Letters to the editor

Re "The tradition of the gold-headed cane"

I read with interest the article entitled "The Tradition of the Gold-Headed Cane" (Winter 2007, pp. 42–46) At the end of the article were listed medical organizations that present a gold-headed cane. Left off this list is the Oregon Health & Science University, formerly the University of Oregon Medical School, which has awarded the Edward S. Hayes Gold-Headed Cane Award to a senior medical student at graduation for more than thirty years.

This is a wonderful tradition and the history of the gold-headed cane is obviously part of that. The Edward S. Hayes Gold-Headed Cane Award states, "This cane with the trust it symbolizes, after a vote by peers and teachers, is given to the recipient to carry henceforth because of compassionate, devoted and effective service to the sick and with a conviction that its holder will forever epitomize and uphold the traditions of the True Physician."

As a former recipient of this award, I continue to feel extremely honored and humbled by it. Reading the article in *The Pharos* about the gold-headed cane reminds me of this.

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Re "Endangered species"

In the Winter 2007 issue of *The Pharos*, Dr. Harris raises important concerns about the decline of primary care and the impact on the nation's health ("Endangered species," p. 1). On a personal note, I recalled an editorial Claire Maklan and I wrote twenty years ago in response to the then perceived "primary care crisis," and we noted our anticipation of the improved outlook for health care the emerging practice of geriatrics would bring.[1] Yet it has become apparent, as Dr. Harris points out, that geriatricians cannot and should not meet the health care needs of the rapidly growing segment of the population over sixty-five years of age. Others have also raised concerns about the very "survival" of primary care, which is "facing a confluence of factors that could spell disaster."[2] Yet primary care survives because it is clearly the practice mode that best meets the diverse health needs of persons of all ages. Indeed, an especially vocal demand for primary care practice is likely to arise from those over eighty years of age (and from their representative organizations) who most need it, require less intensivity, more "value" for less cost, manifest multiple chronic age-related conditions, use many medications, and ultimately seek restorative function rather than cure.

Specialists and generalists alike, and their patient constituencies, realize the essential place primary care holds in the spectrum of health care in this country. The political outcry that is emerging about the current limitations in meeting patient needs will reaffirm the necessity for enhancing primary care, and is likely to promote remedial action by future administrations.

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A new patient to the clinic, Mr. O. calmly describes his story as a worker for a carnival, injuring his leg as the season drew to a close. Awaiting spring in an unfamiliar city, his wound has worsened, now obviously infected and requiring debridement. Continuing his story, he explains that he is homeless and alone, spending the unusually cold nights in an abandoned building nearby. "I can go back to the shelter if you want me to," he adds, "but I'd rather be by myself." For a moment, I allow myself to be moved by his sadness, and then, together, we make a plan.

Ten years ago, knowing little about the practice of medicine, I joined the National Health Service Corps. Entering medical school, I shared the hopes of my peers . . . to somehow help people. Over the next four years I watched as others competed for the most specialized residency positions, ultimately won over by obvious incentives and discouraged by the ever-present challenges of primary care. As a resident of internal medicine, I watched again as the striking advantages of subspecialty care eclipsed the less apparent rewards of outpatient general medicine. Eight months ago, I nervously began working in an urban community health center, and since then I have found unexpected challenges and rewards each day.

As a trainee, I recognized that I would face trials as I left the security of residency, and these are frequently apparent. Without the luxury of working in a tertiary center, standing on the front line remains intimidating, and becoming comfortable with uncertainty is a necessity. Resources, once taken for granted, seem in short supply. As underinsured patients wait months for consults or face overwhelming bills for testing, diagnosis is no longer simple. Furthermore, I am challenged daily to earn patients' trust and to communicate clearly. I struggle with overwhelming disparity of resources, the demand for productivity, the presence of the pharmaceutical industry, and the need for continuing education. And as I look back on my first year in practice, I realize that through such struggles, I have changed.

