ways creative philanthropy can both reform and shape medical education to meet the needs of society.28

The need for educational reform is once again upon us, but the funding constraints of a market-driven health care environment hamper innovation by hospitals and educators.2 Reform in the twenty-first century may require educators to consider again the potential of partnering with the public. The Aliki Initiative is a program designed to create physicians who treat all patients with compassionate, competent, and personalized care.

The Aliki Initiative aims to develop caring doctors who have a genuine and deep appreciation of the importance of knowing each patient’s unique personal circumstances and who make patient care recommendations that apply the best evidence to the individual patient. The program reduces the number of patients assigned to each resident, providing residents more time to spend with patients during and after their hospitalizations, and thus offering new opportunities for residents to learn from and about their patients.

The Johns Hopkins Bayview Medical Center is an academic medical center serving 8700 medicine inpatients per year; twenty percent are poor. Patients hospitalized on the medical service receive care either from a hospitalist service or from one of four house staff teams. Teams contain one resident, two interns, two students on basic medicine clerkship rotation, a faculty attending, and a case manager. A traditional team admits ten patients every fourth night on “long-call” and four patients during an intervening “short-call.” In October 2007, one team became an Aliki Team, admitting five long-call patients and two short-call patients. Hospitalists care for the patients who would otherwise be admitted by this house staff team.

Lower patient load enables more teaching to the Aliki Team

With this reduced census, the Aliki Team has the time to participate in teaching sessions and mentored experiences designed to foster appreciation of knowing each patient as a unique person and understanding each patient’s psychosocial circumstances. This begins from the admission encounter, when house staff learn to elicit a more meaningful, detailed history that includes patients’ understanding of their illness and their health. By engaging in this dialogue with patients, their caregivers, and their outpatient health care providers, house staff learn who and what patients have left behind when they arrive at the hospital, an often forgotten but equally important transition time.

Residents also learn how to provide counseling and treatment to match patients’ needs and concerns. One key component of the Aliki Initiative is learning to assess and overcome potential barriers to medication adherence, particularly by tailoring evidence-based treatment to the patients’ particular preferences and resources.

During each day of the hospitalization, house staff continue these conversations, honing their skills in patient education and joining with patients in shared decision making about diagnostic or therapeutic options. Leading up to and on the day of discharge, house staff prepare patients and their caregivers for the transition to home, rehabilitation centers, or other settings in the patients’ communities.

In contrast to usual practice following discharge, residents call all patients within a few days of discharge to answer questions, check their understanding of the hospitalization and treatment recommendations, review their understanding and ability to adhere to the discharge treatment regimen, and offer assistance with any problems that have arisen in the transition.

Finally, the Aliki Initiative provides the most powerful learning opportunity of all: team members learn to know their patients as individuals within their own homes and communities. Five or more patients per month give residents permission to visit them after discharge in their homes or subacute care facilities. Often, patients allow residents to photograph or film these visits, so the house staff can teach their colleagues about these rich, rewarding experiences during a monthly Aliki morning report conference.
Outcome—narrative medicine yields better patient care

Since October 2007, over half of our house staff have participated in the Aliki rotation. During hospitalizations, residents spend more time at the bedside with their patients and patients’ loved ones, discussing medications and other treatments and coordinating care with outpatient providers. Interns and residents say they gain their greatest insights during their time with patients after discharge, when they call all of their patients and visit five or six patients at their homes or subacute care facilities.

In addition to enhanced time with patients, team members have the time to reflect on their professional and personal growth, both individually and as a team. Each month, faculty and attendings working with the Aliki house staff meet to debrief the team about their experiences. The most striking and consistent observation is how often house staff report “being surprised” by what they have learned about their patients. Prior assumptions about a patient’s preferences, barriers, abilities, or concerns are regularly challenged when residents take the time to know patients individually. This deeper insight, in turn, has repeatedly led to opportunities to provide better patient care. Below we present some examples of “assumption-challenging” Aliki experiences and how they impacted patients and house staff.

Ms. P: The Home Visit
A few days after discharge from the hospital, the Aliki Team intern and attending visited Ms. P at her home, learning more about her home situation and meeting her mother and son. They discovered that—in an attempt to remind herself to take her medications—Ms. P keeps her medications on her dining room table. Otherwise, she reported, the medications are “out of sight, out of mind.” The intern realized that both Ms. P’s mother and her son also keep their prescription and over-the-counter medications in the same location, increasing the chances that any of them could take the wrong medication. The intern also learned about the ways Ms. P copes with caring for her family, including the supports she receives from her community. Together, the intern and Ms. P brainstormed about how to organize...
Teaching residents to know their patients as individuals

her medications more safely and help her remember how to take them.

From the home visit the intern learned more about the challenges of integrating a complex medical regimen into a person’s daily life and ways to engage patients in finding solutions to these challenges. Ms. P expressed appreciation that the intern took the time to come to her home: “They treated me like I was someone special.”

This learning experience is just one of many. Other examples of Aliki experiences include:

- An intern spent significant time with a man facing a difficult decision about treatment for pancreatic cancer. The patient initially told him, “I’ll do whatever you say, Doc.” Nevertheless, the intern patiently spoke with him every day to learn about his goals of care and preferences. He wasn’t sure he was making any difference until one day the patient told him, “Doc, I don’t want any of those things. I want to go home.” The intern helped him transition to home hospice, and felt certain that this was “the right thing to do for him.”

- A former Aliki resident working as the urgent care doctor for the clinic described “an Aliki moment” during which he discovered that a patient with gastrointestinal bleeding was unable to afford his proton pump inhibitor after hospitalization. Experience on an Aliki Team gave him the skill and confidence to ask the patient explicitly and thoughtfully about all barriers to adherence. The resident switched the patient to a generic medication covered by the patient’s insurance and spent time counseling the patient about the rationale for this therapy.

- An intern visited a patient with urinary retention in a subacute care facility and learned that the patient’s Foley catheter had been removed despite notations not to do so in the “hospital course” section of the discharge summary, and despite the patient’s own recall of their recommendations. The team resolved that in the future they would document more explicit instructions with the medications list at the end of discharge summaries and call ahead to subacute care facilities for similar important follow-up issues.

Although residents were initially concerned that fewer patients would mean less opportunity for traditional medical learning, in fact, they report having more time for evidence-based and bedside teaching. One team decided to focus on physical diagnosis skills. The teaching attending physician on this team described the experience as “the first time I am sure that the interns really knew how to examine a patient by the end of my weeks with them.” The supervising residents also relished the additional time to search the literature for articles and prepare teaching for the team.

House staff participating in the Aliki team feel greater pride and more fulfilled in their work. In the words of one intern, “It’s given me time to be the kind of doctor I’ve always wanted to be and do the things I should be doing for all my patients.”

Ms. P: Epilogue

Asked about the home visit, Ms. P said, “I thought those days were over. You know, how the doctors used to come to your house. They came down, sat down to talk, to see how I was getting out of the hospitalization. And that made me feel good because some doctors don’t have that interest or do a follow-up to find out how the patients are doing . . . That’s letting the patients know that someone else cares. That made me feel that I was important, and they’re learning from me! . . . They treated me like I was the only patient they had to see that day. They treated me like I was someone special.”

Where from here?
More opportunities for innovative medicine

Our early experience suggests that the Aliki Initiative has the potential to increase residents’ skills and motivation to deliver patient-centered care. Ongoing and planned evaluations of the program’s outcomes include:

- An assessment of Aliki residents’ self-assessed behaviors, attitudes, and skills before and after participation in the experience.
- Trainees’ perceptions and understanding of medication adherence and cost.
- An audit of the medical records of patients cared for by an Aliki team, compared with patients cared for in other settings, to evaluate prespecified aspects of inpatient care, transitions of care, and the quality of discharge documentation.

In addition, we will examine the impact of the Aliki Initiative on such patient outcomes as hospital length of stay, quality and safety of the transition from hospital to home or to another care team at a skilled nursing facility, rates of rehospitalization, patients’ knowledge about their medical conditions and medications, and patients’ perspectives about the quality of their care and health care providers. These evaluations may help educators at other institutions determine what parts of this curriculum to try at their own institutions, and to secure grant funding to support such efforts. In addition, such evaluations may prove helpful to policy makers as they shape the future funding structure of GME.

Like the Flexner Report a century ago, the Aliki Initiative resulted from private philanthropy directed to improving medical training for the public good. When doctors and private citizens together view medicine and medical education as a public trust, everyone benefits. It also reminds medical educators that we cannot accept the status quo and need to show the public what our vision for patient-centered care can and must be. As Molly Cooke and her coauthors write, “No one would cheer more loudly for a change in medical education than Abraham Flexner. . . . He would undoubtedly support the
fundamental restructuring of medical education needed today. Indeed, we suspect he would find it long overdue.”

Acknowledgment

The Aliki Initiative is funded through the Johns Hopkins Center for Innovative Medicine, thanks to the generosity of Mrs. Aliki Perroti.

