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What’s in a name?

The medical school needed a new name. Why? In the 1980s all of the health science schools (including Rutgers Medical School—RMS) supported by the state of New Jersey were bundled into a new entity, the University of Medicine and Dentistry of New Jersey. A nagging problem then arose for the board of trustees of UMDNJ: whenever RMS was publicized for notable science by its clinical and basic investigators, those who read and heard assumed that Rutgers Medical School was part of Rutgers University, and, of course, it no longer was. The charge to the dean at RMS, was “find a new name!”

A committee of faculty and students worked hard. A consensus was reached. The William Carlos Williams School of Medicine was perfect! Williams was America’s major poet, and an active general practitioner in New Jersey. This issue of The Pharos includes a paper on WCW written by Martin Donohoe, M.D. From it, from others published in The Pharos, and from WCW’s poetry and ten collections of essays, one is struck immediately by the energy, insight, and imagination of the man. WCW cared deeply about his patients, digging without restraint into the physical and mental muck that they brought to his office and what he found on innumerable house calls. This nitty-gritty of his practice is inserted crisply into both his poetry and prose.

He focused upon the people he saw on the street:

The Deceptrices
Because they are not, they paint their lips and dress like whores.

Because they are uncertain, they put on the bold looks of experience.

This is their youth, too soon gone, too soon the unalterable conclusion.

He wrote of the nature of poetry:

The Poet and His Poems
The poem is this: a nuance of sound delicately operating upon a cataract of sense. . .

His references to aging and death are full of pastel imagery:

The End of the Parade
The sentence undulates raising no song—It is too old, the words of it are falling apart. Only percussion strokes continue with weakening emphasis what was once cadenced melody full of sweet breath.

WCW wrote with clarity and conviction about New Jersey. His longest poem was Paterson, the town near where he lived. And he had a need and appreciation for love, in both a carnal and romantic sense, that is provocative.

The Night Rider
Scoured like a conch or the moon’s shell I ride from my love through the damp night. There are lights through the trees, falling leaves, the air and the blood an even mood warm with summer dwindling, relic of heat: Ruin dearly bought smoothed to a round carved by the sand the pulse a remembered pulse of full-tide gone

But back to Rutgers Medical School—the consensus name did not fly. The finished portrait was vandalized, sprayed with paint saying that the renowned poet, humanist, and caring doctor was anti-Semitic. The WCW SoM run was over, and Robert Wood Johnson became the chosen name. WCW . . . we tried!

Edward D. Harris, Jr., M.D.
Editor

Reference

The Pharos/Winter 2004
Treasure hunters differ in the nature of their pursuits. For some, such as Robert Louis Stevenson’s Squire Trelawney and his young protégé, Jim Hawkins, pirate gold may be sought and retrieved from an abandoned island after overcoming a few encounters with bloodthirsty semiretired buccaneers. For bibliophiles like me, treasures may be pursued closer to home on the shelves of a well-stocked bookstore or in the stacks of an excellent library. It was my recent good fortune to locate such a treasure in the history section of the incomparable library of the University of California San Francisco (UCSF), Medical Center.

I was familiar with the work of the book’s author, the late Ralph Major. His text Physical Diagnosis1 had been my introduction to the great bedside clinicians of the past, including Laennec, Skoda, and Babinski. Generations of medical students have had to endure my retelling of Major’s description of Auenbrugger’s introduction of percussion in medical practice (as a youngster in his father’s inn, Auenbrugger had to assess the degree of fullness of beer barrels). Major’s Classic Descriptions of Disease2 is also a longtime valued possession. My find at UCSF was a third work of Major’s, Disease and Destiny3, a first edition published by Appleton-Century in 1936.

Stanley S. Kahn, M.D.
The author (ΩΩΑ, Washington University School of Medicine, 1942) has served on the Berkeley, California, Health Commission since 2002. He is a former clinical professor of medicine at the University of Alabama at Birmingham, and was in private practice in internal medicine from 1950 to 1988.
Did you see these stone offerings from the Eleusinian in Athens. This must have been a forerunner of John Hayden.

Trust if I reach Coz. Boat afterwards all chaps go to Smyrna and have a drop peel before they reach Coz. Then to rather soon. Regarde

Dr Logan Clandenning

Kansas City Mo

E Stats Unis
Disease and Destiny and a postcard

When I discovered Disease and Destiny in the UCSF library, I found more than just the published work of a favorite author. Affixed to the back of the book with stamp hinges was a postcard sent by Major to his close friend and faculty colleague at the University of Kansas Medical School, Dr. Logan Clendening. The card bore Major’s initials and had been mailed from Greece. Although the date on the card is undecipherable, the two standard issue Greek stamps and postage due stamp indicate that the approximate time of mailing was 1937 or later.

The postcard depicts an ancient bas-relief of a man, presumably a physician, clasping a huge model of a leg on which a very prominent varicose or phlebitic vein is portrayed, copied from the collection of the National Museum in Athens. Major wrote, “Did you see these votive offerings from the Eskapian [sic] in Athens. This must have been a forerunner of John Hayden. Doubt if I reach Cos. Boat schedules all changed—go to Smyrna and half a dozen places before they reach Cos. Also it’s rather warm. Regards. RHM.”

Disease and Destiny includes a preface by the same Dr. Clendening, written at least a year before he could have received the postcard. In the preface, Clendening mentions that Major traveled to the former homes of many of medical history’s giants, an observation that clarifies Major’s evident frustration in trying to reach Cos, putative birthplace of Hippocrates. Clendening goes on to say that Major was an accomplished linguist, at home with Latin, French, and German; he also enjoyed considerable familiarity with Italian, Egyptian, and Greek.

In Disease and Destiny, Major describes in vivid detail the enormous impact pandemics of bubonic plague, tuberculosis, smallpox, and typhus had on world history and its leaders and notables as early as the time of Pericles in ancient Athens. Presented with charm and wit, the book is a trove of information. With his historical, quasi-biographical approach, stressing the personal attributes of the individuals involved in medical works, Major brings potentially stodgy material to life.

For example, Major points out the debt humanity owes to Dr. Bretonneau of Tours, who first described diphtheria in the...
early 1820s, and clearly differentiated it from other types of severe pharyngitis. Bretonneau prescribed the first effective remedy, tracheotomy. Thus, the strangulating aspects of this disease were effectively confronted, even though the antitoxin that would counteract the deadly systemic effects of diphtheria toxin was not to appear for another 70 years.

If he were here today, Major would probably modify some statements in his book. He attributed Franz Schubert’s death to typhus. Although it is now generally accepted that Schubert had contracted syphilis, historians are still in the dark as to the cause of the composer’s death.\(^6\) George Washington probably died of acute epiglottitis, a condition recognized only in relatively recent years, rather than from diphtheria, as Major related.\(^6\)

Somewhat puzzling is Major’s failure to mention salvarsan “606” or neosalvarsan in his otherwise highly informative description of “the greatest plague of them all,” syphilis. These agents had been available since the early part of the second decade of the twentieth century. Elliott Joslin, for example, as early as 1916, in the first edition of his text The Treatment of Diabetes Mellitus,\(^7\) described the successful treatment of syphilis with salvarsan. Such minor quibbles aside, Major’s book is a fascinating find, one that was, for me, immeasurably enriched by the inclusion of the postcard from the author.

Finding this work by a long-­-­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­…
Ralph Major’s writings

Among Ralph Major’s other medical writings, probably his best-known works are Classic Descriptions of Disease, first published in 1932, for which he is known to have made many of the translations into English himself, and the textbook Physical Diagnosis, first published in 1937. In the course of describing diagnostic bedside techniques in the latter work, Major supplied thumbnail sketches of medicine’s innovators in bedside diagnosis. Major was unquestionably influenced by Hopkins’s first chief of medicine, William Osler. Although Osler had left Hopkins for Oxford in 1905, before Major’s arrival in Baltimore, his emphasis on bedside teaching and his devotion to medical history continued to influence Major and his colleagues there.

In addition to more than fifty articles on medical history, and numerous chapters in medical texts, Dr. Major published the following books:

- The Doctor Explains (Knopf, New York, 1931), written primarily for patients
- Disease and Destiny (D. Appleton-Century, New York-London, 1936)
- Physical Diagnosis (W.B. Saunders, Philadelphia and London, 1937), with multiple subsequent editions, some of the later editions of which were co-edited with his colleague Mahlon Delp, as well as translated into several languages
- Faiths That Healed (D. Appleton-Century, New York, 1940)
- Fatal Partners: War and Disease (Doubleday Doran and Co., New York, 1941)
- Disease and Destiny, Logan Clendening (University of Kansas Press, Lawrence, Kansas, Logan Clendening Lectures, Eighth Series, 1958)
- An Account of the University of Kansas School of Medicine (University of Kansas Printing Service, Lawrence, Kansas, 1968)
- Memories of a Vanished Era, Kansas City, Missouri (private printing by the Lowell Press, 1968)
- Old Ties and New, Kansas City, Missouri (private printing by the Lowell Press, 1968)
- Torna a Sorrento (private reproduction, paper bound, 1967).

The examples of Munich clinician Friedrich Müller, whom he cited in his textbook, Physical Diagnosis. Possibly also influenced by German professional standards, Major instituted certain disciplinary rules for medical students, prohibiting smoking in the presence of patients, and forbidding the use of elevators.

Major’s clinical work was distinguished by the early successful use of insulin, acquired from friends in Toronto, in the treatment of uncontrolled diabetes, including diabetic coma. He took pride in the fact that of the three published reports in the June 2, 1923, issue of JAMA dealing with that revolutionary treatment of diabetes, one of them was from his department at the University of Kansas.

Finally, Hudson observed of Major that, “He stimulated faculty and student interest in the history of their profession to heights that probably never will be reached again in today’s curricular crush.”

written over thirty years ago, this statement is certainly prophetic.

Logan Clendening—Renaissance man, book collector, and diagnostician

For an account of Logan Clendening’s life, I turned to a memoir published by Major in 1945, shortly after Clendening died. Major met faculty colleague Logan Clendening soon after taking on his new duties at Kansas, and the two became lifelong friends. Clendening shared Major’s enthusiasm for teaching physical diagnosis and exploring medical history. Clendening’s Modern Methods of Treatment enjoyed eight editions, and he later became well known to the general public for his widely syndicated column of health advice.

Logan Clendening was a native Kansan, born in 1884 of Scottish ancestry with strong Jacobite sympathies. In his memoir, Major describes him as a tall, handsome man of ample girth, and full of vigor and good spirits. Clendening was particularly known for his sense of humor, his expertise as a raconteur, and his infectious charm. He attended public schools in Kansas City, Missouri, the University of Michigan, and the University of Kansas School of Medicine. Following graduation from medical school in 1907, Clendening traveled through much of Europe, visiting medical centers in England and Scotland as well as those of the Continent.

He entered private practice in Kansas City and married Dorothy Hixon in 1914. During World War I, Clendening served in the Army Medical Corps as chief of medicine at the
base hospital at Fort Sam Houston. On his return to civilian life, he was appointed to the medical faculty of his alma mater, where his enthusiasm for teaching physical diagnosis extended to demonstrations of gastric lavage and abdominal paracentesis. Major commented that no student ever fell asleep in one of Clendening’s classes.

Although Clendening later gave up private practice to become a full-time writer, he never surrendered the practice of medicine in the dispensary. Major wrote, “He initiated generation after generation of medical students into the mysteries of physical diagnosis.”

Clendening was a collector of rare medical books, in the tradition of Osler and Cushing. Like other notable collectors who left their books to medical schools with which they had enjoyed a close association, Clendening donated his library to the University of Kansas; the collection is now known as the Clendening History of Medicine Library.

So how did an old postcard from Major to Clendening find its way to San Francisco, and to the back of this copy of Disease and Destiny, so many years and miles from the University of Kansas? Its provenance remains a mystery. The vitory image on the card was later reproduced in Major’s splendid two-volume work, A History of Medicine.11 In that volume, the author indicates that the vitory was originally found in the famous Asklepieion temple in Athens.

An acknowledgment on the front flyleaf of the book states that it was given to the library by the estate of the late Dr. Esther Rosencrantz. A 1904 Hopkins medical graduate and a distinguished San Francisco physician specializing in chest disease, Dr. Rosencrantz served as a lecturer in medical history at UCSF, as well as an associate professor of medicine. When she died in 1950, she left her medical history collection (including a valuable accumulation of Osleriana) to UCSF.

Finally, where does Ralph Major belong in the pantheon of physicians? Why are his contributions important today, to me, and, I hope, to many others?

Major’s two principal achievements were developing the Department of Medicine at a young, Midwestern medical school, the University of Kansas, and arousing an interest in and appreciation of the glorious saga of medical history. Unfortunately, the history of medicine has always been a stepchild in the medical school curriculum. Yet the history of civilization can boast no more positive contribution to humanity than the development over the centuries of the modern healing arts, beginning perhaps with Vesalius and Harvey. Ralph Major revered medicine’s pioneers, and his reverence and esteem for those trailblazers is contagious.

Acknowledgments

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References


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Commentary

Medical history without medicine

Robert P. Hudson, M.D., M.A.C.P.

The author (ΩA, University of Kansas, 1976) is emeritus professor and chair of the Department of History and Philosophy of Medicine at the University of Kansas, and past president of the American Association for the History of Medicine and the American Osler Society.

Outside forces continue their termite gnawing at the foundation of medical professionalism. Medicine inching ever deeper into the world of business. Ethical medicine subverted by legal intrusion. Medicine, the profession, without the linchpin of professionalism—autonomy over the very nature of its work.1 These forces are interlocked and widely deplored. Less noticed has been the virtual disappearance of physicians as historians of medicine, both as aficionados and as craftsmen. At a time when physicians desperately need a historical perspective, their waning active involvement in medical history is leading to a medical history without medicine.

More than religion and law, medical history as a discipline was born and reared by its practitioners. Its early twentieth-century pioneers attempted to restore the image of learned men that was lost during the legislative anarchy that ruled American medicine between the 1830s and 1870s. The medicine of those learned men was rescued from its erroneous theory and radical practices by the physician-scientists of Western Europe, who after 1850 were finally putting medicine on a scientific foundation.

By the early twentieth century, influenced by such literate physicians as the legendary William Osler, practitioners increasingly considered it de rigueur to engage medical history as part of their pursuit of complete professionalism.2 The more dedicated wrote history, while the bibliophiles among them collected personal libraries that became the loci of academic centers of medical history such as Johns Hopkins, Yale, the University of Kansas, and others. In the preceding article, you encountered the two men who established medical history at the University of Kansas, Logan Clendening (1884–1945) and Ralph Major (1884–1970).3

Clendening was the bibliophile and popularizer. Major the linguist and scholar. Both laced their writings, including medical works, with the accomplishments of great men of the medical past. Each wrote a book still widely used in historical circles—Major’s Classic Descriptions of Disease,4 and Clendening’s Source Book of Medical History5—that presaged the importance of general literature as a valuable source in writing history.

Henry Haskell, editor of the Kansas City Star and twice a Pulitzer Prize recipient, opined in 1967 that, aside from what he termed “birds of passage” (writers who left the region, such as Eugene Field and Ernest Hemingway), the two greatest writers Kansas City ever produced were Major and Clendening,6 a defensible statement today. Sadly, for our purposes, the two can also now be seen as thriving late in the efflorescence and early in the decline of practicing physicians as leaders of medical history as an academic discipline.

As evidence for the last statement, fast forward to 1952. That year the American Association of the History of Medicine (AAHM) held its annual meeting in Kansas City under Dr. Major’s presidency. Of the some 200 persons attending the lectures, about 100 were medical students who were excused from clinical duties to attend. Today a medical student at a meeting of the AAHM is a rarity. Of the 19 persons on the 1952 program, 16 were physicians.7 Contrast that with the 95 presenters on the preliminary program for 2003, in which 81 were Ph.D.s, eight were M.D./Ph.D.s, and only four were M.D.s.8

In 2002, the president and secretary-treasurer of AAHM were Ph.D.s, and only two of 12 councilors were physicians. Most committees were chaired by Ph.D.s. Since 1991, the AAHM has annually honored a person for a Lifetime Achievement Award. The first three were M.D.s, but no others have been elected during the past 11 years.9

In 1952, there were 315 M.D.s and 29 Ph.D.s in AAHM.7,10 In 2001, there were 430 M.D.s, 386 Ph.D.s or Ph.D. candidates, and 51 M.D./Ph.D.s.9,10 Physicians have been a declining majority of AAHM members over the past several decades, a trend likely to continue.

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Clearly, in the last half century, dominion over the writing, teaching, and politics of medical history has shifted from practicing physicians to Ph.D. historians, most of whom are based in traditional university history departments. Though a minority of AAHM membership, they control the discipline because they run the graduate programs, do the writing, and attend the meetings as active participants. In short, they are full-time historians.

Due to their lack of medical training and the fact that physician-historians have largely neglected the field, Ph.D.s concentrate on the social history of medicine. With reason, they decry as too narrow the physician-historians’ emphasis on “great physicians.” Gradually the Ph.D.s’ emphasis argued that social forces, above all, not the talent and dedication of individuals, shaped the past and present course of medical history. In this process, one critical question was largely ignored: Who but great men and women could shape the social forces themselves?

For current medical students, who are fortunate to get any exposure to medical history, an inordinate social emphasis leaves large and important areas inadequately covered. There
training and practice can offer deeper insights. Among many other examples are the scientific nature of disease that often determines the social effects, the healing power of a humane physician at the bedside, and the patient’s role in healing.

The reasons for the decline of physicians as historians are largely identifiable, but too complex for treatment here. Clendenning and Major became historians because they believed the discipline enriched their lives and improved patient care. The rising Ph.D.s saw the writing of “scientific” history as beyond the formal training of ordinary physicians. They had a point, but the “scientific” history dominating AAHM literature and meetings holds little appeal for practitioners because its utility is elusive and the subjects generally narrow. Given the opportunity, medical students will seek out the history of their profession if it is taught in a way they see as useful to what they will be doing in practice.10

The rise of medical ethics is instructive at this point. For loose purposes, it can be said that modern medical ethics began with the 1954 publication of Joseph Fletcher’s Morals and Medicine.11 Thus, as medical history diminished in importance, life-and-death medical ethics exploded into the daily lives of physicians and the public. Highly publicized cases appeared immune to solution by the conflicting moral principles at hand, yet action was often imperative, leading to the courts for decisions. The inescapable utility of medical morality was quickly perceived by the public and health professionals.