In addition to these obvious struggles, I have found unexpected rewards, centered in relationships. I remember wondering if, as a primary care provider, I would fix problems, or

would this be left to the surgeons and specialists. In fact, I help my patients face life-changing challenges daily, and their perseverance is inspiring. Clinic practice involves frequent diagnostic challenges as well. From breast cancer hidden within a screening exam to polymyalgia rheumatica masquerading as chronic fatigue, pathology is frequently present and rarely apparent. In addition to the developing relationships with patients, our clinic team has grown together as well. Faced with limited resources and the daily challenges of patient care, we share our frustrations, hope, and often laughter. And from different backgrounds, clinging to diverse beliefs, we continue to grow closer.

Residents and students often hear of the challenges unique to the practice of primary care, however little emphasis is placed on the many unique rewards. My short experience so far has been surprising, eye-opening, frustrating, and invaluable. Laughing, crying, celebrating, and grieving with my patients, I have experiencing the human condition much more honestly and completely than I can convey. I have become a more interesting and understanding person, and gained perspective which will help me throughout my career. My faith is now deeper, more firmly grounded in realities of inequality, suffering, and perseverance, and I am becoming a better doctor. This vocation is not for everyone, but as for me, I feel at times overworked, often undervalued, and above all, happy.

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Dr. Faith Fitzgerald comments on Dr. Hegedus's letter

When older doctors get together, their conversations almost invariably turn to patient stories, vying with one another for the finest they each have to tell. The content of these stories are generally not centered around the labs, the images, nor the procedures these patients underwent, but rather the puzzles they presented, the tragedies and triumphs they experienced, the touching or humorous events of their lives—in which their doctors participated, and from which these doctors learned more, and more vividly, than ever they could by lecture or text, syllabus, standardized patients, CD-ROM, or Internet search. If endurance in memory and effect upon the joy of our profession are a measure of the value of curricula, it is the patients for whom we care, and the vast kaleidoscope of the human experience they manifest, that are the best of the curriculum in lifelong medical education.

Young people enter medicine now fully aware that they may no longer assume a future of high status, high pay, or autonomy of judgment. They have been told before application to medical school, even by many physicians, to go into something else, that medicine is not what it was. And these students have answered: "Nonetheless, I want to be—need to be—a doctor." They enter as the most promising of our generations, vocational and idealistic, most pledging future service to the underserved. Then, driven by demanding, burdomsome economic realities, the admirable desire for better mastery both of their craft and of their lives, and by the hierarchical ranking of physician stature by their teachers and colleagues as well as the laity (subspecialty is better—smarter—than generalism, academics better than practice, bench better than bedside, procedures better than contemplation), they turn away from their wider view of service and enter a more focused, more controlled, more predictable life that, though it still serves well, serves less broadly.

What stories will the now young doctors tell thirty years from now, I wonder. Will they compete for pride of place in swiftest and best colonoscopies performed? Will some proudly present their outstanding echocardiograms in competition with others? Perhaps "most exciting anesthetic induction" will be the topic of some exchanges at class reunion dinner tables. Dermatologists could joust in a "dermatopathology derby," radiologists pit their best films one against another.

None of them, I think, will have the same richness, broadness, completeness, and true satisfaction in the stories of their lives as doctors as does the author of this piece.

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Re Intelligent Design

In his essay, "Intelligent Design and the Age of Endarkenment" (Autumn 2006, pp. 4–8), Dr. Weissmann portrays intelligent design theory's challenge to Darwinian evolution as a threat to post-enlightenment thinking.

Intelligent design as theory has both merit and valid criticisms. In reality, however, Dr. Weissmann's piece was not directly about intelligent design, but about his sense of "anti-science" in our current society. To me, the author's saber rattling against the forces of "endarkenment" appears reactionary and unwarranted. I propose that this is a misreading of modern society that is, if anything, centered on technological and scientific progress. Indeed, if the question did not involve the Darwinian sacred cow, it is likely that the issue would never have surfaced. Moreover, Dr. Weissmann errs in calling intelligent design a euphemism for creation science. Intelligent design makes rather modest claims. Thoughtful proponents of intelligent design do not deny the evidence for evolution per se. Rather, inferring design argues against a materialistic form of evolution founded on the accumulation of mindless chance events.