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Requirements:
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3. Four copies, each with poem title (required), author’s name, address, and e-mail address.
4. Poem must be original and must not have been submitted elsewhere. The Pharos will have the right of first refusal.
5. Author need not be a member of AΩA.
Before Everything

before everything
there was this nothing
perhaps like morning fog
not even that
moved without moving
became love
grew infinitely
now is everywhere
reach for it
and it’s gone
feel for it
it is everywhere
you are
perhaps like morning fog

Eric Pfeiffer, MD
Oh! Remember how impatience
Fidgets and paces the eager soul
The nearer comes our promised hour,
Prospects of leaving the Ivory Tower
To pursue writ destiny inscribed
For surgeons with eager, facile hands,
Cupped to spread inspired seeds
Upon their fertile, recently tilled soil.
And yet, who among us in youth,
Who view our role as master fixer,
Can envision ourself imperfected
As a surgeon with nodular tendons,
Afflicted by some ancient forebear
Born to an outlandish clan
Of Nordic descent, like Iceland,
Vegetating off wild Arctic moss,
Giving birth to a faulty gene
Creating a rare mutant scourge
That draws and gnares phalanges,
Terminating dissecting skills,
Leaving a mind-set with no outlet?
If I'm allowed one impertinence
By being the subject of this discourse,
"Let me denounce without amends
The first rogue to spread Dupuytren's."

Robert E. L. Nesbitt, Jr., MD, FACS, FACOG

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Illustration by Jim M'Guinness
Large and noble lines

The life of Howard P. Lewis, American College of Physicians president, 1959–1960

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My opinion of you is best expressed by a line from Isocrates; “He was built on large and noble lines. Whatever he urged was for some high good.”

—Hugh R. Butt, MD (1910–2008), President, American College of Physicians, 1971–1972, and last assistant to Dr. William Mayo.

In late April of 1985, a young pulmonologist named William Holden walked into the hospital to visit his former teacher, Howard P. Lewis. Lewis had interviewed Holden for a residency position fifteen years previously. At that time Holden had answered rapid-fire questions shot from an imposing figure sitting behind the cloud of smoke emanating from his cigarillo. Later, Holden would treat his teacher’s emphysema. Now, Lewis was hospitalized in a room not far from his previously smoke-filled office.

Holden knocked on the door softly, opening it slowly. Lewis’s tall, eighty-three-year-old frame was gaunt, his face ashen. The protrusion of his spleen was almost visible through the sheets. Holden remembered when Lewis was first diagnosed. He remembered walking down the ward, catching a glimpse through a crack in the door: Lewis stood, the back of the gown wide open, and placed a medical resident’s hands on his spleen to show him the correct method of percussion. Now the hematologic malignancy...
had progressed to acute leukemia. Holden knew this time his old teacher wanted no more chemotherapy. Lewis lay in bed, motionless, mouth open, eyes closed. Holden was convinced that he had passed away.

Just then Lewis’ eyes popped open, and he looked around the room and said brightly, “Bill! How are you? I’ve been experiencing interesting vision changes, and I remember reading about it in the Archives of Internal Medicine, about four years ago.”

The phenomenon, he explained, was called Purtscher’s retinopathy—the transient vision loss resulting from aggregated leukocytes in the retinal vasculature. He asked Holden to get the article from the library. He wanted to re-read it. Holden visited with his former teacher, then left, went to the library, and found the article right where Lewis had said. He returned the next day to bring it to him, but Lewis had died. Just days later, as Lewis’ son Richard was cleaning his father’s office, the updated version of the Medical Knowledge Self Assessment Program arrived in the mail, an order the senior Lewis had placed just weeks prior.

Fifteen years after the death of Howard Lewis, I began my training as an internist in his hospital. I heard stories of a man with an unparalleled expertise in medicine. I tried to learn the techniques of physical examination from Lewis’ former students, amid their reiterated disclaimers that Lewis, were he alive today, would be ashamed of their skills. I watched the faces of older doctors light up when I asked about him. I saw fear in the eyes of one of his former students, a former World War II paratrooper who had not dared to disappoint him. I wondered how Lewis had lived his life in medicine. What motivated him? What was the difference between his era and ours today? What part of his teaching is still relevant? Could some of his teaching guide us through the difficulties that our profession now faces?

Before the advent of modern advances in radiology, pharmacology, and molecular biology, clinicians such as Lewis and several others carved out niches as brilliant diagnosticians and electrifying educators. They became larger-than-life pillars of the medical establishment. Many of these leaders were loved by their students, while other most certainly were not. Yet most are respected for a teaching style that, to quote William Osler, “Begins with the patient, continues with the patient, and ends . . . with the patient.” With a religious passion, many of these leaders created the archetype of the physician-healer for the middle of the century.

Of the prominent mid-twentieth-century clinicians—including Arthur Bloomfield at Stanford, Chester Jones at Massachusetts General Hospital, and Walter Palmer at the University of Chicago—many achieved greater recognition than Lewis. Few, however, would challenge the high standards or the diagnostic expertise of the tall stately man from the small northwestern city of Portland, Oregon. What stands out with Lewis, perhaps, is how and why he rose to be one of the nation’s elite physicians while working in a remote city not even served by jetplanes until 1960.

Lewis was born in San Francisco on February 18, 1902. His father, Edmund Phelps Lewis, from a family of East Coast ministers who had migrated to California, owned and managed a successful hardware store in Santa Rosa, California. His wife, Edith Howard, was a tall and stately woman from Oakland who graduated from the University of California in Berkeley. Young Howard, named after his mother’s family name, was the first child of three.

Shortly after the dome of the Sonoma County Courthouse in Santa Rosa collapsed in the 1906 San Francisco earthquake, the Lewis family sought a new future. Edith had grown up in the small coastal town of Marshfield, Oregon, where her ancestors had started the first bank and coal mine, and her father still worked as a watchmaker and jeweler. Marshfield was the largest settlement on the largest bay between San Francisco and the Columbia River, an ideal port for coal steamers to deliver Oregon lumber to California, Mexico, and South America and to return with passengers. The year that the Lewis family arrived, 1909, the new Chandler Hotel was opened by a wealthy mine operator who lived in San
Francisco, complete with an elevator and telephones in the rooms. Edmund Lewis opened the Pioneer Hardware store in the city’s heart, where Howard worked as a boy. Howard spent the rest of his adolescent years in Marshfield, learning to hunt ducks and to play the violin. He graduated from Marshfield High School in 1920.

Howard Lewis arrived at the Oregon State Agricultural College in Corvallis in the fall of 1920 to pursue a degree in chemical engineering. A year earlier, a teaching assistant position in the chemistry department had been offered to a slim sophomore from Portland named Linus Pauling. Enrollment at Oregon State in 1920 had doubled since 1918, and the state had just approved a new property tax to support higher education, allowing the construction of a new engineering laboratory. While a burgeoning time in the life of the college, it was also a time of conservative thought. The Treaty of Versailles had been signed nearly a year earlier, Prohibition had gone into effect in January, and post-war Oregon shared the intolerance and isolation pervasive throughout the nation, as evidenced by restrictive immigration laws, Palmer Raids, and the rise of the Ku Klux Klan.

At the same time, national interest in chemistry, physics, and medicine was exploding. Paul Erlich had recently become one of the founders of modern chemotherapeutics by introducing the first effective treatment for syphilis. The completion of the Panama Canal and the diminishing threat of yellow fever—both unprecedented feats of engineering—suggested the potential of medical research in America. Prominent medical scientists at the time boasted that within fifty years science would practically eliminate all forms of disease.\footnote{The horrific number of wounded and ill patients between 1914 and 1918 created, out of necessity, a medical system of unprecedented scope. New advances in battlefield surgery, a new disease called shellshock, and the influenza pandemic of 1918 spurred a new focus on public health. Physician and medical historian Kenneth Ludmerer calls this post-World War I period “academic medicine’s first bull market.”\footnote{During the post-war years the first human diabetic was injected with insulin, vitamins B\textsubscript{1}, B\textsubscript{2}, and D were discovered, and Willem Einthoven invented the electrocardiogram.}}

The new building represented the collective goals of a medical profession in the West seeking to change from small, proprietary schools with part-time teachers to large medical universities with full-time faculty.

No other book has had such a revolutionary effect on the culture of academic medicine as Abraham Flexner’s 1910...
A self-driven learner, Lewis was the top student in his anatomy class, and was hired as an anatomy instructor, which helped him pay for his tuition. It was likely in the anatomy lab where he first developed the intimidating teaching style for which he became notorious. One of his first anatomy students recalls,

There was a man there by the name of Hod Lewis, Howard P. Lewis, a tall, gaunt, frightening person. He had a face like Abraham Lincoln, and he just scared the hell out of everybody. And he would come around to each table and take a forceps and pick up a little scrap of tissue, and he’d say, “Would you explain what this is?” He had a very sardonic face, a very dour attitude, and you just thought you were going to die. . . .

. . . . He never missed a beat. . . . When I saw him coming down the hall and he had his eye on me, I would just quake in my shoes. . . .

. . . . But he . . . turned out to be such a nice man.  

Demanding, inquisitive, stern, though also always respectful, Lewis frightened two generations of medical students. He did not do it purposely. He simply felt a strong duty to never lower the standards he set for himself and expected of others. He wanted his students to become excellent physicians as they entered a new era in medicine. He wrote in 1969:

Too little time has been given to teaching the basic skills of a physician—perceptive and thoughtful history taking, knowledgeable and technically competent physical examination, clinical diagnosis based upon the scientific method and a passion for precise record keeping. . . . Only by working closely with students and house staff, as I have for many years, does one come to appreciate how difficult it is to learn these skills well, how much and what kind of knowledge is necessary for their successful employment, and how much personal effort on the part of the teacher is required to assure they are learned.  

