Alpha Omega Alpha Honor Medical Society
Founded by William W. Root in 1902

Editor Richard L. Byyny, MD
Editor Emeritus Robert J. Glaser, MD
Associate Editor and Managing Editor (in memoriam) Helen H. Glaser, MD
Managing Editor Debbie Lancaster
Art Director and Illustrator Jim M’Guinness
Designer Erica Aliken

Editorial Board
Jeremiah A. Baroness, MD
New York, New York
David A. Bennnahum, MD
Albuquerque, New Mexico
John A. Benson, Jr., MD
Omaha, Nebraska
Richard Bronson, MD
Stony Brook, New York
John C.M. Brust, MD
New York, New York
Charles S. Bryan, MD
Columbia, South Carolina
Robert A. Chase, MD
Stanford, California, and Jaffrey, New Hampshire
Henry N. Claman, MD
Denver, Colorado
Fredric L. Coe, MD
Chicago, Illinois
Jack Coulehan, MD
Stony Brook, New York
Ralph Crawford, MD
Portland, Oregon
Peter E. Dans, MD
Baltimore, Maryland
Lawrence L. Faltz, MD
Sleepy Hollow, New York
Faith T. Fitzgerald, MD
Sacramento, California
Daniel Foster, MD
Dallas, Texas
James G. Gamble, MD, PhD
Stanford, California
Dean G. Gianakos, MD
Lynchburg, Virginia
Jean D. Gray, MD
Halifax, Nova Scotia
David B. Hellmann, MD
Baltimore, Maryland
Pascal James Imperato, MD
Brooklyn, New York
John A. Kastor, MD
Baltimore, Maryland
Michael D. Lockshin, MD
New York, New York
Kenneth M. Ludmerer, MD
St. Louis, Missouri
Joseph Marr , MD
Broomfield, Colorado
Stephen J. McPhee, MD
San Francisco, California
Robert H. Moser, MD
Madera Reserve, Arizona
Francis A. Neelon, MD
Durham, North Carolina
Eric Pfeiffer, MD
Tampa, Florida
William M. Roggow, MD
Stanford, California
Shaun V. Ruddy, MD
Richmond, Virginia
Bonnie Salomon, MD
Deerfield, Illinois
John S. Sergent, MD
Nashville, Tennessee
Marjorie S. Sirridge, MD
Kansas City, Missouri
Clement B. Sledge, MD
Marblehead, Massachusetts
Jan van Eys, PH.D., MD
Nashville, Tennessee
Abraham Verghese, MD, DSc (Hon.)
Stanford, California
Steven A. Wartman, MD, PhD
Washington, DC
Gerald Weissmann, MD
New York, New York
David Watts, MD
Mill Valley, California

www.alphaomegaalpha.org

Manuscripts being prepared for The Pharus should be typed double-spaced, submitted in triplicate, and conform to the format outlined in the manuscript submission guidelines appearing on our website: www.alphaomegaalpha.org. They are also available from The Pharus office. Editorial material should be sent to Richard L. Byyny, MD, Editor, The Pharus, 525 Middlefield Road, Suite 130, Menlo Park, California 94025.

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

The Pharus of Alpha Omega Alpha Honor Medical Society (ISSN 0031-7179) is published quarterly by Alpha Omega Alpha Honor Medical Society, 525 Middlefield Road, Suite 130, Menlo Park, California 94025, and printed by The Ovid Bell Press, Inc., Fulton, Missouri 65251. Periodicals postage paid at the post office at Menlo Park, California, and at additional mailing offices. Copyright © 2011, by Alpha Omega Alpha Honor Medical Society. The contents of The Pharus can only be reproduced with the written permission of the editor. (ISSN 0031-7179)

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

POSTMASTER: Change service requested: Alpha Omega Alpha Honor Medical Society, 525 Middlefield Road, Suite 130, Menlo Park, CA 94025.
William Root displayed extraordinary leadership when he and other similarly minded medical students established Alpha Omega Alpha Honor Medical Society in 1902. They recognized a lack of appreciation for academic achievement, leadership, professionalism, teaching, service, and research in their fellow medical students and medical school faculty. Root decided to do something positive about it. His leadership vision for AΩA, to promote and advocate for high academic achievement, leadership, professionalism, service, research, and teaching continues today. Now, more than a century later, we need highly effective leadership in medicine, medical education, and health care.

AΩA has done well in selecting leaders in medicine. Fifty-one Nobel Prize winners in Physiology or Medicine and in Chemistry are members of AΩA, exemplifying leadership in science. Nearly seventy-five percent of deans of medical schools in the United States are members of AΩA. Many other members of AΩA are excellent leaders in academic medicine, medical societies, hospitals, clinics, and communities. Unfortunately for medicine, many other AΩA members with leadership potential have not chosen to lead, at least in formal leadership roles.

I believe this is a lost opportunity for medicine, education, and health care, as well as for many of our AΩA members. Leadership is about making a positive difference and every AΩA member has opportunities to make a difference and provide leadership. I believe, therefore, that all AΩA members should consciously consider making the commitment to serve as leaders and to make important contributions to our profession, patients, and society.

Preparing for a position in leadership

Leadership for most people is learned through education, observation, and experience. Developing into an excellent leader requires more than motivation—it is an ongoing, continuous process. One needs to recognize the challenges and opportunities and then proceed to lead, and in doing so, to make a positive difference.

I have been a student of leadership since I was a history major in college. Since then, I have read extensively about leadership, been mentored by excellent leaders, and identified many leadership opportunities. I have also engaged in many leadership experiences where I thought I could make a difference. I have learned much about leadership through this process. Let me share with you some of my experiences—maybe you will recognize your own ability to become a future or more effective leader.

In my opinion, the best and most effective sustainable leadership is grounded in clear professional values, caring, and a dedication to serving others. I recommend reading and reflecting on the writing of two authors: Jim Collins, who wrote Good to Great and Good to Great in the Social Sector; and Robert Greenleaf, who wrote Servant Leadership. Great leadership is about doing the right thing in service to others.

Servant leadership

I remember meeting with a hospital director, a Catholic sister, in a hospital located in a neighborhood that was in transition in a large city. She was the most effective leader in a hospital I had ever met and observed. Her hospital had the highest census, the most satisfied patients and staff, and the best outcomes in the region. I asked her where she had earned her Hospital Administration degree. She told me she didn’t have a degree. She said she had learned to always ask the question when making decisions, “What is best for the patients?” That was her fundamental value: Doing what she knew was right.

Servant leaders live, lead, and act their values based on their inward sense of what is right. Servant leaders also inspire others to care and serve. They develop the best within others. They instill a set of values, including fairness (justice), honesty, respect, contribution, and trust. These leaders follow truth and principles. They share values and trust among team members. This leads to moral authority in the leader and team.

Servant leaders and their teams dedicate themselves to a higher purpose, cause, or principle worthy of their commitment instead of focusing on themselves. They find joy, self-respect, and integrity in being used in the service of others and in contributing to an important purpose. Servant leaders...
Characteristics of Servant Leaders

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listening</td>
<td>One parable states, “Grant that I may not seek so much to be understood as to understand.” Communication is very important, but it starts with listening intently and receptively first. You can better understand the will and point of view of a person or group by listening. Later reflection on what was said can lead to enhanced understanding and increased respect.</td>
</tr>
<tr>
<td>Empathy</td>
<td>Servant leaders work to understand and to empathize with their teams and others. Empathy is developing the awareness of the thoughts, feelings, and experiences of others without having those experiences yourself. We show empathy by respecting other’s views, while not necessarily agreeing with them.</td>
</tr>
<tr>
<td>Healing</td>
<td>Recognize that those who are being served and those involved in serving share a goal of healing. The collaborative search for wholeness is part of the compact with the servant leader.</td>
</tr>
<tr>
<td>Awareness</td>
<td>Be vigilant in observing events and interactions, recognize what is happening, and then draw inferences from what you observe. Be mindful and perceptive in using your knowledge and experience.</td>
</tr>
<tr>
<td>Persuasion</td>
<td>Servant leaders rarely use positional authority, relying more on value-based authority or persuasion. They work to persuade others to adopt a point of view through teaching, and using knowledge, facts, and opinion to convince others to accept their views.</td>
</tr>
<tr>
<td>Conceptualization</td>
<td>This is the ability to conceive and think logically and to evaluate information, issues, events, plans, dreams, visions, and futures beyond day-to-day realities.</td>
</tr>
<tr>
<td>Foresight</td>
<td>This is the ability or art of using knowledge of historical and current events and related situations combined with an understanding of possible consequences to predict the likely future. Foresight allows you to develop intuition, the ability to know or understand something without proof or evidence.</td>
</tr>
<tr>
<td>Stewardship</td>
<td>This involves commitment to the careful and responsible management of an organization or people entrusted to one’s care. In servant leaders it involves first and foremost a commitment to serving the needs of others and in this context relies mostly on openness, caring, trust, and persuasion.</td>
</tr>
<tr>
<td>Humility</td>
<td>This involves being humble, valuing other people, and treating everyone with respect. Too many ineffective leaders are noted for hubris or self-aggrandizement, taking personal credit for what is the work of many. In doing so, they demonstrate an unflattering arrogance.</td>
</tr>
</tbody>
</table>

Great leadership

I assume that those of you who want to lead want to be great leaders rather than just good leaders. Jim Collins argues that the enemy of “great” is “good.” Many are satisfied with being good at what they do, but the leaders who will make the most difference are those who want to be great, and want their teams or organizations to be great. A great leader or organization delivers superior performance and makes a positive, important, and distinctive difference over a long period of time.

Servant leaders work with their teams to define what it means to be great in what they do and how they serve. Good-to-great principles apply to the not-for-profit social sector and to servant leaders as well as they do to the private sector. However, for servant leaders and in the social sector the outputs are caring, service, and helping others rather than profits. The measurement of success is how effectively we deliver on our mission and make a distinctive impact relative to our resources. A consistent and intelligent method of evaluating caring and service allows us to assess improvement—or the lack thereof. In the social sector, as in the for-profit sector, it is useful to set audacious goals.

Good-to-great starts with what Collins refers to as “level 5 leadership.” Level 5 leaders are passionate about and committed first to the cause, movement, mission, or work—not themselves—and have the will and commitment to succeed. They build enduring greatness through a blend of personal humility and professional will, commitment, and perseverance. The servant leader does not have the executive power to make most important decisions alone. In medicine, health care, and education, executive power is usually impractical. In our realm, leadership sets a positive example, taps idealistic passions, and uses persuasion, inclusion, communication,
language, inspiration, shared values, common interests, a sense of community, teaching, balance, discipline, teamwork, and delegation of responsibility to get things done.

Level 5 leaders must be role models and always work as hard or harder than everyone else. They are willing to do whatever jobs need to be done. They are passionate and caring, self-motivated, self-disciplined, and compulsively driven to do the best they can. Servant leaders know their teams share their vision, and they develop and support the best teams of people who are motivated by their service and professional values.

Great leaders need to ask the question: What is the one thing at which our organization can be the best in the world? They focus on that goal and develop a plan to reach it. For most of us, that is a social objective to meet human needs. Once others see tangible results, people will line up to contribute and to “push the wheel” that creates momentum.

The servant leader and team must define how to produce the best long-term results. This involves first understanding what the organization stands for, why it exists, and what its core values are. In other words, what the leader and the team can do best is determined by understanding how the team can uniquely and effectively contribute to the people it serves.

The next greatest need, and a difficult one to achieve, is finding the resources—especially the right people—to do great work, and saying no to things that may impede achieving the vision and service.

Servant leaders celebrate the work and success of those contributing and serving and express appreciation regularly. Remember: Everyone matters and everyone can, and does, make a difference in serving.

**AΩA and leadership in medicine**

Most medical students, physicians, and AΩA members have already learned, developed, and practiced many of the elements of servant leadership, including:

- Competence
- Altruism
- Caring
- Service
- Knowledge
- Attitude
- Skills
- Professional values
- Listening first to understand
- Examining and using data
- Deductive reasoning
- Using probabilities to make decision even with uncertainty
- Working with others who know more about some issues and problems
- Making decisions
- Evaluating the results
- Communication and teaching
- Working with teams
- Continually learning
- Aspiring to be the best

However, many do not recognize their potential for leadership and how to utilize their knowledge, skills, and experience as physicians to lead. Each of you needs to make a conscious choice to aspire to lead, and then seek opportunities to serve as leaders.

Leadership in medicine, education, and health care is more important now, in the twenty-first century, than ever before. Physicians know best what medicine, medical education, and health care are about. Physicians know the core values and professional values of medicine. Physicians have professional experiences serving and caring for people, and working with others in the health professions. Physicians know about clinical medicine and clinical insight. Physicians understand education of students and residents. Physicians understand the vitals importance of medical and scientific research. Physicians have earned respect for their caring, service, values, commitment, hard work, teaching, and manifold other contributions. These are integral parts of the professional life of a physician. Physicians should be more effective servant leaders in medicine, medical education, and health care because of their special professional knowledge, skills, and experiences. To best utilize these special professional attributes, qualities, and experiences, physicians should aspire to become leaders. They can then learn to be effective servant leaders who lead based on caring, service, and professional values.

Leadership and management skills can be taught and learned by motivated physicians. I urge members of AΩA and other physicians to ask themselves where and how they can provide leadership. Making the conscious decision to be and act as a leader is of utmost importance to medicine and society.

How can Alpha Omega Alpha Honor Medical Society both select potential leaders and support those who choose to become leaders in medicine, education and health care? Send me your thoughts at r.byyny@alphaomegaalpha.org.

Richard L. Byyny, MD
**Executive Director, Alpha Omega Alpha Honor Medical Society, and Editor of The Pharos**
DEPARTMENTS

1 Editorial
AΩA and leadership
Richard L. Byyny, MD, editor

40 The physician at the movies
Peter E. Dans, MD
Midnight in Paris
Sarah’s Key
Great Expectations (1946)

47 Reviews and reflections
The Kitchen Shrink: A
Psychiatrist’s Reflections on Healing in a Changing World
Reviewed by Justin Taylor, MD
The Language of Pain: Finding Words, Compassion, and Relief
Reviewed by George D. Comerci, Jr., MD, FACP
User-Driven Healthcare and Narrative Medicine: Utilizing Collaborative Networks and Technologies
Reviewed by P. Ravi Shankar, MD

52 Letters

The list of new members elected in 2011 has been moved to our web site, www.alphaomegaalpha.org, as has the index of The Pharos.

ARTICLES

6 Clinical man (Homo clinicus)
A satire
Clifton K. Meador, MD

8 “You’re sick, we’re quick”
Retail clinics and their implications for the future of the American health care system
Adam Mikolajczyk, MD

14 Dollars and sense of electronic medical records
The impact of EMR on billing, coding, and physician reimbursement
Charles Rutter, MD
Truth, stranger than fiction
Silas Weir Mitchell and phantom limbs
Eliza C. Miller

Hideyo Noguchi
Controversial microbe hunter
Don K. Nakayama, MD, MBA

Ulcers in Papua New Guinea
A contemplation on fairness
Heather Relyea-Ashley, MD

We are transitioning to an updated membership database. Thus, all members are receiving The Pharos at their home addresses unless we do not have a home address on file. If you prefer to receive The Pharos at your business address, please let us know at info@alphaomegaalpha.org. We apologize for any inconvenience.
Clinical man (Homo clinicus)*

A satire

Clifton K. Meador, MD

The author (ΑΩΑ, Vanderbilt University, 1954) is clinical professor of Medicine at Vanderbilt University School of Medicine, clinical professor of Medicine at Meharry School of Medicine, and executive director of the Meharry-Vanderbilt Alliance.

* The term “Clinical Man” includes both the male and female gender.
In 1994, I recorded a fictitious interview with the person whom I imagined to be the last well person on earth. I mistakenly thought well people were disappearing and I wanted to call attention to their disappearance. I missed the big picture and now want to correct my misconceptions. Well people are not disappearing; instead, a new species of man is emerging: Homo clinicus.