A closer look suggests that the real

conflict is not between faith and science, but between faith and materialism, the latter regarding matter as the only reality in the world, thus denying the existence of spiritual realities such as God and the soul. Science is an empirical endeavor that relies on observation and experimentation to explain the physical world. It has resulted in great progress, especially in medicine. But isn't there a degree of arrogance in believing that man's observations and experiments are the sole source of truth?

Readers of *The Pharos* know that there is more to life than laboratory experiments and double-blind placebo-controlled studies. Good physicians routinely acknowledge the importance of our patients' emotions, relationships, and spirituality to their overall health and well-being. Are we to banish discussions of these "non-scientific" factors from medical classrooms, journals, and clinical wards? Rather than a call to arms, may we be called to celebrate together the awe and wonder of all creation.

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Resident duty hours—second thoughts

Physicians in training have historically worked long hours. Public awareness was heightened in March 1984 when Libby Zion, an eighteen-year-old college student, died shortly after admission to New York Hospital. Her father charged that her death was a result of poor care by overworked residents. While no criminal indictments came from a Grand Jury investigation, recommendations included limiting resident working hours. This ultimately led New York to become the first state to codify regulations governing resident hours.[1] As public concern about sleep-deprived residents grew,[2] the Accreditation Council for Graduate Medical Education (ACGME) formulated new duty-hours standards for residency program accreditation in 2002 that became effective on July 1, 2003.[3] There is some documentation that long duty-hours are harmful to patient care.[4] The regulations include a limitation of eighty hours per week averaged over four weeks, one day in seven free, in-house call no more frequently than every third night and continuous on-site duty not to exceed twenty-four consecutive hours with an additional six hours allowable for continuity of care, etc., and a ten-hour rest period provided between all daily duty periods and after in-house call.

The institution of these mandates has led to detailed monitoring. In our institution, medicine work rounds occur with only portions of the team involved at any one time. This makes possible early departure of the on-call resident and frees up time for the other residents to carry out tasks that otherwise might extend their hours beyond those allowable. There is some documentation that preventable adverse events are associated with physicians covering who have less familiarity with the patient.[5] When hour constraints lead to fragmented rounds and the disappearance of the team approach to continuity of care, not only does care suffer, but also lost is the opportunity to learn from colleagues and patients. On surgical services, operating experience, particularly with emergency cases, suffers.

The complexities of modern medicine and reimbursement limitations have led all practicing physicians to compress more in the time we have available. Physicians seem increasingly attracted to the defined hours of hospitalists and emergency room physicians. Now residents are developing a "shift-mentality."

The molding of a physician that begins in medical school and goes through residency training has as much to do with responsibility, compassion, and devotion as it does with actual knowledge. Do patients and the educational process benefit from a major focus on whether one has worked too many hours? It seems clear that patients benefit from a continuous relationship with one physician. The more trade-offs there are, the less intimate that connection becomes.

Some have argued that forced regulation affords an opportunity to create new paradigms.[6] In contrast, a recent survey of pediatric surgery training programs including both program directors (PD) and fellows highlights the discomfort and uncertainty that the hour regulations have created.[7] Neither the trainees nor PD give a ringing endorsement to the new standards.

Medical education should move forward, but those of us who teach have an obligation to foster attitudes that are immutable. An obsession with the time clock, however well intentioned, can produce physicians who have lost the sense of personal responsibility to patients. Boutique practices shouldn't thrive just because they offer the kind of personal attention that was once commonplace.

After four years, it seems time for the ACGME and program directors together to reassess the hours issue, to reflect on the pros and cons of the change, and perhaps to become more flexible and creative in balancing educational rigor and responsibility in training with the need for time away.