For over thirty years Lewis taught medical students physical diagnosis in a lecture class that became central to their medical school curriculum. This duty and determination to train young doctors was a natural extension of the responsibility Lewis felt to his patients. Later, after his tenure as chairman of the American Board of Internal Medicine (ABIM), during which he was well-known for failing students in their oral board examinations, Lewis remarked,
We have to keep constantly in front of us the idea that standard-setting is not done for us; it’s done for the public. There is no excuse for [ABIM’s] existence unless the ultimate goal is bettering the quality of medical care. Keeping that objective in our minds is hard to do in the face of all the distractions.11p42

Lewis found a method to block out those distractions, and he tried to pass the same skills to his students. His chief residents were occasionally invited to sit with Lewis in his study, choose a medical journal from his shelves, and read quietly together. Lewis told one resident that he had found a cure for dozing off while reading—he placed the book on the mantle and stood while reading so he would wake himself up when he fell.3

Despite the high standards Lewis set for himself, he told his son that his students took him more seriously than he would have liked.3 He earnestly tried to reach out to his students. He often consulted with his son, at the time a new medical student, about how best to teach his lessons. He wrote of his teaching sessions, "Every attempt is made to dispel any air of authoritarianism. I find this quite appropriate, because on many occasions I have proved to be no authority."12p28

Still, given his well-recognized expertise in knowledge, and the dedication with which he demanded excellence, one can hardly blame his students for their apprehension.

Adding to students’ fears of a lack of medical knowledge was their struggle to meet his demands on their behavior, physical appearance, and language. Walter McDonald, former chief executive officer of the American College of Physicians (ACP) and co-author of the 2002 ground-breaking Charter on Medical Professionalism, was one of Lewis’s residents. He recalls one department Christmas party at which he wore “a white shirt that had the narrowest blue stripe that you can imagine, and in a very kindly fashion Lewis waited until he got me off to the side and told me that he thought the shirt was perhaps a little loud.” And although McDonald laughs quietly today about this extreme formality, he reminds us of the influences that Lewis had as he goes on to say “He made you not want to do it again.”13

Paralleling the eruption of new medical knowledge in the second half of the century, the culture surrounding the practice of medicine underwent equally revolutionary changes. During the 1960s and 1970s Lewis acted as a messenger from the previous era, reminding and teaching about the important and increasingly forgotten ways of the past. He wrote to his son, “It has been difficult for me to adjust to the current sloppy age. House officers and students often look as if they had just come in from a cookout.”14 But for Lewis, the formality and standards that he demanded were simply part of his method and persona as a physician. They showed his respect for his patients, his attention to detail, his complete commitment to his craft—traits fundamental to the complete physician. He wrote:

My experience extends from the time when little was available in the form of technological and other aids in diagnosis and treatment, to the rich array of enormously helpful procedures and concepts we work with today. I think I can evaluate fairly what of the past is worth retaining and improving—and some is still indispensable. It is disturbing that the crush of our sophisticated medical knowledge and technology of today seriously jeopardizes the excellence and perpetuation of certain of our abilities in old and important fields—abilities that as far as I can see, are timeless.14

By 1942 the demand for physicians in the military had increased, and Lewis joined the U.S. Army Medical Department, serving as the assistant chief of Medical Service at Halloran General Hospital in Staten Island, and then as the chief at Rhoads Hospital in Utica, New York. While stationed there he cared for hundreds of patients, honed his physical examination techniques,
and published a review of tuberculous pleural effusions.\textsuperscript{15} While he felt a strong duty to his country and was later very proud of his service, he yearned to return to Oregon to take a position as a full-time teacher. Prior to the war there were no full-time department heads. The leading internist in Portland split time in a community practice while teaching at the university part time, and was eager to retire. For the university, lacking the money and reputation to conduct a broad search for an Internal Medicine chairman, the motivation to bring Lewis back was strong. Lewis had established a reputation in Portland as one of the city's premier clinicians. To those who knew him and his passion for the improvement of standards in internal medicine, the chairmanship at Oregon was an obvious transition. Discharged from the Army on April 1, 1946, as a colonel, Lewis accepted the position as the first full-time chairman of internal medicine in Oregon in early 1947.

The ideal chairman: Leading his faculty as a conductor his orchestra

Motivated to achieve excellence in patient care, medical education, and research, Lewis was eager to recruit new faculty members to his department. During the first few years of his chairmanship, the budget of the National Institute of Health (NIH) began to increase exponentially, paving the way for many new areas of subspecialty research. Lewis and medical school dean David Baird attempted to attract new research faculty to come out West. As a personal friend of NIH director James A. Shannon, Baird convinced Shannon to take the train to Portland to visit the young institution.\textsuperscript{16} Even so, money did not flow from Bethesda to Portland very easily, and the task of expanding the Oregon medical establishment was difficult. Lewis and Baird struggled with Oregon’s isolation from East Coast medical centers, the school’s lack of an established scientific reputation, and its modest salaries and research space.\textsuperscript{17} They offered their recruits a chance to be part of a new and growing department in Portland, but many turned them down.

Lewis’s first division head, local graduate Herbert Griswold in Cardiology, eventually worked with the prominent cardiac surgeon Albert Starr during the first successful cardiac valve replacements. Lewis continued to recruit division heads with research credentials, preferably from larger, more established medical centers. He gradually hired new heads of Endocrinology (Monte Greer from the NIH), Gastroenterology (John Benson from Massachusetts General Hospital), Dermatology (Walter Lobitz from Dartmouth), Psychiatry (George Saslow from Harvard), and Neurology (Roy Swank from Harvard / McGill). Although these men were recruited largely for their research expertise, Lewis continued to emphasize the importance of medical education in his department. Every Thursday the division heads met in a class with Lewis to hone their skills as teachers.

By the mid-1950s, it became increasingly clear to Lewis that the head of a department of Medicine could not be an expert in all fields:

A modern medical center, then, must be stocked with men and the material of the modern age. . . . The task of the present day head of a clinical department has changed completely. Formerly he was primarily a teacher and clinician. He was more or less the final authority in his particular field. The problems of department management were few. His position now is more like that of the conductor of a symphony orchestra. He cannot play all the instruments, but he knows when they are played properly. He has to know all the music and know it should be played. It is his job to direct the musicians so that they work together as an harmonious and pleasing whole.\textsuperscript{17p6}

Lewis the examiner— the human CT
While Lewis oversaw expansion and recruited new subspecialists to join his department, he carved his niche as an expert in the history and physical examination. Some level of expertise was certainly natural for those who initially trained in the era before new technological advances, but Lewis honed his skills with a precision, and demanded a level of expertise, that few could match.

On one occasion, Lewis was asked to see a fourteen-year-old girl with a fever of unknown origin. Lewis began his interview process (which would often take two hours), and then began the physical exam (which frequently took another two). After inspecting the abdomen, then palpating, he next percussed. As a rule he used the technique of jumping percussion, in which the lighter touch from the hand on the patient allowed for more fine discrimination of structures of differing densities. When finished, he explained that he thought that the patient had a mass in her small intestine, likely a malignancy. Because of her age, and the lesion’s resonating characteristics on jumping percussion he felt that it was likely a myofibrosarcoma—but was quite certain that it had a necrotic center, a diagnosis sustained during the exploratory laparotomy the following day.18

This is one story of the many of Lewis’s skills in physical diagnosis that earned him the nicknames “The Human CT” and “Hod the God.” Lewis furthered the limits of physical diagnostic abilities as much as any physician in the twentieth century. His students often described “being at the foot of a master” and “watching a magic show,” while he demonstrated and taught them his skills.18 Though students delighted in their unsuccessful attempts to stump him, Walt McDonald summarized appropriately: “I can’t remember him missing anything on the physical exam that I thought was important.”13 Forever a student, Lewis found challenge in his pursuit of excellence in the history and exam until the day that he died. He told John Benson, “Patient examination and history-taking, as far as I’m concerned [are] still the most difficult thing[s] in medicine to do well.”11p43

1959–1961: ACP president and ABIM chairman

In the early 1950s and 1960s, about twelve members of the ABIM stood between newly graduating residents and their certification as qualified internists. Lewis was a member of the board for nine years, from 1952 through his chairmanship in 1961. Few board members scrutinized would-be certificate holders with as much intensity as Lewis. The written test was accompanied by an oral examination after the patient was examined. Lewis often failed those who could not demonstrate basic physical diagnosis techniques. Internal medicine residents claimed that they wanted to train in Oregon so they could pass the oral board examination should they draw Lewis as their examiner.

His fellow board members often saw Lewis as the embodiment of the board itself.19 Henry Brainerd, chairman of Medicine at UCSF wrote to him:

You have been our very backbone.

In this day of depreciation of clinical excellence you have been a sturdy lighthouse battered by the wild waves of dubious “progress,” whose beacon has guided the Board in maintaining those standards to which we all subscribe wholeheartedly.20

During the same period, Lewis served as president of the ACP, where he worked to establish basic sciences sessions for the 1960 ACP Annual Session, established the college’s regional scientific meetings, and developed the American College of Physicians Award to recognize outstanding clinicians.21 Addressing the College in 1960, he wrote: “These high standards inevitably mean better patient care. . . . It is my earnest hope that we will never relax our standards and that our measuring stick shall be only one: excellence.”22p89

What motivated Lewis? How did he rise to a position of national leadership in internal medicine from a small northwestern city? From the moment he decided to study medicine, he possessed an unshakable drive to become the most excellent physician possible, and to motivate those around him to do the same. His deep commitment and single-minded dedication affected countless lives and careers: traumatizing some, failing a few, but inspiring many to become great themselves.

