"All Star Operation"

Dr. Halsted - operating
Dr. Finney - 1st assistant
Dr. Cushing - 2nd assistant
Dr. Bloodgood - 3rd assistant

Miss Hampton - operating nurse

Johns Hopkins Hospital
Dr. Young - instruments
Dr. Mitchell - anaesthetist
Dr. Follis - leaving
Dr. Bectje - seated
Alpha Omega Alpha Honor Medical Society
Founded by William W. Root in 1902

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“Be Worthy to Serve the Suffering”
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The making of a Harvey Cushing, Halstedian technique, and the birth of a specialty

Courtney Pendleton, MD, and Alfredo Quiñones-Hinojosa, MD
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Harvey Cushing, the founder of American neurosurgery, began his career as an assistant surgical resident and then as a senior surgical resident at the Johns Hopkins Hospital under the supervision of Dr. William Stewart Halsted. Examination of Hopkins’ surgical files throughout Cushing’s four-year general surgical residency under Halsted shows how he developed the experience, vision, and operative skills he needed to transform neurosurgery into a successful subspecialty during the early twentieth century.1–4

As the demands of subspecialty surgical training increase, and the length of general surgical training decreases, it is worthwhile to reflect on the important role of broad general surgical education in the early development of a surgical subspecialty in the United States.

Structured surgical training programs grew out of an early desire to distinguish tradesmen barber-surgeons from academically trained professionals. In Paris in the thirteenth century, the College de Saint Come identified the two groups by coat length, those with the most formal training having the longest coats.5 This separation of trained versus untrained gave way to the establishment of formal apprenticeships in the sixteenth century.5 Apprenticeships provided...
hands-on training, with an experienced surgeon providing longitudinal mentorship for the young apprentice, and in many fundamental ways forms the basis for contemporary surgical residency training.

In the late nineteenth and early twentieth centuries, as hospitals established themselves as centralized sources of medical care, the need for a more structured training system grew. This new system was first proposed by Sir William Osler at the Johns Hopkins Hospital, although it is William Stewart Halsted who is most often credited with its inception at Hopkins in 1889 and its adoption throughout the United States and Europe soon thereafter.

Halsted's residency training bore great similarities to the apprenticeship model. It was pyramidal, similar to the training programs in Germany where Halsted had studied. The program had as its hallmark stepped responsibility for the residents depending on both experience and successful performance of clinical tasks, and weeded out residents who did not continue to progress during training. This structure ensured that residents continuing through training had extensive experience in the operating theater as well as the wards, but its main drawback was that a percentage of residents had to leave the program with too much training to pursue an alternative career and not enough training to be safe and successful practicing surgeons.

The Hopkins program placed strong emphasis on performing surgery safely, according to the Halstedian method. The Halstedian principles of aseptic operative technique, careful handling of delicate tissues, meticulous hemostasis, and approximation of tissues with minimal tension using multilayered closures were thoroughly emphasized.

Under Halsted's guidance, Cushing learned the fundamentals for improving surgical outcomes, as well as the importance of thoughtful, evidence-based medicine. In his 1905 address on neurological surgery, Cushing offered his perspective on both the role of broad surgical training and the need for further specialization:

granting the wisdom and necessity of a general surgical training beforehand, I do not see how such particularization...
of work can be avoided, if we wish more surely and progressively to advance our manipulative therapy.2

Thus it may be said that the clinical training and emphasis on the concept of the physician-scientist that Cushing received during his four years with Halsted undoubtedly provided him with the skills necessary to pursue any surgical endeavor, and certainly contributed to the success of his chosen field of neurological surgery.

Following approval from our institutional review board, and through the courtesy of the Alan Mason Chesney Archives, we reviewed the surgical cases from Cushing’s year as Halsted’s assistant surgical resident (1896–1897), as well as cases conducted during his time as Halsted’s senior surgical resident (1897–1900) and those conducted as a young attending specializing in neurosurgery (1901–1912). Except where otherwise indicated, quotations regarding these cases are taken verbatim from Cushing’s original unpublished surgical notes. These files document the apprentice model of training proposed by Osler and Halsted,5,6,7,10 and illustrate the role that general surgical experience played in Cushing’s development as a surgical trainee and physician-scientist.