The usefulness of the historical perspective is more subtle, more difficult to define in practical terms. A 1975 book by leading medical historians debated whether medical history had utility at all.12 Yet, physicians rely heavily on history with each new patient. Medical researchers would not consider moving into a new area without searching past literature. Media instruments such as weekly newsmagazines are replete with history. Still, the odds are strong that most Americans could not give a coherent statement on the importance of history to them personally.

Medical history without medicine can only remove one more brick from the unstable edifice of today’s medicine as a profession. Clendenning and Major would never have understood.

References


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Code Blue
I stand before this moment not thinking, not feeling
I stand in this moment become the moment execute crisp, clear action
I leave this moment
raven adrift against the sky trembling leaf as it lets go howl loose in the night air
the moment stands
I return poised between pendulum swings

Jan Young, M.D.

Dr. Young (AOA, Tulane University, 1972) is medical officer of the day at Sonoma Development Center in Santa Rosa, California. Her address is: 2627 Spring Oaks Drive, Santa Rosa, California 95405. E-mail: jannermd@yahoo.com.
Everyday amnesia
The curious effects of a common drug

Michael D. Hope
The author is a fourth-year medical student at Stanford University School of Medicine.

The Pediatric Pre-Operative Unit is an anxious place. Parents wait tensely as their children play with nervous energy, many too young to fully understand or verbalize their uneasiness. Some older children sit rigidly, others become effusive and needy. An eight-year-old girl awaits surgery, repeatedly grabbing her father's arm with playfulness mixed with desperation.

The unit is decorated like a kindergarten classroom, replete with primary colors, Lego sets, and stuffed animals. Yet for many of the parents, the room might as well be bare. Their thoughts are elsewhere, trying to temper nightmarish scenarios with common sense and hopefulness. In some cases, a downward cycle of anxiety and apprehension forms between parent and child, the child sensing the parent's nerves and becoming anxious, making the parent all the more jittery.

As operating rooms are prepared and surgical teams assemble, the families are informed that the time has come to leave their children in the care of the anesthesiologists and surgeons. Instead of being the climactic moment of anxiety, however, this is often a moment of deep relief, largely due to the appearance, a few minutes before, of what the nurses fondly call "happy juice."

Oral Versed is a slightly viscous fluid with a deep pinkish-red hue. It does not look or taste markedly different from cough syrup. It does have a bitter aftertaste, and most of the kids in the unit choose to wash it down with a little water. A surgical resident walking by as a younger squinches his face in disapproval recommends mixing it with apple juice to neutralize the bitterness.

Prior to gulping down a thimbleful of happy juice, a two-year-old boy has been terrorizing the unit, madly throwing balls and performing jump kicks. Oral Versed takes roughly fifteen minutes to reach full effect. The little boy follows this timeline like clockwork. His energy level declines almost linearly over those fifteen minutes, from full speed to three-quarter speed, when his throws become less aimed and exuberant, to half speed, when he loses interest in the ball and only occasionally performs muted
versions of his previously vicious jump kicks, to one-quarter speed, when even running around seems like a chore. The drug achieves its full effect when the child plops down for a light nap on his mom's lap.

Like most kids on Versed, the little boy leaves his parents uneventfully, without fear or agitation. He looks a little sleepy on the gurney, but smiles gently as if in the middle of a pleasant thought. As his eyes scan lazily across the unit and around the operating room minutes later, it is reassuring to know that his last memory will probably be of playing with a ball or lying in his mom's lap. Everyone around him also seems relaxed. His parents appear less jumpy and almost calm at the time the boy is wheeled off for surgery, and the doctors and nurses involved are undoubtedly relieved that everything has gone smoothly. Everyone appears happy, or at least as happy as could reasonably be expected. Versed has lived up to its billing.\textsuperscript{1,2}

Versed (midazolam) belongs to a class of drugs called the benzodiazepines, well known for their sedative, anti-anxiety, and memory-blocking effects. This constellation of effects contributes to a condition aptly termed "conscious sedation." Anxiety and inhibition are diminished, while consciousness is dimmed but preserved. Depending on the dosage administered, a child will fall somewhere on a spectrum of less energetic than normal to very drowsy. Because kids' behaviors are not markedly different (kids become more fun-loving if anything), the drug is pleasant to work with in the clinical setting and parents are relatively undisturbed by its effects. Occasionally, however, Versed will produce a level of disinhibition that can render a child more difficult to manage. Furthermore, the serious side effect of respiratory depression must be carefully guarded against with appropriate monitoring.\textsuperscript{1,2}

Versed is widely and commonly used in pediatrics. The types of procedures for which it is employed cut across many medical specialties. With a few exceptions, Versed has been used for all medical procedures more invasive and uncomfortable than an IV placement, and in certain cases for IV placements as well. For example, Versed is used for diagnostic procedures such as lumbar punctures, bone marrow biopsies, and bronchoscopies; for imaging studies such as CT or MRI scans, for which a child must lie unnaturally still for an extended period of time; for orthopedic procedures such as the resetting of a broken leg; for injections of medicine involving frightening needles; and in continuous infusion for ICU sedation, for which a child must lie still, sometimes for days, amid an intricate web of apparatus. Older people are also soothed and calmed by Versed, which is used for a similar laundry list of indications in adult medicine, though typically administered intravenously.

While Versed's anxiolytic effect is arguably its most clinically useful attribute, the amnesia it produces is its most striking feature. Many doctors who routinely use Versed have a

**One of the benzos...**

**Chemical structure of Versed (midazolam)**
Everyday amnesia

favorite amnesia story. Perhaps it is about a teenager who has visited a clinic numerous times for a certain procedure, but astonishingly does not have even a faint recollection of his or her doctor. Or perhaps it is about a cantankerous man who refuses to believe he has received the medical attention he desires and accuses his doctor of lying.

Trip to amnesia

Under the influence of Versed, a patient can appear normal, and even engage in conversation that is entirely coherent and ordinary. But many patients will have no recollection of what took place during an interval that might last a couple of minutes or a few hours depending on the individual and dosage administered. The experience will simply vanish. This amnesia can seem dramatic and even difficult to believe for someone unaccustomed to Versed. The first time I witnessed the effect of the drug was as a first-year medical student, when I watched a man have his ankle reset. One moment he was writhing and sweating profusely. No more than fifteen minutes later, he was relaxed and oblivious to the discomfort he had just experienced. He had no recollection of the procedure. The precious, central faculty of memory had simply been turned off, a mundane and unremarkable moment for those who have worked for years with Versed. For the unseasoned observer, however, the moment lingers. That a person can experience an event, particularly an emotionally charged one, and emerge minutes later without a trace of recall is unsettling. It prompts one to reflect on the notion of memory.

Memory is the scaffolding upon which consciousness hangs. It is the reference point for everything we do, helping to define our every move and syllable, bounding our perceptions, crafting our personalities, assembling our identities from myriad scraps and fragments. Without it, we would find ourselves in an unimaginable void.

Having said this, it seems remarkable that more attention has not been paid to the role of amnestic agents in modern medicine. Memory is clearly a profound faculty, and simply “turning it off” for a period of time is likewise a profound undertaking. What exactly has been turned off, and what is still getting through? With respect to the typical patient on Versed, there are no definitive answers to these questions.

“Did that really happen?”

A textbook will tell you that Versed, like all benzodiazepines, achieves its anxiolytic and amnestic effect by facilitating the action of the inhibitory neurotransmitter GABA through increased frequency of chloride channel opening. Further, there are studies and statistics addressing such things as the duration and degree of impaired recall; compared to other benzodiazepines, Versed has a higher potency and shorter duration of action.2 Yet one must rely primarily on anecdotes for some of the more complex and qualitative issues surrounding the use of Versed. Are amnestic patients affected by the procedures they undergo? Do they retain anything from their experiences? Are there emotional consequences?

Take, for example, the case of HM, one of the most famous and thoroughly studied of all amnestic patients. To treat his epilepsy, surgeons in 1953 removed large portions of the medial temporal lobe on both sides of HM’s brain. Since the surgery, HM has not been able to encode any new memories. It is as if he has been on Versed for the last five decades. People will have lengthy conversations with HM, leave for a moment and return to find that he has no recollection of who they are or what they were talking about.

The height of the Cold War, Vietnam, Michael Jackson, the Smurfs, hot pants, cell phones—HM has been spared it all. His memory of events prior to 1953 is still intact, so in many ways he is like a time traveler set down in our modern world, interpreting things through an outdated filter, but with logic and intelligence. When HM is confronted with a modern word and asked about its meaning, he guesses by breaking the word into its component parts and applying common sense, just as any high schooler is taught to do for the SAT. “Software” might be construed as some new line of padded clothing, “Watergate” as a contraption used by a hydroelectric dam.

While HM is unable to acquire new knowledge in an explicit fashion, such as developing an updated vocabulary, he does remain capable of certain forms of learning. He retains the ability to be unconsciously influenced and educated by experiences, as do most amnestic patients. This domain of memory is often referred to as “procedural memory” as it cannot be accessed directly, only demonstrated by performance. An amnestic patient could learn to ride a bike, but would retain no recollection of when or how the skill was acquired.

Messed-up memory circuits

Another example of the presence and influence of implicit memory is the often-related anecdote about a researcher who shook an amnestic patient’s hand while holding a small, sharp object. The patient withdrew his hand in surprise, but quickly forgot the event as the researcher left the room. When the researcher returned later and offered to shake the patient’s hand again, the patient refused to do so, but could not explain his asocial behavior. At some level below the surface of awareness, memory circuits that allow an amnestic patient to

The Pharos/Winter 2004
record events—events that slip past the grips of conscious memory—are intact and functioning.3-5

Just as the pathologically amnesic patient refused to shake the doctor’s hand a second time, a patient on Versed who is temporarily amnesic for a procedure during which he or she is uncomfortable might be subconsciously driven to behave antagonistically toward the doctor involved. Such patients have been reported in the literature. Though their conscious memory banks may be vacant after an event, implicit or subconscious channels can have a substantial effect on these patients, influencing their thoughts and dispositions, informing their behaviors.6,7

The subtext to this discussion of the subconscious of amnesic patients is that taking Versed constitutes a tremendous act of trust on the part of the patient. Patients allow themselves to become powerless and vulnerable. They are in a state of diminished inhibition and judgment. And they are not likely to remember much, if anything, about their experiences while on Versed.

While Versed may indeed render patients strikingly vulnerable and potentially leave imprints invisible to the conscious mind, its utility in the clinical setting is undeniable, its effects clearly beneficial. Used properly, Versed can help to dissolve the tension and discomfort of hospital visits for all parties involved and contribute to the efficiency and ease of modern medicine.

References

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Desire

To bed
I said
With lascivious sigh
With lust
For just
Some hours shuts eye
Warm toes
Cold nose
And pillows piled high
To sleep
Dark deep
Until morning is nigh

Catherine M. Birt, M.D.

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Is there magic in tropical rain?

Herbert A. Haessler, M.D.

The author (AΩA, Medical College of Wisconsin, 1957) is honorary pediatrician at Massachusetts General Hospital in Boston, and retired director of emergency medicine at Morton Hospital in Taunton, Massachusetts. He has for the past four to five years participated in medical mission trips to remote villages in Central America, Romania, and Thailand. The photos are courtesy of Dr. Haessler.

I'm in the mountains of Nicaragua. They grow coffee here and spawn poverty. We are in a village school, our hearty band of doctors and nurses. The people form long lines to see us; we'll have trouble seeing them all today. Complaints are ordinary: backaches, stomach pain, and coughs. But there are exceptions. The six-year-old girl walked toward me, she squatted; I could almost hear the murmur across the room. I mention an operation, but the parents turn their heads and frown. "She's too little," they say, and I swallow a tear.

That same day I saw the boy of four whose foot was clubbed. "Oh, yes," I hear, "They could fix the foot in Managua, but there's no money to get there." I pass the hat among my colleagues and he goes. While waiting for who's next, I look out the window. The line is long, the sky is darkening, the air grows cool and smells wet. Suddenly, a torrent of tropical rain pours down. The line doesn't move, they'd lose their places. There must be magic in the rain.

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A medical student’s review of the
British National Health Service

Eric Randolph Bricker

The author is a member of the Class of 2004 at the University of Illinois at Chicago College of Medicine. This essay was the first place winner of the 2003 Alpha Omega Alpha Helen H. Glaser Student Essay competition.

The health care system in the United States is ailing. As a medical student, I am reminded of this fact each day by the frustrations of attending physicians, the anecdotes of desperate patients and the stories of doom-and-gloom in the news media. What do I hear and read? Over 41 million are uninsured; infant mortality is 7.1 per 1000 live births, one of the highest among industrialized nations; and health care costs currently stand at 13.5 percent of our GDP, two to three times those of other industrialized nations.¹⁻³

We occasionally look beyond our borders to Canada, Sweden, and Great Britain; these nations operate their health care systems with far more government involvement than the United States. This paper describes Great Britain’s National Health Service (NHS) from the perspective of an American medical student searching for some answers in a sea of health care dilemmas. What is the NHS in terms of its origins, politics, patient access to care, utilization of health resources, preventive services, medical ethics, and its validity assessed by several key health outcome statistics? To search for answers, I traveled to Great Britain to interview several physicians and a clinical pharmacologist.

The NHS was created in 1948 with the goal of providing all British citizens with free health care at the point of access.⁴ The NHS does not require patients to pay for inpatient stays or outpatient visits and requires only a small copayment for prescription medications and some other services. The British government funds the NHS’s free, universal access through taxation.⁵ In 1997, health care spending in Great Britain was approximately $1,347 per person per year, while the figure in the United States was almost three times as much, $3,925 per person per year.⁶

In terms of physicians, there are two parts to the NHS: (1) hospitalist and specialist care and (2) primary care. For hospitalist and specialist care, the NHS allocates funds to hospital trusts, which are the administrative arms of the government that run either a single hospital or a small group of hospitals. These trusts then use the funds to pay for physician salaries, hospital staff, utilities, maintenance, and new equipment. The trusts are relatively autonomous, but the NHS reserves the power to control their activities. All specialists—called consultants in Great Britain—are paid a yearly salary. For primary
A medical student’s review of the British National Health Service

By and about the author

I grew up in the Washington, DC, area and at age 16, was offered a summer internship at the NIH by Nancy Dwyer, a laboratory researcher there. For the next three summers under her guidance and that of Dr. Joan Blanchette-Mackie, I became very interested in biological science. Four years studying at Northwestern University as an economics major and two years working at a hospital finance consulting firm taught me there is more to medicine than patients and disease—for better or for worse, money is a major issue.

I am currently a fourth-year student at the University of Illinois at Chicago College of Medicine, where I am a member of the College’s James Schlar Program for Independent Study. This paper was made possible by the guidance of the program’s director, Dr. Truman Anderson and the editing skill of Julie Eisengart. I owe them both deep thanks and gratitude.

care, the government pays independent general practitioners (GPs) a capitated amount for each patient, along with some fee-for-service payments for a few procedures. Patients are free to choose their GPs, but are not free to see specialists of their choice. GPs refer patients to assigned specialists. How this system, which is far different than our own, came to be is deeply rooted in British political history and culture.

The NHS Act of 1911

The creation of the NHS in 1948 was the result of years of incrementally increasing government involvement in medicine. During the nineteenth century, the British government’s role in medicine was limited to providing hospitals for the poor, apparently the only benevolent provision in the otherwise harsh Poor Laws that generally discouraged anyone from seeking support from the government. The first expansion of the government’s role came in 1911 with passage of the National Health Insurance Act, which provided primary care for lower-paid workers (but not their dependents) in an effort to ease social unrest among the poor. During the 1920s and 1930s, the government made several other small steps in expanding its involvement in providing care, but by far the greatest leap forward was during World War II. It was then that the government took over and upgraded existing hospitals to operate the Emergency Medical Service, which treated casualties from the many bombings by German forces. Near the end of this war, physicians, the government, and the public were ready to accept the creation of the National Health Service: Prime Minister Winston Churchill announced his administration’s intent to do so as World War II ended. It was generally accepted that the provision of health care was part of the state’s responsibility to its citizens and that the right to health care was an essential part of any reasonable life. Just as World War II did much to foster the provision of private health insurance by employers in the United States, so too did it have a very different, yet equally profound effect on the British means of providing health care.

Rivalization? in the NHS?

While many in Britain share the same vision for the NHS, how the government should execute this vision changes with each new government. The first major political change for the NHS came in the late 1970s, with the Conservative Party administrations of Margaret Thatcher and John Major. These administrations commercialized many aspects of government, including the NHS, by eliminating an entire level of management, attempting to hold physicians more accountable for the resources they use and, finally, creating a free-market within the NHS.

This last change took place in 1990, when the government experimented with giving GPs much greater autonomy. To improve service delivery, the government gave GPs funds to contract with specialists and hospitals for certain health services for their patients. Through the NHS and Community Care Act, the GPs who received additional funds became known as “fundholders.” Essentially, these fundholding GPs became their own HMOs, bearing the financial risk of their patients becoming sick and requiring health care services. Not all services were funded through the fundholding GPs. For example, emergency hospital admissions and surgery costing more than $10,000 were still paid directly by the NHS. GPs were not required to join this program, and only 30 percent participated. The hope was that competition among specialists and hospitals for GP contracts, combined with financial restraint on the part of the GPs, would improve patient care and cut costs.

This attempt at partial privatization of the NHS was a complete failure. Most GPs lacked the skill or energy to set up contracts effectively or to manage the additional funds. For GPs, the increased control over their practices was more of an administrative hassle than it was worth. The government repealed the act in the mid 1990s, leaving the NHS in a period of uncertain transition.
To remedy this uncertainty, the more liberal administration of Prime Minister Tony Blair proposed another reorganization of the NHS in 2002. This newest proposal included dramatically increased funding for the NHS with a rearrangement in NHS bureaucracy. Certain levels of administrative control were eliminated and new ones were created.  