An evolution of the symbiotic relationship between man and medicine has been going on for some time. Lewis Thomas deserves the credit for an early spotting of the new species, first observed in America. He called our attention to this phenomenon in the 1970s.

Nothing has changed so much in the health-care system over the past twenty-five years as the public’s perception of its own health. The change amounts to a loss of confidence in the human form. The general belief these days seems to be that the body is fundamentally flawed, subject to disintegration at any moment, always on the verge of mortal disease, always in need of continual monitoring and support by health-care professionals. This is a new phenomenon in our society.

There has been a progression of terms for this new species. First, there was the “early sick” then “the worried well.” That was followed by “the worried sick.” We now have arrived at a definable new species that differs from pre-clinical man.

Preclinical man lived largely with medicine out of his consciousness. In fact he lived to avoid medicine. Those of us who are still preclinical will recall the earlier saying, “An apple a day keeps the doctor away.” That is almost pure preclinical thinking. Preclinical man only went to the doctor when he was sick or injured. It was up to preclinical man to decide if he was sick or well. It did not take a physician to make that decision. If he felt all right he was well; if he felt sick he was sick. Not so with clinical man. Feelings are no longer a reliable guide to health. Feeling good is not enough. There must be objective data that nothing is wrong. That’s the problem. Something is always wrong if you look long and hard enough at or inside any human. As a medical resident told a colleague, “A well person is someone who has not been worked up. We can always find something wrong, if we look hard enough.”

Clinical man is neither sick nor well. He is simply in clinical limbo. As you will see in the definitions of this new species below, he is always under medical surveillance. Clinical man requires it. More importantly, medicine requires it. Clinical man either has something that is not quite right or something that needs to be rechecked.

Medicine and man have evolved in a symbiotic manner—like the whale with those little fish that swim in and out of the whale’s mouth. The fish need the whale for food particles and the whale needs the fish for dental hygiene—something like that. There is nothing strange about this symbiosis of medicine and man. Big medicine needs clinical man and clinical man needs big medicine. That’s just the way it is. Where would all the endoscopists be without clinical man? And what about all those proceduralists who do interventions and biopsies? What would we do with all the CAT scans and MRIs and PET scans without clinical man? How would all the surgicenters and imaging centers and standalone diagnostic centers survive without a long line of clinical men? Don’t forget the insatiable needs of big pharma and the relentless mongering of created, pseudodiseases on television.

Clinical man goes to the doctor when not sick. That’s part of the definition of the new species. No longer able to decide by themselves, they come in increasing numbers to find out if they are sick or well. Some even demand to know what disease might loom in the future for them.

Here are a few of the characteristics of clinical man:
1. Knows his cholesterol level within 10 milligrams percent
2. Has been biopsied in at least one nonpalpable organ by age fifty
3. Has been biopsied in a palpable organ by age forty
4. Has had at least one major orifice endoscoped within the past twelve months
5. Is always waiting on a biopsy report or a repeat of a borderline or false positive lab result
6. Never goes more than twelve months without medical contact

How did this evolution from an avoidance of medicine to medicine becoming a necessity occur? It is actually quite simple: medicine has been assigned successes by television and the public that are not attributable to medical care. Nearly all of the increases in health and life expectancy from birth are traceable to public health measures, clean water and milk, vaccinations, and a myriad of positive effects of the age of modernization.

It is a strange irony that at a time of maximum health, more people than ever are coming to see doctors. Preclinical man will soon be extinct.

References

The author’s address is:
Meharry-Vanderbilt Alliance
Bio-Medical Building
1005 D. B. Todd Boulevard
Nashville, Tennessee 37208
E-mail: clifton.meador@vanderbilt.edu

The Pharos/Autumn 2011

7
We live in a world in which innovation is driven by the desire to create products or develop concepts that are more convenient than those that already exist. If something does not make life easier, it will not survive in today’s society.

This pervasive drive to always improve the ease of using something has extended to the medical field with benefits for the care provider that include automatic blood pressure cuffs, Rapid Strep Tests, and electronic order entry and medical records. Only in the past decade, with the establishment of retail clinics characterized by flat fees, quick and efficient delivery of services, and walk-in visits, have patients begun to benefit from the drive for increasing convenience.

The story began in 2000 in the Minneapolis-St. Paul metropolitan area with a partnership between Cub Foods, a local grocery chain, and QuickMedx (founded by Rich Krieger, who had been recently frustrated by a long wait time at an urgent care clinic to receive care for his son’s sore throat). This joint
venture established the first in-store clinics to provide quality care for relatively simple illnesses in a timely, affordable manner. These pilot clinics charged a $35 cash-only flat fee for rapid testing, diagnosis, and treatment of eleven common medical conditions, including pharyngitis, conjunctivitis, otitis media, and seasonal allergies.\textsuperscript{1,2}

Following the success of these initial clinics, competitor companies were established and store-based clinics began to rapidly proliferate—from sixty-two in January 2002\textsuperscript{3} to approximately 1,200 located in thirty-two states in 2010.\textsuperscript{4}

QuickMedx changed its name to Minute Clinic and formed

---

**Conditions Treated**

- Allergies
- Athlete’s foot
- Bladder infections
- Bronchitis
- Chlamydia
- Cholesterol screening
- Cold sores
- Diabetes screening
- Diarrhea
- Ear infections
- Influenza
- Impetigo
- Insect bites
- Laryngitis
- Lice
- Minor burns and rashes
- Minor skin infections
- Minor sunburn
- Mononucleosis
- Nausea and vomiting
- Pinkeye and sties
- Poison ivy
- Pregnancy testing
- Ringworm
- Sinus infections
- Strep throat
- Swimmer’s ear
- Swimmer’s itch
- Wart removal

---

**Vaccines**

- Diphtheria, tetanus, and pertussis
- Influenza
- Hepatitis A
- Hepatitis B
- Measles, mumps, and rubella
- Meningitis
- Pneumonia
- Polio
- Tetanus

*Based on a table in reference 8.*
a partnership with CVS. It has become the largest retail clinic company with about 500 clinics in twenty-six states. Minute Clinic’s major competitor, Take Care Health Systems LLC, has partnered with Walgreens, the nation’s largest pharmacy chain, to open more than 340 clinics in thirty cities. In 2006, the Convenient Care Association was created to establish shared quality standards of practice for retail clinics and to foster professional relationships with the medical community.

In-store clinics are typically located in retail stores, pharmacies, supermarkets, and shopping malls, where they generally occupy 200 to 500 square feet of space, with one to two exam rooms equipped with all the necessities of an outpatient health care office. Most of these clinics are open seven days a week for twelve hours on weekdays and eight hours on weekends, a schedule that is much more convenient for patients than that of a traditional physician’s office. No appointments are needed, and a typical visit lasts fifteen to thirty minutes because of the limited number of services rendered and the maximal use of technology to provide efficient care.

The table on page 10 shows the typical “menu” at a retail clinic.

These clinics do not treat medical emergencies or chronic conditions, and they refuse to refill prescriptions that require continual use, such as birth control pills or antidepressants. The prices of the services are clearly posted, and the average cost of a basic visit is low. Treatment for a sore throat can range from $35 to $254, while a tetanus booster ranges from $15 to $254. Retail clinics initially accepted only cash, but by 2008 approximately eighty-five percent of clinics accepted insurance. Today many major clinics also accept reimbursement from Medicare and Medicaid.

Clinic charges are low because they typically rent small spaces and employ nurse practitioners, or sometimes physician assistants, who can proficiently diagnose and treat the most common illnesses found in family practice. Although state laws vary regarding the autonomy of nurse practitioners, most companies require that they operate under the oversight of an on-call physician.

Much of the efficiency of care provided by these store-based clinics is attributable to their use of technology. Most use touch-screen computer terminals similar to airline self check-in kiosks for the check-in process and computer software programs to guide the caregivers through various medical protocols that complement the decision-making process; software can be overridden by the caregiver. In addition, many clinic computer systems track each patient’s total number of visits for a given complaint. After a predetermined number of visits, the program notifies the provider that the patient needs to seek the care of a physician. Most clinics further use electronic medical records and electronically submit prescriptions to the adjacent retail pharmacy.

The rapid emergence of store-based clinics has sparked a wide range of responses from the American public, employers, insurance companies, and the medical community. In the Harris Interactive Health Care Poll from 2008, only seven percent of adults reported visiting a store-based clinic, but ninety-three percent of those said they were satisfied with the convenience these clinics provided, and ninety percent said they were satisfied with the quality of care. Both percentages have trended downwards over the three years.

Nevertheless, sixty-five percent all respondents expressed concerns about the qualifications of the staff of the clinic, and an equal percentage expressed worry about receiving an accurate diagnosis for a serious medical condition. However, both percentages have trended downwards over the three years from seventy-one percent and seventy-five percent in 2005. This may reflect increasing acceptance. These subjective concerns are not supported by the current data on the quality of care provided by store-based clinics. In a 2009 paper in the Annals of Internal Medicine, Ateev Mehrotra and colleagues found no significant differences in the quality of care provided by retail clinics, physician offices, and urgent care clinics across fourteen quality measures for treatment of otitis media, pharyngitis, and urinary tract infections (all three were slightly superior in quality to emergency departments). A review of the literature reveals many
studies demonstrating that the quality of care provided by nurse practitioners for basic medical treatment is equivalent to that of physicians. Finally, from the patient point of view, of the 313 respondents who visited a clinic in 2008 eighty-eight percent agreed with the statement that their providers were qualified.13

Some companies have reported savings of $100,000 or more per year when employees use store-based clinics, leading several employers—including Target, General Mills, and Bank of America—to encourage their employees to use these clinics for the treatment of minor illnesses.12 Because these clinics are dramatically cheaper for identical services than traditional clinics for insurance companies, some insurers use the incentive of reduced or no copayments for visits to a store-based clinic to encourage patients to use them instead. Mehrotra and coworkers found that the overall cost of care in retail clinics for otitis media, pharyngitis, or urinary tract infection was significantly lower than in physician offices, urgent care clinics, and emergency departments ($110 versus $166, $156, $570).14

The reactions of physicians and physician organizations to retail-based clinics have ranged from acceptance to intense opposition. The American Academy of Pediatrics (AAP) recently issued a policy statement declaring its opposition to retail-based clinics being used to care for infants, children, and adolescents. It is concerned about the following: increased fragmentation of care; the use of episodic care to treat children with special needs and chronic diseases; lack of access to and maintenance of complete health records; potential public health crises as patients with contagious diseases wait in commercial, retail environments; and fewer opportunities for pediatricians to treat minor illnesses, which often affords them the chance to strengthen their relationship with the child and family. Most importantly, the AAP states that these clinics are not committed to the medical home model, which is characterized by the provision of accessible, family-centered, comprehensive, continuous, and coordinated care.15

Believing that it is more practical to guide the evolution of such clinics than to prevent their use, the American Academy of Family Physicians (AAFP) released a list of attributes it feels are essential for patients to receive continuous, coordinated care. They feel that retail clinics should possess a well-defined and limited scope of medical services; that these services be evidence-based; that nurse practitioners work in tandem with the patient’s physician to ensure continuity of care; that the clinic have a referral system for cases that surpass its scope of services; and that the clinic utilize electronic medical health records to both communicate patient information and facilitate continuity of care.16

In a similar vein, the American Medical Association created eight principles to guide the operation of store-based clinics. These criteria are very similar to those of the AAFP, but include a call to establish appropriate sanitation/hygienic guidelines and to clearly inform patients about the qualifications and limitations of the clinic.7,12 A review of the general characteristics of the store-based clinics (as described above) demonstrates that they have adhered to the recommendations from the AAFP and the AMA.

Many individual physicians report feeling threatened by the potential, unwanted effects of retail clinics on their practices, including a loss in the variety of medical cases encountered, fragmentation of relationships with patients, lost opportunities for preventive care, and a drop in revenue. Yet there are no data to uphold these fears. Mehrotra and colleagues report that just ten simple clinical issues—including upper respiratory infections, urinary tract infections, sinusitis, and immunizations—constitute more than ninety percent of all retail clinic visits, whereas these same ten issues only comprise thirteen percent of adult primary care visits, thirty percent of pediatric primary care visits, and twelve percent of emergency department visits.17 It therefore seems unlikely that these clinics lead to a loss in the variety of cases. Instead, these clinics may alleviate the ever-increasing demands on the health care system.

The profile of the majority of patients using retail clinics is similar to those who visit emergency rooms—young adults age eighteen to forty-four who pay out of pocket for their care and do not have a primary care physician. Three out of five patients visiting store-based clinics did not report having a primary care doctor so that in most cases no relationship was disrupted. Preventive care was administered at only eleven percent of primary care visits for the ten simple clinical issues addressed at ninety percent of retail clinics. Thus, instead of thwarting preventive care, these clinics could actually serve to strengthen it by increasing the convenience of getting immunizations.17 It can also be argued that visits for simple, acute issues lost to retail clinics will be replaced by visits for more complex issues that are reimbursed at a higher rate, resulting in no dramatic change in revenue. The financial impact of clinics should be studied more thoroughly.

Many physicians and hospital systems are taking an “if you can’t beat them, join them” approach to the upsurge in retail clinics.18 Institutions such as the Mayo Clinic and Sutter Health have opened “satellite care centers” in retail settings. As of 2008 twenty-six of forty-two (sixty-two percent) clinic operators were hospitals or physician groups owning twelve percent of total retail clinics in the United States. In that year Walmart, in partnership with local hospital chains, began to co-brand retail clinics in its stores, and Cleveland Clinic began planning a partnership with Minute Clinic to open nine retail clinics with integration of their electronic medical records.9 At the same time, some traditional practices have begun to offer extended clinic hours or “open access/advanced access” scheduling, in which a portion of the physician’s schedule is open for same-day appointments.18
Retail clinics, in keeping with their complementary business model, have implemented many systems aimed at maintaining continuity of care with a patient’s primary care physician. They provide summaries of each clinic visit that include a listing of the laboratory results, services rendered, and prescriptions administered that can then be accessed through the clinics’ electronic medical records, facsimile, or printed copy. Research exploring the effectiveness of this communication is still needed. Patients presenting with conditions beyond the scope of practice of the clinic are referred to their primary care physicians, or to an office or hospital that is part of the retail clinic’s network of established relationships that will treat the patients whether they have insurance or not.1 Take Care Clinic, for example, states that twenty percent of its Chicago-land patients have been referred to a primary care physician or specialist for follow-up care.2

Clinic operators and the media herald the emergence of retail clinics as an effective solution to health care disparities that provide high quality care for the uninsured, underinsured, and populations with difficulty accessing health care resources. This claim is supported by data from the 2007 Health Tracking Household Survey, which revealed that twenty-seven percent of retail clinic patients were members of uninsured families and that families with any member uninsured were more likely to use retail clinics than insured families. Hispanic consumers and families with no usual source of medical care were also more likely to use retail clinics than their respective counterparts. The likelihood of citing cost concern or the lack of a usual source of care was much higher among uninsured and minority clinic users than with their insured and white counterparts.3

To truly combat disparities clinics must be located in areas accessible to underserved populations. Unfortunately, a study by Craig Evan Pollack and Katrina Armstrong found that retail clinics are more likely to be located in census tracts characterized by higher resident income, lower numbers of black residents, and lower rates of poverty, and that they are less likely to be located in medically underserved neighborhoods.4

Store-based clinics fill a need for change in the American health care system and attempt to offer cost-effective, high quality, and timely care to patients who are frustrated with America’s rising health care costs and lack of access to care. Such clinics are likely to grow to become a more critical element of the delivery of medical services in the United States. Much research is needed to further understand the delivery of care at retail clinics, and the leaders of these clinics should remain committed to a business model that complements primary care physicians and expands services to underserved areas of the United States.

References

The author’s address is:
924 E. 57th Street
Suite 104
Chicago, Illinois 60637-5414
E-mail: aemikolaj@gmail.com
Dollars and sense of electronic medical records

The impact of EMR on billing, coding, and physician reimbursement

Charles Rutter, MD

The author (AΩA, University of Maryland, 2010) is an intern at St. Mary’s Hospital in Waterbury, Connecticut. This essay won honorable mention in the 2011 Helen H. Glaser Student Essay Competition.