As the field of medicine expanded with new knowledge, Lewis and his colleagues on the ABIM helped to define the standards of our profession from the 1940s into the 1970s. As medical knowledge increased and the pace of medical research quickened, these clinicians strove to achieve a balance between research, education, and patient care. To them, the continuous respect given to their patients represented the fundamental force of their profession. A young trainee who acted in a way that limited that respect was corrected, and the patient protected.

In a time when the qualities of the excellent physician are surprisingly hard to define, when our field has fragmented into numerous subspecialties, when young physicians face cynicism, and when our public image shows tarnish, we need reminders of those who brought a human understanding
and an excellence in skill to the bedside of the sick, and who inspired students to do the same. Howard Lewis strove for excellence in our field with a vigor like that of few others. If Howard Lewis were here today, he would remind us first to listen to our patients, to treat them with the utmost respect, and to learn the art of the physical exam at the bedside. Then, while scrutinizing our technique, he might very well inspire us to do better.

References

12. Lewis HP. Integration of basic science with clinical training. JAMA 1956; 161: 27–9.
17. Lewis HP. Thoughts and opinions on the medical curriculum and the operation of clinical departments in a modern medical school. 1956 Jun 1. Oregon Health & Science University History of Medicine Library.

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Always turn into the wind.
Let your sails fill.
This journey will take you out of sight of land.
No compass. No charts.
Your only satellite is our moon,
And tonight that is dark.
Where will this journey end?
Old sailor, don’t you worry.
This journey will end.
Turn into the wind.
Let your sails fill.

Robert L. Chesnow, MD
In 1982, the board of directors of Alpha Omega Alpha established five student research fellowship awards to encourage and support student research. Since then, the awards have grown in number and dollar amount. As many as fifty $5000 awards are made, and $1000 is available for travel to a national meeting to present the research results. In 2004, the name of the fellowship program was changed to the Alpha Omega Alpha Carolyn L. Kuckein Student Research Fellowship awards in honor of Carolyn L. Kuckein, AΩΑ's longtime administrator, who died in January 2004.

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Daniel Sand  
Case Western Reserve University School of Medicine  
Connective tissue growth factor involvement in Graves' disease  
Terry J. Smith, MD, mentor  
Jeffrey L. Ponsky, MD, councilor

Elizabeth Seidler  
Tufts University School of Medicine  
The impact of early onset chronic psoriasis on quality of life  
Alexa B. Kimball, MD, MPH, mentor  
Amy L. Lee, MD, councilor

Nishtha Sodhi  
Drexel University College of Medicine  
PARTNER Trial: Placement of Aortic Transcatheter Valve  
Joseph E. Bavaria, MD, mentor  
Allan R. Tunkel, MD, PhD, MACP, councilor

David Soleimani-Meigooni  
University of California, San Francisco, School of Medicine  
A Genome-Wide Screen for Genes Important for microRNA Biogenesis  
Michael T. McManus, PhD, mentor  
Steven Z. Pantilat, MD, councilor
HOPE team member Jackie Brown, a patient, and the author, with their van.

Photo courtesy of Dr. Christensen.
The language of care is greater than the act of speaking. It is a language of sensitivity, patient presence, and gentle approach; a language of concern and mutual respect. It does not depend on our particular roles or the labels the world gives us. Healing words flow from our common humanness, our feel for a person’s life condition, and our compassion for someone else’s suffering.

—Craig Rennebohm

Over the years I have become increasingly reluctant to tell others that I am a psychiatrist. While getting my haircut, or on a long-distance flight, the inevitable question arises, “And what do you do?” When I finally come out with it, I just know my acquaintance has begun to mentally conjure those cartoon images from The New Yorker of the bearded, cigar-smoking psychiatrist, scribbling on a pad while “analyzing” the patient lying on a couch. I know those cartoons are playing a role in the questioning because I usually start fielding a string of queries about dream interpretation and long-smoldering conflicts with mother figures. In my most therapeutic way, I usually respond with, “Well, I don’t actually practice that type of psychiatry.”

I then talk about my work with the mentally-ill homeless.
Individuals who suffer from serious and persistent mental illnesses comprise nearly one-third of the homeless population in this country.\(^2\) The most vulnerable are those who are both mentally ill and chronically unsheltered, who differ in a number of respects from homeless persons who are temporarily domiciled within a shelter system or service agency. The mentally ill who are chronically unsheltered are more functionally and socially impaired than their shelter-based counterparts and are less likely to pursue or accept basic services (e.g., food, shelter, appropriate clothing), case management assistance, and medical care.\(^3\)

Nearly a decade ago, Jacksonville's civic leaders and mental health advocates recognized the need to engage the segment of the homeless population in our city that appeared to be in greatest need for basic human services. These were the persons, it was argued, who were most difficult to engage because many cycled through the hospital emergency departments, jails, and psychiatric crisis units only to wind up back where they started: on the street. The city provided funding of several hundred thousand dollars per year, renewed annually for the past nine years, to implement a medical street outreach team comprised of two case managers, a nurse, and a part-time psychiatrist. A local car dealership donated a van modified to store medical supplies that could be used to transport the team. Through our academic department's community psychiatry program, I signed on as the "street" psychiatrist.

Most of my patients live in the urban niches provided by parking garages, or in scooped-out sand dunes alongside the beach walkways, or in the corners of a seldom-used bus stop shelter. Much of my clinical work over these years has been carried out, literally, on the street. My "office" is portable and my "patient follow-up" schedule varies dramatically depending upon who our outreach team can locate on any day. Most of the time we find the usual persons in the usual places, but tropical storms, relentless heat, or unannounced police sweeps of public spaces can wreak havoc on our search-and-find efforts.

Of course, our outreach team is always on the lookout for that new person navigating the street who has recently been released from jail, or discharged from the hospital without safe shelter, or cast out of an apartment by a rent-jilted landlord. Many times the outward signs of severe mental illness are obvious, but not always. As we roll up in our medical outreach van and introduce ourselves, I almost always experience that gnawing reluctance to reveal my professional identity. From experience, I know well that persons with chronic mental disorders living on the street seldom have images and memories of psychiatrists framed in comical Freudian stereotypes. For most, interactions with the public mental health care system—overcrowded crisis units, detoxification facilities, forensic hospitals and jails—have left them with painful recollections of involuntary hospitalizations, coercive treatment and less than compassionate recovery-oriented care. Rarely does the person say, "Wow, am I glad to see you, Doc!"

In fact, after introducing myself, the usual reactions are shot through with a glaring suspiciousness: "Why do you think I need to see you?" or "Ya gonna lock me up?" Hostility and flat-out rejection occasionally occur: "I don't want nothin' from you!"

I have over the years learned to take nothing personally during those initial encounters because I now have a different perspective. When I first began doing street outreach my approach was still shaped by my experience of interacting with patients who willingly came to my clinic: patients came for treatment and I provided it. That is not the case when conducting street outreach. On one of our team's initial forays years ago I made contact with a woman living on the street who was floridly psychotic, malodorous, filthy from head to toe, and fairly agitated. After telling her who I was and what I did, she totally and completely ignored me. Staring off into the distance, she pressed on with a monologue that made sense only to her. I was flustered because I was unable to interrupt or otherwise get her attention. Looking for any hook to engage her, I said something along the lines of, "You know, Ms. Virginia, I could give you medications that would make you feel better." At that moment, she stopped her psychotic soliloquy in mid-sentence, looked me full in the eyes, and replied, "Hmmm . . . Ya think? Well, I think giving me medication would make you feel better, but it sure as hell won't make me feel better!"

Since that time I have come to more fully recognize that meaningful psychiatric street outreach is not based on developing a diagnosis, formulating a treatment plan, or dispensing medication. Although our street outreach efforts yield over 120 contacts per month, providing shelter and/or medical care to approximately fifty percent of this population, our work is not only about producing measurable clinical outcomes. Rather, it is all about cultivating relationships. Those "first meetings" are given to making sure at least two things happen: first, I acknowledge the essential worth and dignity of the person, and second, I ensure that he or she is willing to see me again. Nothing else matters. Indeed, no truly meaningful medical treatment can begin until some semblance of a healing partnership has been established.

Four years after the initial encounter with Ms. Virginia, and after many, many street "appointments" during which medications were never mentioned again, she agreed to move into
safe housing. Today she fully participates in her recovery from devastating mental illness and actively directs her own care.

In reaching out to those who endure harrowing, isolated existences on our city streets because of confused minds and crushing fear, compassionate acts of human recognition and deep listening carry far greater transformative power than do initial offers of medication and treatment. If nothing else, my work on the streets as a psychiatrist has taught me that the slow dance of healing always begins with a “language of care” that speaks of presence rather than analysis, invitation instead of interpretation.

References

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When I was near the center of your life
You cleaved to me for safety and for love.
We shared a closeness that was free from strife,
Shared confidences, lifted life above

The ordinary. We were quite a pair;
An aging man and a spirited young boy,
One who was losing, one who was growing hair.
Unlikely combination, bringing joy.

Not every day was easy, some were tough;
A child’s perceptions are not always fun.
But we could overcome; it was enough
To be together. Races to be run

Were happy moments, trials to be a test
Of skill, endurance, perseverance, too.
And after you and I had done our best
We laughed and hugged and shouted to the blue.