Even though the NHS provides universal health coverage, this does not mean patients have all their health care needs met immediately. To control costs, the NHS rations the supply of health services by limiting the number of physicians, nurses, hospital beds, and other resources necessary for diagnosis and treatment. As a result, patients must be triaged, either in the emergency department or by their GP.

If their health problems are not urgent, the NHS puts patients on a waiting list. London GP Dr. Richard Stock (interviewed on January 31, 2002) sees waiting lists in his practice. If he suspects that one of his patients has cancer, the appropriate consultant sees the patient within a week. According to statistics kept by the NHS, 85 percent of cancer referrals in England were seen within four weeks during the first quarter of 2002. Dr. Stock added, however, "If I find a benign dermatologic lesion on one of my patients, that patient may have to wait up to 18 months to see a dermatologist." Only 29 percent of dermatology referrals were seen within four weeks early in 2002. In 1996, nonurgent procedures such as elective cholecystectomies and cataract surgery had waiting lists of 18 months to two years. As of January 2002, there were just over 1 million patients on NHS waiting lists, almost 30,000 of whom had been on the list for more than one year.

Waiting lists may harm patients and create additional treatment challenges for physicians. London psychiatrist Dr. Tom Sensky (interviewed on January 30, 2002) told me, "Waiting lists for psychiatric services can come back to haunt you because people generally deteriorate over the course of waiting. [As a result] patients become more complicated to manage in the long term." A Dutch study found that patients waiting an average of 100 days for coronary artery bypass grafts suffered complications, and that these complications often occurred relatively early in their wait.

Patients and physicians can circumvent NHS waiting lists by using private health insurance. Approximately 13 percent of the British population has private insurance purchased individually. The government allows British physicians to earn up to 10 percent of their income from seeing privately insured patients, although this limit is rarely enforced. Patients and physicians use private insurance to avoid waiting lists for elective surgeries such as hip replacements, hernia operations,
A medical student's review of the British National Health Service

hemorrhoid repair, and gynecologic and ophthalmologic surgery. A 1996 study found that the wait for an NHS orthopedic consult ranged from three months to two years for the study's sample of physicians, whereas a privately insured patient could be seen by the same physicians within one to seven weeks. Patients with private insurance receive care more quickly, and physicians with private patients can earn an additional £15,000 to £75,000 per year. With such financial incentives, NHS waiting lists may be becoming even longer because physicians are caring for private patients rather than NHS patients.

The British public has voiced great frustration with NHS waiting lists and, as a result, the government created the NHS Plan to decrease the length of these lists. The NHS Plan calls for a 33 percent increase in government spending over the next five years. These additional funds will be used to build 100 new hospitals and add 7,000 new beds by 2010. Further, the NHS will fund 7,000 more consultants and 2,000 more GPs, and will create 1,000 new medical school slots. With these additional beds and personnel, the NHS hopes to reduce the maximum wait time for an inpatient visit to six months and for an outpatient visit to three months.

NHS waiting lists are the result of government-regulated rationing of health care resources, whereas in the United States, uninsured patients who are unable to pay for care suffer a similar fate. Given the scarcity of health resources on both sides of the Atlantic, how does the NHS maximize its resources to treat the greatest number of people possible?

The NHS has taken several measures to increase the efficiency of health care delivery. The NHS uses a restricted drug formulary for GPs and has used its purchasing power to negotiate lower rates for medications from pharmaceutical companies. Additionally, the NHS sets medication budgets for GPs and monitors their prescription practices. Those GPs who are consistently over budget are reprimanded. Mirroring a similar trend in the United States, the NHS also encourages more outpatient surgery. From 1978 to 1991, outpatient surgery doubled from 10 percent of hospital procedures to 20 percent. This increase in outpatient surgery has come at the cost of increased GP visits to care for patients that would normally have been cared for in the hospital.

need a bed!"

One paradoxical hindrance to efficient delivery of health care is the scarcity of NHS hospital beds. In 2000 and 2001, the average NHS hospital occupancy rate was 84 percent. Dr. Garrard told me that his 18-bed intensive care unit is rarely at less than 90 percent capacity and that John Radcliffe Hospital where he works is "absolutely full" three or four days out of the week. According to NHS statistics, John Radcliffe Hospital was at almost 90 percent occupancy on average during 2000 and 2001.

The high level of NHS hospital occupancy leads to two distinct challenges for physicians treating inpatients. First, it makes moving patients within the hospital difficult. Dr. Garrard stated that he often wants to move a stable patient from an ICU bed to a medical bed but finds no medical beds available. The patient must stay in the ICU, unnecessarily holding an ICU bed that another more seriously ill patient could use. Second, it makes moving patients from hospital to step-down facilities difficult. Dr. Sensky described this challenge in regard to psychiatry patients. A psychiatric patient may be temporarily discharged for a trial outpatient period and have his or her vacant hospital bed filled by a new psychiatric patient. If the original patient’s trial period does not go smoothly, he or she must be readmitted, causing an immediate conflict in hospital bed availability. Dr. Sensky believes more hospital beds are needed to allow for fluidity in the system.

One criticism of the U.S. health care system is the excess of hospital beds and the associated duplication of expensive technology: total U.S. hospital occupancy rate was 66 percent in 1999. The United States has an average inpatient length-of-stay of 7.8 days compared to Britain’s 9.8 days. The excess capacity and duplication of resources in the U.S. health care system allow physicians to move their patients more freely and have tests performed in a more timely fashion than in the bottlenecked NHS system, and this may be one of the reasons for shorter hospital stays in the United States. However, this reasoning is only a possible explanation and requires more study.

The NHS has various preventive medicine programs. It encourages GPs to perform preventive measures through financial incentives, and gives monetary bonuses if they reach specific targets for their practice, i.e., percentage of children immunized or percentage of women screened for cervical cancer by an annual Pap smear. The NHS also requires that GPs provide yearly check-ups for patients older than 75, and it offers mammograms once every three years to women ages 50 to 64, with older women having mammography if requested.

In addition to creating physician incentives and disease screening opportunities, the NHS also has community programs to reach those who may be at most risk for future disease. The First Parent Health Visitor Scheme actively enrolls first-time mothers from low-income areas for scheduled home visits from a specially trained health visitor. This health visitor trains mothers in parenting skills, child safety, and disease
preventive for their babies. A 2002 study found that mothers involved in the program had higher breast feeding rates and increased use of electric socket covers, while their children had lower accident rates in the second year of life.19 These preventive measures make sense for the population and for the NHS as it tries to maximize health and minimize costs, but sometimes the decisions concerning the health of an individual versus the health of the nation are not so clear-cut.

How much rationing is too much?

The explicit rationing of health care services in the NHS accentuates a major ethical dilemma faced by the medical profession and societies everywhere. How does society reconcile the ideal that doctors must do everything in their power for the well-being of a patient with the reality of limited resources to distribute among all people? As an example, in the mid 1990s, public outcry arose when a hospital refused a third transplant attempt for a child because the cost was not justifiable when weighed against the probability of a successful outcome.20 This decision could be interpreted to mean that the hospital would allow the child to die so it could save money. Using the slippery slope argument, such a decision could be extrapolated to refusal to treat the disabled on the grounds that their treatment is also a waste of resources.

The current NHS solution to this dilemma is to handle each decision openly on a case-by-case basis, keeping in mind personal and local circumstances.20 While NHS policy toward this key ethical challenge in medicine is by no means definitive, it shows a willingness on the part of the NHS and the British people to confront a very difficult issue openly. Arguably, openly confronting the issue may bring the British closer to an acceptable solution for their society.

Measurable outcomes: not so bad

With the many differences in how the NHS delivers health care in comparison to the United States, it is of interest to examine the results of these two systems’ efforts. However, before making comparisons it is important to point out that it is widely accepted by research authorities that life expectancy and other such measures are questionable indicators of a nation’s health. Further, these measures are a product of many different variables including diet, accidents, education, and poverty rate, among others, with only one of these variables being the form of a nation’s health care delivery. Caveats aside, in 1997 life expectancy at birth in Great Britain and the United States was virtually the same for women at 79.3 years, and higher for men in Britain at 74.4 years, compared with 72.7 years in the United States. If a woman reaches the age of 65 in Great Britain, she can expect to live an average of 18.4 more years, with the value for women in the United States being the same. If a man reaches the age of 65 in Great Britain, he can expect to live an average of 14.7 more years, and a statistically similar man in the United States can expect to live an average of 15.7 years.5 This last statistic illustrates that the lower U.S. male life expectancy from birth is due to mortality before the age of 65. At the opposite end of the age spectrum, U.S. infant mortality rate is 7.1 per 1000 live births, with British infant mortality rate considerably lower at 5.8 per 1000 live births.6

So where does this analysis of the British National Health Service leave a medical student evaluating the U.S. health care system? Had the United States been heavily bombed in World War II, necessitating a government takeover of hospitals, perhaps the country would have a national health service. The U.S. health care system may unfairly and inefficiently distribute its resources as dictated by capitalism, but Britain’s model of central control leaves decisions on health care resources to politicians and the news media. The United States has its uninsured; Britain has its waiting lists. Centralizing health care confers bargaining clout with pharmaceutical companies for lower prescription drug costs—certainly a topic of interest for U.S. seniors—but centralizing health care also means slow response to the need for more hospital beds when they are obviously necessary. The United States often gives preventive medicine lip service, and U.S. insurance companies rarely reimburse for it, whereas the British make a concerted effort to keep their population well, a clear advantage to being responsible for a patient’s entire life. Both systems wrestle with the same moral dilemma of the good of the individual versus the good of society. And when it all comes down to the final score of life and death, the outcomes are similar with the unacceptable exception that the United States fails to provide adequate care to pregnant women and newborns. In the end, perhaps the choice between the U.S. and the British health care systems is a choice between the lesser of two evils.

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Commentary

“A Medical Student’s Review of the British National Health Service” was written with the thoughtful concern of a young man alert to the realities of trying to provide quality health care. It draws the reader to look more closely into the historical, social, and ethical forces that shaped the provision of health care in the United Kingdom, and their expression in that most humane legislation, the National Health Service (NHS) Act of 1948. The Act was the culmination of an ideal present in the program of reforms in health and in general public policy that began 100 years ago, and fully expressed when the 1948 Act enshrined the view that there should be free access to services on the basis of clinical need, and that the service should be funded by the state, from general taxation.

The NHS described so ably in Mr. Bricker’s paper has served well at a level commensurate with the resources allocated to it. But for many years its development has not matched the demands made upon it. Among the responses have been restructuring, reorganization, and the introduction of market mechanisms to improve efficiency, effectiveness, and quality. These approaches have not been conspicuously successful, not least because they were not supported by the level of investment now accepted as necessary.

The reforms that preoccupy government, the NHS, and the professions today put patients at the center of service thinking and action. They embody national clinical and access standards, accountability, local delivery of services, independent inspection, and a small but growing element of patient choice; and they promote contestability, to drive efficiency and reward innovation.

To contain the costs of growing needs and expectations for health and care services, there is an increasing emphasis on the clinical and cost effectiveness of health care, with evaluation of procedures and technologies, targeting of resources to services and interventions of proven effectiveness, and emphasis upon health promotion and the prevention and early detection of disease.

To give better access with greater choice there must be increased capacity—more trained staff, more facilities.
must also be changes in the way clinicians work, in which removal of traditional professional boundaries extends the scope of clinical practice. There must be new ways of providing services, with integration of the health and care components and unifying care between community and hospital. There is also another explicit aim—to remove the inequalities in health and in health outcomes, and of access to and uptake of health care, across the nation.

There are important implications for the medical profession. The Medical Royal Colleges in the United Kingdom have set and stood by independent standards for postgraduate medical education and practice for many years. But government wishes other stakeholders to have an increasingly influential voice in medical education and training, to bring them into closer alignment with its service priorities.

Clinicians regard their service with a sense of ownership. This follows naturally—it is at once a great strength of the service and an impediment to change. Inherent in such ownership is acceptance of accountability for practice, for service improvement, and for the reforms needed to bring about cost effective improvements for patients and for society. It is no surprise that doctors and their clinical colleagues resist change unless they see benefits for their patients, and an improvement in the standard of care. Strategies that appeal to this motivation are more likely to attract commitment than those based on control. Yet the NHS depends on the leadership of clinicians to achieve the desired changes. At the same time, clinicians have a responsibility to ensure the most effective use of limited resources.

Authorities in many countries face similar problems, each against the background of its own historical and cultural heritage. We should learn from each other how to do things better, for all our populations.

Carol M. Black, C.B.E.
(AQA Honorary Member, 2003)
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VA April 2002

Old men supine on metal beds,
White sheets and covers mauve or blue,
Doors open wide so passing aides can view
The resting, breathing, heavy heads.
Next to each bed a five-toed stand
With plastic tubing hanging loose,
Delivering a measured dose
Drip by drip into each hand.

And you, dear man, eyes softly shut,
Cheeks sunken, bearded, grey,
What thoughts go through your subtle mind?
What mortal deal have you cut
With Life to let you stay
Or Death to let life’s thread unwind?

Sheila Kaplow, D.Phil.

Dr. Kaplow received her D.Phil. in pharmacology from Oxford University. She is retired from teaching physiology at Quinnipiac College in Hamden, Connecticut. Her husband, Dr. Leonard S. Kaplow (AQA, University of Vermont College of Medicine, 1958), was the author of “Thirty-seven Days on a Hospital Ship” published in the Summer 1999 issue of The Pharoa. Leonard Kaplow died recently of multiple myeloma at the Veterans Administration Hospital in White River Junction, Vermont. Dr. Sheila Kaplow’s address is: P.O. Box 539, Bradford, Vermont 05033. E-mail: sheilakap@together.net. The photograph is courtesy of Sheila Kaplow.
Guidance for the doctor’s physician child

Herbert Y. Reynolds, M.D.

The author (AΩA, University of Virginia, 1965) is a member of the Division of Lung Diseases, National Heart, Lung, and Blood Institute, National Institutes of Health in Bethesda, Maryland, and professor of medicine emeritus at the Pennsylvania State University College of Medicine.

I have been through the family ritual with my sibling of disposing of our deceased parents’ personal effects in preparation for selling the family home place. We could not confront this for a long while, but a vacant house does not do well, even with a caretaker, and an acquaintance of my parents who had always liked the house wanted to buy it. I had to deal with the past, which was inextricably linked to my present work.

My father was a solo general practitioner in a small rural town for almost 50 years. He was available virtually all the time to care for people, occasionally trading some evening coverage with the other GP in town. He worked out of a small, white frame, shuttered office, made house calls, saw patients in their cars when they came to the back of our home, or even in our kitchen if an injection or some suturing was needed. He occasionally sutured pets that had been injured in traffic. He attended about 700 home deliveries, and in the early years of his practice took out tonsils in his office, casted extremity fractures, and did his own radiology (he had worked an extra job in medical school as a radiology technician). He was the county medical examiner during most of his practice. Adults around town who knew him well would usually greet him, “Hi, Doc.” Much later, I realized that this salutation was the ultimate in acknowledging who and what he was.

The doctor and his wife—A team

When he finally closed his practice, on the advice of a close physician friend, the office and all its equipment were lovingly disassembled and packed by my mother, who for decades had been the business-receptionist staff and prob-
ably dispensed telephone advice to protect him from overwork. It was “their” practice in many ways. I know she did the packing (she said she couldn't bear to do it), because when I found them, all of the surgical instruments and utensils were grouped, wrapped in white towels and labeled (and dated); even the stirrups to the patient examining table were tied together and labeled, left and right. Everything had been placed in sturdy boxes and stored in their backyard garden house—20 years ago. I knew “the office” was all in there, and could not imagine dealing with it. But a local historical society wanted some items to complete a rural doctor’s office museum, and this seemed fortuitous because it would preserve some of this tradition of rural medicine as practiced in the past.

**Transfusion of guidelines for practice**

What I did not expect, after almost 40 years of my own career in medicine, was that I would reconnect so forcefully with this man whom I idolized and wanted to follow. I found myself drawn into the intimacy of his medical practice through handling his instruments and disposing of his office effects. His advice, dispensed during my medical school years and residency, flooded back. I realized that many of his suggestions about caring for patients had been skillfully and subtly transfused into me:

- If the patient’s initial symptoms and history are confusing and do not lead to a clear diagnosis, shift questions to the review of systems, which will often provide the diagnostic clue(s) needed.
- Wash your hands and clean the stethoscope’s diaphragm before you begin examining the patient and let them see you doing it.
- For patients who are anxious and need to feel more in control of the medical examination, squat down and begin by examining their feet, feeling for pulses and pressing for edema.
- Write out specific instructions for therapy, especially any changes in medical doses, because errors in medications are frequent and cause many health problems.
- You can’t communicate too much with the patient (and family). Discuss the illness as time permits, but send the patient a copy of your office notes, laboratory results, and any letters sent to referring physicians.
- Do the test yourself (analysis of a fresh urine sediment, peripheral blood smear or sputum gram stain), if an immediate result is important.

When I touched the instruments and imagined how he had used them, a film of tears welled up. There was the wonderful Zeiss microscope for viewing blood smears and urine sediments (and I wondered how he had gotten along without it for the semester he loaned it to me for my medical histology course). There were long-handled obstetrical forceps, a Boivé cauterying machine, cervical biopsy forceps, casting frames, a needle to puncture a maxillary sinus for drainage, and a lancet for a myringotomy. These were things I had never used or done, but then he had never managed a patient on a ventilator or been involved with a bronchialveolar lavage. When I was young, it seemed that he was able to do everything. Though he had all the tools for minor surgical procedures, he always seemed cautious and never a risk taker. He did not prescribe many medications, especially antibiotics. Not giving out an antibiotic for viral upper respiratory infections, he told me, put him on the defensive with some patients who always expected to get one from a doctor. He was criticized for not doing enough treating.

I remembered that he had wanted to train in otorhinology, but the depths of the depression years in the 1930s precluded that, and he said the prospects of rural practice seemed an attractive option. He always liked to examine and treat naso-oropharyngeal problems, and I realized I did also, and that really the lungs, where I have practiced, were just an extension from the upper respiratory tract.