A national shortage of primary care physicians is mounting, with an estimated need for an additional 45,000 doctors by 2020. Nowhere is this dearth felt more severely than in rural areas of the country.1 While senior medical students undoubtedly take many factors into account when picking a field for further training, the two disincentives to a career in primary care most often quoted by the media are lower income relative to more lucrative specialties and a crushing burden of paperwork. These factors have resulted in a drop in the percentage of graduating senior medical students going into primary care specialties—from fifty percent in 1998 to thirty-eight percent in 2006.2 Electronic medical record systems (EMR) may help alleviate these unsatisfactory attributes of a career in primary care, offering the potential benefits of improved quality of patient care, more consistent documentation, more efficient clinical management, and improved physician remuneration. However, there are many barriers to the successful implementation of EMR, the most important of which is cost. The balance of risk and benefit is most important for small private primary care practices, whose financial stability may be more uncertain. As of 2004/2005, only eleven to fifteen percent of private primary care practices had implemented EMR.3,4

In a pair of May 2010 articles in the Canadian Medical Association Journal (CMAJ), author Paul Christopher Webster noted that without EMR, as much as thirty percent of patient care time is spent in a “paper chase.”5–6 Better known to medical students as “scut work,” these tasks include tracking down laboratory results, radiology reports, and consultant’s letters, as well as documenting clinical visits, writing prescriptions, making referrals, and ordering labs and imaging. As patients age and comorbidities accumulate, diagnostic and follow-up tests clog their medical records, causing chart size and physical space requirements to skyrocket.7 Furthermore, multiple staff members frequently need to access a patient’s chart simultaneously: nursing staff to chart the chief complaint and vitals, physician staff to document the visit and management plan, and secretarial staff to schedule follow-up tests, consults, and submit the visit for insurance reimbursement. As highlighted in the CMAJ articles, effective EMR reduces this astronomically frustrating paper chase, allowing physicians to function more efficiently and perform the duties they were trained for.5–6

Studies in the literature

A four-physician practice in rural upstate New York published a qualitative paper in 2007 describing its experience using EMR. Following the progressive implementation of a commercially available EMR system over one year, the practice saw an upswing in efficiency, evidenced by shorter turnaround times for prescription refill orders and school and work letters, improved internal communication, and fewer medication errors and calls from the pharmacy. Physician quality of life was improved by the installation of a virtual private network (VPN) that allowed physicians to access patient data and field after-hours calls from home, and allowed greater latitude in scheduling.3 The observations from this practice were echoed in a publication from the outpatient clinic at Cincinnati Children’s Hospital. Following the installation of EMR, the delay in medication refill turnaround was cut from two days to just twelve hours, and the time to generate school notes was halved. The number of paper chart pulls was reduced, allowing staff to perform their duties more efficiently. At the same time, the switch from paper to electronic records freed up space for the creation of two additional exam rooms.7

Several studies have cited an improvement in patient safety and quality of care with EMRs.4,8 In part this is due to fewer medication errors from misreading prescriptions.8 Additionally, a customizable EMR interface makes grouping disease-specific signs and symptoms possible, leading to more consistent and thorough questioning and examination
by physicians,8 which further allows for improved disease surveillance and adherence with guidelines and medication regimens.3,4,8 Patients are also spending less of their time in the doctor’s office, with a drop of 5.4 percent seen in one study.4 Finally, another study shows an increase in the percentage of charts containing a problem list from twenty-nine percent to eighty-four percent over two years.7

Every benefit, however, has its price, and when it comes to EMR systems, the sticker shock can be staggering. In a study published in 2007, five offices with twenty-eight physicians at the University of Rochester Medical Center performed a staged implementation of an EMR system at a total capital cost of nearly $485,000, with an additional $25,000 in first-year expenses (about $18,000 per provider). Annual costs for years two and beyond averaged $114,000 (about $4,000 per provider).4 The initial costs were recaptured within sixteen months, with ongoing annual savings of nearly $10,000 per provider. However, for many practices, particularly smaller groups, implementing EMR may be a serious gamble, as the large expense is divided among fewer physicians. Moreover, with the exception of this study, data on return from this investment is largely anecdotal.4 For practices with deep pockets, fully-customized EMR systems can be linked to a practice’s existing billing and scheduling systems, perform complex tasks, and be custom designed to fit client requirements.3,8 But for more cash-strapped groups, off-the-shelf systems can be significantly cheaper.

To cover this expense, along with the other costs of running a practice, a doctor’s office has to get paid. Reimbursement by insurance providers is based on a process known as coding. For a given situation (i.e., new patient evaluation, established patient visit, hospitalized patient, etc.), the level of complexity and scope of the history and physical determines the rate at which the encounter can be billed. For the sake of this discussion, we will use an established patient visit, where the current procedural terminology (CPT) codes vary from 99212 to 99215. The amount of history taken varies from a problem focused history (99212) to a comprehensive history (99215). The physical exam is stratified in a similar fashion. The third component of coding is what is referred to as “medical decision making,” which is classified as straightforward, or low, moderate, or high complexity. Based on how the history, physical exam, and medical decision making qualify, a code is assigned, and a given amount of money is paid. The table following is a highly simplified overview of the process of coding. Physicians can also bill for ancillary services, which include reviewing labs and imaging, discussing a case with a colleague, and so forth.

The table illustrates that the process of coding is tedious and time consuming. Physicians and staff members without a solid working knowledge might easily undercode a visit (i.e., label what should be a 99214 as only a 99213) or neglect to bill for services for which they do not know the code, resulting in lower remuneration. A major benefit of EMR systems is that they store such information and reference it automatically. A ten percent drop in undercoding was seen in the study from rural New York, along with an increase in billing for ancillary services, resulting in an eleven percent increase in annual revenue in the first year after EMR installation, and twenty percent increase in the second year.3 A significant decrease in 99211 and 99213 codes was seen in the study from the surgical practice discussed earlier, with a corresponding increase in 99214 and 99215 codes. This change netted the practice nearly $10 more per visit compared to their pre-EMR days. An increase in charge per visit of up to

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>History</th>
<th>Physical Exam</th>
<th>Medical Decision Making (MDM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>Problem focused history •Chief complaint (CC) •Brief HPI (1 to 3 descriptors*)</td>
<td>Problem focused exam •Limited to affected area/system</td>
<td>Straightforward MDM •Minimal diagnostic/treatment options •Minimal amount/complexity of data •Minimal risk of complications</td>
</tr>
<tr>
<td>99213</td>
<td>Expanded problem focused history •CC and HPI as above •Problem-pertinent review of systems (ROS)</td>
<td>Expanded problem focused exam •Affected area/system •Related systems (2 to 7)</td>
<td>Low complexity MDM •Limited diagnostic/treatment options •Limited amount/complexity of data •Low risk of complications/mortality</td>
</tr>
<tr>
<td>99214</td>
<td>Detailed history •CC •Extended HPI (4+ descriptors) •Extended ROS (2 to 9 systems) •Pertinent past medical, surgical, family, or social history (PMH, PSH, FH, SH)</td>
<td>Detailed exam •Extended exam of affected area/systems •Exam of other symptomatic or related areas/systems (2 to 7)</td>
<td>Moderate complexity MDM •Multiple diagnostic/treatment options •Moderate amount/complexity of data •Moderate risk of complications/mortality</td>
</tr>
</tbody>
</table>

This table uses an established patient as the example.
* Onset, location, quality, radiation, improving factors, exacerbating factors, severity, etc.
Note: For each CPT level, two out of three key components (History, Physical, MDM) must be satisfied for that coding level.
$26 has been reported in other studies.4
The paper from Cincinnati Children’s Hospital above and a study from the Medical University of South Carolina (MUSC) both identified an improvement in chart completion rates, allowing for increased billing and reimbursement, as many insurance providers require visits to be submitted with completed documentation within thirty days.7-8 In the MUSC study, completeness at seven days after the visit bumped from 75.3 percent to 78.7 percent, and at thirty days from 94 percent to 98.4 percent. At thirty days, this 4.4 percent increase in completed charts is equivalent to 4.4 percent more billable visits. With approximately 29,550 patient visits per year, this is roughly 1,300 more billable visits. Billable visits at this clinic average $72, and so this seemingly insignificant 4.4 percent increase in completeness results in an additional $93,600 annually.8 These findings mirror those seen in the rural New York practice described above, where an increase in revenue was due in part to a drop in the number of claims rejected due to incomplete charting or submission beyond insurer deadlines.9 Moreover, one study documents a decrease in the time from the initial visit to reimbursement of five days.4
Clearly, EMRs allow practices to capture revenue that may otherwise slip through the cracks. But EMRs also allow doctors offices to cut costs by removing paper charts from

the equation, thus eliminating the materials costs associated with assembling new paper charts. In the study from the University of Rochester described above, 4,288 new charts costing $6.50 each were created annually before implementing EMR. The elimination of the charts saved the practice nearly $28,000 a year in materials,4 as well as reducing the amount of time staff members spent gathering charts. By six months after EMR implementation, there was a 79 percent decrease in the need to track down paper charts, with a 96 percent decrease at two years. Based on the amount of time to pull one chart, the number of charts pulled annually, and the cumulative pay for the man-hours required, the authors estimated an annual savings of $250,000. There was also approximately $25,000 saved based on reduced filing time for placing documents into charts. In offices previously using transcription services, approximately $30,000 was saved annually.4 Finally, office workflow was made so efficient by EMRs that two full-time positions were eliminated despite an additional six physicians added to the practice, saving the group approximately $90,000 annually.4
The annual savings in this practice (excluding transcription service, which was used sporadically) thus

---

**About Charles Rutter**

I grew up in Ellicott City, Maryland, with my wonderful parents, Eugene and Mary, and my siblings, Callin and Sean. My undergraduate education was at the University of Maryland, Baltimore County, where I majored in biology and met my beautiful wife Victoria. I then attended the University of Maryland School of Medicine, graduating in May 2011. I will spend my medicine intern year at St. Mary’s Hospital in Waterbury, Connecticut, before heading to Yale-New Haven Hospital for a residency in Radiation Oncology. I thank Drs. Bui and Saxena of Hagerstown Family Medicine for their insight into the business of running a small private practice, my inspiration for writing this article.
Dollars and sense of electronic medical records

The demonstration of results at patient visits. Doctor’s notes for work and school can be created using predesigned templates. Charts are easily accessed both in-office and from home using the office’s VPN, allowing easy coverage of after-hours calls from home. The VPN also allows administrative duties to be performed from home. These changes in data access have allowed a significant improvement in lifestyle and more time away from the office, while maintaining the quality of patient care.

In her 2006 article in the New England Journal of Medicine, Dr. Beverly Woo candidly discusses the good and bad of being a primary care physician—and the challenges facing the field. The highlights of her career, it seems, are the long-term relationships she has with patients and their families, the intellectual challenges posed by having to diagnose any one of a myriad of diseases and conditions presenting with such protean symptoms as fatigue and abdominal pain, and the opportunity to improve her patients’ health by understanding and working within the confines of their sometimes-complicated social situations. However, she too is clearly distraught by the pressure placed on primary care physicians to see more patients in less time, the insufficient remuneration for her efforts, and the Everest-sized piles of paperwork that she and her colleagues slog through daily. While EMR systems may not be the panacea for all that ails primary care medicine in the United States, their many benefits may be the shot in the arm that the field so desperately needs.

**One case study**

Hagerstown Family Medicine is a small practice in western Maryland consisting of three physicians, two nurses, two medical assistants, and three administrative assistants. Prior to installing a commercially available EMR system several years ago, the practice used a combination of paper charts housed in the clinic and a warehouse, as well as a DOS-based records system. During the transition from old to new, forty to sixty hours of on-site training was supplied by the vendor, and implementation was performed all at once. The new system ties together nine computers, a printer, and over one thousand gigabytes of files via an office intranet. The practice utilizes an off-the-shelf EMR that includes billing and scheduling applications and fits its needs well while still remaining affordable.

Hagerstown Family Medicine invested approximately $70,000 up front for the EMR system, with annual license and support fees totaling about $20,000 (roughly $23,000 and $6,700 per provider, respectively). Following installation of the EMR system, the practice discontinued its transcription services, saving $24,000 to $30,000 annually ($8,000 to $10,000 per provider). The time requirement related to record keeping and finances decreased markedly, such that one staff position was no longer necessary, allowing additional savings. However, no changes were observed in the percentage of charges generating revenue, the percentage of claims rejected due to missing submission deadlines, coding trends, or time to reimbursement. The absence of these outcomes is explained, at least in part, by the fact that one of the practice physicians is a certified professional coder. The patient volume did not change following EMR installation. Notably, while overall revenue did not change with implementation of the EMR system, annual savings top $20,000, which allowed the practice to break even with its initial investment within two and a half years.

The most notable improvements experienced by Hagerstown Family Medicine are in the areas of practice efficiency and physician lifestyle. Adjustment to the new system was fast and very easy, allowing the providers to see fifteen patients in the first day following EMR installation. One of the major gains noted by the physicians is the ability to complete all documentation while in the room with the patient, shortening the working day. Writing prescriptions and refills is fast and easy because the EMR is capable of Internet faxing prescriptions to most local pharmacies. Lab tests are automatically uploaded within twenty-four hours of their release, allowing efficient review

of results at patient visits. Doctor’s notes for work and school can be created using predesigned templates. Charts are easily accessed both in-office and from home using the office’s VPN, allowing easy coverage of after-hours calls from home. The VPN also allows administrative duties to be performed from home. These changes in data access have allowed a significant improvement in lifestyle and more time away from the office, while maintaining the quality of patient care.

In her 2006 article in the New England Journal of Medicine, Dr. Beverly Woo candidly discusses the good and bad of being a primary care physician—and the challenges facing the field. The highlights of her career, it seems, are the long-term relationships she has with patients and their families, the intellectual challenges posed by having to diagnose any one of a myriad of diseases and conditions presenting with such protean symptoms as fatigue and abdominal pain, and the opportunity to improve her patients’ health by understanding and working within the confines of their sometimes-complicated social situations. However, she too is clearly distraught by the pressure placed on primary care physicians to see more patients in less time, the insufficient remuneration for her efforts, and the Everest-sized piles of paperwork that she and her colleagues slog through daily. While EMR systems may not be the panacea for all that ails primary care medicine in the United States, their many benefits may be the shot in the arm that the field so desperately needs.

**References**


The author’s e-mail address is: crutter1@gmail.com
Ode to a Suppository

You dwell
In cool repose
Shelved, clad in foil
With others of your kind
Until
You by trembling hands
With gentle care
Are
Uncloaked; your silver
Refrigerated wrapper
Wantonly cast aside.

Now exposed,
How to describe you;
To capture your essence?
No single word does you justice.
You are
Opaque,
Silvery white,
Oddly luminous,
Sleek,
Conical.
Less like a Byzantine dome
Than a fleetly flying rocket
Soft, yet firm to touch
Waxy.
Slippery.
Evasive.
Penetrating
(after a struggle)
Finding your target
Exerting your soothing power
Aah . . .

Myron F. Weiner, MD

Dr. Weiner (AΩA, Tulane University School of Medicine, 1955) is clinical professor of Psychiatry and Neurology at the University of Texas Southwestern Medical Center in Dallas. His address is: 5945 Still Forest Drive, Dallas, Texas 75252. E-mail: myronweiner@tx.rr.com.
Eliza C. Miller
The author is a member of the Class of 2012 at the Columbia University College of Physicians and Surgeons. Her essay, “Attuning to Equilibrium: Physician as Artist, Artist as Physician,” won first prize in the 2010 Helen H. Glaser Student Essay Contest. She is a former dancer and choreographer.

In July of 1866, just over a year after the final shots of the American Civil War were fired, an odd account appeared in the pages of the elite New England literary journal the Atlantic Monthly. Entitled “The Case of George Dedlow” and with no author cited, the article began, “The following notes of my own case have been Declined on various pretexts by every medical journal to which I have offered them.”¹ A first-person narrative, the piece told the story of a physician-turned-soldier who had the misfortune to have all four of his limbs amputated in the course of his service to the Union army. He graphically recounted the horrors of his experiences in battle and in field hospitals, and his recuperation in the famous “Stump Hospital” in Philadelphia where hundreds of Civil War amputees were cared for.