I happily remember New Year’s Eve
When you were four and I was sixty-plus.
We pounded metal pots with spoons, to leave
An echo of our jollity. We must

Have thought that we alone brought in the year,
That we could see Old Father Time retreat
As infant New Year entered to make clear
That life could start again, renewed, complete.

When you were sick I cradled you and sang
And walked the floor until you were asleep.
And when you learned to drive I felt a pang
Of pride and fear that made my poor heart leap.

Now you’re a man; your childhood’s been replaced
By girls and friends and school and grown-up life,
And by a changing world you are embraced.
One day you’ll introduce me to your wife.

The center of your life will shift to her,
And I will cheer the two of you; it’s right.
And we’ll remember happy days that were,
And I will love your children, a delight.

Our time is measured not so much by years
As by the love that people share with us,
And you have been my little boy who cheers
My life until it vanishes to dust.

Melvyn H. Schreiber, MD

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Letters to the editor

Time for change in AΩA

Regarding your editorial in the Autumn 2008 Pharos concerning change in AΩA, I will give you my perspective on some of the issues you raise.

While I was honored to be elected as a member of Alpha Omega Alpha, from a practical standpoint this is just another line on a curriculum vitae. The only tangible benefit beyond self satisfaction might be an edge in application for a competitive residency and/or academic position.

I pay dues to AΩA, i.e., stay active, as I enjoy the dialogue presented in The Pharos and feel it is important to sustain an organization which recognizes the upper echelons of achievement for medical students. In the real world, however, CPT 99254 for a hospital consult will pay the same whether you graduated first from Hopkins, last from Guadalajara, or perhaps didn’t even go to medical school now that PAs and nurse practitioners wander through hospitals in the role of de facto physicians.

Election to Alpha Omega Alpha is earned not purchased. Thus I feel that regardless of whether an individual chooses to support the organization, they earned this recognition early in their career, similar to an undergraduate degree with cum laude distinction. AΩA is not a highly visible entity at most schools which simply reflects that most medical students and physicians are not prone to boastful behavior but rather allow their accomplishments to speak for themselves.

In an academic setting, publication, research grants, and speaking opportunities mark a prominent physician.

In clinical medicine, recognition and reward for the extra work and dedication required to achieve improved outcomes no longer exists. It is little wonder then, as our training programs engender a shift-work mentality, non-physicians assume an ever expanding role in primary care, and excellence is considered an EMR with the right boxes checked regardless of critical thinking, that one might ask: who needs AΩA?

Henri R. Carter, MD, FACS
(AΩA, University of Arizona, 1981)
Yuma, Arizona

Election to AΩA

I cannot tell you how delighted and honored I am to be elected to AΩA. I have been engaged in teaching medical students for thirty-four years now—the majority of them here at Washington University School of Medicine. As the daughter of physician parents, I had thought I would follow in that same estimable path—but my passions for anthropology and animals directed me instead to a PhD in Biological Anthropology and a research career among the baboons of Ethiopia, Tanzania, and Zambia. It has been a wonderful career, particularly as I have been most fortunate to be able to satisfy my love of medicine by teaching Human Anatomy to extraordinarily bright and committed students. It has been a challenge, a privilege, and a delight.

I have been fortunate to have received a number of honors in my career, but election to AΩA is one I never anticipated. Indeed, I did not think it was possible for a non-physician to be given this wonderful honor. This was an extraordinary surprise and it will be a most treasured recognition. I thank you and the officers of AΩA for this most unexpected and greatly appreciated honor.

Jane E. Phillips-Conroy, PhD
(AΩA, Washington University, 2009)
Professor of Anatomy, Department of Anatomy and Neurobiology, and Professor of Anthropology
Washington University School of Medicine
St. Louis, Missouri
The dreaded burnout

Thank you for the thought-provoking editorial on burnout and suicide in medical students. We need to address this issue with compassion and intelligence. Just as many patients leave allopathic medicine for alternative therapies, many of our students cannot cope with what we dish out to them. The notion that we could invest more in student support and wellness programs makes very good sense. The student who learned a variety of coping strategies would not only fare better but would be in a position to work with patients who lived with chronic illness in stressful times. There are many helpful techniques and therapies, such as yoga, meditation, Brain Gym, Energy Psychology, Heart Math, and Narrative Practices, to name a few, along with the old standby of regular aerobic exercise. Unfortunately these programs are usually add-ons, if available at all, and seen as elective and at the periphery of what is important. What could be more important than equipping our young students for the difficult, challenging and often stressful life of practicing medicine? It should not be a trial by ordeal that only the fit few can endure.

David Tinling, MD
(AΩA, University of Washington, 1959)
Brooklyn, New York

I am a fifty-seven-year-old physician. Reading your editorial, “The dreaded burnout,” in the Winter 2009 issue, I could understand and empathize with Heather Finlay-Morreale and Mike. I was a “burnout” with depression and suicidal thoughts during my first year of medical school. Thankfully my dean of student affairs recognized my condition, got me help, and gave me a leave of absence for one year. I returned and successfully completed my training. I have had a productive and rewarding career thanks to a forward-thinking dean and the support I received. Because of my experience I have intervened several times during my medical training to help others that I recognized with similar symptoms. I believe that physicians are sometimes too busy to look at each other and reach out. That we tend to hide our perceived weaknesses and faults until it can be too late. Thus drug addiction, burnout, and suicide. I support your idea that AΩA can help is to organize mentoring programs for students. Students can’t be expected to mentor themselves, and AΩA can’t mold existing curricula single-handedly or rapidly. But mentors can absolutely be a measured calm in the treacherous training waters. However, I argue that the AΩA can do more than simply mentor.

I argue that our esteemed older colleagues can take the time to notice eroding morale. Further, our residents can slowly change the harsh stigma facing “impaired physicians.” Also, our students can speak up and ask for services. AΩA can surely do better than simply mentor—it can garner acceptance of recognizing potential warning signs and asking for help.

Medical students (and it stands to reason, residents) are masters of excuses, and the poor concentration, low energy, and disrupted sleep associated with a clinical depression can be blamed on busy schedules, stress, or simply a lack of time. Weight loss and appetite change are easily written off as “I’m too busy to eat” while on more rigorous rotations. A lack of interest or isolation can be excused by “I just want to get away from everyone because it stresses me out!” Individually and intermittently the disruptions are not cause for alarm; but as a cohesive syndrome combined with a low mood (also explained away by rigorous standards and just being fed up with superiors), it should set off bells that something is amiss and warrants appropriate intervention. The hectic schedules of training at any stage can mask a clinical depression or be described as burnout. But trainees need to be taught to recognize signs and symptoms in themselves and colleagues—they already know how to recognize them in patients but can rarely view themselves the same way.

Recognition and some sort of validation for our colleagues struggling with overwhelming stress, anxiety, depression, or substance use is of utmost importance—to realize that it is okay for the health care professional to become a patient and take care of himself. Untreated syndromes (especially when combined with the substance use that can alter people’s impulse control) can evolve to include passive suicidal ideation, that in turn can lead to active thoughts complete with plan,
intent, action, and in the worst case scenario, completion. For psychiatry residents, the issue of suicide comes up on a daily basis. It’s not as inherent for other specialties to regularly screen for safety. However, even those of us in mental health are not immune to the illnesses we treat and the grim consequences. The United States is really the only country to separate mental and physical health, and as a result reinforce the stigma attached to recognition of mental illness when it hits close to home—when it hits the physician, medical student, or resident. Many students, for instance, view depression as a sign of personal weakness rather than a clinical entity worthy of as much attention as hypertension. \(\Omega\) can be instrumental in chipping away at some of that stigma, reinforcing instead that it is okay, nay, requisite, for providers to recognize signs and symptoms of depression, anxiety, and substance use in themselves and colleagues so that they may receive adequate treatment. It is certainly accepted for a doctor to treat his hypertension, but for some reason stigma prevents easy treatment of depression for the same physician. A temporarily impaired (or permanently impaired, i.e., dead) clinician is of no good to any patient.

It is hardly reasonable to expect a person in the depths of a depression—with all concurrent cognitive distortions—to voluntarily bring up a difficult time to colleagues that have dozens of patients on their minds. It is even harder to expect a person already fed up with work, and likely struggling as a result, to seek help from colleagues that have been trained to hide imperfections and difficulties; stigma sets it up to be career (and sometimes personal) suicide.

I challenge \(\Omega\) to take a stand more basic than providing mentoring programs—and erode the stigma associated with admitting a need for help among physicians and medical students by simply opening the lines of communication once the white coats come off—whether that’s in lecture, in the parking lot, or in a pub. Regardless of clinical experience, chosen specialty, or discomfort with tears, I challenge each member of \(\Omega\) to simply ask, “How are you doing?” of a colleague—and actually wait for an answer. In simply waiting for a response, we can uphold \(\Omega\)’s goals of professionalism, scholarship, leadership, and service. All it takes is for someone to hurry up and wait. Perhaps we’ll hear the nuances in the reflexive “fine,” if we look.

Marika Wrzosek, MD
\(\Omega\), University of Illinois at Chicago, 2008
Chicago, Illinois

The U.S. crisis in health care

This feels almost like déjà vu all over again. In 1991, Bill Clinton was hoping to institute universal health care; it didn’t happen. The situation has only gotten worse. It is not only an economic issue, it is an “in your face” moral issue. It is a matter of injustice for the approximately 50 million Americans who lack health care coverage and those who may join them as they lose their jobs as a result of the recession.