I was aware that he had graduated second from the top in his medical class at a first-class school; he was smart in a very logical but thorough manner that made you feel he was always examining all the possibilities. He read incessantly, making neat notes on a pad. He ripped and filed journal articles. He attended CME courses faithfully—his recreation, I thought. He was a good diagnostician, as I learned when a specialist colleague of his told me, “Your dad only refers for confirmation and has the problem all figured out in the referral letter he writes.” Attached to a pack of obstetrical instruments was a newspaper picture and caption about a young honors graduate from a local university who was going to graduate school in engineering, with a note written on it (by my mother) that this man was the last infant he delivered. And why wouldn’t he be interested in following the career of an alumnus of his prenatal care program, as I have followed the students, housestaff, and fellows in our training and research programs?

**Grateful and loving payback**

But the gratitude felt by patients may never be known completely by the physician, or it may come unexpectedly. This occurred for my father, as his life was closing. He was nearly 90 years of age, had chronic dementia, and lived in a local nursing facility. He seemed particularly well cared for. One night I commented on this to his charge nurse. She looked directly at me and remarked, “Your father borned me and a couple of the other staff working here also, and he took care of us as
children, too. We take care of Doc.” I hoped, though never knew for sure, he could feel their devotion and admiration, but we, his family, certainly did.

Although doctors have to give a great deal of themselves to patients and the community, perhaps at the cost of some neglect to their families and personal interests, the practice of good medicine helps people immensely, and it is appreciated.

Acknowledgment
This is dedicated to two special medical students (W.S.R. and A.S.R.) who will be wonderful physicians. I appreciate the review of Dr. Anne H. Hawkins, Professor of Humanities, The Pennsylvania State University College of Medicine, and preparation of the manuscript by Mrs. Susan Crawford.

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What Doctors Depend On

Intuition, insight, and interns
Patients' stories
Nurses' stamina
Pharmacists who can decode cryptic script
Resilient receptionists
Computers, CAT scans, and coffee
Gray's Anatomy
Second opinions
Gumption
And grace
Occasional comic relief
Stethoscopes, X-rays, and common sense
Seeing, touching, and talking
People who don’t expect miracles
And people who do

Marilyn C. McEntyre, Ph.D.

Dr. McEntyre is professor of English and medical humanities at Westmont College in Santa Barbara, California, and a member of the boards of Literature and Medicine, the Online Database of Literature, Arts and Medicine, and the Center for Medicine, Humanities, and Law at the University of California, Berkeley. Her address is: Westmont College, Department of English, 955 La Paz Road, Santa Barbara, California 93108-1099. E-mail: mcentyre@westmont.edu.

Guidance for the doctor's physician child

Dr. George A. Reynolds. Photo taken from the Caroline Progress, weekly newspaper of Caroline County, Virginia, Bowling Green, Virginia, June 23, 1976.
Sleeper Cells

For Randy Kottenbrook

The Child is father of the Man
—William Wordsworth, “My Heart Leaps Up”

That very first day (and always)
Your smile was generous
Filling the room
Overwhelming, essential
Like mountains, oceans, air
You were Life personified!

A spongy mass
With rapid growth
In the upper eyelid
A small imperfection
Appearing innocent
As an adolescent blemish

Diagnosis cancer
A word that evokes fear
A word after which
No others are perceived
A sucker punch
To the solar plexus

What genetic defect
What environmental exposure
What combination of events
(Nature and nurture)
Was responsible for
This bodily debacle?

Prognosis measured
In mitoses per high powered field
Disorderly maturation
Anaplastic features
An odious visage
In stained glass

How barbaric was radiation
Cooking all in its path
A temporizing microwave
Slow roasting tumor and flesh
Into charcoal blocks
That crumbled like clay dreams?

And what poison cocktail
Can we conjure up
To stave off the inevitable?
Whether the smart bomb
The cellular Scud missile
To repel this terrorist sleeper cell?

And if the battle is won
But the battlefield decimated
Soft tissue damage
With functional consequences
What quality of life
Is a life worth living?
And if the battle is lost
Cancer cells proliferating
With reckless abandon
Uncontrolled, chaotic
A mirror to the universe
Deep pool of the unknown

My heart grows angry
And my soul cries out
Resolute in this microscopic struggle
You were the boy
Who looked cancer
In the face
And never blinked
Embracing your last days
With eyes wide open

On that vivid night
Leaving the Schottenstein Center
(The Buckeyes lost)
After a firm embrace
I kissed your forehead
And we said goodbye

I turned back
With sudden urgency
And you turned back too
Your exenterated right orbit
A quintessential wink
Saying “It’s okay.”

Our three eyes met
For the last time
A mischievous smile
On your battle-scared face
As if you knew something
I did not

My gaze fixed
In your direction
As you blended
Into the darkness
Suddenly you were gone
And the world was empty

Will you remember me?
Your question echoed

As I drove alone
In my thoughts
Across Ohio farm lands
To witness
The finality
Of your burial

The white formica casket
Was inscribed
With heartfelt messages
In black sharpie marker
As if you were coming home
From summer camp

Images rose from the cold
Rain-soaked grass
The loving husband
The doting father
That you will never
Get to be

How could I not be changed?
I will not forget
Your inner strength
Your sense of adventure
Your promise to become
A cancer researcher
If you survived

The burden is ours
To fulfill your promise

Steven E. Katz, M.D.

Dr. Katz (ΩΩA, Ohio State University College of Medicine, 1989) is an associate professor of ophthalmology at the William H. Havener Eye Center and the Arthur G. James Cancer Hospital at Ohio State University. His address is: 5717 University Hospitals Clinic, 456 West 10th Avenue, Columbus, Ohio 43210. E-mail: katz.16@osu.edu.

The photograph of Dr. Katz and Randy was taken by Tracy Kottenbrook, Randy’s mother.
Perspectives

How life imitates baseball

David S. Goldfarb, M.D.

The author is assistant chief of the Nephrology Section at the New York VA Medical Center and associate professor of medicine at New York University School of Medicine.

When the clinic’s medical resident told me that she had just seen a patient with von Hippel-Lindau syndrome (VHL), I asked her to send the patient to my nephrology clinic immediately. I knew the disease was associated with renal cysts and kidney cancer, but I had never before seen a patient with this rare genetic disorder, and I looked forward to the visit. During the next month, I read the basic science and clinical literature. I learned that renal cell carcinoma was frequent enough in VHL to warrant CT scanning of the kidneys as a screening test. But my new and useful medical arcana was not what Gil really needed, of course. The support he needed was psychological, not scientific.

At our first meeting, I explained the screening tests to Gil, a wiry, anxious, and hostile 45-year-old man. Some of his volatility, as I learned gradually over the next 10 years, was a result of his ordeal with his disease, but some of it derived from what he considered the humiliating experience of military service. The trust in me that he grudgingly developed sprang more from our mutual hatred of the New York Yankees (or the “Hankies,” as Gil insisted on calling them), as two long-suffering New York Mets fans, than from any convincing demonstration of my competence. On the occasions during which he could suppress his too-easily expressed rage, Gil was cuttingly sardonic, and paranoid in an appealing and funny way. “No, I won’t go to a baseball game anymore. They’re aiming foul balls at my face,” he’d say.

I learned that Gil’s visual acuity had diminished soon after leaving the army. An ophthalmologist had found the diffuse retinal blood vessel growth that characterized this disorder of vascular proliferation. The subsequent onset of unsteadiness led to the discovery of a cerebellar hemangioblastoma, another manifestation of VHL. After retinal laser surgery and a craniotomy, Gil’s course was complicated by avascular necrosis of his shoulder, necessitating a total replacement. His expectation of sudden death and his incessant complaints about the incompetence of the hospital staff were not surprising, but his vehemence and melancholy made him difficult to assuage.

With this woeful history as background, it was also almost inevitable that the screening CT scan that I ordered after our first meeting revealed cancer in both kidneys. Although I prepared him for the possibility of renal failure, half of one kidney was luckily spared. We began a grim yearly ritual of inspecting his small residual kidney fragment for signs of cancer. He never believed that a quarter of his original renal mass could function nearly as well as two kidneys.

For Gil, the dialysis unit loomed. Each year he asked, “Do you have a kidney for me? When are you going to do that kidney transplant?”

When it fit his schedule, I had him speak with my medical students. He enjoyed playing
the colorful and irascible veteran for them. He charmed them, amused them, then brutally shocked them as he described his sufferings at the hands of the United States government and its conspiratorial agents. Once, after hearing of his long history of inadequate medical care, a student asked him, “What about Dr. Goldfarb? Didn’t he help you?” He responded derisively, without smiling, “Him? He only brings me bad news!”

After some years of relative stability, another cerebellar tumor was found. Consistent with his long losing streak, the atypical chest discomfort Gil had kept secret for some months led to a pre-operative evaluation. No procedure could be performed unless Gil saw that I was in the hospital and available. He came to my office before every procedure, and said, “They’re going to do a stress test; I expect the worst. If there’s bad news, I want to hear it from you.” The stress test led to a cardiac catheterization, and he arrived in his hospital pajamas at my door: “I expect them to be cutting me today. They’ll bury me outside the medical examiner’s office; that’s why the plants are so beautiful there.” After an uneventful angioplasty, the craniotomy was scheduled.

Although he was always mordant and irretrievably pessimistic, Gil appeared in my office one day in a state of surprisingly good-natured agitation, carrying a large, flat cardboard box. He explained that it was something for me to mark the occasion and his trip to the O.R. to get his “nut cracked.” He wanted my dialysis patients to see it, too, he said.

I opened the box and removed a large black and white photo, autographed in black by a most famous pair of rival baseball players, Bobby Thomson and Ralph Branca. Thomson had hit one of baseball’s most renowned, last-chance, miracle home runs off a pitch from Branca to win the playoff series for the New York Giants, as they beat their ancient rivals, the Brooklyn Dodgers, in 1951. The photo showed Thomson crossing home plate, mobbed by his resuscitated teammates, while Branca forlornly walked off the pitcher’s mound. Taken from center field, the photo also showed the Dodgers’ great second baseman, Jackie Robinson, looking in at Thomson scoring, hands on hips.

“Dr. Goldfarb, do you know what this is a picture of?” Gil asked.

“Of course, Gil, it’s Bobby Thomson’s home run.”

“NO!” he roared, “Don’t say that! My parents sat shiva in Brooklyn that day! My mother covered the mirror!” He was describing Jewish rituals for mourning the dead. “No, that’s a picture of Jackie!” he said in triumph. This was the ultimate conceit in Brooklyn Dodger fandom. “Do you know what he’s doing?” he asked. None of my feeble answers satisfied him. “He’s making sure that Thomson touches all the bases! You know why, right? Remember that! Now look at the other picture.”

I took out an equally large color photo of what might be the best remembered moment in New York Mets history. Gil said, “I know you know what this is,” giving me more credit than he thought I deserved. Mookie Wilson ran down the first base line as the batted ball skidded between the legs of Boston Red Sox first baseman Bill Buckner. As a result of Buckner’s error, the Mets came back from their own near-death experience to win the sixth game of the 1986 World Series. They went on to win the seventh and last game as well. The picture was signed by both Mook and Buckner in Met-blue ink. I was sincerely moved. These were the autographed records of two unforgettable, legendary, last-gasp baseball moments.

Gil was really revved up now. He had to get to the punch line, and he could see that I had still not put the whole story together. He raised his best bleacher voice, now a little hoarse, a little desperate in the late innings. “Now, Dr. Goldfarb, do you understand why I’m giving you these pictures, to put up on your wall, to show your dialysis patients, just when I’m about to go get my nut cracked? Do you know why Jackie watched Thomson touch the bases? Why Mook hung in there until the end of that at-bat?”

“No, Gil, explain this to me,” I pleaded.

He shouted the too often quoted words of Yogi Berra, (a despised Hankey): “Dr. Goldfarb, don’t you see, it ain’t over till it’s over!”

Gil died in December. This was a great loss to baseball fans everywhere, and particularly the Brooklyn Dodgers.

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2003 Alpha Omega Alpha Robert J. Glaser Distinguished Teacher Awards

Each year, in collaboration with the Association of American Medical Colleges (AAMC), faculty members in American schools of medicine are nominated by their colleagues and deans to receive one of the prestigious Robert J. Glaser Distinguished Teacher Awards. Nominations are reviewed by a committee of their peers chosen by AΩA and the AAMC. This year’s committee members were: Walter J. Bo, Ph.D., Frank M. Calia, M.D., Jordan J. Cohen, M.D., Ph.D., Ruth-Marie Fincher, M.D., Cyril Grum, M.D., Jeanette Norden, Ph.D., Kelley Skeff, M.D., and Steven E. Weinberger, M.D. Robert P. Sabalis, Ph.D., Associate Vice President, Section for Student Affairs and Programs at the AAMC coordinated the nominations and selection process.

Winners are outstanding teachers in either basic science or clinical disciplines, and each receives $10,000. The medical dean’s office is given $5,000 to enhance teaching programs for medical students, and the local Alpha Omega Alpha chapter receives $1,000. The awards were presented at a black tie reception and dinner at the annual AAMC meeting in Washington, DC, November 8, 2003.

This year’s distinguished teachers are:

Joel M. Felner, M.D.
(AΩA, Emory University School of Medicine, 1980)
Professor of Cardiology and Associate Dean for Clinical Education at Emory University School of Medicine

How pleased we are that one of our Distinguished Teachers is not only a cardiologist, chief of echocardiology, and co-director of the Coronary Care Unit, but also is heavily invested in teaching medical students. Perhaps Dr. Felner was bitten by the teaching bug while working at Emory with Dr. Willis Hurst, but whenever this happened, he has contributed mightily both to teaching and to designing better ways to teach. Dr. Felner is a graduate of Columbia University, where he earned a B.A. in history, and the University of Cincinnati, where he received his internal medicine training. Emory provided his fellowship training in cardiology, and he has remained on the faculty there since his first appointment in 1974.

Cardiology is a field dependent upon careful history and physical examinations of patients. In addition to traditional emphases on the physical exam of the heart, however, Dr. Felner is one of the principal designers of “Harvey,” a computer-dependent simulator that can reproduce multiple cardiac conditions. Despite Dr. Felner’s multiple important contributions to the echocardiographic literature, he would never state that echocardiography has replaced the cardiac physical examination!

At Emory, Dr. Felner received the Best Basic Sciences Professor Award twice for his success in directing the pathophysiology course for preclinical students. Students have recognized his clinical teaching by awarding him the Outstanding Clinical Professor Award seven times. Emory gives several awards for teaching, and Dr. Felner received the Evangeline Papageorge Award for Outstanding Teaching in 1997, and the Emory Williams Distinguished Teaching Award in 1998. The American Heart Association named him Teacher of the Year in 1995/1996. Dr. Felner’s abilities to bridge the gap between basic science and clinical diagnosis makes him an exciting as well as informative teacher.

Barry D. Mann, M.D.
(AΩA, Drexel University College of Medicine, 1999)
Associate Professor of Surgery at Drexel University College of Medicine

Barry Mann is the fifth member of a department of surgery to receive an AΩA Distinguished Teacher Award, and he is recognized for his many creative methods of teaching that have enhanced the learning experiences of students at Drexel University School of Medicine (formerly MCP-Hahmemann). Interestingly, Dr. Mann’s A.B. degree from the University of Pennsylvania was in classical studies. He received his M.D. from the University of Pennsylvania and his surgical training at Tufts and UCLA. Some of his interests in teaching have been stimulated by a Surgical Education Research Fellowship from the Association for Surgical Education, and a stint at the Harvard-Macy Institute for Leaders in Medical Education.

Dr. Mann’s innovative teaching strategies include the teaching of three-dimensional surgical concepts by use of two-dimensional paper cutting, and the
use of an interactive game-based tool for learning surgical management algorithms on the computer. He has led a working group at Drexel to create a curriculum for years one and two, now termed the Interdisciplinary Foundations of Medicine, and well received by both students and faculty. Dr. Mann's formal commitments to teaching now include the chairmanship of the Education Coordinating Committee and program director in general surgery.

From 1993 to 2003, Dr. Mann was awarded 17 special teaching awards at commencement, including the Golden Scalpel Award, Golden Apple Award, the Blockley-Osler Award for Excellence in Teaching Clinical Medicine at the Bedside, the Christian R. and Mary F. Lindbach Foundation Award for Distinguished Teaching, and the Dean's Special Award for Excellence in Clinical Teaching. Four classes at Drexel have invited him to administer the Hippocratic Oath to them at graduation. The Association for Surgical Education presented Dr. Mann with an Outstanding Teacher of Surgery Prize in 1998.

Gabriel T. Virella, M.D., Ph.D.
(ÂΩA, Medical University of South Carolina College of Medicine, 1989)
Professor, Department of Microbiology
and Immunology at the Medical University of South Carolina

Gabriel Virella received this Distinguished Teacher Award for contributions to learning in basic sciences. We are especially proud of him, because for many years he has been the councillor for the MUSC chapter of Alpha Omega Alpha and for three years a member of ÂΩA's board of directors.

Dr. Virella was trained in medicine and pathology in Lisbon, Portugal. He arrived at MUSC in 1975, and was promoted to professor in 1980. His contributions to education have been many: he worked out a successful fusion of the microbiology and infectious disease courses, and has served as general coordinator of this combined presentation. In 1999, immunology joined this group and Dr. Virella became its director. As early as 1977, he introduced patient-oriented problem solving (POPS) into the preclinical curriculum, where it is still used today. POPS packages based upon Dr. Virella's innovative presentations have been introduced into eight other courses. In 1993, he added computer-assisted learning as regular features of his courses; the courses in microbiology/infectious diseases are available for national distribution. Dr. Virella's leadership in curricular reform has earned him the opportunity to direct revision of the entire year-two curriculum.

At MUSC Dr. Virella received the University Teaching Excellence Award and the state Governor's Distinguished Professor Award. Students awarded him Golden Apple recognition for seven years. MUSC recognized Dr. Virella in 2002 by making him an Honorary Alumnus.