In addition to his grisly descriptions of the atrocities of war, the author of this account provided a vivid portrayal of his unusual sensory experiences after amputation, which were not unique to him but shared by many of his comrades:

I found that the great mass of men who had undergone amputations, for many months felt the usual consciousness that they still had the lost limb. It itched or pained, or was cramped, but never felt hot or cold. . . . I should also add, that nearly every person who has lost an arm above the elbow feels as though the lost member were bent at the elbow, and at times is vividly impressed with the notion that his fingers are strongly flexed.

Another set of cases present a peculiarity which I am at a loss to account for. Where the leg, for instance, has been lost, they feel as if the foot was present, but as though the leg were shortened. If the thigh has been taken off, there seems to them to be a foot at the knee; if the arm, a hand seems to be at the elbow, or attached to the stump itself.¹

The Atlantic Monthly was one of the most widely read periodicals of the day (at least among the intellectual elite of the Northeast). George Dedlow’s fascinating and gruesome account provoked an overwhelming response from the public, many of whom sent donations in his name to the Stump Hospital, a real enough institution.² But George Dedlow did not, in fact, exist. The anonymous author of the article was Silas Weir Mitchell, a prominent Philadelphia physician and physiologist. Mitchell, who had never before tried his hand at fiction, had shown the manuscript to a friend. As Mitchell wrote later, “He, presuming, I fancy, that every one desired to appear in the Atlantic, offered it to that journal. To my surprise, soon afterwards I received a proof and a check.”³

Silas Weir Mitchell (1829–1914) is broadly credited with the first clinical description of phantom limb syndromes, although they had actually been previously described by a number of authors, most notably sixteenth-century French surgeon Ambroise Paré and seventeenth-century philosopher René Descartes.⁴ It is certainly true that Mitchell coined the term “phantom limb” in an 1871 article in another lay publication, Lippincott’s Magazine, four years after the Atlantic piece. In this second article, he described more fully the syndrome to which George Dedlow had alluded, but again for a lay audience; he still did not disclose his authorship of the Dedlow account. Only with the publication of his 1872 classic

---

¹ Dedlow account. Only with the publication of his 1872 classic
book, *Injuries of the Nervous System and Their Consequences*, did Mitchell thoroughly describe the syndrome to a purely medical audience as part of his chapter “Neural Maladies of Stumps.” In 1905, almost forty years later, Mitchell finally acknowledged in print that he was the true author of “The Case of George Dedlow.”

Mitchell received his initial training in medicine in his physician father’s office, but showed little promise or enthusiasm for the profession. (Apparently, his father informed him early on, “You are wanting in nearly all the qualities that go to make success in medicine. You have brains enough, but no industry.”) Nevertheless, he went on to medical school at Jefferson Medical College, graduating in 1850, and subsequently opened a private practice in his native Philadelphia. Mitchell showed a lifelong interest in experimental physiology, with particular emphasis on the effects of poisons and toxins. One paper, published in the *British Medical Journal* in 1896, recounted his personal experiments with mescaline: he took a large dose and then went on with his busy day of general medical practice, all the while recording his own physiological and psychological responses in scrupulous detail.

With the advent of the American Civil War, Mitchell’s career took the turn that led to his eventual recognition by his contemporaries as “one of the foremost neurologists of his time” (as noted in his 1914 obituary in the *British Medical Journal*). In 1863, he was asked to...
take charge of a Philadelphia hospital dedicated to the care of soldiers “suffering from nervous diseases” or “injuries of the nerves.” During the course of the war, Mitchell cared for hundreds of soldiers who had suffered traumatic nerve injuries, including amputations. His descriptions of these cases in his 1864 monograph, entitled Gunshot Wounds and Other Injuries of Nerves, rocketed him to the forefront of contemporary neurology, a field in which he had little prior expertise. In addition to his descriptions of phantom limb syndromes, he is renowned for his early description of causalgia, a term he coined in 1867. He reported this disorder as a consequence of peripheral nerve injury, with the symptoms that are now known by the moniker “complex regional pain syndrome” (CRPS). Indeed, his fictional George Dedlow describes this condition in one of his arms prior to amputation, noting that the hand was “red, shining, aching, burning, and, as it seemed to me, perpetually rasped with hot files,” all of which illustrate cardinal features of CRPS: burning or throbbing pain, allodynia, edema, and sudomotor abnormalities.

Mitchell had a flair for words; his obituary in the British Medical Journal noted that “Even the purely medical writings of Weir Mitchell are marked by a charm of style very rare in medical authors.” “The Case of George Dedlow” was his first foray into fiction, but by no means his last, and by the end of his life he had published several novels and “held a leading place among American writers of fiction.” His friend and protégé, the legendary American physician Sir William Osler, wrote in a personal addendum to Mitchell’s obituary that

Versatility was the striking feature of Weir Mitchell’s mind, and it is shown by the remarkable success obtained in other than professional fields. In large part he was able to do this by living a double life and by the development of an extraordinary capacity for continuous work.

Mitchell’s “charm of style,” “versatility,” and “double life” is nowhere more evident than in “The Case of George Dedlow.” The narrator’s account begins conversationally, and though Dedlow acknowledges his training as a physician, he is careful to distance himself from the medical community (as witnessed by the purported rejection of his case for publication in all medical journals) and align himself more with the common infantry soldiers with whom he served. As the story becomes more gruesome, the narrator assumes a more detached style, in which his considerable powers of observation and interpretation come to light, but always tinged with the distinctive Mitchell “charm.” In this passage, for example, Dedlow hypothesizes about the cause of his sensations of pain in amputated limbs:

I think we may to some extent explain this. The knowledge we possess of any part is made up of the numberless impressions from without which affect its sensitive surfaces, and which are transmitted through its nerves to the spinal nerve-cells, and through them, again, to the brain. . . . In other words, the nerve is like a bell-wire. You may pull it at any part of its course, and thus ring the bell as well as if you pulled at the end of the wire; but, in any case, the intelligent servant will refer the pull to the front door, and obey it accordingly.

Here we find evidence of Mitchell’s burgeoning interest in neurology, as well as a strikingly accurate description of dorsal column-medial lemniscus pathways mediating cortical sensory experiences.
The end of the story is perhaps the most remarkable. Dedlow, having lost all of his limbs, begins to question his own existence (“I felt like asking someone constantly if I were really George Dedlow or not”1) and he becomes “moody and wretched.” In search of healing, but with great skepticism, he attends a spiritualist séance. Much to his shock, he has a transformative encounter in which he briefly experiences the illusion that his legs have returned to him, and he is walking; this causes him to feel “re-individualized,” but only for a fleeting moment.1

In considering this extraordinarily strange ending, one cannot help but bring to bear some current thought on phantom limb syndromes. A 2006 review in Nature Reviews Neuroscience, published 140 years after “The Case of George Dedlow,” offers some insights. The components of phantom limb syndromes, all well described by Mitchell, may include pain, paresthesias, sensations of cramping or limb flexion, and the bizarre telescoping phenomenon that Dedlow mentioned (e.g., a foot at the knee). Current research points to both peripheral and central mechanisms for these symptoms, with cortical reorganization and so-called “maladaptive plasticity” playing a prominent role. For example, the somatosensory map in the primary sensory cortex may remodel in the absence of normal peripheral afferent information, causing the mouth area to shift into the area formerly occupied by the now-absent arm. These cortical changes appear to correlate closely with increased phantom limb pain. Of particular note is the finding that, while analgesic, antidepressant, and stimulant treatments appear to have little effect on phantom limb pain, in some cases “mirror treatments” have been employed.
successfully (in which a mirror provides the illusion that the lost limb is restored).\(^8\)

Mitchell appears to have understood that phantom limb syndromes were complex phenomena, involving both peripheral and central mechanisms. Bearing in mind today’s experimental mirror treatments, Mitchell’s description of Dedlow’s séance seems less oddball and more prescient. Perhaps, overwhelmed by the suffering of the many amputees he treated (in his 1872 book, he noted that eighty-six out of ninety amputees he cared for suffered from phantom limb syndromes\(^3\)), Mitchell turned to fiction as a way to imagine a possible cure. It would take 140 years for his musings to be translated into the peer-reviewed literature.

A final note on Silas Weir Mitchell, from his Lancet obituary:

Perhaps the most striking lessons of his work are the evidence it affords that success in no field need be despaired of because it delays its appearance until well on in middle life (for his first really successful novel was published when he was 68) and the compatibility of a simultaneous devotion to both literature and the exacting profession of medicine.\(^9\)

As an older medical student with a prior career in the arts, coming late to neurology, I find Mitchell’s example both inspirational and encouraging.

References


The author’s address is:
875 West 181 Street #1E
New York, New York 10033
E-mail ecm2137@columbia.edu
I wish I could carefully
Collect sea foam in a plastic
Bucket with a plastic shovel,
Covet it as treasure, and still
Not be disappointed as it slowly
Disappears.

Or spend a day without
A purpose—consider it neither
Useful nor wasteful—or,
Consider not considering
It at
All.

Or how about continuing
The walk on the beach
As endlessly as the waves,
Smiling as strangers pass,
Knowing I have succeeded at
Last.

*Steven F. Isenberg, MD*

Dr. Isenberg (ASL, Indiana University, 1975) is assistant professor of Otolaryngology—Head and Neck Surgery at Indiana University School of Medicine. His address is: 1400 North Ritter Avenue, Suite 221, Indianapolis, Indiana 46219. E-mail: sisenberg@gooddocs.com.

Illustration by Laura Aitken.
Ulcers in Papua New Guinea

A contemplation on fairness

Heather Relyea-Ashley, MD
The author is a resident in Internal Medicine-Pediatrics at the University of Cincinnati. This essay won honorable mention in the 2011 Helen H. Glaser Student Essay Competition. All photos are courtesy of the author.

He was slightly smelly. Tottering towards me, his worn stick steadied his atrophic spindly legs. His toothless beaming mouth was accentuated by his beard. This beard, a rarity in the village, was a long, scraggly brown and gray affair with many kinks. He was most proud of it, and it was a constant source of entertainment for him and a consistent source of fear for the small children he chased with it. Screaming with delight and semi-horror, they would dash away, bare feet pattering, their dingy, holey clothes flapping behind them as the adults laughed merrily.

“Ivau is here,” the seven-year-old messenger had announced a half hour earlier. The small boy had stood quietly until we noticed him at the top of the long stairway leading up to our house, which towered on fourteen-foot stilts—an attempt at maximizing tropical wind flow into the house and minimizing invading snakes. I stifled a sigh. Standing at the sink washing the dishes in rainwater, I was weary. Grief still hung over us, and yet there were needs to be met. Endlessly. Compassion was hard to resurrect when pain still ran so deep.

Ivau had been in my life as long as I’d had memory. My parents, American linguists and missionaries, arrived in Tiap Village with a very small me in tow in the 1980s. Living in the deep, thick, remote rainforest of Papua New Guinea, the Aruamu were isolated from the outside world, but quickly became our family. When childless Ivau laid eyes on my parents, he announced to the village that my mother would be his daughter. This pronouncement automatically placed my father in the other clan, because the Aruamus avoid consanguinity. Thus, I became the first grandchild.

He was the village hypochondriac. In such a remote rainforest location having a myriad of terrible illnesses, Ivau’s real and imagined health difficulties often brought him to our house. He lived down the hill, alone, in a small shack. Somehow, he was taken care of, more or less—the Aruamus do not let anyone utterly starve, even if rain does not fall on the gardens and food is scarce at times. Ivau lacked the closeness of a family unit since his wife had died and, especially as he continued to age, his ailments became a way for a lonely man to milk attention. My mother—as a daughter should be—was dutifully compassionate and sympathetic. He was entertaining and we all loved him.

A quintessential Ivau incident occurred one afternoon when a group of men and women sat in a circle at our house to work on literacy and scripture checking in Aruamu. Ivau was mentally sharp and being involved with the
Literacy Committee was a source of pride for him. This day, however, went down in our family lore. Ivau had managed to zip a part of his scrotum in his worn pants. He evidently failed to notice it, but my father found the obvious loop of skin quite distracting as the group delved into the Aruamu Bible.

Dad always had a special relationship with Ivau. Both knew how to ham it up and get under each others’ skins. For reasons of propriety and to avoid sexual innuendo, Aruamus never say the name of an in-law. The friendship between my father and Ivau, however, was a joking relationship. Dad often called Ivau by his name, which almost always elicited laughter from everyone. Either that, or he would call him “Tambu”—“In-Law”—and Ivau would actually answer to this, contrary to usual custom. Sometimes throwing cultural boundaries aside is appropriate for forging deep friendships.

Since my recent return to the village Ivau had been refusing to bathe. No one was truly responsible for him since he had no family. Despite regularly hobbling all over the village he refused to go to the river to cleanse himself. The good village women—including my aunt Watarak—did their best to intervene. They offered to carry buckets of water up the mountain for him to use. He refused. Like a stubborn little boy who relished his own sticky dirt, he simply...
I’d merely the until otherwise. However, the Pharos village, I old were fordable News
just treatable and days I were dropped doxycycline for
burns is Ivau. I had reached 10,000 miles the
burn was still very ugly. There was no
early excision and grafting to be found
in the jungle. My sister Brigette and
I selected the supplies we needed to
do the best we could. When we met
Ivau under Watarak’s house next door,
however, we drew the line at his odor.
We refused to dress the wound unless
he agreed to wash with a bar of soap
we provided. After much coercion, and
not a little teasing, he reluctantly took
the soap and washed himself under the
rainwater tank. Then his dutiful granddaughters dressed his oozing wound
yet again. In his typical joking fashion
he asked us where our medical degrees
were that allowed us to treat him.

There was something therapeutic
about caring for wounds in the village. It
was peaceful and it gave us time with our
friends. Brigette and I and our brother
Bobby had been doing this for years.
Growing up, there were so many needs
that our parents harnessed all of us to
care for those around us. Many afternoons after school, beginning when we
were in grade school, were spent caring
for tropical ulcers. Some people take
talent in elementary school—we fixed
ulcers. Villagers of all ages would walk
up with open sores, sometimes bandaged
with a bit of hibiscus leaf or dirty
cloth. These ulcers were, in fact, how I
knew vaguely that HIV had invaded our
island—our parents suddenly made us
wear gloves sometime in the early-
to mid-1990s. I didn’t understand what
HIV was at that point, but I remember
feeling frustrated with the barrier I felt
the gloves put between my friends and
me. I felt rude putting on gloves to touch
them, but I obeyed; my parents seemed
very serious about the issue.

We spent hours with cotton balls,
bleach, vats of hot water, disinfectant,
antibiotic powder—all low cost ways
of dealing with the wounds. It was some-
thing tangible we could do to love our
friends. With the ever present flies,
infections ran rampant. Some lasted for
years. My friend Gumi had numerous
ulcers on her legs and feet for most of
our childhood. They never healed, no

About Heather M. Relyea Ashley
The daughter of missionaries, I grew
up in Papua New Guinea. After obtaining
my undergraduate degree at Harding
University, I worked for one
year in clinical research at Texas
Scottish Rite Hospital for Children.
I attended medical school at the
University of Texas Medical Branch
in Galveston, where I was an Osler
Student Scholar, a Gold Humanism
Society member, and a Finalist for the
Gold-Headed Cane award. I am
thrilled to be starting residency in
Internal Medicine-Pediatrics at the
University of Cincinnati. I am mar-
rried to my high school sweetheart,
an orthopedics resident, and we
both share the goal of working long-
term in global health. My hobbies
include drinking tea from around
the world, playing with my two par-
rots, reading, traveling, and spend-
ing time with my family, who are
often scattered around the globe.
matter what we did. In that jungle, you sure need your feet. I did not know enough of medicine to consider yaws or mycobacteria as etiologies for the cavernous, hideous openings that exposed my friends’ flesh like hamburger meat. We did the best with what we had and with what we knew.