Only the lead surgeon was recorded consistently in the surgical record operative notes, with the first assistant or resident in attendance only sporadically documented. The hospital records thus do not thoroughly document Cushing’s early presence in the operating room under Halsted’s supervision. The earliest record of Cushing as a participant is dated November 27, 1896. At this time, a twenty-two-year-old woman presented with tuberculosis of the skin along her jaw. Cushing is listed as the surgeon of record, and the brief operative note describes the procedure, conducted under local cocaine anesthesia:


The patient was discharged on December 1, 1896; no further follow-up was available.

It is interesting that here, in Cushing’s first case as the lead surgeon, the operative note refers to Cushing by name. Although the majority of the roughly 1100 operative notes reviewed were written in the third person, Cushing typically omitted agency or referred to himself as “the operator.” This is the only note in which he refers to himself by name. Operative notes were not customarily typewritten before about 1900. Thus a comparison of handwritten notes initialed by Cushing with the operative note for this particular case shows that it was written by Cushing rather than Halsted. The unusual reference to himself as operator may reflect pride at being the lead surgeon for the first time, months of previous experience documenting operations conducted by other surgeons, or close supervision in this case by Halsted, both in the operating theater and in post-operative chart documentation.

Cushing quickly progressed to more complex cases. On December 13, 1896, a sixteen-year-old woman employed in a shirt factory presented with “ingrowing toenails.” She was brought to the operating room on December 14, 1896, where Cushing excised the toenails. His hand-drawn illustration from the surgical chart and the detailed operative note document the procedure:

A double cutting done on the left, the bad toe, nail not removed. A generous slice of tissue removed. On the right foot a simple excision of granulating area, removing ⅛” of the nail and matrix back to the neighborhood of the distal joint. Wound closed.

Cushing’s original illustration of an ingrown left toenail, his second operative procedure during his year as assistant surgical resident under Halsted.

Courtesy of the Medical Records Office and the Alan Mason Chesney Medical Archives of Johns Hopkins Institutions.
The post-operative chart documentation is in Cushing's handwriting, and indicates that he performed his own dressing changes. This is not surprising given Halsted's expectations for the residents, as well as Cushing's own dissatisfaction with the surgical staff's attention to detail. Shortly after the operation, Cushing documented marked improvement in the patient's condition: "Toes doing well—Been up and walking about for 48" [sic: minutes] & discomfort." This rather simple procedure was Cushing's second performance as a resident operating independently, and would certainly have been a source of pride for the young surgeon.

Halsted was not the type of mentor to allow trainees to rest on their laurels. Cushing would have been expected to expand his experience to include increasingly complex cases, as well as schedule more time for surgery. On December 26, 1896, less than a month after his first experience as a lead surgeon, Cushing performed two separate operations, each significantly more complex than the preceding ones.

On December 21, 1896, a twenty-three-year-old African American man presented with osteomyelitis at the lower end of his femur. Cushing operated on the patient on December 23, 1896. His operative note describes the procedure:

Incision 15 cm long over internal condyle and above. Sinus excised to point of entrance into bone. An opening at about site of adduction tubercle leads through about an inch and a half of eburnated periosteal (?) bone to a cavity in the end probably of the diaphysis. Here some dead bone can be felt. The sinus leading to it lined by flabby gray granulations.
The bone chiseled away till would have held a hen's egg. A flat sequestrum size diagram removed. Cavity curetted—irrigated with HgCl. Iodaform powder introduced. Wound closed & silver over large blood clot. Dressing.

There appeared to be no extension of granulation along the medullary cavity, which in fact seemed completely walled off from the cavity. Apparently 4.5 cm of sclerosed bone chiseled through before reaching the sequestrum.

The tone of the operative note, with its parenthetical question mark and conditional wording, may indicate self-doubt and a tendency to over-analyze, marking the transition from supervised resident to independent operator. In his later operative notes, Cushing continued to employ these occasional indicators of uncertainty, transforming the worries of a young resident into the hallmarks of a thorough and introspective attending surgeon. As Cushing matured as an attending, his operative notes reflected on similarities between the operation being conducted and other operative procedures. He referenced other cases where errors were made, and described his attempts to avoid those adverse outcomes in subsequent operations.

Despite the doubts reflected in this early operative note, and the apparent amazement at the defect created intra-operatively, the patient had an uneventful post-operative course. His final outcome remains unknown, as on February 6, 1897, following a forty-six-day hospital stay, the patient was "discharged by Dr. Hurd for bad conduct." No details regarding the patient's behavior were documented, and given the race of the patient in a segregated hospital in the South only a few years after the end of post-Civil War Reconstruction and the enactment of the Jim Crow laws, it is not possible to speculate profitably. From the post-operative documentation at the time of the patient's discharge, Cushing would have seen the operation as a successful intervention.