Lawrence D.H. Wood, M.D., Ph.D.
(ÂΩA, University of Chicago Division of the Biological Sciences Pritzker School of Medicine, 1993)
Dean of Medical Education at the University of Chicago Pritzker School of Medicine

Lawrence Wood's Distinguished Teacher Award comes as the logical capstone of his many years of recognition by students for his teaching prowess and his continuing role in the revisions of the medical school curriculum. His current administrative post puts him in command of all medical education, including medical school admissions and student services, as well as the curriculum. Dr. Wood founded the University of Chicago's first organization recognizing those interested in and good at teaching, the Society of Medical Educators, a group that meets frequently to discuss current issues and challenges in medical education. Research in education also has been his forte; he has received a grant from the National Institute for Healthcare Research on “Spirituality in Medicine,” from the Harvard-Macy Institute on “Teaching Residents How to Teach Medical Students,” and an award from the Gold Foundation, “Residents as Teachers and Role Models for Medical Students.”

In 1984, less than two years after joining the UC faculty, the medical school graduates presented Dr. Wood with the J.A. McClintock Award for Outstanding Teaching in the Medical School, and in each of the last 19 consecutive years he has been named one of the Outstanding Teachers by the graduating class. Not surprisingly, this is an institutional record! Dr. Wood has received recognition as the Outstanding Basic Science Teacher at the Pritzker school three times, and, independently of the Robert J. Glaser Distinguished Teacher Award, Pritzker ÂΩA students chose him twice as the local ÂΩA Outstanding Teacher.

Edward D. Harris, Jr., M.D.
Editor

The Pharos/Winter 2004
The physician at the movies

Peter E. Dans, M.D.

Under the Tuscan Sun

Starring Diane Lane, Sandra Oh, Lindsay Duncan, and Raoul Bova.

Directed by Audrey Wells. PG-13. Running time 111 minutes.

Under the Tuscan Sun begs the question, “Why bother to buy the movie rights to the book if you are going to completely gut it?” I guess the title was worth it. A runaway bestseller, Frances Mayes’s memoir recounted how she and her second husband decided to buy a “fixer-upper” villa after having spent a few summers in Tuscany.1 The book was fused with local color and the pair’s persistence in the face of the inevitable snafus and travails of adapting to how things work in a very different culture. It appealed to all those who had spent time in that lovely region, as well as the armchair travelers who dreamt of owning a villa in Tuscany, even those of us who can’t hammer a nail straight.

So what happened on the way to the movie? Well, one good thing, namely Diane Lane, whose luminous performance, as well as the cinematography of the beautiful Tuscan countryside around Cortona and Montepulciano, make the movie bearable. Mayes is portrayed as a successful author who, in the midst of a triumphal book party, learns that her husband is cheating on her. She also meets an author whose book she tossed, which occasions one of the film’s best lines. The young man will reprise the line about two hours later, Hollywood-time. Despite having supported her husband through his Ph.D. studies, Mayes is left without a house and almost destitute after a messy divorce. She moves into a grim apartment house filled with others going through a divorce, including a lawyer who has daily crying fits. He’s kind enough to cool it when Mayes, who hears him through the paper-thin walls, asks him to stop.

Her best friends, a lesbian couple who planned to take a tour of Italy but decided to have a baby, convince her that she needs to get away. They trade in their tickets to pay for their passage, and Mayes joins the “Gay Away Tours” where she is toasted with champagne as the only straight passenger on the bus. We are now in the Rome Adventure or If It’s Tuesday, This Must Be Belgium phase of the movie, as the scene shifts from the wedding-cake architecture of the Vittorio Emmanuelle monument in Rome, to Orvieto and into Tuscany. Lo and behold, she gets a premonition about a name, “Bramasole,” and then sees it on a for-sale sign as the bus approaches a decrepit villa. She shouts to the driver to let her off, and, after sending the bus on its way, impulsively proceeds to buy the property. So far, the only thing that this script has in common with the book is that Mayes is a writer who lived in San Francisco and had been divorced.

Mayes is clearly out of her depth as she tries to cope alone in a house with bad plumbing, hazardous electrical wiring, bats, and other assorted inconveniences. She is aided by a very simpatico realty agent, Signor Martini Vincent Riotta, who turns out to be, wonder of wonders, a married Italian who is faithful to his wife. He does admit at one point that his desire to cheer her up, as her solitude plunges her into depression, does try his fidelity. He tells her about a rail line that was built in the Alps between Italy and Austria before there was a train that could negotiate the curves. In other words, be patient, build it and love will come. He helps her get a group of Polish workers to transform the villa. This sets the scene for her facilitating a love affair between a young handyman, Pavel (Pawel Szadja), and the neighbors’ daughter, Chiara (Giulia Steigerwalt), much to the parents’ dismay. Mayes becomes pals with Katherine (Lindsay Duncan), a British “expat” realtor, who oversees the sale’s paperwork. Once beautiful, she has aged into a garish hedonist who tries to recapture her youth by having affairs with younger men. Katherine seems more at home in Fellini’s Roma than in this small town, and, indeed, constantly refers to “Federico” and fancies herself to be Ursula Andress in La Dolce Vita. Naturally, the screenwriter couldn’t resist using the fountain in the town square to replicate that famous scene in the Trevi Fountain.

Diane Lane and Raoul Bova in Under The Tuscan Sun.
Meanwhile, Mayes heeds Katherine's advice to look for some action in Rome. While trying to escape a pair of Italian wolves, she hooks on to a hunk, Marcello (Raoul Bova), who takes her to lovely Positano for some wild lovemaking. She keeps fantasizing about him as the "one," but later, when she returns to Positano, she learns that he is spoken for (the scenery is nice, though). The writer-director begins to bring closure by harking back to the beginning of the picture, when Patti (Sandra Oh), Mayes' very pregnant friend, arrives on her doorstep, very distraught. It turns out that her partner left her because she "didn't want to be a mother." The arrival, on his bike, of the author Mayes trashes completes the circle. When the Pole, his Italian bride, the Asian-American woman, her baby, the biker/author, the crazy friend, and Mayes sit down to a great feast, Signor Martin's prediction that she will find a new family in Bramasole is fulfilled. The only thing missing was Sister Sledge's 1979 hit, "We Are Family," playing in the background. Had this contrived mess been the original story, I doubt that anyone would have bought the rights, assuming it could have gotten published.

Reference

Doctor movies
My charge is preferentially to review movies that have some connection with medicine or doctors. So here are my thoughts about two films that meet the criteria, but for which my wife and I had limited tolerance.

Beyond Borders
Starring Angelina Jolie and Clive Owen.
Directed by Martin Campbell. Rated R.
Running time Too Long.

Beyond Borders would have been better titled Beyond Belief. It stars Angelina Jolie as Sarah Jordan, a spoiled American seemingly happily married to Henry Bauford (Linus Roache), a stockbroker and son of a wealthy London industrialist. The movie opens with her playing a Schumann sonata and then flashes back to a night shortly after her marriage, at a fundraiser for a charity run by her father-in-law to aid refugees, presumably Doctors Without Borders. There, she meets Nick Callahan (Clive Owen), a boorish, self-righteous doctor who crashes the party and chastises her father-in-law on his stinginess in helping the refugees in Ethiopia. He brings a starved child along as an exhibit. Sarah becomes love struck and filled with the desire to leave her affluent life to travel to Ethiopia. The filmmakers missed a soundtrack opportunity; I was hoping to hear, "Just One Look, That's All It Took." The doc is taken to jail and separated from the young boy, who escapes from the airport van taking him for deportation, only to freeze to death. This was the first of many "I'm outta here" scenes, but I persevered because that's my mission. Sarah then tells her husband, "I know this sounds like little Miss Bleeding Heart," but will he please cadge $100,000 from his father for supplies she can transport to Ethiopia. Throughout all her appearances at such places, whether in Cambodia, Africa, or Chechyna, Sarah is immaculately coiffed and dressed in white chiffon. In contrast to the terrible conditions around them, she and Doctor Arrogant Savior are in pretty nice digs. The Ethiopian camp where they are struggling to find water even has a well-tuned spinet so she can play her favorite Schumann piece, "Themes from Childhood," which soothes "the savage breast" of Callahan, who had been ridiculing her unmercifully up to then.

The scariest thing was to watch Jolie emote with her numerous soulful close-ups and to see her pouty lips filling up about two feet on the screen. To give Jolie her due, the movie apparently was life transforming, and she is now the goodwill ambassador for the United Nations High Commissioner. I guess she thought the movie was doing the cause a favor. I can't speak for Doctors without Borders, but Doctor Callahan is an...
The physician at the movies

affront to all doctors who have worked overseas in primitive settings. Callahan says that, given the death rate, he doesn’t bother to learn the patients’ names, because if he did, he “would have to remember them.” Ironically, the movie makes a good case for the “compassion fatigue” of which Callahan accuses his patrons, in that in each country, the governments are run by corrupt indigenous leaders who for decades have taken their large cuts from the aid earmarked for the needy. The countries are ravaged by civil (or rather not so civil) wars, e.g., between Communist Khmer Rouge and another corrupt indigenous group of Communists. Each governing authority is oblivious to meeting their countrymen’s basic needs and brutally repressive to people whom they should regard as their brothers and sisters. As I found in Calcutta, our efforts against cholera would have been rendered relatively moot if there had been adequate sewage and a proper water supply, but year after year, like Groundhog Day, the toll of sickness and death recurred in their absence.

The film becomes tedious as it tries to merge these issues with a bogy romance between Sarah, now Lady Bauford, and Callahan. Lady Bauford joins the United Nations staff in London, and it is very cold to her burgeoning family, always thinking of joining Callahan wherever he is. As her husband loses his job during a stock market slump and starts an affair with his father’s secretary, Jolie’s character becomes increasingly hard to take. She thinks nothing of leaving her own children to go save the world’s children, and becomes increasingly self-righteous. She loses her cool at a Cambodian checkpoint, when she learns that Callahan, her Beau Ideal, has accepted money from the rebels for running guns along with the medicines. The film’s director must have realized that Jolie was coming across too soft, so he has her reprise her Lara Croft kick-butt image in decking Callahan, which wins over the officer in charge of the checkpoint.

In the next scene, she lectures another warlord about letting her through because she works for the United Nations, because if anything happened to her, the United Nations would come down on him. Just the thing to get him quaking in his boots, I thought, especially because that was the day when the first of two panels reported that the United Nations had refused many attempts to secure its mission in Baghdad and ignored explicit warnings of a terrorist attack, thus resulting in five times the number of casualties. Did the United Nations confront the attackers? No, they blamed the United States and then pulled out. My wife and I took that as our cue to leave as well. The film’s promoters say the movie has an interesting twist at the end, but we decided we could live without knowing what it was.

Reference


The Secret Lives of Dentists

Starring Campbell Scott and Hope Davis. Directed by Alan Rudolph. Rated R. Running time 104 minutes.

Once, while fielding questions on a radio show about my book on doctors in the movies, a Knoxville dentist gently noted that dentists are doctors, too. He then went on to say that physicians hadn’t had it half as bad with their movie image as dentists, and asked me if I could name a film where they came off well. I couldn’t. All I could think of were images of Marathon Man, Little Shop of Horrors, and W.C. Fields’s The Dentist. In preparing a set of film clips for the recent San Luis Obispo Medical Society Champions in Health Care dinner, I found it quite easy to find sympathetic portrayals of nurses and physicians, but less so for pharmacists and dentists, the other groups being honored. I did come up with a lesser-known Preston Sturges film, The Great Moment, about William Morton, the dentist who used ether as an anesthetic for performing painless dentistry at the suggestion of chemist Charles Jackson. The picture ends with the surgery performed in the dome of the Bulfinch building of the Massachusetts General Hospital by one of its founders, John Collins Warren, on October 16, 1846. At the surgery’s conclusion, Warren is reported to have said, “Gentlemen, this is no humbug.” His support catalyzed ether’s widespread use. The surgical amphitheater became known as the “Ether Dome” and is now a registered national historic landmark.1

Morton died penniless at age 49 after 22 years of bitter litigation defending pending patents for “lethoan,” his name for ether, which was already in the public domain, and the delivery mechanism, a glass retort with an enclosed sponge. The credit for the advent of anesthesia has been accorded to Long, who first used ether in surgery in 1842, even though it wasn’t until 1848 that he publicly announced its use, and a year later that he wrote it up, having failed to realize the significance of his milestone at the time.2

I resolved to augment my dentist movie database by seeing The Secret Lives of Dentists. Big mistake! The film begins in the office of a husband and wife dentist team, the Hursts, as both tend to their patients, among other matters. The wife, Dana Hurst, presumably the better dentist, lives for the opera chorus she sings in. She is played by the mousy Hope Davis, about whom the critics rave, but who leaves me cold. She is inattentive to her children, one of whom is in the “I love Daddy more than Mommy” phase. The other daughter, trying to reach out to her mother, gives her a rabbit’s foot on the way to her one-night performance of Verdi’s Nabucco. When she promptly leaves it in the car, her nabbish of a husband, David (Campbell Scott), a caring father, runs backstage to give it to her and seeing her in the arms of the tenor, immediately retreats.

On returning to his seat, he is accosted by a crazy patient,
Slater (Dennis Leary), a nasty trumpeter with bad teeth. Slater yells out that his filling has fallen out and that he wants his money back. It’s just what he needs on an evening out with his kids. The next day, Dana is inconsolable because the opera is over. She gets all dressed up to go to the store and David thinks she’s meeting the tenor. After a long time, she returns with groceries and suggests that they go to their country house, which is covered with decayed leaves. Opening the refrigerator full of rotten food prompts David to tell the children that living things rot, reflecting the filmmakers’ very deep theme, “Teeth outlast everything. Death is nothing to a tooth. Life is what destroys teeth.”

The next day, David asks Dana to see Slater, who has been dumped by his wife and will later be David’s Iago, making one wonder if staging Verdi’s Otello might have been more apt. Dana calls David to ask him to fix dinner for the children because she will be late. Thisconjures up a vision of her having a bout of sexual frenzy with her male dental assistant and a male patient. There being only so much inanity we could stand, my wife and I checked out at that point; so there were many secrets we must have missed. It wasn’t until I read the production notes that I realized that this is another American Beauty knockoff. The screenwriter said he was thrilled to find a story “about middle class Americans where the husband fought for the marriage, and I found it very moving that this woman was in a place in which prototypically men get caught.” He goes on to say that the husband is in “denial” and “That’s postwar American men as I’ve experienced them: no one has ever told them what to do with their feelings. They are lost.” He describes the wife as being passionate and wanting to experience life, and presumably get a little rotten in the process.

One thing my wife and I could agree on was that it was hard to believe that any of this trash was applicable to the wonderful dentists we have had in New York, Colorado, Virginia, and Maryland. Here’s to Doctors Caruso, Schoenbaum, Spence, Smith, Scott, and Weiss, champions all.

References

Bend It Like Beckham

Starring Parminder Nagra, Keira Knightley, Jonathan R. Meyers, and Anupam Kher.

This delightful, unpretentious film might best be characterized as Gregory’s Girl meets My Big Fat Greek Wedding. The first, Bill Forsyth’s 1981 film set in a Glasgow suburb, also revolves around a superb teenage female soccer player or footballer, as they are known outside of the United States, and explores the angst of adolescent crushes and growing pains. In Bend it Like Beckham, Jess (Parminder Nagra), the adolescent daughter of Punjabi immigrants to Britain via East Africa, idolizes David Beckham, the mega-star who played for Manchester United before being sold to Real Madrid. Half the movie focuses on football and how it challenges the cultural conceptions of a woman’s role generally and specifically in traditional families, whether Indian or British. Adolescent crushes and romance are also integral to this part of the film.

The other half shows Jess’s sister, Pinky (Archie Panjabi), going down a more traditional path and making her parents, especially her mother, happy by marrying a nice Indian boy. The girl’s mother says about the groom’s family, “We’ll show them we’re not poor. We’ll give a wedding they’ll never forget.” Think My Big Fat Greek Wedding plus, but without the cultural divide between the bride and groom. Thus we see the rituals involved in the ramp up to the big Punjabi extravaganza, full of merriment and bonhomie. Having spent months working in India, I got to see the sweetly innocent side of the Indian nature, so much in evidence in this film.

Jess lives for football. Her room is dominated by a poster of Beckham scoring. Her mother can’t understand why a daughter of hers wants to play football and can’t make chappatis,
The physician at the movies

Indian bread resembling a tortilla. The mother, Mrs. Bhamra (Shaheen Khan), keeps turning to the enshrined picture of the family guru and asking what she did to deserve two deceiving daughters: one who sneaks off to play football and the other who says she's at work when she's making out with her boyfriend. Both girls navigate rocky roads to their dreams. Jess is recruited to play on a traveling football team by an older English girl, Jules (Keira Knightley). They become fast friends and great teammates. Their friendship is tested when Joe (Jonathan Rhys Meyers), the young Irish coach whom Jules has a crush on, begins to fall for Jess. Ironically, both girls are suspected of being lesbians by their mothers who can't abide football. When the groom's parents see the two girls being affectionate at a bus stop, they immediately jump to conclusions and go to the girl's house to break up the sister's arranged marriage. Later, there will be an ironic twist. Jules' mother, Paula Paxton (Juliet Stevenson), is worried because her daughter doesn't date and is into sports, although her father, Mike (Frank Harper), is just as happy that she isn't boy-crazy. There's a very funny scene in which Mike tries to teach his wife the intricacies of football at lunch, using jars of French mustard and teriyaki sauce, and a shaker of sea salt.

There is an interesting sidebar involving Jess's father (Anupam Kher), who is supportive of her playing football when he realizes that she is good. He recounts how he was the best forward when they won the East African cricket championship, but when he came to England, the All-England cricket club members made fun of his turban and wouldn't let him play. After learning that Jess surreptitiously flew to Germany for a match, he rescinds his support. He sees no future in it for her and wants her to go to university. The parents forbid her to play in order to concentrate on her university entrance exams. There's a great scene involving their opening the thin admissions letter after praying before their guru. "Now you can be a fine doctor," the father exclaims. The conflicted father will later weaken again in a wonderful scene in which he realizes that his daughter must get a chance to follow her dream. He says, "Bloody English threw me out of their club and I vowed I never would play again. Who was hurt? Me!" See the film. You'll like it. I also enjoyed seeing the director's dedication of the film to her "Dear Dad." She also thanks David and Victoria Beckham, who appear fleetingly in the film, and Mia Hamm, the American soccer star. As for the title, here's the director's explanation: "As an athlete you simply have to admire Beckham's ability to defy gravity and bend the ball, in the way that he does. . . . We came up with the title because it also works as an excellent metaphor for the film as the girls 'bend' the rules rather than 'break' them so they can get what they want."4

Reference

1. Production notes, Bend It Like Beckham. Fox Searchlight; 2003.

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Parminder Nagra and Keira Knightley star in Bend It Like Beckham.
Reviews and reflections

Robert H. Moser, Book Review Editor, and David A. Bennahum, Associate Book Review Editor

Iconoclast: Abraham Flexner and a Life of Learning
Thomas N. Bonner
Johns Hopkins University Press, Baltimore, MD, 2002

Reviewed by Alan R. Nelson, M.D.