I am however encouraged by what I see happening around the country. I think the country has hit the “tipping point.” It seems people realize that for the well being of the country every American—not some, everyone—should be enrolled in a basic, affordable health care plan that includes home visits, hospitalization, and preventive services, mental health care, dental care, prescription drugs, physical and occupational care. A plan, in other words, similar to the benefits our elected representatives in Washington have.

Reform will not be as easy, but the following concepts should be non-negotiable.

First, we need to end the present system, which is largely dependent on employer coverage. Businesses need to be able to compete in the marketplace and to pay higher wages. They cannot do this when saddled with rising health care costs. Instead, we need public financing. Some have suggested a payroll tax, or a dedicated value-added tax on purchased goods. I think a dedicated income tax would be the fairest way to underwrite health care; any other scheme is too complicated.

Second, administratively the present way we manage health care is too costly and inefficient. Some advocate for the government to take over and do away with private insurance altogether. There are others who support a hybrid system of public/private managers. A health care certificate would be issued whereby an individual could enroll with either a private nonprofit insurer or one that was administered by the government. All programs would be regulated by a regional, politically-independent health board. It would be totally portable from job to job and no one could be refused health care.

Third, it is not enough that individuals adopt healthy lifestyles; we need to have an independent Institute of Technology and Outcomes Assessment to ensure that everyone receives appropriate diagnostic tests and high-quality care.

Contact your U.S. representative and senators and tell them to support health care reform that offers a high quality, publicly-funded health care package to all Americans. The current system is economically unsustainable. We cannot afford to have comprehensive health care.

Paul Manganiello, MD
\(\Omega\), Dartmouth Medical School, 1992
Lebanon, New Hampshire

More new medical terms

I was amused and inspired by your cover story on “New Medical Terms” in the Spring 2009 issue of The Pharos (pp. 26–28). Here are some diagnoses recorded by admission clerks at my university hospital in the 1970s and 1980s.

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Letters

Crone's disease
Acute gastroneuritis
Status of Osmaticus
Mass of ascites
Protein-losing interapathy
Mastopsychosis
College inn disease
Acute lover failure
Carcinominous meningitis
Grand negative sepsis
Laceration of Dora
Rule out subdural hematuria
Atopic pregnancy
Digital toxicity
Tumble phlebitis

Saul Moroff, MD
(AΩA, Columbia University College of Physicians and Surgeons, 1959)
New York, New York

Movies: profanity, nudity, and violence
Dear Dr. Dans,

Congratulations on your review of 3:10 to Yuma and your comments regarding gratuitous profanity, nudity, and on-screen violence. While I am certainly no prude I much prefer a good story than “good” special effects. Regarding the gratuitous part of today’s movie industry I believe it is a strong manifestation of the well-known neurophysiological phenomenon of adaptation. We see one building blown up and the next time it has to be a city block, then a city, then the entire nation, etc., etc.—and the same with nudity and language.

I think Tommy Lee Jones had it about right in the movie version of No Country for Old Men (and also in the book) when he remarked regarding the splurge of killing in his county, “I think it all began when we stopped saying ‘No, sir,’ and ‘No, ma’am.’” It just may have.

Ernest C. Fokes, Jr., MD
(AΩA, Medical College of Georgia, 1961)
Hayden, Idaho

The third annual Pharos Poetry Competition awards were made in May. This year’s winners are:

First prize, $500: Ashley Mann of the Class of 2011 at the University of Missouri-Kansas City School of Medicine for her poem, “Smoke.”

Second prize, $250: Jenna Le of the Class of 2010 at the Columbia University College of Physicians and Surgeons for her sonnet, “Meditation on Surgical Masks.”

Third prize, $100: Joanna Pearson of the Class of 2010 at the Johns Hopkins University School of Medicine for her poem, “The Mugging.”

Honorable mentions, $75 each: Melanie Buskirk of the Class of 2011 at Mayo Medical School for her poem, “Informal Education”; Christina Crumpecker of the Class of 2011 at the University of Colorado School of Medicine for her poem, “Pediatric Traumatic Injury at City Park, July 2008”; Vaishali Jayant Gajera of the Class of 2011 at Florida State University College of Medicine for her poem, “Betrayal”; Margaret Moore of the Class of 2012 at the University of Chicago Pritzker School of Medicine for her poem, “Memorial”; Erika Elise Reid of the Class of 2011 at Northwestern University, the Feinberg School of Medicine for her poem, “Studying in the Afternoon”; Cheng Tou of the Class of 2011 at the Sophie Davis School of Biomedical Education of the City College of New York/SUNY Stony Brook School of Medicine for her poem, “Anatomy”; and Mark Warren of the Class of 2010 of the Loma Linda University School of Medicine for his poem, “Rhabdomyoscarcoma.”
I’m tired of walking down this hall to meet their wives for the last time. Sometimes I stop and plan my words as if they were born today. Looking out of a window at clouds prompts me to search for softer words. Time runs out, nurses and chaplain linger in the doorway to hear if I’ve found a different way to say he’s dead.

Henry Langhorne, MD

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David A. Bennahum, MD, and Jack Coulehan, MD, Book Review Editors

Our Daily Meds: How the Pharmaceutical Companies Transformed Themselves into Slick Marketing Machines and Hooked the Nation on Prescription Drugs

Melody Petersen

Reviewed by Michael B. Bevins, MD, PhD (ΩΩΩ, University of Texas Medical Branch at Galveston, 2004)

In recent years, many physicians, administrators, and journalists have critically examined the pharmaceutical industry’s influence on everything from the publication of medical research to physicians’ prescribing habits. A number of high-profile lawsuits over adverse drug effects have alerted the lay public as well to the conflict of interest inherent in marketing prescription medications. For anyone remotely familiar with this issue, or with a realistic sense of today’s business climate, it will come as no surprise that the pharmaceutical industry has employed some less-than-honest practices to sell its products. Many of us in the medical community, including the leaders of several influential academic medical centers, have taken steps to buffer the industry’s influence on our profession by, for example, scrutinizing authors’ financial ties to industry and refusing to accept gifts from pharmaceutical sales representatives.

Melody Petersen is an award-winning journalist who has been on a crusade against the pharmaceutical industry’s influence on health care. She previously worked for the New York Times, where she often wrote illuminating and scathing reports on the profit-mongering practices of drug companies. As such, Ms. Petersen surely deserves much credit for bringing to light such practices and for their recent scrutiny. Her book, Our Daily Meds, is a passionate detailing of the lengths to which the pharmaceutical industry will go to sell its products. By her own estimation, it is a book about how the industry transformed itself from one focused on science and discovery to one focused on marketing and profits, and the results of this transformation. She focuses most of her attention on the latter, describing and decrying the many morally questionable ways pharmaceutical companies promote and market their products, while dedicating only one of the book’s nine chapters to the industry’s history.

The book opens with an interesting chapter on creating diseases. While many of us speak of disease on a daily basis, and take for granted that we and others know what it means, it turns out the concept of disease eludes a neat definition. This fact has been exploited by the pharmaceutical industry for nearly one hundred years. As illustrated by Ms. Petersen, marketers of Listerine in the 1920s self-consciously created public anxiety about a condition they called halitosis, in a deliberate attempt to frighten people into buying their product. More recently, Pharmacia, the manufacturer of Detrol, openly discussed and then carried out a plan to expand the market for its drug by creating the condition known as overactive bladder. The company recruited (and heavily compensated) legions of influential physicians to help promote Detrol for overactive bladder by educating their colleagues about this new condition and its treatment.

Most of the stories in Our Daily Meds come from Ms. Petersen’s home state of Iowa, where she attended various drug marketing events and interviewed patients adversely affected by their medicines. The stories ring all too true, and the physician-reader cannot help but despair at these reminders of the industry’s influence on his profession. In chapter seven, she makes a case study of the marketing of Neurontin, and interviews a pharmaceutical saleswoman who was pushed into dishonestly promoting off-label uses of the drug. Originally approved for limited use as an epilepsy drug, Neurontin was promoted for a number of other conditions, including migraines, attention deficit disorder, and bipolar disorder. In promoting its drug for these conditions, the company did not set out to research and develop the best treatment for patients. Instead, it started with a wish list of conditions it thought would most widely expand its market, and it began to promote Neurontin for those conditions, despite the lack of evidence or FDA approval. In exposing the industry’s marketing strategies, Ms. Petersen reveals what the physician doesn’t know about the generous drug rep that visits his office, which is what she is told by her company’s marketers: the strategies for promoting her particular drug at all costs, the scripted, and perhaps entirely fictional, answers to the doctor’s anticipated questions.

In Ms. Petersen’s opinion, the industry’s influence cannot be overestimated. She likens the societal effects of marketing prescription drugs to those of “the Internet, electricity, or the printing press.” Such overreaching, however, proves to be the Achilles heel of this book. While her passion for her subject...
is undeniable, Ms. Petersen’s zeal too often comes across as a frenzy, in which bombastic rhetoric displaces reasoned argument. Most of the book consists of short, loosely-related paragraphs, with many passages seemingly afloat with no context to support them. The reader is left with the impression that Ms. Petersen has unselectively tried to cram into the book’s 335 pages everything she knows about the marketing of prescription drugs.