Cushing's second case on December 23, 1896, had a very different outcome. The patient was a fifty-six-year-old African American man who presented with hemorrhoids on December 16, 1896. The patient was brought to the operating room for what Cushing described as an "excision of unilateral prolapse of bowel. Whitehead method. Prolapse covered & verrucous growths." Cushing's operative note documents the procedure:

![Cushing's original illustration of his excision of osteomyelitis of the femur during his internship year. The note in Cushing's handwriting reads: “The bone chiseled away till would have held a hen's egg.”](image-url)

Courtesy of the Medical Records Office and the Alan Mason Chesney Medical Archives of Johns Hopkins Institutions.
A prolapse of right side of rectum. The prolapse covered with 8-10 pedunculated growths, about the size of a pea. Above them the pedicle of the extruded gut caught by the sphincter. Sphincter dilated—Rest of bowel seems normal. No similar growths seen. 6 small high internal hemorrhoids. Excision of prolapse by Whitehead method. One side only so treated. Closed 2 catgut.

The surgical file offers no information regarding the post-operative management. The patient’s outcome at discharge was documented as “dead,” and his date of discharge/death is December 23, 1896.

Cushing had developed a reputation early in his career as a surgeon with high expectations for himself and those around him, but in this case the operative note describes notable departures from Halstedian technique: Halsted used black silk suture or silver wire for tissue approximation and closure, while Cushing here used catgut, a thicker natural-fiber suture. While it is unlikely that the choice of suture material alone was a cause of mortality, coarse catgut suture provided inferior wound closure, and may have contributed to wound dehiscence, infection, or sepsis, any of which may have caused the patient’s death. Cushing used catgut suture in future hemorrhoid operations, but his later endeavors employed black silk suture layers in addition to this coarser suture material. The chart does not provide insight into Cushing’s approach on the case, but the modification of his approach in future operations implies that he may have connected the death of the patient with his failure to follow Halsted’s technique.

Cushing did not perform two cases in a day again until July 10, 1897. Given the apprentice model of training, it is probable that this was a result of the outcome of the second December 23 case, which had shown Cushing’s limits. The case load for young residents was always light, and this, coupled with Joseph Bloodgood’s extended presence as Halsted’s senior resident and Halsted’s intermittent absenteeism as a result of his ongoing struggles with cocaine and morphine, may have resulted in a dearth of cases for Cushing to pursue during the latter half of his first year of residency. After the December holidays, Cushing returned to the operating room as the surgeon of record in an excision of a rectal abscess, with good results. Although Cushing’s case load remained light, the complexity of the cases he was given in the operating theater increased, and he soon returned to the same operative procedure involved in his first patient mortality as the surgeon of record. This time, Cushing used Halsted’s preferred black silk sutures, as well as a second layer of catgut suture. The patient was reported “cured” post-operatively.

Throughout Cushing’s four years of surgical training under Halsted, the two men were co-lead surgeons in a handful of cases. These operations offer insight into the surgical techniques Cushing observed in his direct interactions with Halsted in the operating theater.

In December 1897, with Cushing now serving as Halsted’s senior surgical resident, the two men performed a simultaneous repair of bilateral inguinal hernias in a forty-one-year-old man. Each surgeon dictated his own operative note, although both are in Cushing’s handwriting. One can imagine Halsted conducting his operation on the right side, while supervising Cushing’s handiwork on the left. Cushing’s illustrations document the attention to detail throughout the operation, as well as the careful handling of the tissues. His note confirms that “six retractors” were used to separate the tissue without damage and indicates a multilayered closure in line with the Halstedian principles of careful tissue approximation and minimal tension along suture lines:

[The rectus muscle transplant] were then closed with about six silver mattress sutures including aponeurosis . . . The aponeurosis of the ext. oblique was then closed by interrupted silk sutures above the projecting muscle—silver wire for skin. (See page 14)

In April 1898, halfway through Cushing’s training period, he and Halsted scrubbed into a radical mastectomy for a forty-year-old woman with a tumor in her left breast. The operative note is in Cushing’s handwriting, and describes in detail the removal of gross tumor, potentially infiltrated lymph nodes, and surrounding tissue, the hallmarks of Halsted’s operation. The Halstedian obsession with meticulous hemostasis is reflected in Cushing’s note: “Vein exposed and dissected clean before the breast with pectorals was removed . . . Bleeding points tied 2 fine silk.”