During those years, growing up so closely intertwined with the village as we did, we didn’t see much of a difference between our Aruamu friends and ourselves. We barely noticed the skin color difference. Who cared? What was a difference in melanin among friends, family? As the years progressed though, differences arose—it became apparent that life was not the same for my Aruamu friends as it was for my family. From the start, we had more access to medical care. This was when I first deeply grasped the concept of disparity, if not the word itself.

My father was exceedingly careful in his insistence on two things. We must wear sunscreen, due to our light skin—my brother and I were blond, my sister a redhead. His voice would echo across the palm trees, “Did you remember sunscreen?” as we tried to escape into the bush with our friends. It was a family joke, with a serious twist. His second rule was equally inflexible: any sort of cut we received must be taken care of immediately. Infection was not permissible. I’ll never forget that difference between the Aruamu and my family—scars from large ulcers did not mar our bodies. I remember in college, walking into my microbiology incubator and thinking it felt just like Tiap Village—any wound allowed to go untreated even a few hours ended up infected. Tiap Village was one of the only places on earth that I think truly warranted showering with antibacterial soap. But this was a place where soap was quite rare; we used to give bars of soap out for Christmas presents.

We did get many of the illnesses our friends had—all of us had malaria multiple times. Brigette and Bobby both survived the cerebral form, somehow. Even so, there was still a crucial difference between us and our friends. While by American standards we were not rich, we still had numerous resources at our disposal. Although my sister and brother could have died from malaria, they didn’t. I received major spinal fusion surgery for scoliosis in Dallas at age fourteen. My mom received her hypertension medications. When she needed it, she had Mohs surgery complete with a 3.5 centimeter exquisitely stitched incision on her forehead for squamous cell carcinoma, as well as topical chemotherapy. We had far more access than our friends did, even at our remote location. We could leave for help if necessary. While my father did die in New Guinea, and lacked the adequate access to care that might have saved him, medical help was also almost never available to our Aruamu friends. Life expectancy for the Aruamus is in the forties; Dad died at a comparable age.

In the grand scheme of things life is not fair. It was largely this realization of the horrors of the health disparity between the first and third worlds that compelled me to pursue medicine. In my career goals, I want to fix the world, somehow. The ideas of fairness and shamal are quite lofty concepts. How hard it can be to put feet on such dreams.

And yet, during those long afternoons sitting under bamboo and jungle-wood houses in the foothills of Papua New Guinea’s northern coast, the wind rustling through the palm trees, we could tangibly make life a little more fair, even as we laughed and told stories and cleaned sores. Ulcers aren’t fair. Neither are burns and not having medicine, vaccines, food, or education. Neither is a father dying at forty-nine.

That day with Iva'u, I couldn’t make the world right, bring back my dad, or cure the village from all its ailments. But I could clean Iva'u’s sore. And that, I think, made the world a little less unfair. All those endless afternoons spent cleaning ulcers could be viewed as a waste. After all, ulceration would recur after the next cut or bump in the hard life the Aruamus live in the rainforest. To me, however, it wasn’t a waste. I have never regretted those hours. It was a way to connect, to show care. At its deepest level, cleaning ulcers was, for my brother and sister and I, a connection between friends who may look different, but are not. And that heals more than just ulcers.

The author’s address is: 321 Albert Sabin Way, ML 0535 Cincinnati, Ohio 45267-0535 Email: heather.relyea-ashley@cchmc.org
One hundred billion spinning galaxies, one hundred billion spinning stars in each, and spinning planets perhaps to Avogadro’s number, began with a BANG from a microscopic font thirteen and a half billion years ago. These luminous fusion factories represent but 5 percent of universal mass-energy. The rest is mysterious dark matter and the enigmatic energy driving the accelerating expansion of spacetime.

In the simplest atom, a spinning electron orbits a spinning proton. It is a particle of known mass and charge. But, KERPLANK—it can be at once both here and there! Perhaps it is a wave, or a wave/particle, or neither.

On spinning planet GOLDILOCKS, several billion years ago, lightning in an anoxic atmosphere synthesized amino acids. Living cells then developed somehow, somewhere, and, after almost infinite spin cycles of birth, growth, senescence, death, genus Homo and species sapiens evolved.

Sapient priests, Parsons, rabbis, imams, mullahs, patriarchs, heads of state, and voices on the media, often claim to know the mind of God and invoke his blessing.

Daniel J. McCarty, MD
The physician at the movies
Peter E. Dans, MD

Midnight in Paris
Starring Owen Wilson, Rachel McAdams, Marion Cotillard, Kathy Bates, and Adrien Brody.

Midnight in Paris, which may be characterized as Purple Rose of Cairo meets Manhattan, represents a return to the form Woody Allen displayed in some of my favorite Allen films: Play it Again Sam, Broadway Danny Rose, Love and Death, Manhattan, and Annie Hall. It’s hard to believe that he has written and directed over forty films since writing the screenplay for What’s New Pussycat? in 1965 and then taking over as director as well as screenwriter for What’s Up, Tiger Lily? the following year.

Despite his shunning of the Oscar ceremonies except on two occasions, he has received twenty-one nominations and three Academy Awards. Fifteen actors have received Oscar nominations and five actors have won Oscars for performances in his films: Diane Keaton as the unforgettable Annie Hall; Michael Caine and Dianne Weist for the angst-ridden Hannah and Her Sisters; Dianne Weist again, this time as a gangster’s talentless moll in the witless Bullets over Broadway; Mira Sorvino as that hardy Oscar-winning perennial, the heart of gold prostitute in another silly contrivance, Mighty Aphrodite; and Penelope Cruz as the tempestuous ex-wife in Vicky Cristina Barcelona. That helps explain why, despite his sordid personal life, actors are excited to work with him. Starting as a comedy writer (especially for the inimitable Sid Caesar), a standup comic, and an essayist for the New Yorker, much of Allen’s work has been autobiographical and psychoanalytic in nature, no doubt drawing heavily on his estimated thirty years in analysis.

Midnight in Paris has a lightness and good humor that has been missing in many of his later films and, as a result, in five weeks, it became the highest grossing of any of his films in North America. It opens by treating the viewer to an homage to Paris to the strains of saxophonist Sidney Behcet’s, “Si tu vois ma mere,” similar to his great cinematographic paean to New York City in Manhattan. Unlike the latter, it was not shot on-site but involves what appears to be a series of picture postcard views that show Paris to advantage as the City of Light both in day and in night, as well as in the rain. I have
visited Paris three times, and the sequence brought back a flood of happy memories. Ironically, the film’s major theme is to live in the present and not persist on nostalgia for a past or golden age that may never have existed.

The Woody-proxy is played very well by a surprising choice, Owen Wilson, better known for his more broad comedy as a slacker or a surfer dude. Here he sensitively carries off the role of Gil, a screenwriter who, although well paid, aspires to be a novelist but is suffering from writer’s block. He and his fiancée Inez (Rachel McAdams) are visiting Paris with her parents John (Kurt Fuller) and Helen (Mimi Kennedy). Inez is a shallow materialistic princess and her parents are the stereotypic wealthy and obnoxious Americans. They clearly inhabit a different planet than Gil does. They want to go shopping and sightseeing. Gil would rather search for the Paris of the 1920s, where he and Inez might reside while he conquers her writer’s block. She wants none of that. This trio represents a movie set-up to get us on Gil’s side and is the weakest part of the film. Fortunately we don’t see them much except as brief bridges between Gil’s visits to the past.

On a sightseeing expedition to Versailles, their estrangement surfaces as Inez becomes attracted to her college hero Paul (Michael Sheen), a pedantic pompous ass. When Paul suggests that Gil and Inez join him and Carol (Nina Arlanda) that evening to go dancing, Gil opts to stay in the hotel. Going out for walk, he hears midnight strike and all of a sudden F. Scott Fitzgerald (Tom Hiddleston) and wife Zelda (Alison Pill) pick him up in a 1920s roadster and he time travels to the world he seeks. There he meets Ernest Hemingway (Corey Stoll), who amusingly declaims his work, and Gertrude Stein (Kathy Bates), who agrees to read his manuscript. He also meets Salvador Dalí, played wildly over-the-top by Adrien Brody, as well as Pablo Picasso (Marcial Di Fonzo Bo) and his mistress Adriana (Marion Cotillard). When the latter splits, a thoroughly besotted Gil hopes to stay with Adriana in that world, but it turns out that her concept of a golden age is La Belle Époque, to which they then time travel. There she introduces him to the Paris of Henri de Toulouse-Lautrec, Paul Gauguin, and Edgar Degas, a world in which he feels less at home. Mix in Man Ray, T. S. Eliot, Luis Buñuel, Jean Cocteau, Henri Matisse, Cole Porter at the piano, and the dancers at Maxim’s and you have an very appetizing artistic bouillabaisse. The screenwriting is vintage Woody Allen: clever, literate, and funny. Watch for Carla Bruni, the wife of French president Nicolas Sarkozy as a sympathetic museum guide.

As to Allen’s thesis about a golden age, by chance, shortly after seeing the film, I listened to the audiotope of David McCullough’s new book, A Greater Journey, about Americans who went to study and experience Paris from the 1830s to 1900. It too has a hearty assemblage of famous characters starting with James Fenimore Cooper, Charles Sumner, and Samuel F. B. Morse, and ending with Augustus Saint-Gaudens. McCullough makes clear that Paris had a series of golden ages besides those pictured in the film. For example, he devotes considerable space to “Paris medicale” with its École de Médecine, and numerous hospitals and illustrious physicians like Guillaume Dupuytren and Philippe Ricord, and especially Pierre Louis. He makes a good case for the period from 1832 to 1860 as being Paris’s golden age of medicine that attracted the likes of Bostonians Oliver Wendell Holmes, James Jackson, Henry Ingersoll Bowditch, and John Collins Warren, who made extended stays there, becoming exposed to a different form of medicine, which they then brought back to the United States to create our own golden age. McCullough quotes Osler as saying in the 1890s that “modern scientific medicine had had its rise in France in the early days of this century. More than any others, it was the pupils of Pierre Louis who gave the impetus to the scientific study of medicine in the United States.”

Yet, as much as one would be thrilled to study under Louis, one would not want to inhabit a golden age of medicine in Paris before anesthesia and asepsis. In fact, the professional jealousies and political turmoil in France were such that by Osler’s time the place to go was Vienna or Berlin, which were superseded by the United States in the twentieth century. It led me to reflect on how fortunate I was to be trained in the period of the 1950s and 1960s in what might be called the Golden Age of Internal Medicine (before it splintered into subspecialities) that included exposure at Columbia to David Seegal, Arthur Wertheim, Dana Atchley, and the physicians recruited by Robert Loeb; at Hopkins to Mac Harvey and his faculty, including Victor McKusick, Leigh Cluff, Lock Conley, and Dick Ross; at the Thordike to Max Finland, Ed Kass, and Lou Weinstein; and later to Gordon Meiklejohn and Paul Beeson. I might have hoped that my daughter and other recently minted physicians could have been exposed to the likes of them. Yet, like the Paris of Louis, I wouldn’t want them for their patients’ sake to linger long in that era, given how little we could do for patients in too many areas compared with today. In short, what Allen may be saying is that we can’t go back to that golden age, nor should we want to, but must make of the present our own golden age.

Addendum: I can’t resist giving a plug for AIΩA’s Leaders in American Medicine series, endowed by David Seegal. It’s a set of video interviews with past “giants” of medicine, some of which have been discussed in The Pharos by Oliver Owen, and which can provide some interesting course material for both history of medicine and clinical skills.

References
2. Leaders in American Medicine. alphaomegaalpha.org/leaders.html.

Sarah’s Key

Starring Kristen Scott Thomas, Melusine Mayance, and Aidan Quinn.

Sarah’s Key is based on a novel of the same name written by Tatiana de Rosnay.1 It tells the story of a July 1942 round-up in which the French police arrested 13,152 Jews, including 5,802 women and 4,051 children. They were detained for days in the Vélodrome d'Hiver or Vél d’Hiv, an arena built for winter indoor bicycle racing, before being deported to an internment camp and then on to Auschwitz. De Rosnay’s manuscript was rejected by over twenty publishers. Finally, when published years later, it sold over five million copies and has been released in thirty-eight countries.2 It’s a good example of why one must be persistent and believe in one’s work. Having had the same number of rejections for two of my books before acceptance, I can relate, but obviously not to its economic and artistic success.

The movie opens on a happy note in an apartment in the Marais, the predominantly Jewish quarter of Paris. Young Sarah Starzynski (Mélusine Mayance) and her little brother Michel are tickling one another and giggling under the covers when they are interrupted by the police at the door. Having rounded up almost 4,000 men on May 10, 1941, the French have been directed by their German overseers to conduct a round-up of women and children. Before leaving the apartment, Sarah and her mother are allowed to take a blanket, a sweater, a pair of shoes, and two shirts. Sarah tells Michel to wait in the closet until they return. She gives him food and water, locks the closet, and holds on to the key. In the street, they are joined by the father who is not very happy with Sarah’s decision but is prevented from re-entering the house.

At the Vél d’Hiv, they are all herded together in a facility with only ten lavatories (all of which were sealed to prevent escape) and one water tap.2 The sun coming through the glass skylight combined with the body heat from so many prisoners made it so unbearably hot that some committed suicide or went mad. Some Quakers, Red Cross workers, and a few doctors were allowed in but they could do little to relieve the suffering.2

Sarah escapes with a friend from the children’s section of
the internment camp with the help of a guard who had allowed her to keep an apple and her key during previous encounters. They run for their lives and finally arrive at a small cottage where an elderly couple refuses to take them in. They sleep with the dog and the next day, the man, seeing that her companion is desperately ill, gives them shelter. At first, he decides not to get medical aid because the town doctor is on holiday and his substitute is a collaborator. Finally, he does call the doctor who arrives with a German SS officer. The child dies of diphtheria. The German officer wants to know if there's anyone else there and the old man asks him if he would have called them if there were.

Sarah then convinces the couple to take her to Paris to check the apartment and to let her brother out of the closet. The film goes back and forth between the present and past focusing on journalist Julia Jarmond (Kristin Scott Thomas) who is writing an article about the Vél d'Hiv atrocity. Coincidentally her husband is related to the family that took over the apartment shortly after the Starzynskis were forcibly evicted and they are renovating it to live there. As Jarmond tries to learn what happened to Sarah and what her in-laws knew, the search leads her to Brooklyn, Florence, back to Paris, and then Manhattan. I'll leave it there but I will add that a friend who accompanied me to the screening said that the film reminded him of Sophie's Choice. He has a good point, especially with regard to the effects on Sarah of her well-meaning spontaneous decision and her survivor guilt.

The film is very well done. There is a lot of French dialogue with excellent subtitles in addition to the English, as well as a sprinkling of German and Italian (which are not translated). Scott-Thomas does a great job in tying together the many threads in the different storylines, and the girl playing Sarah is outstanding. The film could have been shortened, especially towards the end where it starts to drag to heighten the suspense about "surprises" that turn out not to be so surprising. The portrayal of Julia's husband Bertrand Tezac (Michel Duchaussoy) is rather hard to believe. His late hours and lack of attention to his wife while trying to close a deal with the Chinese are totally believable. What is not is his reaction to her happiness about being pregnant. After having gone through fertility treatments to have what they called "a miracle baby" and now having one naturally, his adamant stance on her having an abortion surprises the viewer as much as it does Julia.

Finally, the first scene in which Julia meets Sarah's son William Rainsford (Aidan Quinn) in Florence doesn't ring true, especially in contrast to their second meeting at the Tavern on the Green, which concludes the film. Whatever the case, these are minor flaws in a picture well worth seeing, especially since these tragic and heinous events are so little-known.

Addendum: The Vél d'Hiv round-up accounted for more than a quarter of the 42,000 Jews sent from France to Auschwitz in 1942, of whom only a little over 800 were said to have returned to France at the end of the war. It wasn't until 1995 that Jacques Chirac acknowledged the guilt of the French police for collaborating with the Germans and issued an apology.