A
braham Flexner was the catalyst that brought about a revolution in medical education at the turn of the last century. This dramatic sea change arose from a fortuitous convergence of dynamic forces: growing public recognition that many of America’s doctors had virtually no training for the task of providing care to patients; academic leadership in the American Medical Association willing to set medicine’s house in order; and philanthropy that provided millions to make it happen. Medical education reform would likely have happened in any event, sooner or later, because of the clear need for it in this country, and the fact that medical education in Europe was predicated on generally higher standards. But how and when it happened can be related directly to the enormous talents of this determined, stubborn man.

Flexner’s vision was to convert medical education from an apprenticeship model, the sole mentors of which were private practitioners, to a university-based system in which teaching would be intertwined with research and scholarly pursuit. He sought to “drive the money lenders from the temple,” and this issue became as contentious in his day as it is in ours.

The insightful Flexner report (Medical Education in the United States and Canada, 1910) provoked fundamental change in the structure and process of medical education. It facilitated the demise of the notorious medical diploma mills and established standards of education that persist to this day. Yet the most remarkable aspect of this phenomenon was that the author of that report had never worked within a university or medical school and lacked a medical degree. How did this son of poor immigrant Jewish parents create such profound change, when today making even a simple modification of the curriculum in a single medical school is so daunting? Thomas Neville Bonner provides the answer in Iconoclast: Abraham Flexner and a Life in Learning, a book meticulously researched and written in scholarly prose. Anyone interested in medical history, medical education, or health policy will enjoy this finely drawn biography.

Abraham Flexner was an early intellectual, reading the complete works of Plutarch at age 13. He was able to complete high school despite his family’s poverty, and entered Johns Hopkins University with the financial assistance of his older brother. Young Abraham became a schoolmaster in Louisville, supporting his family for the next ten years until he married Anne Crawford. Anne, a talented playwright, soon published Mrs. Wiggs of the Cabbage Patch. The income from the play provided financial security for the couple and allowed Abraham to pursue a masters degree at Harvard. That experience, and study in Germany, led him to form ideas that were the basis for his book, The American College, published in 1908. He came upon the scene, little known and unemployed, taking on the academic icons running America’s colleges. His accusations were sharp and uncompromising, stating that all colleges were “deficient in earnestness and pedagogical intelligence.”

Meanwhile, the Carnegie Foundation was considering conducting a series of studies of professional education with the goal of setting national standards. The American Medical Association’s Council on Medical Education had started the process of reform, partly because of growing public concern. (The New York Times had published a story reporting that “incompetent physicians were manufactured by wholesale in this country”). And, indeed, medical education was a disgrace. Four hundred and fifty-seven medical schools had sprung up over the preceding century, of which 150 survived. Many students had less than a high school education. Half of the schools provided their sole practical experience in a neighboring hospital or clinic, and students were often “graduated” without serious testing. Of these schools, 89 required only an elementary education, and only one of eight required two years of college. Degrees were sometimes “conferred on any man who had settled his tuition.”

The Carnegie Foundation picked Flexner to head up the study, with the collaboration of the AMA Council on Medical Education. According to Bonner, Flexner was chosen despite his lack of experience in medical education, probably because he was “willing to criticize the status quo boldly and had the ability to write clear, trenchant prose.” He “stood at the vortex of swiftly moving scientific, educational, and philanthropic currents that strongly favored reform.”

The Flexner report, which included the minimum requirements for study, equipment and finances, as well as a survey of all schools (performed personally by Flexner), was an immediate sensation. Flexner was seen as “fiercely independent, often quarrelsome, an abrupt man who had definite ideas of his own.” The pungency of his reports captured attention with such statements

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as, “Chicago, with 14 schools is the plague spot of the nation.” It called for reducing the 148 existing U.S. schools to 31, which would be strategically located and connected to universities or major teaching hospitals. Teaching was to be done personally by full-time teachers in laboratories and clinics, with less time in large lecture classes. Entrance requirements were to include two years of college. This was to be followed by two years in preclinical training, then two years of supervised clinical experience. It was an amazing demonstration of insight, setting the stage for generations of medical school curricula.

The report was given broad exposure, and state legislatures began to adopt its recommendations. Flexner’s name became a household word in education circles. He began a long and fruitful career as head of the Rockefeller General Education Board, using foundation money to influence adoption of education reforms in his ongoing battle to “crush the commercial spirit in academic medicine.” It was a historic struggle.

Yet, eventually, Flexner wore out his welcome. Earlier triumphs had been based on the “elegant simplicity of his reasoning and the remarkable clarity of his writing.” According to Bonner, compromise and accommodation were never his strong suits. In his decline at Rockefeller, he became more polarized, rigid, and marginalized, especially around the notion of paid full-time faculty. Still, Flexner remains the founder of philanthropic management, the one who developed the art of matching grants. He achieved rare success as an “organizer, fund raiser and cheerleader without peer in the cause of American education.”

The last third of Bonner’s book covers Flexner’s outstanding career as founder and director of the Princeton Institute for Advanced Study. He recruited Albert Einstein, among others. He remained candid to a fault, a trait epitomized by a fascinating anecdote. While he was a lecturer at Oxford and a guest of Lady Astor, he and Winston Churchill “got into a grand scrap.” Churchill asked him what he thought “ailed” England. Flexner replied, “It’s governed by amateurs.”

At age 81, Flexner started a new life, taking classes on Shakespeare, Chaucer, and Russian history and culture at Columbia. He walked daily to his office downtown, wrote, and received callers. He died at 93. Bonner’s book is a rich document, replete with abundant notes, a bibliography, and a listing of the published writings of the unique and remarkable Abraham Flexner. Perhaps no other single individual has had a more profound and enduring impact on the quality of medicine in America.

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Science on the Witness Stand: Evaluating Scientific Evidence in Law, Adjudication, and Policy

Tee L. Guidotti, and Susan G. Rose
OEM Health Information, Beverly Farms, Massachusetts, 2001

Reviewed by Lee J. Dunn, Jr., P.C.

As a practicing attorney who specializes in litigation in the health care field, my opinion of this book was so strongly negative the first time I read it that I was obliged to lay it aside. I did not read it again for several weeks. Having read it a second time, my opinion is unchanged. I really don’t like it!

I have tried to conjure up an image of how this book came to be written. I picture a group of old friends sitting around a table, when someone came up with the idea of writing a book, to which they all respond, “Wouldn’t that be fun?” Unfortunately, that is the last time any common goal was achieved by the contributors to this book. It is not an explanation or discussion of the evaluation of scientific evidence in the legal process. It is not true to its title nor its subtopics. This book should never have made it past a strong, discriminating editor. There is no common thread, and the chapters don’t build a central thesis, nor do they complement each other. In critique:

1. It is unclear what audience they seek to address. If the book was aimed at young practicing lawyers, Chapter 3, “Civil Litigation: Principles and Providers,” would have been sufficient, and the rest of the book superfluous—since it bears no clear direction or theme. In an attempt to provide examples to support their arguments, the authors unleash a blizzard of unrelated scenarios. It is thoroughly confusing.

2. Chapters 9 (“Causation”) and 11 (“Appointment”) are written by the same physician, who reveals his bias by referring to medicine as “we.” These chapters are largely duplicative. In Chapter 9, he leads with his worst: “Causation is akin to the concept of etiology in clinical medicine but without the implication that there can be only a single cause. In clinical medicine, etiology is usually not as important as diagnosis, because in clinical practice, regardless of what caused the condition, the task at hand is to treat the patient. In law and policy, however, the assessment of cause is critical.” (Italics mine.)

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How wrong can one man be in 64 words? If "etiology is usually not as important as diagnosis," how can one ever be sure of the diagnosis? A diagnosis is only as sound as its known base(s). For example, chest pain can be caused by any number of factors. I settled three cases in the last 18 months in which patients had died because the rush to (incorrect) diagnosis without appropriate work-up led to misdiagnosis and death. One can only wonder if the author is a nonclinician, out of his element.

His definition of "legal causation" is also off the mark. He writes, "The concept of causation in law has been described as the 'occurrence or aggravation of an underlying disorder by the one causative element in isolation'. This definition has many features. It requires the fact of contribution to the disorder; it admits, by making an effort to isolate the pertinent cause, that effects may be moderated by complexity; it is deterministic and assumes a proximate cause; and it admits preexisting condition and permissive factors." Even if you manage to untangle the semantics, as a practical definition it is wrong. He cites no source or reference to support this statement.

He concludes this introduction by writing, "This legal concept of causation therefore is remarkably flexible and concordant with the following essential features of the idea of causation in science: strict cause and effect, moderation by complexity and interaction, a chain of events the outcome of which may be unforeseeable (as in chaos theory), contributing causes in deterministic mechanisms, and multifactorial risk factors in stochastic phenomena."

I doubt that one in ten readers will understand what these last 12 words mean. I certainly did not.

Chapter 15 is an example of an all-too-common flaw. Entitled "Communication in Medical Dispute Resolution," it is a verbose, anfractuous, superficial discussion (the author says) of linguistics, semiotics, semantics, pragmatics, 'languid language,' and 'fallacies of logic in language'; all subjects addressed by an author seemingly enamored of his own rhetoric. This is the flaw. The method and content of communication between participants in the legal process is, of course, integral to the proper functioning of the process. However, I challenge anyone to defend the legal process and content of this chapter. If the topic requires any discussion, it could have been addressed in far fewer pages.

Chapter 8, entitled "Looking Backward: The Bayesian Approach to Assessing Causation," uses the Daubert opinion as justification for discussing the theories of one Reverend Thomas Bayes (1702–1761), described as "an eighteenth century approach to probability that eventually was eclipsed by controversy and by the frequentist methods that evolved into the statistical analytic approaches." The reader is then inundated with too many pages of mathematical formulae in a purported attempt to convince the reader that mathematics may (repeat, may) be helpful in determining causation. I read (and reread) this chapter; the question kept arising in my mind—who cares? For a book allegedly devoted to "how to," this excursion into the murky world of Bayesian dynamics of "how might" seems misplaced.

Chapter 21, "Parity for Mental Health Issues," is an editorial, inappropriate for what purports to be a learned treatise. The author decry[s] the fact that mental health issues have generally not been accorded the same respect and attention as physical problems, when society evaluates and compensates for illness. Then she stops. This book, we have been told, is about how to deal with the system as it exists, not how it should exist in a perfect world. This chapter belongs on the op-ed page of a newspaper, not here.

The author of Chapter 22 simply does not understand the early history of ERISA litigation. The brouhaha was not about insurers establishing a standard of care. It was about insurers preventing physicians from rendering care to their patients (insureds) and trying to prevent the initiation of any malpractice litigation that arose from this enforced level of practice.

In the prevailing climate of "litigation awareness" that permeates medical practice today, a book with this seductive title might entice nervous practitioners to purchase it. That would be a mistake. In sum, this is a collection of suggestions directed primarily to individuals who deal with workman's compensation and environmental cases about how to deal with evidentiary problems. That said, that's all it is. Once outside this limited area, the authors keep tripping over the same topics, deploy terms that are unusual or unknown, and make statements about the law that are simply wrong. Finally, at times the semantic underbrush is almost impenetrable.

I hesitate to go on. Don't buy this book!

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Affirmative Action in Medicine: Improving Health Care for Everyone

James L. Curtis, M.D.
The University of Michigan Press, Ann Arbor, Michigan, 2003

Reviewed by Steven A. Wartman, M.D., Ph.D. (ΩΩΩ, Johns Hopkins University School of Medicine, 1970)

Affirmative action. These words create emotional intensity. To some, they represent a just and needed methodology to achieve a diverse and culturally competent workforce, as well as an

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effort to address past wrongs and current racism. To others, these words represent a form of reverse discrimination that only exacerbates ethnic differences, drawing comparisons to rulings by the NCAA for violations of past varsity athletes while punishing innocent current athletes.

Curiously, this latter situation affects the University of Michigan, which was also the defendant in two recent U.S. Supreme Court decisions involving affirmative action. From the point of view of medical school admissions, the decision involving the law school is perhaps more relevant, with its finding that “student body diversity is a compelling state interest that can justify using race in university admissions.” It is therefore most timely that Dr. James L. Curtis (in a book published by the University of Michigan Press) presents his well thought-out views and accumulated data on the topic. Dr. Curtis was the only black graduate in a class of 145 at the University of Michigan Medical School. He trained in psychiatry, and after a stint in private practice, joined the faculty of Cornell University Medical College (now known as the Weill Medical College of Cornell University) as associate dean in 1968, where he led the medical school’s new minority admissions program. This book is a recapitulation of Dr. Curtis’s experiences and candid opinions about the impact of minority students in medicine, as well as a 30-year follow-up of a cohort of minority students admitted to medical schools in the 1970s. From 1980 until his retirement nearly 20 years later, Dr. Curtis was chairman of the Department of Psychiatry at Harlem Hospital Center.

Following a brief preface and introduction, in which the tone is set and the author’s views made known, the book is divided into three main parts. Part 1 discusses the history of affirmative action at Cornell’s medical school in the 1970s. Curtis notes that there must be minimally acceptable and fair levels of minorities in medical school classes not just for civil rights purposes, but also because “an ethnically diverse student body will, by its very composition, obtain a sounder medical education and as physicians be more responsive to the medical needs of the diverse American public.” Under his leadership, minority admissions at Cornell went from two in 1969 to an average of about 14 each year between 1970 and 1977. The selection criteria and many other issues surrounding the admissions process are fully discussed. Despite obvious success at the student level, Dr. Curtis notes the ongoing difficulty in the hiring and retention of minority faculty.

There is also an important chapter in this section on civil rights in health care that includes the following comment: “During slavery the health care and health status gap between Whites and Blacks was less than at any time since Blacks became free.”

Part 2 presents data on the cohort of about 4000 minority and nonminority medical students who graduated from 1973 to 1977. Curtis followed 2109 minority medical students and 2191 randomly chosen nonminority medical students (by picking the next name following a minority on the NRMP alphabetical list). The minority group represented 45.3 percent of the sample of minority students who graduated during this period, and the nonminority control group represented 3.1 percent of their peers. Geographic location, internship positions, and a number of other factors are analyzed. Interestingly, Dr. Curtis makes the following general observation: “The addition of as few as twenty new minority physicians in almost any state would favorably improve access to physicians care by the minority population of that state, whereas the same number of new nonminority physicians would have much less effect.” It is unclear how this claim is substantiated; however, it does raise a host of issues regarding specialty choice, patient preferences, and practice locations.

Part 3 follows up this cohort nearly 30 years later. Practice location by state and ethnicity, as well as income of the practice neighborhood, among other factors, are reviewed. Minority black physicians tended to practice in economically disadvantaged urban areas independent of their own family income status. Dr. Curtis points out that “these findings do not support those who maintain that affirmative action programs should only be aimed at the most economically disadvantaged among the minority groups.” The concluding chapters of this section focus on the impact of affirmative action in medical school, special problems for black physicians (“It is my concern that we may be desegregating faster than we are integrating.”), and the future of affirmative action. Fortunately, there is a strong focus on the pressing and critical need for improved education at elementary and high school levels as a key to bringing about more equality in higher education opportunity, as well as job opportunity. Finally, Dr. Curtis comments on health status and concludes that “affirmative action at all levels of education, from preschool through university, represents the best policy and program to build a strong, single, and ethnically integrated nation.” As you might infer, the book is not a quick read; nor does it deserve to be read quickly. It is a combination of Dr. Curtis’s experiences, accumulated insights, and data analyses, alongside a treatise on the subject of affirmative action. Parts 1 and 2 do not really break any new ground, having mostly
a historical focus. Part 3 is an interesting combination of analysis of data and personal reflection.

Jordan Cohen, president of the AAMC, argues powerfully in a recent paper that abandonment of affirmative action in medical schools could be “catastrophic.”2 He summarizes four strong reasons in favor of affirmative action programs, and concludes that “For the foreseeable future, the use of race-conscious decision making in medical school admissions is the only way medicine can meet its obligations to everyone in our society.” In a recent television special on the topic, Tom Brokaw presented a fairly balanced view of the controversy.3 Some of the most telling moments of the program involved a minority student accepted to MIT who worried that other students in his class would automatically think he was not as qualified as the other accepted nonminority students. He also seemed to imply that there may be some lingering doubt in his own mind. Another minority student, reflecting back on her experiences at the University of Michigan, was asked if she had made any white friends during college. Her answer was “none.” A recent review of the topic was published in the May 2003 issue of Academic Medicine. In a series of articles, affirmative action is accepted because of the need for more diversity in medical school classes; the articles review what has been working at some institutions to achieve it. In his opening commentary, Michael E. Whitcomb echoes Dr. Curtis in pointing out the need for a “dramatic” improvement in the qualifications of minority applicants before any meaningful increase can be achieved.4

This raises another perspective to consider: namely the data that suggests a growing physician shortage and the need for expansion of medical school capacity.5,6 This pipeline issue may well extend beyond the United States.7 Thus the issue remains that even if race-conscious admissions were a fully accepted reality, there would not be sufficient numbers of minority students who are both qualified and willing to apply to medical school. In Richard A. Cooper’s trenchant analysis, the hurdles to college graduation, combined with medical school application trends, will result in a yield of medical school applicants that “will not be sufficient to allow significant expansion of medical school capacity,” leaving a “racial and ethnic composition of the physician workforce . . . at serious discordance with the characteristics and needs of the population overall.”8

My view is that affirmative action is ultimately more an issue of philosophy than fact. Data-driven analyses, no matter how compelling, can only go so far within the limitations of social science research and politics. In the field of medicine, it boils down to whether diversity of the health care workforce—and all that it implies—serves the best interests of the health care system and the nation. As pointed out, it may be a generation or more before substantially larger numbers of qualified and willing minorities are applying to medical schools. Perhaps, as the Supreme Court notes, “25 years from now, the use of racial preferences will no longer be necessary to further the interest approved today.”9 In the meantime, medical schools must aggressively develop curricula and environments that emphasize cultural competence, professionalism, and humanism. Affirmative action—however you define it and feel about it—is a core issue for medical schools and health care.