During his tenure as Halsted’s senior surgical resident from 1897 through 1900, Cushing performed more than 200 general surgery cases. As a general surgical trainee, Cushing began to explore the field of neurological surgery, which remained fraught with difficulty and was yet to be developed as a truly independent surgical specialty. Under Halsted’s tutelage, Cushing performed a wide variety of neurosurgical cases, beginning in 1897 with a craniotomy for an extra-dural abscess—these early cases encompassed the operative treatment of spinal cord and column pathology, trauma, facial neuralgia, and the removal of components of the calvarium for treatment of recurrent bony tumors. As Cushing’s interest in neurological surgery increased during the latter half of his general surgical training, Osler’s interest in neurological disorders added to Halsted’s influence on Cushing’s surgical technique. The surgical records document physician referrals to Cushing from outside institutions, but do not provide a consistent record of patients referred to Cushing’s service from Hopkins. A review of referrals from clinics overseen by Osler would provide insight into that relationship.

After Cushing completed his general surgical training under Halsted, he spent nearly a year in Europe observing operative techniques and participating in clinical and research endeavors with the brightest surgeons and physician-scientists of the day, including Emil Theodor Kocher, with whom
Halsted had trained. When Cushing returned to Baltimore in 1901, his future at Hopkins remained uncertain until the late fall, when he obtained an associate position within the hospital, and received Halsted’s blessing to pursue neurosurgery at least one day each week. Beginning in September 1901, Cushing expanded his surgical repertoire to include operative interventions for epilepsy, cerebral palsy, spina bifida, and trigeminal neuralgia. Even though these operations were a far cry from the general surgical procedures he had performed during his training with Halsted, Cushing’s neurosurgery at Hopkins owed a tremendous debt to the meticulous operative techniques he learned from Halsted.

The personal and professional relationship between Cushing and Halsted was stormy at best, but it cannot be doubted that Cushing had confidence in Halsted’s surgical practices; after all, Halsted had successfully removed Cushing’s appendix in 1897, following an episode of appendicitis. This faith in his mentor is perhaps underscored by the fact that, before his own bout with appendicitis, Cushing had performed an appendectomy on a patient who died after the operation. Cushing thus understandably integrated the surgical and academic techniques of his mentor into his own practice.

The importance Cushing placed on accurate wound approximation with minimal tension through the use of multilayered closures, an integral part of Halstedian technique, is reflected in Cushing’s decision to use three to four layered closures in five of his ten operative interventions for the repair of spinal dysraphism. The technique had been previously used in Europe, but did not become popular in the United States until 1918, following the publication of Charles Frazier’s book on operations of the spine. The mortality rate for these patients remained high, but Cushing’s application of Halstedian principles led to long-term improvement in two patients at a time when operating was considered largely futile.

Cushing’s operative notes show his attention to hemostasis, albeit through somewhat unconventional means, as in a right subtemporal decompression from 1912:
injury to posterior branch of meningeal artery lead to temporary difficulties with an annoying hemorrhage. The vessel was definitely flattened with a spoon.

Although the cutlery method of hemostasis never caught on, Cushing devised silver clips for controlling hemorrhage that became widely used. His operative note from the same 1912 case documents their use: “many silver clips being necessitated owing to oozing points along the edge of the dura.” Cushing also meticulously documented blood loss, and expressed his frustration with operations muddled by vascular ooze and frank hemorrhage because this interfered with his ability to maintain the nearly bloodless operative field so strongly endorsed by Halsted.

Halsted further insisted on maintaining aseptic technique in the operating theater.\(^6,7\) In his 1904 Annual Address in Medicine at Yale University, Halsted praised the German surgical school for adopting antiseptic operative approaches, and lamented the limited foothold this theory had gained within the United States.\(^7\) Cushing appears to have taken this lesson to heart, and documented his patients’ surgical site infections possibly to guard against future mishaps. An operative note for a second stage operation on a ten-year-old patient with a suspected brain tumor, performed without anesthesia, shows Cushing’s introspective approach to his failures in aseptic operative technique:

> Child in excellent condition, in spite of high temperature and rapid pulse which I had taken to be from a central disturbance rather than from any possible infection. When the dressing was removed the incision was found to be perfectly dry and beautifully healed, so much so that I commented upon it. To my intense chagrin, on opening the incision, however, there poured out what seemed to be thick creamy pus.