References

Great Expectations (1946)
Starring Jean Simmons, John Mills, Francis L. Sullivan, Martita Hunt, Finlay Currie, Alec Guinness, and Valerie Hobson.

In June, Turner Classic Movies had a Jean Simmons retrospective and I taped this classic. Given the dearth of quality films in today's theaters, I decided to review it. Great Expectations, which was beaten out by Gentleman's Agreement for the 1947 Oscar for Best Picture, is another top drawer J. Arthur Rank production started off by their hardest-working employee striking the gong. The director is David Lean, who went on to direct such memorable films as Lawrence of Arabia, The Bridge on the River Kwai, Summertime, Doctor Zhivago,
and *A Passage to India*, among others. Lean and his co-screenwriters did an extraordinary job in distilling Dickens’ sprawling narrative and communicating the essential story without sacrificing the richness of the characters. It helped that the cast was a virtual Who’s Who of British character actors, many of whom had acted in previous adaptations of the book for the screen and stage. Though color was available, Lean wisely chose to film in black and white, just as Carol Reed did in filming *The Third Man* in 1949.

The book was the next-to-last of Dickens’ novels. At the time, Dickens was having problems sustaining his literary magazine *All The Year Round*. The author who had supplied him with two chapters of a novel each week for serialization had done great work, but this time his story was a dud and sales were down. So Dickens decided to use a story he had sketched out to publish elsewhere for bigger payments. Serializing novels often encouraged authors to pad the writing, especially when getting paid by the word. Yet with a writer of Dickens’ caliber, much of the filler enriches the characterization while stringing the reader along so he or she could not wait for the next installment. Dickens was so popular in the United States that some people waited at the dock to meet the ship from England to get the latest installment. This serialization ran from December 1, 1860, to August 3, 1861, allowing him to incorporate readers’ comments, including that of Edward Bulwer-Lytton, the author of *The Last Days of Pompeii*, who suggested that he change the original downbeat ending to a “more acceptable” one.1

Like the book, the film is narrated by the central character Philip Pirrip, Pip (Tony Wager), an orphan boy who is being raised by his sister, Mrs. Joe (Freda Jackson), and her husband, Joe Gargery (Bernard Miles), a blacksmith. The opening is one of the greatest scenes in cinematic history, which the Motion Picture Academy acknowledged by awarding the film Oscars for Best Cinematography and Art Direction. Pip is visiting the graves of his father and mother in the marsh country of England. It’s “a dark and stormy” night, the wind is howling, and a prison ship lies at anchor nearby. Suddenly, Pip is accosted by escaped convict Abel Magwitch, played with gruff menace by Finlay Currie (who would later portray a quite different character, Saint Peter, in *Quo Vadis*, another classic film). When Magwitch ascertains that the boy lives with a blacksmith nearby, he orders him to bring him a file to remove his leg irons, as well as “wittles” (victuals), or he will tear out his heart and liver, and roast and eat them.

When Pip returns home, he learns that his sister has been looking for him. She beats him with a switch, which she also administers to her husband (a classic spouse and child abuser). The next morning before daybreak, Pip sneaks out with a file, some brandy, victuals, and a pot pie. He is so fearful that he thinks he hears the cows and sheep calling out at his perfidy. He manages to see the convict, but not before he sees another escapee, a sworn enemy of Magwitch. After Magwitch is refreshed, the boy asks him if he wants to share the rest with his brother escapee. Magwitch flies into a rage and seeks out the other and, at the risk of being caught, he sets upon him. This easily allows the soldiers in a search party to apprehend them. Before Magwitch boards the boat, he makes sure to say that he stole the food so as to protect Pip.

Shortly thereafter, Pip’s Uncle Pumblechook (Hay Petrie) is asked by his landlady, the very eccentric Miss Havisham (Martita Hunt), if he knows of a boy who could play with her ward Estella (Jean Simmons). Miss Havisham has been living in the same house since she was jilted on her wedding day. All the clocks have stopped at twenty to nine and all the wedding trappings have been left as they were. This rejection engendered such an antipathy to men that her request that Pip come and play with her ward is part of her training Estella to break men’s
hearts. Simmons is excellent as the beautiful but malicious Estella, whom Pip describes as “proud,” “pretty,” and “insulting,” although he is mesmerized by her. When he confesses on the next visit that she is not as insulting, she slaps him and then asks what he thinks now. Later, she allows him to kiss her before turning him out. The visits continue until they reach fourteen, when Ms. Havisham sends Estella off to France for finishing school and Pip starts his apprenticeship with Joe, who, though illiterate and uneducated, is the noblest and most warmhearted character in the story.

Six years pass, when Miss Havisham’s lawyer, Mr. Jaggers, played with gusto by Francis L. Sullivan, arrives to tell Pip that he has “great expectations” in that an anonymous donor has set up a fund for him to be educated as a gentleman. The post horn sounds and a carriage sets off for London with the twenty-year-old Pip dressed up and wearing an expression of wonder as he embarks on this new adventure. The actor who played Pip as a child is replaced by a young John Mills, who went on to a long career in film and was the father of Hayley and Juliet Mills. He is a more fresh-faced tenderfoot than one would expect from someone who has worked as a blacksmith for six years.

Pip is reunited with Herbert Pocket (Alec Guinness), whom he had encountered at Miss Havisham’s. Herbert is now his roommate and unofficial mentor on manners and how an affluent dandy should act. As he absorbs those manners and an education, he becomes in his own words “a snob” who is embarrassed when Joe visits him in London. Despite feeling guilty at his shoddy treatment of Joe, Pip decides not to stay at his old home at the Forge on a visit, but at the Blue Boar Inn “where people of quality stay.”

Pip visits Miss Havisham who, he is convinced, is his benefactress. Miss Havisham tells him that “if Estella favors you, love her; if she tears your heart to pieces, love her.” Estella, who is back from France, re-enters his life in the person of actress Valerie Hobson, who is a distinct change from Jean Simmons. Although she’s still disdainful of the lovesick Pip, saying, “You meant nothing to me. You must know, Pip, I have no heart,” somehow she does not have the edge, haughtiness, and, yes, venom that Simmons conveyed. It’s almost like the game has lost its allure and she wants to protect him from herself. He still is attracted to her and tries to win her heart but she is betrothed to someone else. The story unfolds in a very interesting manner when the convicts re-enter the picture and provide new links to the principals. Let’s leave it there, except to say that the ending is even brighter than the book’s revised ending.

Maybe, like me, you’ll wonder what Miss Havisham’s room must have smelled like with the rats running around a place that had not seen the sun all those years while Pip and Estella were growing up. In a sense, it’s like those Gothic novels where you’re not supposed to really think very much about their absurdity and to just allow yourself to be caught up in the story and the performances. It’s easy to see how this captivated readers at the time, to be fed only two chapters and then be left like the old-time movie serials waiting for the next installment. The film is definitely worth putting on your Netflix list, and if you are inclined to read the book, you may wish as I did to locate a copy of the very beautifully read compact disc version. Be forewarned, though, it consists of sixteen discs.

References

Dr. Dans (ΩΩA, Columbia University College of Physicians and Surgeons, 1960) is a member of The Pharos’s editorial board and has been its film critic since 1990. His address is: 11 Hickory Hill Road Cockeysville, Maryland 21030 E-mail: pdans@comcast.net
We would see all of him:
the wisps of hair around his nipples,
the parachute valves inside his heart,
his guts, blooming from his abdomen.

We would open his kidney like a book
and find old pyramids and columns.
We would admire the tendons of his palm
as they fanned out toward manicured fingernails.

We would break into his joints,
and bend his knee to find
a thick rim of silver, gliding against
a translucent root, which was labeled: "ANT."

But on the first day, when we pulled off the cloth
(back then, it was still white)
and Tommy slid the blade
onto the stalk of the scalpel,

I looked down and found
my gloved hand resting on a pale forearm,
my thumb moving back and forth,
back and forth.

Emily Silverman

Ms. Silverman is a member of the Class of 2014 at the Johns Hopkins University School of Medicine. This poem won second prize in the 2011 Pharos Poetry Competition. Ms. Silverman's e-mail address is: ems7022@gmail.com.

Illustration by Erica Aitken.
Reviews and reflections

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

The Kitchen Shrink: A Psychiatrist’s Reflections on Healing in a Changing World
Dora Calott Wang, MD
New York, Penguin Group, 2010, 354 pages
Reviewed by Justin Taylor, MD (AΩA, University of New Mexico, 2009)

While the catchy title of this book will entice some to crack its cover, some others may overlook it because it appears to be a book solely about psychiatry. They don’t know what they are missing. This intelligent book by psychiatrist turned first-time author Dora Wang is actually less about psychiatry than it is about the American health care system. Psychiatry is simply a window for examining the system. Dr. Wang’s vivid memoir shares experiences from her medical training, career, and personal life as well as insights from the lives and stories of her patients to point out the changes that have occurred in medicine at the turn of the century.

The major theme of the book is driven by the story of a young patient that Dr. Wang cares for at the University of New Mexico Hospital. After the liver transplant service at the hospital closes permanently, Dr. Wang continues to follow transplant recipients as the team psychiatrist. One particular patient, a young girl named Selena, struggles with family issues and grief that impede her ability to adhere to her post-transplant medication regimen. Selena ends up in need of evaluation for another transplant, this time at a new hospital. Below is an excerpt showing the frustration that Dr. Wang faces when trying to schedule her patient for that evaluation.

Finally I resort to calling UCLA, where I first cared for transplant patients as a resident.

“I used to evaluate transplant patients at UCLA,” I tell their coordinator.

She is sympathetic, kind. “Your patient was just a child. We make allowances in cases like this. Our team would give her a second chance. But if the insurance company won’t pay, there’s nothing we can do.”

“So the insurance company decides? Not doctors, nurses, or the patient?”

“Basically,” she says, “there’s nothing we can do.”

Kaliani listens, watching me do this strange new work of a doctor.

By now it is too late, anyway. Beneath the ICU’s fluorescent lights, I read Selena’s flowsheet. Her creatinine is rising, meaning now her kidneys are also failing. The soft beeps of the green monitor screen tell me her heart no longer beats regularly.
I stand beside Selena's bed. I hold her jaundiced hand. Dr. Biro believes that expressing pain seems impossible, whether the paralyzing pain from ulcers spreading through the body can be measured or not.

Under the old fee-for-service system, there were abuses, of course, by physicians who overcharged and overtreated. However, the reasonable, ethical physician was in no jeopardy. The reasonable physician was compensated reasonably. Under the for-profit managed-care system, many reasonable physicians have found it impossible to survive.

Rather than continue to see more patients to try to break even, Dr. Wang decides to work for an institution where she can serve as an employee and leave the institution to deal with insurance companies. However, she soon learns that insurance companies that also own health care institutions are finding cheaper ways to practice medicine to make a profit. Then even the physician-owned institutions must do the same to compete. She relates how she was asked to see patients in less than fifteen minutes and how her patients no longer received their psychotherapy from her, but from psychologists and therapists. Thus, in order to cut costs, medicine has become more fragmented, less coordinated, and the patient-physician relationship has eroded.

The book is threaded with harrowing stories of some of the consequences for both physicians and patients of changes in the practice of medicine. Dr. Wang co-authored a paper demonstrating that one in five physicians working at medical schools in 2001 had significant symptoms of depression. She shares her personal battle with anxiety and the story of a colleague whose work contributed to her illness. She aptly explains how patients are also negatively affected, relating stories of her father’s poor medical management and the tragic murder of two Albuquerque police officers by a mentally ill man whom the health care system had failed to help. And of course, there is the story of Selena.

The Kitchen Shrink is a compelling and timely read, published in the midst of health care payment reform. Its narrative format and humor make it easy to read and the author’s positive outlook gives the reader hope. This memoir will provoke physicians to remain active members of the health policy debate and will, above all, remind us to consider the art of healing above the business of medicine.

Reference

Dr. Taylor is a 2011 graduate of the University of New Mexico School of Medicine, where he was the recipient of Alpha Omega Alpha honors in his junior year and the Gold-headed Cane award in his senior year. He is beginning Internal Medicine residency training at the Brigham and Women’s Hospital in Boston. His address is:

7 Alveston Street
Jamaica Plain, Massachusetts 02130
E-mail: jtaylor24@partners.org

Have you ever read The Decline and Fall of the Roman Empire, Doc?” my patient asked during our first encounter in the pain clinic. “Well,” he continued, “there was a story in the book about a woman that was flayed alive with sharpened oyster shells. That’s how my pain feels, day and night, like somebody shaving my skin off with oyster shells.”

This patient’s incredibly graphic description of chronic neuropathic pain, I learned after reading David Biro’s excellent book, The Language of Pain, was an example of an agency metaphor. This occurs when the patient likens his pain to some external agent acting against the patient’s body. Motivated to write this book after experiencing his own very painful illness, Biro, through examples from literature and art, describes the difficulties inherent in expressing pain and the manner in which metaphor is utilized to achieve this.

Pain cannot be measured with a blood test, imaged by an MRI, or adequately described by the analog pain scale which ranks pain on a scale of one through ten. Biro believes that expressing pain seems impossible, whether the paralyzing pain from ulcers spreading through the
gastrointestinal tract or the less debilitating kind caused by a blood clot in the eye. Patients, even physicians who become patients, find themselves tongue-tied, unsure how to begin—how to describe what feels so immediate and yet so intangible at the same time.\textsuperscript{p12–13}

Biro devotes the first part of this book to exploring the difficulties in describing pain and the effects that pain can have on the individual. He notes that pain is often a very private experience that isolates the sufferer from his world; an experience that cannot be known, shared, or understood by the nonsufferer. Of the many examples from the works of Oliver Sacks, Virginia Woolf, William Styron, and others that Biro uses to illustrate pain, his description of Harry, from Ernest Hemingway’s \textit{The Snows of Kilimanjaro}, conveys this concept most effectively. Describing a scene from the story in which Harry is contemplating his painful, gangrenous leg, the author writes

\begin{quote}
Harry’s connection to the world has been severed. He has retreated into the depths of his body, the only world that matters now. His girlfriend cannot penetrate that world; what is so overwhelmingly present for him is entirely absent for her. Nor can he convey what is happening inside him; language has become useless. Harry is alone.\textsuperscript{p24}
\end{quote}

The second and most prominent part of this book encompasses what Biro feels is the most effective and important means of communicating pain: the use of metaphor that

\begin{quote}
isn’t merely a rhetorical device that dresses up language but a powerful and necessary resource of the imagination that literally extends the boundaries of our shared world.\textsuperscript{p16}
\end{quote}

Biro notes that three different types of metaphors are commonly used to describe pain. The \textit{agency metaphor} is used when the pain sufferer imagines an agent acting upon the body. An example of this would be the description of pain as “like being cut with a knife” or having one’s skin flayed as noted above. Biro further describes a more elaborate version of agency that clinicians use regularly: the \textit{military metaphor}, which he attributes to Susan Sontag in her \textit{Illness as Metaphor}. He illustrates this by quoting a passage from Solzhenitsyn’s \textit{Cancer Ward}, in which the main character’s pain is described as “secondaries tearing his defenses to pieces like tanks.”\textsuperscript{p87} The agency metaphor is perhaps our most effective tool to describe pain.

A second type, the \textit{projection metaphor}, is used when the pain sufferer attempts to transfer his pain and feelings onto an object or an animal. As Harry becomes worse, finding himself unable to communicate his pain to his girlfriend, he imagines his pain in the form of one of the hyenas that had been stalking their camp. The ability to attribute one’s back pain to a prolapsed disc, whether or not this is the true pain generator, can be particularly validating, especially for the chronic pain sufferer who is made to believe that her pain is not real. In attributing pain to something else, the individual may also be able to infer meaning to the pain.