References

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The Pharos/Winter 2004
Letters to the editor

Dame Cicely Saunders
It was wonderful to read the articles about Dame Cicely Saunders in the recent issue of The Pharos (Summer 2003, pp. 4–10). I wanted to provide an additional anecdote that illustrates Dr. Saunders’ generosity. During the 1982–83 academic year, I was a visiting professor at St. Thomas’s hospital working on cross national issues of health care organization and financing. During that time I inquired as to whether I could visit St. Christopher’s Hospice, about which I was hearing interesting stories, though I was not at that point involved in any formal hospice-type care. Dame Cicely was incredibly generous and spent a full day showing me through the center and explaining its history and how it operates.

About nine years later, when I had come to The Robert Wood Johnson Foundation, I heard the results of the SUPPORT study. Based on those dismal results, and in cooperation with leaders such as Dr. Kathleen Foley, I was able to help The Robert Wood Johnson Foundation establish a multifaceted program to improve care of the dying in the United States. Chief among our actions was to promote the use of hospice care, as well as palliative care. I like to think that Dr. Saunders’ generosity helped to fuel this movement.

Steven A. Schroeder, M.D.
(AOA, Harvard Medical School, 1964)
San Francisco, California

“What I Learned while Dying”
Dr. Giller’s article “What I Learned while Dying” (Summer 2003, pp. 12–15) should be required reading of every medical student and every doctor!

The article gives clarity and focus to the thoughts we sense in our patients, but can’t really understand or fully comprehend. It is difficult to empathize with feelings that one may not intuit or imagine; the possibility that those of us who have never been really sick could misread, misinterpret or underestimate a patient is not small.

Recently a friend’s wife was diagnosed with Stage 4 recurrent breast cancer and the outlook is miserable. When I read his comments about a patient’s terror, it hit me hard when thinking about her situation. That’s what I was sensing when talking to her and her husband, though they would have you think it is not there. Terror, and overwhelming sadness, and grief.

Incidentally, her experience with oncologists has been terrible. I have to believe there is better language and better displays of empathy to use when handling a situation as dismal as hers, even when conveying horrifying news; this is where I think Dr. Giller’s article could be helpful. If doctors better understood how it must feel from the other side, they would listen and take time and say the right things . . . or at least try to avoid harmful words and behaviors.

Kit Powers, M.D.
(AOA, University of Iowa, 1987)
Olathe, Kansas

Re Antwone Fisher
I enjoyed reading Peter Dans’s review of Antwone Fisher in the Summer 2003 issue of The Pharos.

I was a medical officer in the U.S. Navy from 1967–1969 and like to spot factual inconsistencies in such movies. Dr. Davenport seemed to have too many service ribbons. So, using the picture of Denzel Washington in summer khakis, which accompanied the review, I magnified the ribbons on his shirt and then identified them with a current USN service award chart. Here are Dr. Davenport’s awards (from top right to bottom left):

- Meritorious Service Medal
- Joint Service Commendation Medal
- Distinguished Flying Cross
- NATO Medal (Yugoslavia)
- Navy Achievement Medal (with attachment)
- Fleet Marine Force Ribbon
- National Defense Medal
- Purple Heart (with attachment—he received more than one!)

Unidentified (looks like a Silver Star, but not a ribbon from any of the U.S. armed services)
- Expert Rifleman Medal
- Expert Pistol Medal

Dr. Davenport would probably have earned only the National Defense Medal as a junior Navy psychiatrist who (presumably) never saw combat. The ribbon is presented to all service personnel when they enter the military. Nevertheless, the ribbons Dr. Davenport wore were colorful and made him look more heroic.

I also recall that Dr. Davenport was called “Commander” during the movie. He was, in fact, a Lieutenant Commander; they are called “Doctor.” This tradition is identical to that of Navy line officers, who call each other “Mister” until they reach the rank of full Commander.

Finally, I noticed that the Medical Corps insignia worn by Dr. Davenport on his collar was, in fact, the insignia of the Nurse Corps (the latter is a gold oak leaf, while the former is a gold oak leaf with a superimposed silver acorn). If you get to watch this movie again, check it out!

William Fiedelman, M.D.
(AOA, New York Medical College, 1965)
New York, New York

Affirmative action: PC, M.D.
In her review of my book, PC, M.D.—How Political Correctness Is Corrupting Medicine (Summer 2002, pp. 57–58), Dr. Faith Fitzgerald misunderstands and misreports data on minority performance in medical school and residency, a subject I took pains to clarify. Worse, she accuses me of using data selectively.

The material concerns the qualification of African-American and Hispanic applicants to medical schools. Data published by the Association of American Medical Colleges and elsewhere (up until 2000, when my book went to press) are consistent in the picture they paint: minority students (excluding Asians) are
admitted with significantly lower grades and MCATs, take longer to graduate, are more likely to repeat their first year, drop out and are dismissed from residency more often. When qualifications (grades and scores) are comparable to others admitted by merit, not surprisingly, minorities perform no differently from nonminority students.

To make her point, Dr. Fitzgerald uses a study by her colleagues, Robert C. Davidson and Ernest L. Lewis, at UC Davis. Briefly, she implies that their study found that minorities had a graduation rate of 94 percent compared to 97 percent for nonminorities. That is not what this study showed. In fact, Davidson and Lewis were not able to discern the outcomes for minority students accepted via affirmative action, or, more accurately, racial preference. Specifically, they broke down their analysis into “regular admissions” (4 percent of this group were minorities) and “special consideration admissions” (53 percent of this group were minorities). A special consideration applied to standard racial preference admission as well as to nonminorities with strong leadership skills. The graduation failure rate for the special admissions group was twice that of the merit-based admissions students, 6 percent versus 3 percent.

Over the study’s 11-year period, between 10 percent and 45 percent of the class on a given year was comprised of these “special consideration admissions.” The performance of this group was inferior to that of those admitted on academic merits: far lower grades in medical school courses, lower scores on Parts I and II of the National Medical Boards. Because Davidson and Lewis did not isolate those within the special category admissions group who had been admitted through racial preferences, no conclusions can be drawn about them or their performance. It is possible, of course, that the racial preference students did well—we cannot know from the way the data were analyzed—but given the track record of students admitted via preferences, that is not what one would predict. A number of letters to the editor of JAMA pointed out the limitations of the Davidson and Lewis study regarding what one can safely infer about the performance of minorities admitted under race preferences.2-4 One respondent specifically and rightly questions the meaning of high medical school graduation rates in general, considering the pressures on schools to pass students along into residency.

I stand by my characterization of racial preference admissions policy in medical schools as one that—regardless of the good intention behind it—compromises standards of fairness and excellence in medical schools.

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1. Davidson RC, Lewis EL. Affirmative action and other special consideration admissions at the University of California, Davis, School of Medicine. JAMA 1997; 278: 1153-58.
Sally Satel, M.D.
Washington, DC

Dr. Fitzgerald responds to Dr. Satel
All seems infected that th’ infected spy
As all looks yellow to the jaundiced eye . . .

—Alexander Pope
Essay on Criticism, Part ii, Line 358

Dr. Satel did indeed include in her book her awareness of the limitations of the study by Davidson and Lewis,1 but it is disingenuous to suggest (given its citation in the chapter of her book entitled “Race and Medicine,” and surrounded by her discussion of the perceived academic and postgraduate inadequacies of affirmative action students) that it was not intended to be a supporting reference to her contention that such students were inferior to those she calls, in her letter, “merit-based” admissions (Davidson and Lewis, in revealing contrast, termed such students “regular” admissions).

She says that the graduation failure rate for these students (6 percent) was twice that of those she labels “merit-based” (3 percent), but fails to say that the absolute number of failures, given the disproportionate size of each group (1,428 “regular” and 356 “special consideration” students in 20 years) was twice as high (43) in the “regular” as in the “special consideration” (21) group: It appears that premedical grades and test scores are not infallible predictors of success or failure in medical school, which was the major point of the study. She fails also to mention that 18 of the “special consideration” students (to whom, presumably, she would have denied admission) were ultimately elected to AΩA. Most importantly, I think, she fails to mention the conclusions of the authors themselves, substantially unaltered by any subsequent criticisms of the study: “After graduation, the residency experiences of the 2 populations were quite similar, with both populations equally likely to receive honors evaluations and no detectable difference in academic difficulty in their residency training program.”2p1158

The salient point is not that some of the “special consideration students” failed, but that so many, handicapped though they were from the start by academic shortcomings, succeeded. To use selected data from this study to support the opposite conclusion seems to me to be wrong.

Alexander Pope, of course, was mistaken: people with jaundice don’t see all things as yellow . . . but we know what he means.

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1. Satel S, PC, M.D.—How Political Cor-
Letters

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Faith Fitzgerald, M.D.
(AUA, University of California, San Francisco, 1969)
Sacramento, California

Re “Draw the Line”

Many in society take the position that abortion is a morally acceptable solution to unwanted pregnancy. Consequently, the question of when life begins has been kept open. The tools of contemporary ethics consist of quantitation and consensus. Thus we read Dr. Mazzarelli (“Draw the Line,” Spring 2003, pp. 32–34) urging upon us the idea that the presence of brain activity as detected by electroencephalography in the fetus is the starting point of human life. Now science long ago has settled the question as to when life begins, and it is difficult to believe that anyone with any degree of scientific sophistication during their quiet and reflective moments does not know this deep in their heart.

Dr. Mazzarelli dismisses conception as the beginning of life with weak argumentation. This is an argument with a sound logical basis that deserves more vigorous disputation. The argument rests simply on the idea that each human genome is unique and has never before existed in the universe and came into existence overcoming overwhelming odds and that no power on earth has the right to destroy it. As G.K. Chesterton once said, “Every human being is a person who might not have been.” The human genome contained within the fertilized zygote is a structure of great complexity consisting of hundreds of thousands of large molecules arranged in an intricate spatial configuration. Within it is stored all of the information required to control all of the myriad characteristics of a new human individual. In a sense, it is the person’s software. The structure is contingent on an infinite series of antecedent events that might not have occurred. Once it exists, a perilous journey remains. This nine month’s journey is full of uncertainties, but is a walk in the park compared to the journey of its constituent elements throughout the distant past.

The sperm, if left alone, is going nowhere without the ovum. The ovum, if left alone without the sperm, also is going nowhere. The fertilized zygote, however, if merely left alone, if not attacked by curettes, chemicals or other noxious agents, within a few months of differentiation and growth emerges as a being that walks, talks, laughs and cries, fully prepared to enjoy a full conscious life. Potentiality to actuality. Destruction of the acorn does destroy the oak. But we are not talking here of trees, rather of human persons. No one has the right to interrupt this unfolding sequence at any stage including its very beginning which is the human genome. This truth may be inconvenient to some and may have even tragic consequences, but it is the truth. Dr. Mazzarelli has provided his answer to a question that has already been answered with logic, not quantitation, consensus or wishful thinking.

Patrick J. McCormick, M.D.
(AUA, University of Wisconsin, 1958)
Palos Heights, Illinois

I read with great interest the article “Draw the Line” by Anthony Mazzarelli, M.D., in the Spring 2003 edition of The Pharos (pp. 32–34). Being very interested in the issue, I was intrigued with his proposal to employ the same EEG criteria used for brain death to pinpoint the beginning of life. I have two comments to make.

First, I think that in his critique of the “conception rule” for establishing the beginning of life, he has oversimplified. True, conception is a point in time that is determinable, but this is not the reason it is proposed. Rather, it is the point in time when a genetically unique, never-before-seen and never-to-be-repeated individual is constituted. This happens when one 23-chromosome sperm fuses with one 23-chromosome egg to form a 46-chromosome entity, i.e., conception. Further development will never alter this genetic individuality, only unfold it. Thus, the point cannot be moved later in life. His hypothetical proposal of a point of inevitable fertilization does not really move it to an earlier time, because it is very unlikely that at that time there would be only one sperm “in the running.” While it would (hypothetically) be certain at that time that an individual would be constituted, until one sperm “won the race” and fused its nucleus with that of the egg, it would be unknown and unknowable which of hundreds or even thousands of “potential individuals” would be formed. I submit that this is the proper use of the term “potential life.” The gametes, while certainly alive individually as cells, really do represent potential life when viewed as precursors of a new individual. This potentiality does not consist in their single cell status, but in their being haploid rather than diploid. Once two gametes join, that potentiality has been reduced to act, and life is not potential, but actual. There is thus no ambiguity or inconsistency in defining “life” as beginning at conception when a unique individual starts to grow and develop.

Secondly, I noted in his diagram of the brain activity of the fetus and the dying individual that the lines have opposite slopes. This is not a trivial or unimportant distinction. When the dying person’s brain reaches that level of function, what it means to call it “dead” is that a point of no return has been passed. If no intervention is made, and often even if vigorous intervention is made, the body in question will soon be “dead” in the most unmistakable fashion, with bodily functions halted and the body sinking into decay. This is emphatically not the case for the fetus. Below this point or above it, the
fetus continues one steady process of increasing function, orchestrated by its unique genetic composition. Unless some outside force intervenes, the fetus can be expected to be born and assume the state which most people recognize as “being a person.” Aside from a theoretical construct, there is no event at this point that distinguishes the living from the dead. Below this point it may not have the requisite brain activity, but, unless a catastrophe occurs, it predictably will. And this biological engagement in growth and development is one of the major elements which we point to in calling any organism “alive.” It seems specious to deny to a human fetus what we would unhesitatingly predicate of a fetal pig (before being preserved in formaldehyde, of course!).

Finally, I applaud Dr. Mazzarelli’s concluding clause. Indeed, this is the crux of the matter. Once “an entity,” at least a human entity, meets the definition of life, it should be accorded the protection from deliberate illegal harm that all human societies accord to their own members. Past societies could not know that an entity was growing and developing so competently in the womb at these early stages. We cannot plead such ignorance. And what reason, other than a desire to have the liberty to do what are perceived as useful, if potentially or certainly harmful, things to them would provoke a society to define its offspring as “dead” for the first and most wonderful twenty weeks of development?

Ellen H. Gryniewicz, M.D.  
(AÔA, University of Michigan, 1971)  
Ann Arbor, Michigan

More on “Eurekapenia”

I was pleased to see the thoughtful piece on “Eurekapenia” in the Spring 2003 (pp. 24–26) of The Pharos. I am in very strong agreement with you that the lack of a sense of discovery for today’s students and residents, replaced by a sense of relatively superficial management of problems without discerning their causes, can be somewhat intellectually inhibiting and stultifying. I look back with glee and affection on the search for red snappers and granular casts in my own training.

However, I am not sure that the provision of these kinds of tools to residents, tools that they will never have a chance to use outside of the residency setting, is the best use of resources. Although it is attractive to provide them with links to the intellectual past by giving them opportunities to read blood smears or Gram stains, I am not sure that that is the best way to prepare them for the future, or to train them to make future discoveries on their own. I wonder about training them in the use of techniques for intellectual structures that will be useful for them in the later careers. For instance, in today’s diagnostic world, there is progressively less use for Gram stains and much more for molecular diagnostic approaches. Perhaps the time on rounds could be spent reminding people how PCR is done or showing them how the data from PCR reactions is translated into the determination of whether an organism is a suspected pathogen. Flow cytometry is another example. These techniques are the critical diagnostic studies for the next generation. Techniques that residents are unlikely to learn to do well, because they will never do a significant volume, and that they probably cannot legally decipher on their own, even in the hospital setting, conspires to make the use of the older generation of bedside diagnostic tools somewhat obsolete.

The more difficult question is how to teach them the newer ones, once one decides what it is that ought to be taught. I still believe that the didactic experience of good ward rounds is well worth the effort. Smears and stains are very exciting in that context if someone who knows what they are looking at is there to explain them. So I would suggest an investment in projection screens or television cameras that would allow you to show to the group the slide under discussion. You rightly point out that as the process of patient care becomes more and more one of interpreting data that comes in from other sources and consultants, the innate thrill of seeing things oneself for the first time becomes more elusive. However, I suspect that the way to get around that is to teach residents how to connect the dots themselves, rather than how to draw them in the first place.

Thank you for such a thoughtful and provocative piece.

Steven M. Holland, M.D.  
(AÔA, Johns Hopkins University, 1983)  
Bethesda, Maryland

I don’t know how to categorize this letter: manuscript, editorial, or just informational. At any rate, I really enjoyed “Eurekapenia” (Spring 2003, pp. 24–26). Dr. Hellmann stimulated wonderful memories for me, as I’m sure he did for many others. What physician wouldn’t enjoy thinking back on some of their finest diagnostic successes? It’s very satisfying to score a triumph now and then, particularly if that “triumph” means therapeutic benefit to the patient. It makes the hard work of medical training certainly worthwhile, and in a flash. Perhaps it’s mostly ego. Nonetheless it’s a victory, a lasting one.

For me the satisfaction came from making a diagnosis from only the history (best), physical exam (great), or a confirmatory lab test I could perform (good). My examples are as follows:

1. As an intern assigned to the neurology service I was the first to examine a boy sent from a hundred miles away because of frequent convulsions. At that time I was still developing my routine work-up physical exam and this included a Chvostek test. I tapped the boy’s facial nerve and obtained a tremendous facial contraction! After several more taps in confirmation, I performed a Trouseau test on his arm and the response was a vigorous contraction. I performed a urine calcium test and it was 4+. Other laboratory studies confirmed the diagnosis of hypoparathyroidism.
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2. As a resident I was asked by an attending to see a middle-aged suburban homemaker who complained of feeling tired. I don’t recall any of the details of my work up until it came to examining her chest. Upon touching the skin over her sternum—eureka!—it felt just like that of several myxedematous patients I had seen within the previous two years. With further questioning and lab studies this diagnosis was confirmed.