Cushing made notes for future improvement:

> I had no idea . . . that it could be otherwise than an infection and it was attributed to the technical slip at operation I, namely, the withdrawal of the drainage tubes from outside in, instead of by reopening the old wound and drawing them out through the scalp and draining so as to be sure that no infection could come from the small point of skin infection above mentioned [from prior operative note].

This early willingness to reflect on errors that may have led to poor results contributed to Cushing’s ability to perfect his aseptic technique in future. Within his series of transfacial approaches to lesions of the skull base, as well as transnasal approaches to the sella turcica and the pituitary gland, only rarely did surgical site infections or meningitis occur. For a surgeon operating in the pre-antibiotic era, this was certainly a hard-won achievement.

Beyond operative technique, Cushing learned from Halsted the importance of integrating laboratory research into his clinical practice. In a 1904 address, Halsted gave an early description of the physician-scientist:\(^6\)

> After all, the hospital, the operating room and the wards should be laboratories, laboratories of the highest order, and we know from experience that where this conception prevails . . . the welfare of the patient is best promoted. . . . The surgeon and the physician should be equipped and should be expected to carry on work of research.\(^7\)

Cushing continued in this tradition, using cadaver models to perfect novel operative approaches.\(^1\) A case of attempted resection of a pituitary lesion from 1910 offers a detailed analysis of the result laboratory-based cadaver experiments had on actual operations:

> Cushing went beyond cadaver models, bringing clinical puzzles into the laboratory to search for answers within animal models of disease.\(^14,15\) During his year of observerships and research in Europe, Cushing assisted Sir Charles Scott Sherrington in his laboratory exploration of the motor and sensory cortices in primate models.\(^1,9,16\) After returning to Baltimore, Cushing brought the laboratory technique of Faradic stimulation into the operating theater for treatment of epilepsy, brain tumors, and trauma. The note accompanying the surgical treatment in 1905 of a three-year-old boy for “Epilepsy, infantile convulsions,” illustrates Cushing’s attention to detail, as well as his attempts to thoroughly map the motor cortex:

> It was quite easy to recognize the situation of the motor strip and efforts to obtain response by electrical stimulation met with most unaccountable results. Anywhere over the exposed part of the cortex movements of the right foot could be elicited, even with moderately slight currents. These movements consisted of quick, sharp plantar flexion
of the toes and foot. Only on using stronger currents could any movements be produced in the head or arm areas which were exposed. (Note that the leg area was not exposed in the wound at all.) These movements of arm and face were very slight even with the strongest currents and it was impossible to carry them on to an epileptic seizure. The closure of the jaw, shrugging of the shoulder and slight movements of the arm were all that were elicited.

In this case, and many others, Cushing used the information gleaned from intra-operative motor mapping to guide his attempted surgical cure of epilepsy. “From the area which gave movements of the arm a piece of the cortex was extirpated measuring about 1 x 1½ cm. in its surface extent.” This patient was discharged in improved condition, and her parents sent a note two months after the operation saying that she had experienced no more seizures.

Through his synthesis of Halsted’s vision of a physician-scientist with his own clinical observation, laboratory investigations, and surgical techniques, Cushing devised novel operative treatments for trigeminal neuralgia,1,4 hydrocephalus,5 and hypopituitarism,6,7,10 among other maladies.

The four years Cushing spent learning general surgery from Halsted proved invaluable to his later work. He credited a strong understanding of general surgery as the foundation on which all further knowledge was built.

Today’s neurosurgical residents spend six months to a year on general surgery training. While such abbreviated training allows residents to pursue research and rotations through the neurosurgical procedures.

Cushing’s thoughts on general training for the subspecialist are clear in his papers on neurological surgery:2–4

those who can best take advantage of existing opportunities, or can originate others, not only must have had a good general training in clinical medicine and surgery, but must have been thoroughly schooled in the fundamental subjects . . . for without this knowledge any special branch is supported by a root lodged in sand which does not long survive overloading.4pp605–06

Cushing’s extensive experience in general surgery, with Halsted’s emphasis on operative technique, provided him with the meticulous surgical skills necessary to transform neurological surgery from a fool’s errand into a flourishing subspecialty within the span of a decade.