Furthermore, while informative and expository, Ms. Petersen’s writing betrays a lack of understanding of the world of doctors and patients. For instance, she defines a family physician as “a doctor not trained in the intricacies of psychiatric disorders,” and she consistently stereotypes physicians as one-dimensional, unscrupulously willing to bend to the will of pharmaceutical marketers without regard for data or their patients’ welfare. Corporate marketers, she writes, “decide how patients will be treated, and the doctors just follow along.” Of course, many physicians are too influenced by marketing, and there is good evidence to prove it. Regrettably, however, this book neglects such evidence, and seems not to appreciate that the reality of caring for people is complex and fraught with uncertainty. This book would have benefited from such consideration, as well as from some acknowledgment of the many reforms instituted in recent years by medical journals, academic health centers, and individual physicians to limit industry influence.

Additionally, this book could have been improved by some more time on the editor’s desk. It is inconsistent in format, while its content is often redundant. Inexplicably, only chapter six contains an epigraph, and chapter eight is the only one with subchapter headings. There are notes at the end of the book, but they are not referenced in the text. While these and other inconsistencies do not detract from the importance of Ms. Petersen’s message, they do distract from it, and in the end the book winds up seeming like a pastiche of disparate essays and aphorisms on a central theme rather than a coherent work.

The book’s epilogue contains what Ms. Petersen has determined must be done to eliminate the pharmaceutical industry’s influence on medicine. Her suggestions range from reasonable (emphasize preventive medicine) to unrealistic (the FDA could create a brochure for every drug available, which doctors would download and review with patients when prescribing a medicine). In the end, Our Daily Meds is admirable in its aims, if somewhat flawed in its presentation. Its only true fault is that it goes too far on some fronts, but we should forgive its author for this. After all, with a subject this important, we should thank Melody Petersen for pushing the proverbial envelope, even if at times she pushes a little too hard.

Dr. Bevins is a family physician and hospice medical director in Marble Falls, Texas. He does not meet with or accept any gifts from pharmaceutical representatives. His address is:
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Selling Teaching Hospitals and Practice Plans: George Washington and Georgetown
John A. Kastor
The Johns Hopkins University Press, Baltimore, 2008

Reviewed by Pascal James Imperato, MD, MPH&T (ΩΩ, State University of New York, Downstate Medical Center, 1976)

This is the latest of four volumes in which John Kastor has documented and analyzed the impact of changes in the U.S. health care system on academic medical centers. Employing the same methodology applied in his previous three studies, he here recounts the stories of how two marquee universities in the nation’s capital struggled for over a decade to grapple with increasing deficits and how in the end they came to a decision to sell their teaching hospitals. As in his previous volumes, Mergers of Teaching Hospitals in Boston, New York, and Northern California (2001), Governance of Teaching Hospitals: Turmoil at Penn and Hopkins (2004), and Specialty Care in the Era of Managed Care: Cleveland Clinic versus University Hospitals of Cleveland (2005), Kastor interviewed large numbers of relevant individuals, in this instance 335, who are or were associated with these two academic medical centers.

Despite their location in the nation’s capital, both George Washington and Georgetown were forced to sell their hospitals following the decreased reimbursements created by managed care and the Balanced Budget Act of 1997. In an environment of decreasing revenues for hospitals, Washington, D.C., became an extremely adverse environment for these two academic medical centers. Surrounded by affluent suburbs with community hospitals, they also had to compete for insured patient share with city-based hospitals and nearby centers such as Johns Hopkins. This situation markedly contrasted with the previous flush financial times when both hospitals regularly generated annual surpluses, some of which were siphoned off to support other university programs.
and activities. George Washington’s ability to successfully compete was also greatly hampered by its long undercapitalized 1948 physical plant.

In three excellent chapters, the author describes in great detail George Washington University’s decision to sell its hospital, separate its practice plan, and close its Health Maintenance Organization. Like Georgetown, George Washington had little choice in the selection of a buyer, and eventually sold its hospital to a for-profit corporation, Universal Health Services, that saw having a presence in the nation’s capital as overriding the serious liabilities of ownership. Woven into the account are interesting insights, analyses, and opinions expressed by various informants which together allow for a fuller understanding of not only the transfer of ownership, but also of the subsequent impacts on medical education, research, and clinical practice.

Three subsequent chapters are devoted to Georgetown, which sold its hospital and practice plan to a not-for-profit local company, MedStar Health. As at George Washington, declining revenues played a major role in this decision. However, so too did the longstanding absence of local control, which prevented hospital administrators from quickly responding to financial difficulties. Georgetown, like George Washington, also lacked a robust research enterprise capable of generating indirect revenues, had a small endowment against which money could be borrowed, no access to state or city subventions, and little hope of possible philanthropic donations because of the transient character of much of the city’s monied elites. Then, too, Georgetown incurred significant losses in closing its dental school because it still had to maintain the physical plant and pay salaries even as tuition income evaporated.

In his concluding chapter, Kastor cogently observes that, post-sale, George Washington and Georgetown are very similar, being schools that emphasize education and clinical care, and that depend on revenues from tuition paid by large enrollments of students. One of the thus-far enduring consequences of the sale of care assets for both medical centers has been a continued weak research enterprise. However, Georgetown is educationally advantaged over George Washington in that as a result of the acquisition of its hospital by MedStar Health, it now has access for teaching purposes not only to its former hospital, but also to Washington Hospital, which is also owned by the company.

In an excellent Appendix A, the author briefly discusses six other universities with teaching hospitals owned by for-profit companies. These include Creighton University, the University of Southern California, Tulane University, the University of Oklahoma, Saint Louis University, and Drexel University. Appendix B, Reducing Deficits and Increasing Surpluses in Private Medical Schools That Do Not Own Their Primary Teaching Hospitals, is prescriptive in character. It is based on interviews conducted with thirty knowledgeable individuals including deans, chief financial officers of medical schools and hospitals, practice plan directors, and associate deans concerned with finance and organization. The excellent advice provided here under several sections and some thirty-six subsections represents learned consensus, and will be of great value to those responsible for the financial well-being of private medical schools. These sections include: General Concepts, Practice Plan Problems, Practice Plan Solutions, Central Administrative Structure, Reducing Expenses, Increase Income by Convincing the Principal Teaching Hospital to Better Support the School, Increasing Income by Other Methods, Some Principles, and Caution. The author’s final section in this appendix, Caution, is among the most important. In it, he states: “Some members of the faculty will oppose instituting the changes discussed in this document, and, when the changes strike home, may even try to have the dean dismissed. Consequently, it is essential that the university leadership approve the strategy and support the dean in the changes he will make.”

Appendix C lists all the interviewees, along with their current or former George Washington or Georgetown positions. Current positions, where applicable, are also given. Several pages of meticulous notes document published sources and the place and date of all interviews, followed by a comprehensive index.

_Selling Teaching Hospitals and Practice Plans_ joins John Kastor’s three other excellent volumes in a series that uniquely documents how the vast changes in the U.S. health care system have led to the restructuring of leading American academic medical centers. Like its predecessors, it is superbly researched, well organized, and an engaging read. It is must reading for all those involved in health care, hospital administration, and medical education.

Dr. Imperato is Founding Dean of the School of Public Health, and Distinguished Service Professor at SUNY Downstate Medical Center in Brooklyn, New York. He is a member of the editorial board of _The Pharos_ and a previous contributor to the journal. His address is:

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**Memory Lessons: A Doctor’s Story**

Jerald Winakur
Hyperion, New York, 2009, 287 pages

Reviewed by Dean Gianakos, MD

Physicians who care for elderly demented patients are familiar with the challenges of managing physical, cognitive, and emotional frailty. Physical therapy, social support, counseling, and...
medications may help these patients, but they do not halt inevitable decline. It is easy for most clinicians to accept this reality—unless the patient happens to be a mother or father.

In the introduction to his book Memory Lessons: A Doctor’s Story, Jerry Winakur—an internist and geriatrician for the past thirty years—facetiously notes that the book is not an instruction guide to caring for aging parents. His stated goal is to share his journey caring for his demented “old, old” father, in hopes that his stories will resonate with readers, and help them to discern their own truths—truths about loss, death, and the limits to what a son or daughter can do to slow the certain deterioration of one’s aging parents. As a baby boomer internist with elderly parents, I believe he achieves this goal.

There are at least three categories of memory lessons in the book. The first category deals with Winakur’s experience trying to revive the memories of his eighty-six-year-old demented father—memories of working together in his dad’s pawnshop in Baltimore, birdwatching near the Gulf of Mexico, and fishing on the Chesapeake Bay:

He was my captain then and now I am his. His son, the geriatrician, who comes to fill some of his empty hours with conversation, comes to fill his daily pill containers, who adds a tad more diuretic when he is short of breath, who tries something new at night to ease the terrors—and takes it away again when it just seems to make things worse. I am the son who tries, mostly in vain, to crank his memory over one more time, jump-start it in the hope that we can skim across the water together for just one more trip out to the lighthouse.\textsuperscript{p12}

This is beautiful writing, and provides insight into a significant problem Winakur struggles with and readily acknowledges in his remarkable book: how responsible is he for his father’s care? Should he really be tinkering with diuretic doses and adjusting sleep meds? Why is he so involved? Where is his father’s physician in all this doctoring?