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Dr. Lawrence Faltz comments on Dr. Rogoway's thoughts

To suffer woes which Hope thinks infinite;
To forgive wrongs darker than death or night;
To defy Power, which seems omnipotent;
To love, and bear; to hope till Hope creates
From its own wreck the thing it contemplates;
Neither to change, nor falter, nor repent;
This, like thy glory, Titan, is to be
Good, great and joyous, beautiful and free;
This is alone Life; Joy, Empire, and Victory!

—Percy Bysshe Shelley,
Prometheus Unbound

To undergo trials and make sacrifices in pursuit of great rewards is an elemental human theme. It's the subject of mankind's oldest book, the *Epic of Gilgamesh*. Odysseus had twenty years of challenges before he could get home to his wife and kingdom. Tamino must undergo trials of temptation, silence, water, and fire to win Pamina in Mozart's *Magic Flute*. And so for Don Quixote. Robin Hood. Rocky. Luke Skywalker. Dr. Kildare.

Residency, in its former 110-plus hour week format, was often unpleasant, and there were casualties, but something profound was achieved by giving one's self over fully to the world of medicine. One was *transformed*, marked by the experience with a different perspective on one's role in society and an intrinsic understanding of what it means to be a professional.

What society offered in return was that the newly minted doctor would have a future of high societal standing, personal and professional independence, and substantial income. During the 1980s, economic, social, and political pressures began to erode medicine's special place. That decade saw the rise of HMOs, the imposition of Medicare fee freezes, a marked rise in liability cases, increased regulation, and a drastic fall in the public's opinion of physicians. For residents perceiving limited prospects, every second or third night rotations and 110-hour weeks were no longer a reasonable investment. Even without the Libby Zion case and the Bell Commission, residency as a total immersion experience was doomed.

I was a program director in New York in 1989 when the Bell Commission rules went into effect. As we redesigned our staffing and call systems, we worried about how to preserve continuity, responsibility, professionalism, effective teaching, and the balance between service and education, things implicit in the total immersion paradigm. These are now threatened, or have been completely lost.

I agree with Dr. Rogoway that we have to consider what has been given up in exchange for more rested physicians-in-training. But it's not only a matter of cleverly designing training programs. Is the objective to have residents alert enough to flawlessly interpret that 3:00 AM EKG, or to develop a professional persona that lasts a lifetime? The two goals may not be compatible. If there is truly value in professionalism in medicine, and that's what's being lost, society will have to make changes in the health care system that make an epic quest again worthwhile.

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Drs. Kelley Skeff and Lawrence Smith comment on the thoughts of Drs. Rogoway and Faltz

The comments by Drs. Rogoway and Faltz are understandable and worrisome, as they are both concerned about losing some of the core values of the profession. Although the eighty-hour workweek receives a great deal of attention, that concept, in and of itself, should not be the daunting one. We should be able to deliver an effective learning experience for residents and fellows within this time allotment. However, addressing these requirements has been a significant challenge for program directors, residents, faculty, and institutions. Compressing a 110-hour week into eighty hours of frenetic patient care is not the answer. For residents, the result is a loss of time to reflect on doctoring, to have collegial discussions, and to grow personally and professionally into the social culture of physicians and medicine. For faculty, the result is inadequate time for teaching and far less a "sense of team."

In attempting to create approaches that respond to the requirements, many have understandably moved to models of overlapping care, e.g., night float and physician extenders. Yet in implementing these methods to enhance goals of efficiency, we can have the unplanned consequences of separating patients from residents, thus diminishing residents as caregivers. While incorporating new shifts for residents and physician extenders, we must be careful that we do not abandon the physician role of healer by giving the

act of touching the patient to someone else. Although sensible from a practical point of view, these approaches can lead to fragmentation of educational experiences, a move toward shift work, and a shared care approach that can diminish the individual trainee's sense of patient ownership—a key part of the profession of medicine.