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Woman, give me to drink
You hide half your face
and more of your history
But you have water.
Can we start here now with water?
Four centuries of men came
captured your kin
left you with little
Yet you had this well,
this water, long before
And yes you have had more
than one husband all deserted you
left you noma, gaunt
with AIDS and little else
But you have water.
Even those men, if solely by god-grace,
have water
and don’t we all?
Could you ever begin anew with that,
with this water?

Water that might slake my thirst,
stranger that I am in your land
Water that drawn now from your well
could quell my censure
of that selfsame water wallowed by swine
in your dirty dooryard days before
but since redeemed by its slow subterranean sojourn
So that neither you nor I nor your daughters
will die the water-demon’s algid death
Would you that I, this thirsty stranger, prune
your trees, dress your wounds, fend off
your fevers, teach your children, build
your church?
Or sit first at
your well,
hear your story, hoping someday,
we are, all of us, baptized
with forgiveness?

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When I attended medical school during the late 1960s, I learned that primary care was well on its way to extinction, soon to be replaced by a matrix of organ-based specialties and subspecialties. General practitioners had recently begun to fight this trend by creating the specialty of family medicine, but my medical school scoffed at this seemingly unscientific development and for many years resisted establishing a department of family medicine. Health policy at that time dictated that the way to improve America’s medical care was through training large numbers of subspecialists, who would then evenly distribute themselves in small towns throughout the country and bring the blessings of specialization and new technology to populations that had relied only on general practitioners. While medicine still honored the tradition of the compassionate generalist doctor, the *beau idéal* no longer represented state-of-the-art care. In fact, some aspects of traditional practice were considered a waste of time, if not actually harmful.

House calls were a notable example. Once the core of American medical practice, home visits were now deemed inefficient, unproductive, and possibly dangerous. If a patient was too sick to...
come to your office, he ought to go to the hospital emergency room. There was nothing you could do for him at home. Moreover, how could you justify spending an hour or more on a house call, when you could use the same amount of time to see several patients in your office? And what if you missed a crucial diagnosis because of the lack of x-ray equipment or specialist consultation? House calls, along with other traditional rituals of medical practice, appeared destined for extinction.

This position seemed unassailable during the next thirty years, as medicine transformed itself from a cottage industry into a vast and powerful technocracy. Yet the public, which certainly appreciated the benefits of intensive care units and organ transplants, began to experience lingering regret over the death of personal medicine. By the late twentieth century, regret had developed into a sentimental yearning for the return of the healer's touch. The old-time general practitioner evolved into a therapeutic and moral hero, far more honored in his absence than he had ever been when actually present.

In this revisionist view, the Old Doc was a paragon of compassion, knowhow, dedication, and seat-of-the-pants psychology. He—sorry, women docs were scarce in that patriarchal era—could, on a single day, perform an appendectomy on a kitchen table, talk sense into a young man suffering from venereal disease, and patiently keep vigil at the bedside of a dying child. He exemplified all the professional virtues—integrity, fidelity, courage, compassion, and humility—we continue to celebrate and attempt to create in the early twenty-first century. But did this iconic healer ever exist? Surely there were excellent doctors then just as there are now. But what were they like? How much of the ideal Old Doc is based on reality instead of nostalgia or desire?

A few years ago I came across a book that presents at least one example of a plain-speaking but articulate country doctor who practiced for the first forty years or so of the twentieth century. *The Horse and Buggy Doctor* is a memoir by Dr. Arthur E. Hertzler, who graduated from Northwestern Medical School in the 1890s and practiced in Halstead, Kansas. He later opened a clinic and hospital in Halstead and eventually became the first professor of surgery at the University of Kansas Medical School in Kansas City. For decades Dr. Hertzler divided his time among his practice in Halstead, teaching in Kansas City, and conducting clinical research on wound healing, chronic appendicitis, neuralgia, and goiter.

With its publication in 1938, *The Horse and Buggy Doctor* turned its sixty-eight-year-old author into an overnight celebrity. The book climbed to number five on that year's nonfiction bestseller list, edging ahead of Dale Carnegie's *How to Win Friends and Influence People*. Its author became so famous that sixty years later the *Kansan City Eagle* proclaimed Arthur Hertzler one of the most important Kansans of the twentieth century. While Hertzler was not a typical country doctor, his story provides a fascinating background against which to consider today's debates about professionalism, compassion, and patient-centered medicine.