3. Some years ago my wife and children went picnicking with an in-law who said that he perspired so heavily that he dare not sit in upholstered chairs. His responses to a few questions and a brief “public” physical exam led to classic hyperthyroidism, cured by subsequent thyroidectomy.

4. A concerned student nurse was referred to our clinic because of persistent microscopic hematuria with red blood cell casts, diagnosed as glomerulonephritis. In my routine family history I asked about any known renal disease and she recalled that someone from Utah had come to her home in Idaho and taken urine samples from her relatives. Upon subsequently contacting the Utah group that had reported a large kindred with familial nephritis (Alport’s syndrome), I learned that her family was included in the group. Affected females had a benign prognosis, hence I had very good news for her.

5. I’ve had some embarrassing losses, too. The most remarkable occurred in my navy days, while at anchor offshore. A seaman who had been on deck came to sick bay complaining of sudden pain in his eye, as if something were in it. (It was windy on deck.) I put in a drop of fluorescein and the result was a huge stain on his cornea. Horrible! A huge corneal abrasion! This was not for me, a general internist at the time. Fortunately, there was a permanent hospital ship at the dock and the seaman and I promptly motored over to it and its (thankfully) ophthalmologist. Eureka! The latter promptly removed a piece of cellophane (from a cigarette wrapper) and the seaman and I (chastened) returned to our ship.

Roy H. Maffly, M.D.
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Palo Alto, California

Instructions for Pharos authors

We welcome material that addresses scholarly and non-technical topics in medicine and public health such as history, biography, health services research, ethics, education, and social issues. Poetry is welcome, as well as photograph/poetry combinations. Photography and art may also be submitted. Fiction is not accepted. All submissions are subject to editorial board review. Contributors need not be members of Alpha Omega Alpha. Papers by medical students and residents are particularly welcome.

Submissions must meet the following criteria:
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2. Essays should have a maximum of 15 pages (approximately 5000 words), and be submitted in 12-point type, double-spaced, with one-inch margins. They should be accompanied by a covering letter, a 150-word abstract, and a title page with the word count (or page count), return address, and e-mail address. Papers exceeding the page count noted will be returned to the author. References should not exceed 20 unique items (see below).
3. Poems or photographs/poetry combinations should be in 12-point type, with one-inch margins, with the author’s name, address, and e-mail address on the first page.
4. Send your submissions to Edward D. Harris, Jr, M.D., Editor of The Pharos, 525 Middlefield Road, Suite 130, Menlo Park, California 94025. You may also e-mail them to: postmaster@alphaomegaalpha.org.

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Authors are responsible for the accuracy of citations and quotations in their papers. Once a manuscript has been accepted for publication, therefore, the author will be required to provide photocopies of all direct quotations from the primary source material, indicating page numbers. In addition, the editors will require photocopies of all references: the title page and copyright pages of all books cited, the first and last pages of book chapters cited, and the first and last pages of journal articles cited, as well as the Table of Contents of the particular issue of the journal in which the cited article appeared. The foregoing items will be used to verify the accuracy of the quotations in the text and the references cited, and to correct any errors or omissions.

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Citation of web sites as references is discouraged unless a site is the single source of the information in question or has official or academic credentials. Examples of such sites are official government web pages such as that of the National Institutes of Health. Encyclopedia sites such as britannica.com are not primary references.
The 2003 Pharos Editor’s Prize Winners

I am pleased to announce the winners of the 2003 Pharos Editor’s Prize. The award was set up in 1998 to encourage younger authors to submit manuscripts to The Pharos. In 2003, 10 authors were eligible for the prize; each of them contributed very effectively to the content and appearance of our quarterly. The 2003 winners, each of whom will receive $1000, are:

Farhood Farjah, M.D., for his paper written with Donald Trunkey, M.D., titled “The Medical and Surgical Care of Our Four Assassinated Presidents” (Spring 2003, pp. 4–12), a well-referenced and detailed essay, presented in a sequential and interesting manner. Those four unfortunate chief executives were, of course, Lincoln (1865), Garfield (1881), McKinley (1901), and Kennedy (1963). The authors ably support the thesis that Presidents Garfield and McKinley received less than optimum care because of (1) inadequate access to resources such as instruments, lighting, and nursing staff; (2) poorly sterilized surgical equipment and failure of sterile technique; and (3) physicians with inadequate training and experience in management of traumatic injury.

Prashant Vaishnava for “Journey through Illness: A Perspective on the Patient-Physician Relationship” (Summer 2003, pp. 24–26). This creative essay posited that Virgil would have been the ideal physician, given the model of him guiding Dante through the nine circles of Hell toward God in the Inferno. Virgil provided support, hope, and information, and he encouraged “shared decision making,” all of which are components of what physicians in the twenty-first century should be bringing to care of their patients. Deserving some credit for the ideas expressed are Janet Osuch, M.D., and Yasmin Richmond, M.A., teachers of a Patient-Physician-Relationship course at Michigan State University for first-year medical students. This paper was not submitted to the Student Essay Contest held annually by The Pharos.

Richard B. Gunderman, Ph.D., M.D., for his paper titled “Images of Our Professional Endowment: A Credo for Doctors in 2003.” In articulate and flowing style, Dr. Gunderman uses “professional endowment” as a base for forming images that are useful, including: (1) the consideration of ourselves as malleable and adaptable lumps of clay throughout our professional lives, (2) looking at the sequence of learning as the multiple strands of a thread that are woven together into a strong whole, and (3) thinking of our professional lives as a blank sheet of paper on which we draw “to help something meaningful take shape in the lives of our patients. . . we must be artists, not mere observers waiting for something to happen.” His last paragraph includes the important sentence: “For those who approach medicine with the eye of an artist—who develop their curiosity, hone their capacities for creativity, and deepen their passion for coherence—great rewards are in store.” We must hope that this can be true for us all.

Edward D. Harris, Jr., M.D.
Editor

Announcing the 2004 Pharos Editor’s Prize Competition

For the seventh year, Alpha Omega Alpha is pleased to offer up to three prizes of $1000 each to the author(s) of original nonfiction manuscripts published in The Pharos. Authors need not be members of AΩA, but must be 45 years old or younger as of December of the calendar year in which the paper is submitted. To be competitive for a prize, the paper submitted must be in the standard format of The Pharos (see “Instructions for Pharos Authors” elsewhere in this issue), and not published previously in any form. Content should be in the areas emphasized by The Pharos—medical history and biography, ethics, professional issues, and personal essays. Essays submitted to the AΩA Helen H. Glaser Student Essay competition are not eligible for this prize, nor are previous winners of the Editor’s Prize eligible to compete. All manuscripts are subject to review of Pharos editorial board members. Judging will be on the basis of style and composition, originality, scholarship, and interest and relevance to medicine.
New to The Pharos editorial board

I am pleased to report that Dr. David Hellmann, the Mary Betty Stevens Professor of Medicine at Johns Hopkins University School of Medicine and chairman of the Department of Medicine at Johns Hopkins Bayview Medical Center, has been appointed to the editorial board of The Pharos. Dr. Hellmann’s research interests are in the pathophysiology and management of systemic vasculitis.

Dr. Hellmann’s recent paper for The Pharos, “Eurekapenia: A Disease of Medical Residency Training Programs?” (Spring 2003, pp. 24–26) produced unprecedented numbers of letters to both Dr. Hellmann and the editor. Many of them were published in the Autumn 2003 issue; a few are included in this issue.

Edward D. Harris, Jr., M.D.
Editor

Leaders in American Medicine

In 1967, as a result of a generous gift from Drs. David E. and Beatrice C. Seegal, Alpha Omega Alpha initiated a program of one-hour videotapes featuring interviews with distinguished American physicians and medical scientists.

The collection has been donated to the National Library of Medicine, which will maintain it for permanent use by scholars visiting the library. Videotapes continue to be available for loan from AOA. A listing of available tapes can be found on our web site: www.alphomegaalpha.org, or by contacting Ms. Debbie Lancaster at d.lancaster@alphaomegaalpha.org or (650) 329-0391. Please also contact Ms. Lancaster to borrow tapes. Those wishing to purchase copies may do so by contacting Ms. Nancy Dosch, manager, Historical Audiovisuals, History of Medicine, Building 38, Room 1E-21, 8600 Rockville Pike, Bethesda, Maryland 20892. Telephone (301) 402-8818, e-mail nancy_dosch@nlm.nih.gov.

Minutes of the meeting of the Board of Directors

The board of directors of AOA held its annual meeting on September 20, 2003, in Chicago, Illinois, at the Searle Conference Center on the campus of Rush Medical University. Thanks are due to Dr. Richard I. Abrams, councillor of the Rush Medical College AOA chapter, for making the arrangements.

Board members present were:
C. Bruce Alexander, M.D., councillor member, University of Alabama School of Medicine
President Michael V. Drake, M.D., University of California
N. Joseph Espat, M.D., councillor member, University of Illinois at Chicago College of Medicine

Benjamin Eyer, student member, Medical University of Wisconsin
Aaron N Hata, student member, Vanderbilt University School of Medicine
Executive Secretary Edward D. Harris, Jr., M.D.
Rae-Ellen Kavey, M.D., member at large, Northwestern University Feinberg School of Medicine
Don W. Powell, M.D., councillor member, University of Texas Medical School at Galveston
Vice-President Martha G. Regan-Smith, M.D., Dartmouth Medical School
Donald B. Russell, M.D., member at large, University of Alberta Faculty of Medicine and Dentistry
Troy L. Thompson, M.D., member at large, Jefferson Medical College of Thomas Jefferson University
Donald W. Wilson, M.D., member at large, University of Maryland School of Medicine.

Representatives of the national office attending were:
Ann R. Hill, administrator
Debbie Lancaster, managing editor, The Pharos
Bill Nichols, assistant treasurer.

Members absent were: Ruth-Marie Fincher, M.D., member at large, Medical College of Georgia; Secretary-Treasurer David Robertson, M.D., Vanderbilt University School of Medicine; Steven Robert Anderson, M.D., student member representing Wake Forest University School of Medicine, now at Duke University School of Medicine; Trisha Clarke, M.D., student member representing Uniformed Services University of the Health Sciences.

The nominating committee presented the roster for new board members:
• Don W. Powell of University of Texas Medical School at Galveston for a three-year term as member at large;
• William Frishman of New York Medical College for a three-year term as councillor member;
• Benjamin Eyer of Medical College of Wisconsin for a three-year term as student member.

The slate was approved unanimously.

Dr. Harris, on behalf of Dr. Robert J. Glaser, the honorary committee chairman, presented the proposed honorary members for 2003:
• Carol M. Black, CBE, London, United Kingdom
• James Burrows Edwards, D.M.D., Charleston, South Carolina
• Peter J. Ell, M.D., London, United Kingdom
• Shigeaki Hinohara, M.D., Tokyo, Japan
• James Orbinski, M.D., Toronto, Canada
• H. Momir Polenakovic, M.D., Skopje, Republic of Macedonia
• Heonir Rocha, M.D., Bahia, Brazil
• Faith Wallis, M.D., Montreal, Canada.

Each was elected to honorary membership by unanimous vote. Honorary membership may be conferred on

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outstanding contributors to professionalism, scholarship, leadership, and service in medicine who are not eligible for AΩA membership by any other means. Brief biographies of new honorary members will be published in a future issue of The Pharos.

Mr. William Nichols, treasurer, presented the financial data for the year. Investments turned around to end with a positive balance. It is unlikely that, without a surge in dues pays, new programs will be funded in the year ahead, but current programs for the chapters will be intact.

The board plans to have a retreat in March 2004 to evaluate the programs that AΩA provides to chapters for effectiveness and for benefits versus costs. Dues-paying members of the society are encouraged to forward to the executive secretary (e.harris@alphaomegaalpha.org) ideas about how the national office can better serve chapters and members.

In addition, the major problem of members who do not pay dues (about 60 percent of those elected) was discussed, and will be continued at the retreat. The agenda will include new strategies for encouraging lapsed members to pay either annual or lifetime dues, and the alternative of changing the constitution to make it possible for those who have not paid dues for a certain number of years to have AΩA membership and recognition as such terminated.

The Centennial Society was initially formed as the 2002 Society in honor of AΩA's centennial and aimed at lifetime dues pays. In 2002, $33,940 was raised, and $5,250 has been received this year. There was general discussion about using new brochures as means of informing members about the society, as well as to persuade non-dues-paying members to become active. Dr. Wilson recommended that when solicitations were distributed for Centennial Society gifts, the requests be made for specific programs, not general operating expenses, and this will be adopted as policy. A new brochure is being prepared.

The proposed anthology of The Pharos, introduced by Dr. Harris, was received with enthusiasm. Discussions followed about cost, number of copies, and whether to self-publish or have it out-sourced. The leading proposal, one that would assure that AΩA could retain the copyright, is from Ovid Bell Press, the printer of The Pharos. Printing of 5000 standard cloth-bound and leather-bound copies is planned. The anthology will cover the years from 1938, when The Pharos was first published, through 1998, and contains many brilliant essays.

Discussion was enthusiastic on the topic of AΩA Associations, allowed by the constitution and formed by members living where no chapter exists. These could be in rural areas far from any medical center, or in one of the U.S. and Canadian medical schools that has no chapter of AΩA. The associations, in addition to providing venues for professional and social interaction among members, would have access to all AΩA national programs, but could not elect students.

Through his work with the University of California, President Drake observed strong interest in Mexico in an honor medical society in some of the medical colleges there. The board encouraged the concept of providing the qualified Mexican schools of medicine with assistance in developing structures for an AΩA-like organization in Mexico.

Joining the board for lunch were Todd Novak and MatteoJursek of the University of Illinois at Chicago AΩA chapter.

The board renewed its enthusiasm for the mission and goals of Alpha Omega Alpha, and is focused on professionalism, scholarship, leadership, and service as the society enters its second century.

Edward D. Harris, Jr., M.D.
Executive Secretary

Councillor meeting

On September 19, 2003, in conjunction with the AΩA board of directors meeting in Chicago, a special meeting for new councillors was held, with Dr. Edward D. Harris, Jr. (executive secretary of AΩA and editor of The Pharos), and Dr. Troy L. Thompson II (councillor of the Jefferson Medical College chapter of AΩA and member at large of the board of directors) directing the discussion. Ann Hill, administrator, and Debbie Lancaster, managing editor of The Pharos, represented the national office. Councillors present were:

Richard I. Abrams, M.D., Rush Medical College of Rush University
Robert G. Atnip, M.D., Pennsylvania State University College of Medicine
Billy R. Ballard, D.D.S., M.D., Meharry Medical College School of Medicine
Lyman Bilhartz, M.D., University of Texas Southwestern Medical Center at Dallas, Southwestern Medical School
Charles Bryan, M.D., M.A.C.P., University of South Carolina School of Medicine
Peter DeBlieux, M.D., Louisiana State University School of Medicine in New Orleans
Larry Dial, M.D., Joan G. Edwards School of Medicine at Marshall University
Mark Fergeson, M.D., University of Oklahoma College of Medicine
Jack Fuhrer, M.D., Stony Brook University Health Sciences Center
Carl Fuhrman, M.D., University of Pittsburgh School of Medicine
2003 Councillor’s Meeting in Chicago. Left to right: Ted Harris (executive secretary of AΩA), Jack Fuhrer, Alex Mechaber, Carl Fuhrman, Larry Dial, Peter Deblieux, Mark Ferguson, Greg Strayhorn, Richard Abrams, Eric Gall, Kate Heilpern, Jim Sebastian, Charles Bryan, John Unterborn, Rodney Parry, Ann Hill, Andy Varney, Adrian Jones, Michele Mass, Robert At nip, Lyman Billhartz, and Billy Ballard.

Eric P. Gall, M.D., Finch University of Health Sciences/Chicago Medical School
Katherine L. Heilpern, M.D., Emory University School of Medicine
Adrian B. Jones, M.D., University of Alberta Faculty of Medicine and Dentistry
Michele Mass, M.D., Oregon Health & Science University School of Medicine
Alex J. Mechaber, M.D., University of Miami School of Medicine

Rodney R. Parry, M.D., University of South Dakota School of Medicine
James L. Sebastian, M.D., Medical College of Wisconsin
Greg Strayhorn, M.D., secretary-treasurer at Morehouse School of Medicine
John Unterborn, M.D., Tufts University School of Medicine
Andrew Varney, M.D., Southern Illinois University School of Medicine.


The Duke Center for the Study of Medical Ethics and Humanities is sponsoring a two-day conference, Vital Lines, Vital Signs: A Conference on Poetry and Medicine, on April 23 to 25, 2004, in Durham, North Carolina. The conference will gather poets, scholars, and health care professionals from across the country to discuss various aspects of the relationship between poetry and medicine.

Speakers and readers include Rafael Campo, Lucille Clifton, Jack Coulehan, Mark Doty, Li-Young Lee, Kathryn Montgomery, Sharon Olds, Suzanne Poirier, Reynolds Price, Alan Shapiro, and John Stone.

For more information about the conference, please go to http://poetryandmedicineconference.mc.duke.edu
Questions should be directed to poetryandmedicine@mc.duke.edu.
The Hypochondriac

In general, I think I'd rather
Skip parties where we doctors gather
It's true, they're oftentimes unique
And always have a certain chic
They tend to have their own panache
And usually cost a lotta cash.
Take this party here tonight
The hostess thought: "I'll do it right"

So, to each side and at your backs
Sit twenty hypochondriacs
Transported to this catacomb
To make us docs feel right at home.

Each one has some malady
Which he alone can feel or see
And they are, at the host's behest,
Apportioned out, one to each guest

They table-hop throughout the dinner
And ask how come they're getting thinner
They scurry 'round, from chair to chair
Getting consults here and there

They question us about their itch,
Complain that all the food's too rich
And ask if their own doctor's pills
Are really needed for their ills.

Running hither, running yon,
They'd carry out their marathon
In retrospect, they could have had
The world's first "crock" Olympiad

So here's advice: amidst the panic
When guests whose ills are non-organic
Have cornered you and they attack,
Just do a disappearing act

And hide someplace where they can't reach you
Like Irkutsk, Nome or Machu Picchu
Or, better, to avoid those cranks,
On your R.S.V.P. write: "No, thanks."

Benjamin Mildes, M.D.

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