The comments and attitudes of program directors at the most recent APDIM meeting indicates widespread concern regarding the effectiveness of many recently applied methods, echoing agreement with Drs. Rogoway and Faltz of the need for a re-examination of our approaches. However, the re-examination cannot be one focused on the hours' requirements, since these are sensible from both educational and patient care points of view. Rather, the redesign must focus on two issues: (1) re-emphasizing the values of physician responsibility and patient ownership, something desired by faculty and residents alike, and (2) collaborative redesign by both educational and hospital administrators. The latter point is critical, as the accomplishment of the educational goals also and ultimately must accomplish the goal of the hospital, effective delivery of patient care.

Collaboration between educators and administrators has great potential in improving both current and future patient care by simultaneously emphasizing patient care outcomes and education, via redesign of the system. By emphasizing the integration of patient care and education, we have the opportunity to again foster the commitment of each individual trainee to his or her patient throughout training. Moreover, we can foster an evolving new professional behavior, the collective responsibility of all practitioners toward the improvement of the health care system, both locally and nationally. In sum, we have the opportunity to re-examine our current methods, looking beyond the eighty-hour workweek to our major goal as a profession: excellent care for all patients now and in the future.

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The 2007 *Pharos* Poetry Competition winners

The *Pharos* Poetry Competition was held for the first time this year. Sixty-eight poems were submitted, and the winners were selected in April. One first prize and three honorable mentions were awarded:

First prize, $500: Hilarie Tomasiewicz of the Class of 2012 at Mount Sinai School of Medicine of New York University for her poem, "New Art."

Honorable mention, $100 each:

Jay Augsburger of the Class of 2007 at the University of Cincinnati College of Medicine for "Dance of the Student Doctor."

Madhu Iyengar of the Class of 2010 at the University of Kansas School of Medicine for her poem, "My Own Two Eyes."

Jade B. Tam of the Class of 2010 at the University of Missouri—Columbia School of Medicine for her poem, "She Lay Quietly."

The winning poems will be published in future issues of *The Pharos*.

Judging the poems were members of the editorial board of *The Pharos*: Henry Claman, MD; Jack Coulehan, MD; Dean Gianakos, MD; J. Joseph Marr, MD; Eric Pfeiffer, MD; Richard C. Reynolds, MD; Bonnie Salomon, MD; Audrey Shafer, MD; John H. Stone III; Jan van Eys, PhD, MD; David Watts, MD; and Editor Edward D. Harris, Jr., MD.

2007 Alpha Omega Alpha Helen H. Glaser Student Essay Awards

The twenty-fifth annual Alpha Omega Alpha Helen H. Glaser Student Essay awards were made in April of this year. This year's winners are:

First prize, $2000: Samantha L. Williamson of the Class of 2009 at Johns Hopkins University School of Medicine for her essay, "The Congressional Polio Vaccine Hearings of 1955: A Landmark in Biomedical Research."

Second prize, $750: Heather Finlay-Morreale of the Class of 2010 at the University of Cincinnati College of Medicine for her essay, "And then there were eight."

Third prize, $500: Lori K. Soni of the Class of 2008 at Northwestern University's Feinberg School of Medicine for her essay, "Hypochondriac."

Honorable mentions, $250 each: Lara Devgan of the Class of 2007 at Johns Hopkins University School of Medicine for her essay, "What Does a Doctor Look Like?"; Mok-Chung Jennifer Chow of the Class of 2007 at the University of Virginia School of Medicine for her essay, "Things Remembered"; and Phoebe Este Koch of Yale University School of Medicine's Class of 2007 for "Wear a Red Robe."

Winning essays will be published in future issues of *The Pharos*.

Judging the essays were members of *The Pharos* editorial board: John A. Benson, Jr., MD; Lawrence L. Faltz, MD; Robert H. Moser, MD; Marjorie S. Sirridge, MD; Editor Edward D. Harris, Jr., MD; and Managing Editor Debbie Lancaster. Also judging was Natalia Berry, ΑΩΑ student at Dartmouth Medical School.