The second category of memory lessons provides clues about the source of Winakur’s over-involvement. In these lessons, Winakur recalls emotional events and experiences from his own medical training and practice. He writes about intimidating, unforgiving attendings who supervised him in residency; attendings who stressed the importance of not missing diagnoses—ever. In his eighteenth year of practice, Winakur sees a thirty-year-old diabetic man in his office complaining of nausea and a stomachache. The physical examination and laboratory evaluation are normal, and the patient is given a diagnosis of viral infection. Three days later, the patient’s wife finds him dead on the floor—cause unknown. Winakur recounts how his perfectionism and worry made it difficult to forgive himself, even though he apparently did everything possible a prudent physician would do in a similar situation. He subsequently slips into a mild depression, a depression his Aunt Lena helps him shake by introducing him to the Jewish concept of Bashert: “Meant to be. Fated.” However, in my view, Winakur never seems to be comfortable with this concept when it comes to caring for his father. There is always more to do.

The third category of memory lessons revolves around aging in America and the dysfunctional health care system. Winakur refreshes the reader’s memory about problems such as too little primary care, reimbursement inequities (procedures pay, cognitive services do not), physician-assisted suicide, medical student suicide, and the power of pharmaceutical companies to influence medical decision making. Winakur is sometimes on a soapbox here, and his prescriptions and stories will be old news to many readers.

I highly recommend this book for any physician who cares for frail, elderly patients, but particularly for physicians who have aging parents. Winakur’s words resonate with me whenever I’m about to give medical advice to my own, ailing parents:

Yet I was heavily involved in my father’s medical care. How could I not be? How could his son, the geriatrician, the one visiting several times a week, sometimes daily, the family member who spent a life observing the effects of the aging process on thousands of people, their responses to medications, the one able to spot a change in his patient instantly upon walking into an exam room—how could I not be involved in my father’s care? How could I fail to notice when he was more short of breath and could do with a bit more diuretic? Or hear my mother’s concerns about his agitation or anxiety or nighttime perambulations and not try a slight dosage change in the medications used to control these behaviors?

Dr. William Osler, the father of Internal Medicine, once said that the physician who treats himself has a fool for a patient. Perhaps, by extension, I was a fool to treat my own father at times.\textsuperscript{p264}

Dr. Gianakos is the associate director of the Lynchburg Family Medicine Residency in Lynchburg Virginia, and a member of the editorial board of The Pharos. His address is:

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Stride up the incline toward the patient wing, a windowless hallway with institutional green walls knowing neither sun nor shade: an ascent into decline. Pass the wall of memorial boards, covered with brass plaques, marking residents who ended life here (as if a reminder is necessary). Then under the ceiling that leaks in heavy rains. Next the courtyard where save for extreme weather some always sit in wheel chairs, still enjoying their cigarettes. Finally the wing’s double doors, guarding entry and exit.

Since my patient transferred I come here often. I’ve cared for her over twenty years. I doubt we’ll make twenty-one. My feet know the way without me. The staff greet me; I’m a regular. Decay is pervasive—in both the drab walls and those inhabiting them. Odors of dried urine and body lotion blend. The two dance together just below the ceiling, an olfactory canopy of despair and resignation. Medicine now does little for my patient’s frail ninety-two year body. Infirmitiy succumbs to infirmity, yet her mind remains firm. Poetry, photos and stories replace new pills and procedures. They work for short periods, and bring smiles to her thin saddened face. I will continue these visits despite their pain. Abandonment is not an option. On the final part of our journey caring has replaced healing, soothing has replaced science.

Barry L. Zaret, MD
Two new members for the Pharos editorial board

We are pleased to announce the appointment of John A. Kastor, MD, and Michael D. Lockshin, MD, to the editorial board of *The Pharos*.

**John A. Kastor, MD**

Dr. Kastor (ΩΩA, New York University, 1981) is professor of Medicine at the University of Maryland School of Medicine. He consults with academic medical centers, medical schools, and teaching hospitals about governance, organization, and related issues. A review of his latest book, *Selling Teaching Hospital and Practice Plans: George Washington and Georgetown*, is featured in this issue’s Reviews and Reflections. He says this about *The Pharos*:

I loved history even before majoring in it in college. Books on history and biography crowd our bookshelves. Since I understand that reading while driving can be dangerous, I listen to books that I download from the Internet, currently an excellent study of Osama bin Laden and his family. In the books I have written, the history of the subject is always featured. Consequently, *The Pharos* is a favorite magazine that I read with great enthusiasm as soon as it arrives, and accordingly, I’m particularly pleased to have been invited to join its distinguished editorial board.

Unfortunately, most medical students don’t seem to appreciate historical culture that much. When lecturing and giving conferences, I always try to work in some medical history though I doubt that it registers with many of my listeners. *The Pharos* provides an opportunity for the members of ΩΩA, all talented or they wouldn’t be members of the society, to consider the broader aspects of their profession, how medicine became what it is today and how its history and traditions affect how we treat our patients.

**Michael D. Lockshin, MD**

Dr. Lockshin (ΩΩA, Cornell University, 1971) is professor of Medicine and Obstetrics-Gynecology at Weill-Cornell Medical School and director of the Barbara Volcker Center for Special Surgery in New York City. In partnership with his patient Alida Brill, Dr. Lockshin recently wrote *Dancing at the River’s Edge: A Patient and Her Doctor Negotiate Life with Chronic Illness* (Schaffner Press, 2009). This is what he has to say about *The Pharos* and his appointment to our editorial board:

In college I majored in History and Literature and wrote my honors thesis on the French poet and essayist, Paul Valéry. I have maintained my interest in, and enthusiasm for, the literary and historical side of medicine ever since. I now receive many journals; the only one I routinely open on the day it arrives is *The Pharos*, because I enjoy reading the writing and the thinking within. It will be a joy to see the contributions as an editorial board member.

**Medical Student Service Project Award, the Sophie Davis School of Biomedical Education at the City College of New York—The Sophie Davis Health Fair**

The Sophie Davis Health Fair was held on Saturday, May 9. Held on a plaza outside the main academic building at City College, the fair was very well received, as over fifty students volunteered and assisted over 150 community members. Thanks to the generous support from Alpha Omega Alpha, the fair was a resounding success.

The health fair’s set-up encouraged all participants to go through all the stations. These included: BMI, blood pressure, blood glucose, a booth operated by the American Diabetes Association, face painting for children, and a community physician, Dr. Maria Molina. The two most popular tables were the blood pressure and blood glucose tables, and patients were constantly asking students questions about what the implications of the results were. Each station also had various brochures specific to that station, including healthier dieting, implications of high blood pressure, diabetes, etc. Many of these brochures were
created by students at the Sophie Davis School of Biomedical Education, and some were adapted from brochures from other institutions. The New York City Department of Health and Mental Hygiene provided Take Care New York Health Passports, in English and Spanish, in which patients could record all of their vital statistics, including blood pressure, cholesterol, vaccination, and medication history, etc. All brochures were made available in Spanish and English, where possible.

Volunteers reached out to the community by speaking to local churches, radio stations, and web sites, such as Harlem OneStop. Fliers were posted around the neighborhood every day for at least two weeks and given out around the community during the time of the fair. While the weather during the week leading up to the fair was not ideal, with fewer people were outside to notice the fliers, word of mouth proved to be essential to getting people to come to the fair. Indeed, some patients were calling up friends while at the fair encouraging them to stop by. In order to attract even more patients, all promotional material emphasized the free giveaways and services offered at the fair. Most important of these were the free Metrocards given out to patients that completed all three stations. Other giveaways, such as pill-holder key chains, water bottles, and pedometers were also popular.

The evaluation of the fair included a survey instrument and the recording of anecdotal comments and suggestions. The results were conclusive in showing that the community wholeheartedly appreciated the services we were providing. No patient gave a rating below 3 out of 5, and the overwhelming majority gave a rating of 5 for each question.

Clearly, the community loved attending the fair, and indeed is asking for more events just like these.

The final cost of the health fair was a little over $3,300, supported in large part by the $2,000 grant from the Alpha Omega Alpha Honor Medical Society, the Sophie Davis Student Government club funds, and the Sophie Davis School of Biomedical Education.

There are a great number of people to whom we owe our thanks for helping make this fair a success, including, but certainly not limited to, the Alpha Omega Alpha Honor Medical Honor Society; Dr. Stanford Roman, Jr., Dean of Sophie Davis School of Biomedical Education; Dr. Donald Kollisch, Deputy Dean for Academic Affairs; Dr. Dani Mcbeth, Associate Dean for Student Affairs; Mr. George Kaler, Associate Dean for Administration; Mr. Robert McDonald, Director of Housing and Student Activities; Ms. Yvonne Kilpatrick, Director of Department Administration and Community Liaison—Community Health and Social Medicine; and Dr. Darwin Deen, Medical Professor—Community Health and Social Medicine.

The Sophie Davis Student Government would like to thank the Alpha Omega Alpha Honor Medical Society for its support in holding our first ever health fair. With your generous support, we hope to make this an annual event, one certainly warmly received by the Harlem community.

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you told me
  quoting the philosopher
that life is best
  lived forward
as though I could peer
  today into the sun
rising over the lake
  and not remember
last night’s crescent
  aligned with Venus
and far flung Jupiter
  seeming only fingers apart
an art not happening
  for fifty more years
as though
  I could forget
the indelible, light-bearing
design of your being.

Janice Townley Moore

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