The third metaphor is the \textit{anatomic metaphor}, or what Biro describes as the use of metaphor to “make pictures of the body’s interior with words.”\textsuperscript{p180} Instead of projecting pain outside the body, it is projected inward in a manner that helps the sufferer better understand her pain. A common example of this is the arthritic who envisions his pain as “like rusty hinges or worn bearings. Biro’s most effective explanation of the anatomic metaphor is his description of Frida Kahlo’s famous self portrait, \textit{Broken Columns}. In this painting, the artist—who suffered a disabling spinal fracture as a youth—paints herself bisected in such a manner that the viewer sees her spine depicted as an Ionic column broken in several places.

As a physician with both a professional interest in pain and a personal interest in literature I found this very thoughtful book to be transformative in that I have a new appreciation of the importance of metaphor in not only communicating pain, but in describing it. This book is more about literature and language than medicine and, as such, can be bit daunting, especially to those of us who are more comfortable with \textit{Harrison’s Textbook of Medicine} than Hemingway. In rare instances, Biro’s prose became a bit ponderous and a bit repetitive. Nevertheless, I highly recommend this excellent book to any clinician who has struggled to understand the language of suffering and, particularly to understand the language of those who suffer with chronic pain.

Dr. Comerci is a professor of Internal Medicine at the University of New Mexico. He is the co-director of the UNM Center for Pain Assessment and Rehabilitation and the ECHO Telemedicine Pain Clinic. His address is:

\begin{itemize}
\item Department of Internal Medicine
\item Project ECHO: Chronic Pain and Headache Clinic
\item University of New Mexico
\item Albuquerque, New Mexico 87106
\item E-mail: gcomerci@salud.unm.edu
\end{itemize}

User-Driven Healthcare and Narrative Medicine: Utilizing Collaborative Networks and Technologies

Rakesh Biswas and Carmel Mary Martin
IGI Global, Hershey, Pennsylvania, 2010, 610 pages

Reviewed by: P. Ravi Shankar, MD

The doctor-patient relationship is a mainly unequal one, with the patient in a subordinate role, although changes have been slowly occurring around the world. In the case of medi-
user-driven health care, starting with a description of one patient’s struggle with idiopathic thrombocytopenic purpura and her journey to recover her health. The book uses conversations to explore various issues in medicine from a broader perspective. For too long I believe that we have been concentrating on the technical issues of illness and ignoring the personal, family, and social dimensions. Patient stories, the impact of their illnesses on self and family, and how patients coped or are coping is a major theme. I especially liked the chapter in which authors, using patient stories, explore critical illness and the emergency room. The book introduces the concept of patient journey record systems (PaJR), which examines illness and the struggle to regain health from the patient perspective.

Many chapters also explore the personal perspectives of doctors, health professionals, and medical students. Dr. A. K. Das writes beautifully about being a medical student and cardiothoracic surgeon in a government institution in Kolkata, India, and how they reused materials and equipment to reduce costs. The poor socioeconomic condition of the population in eastern India and how they could not afford basic health care and the implications of the loss/sickness of a working family member on family finances are powerfully described. An American physician reflects over seven decades of medical practice and describes the changes throughout the period. Today he abstracts articles from medical journals for the benefit of busy clinicians.

The book covers issues ranging from descriptive statistics, medical humanities, user-driven learning both in medicine and other subjects, on-line learning in discussion groups, on-line health education, developing community ontologies in user-driven health care, social networking, and the doctor-patient relationship. Patient perspectives in diseases ranging from spinal injury to cystic fibrosis are covered. I am not sure about whether some of the topics covered are strictly useful to understanding and within the domain of health care. While they provide a different perspective, they also make the book bulky and constitute more information for the reader. The book is hardbound, which presents for me a basic conflict about what kind of book it aspires to be. The personal stories are interesting and engaging and I feel are best read curled up comfortably in bed, while its size and weight makes that difficult! Some of the other chapters are full of theoretical constructions and concepts and are a traditional scholarly read.

The strength of the book lies in personal stories and stories (conversations) about how to interact with other doctors, health professionals, and patients, both face to face and using the Internet. The detailed table of contents at the beginning will help the reader decide which chapters to read and in which order. The compilation of references at the end, the contributors section, and the index are useful. The book caters to a wide range of readers, from physicians, other health personnel, patients, other academics, and interested lay readers. The editors are to be congratulated on their work and the publishers for their high standards. The publishers and the editors are publishing a journal titled *International Journal of User-Driven Healthcare* (http://www.igi-global.com/bookstore/titledetails.aspx?titleid=41022) to continue the debate and discussion on this interesting topic.

Dr. Shankar is a Professor of Medical Education at KIST Medical College in Lalitpur, Nepal. His address is: KIST Medical College P.O. Box 14142 Kathmandu, Nepal E-mail: ravi.dr.shankar@gmail.com
Mom was insistent:
Don’t live this way. Just fix it.
Deep within me I cried, I am not broken
but nobody could hear.
Pressing a hand to my ear, I felt
the hardness of my hearing aid, nestled snugly
in its canal, smugly mocking:
fix it, fix it.

My ear was fixed quickly by steady hands
that brushed swiftly past the curtain of my membrane
and entered the domain of ossicles that had turned to stone.
The scalpel spoke sharply
but scarred ossicles could not vibrate.
A titanium incus was set lovingly in its place
like the final piece of a puzzle,
Or the last block on a precarious tower of Jenga.

I woke up to a world where sirens blare
and people scream secrets into cell phones.
Everyone hears the nasty rumors whispered in lecture halls,
But they leave school and suddenly they are deaf
to shouted pleas: “Can you spare a little change?”
that follow them on the walk to the subway.

This 20 decibel gift given to my ears
has opened my eyes. The world is less kind than I knew.
Honking cars and intermittent curses
set the beat for the 5 o’clock symphony
of clicking heels, trains that clatter across tracks and into the station.
I listen to the sounds of the sad city I love
but never really knew,
And my gleaming incus pulses in time with my heart:
fix it, fix it.

Krishna Sury

Ms. Sury is a member of the Class of 2013 at the State University of New York Downstate Medical Center College of Medicine. This poem won honorable mention in the 2011 Pharos Poetry Competition. Ms. Sury’s e-mail address is krishna sury@yahoo.com.
Letters to the editor

Re: “Community-acquired pneumonia”

Kudos to Drs. Lorber and Fekete for pointing out the inanity of the term CAP (Spring 2011, pp. 19–21). For years I have tried unsuccessfully to teach our residents not to use the term, but to think in terms of the etiology of the infection. However, given the endorsement of the term CAP by both the IDSA and the ATS we have little chance of eliminating it from the lexicon. In most cases they use the term CAP in place of pneumococcal pneumonia (the most common cause of pneumonia in adult civilians), because they never attempt to isolate a pathogen from the sputum. As the authors point out, clinical microbiology has been sadly devalued by hospital administrators, who outsource the work, and most physicians, who don’t order the tests. One of the consequences of not making an etiologic diagnosis is the reliance on broad spectrum antibiotics, and this is one practice that drives the current epidemic of antibiotic resistance. It also contributes to the shockingly high incidence of nosocomial *Clostridium difficile* infections.

The authors also point out that there is an overuse of broad spectrum antibiotics for anyone admitted with a respiratory complaint. This is in response to the standard imposed by the Joint Commission, that “initial antibiotic be received within six hours of hospital arrival” (the previous standard was four hours). However, I disagree with the authors that there are studies that provide a rationale for this practice. In the article they cite,1 the graph relating time of administration to outcome is very revealing; the group with the highest mortality was the one that received antibiotics within one hour of arrival. The most likely explanation is that the sickest people got treated fastest, and of course were the most likely to die. Similar confounders are almost certainly at work for those whose therapy was delayed. Observational studies such as this one can never establish causality, only associations. This is a very weak reed to support a national health care policy with many unintended consequences.

I can only hope that in the future hospitals will be required to have microbiology laboratories as part of accreditation and that physicians will again learn to turn to the laboratory to help them to diagnose and treat this group of patients rationally. Laboratories really can diagnose pneumococcal pneumonia if they get sputum from the patient before antibiotics are started. That will not always be possible, but it is a goal.

Reference


Joshua Fierer, MD, FIDSA
(AΩA, New York University, 1963)
University of California, San Diego,
School of Medicine
VA Healthcare San Diego
E-mail: jfierer@ucsd.edu

I understand and fully support the point made by Drs. Lorber and Fekete in their article on community-acquired pneumonia (Spring 2011, pp. 19–21), which suggests that the term is so broad and nonspecific that it under-mines the thoughtful investigation of the individual patient. However, I would be remiss if I did not point out that the authors fall into exactly the same trap when they observe that the patient had a “left mid-lung infiltrate.” In fact, this patient has a cavitary lesion in the superior segment of the left lower lobe with an associated left pleural effusion. Those observations, had they been made, would have strongly suggested the correct diagnosis of *Mycobacterium tuberculosis* infection at the time of the initial X-ray examination. Failure to correctly characterize the “infiltrate” allowed the physicians caring for this patient to proceed down the wrong track. I would strongly suggest that, had the film been reviewed by a trained, experienced physician, the correct diagnosis would have been made at the outset and the patient’s subsequent complicated course potentially avoided. Failure to appreciate the precise location of the abnormality (superior segment of the left lower lobe), the fact that it was cavitory with an air fluid level within it, and the presence of an associated left pleural effusion is almost unforgiveable. Reliance on a generic description such as “left mid-lung infiltrate” is simply too imprecise and leads to the same kinds of errors as lumping all pneumonias into the “community-acquired pneumonia” category creates. As the authors point out, “language matters,” as does the need to fully appreciate the abnormalities so clearly demonstrated on the initial chest radiograph.

Carl E. Ravin, MD
(AΩA, elected as faculty, Duke University, 1986)
Duke University Medical Center
Durham, North Carolina
E-mail: carl.ravin@duke.edu
2010/2011 Administrative Recognition Awards

This award recognizes the AΩA chapter administrators who are so important to the functioning of the chapter. The nomination is made by the councilor or other officer of the chapter. A gift check is awarded to the individual, as well as a framed Certificate of Appreciation.

The following awards were made in 2010/2011:

GEORGIA
Mercer University School of Medicine
Elaine Pergerson

KANSAS
University of Kansas School of Medicine
Laura Zeiger

MASSACHUSETTS
Tufts University School of Medicine
Mary Broderick

MINNESOTA
Mayo Medical School (Association)
Barbara Westmoreland

NEW YORK
University at Buffalo State University of New York School of Medicine & Biomedical Sciences
Jacklyn T. Ulinski Good

NORTH CAROLINA
University of North Carolina at Chapel Hill School of Medicine
Sharon Windsor

OHIO
Ohio State University College of Medicine
Eileen Mehler

SOUTH DAKOTA
Sanford School of Medicine The University of South Dakota
Mary Sutter

VIRGINIA
Virginia Commonwealth University School of Medicine
Sandra Sorrell

2010/2011 Medical Student Service Project awards

Begun in 1993 as the Chapter of the Year award, this program was intended to recognize outstanding contributions made by an AΩA chapter. In 1997, the program became the AΩA Chapter Development Award, aimed at encouraging ongoing original and creative programs being carried out by AΩA chapters. In 2003, the program again changed to the AΩA Medical Student Service Project Award, available to any student or group of students at a school with an active AΩA chapter.

Medical Student Service Projects funded by AΩA during the 2010/2011 school year were:

ALABAMA
University of South Alabama College of Medicine
Health and Screening Fair (Katrina)

CALIFORNIA
University of California, Davis, School of Medicine
LGBT Psych-Ed Support at Sacramento Mental Health Clinic

INDIANA
Indiana University School of Medicine
Taking Root in the Community: Beginning of a Lifelong Journey of Serving Others

MARYLAND
Johns Hopkins University School of Medicine
Wolfe Street Roots & Shoots (multiple projects)

MASSACHUSETTS
Tufts University School of Medicine
Educating local hair stylists on recognizing suspicious skin lesions as possibly cancer of the head or neck

MINNESOTA
Mayo Medical School
Winter Warmth Festival (second year)

NEW JERSEY
University of Medicine and Dentistry of New Jersey—New Jersey Medical School
Healthy Awareness: Promoting disease prevention in Newark, New Jersey

NEW MEXICO
University of New Mexico School of Medicine
Spring Giving Tree

NEW YORK
Columbia University College of Physicians and Surgeons
Columbia University Stay Shady! Program
New York University School of Medicine
Improving Attitudes and Behaviors Among Patients of Low Health Literacy Through a Novel Health Education Literacy Program
University of Rochester School of Medicine and Dentistry
SNACKS (Serving Nutritious and Appetizing Cuisine to the Kin of the Sick)

NORTH CAROLINA
University of North Carolina at Chapel Hill School of Medicine
UNC Craniofacial Center—Spanish Resources (second year)

OHIO
Case Western Reserve University School of Medicine
AΩA Research Experience—Connecting Local Cleveland High Schools to Local Researchers
Ohio State University College of Medicine
The Buckeye Blanket Bash
Wright State University Boonshoft School of Medicine
Community Collaborative Spring Food Drive (second year)

 PENNSYLVANIA
Jefferson Medical College of Thomas Jefferson University
Refugee Health Partners (second year)
Drexel University College of Medicine
Accessibility Adventure Day (second year)

SOUTH CAROLINA
University of South Carolina School of Medicine
SNMA—Secondary School Health Science Collaborative

TEXAS
The University of Texas School of Medicine at San Antonio
BEST (Breastfeeding Education and Support for Teenage mothers) (second year)
University of Texas Southwestern Medical Center at Dallas Southwestern Medical School
Syringe Disinfection Volunteer Program

VERMONT
University of Vermont College of Medicine
SAT Preparatory Course for HS Students from Refugee or Underprivileged Families in Winooski, Vermont

WEST VIRGINIA
West Virginia University School of Medicine
CHASM (Charleston Homeless And Street Medicine)
West Virginia University School of Medicine CHASM (Charleston Homeless And Street Medicine)
The Alpha Omega Alpha Volunteer Clinical Faculty Award is presented annually by local chapters to recognize community physicians who have contributed with distinction to the education and training of medical students. AOA provides a permanent plaque for each chapter’s dean’s office; a plate with the name of each year’s honoree may be added each year that the award is given. Honorees receive framed certificates. The recipients of this award in the 2010/2011 academic year are listed below.

ALABAMA
University of South Alabama College of Medicine
Charles Scott Markle, MD

CALIFORNIA
University of California, San Francisco, School of Medicine
Elizabeth Kantor, MD

DISTRICT OF COLUMBIA
George Washington University School of Medicine and Health Sciences
Peter A. Moskovitz, MD

FLORIDA
University of Miami Leonard M. Miller School of Medicine
Raul de Velasco, MD

GEORGIA
Morehouse School of Medicine
Jose O. Rodriguez, MD, MBA, FAAP

HAWAII
University of Hawaii, John A. Burns School of Medicine
Melvin Palalay, MD

ILLINOIS
Chicago Medical School at Rosalind Franklin University of Medicine & Science
Matthew Nash, MD

INDIANA
Indiana University School of Medicine
Mark M. Walsh, MD

IOWA
University of Iowa Roy J. and Lucille A. Carver College of Medicine
Andrea Venteicher, MD

KANSAS
University of Kansas School of Medicine
Christopher Brunner, MD

KENTUCKY
University of Louisville School of Medicine
Carlos Ramirez-Icaza, MD

LOUISIANA
Louisiana State University School of Medicine in New Orleans
Edward Lafleur, MD
Louisiana State University School of Medicine in Shreveport
Sherry L. Ryan, MD

MARYLAND
University of Maryland School of Medicine
John C. Perkins, MD

MASSACHUSETTS
University of Massachusetts Medical School
George Abraham, MD, MPS, FACP

MICHIGAN
University of Michigan Medical School
John D. Segall, MD

MINNESOTA
University of Minnesota Medical School
Michael Cady, MD

NEBRASKA
University of Nebraska College of Medicine
Dennis Jones, MD

NEW JERSEY
University of Medicine and Dentistry of New Jersey—New Jersey Medical School
Mario Capio, MD
University of Medicine and Dentistry of New Jersey—Robert Wood Johnson Medical School
Larnie Booker, MD

NEW YORK
Mount Sinai School of Medicine
Michael Silverstein, MD
New York Medical College
Michaela Mocanu, MD
New York University School of Medicine
Elizabeth K. Hale, MD
State University of New York Downstate Medical Center College of Medicine
Jacob Dimant, MD
University of Rochester School of Medicine and Dentistry
Benson Zoghlin, MD
Weill Cornell Medical College
Jason Kendler, MD

NORTH DAKOTA
University of North Dakota School of Medicine and Health Sciences
Patrick Welle, MD

OHIO
Ohio State University College of Medicine
Patricia Litts, MD
University of Cincinnati College of Medicine
Barry Brooks, MD

PENNSYLVANIA
Drexel University College of Medicine
James Reilly, MD
Jefferson Medical College of Thomas Jefferson University
Michael Belden, MD
University of Pittsburgh School of Medicine
Kenneth Dzialowski, MD

SOUTH CAROLINA
Medical University of South Carolina College of Medicine
Margaret Murphy, MD
University of South Carolina School of Medicine
William M. Moore, Jr., MD

TENNESSEE
Meharry Medical College
Ugo Nwachuku, MD
Vanderbilt University School of Medicine
Tony Ross, MD

TEXAS
University of Texas Medical School at Houston
Ronald W. Kirkwood, DO
University of Texas Southwestern Medical Center at Dallas Southwestern Medical School
Rebekah A. Naylor, MD

WASHINGTON
University of Washington School of Medicine
Roger Rowles, MD

WEST VIRGINIA
West Virginia University School of Medicine
Brian A. Plants, MD

2010/2011 Volunteer Clinical Faculty Awards
Beginning in 2002, Alpha Omega Alpha's board of directors offered every chapter the opportunity to host a visiting professor. Fifty chapters took advantage of the opportunity during the 2010/2011 academic year to invite eminent persons in American medicine to share their varied perspectives on medicine and its practice.

Following are the participating chapters and their visitors.

**ALABAMA**
- University of Alabama School of Medicine
  - J. Bruce Beckwith, MD, Loma Linda University School of Medicine

**ARKANSAS**
- University of Arkansas for Medical Sciences College of Medicine
  - John Holcomb, MD

**CALIFORNIA**
- University of California, Los Angeles David Geffen School of Medicine
  - Julie Freischlag, MD, Johns Hopkins Medicine
- Loma Linda University School of Medicine
  - Darrell Kirch, MD, Association of American Medical Colleges

**DISTRICT OF COLUMBIA**
- George Washington University School of Medicine and Health Sciences
  - Edward J. O’Neil, Jr., MD, Tufts University School of Medicine

**FLORIDA**
- University of Miami Leonard M. Miller School of Medicine
  - Lewis Goldfrank, MD, New York University
- University of South Florida College of Medicine
  - Ary L. Goldberger, MD, Harvard Medical School

**GEORGIA**
- Morehouse School of Medicine
  - Juanita L. Merchant, MD, PhD, University of Michigan

**ILLINOIS**
- University of Chicago Division of the Biological Sciences The Pritzker School of Medicine
  - L.D.H. Wood, MD, PhD, University of Chicago (emeritus)
- Loyola University Chicago Stritch School of Medicine
  - John Callaghan, MD, University of Iowa

**LOUISIANA**
- Louisiana State University School of Medicine in New Orleans
  - Lewis Goldfrank, MD, New York University
- Louisiana State University School of Medicine in Shreveport
  - Thomas J. Nasca, MD, MACP, Accreditation Council for Graduate Medical Education

**MARYLAND**
- Johns Hopkins University School of Medicine
  - Richard Schurick, MD, Johns Hopkins University School of Medicine

**MASSACHUSETTS**
- Tufts University School of Medicine
  - Joseph E. Scherger, MD, MPH, Eisenhower Medical Center

**MICHIGAN**
- University of Michigan Medical School
  - Allan M. Brandt, PhD, Harvard University

**MINNESOTA**
- University of Minnesota Medical School
  - Timothy Quill, MD, University of Rochester School of Medicine and Dentistry

**MISSOURI**
- University of Missouri—Columbia School of Medicine
  - Douglas Wood, MD, Mayo Clinic
- University of Missouri—Kansas City School of Medicine
  - Jonathan Metzl, MD, PhD, Vanderbilt University School of Medicine

**NEBRASKA**
- Creighton University School of Medicine
  - Oliver J. Harper, MD
- University of Nebraska College of Medicine
  - John Frey, MD, University of Wisconsin School of Medicine

**NEW JERSEY**
- University of Medicine and Dentistry of New Jersey—New Jersey Medical School
  - Lawrence C. Parish, MD, MD (Hon), Jefferson Medical College

**NEW YORK**
- Albany Medical College
  - Sue Goldie, MD, MPH, Harvard School of Public Health
- Columbia University College of Physicians and Surgeons
  - David Valle, MD, Johns Hopkins University School of Medicine
- Mount Sinai School of Medicine
  - Joseph Loscalzo, MD, PhD, Brigham and Women's Hospital
- New York Medical College
  - Molly Cooke, MD, University of California, San Francisco, School of Medicine
- State University of New York Downstate Medical Center College of Medicine
  - Hugh E. Evans, MD, New Jersey Medical School
- State University of New York Upstate Medical University
  - Lewis First, MD, University of Vermont College of Medicine
- The School of Medicine at Stony Brook University Medical Center
  - Edward J. Benz Jr., MD, Dana-Farber Cancer Institute, Harvard Medical School
- University at Buffalo State University of New York School of Medicine & Biomedical Sciences
  - Seymour Schwartz, MD

**NORTH CAROLINA**
- Wake Forest University School of Medicine
  - James Wilkins, MD
- Penn State Milton S. Hershey Medical Center College of Medicine
  - Daniel Dempsey, MD, FACS, Penn State Milton S. Hershey Medical Center College of Medicine

**OHIO**
- Ohio State University College of Medicine
  - Perri Klass, MD, New York University

**PENNSYLVANIA**
- Jefferson Medical College of Thomas Jefferson University
  - Richard G. Roberts, MD, JD, FAAFP, FCLM, University of Wisconsin School of Medicine and Public Health
- Temple University School of Medicine
  - Barbara Bass, MD, FACS, The Methodist Hospital Department of Surgery
- Penn State Milton S. Hershey Medical Center College of Medicine
  - Daniel Dempsey, MD, FACS, Penn State Milton S. Hershey Medical Center College of Medicine

**PUERTO RICO**
- Ponce School of Medicine and Health Sciences
  - Blanca Durand, MD, Ponce School of Medicine and Health Sciences
- Universidad Central del Caribe School of Medicine
  - Daniel Schidlow, MD, Drexel University College of Medicine
- University of Puerto Rico School of Medicine
  - Debbie Salas-Lopez, MD, Chair, Lehigh Valley Health Network

**RHODE ISLAND**
- The Warren Alpert Medical School of Brown University
  - Ezekiel Emanuel, MD, PhD

**SOUTH CAROLINA**
- Medical University of South Carolina College of Medicine
  - Nathan Thielenman, MD, Duke Global Health Residency Program
- University of South Carolina School of Medicine
  - Darrell Kirch, MD, Association of American Medical Colleges

**SOUTH DAKOTA**
- Sanford School of Medicine The University of South Dakota
  - David Mutch, MD, Washington University School of Medicine

---

**2010/2011 Visiting Professorships**

The following chapters and their visitors:

- **ALABAMA**
  - University of Alabama School of Medicine
    - J. Bruce Beckwith, MD, Loma Linda University School of Medicine
- **ARKANSAS**
  - University of Arkansas for Medical Sciences College of Medicine
    - John Holcomb, MD
- **CALIFORNIA**
  - University of California, Los Angeles David Geffen School of Medicine
    - Julie Freischlag, MD, Johns Hopkins Medicine
  - Loma Linda University School of Medicine
    - Darrell Kirch, MD, Association of American Medical Colleges
- **DISTRICT OF COLUMBIA**
  - George Washington University School of Medicine and Health Sciences
    - Edward J. O’Neil, Jr., MD, Tufts University School of Medicine
- **FLORIDA**
  - University of Miami Leonard M. Miller School of Medicine
    - David T. Stern, MD, Mount Sinai School of Medicine
  - University of South Florida College of Medicine
    - Ary L. Goldberger, MD, Harvard Medical School
- **GEORGIA**
  - Morehouse School of Medicine
    - Juanita L. Merchant, MD, PhD, University of Michigan
- **ILLINOIS**
  - University of Chicago Division of the Biological Sciences The Pritzker School of Medicine
    - L.D.H. Wood, MD, PhD, University of Chicago (emeritus)
  - Loyola University Chicago Stritch School of Medicine
    - John Callaghan, MD, University of Iowa
- **LOUISIANA**
  - Louisiana State University School of Medicine in New Orleans
    - Lewis Goldfrank, MD, New York University
  - Louisiana State University School of Medicine in Shreveport
    - Thomas J. Nasca, MD, MACP, Accreditation Council for Graduate Medical Education
- **MARYLAND**
  - Johns Hopkins University School of Medicine
    - Timothy B. Johnson, MD, University of Michigan Medical School
  - University of Maryland School of Medicine
    - Arnold Relman, MD, Harvard Medical School
- **MASSACHUSETTS**
  - Tufts University School of Medicine
    - Richard Schurick, MD, Johns Hopkins University School of Medicine
- **MICHIGAN**
  - University of Michigan Medical School
    - Allan M. Brandt, PhD, Harvard University
- **MINNESOTA**
  - University of Minnesota Medical School
    - Timothy Quill, MD, University of Rochester School of Medicine and Dentistry
- **MISSOURI**
  - University of Missouri—Columbia School of Medicine
    - Douglas Wood, MD, Mayo Clinic
  - University of Missouri—Kansas City School of Medicine
    - Jonathan Metzl, MD, PhD, Vanderbilt University School of Medicine
- **NEBRASKA**
  - Creighton University School of Medicine
    - Oliver J. Harper, MD
  - University of Nebraska College of Medicine
    - John Frey, MD, University of Wisconsin School of Medicine
- **NEW JERSEY**
  - University of Medicine and Dentistry of New Jersey—New Jersey Medical School
    - Lawrence C. Parish, MD, MD (Hon), Jefferson Medical College
- **NEW YORK**
  - Albany Medical College
    - Sue Goldie, MD, MPH, Harvard School of Public Health
  - Columbia University College of Physicians and Surgeons
    - David Valle, MD, Johns Hopkins University School of Medicine
  - Mount Sinai School of Medicine
    - Joseph Loscalzo, MD, PhD, Brigham and Women's Hospital
  - New York Medical College
    - Molly Cooke, MD, University of California, San Francisco, School of Medicine
  - State University of New York Downstate Medical Center College of Medicine
    - Hugh E. Evans, MD, New Jersey Medical School
  - State University of New York Upstate Medical University
    - Lewis First, MD, University of Vermont College of Medicine
  - The School of Medicine at Stony Brook University Medical Center
    - Edward J. Benz Jr., MD, Dana-Farber Cancer Institute, Harvard Medical School
  - University at Buffalo State University of New York School of Medicine & Biomedical Sciences
    - Seymour Schwartz, MD
- **NORTH CAROLINA**
  - Wake Forest University School of Medicine
    - James Wilkins, MD
  - Penn State Milton S. Hershey Medical Center College of Medicine
    - Daniel Dempsey, MD, FACS, Penn State Milton S. Hershey Medical Center College of Medicine
- **OHIO**
  - Ohio State University College of Medicine
    - Perri Klass, MD, New York University
- **PENNSYLVANIA**
  - Jefferson Medical College of Thomas Jefferson University
    - Richard G. Roberts, MD, JD, FAAFP, FCLM, University of Wisconsin School of Medicine and Public Health
  - Temple University School of Medicine
    - Barbara Bass, MD, FACS, The Methodist Hospital Department of Surgery
  - Penn State Milton S. Hershey Medical Center College of Medicine
    - Daniel Dempsey, MD, FACS, Penn State Milton S. Hershey Medical Center College of Medicine
- **PUERTO RICO**
  - Ponce School of Medicine and Health Sciences
    - Blanca Durand, MD, Ponce School of Medicine and Health Sciences
  - Universidad Central del Caribe School of Medicine
    - Daniel Schidlow, MD, Drexel University College of Medicine
  - University of Puerto Rico School of Medicine
    - Debbie Salas-Lopez, MD, Chair, Lehigh Valley Health Network
- **RHODE ISLAND**
  - The Warren Alpert Medical School of Brown University
    - Ezekiel Emanuel, MD, PhD
- **SOUTH CAROLINA**
  - Medical University of South Carolina College of Medicine
    - Nathan Thielenman, MD, Duke Global Health Residency Program
  - University of South Carolina School of Medicine
    - Darrell Kirch, MD, Association of American Medical Colleges
- **SOUTH DAKOTA**
  - Sanford School of Medicine The University of South Dakota
    - David Mutch, MD, Washington University School of Medicine
The Board of Directors of Alpha Omega Alpha is pleased to announce the winner of the 2011 Edward D. Harris Professionalism Award. The award emphasizes AΩΑ’s commitment to its belief that professionalism is a crucial facet of being a physician, a quality that can be both taught and learned. Originally named the AΩΑ Professionalism Fellowship, the award has been renamed to honor Edward D. Harris, the long-time executive director of the society, who died in May 2010. Applications were open to medical schools with active AΩΑ chapters. Faculty who have demonstrated personal dedication to teaching and research in specific aspects of professionalism that could be transferred directly to medical students or resident physicians were encouraged to apply for these funds.

The winner of the 2011 Edward D. Harris Professionalism Award is:

Paul Haidet, MD, MPH
Director of Medical Education Research, Penn State Milton S. Hershey Medical Center College of Medicine

Dr. Haidet received $30,000 funding for his project, “Promoting Professionalism Through Reflective Practice and Identity Formation.”

A large body of research suggests that medical learners change during their training in response to the organizational culture, or “hidden curriculum,” of medical environments. Documented changes include erosion of altruism, humanism, patient-centeredness, and advocacy. Further, evidence suggests that some physicians discard moral values in order to accomplish specific management tasks.

Reflective practice offers a solution to the hidden curriculum’s deleterious effects. While trainees may make sound choices when given time and a safe environment to reflect on professional dilemmas, clinical settings, in contrast, are fast paced, hierarchical, and emotionally charged. In order to be reflective practitioners, trainees and physicians need to build capacity to reflect in action, accessing their own values and creativity while at the same time making choices within the constraints of a given clinical environment. While many medical schools and residency programs have built structures to foster reflection, these structures are often aimed at reflecting after the fact, rather than in real time at the point of care. This program aims to address this gap by implementing a curriculum that will build trainees’ capacity to reflect in action in real-world clinical environments.
Her white cap created my white coat
Nursing was her music of healing
I marveled at the strains that drifted from her maternal hands
Never guessing my future would require similar notes of feeling

She was beside me when the letter came
Granting the privilege to practice her song
Though in a different key with several extra notes
I prayed to play it half as strong

Unexpectedly, melody gave way to dissonance
Cellular rebellion silenced the beat of her heart
Though it seemed that science triumphed over spirit
The chaos of cancer did not silence her part

For we have always known the Composer of life's symphony
Ever trusting His timing and decision
For twenty-six years I was her understudy
Now I’m the musician

Sarah Rapp

Ms. Rapp is a member of the Class of 2012 at the University of Texas Medical School at Houston. This poem won honorable mention in the 2011 Pharos Poetry Competition. Ms. Rapp’s e-mail address is sarah.e.rapp@uth.tmc.edu.
Gifts to 
Alpha Omega Alpha

ΛΩΛ is pleased to announce two generous gifts to the society.

In the memory of Ted Harris, late executive director of the society and editor of *The Pharos*, the Edward D. Harris Jr. Family has donated $10,000 to support the Edward D. Harris Professionalism Award.

In the memory of late ΛΩΛ member Dr. William Gary Giles, his widow Dr. Hannelore Giles has made a $500,000 charitable remainder trust gift to the Alpha Omega Alpha chapter of the Louisiana State University in New Orleans.