When Dr. Hertzler hung out his shingle in the 1890s, patients flocked to him with scarlet fever, typhoid, empyema, lockjaw, and pneumonia. He did what he could for them, which wasn't much. Writing forty years later, Dr. Hertzler admitted that most of his treatments were "merely symbols of good intentions." For fever he employed aspirin and cold baths. Enemas and castor oil were among his sure-fire, all-purpose remedies. He stitched lacerations, set bones, and delivered babies. He considered prognosis a major part of the physician's work. Though he might not be able to cure pneumonia, he could at least tell the patient and family what to expect. He believed that house calls conveyed a "sense of security" that was therapeutic in itself. Hertzler almost never refused to see a patient "no matter what the condition, or what the chances of remuneration." For him the patient's interest always came first, and the doctor's primary obligation was to relieve suffering. "The important thing is that the suffering patient wants action," he wrote. He believed that the practitioner needed to understand that "It is the relief of pain that chiefly interests the patient, and skill along this line is the big factor." Indeed, the horse-and-buggy-doctor carried in his bag plenty of morphine and laudanum (tincture of opium) to use liberally to alleviate pain and anxiety. He criticized doctors who focused exclusively on the disease while ignoring the patient's existential state. He also stressed the importance of using the physician-patient relationship in a conscious way to alleviate the patient's fears, anger, and depression, all of which he believed were barriers to healing.

In many ways Arthur Hertzler exemplifies the country doctor ideal. He had compassion. He listened. He never abandoned his patients. Most of all, he took their symptoms and suffering very seriously. Like his contemporary, Dr. William Carlos Williams, he believed that empathy lies at the core of healing. As Williams wrote regarding his patients, "I lost myself in the very properties of their minds: for the moment at least I actually became them, whoever they should be." Yet, while Hertzler's passion for doctoring demonstrates many of the core values associated with today's medical professionalism, in other respects his attitudes and behavior differ markedly from current concepts of professional ethics. He was a full-fledged paternalist and anti-intellectualist who felt no need to sanitize his beliefs for public consumption. He was a misogynist. He largely blamed the poor for their own poverty. In other words, Dr. Hertzler was a fairly typical man of his times.

The concept of patient rights had not yet been clearly articulated in Hertzler's time, but he surely would have opposed the very idea. He believed that the
doctor always knew best and that knowing best often required concealing the truth from patients. In serious or fatal illness, he argued, truthfulness conflicts with the physician’s duty to do no harm, because it diminishes the patient’s hope: “The most disastrous results may follow a tactless warning.” The physician should therefore manipulate the truth, or, if necessary, tell outright lies about the patient’s condition.

The Horse and Buggy Doctor was written in 1938, but most American physicians shared these beliefs into the 1960s; only in the ensuing decades did a radical change occur. Hertzler’s practice adhered closely to the original 1847 AMA Code of Ethics, which stated in part, “The life of a sick person can be shortened not only by the acts, but also by the words or the manner of a physician. It is, therefore, a sacred duty... to avoid all things which have a tendency to discourage the patient and to depress his spirits.” He would have been dumb-founded by statements in the AMA’s current Code of Ethics requiring doctor to be honest in all professional interactions and respect the rights of patients.

Nor would the horse-and-buggy doctor find himself at home in today’s coed medical environment. His striking misogyny to some extent reflected mainstream medical beliefs of the early twentieth century that viewed women quite literally as the weaker sex, but Dr. Hertzler went beyond the call of duty in his anti-feminine rhetoric. He wrote that women’s complaints were largely “due to maladjustments between the biologic and the ethical.” Moreover, he considered the gynecologist “an unfortunate individual whose mission in life it is to aid the human female to correlate her biologic instincts with the dictates of Christian ethics.” In Hertzler’s mind, misdirection or frustration of the woman’s animal urge produced dysmenorrhea, vomiting, and gastric distress. But she was in a double bind: a woman who actually expressed her animal urge developed even worse medical problems. Marriage was undoubtedly the healthiest compromise, given the gender’s sorry lot. Yet marriage brought its own difficulties, including self-pity, overeating, and under-exercise. He also warned against female “alimony hunters,” who “can be diagnosed at a glance by an experienced practitioner... They have faces that would congeal boiling oil in August.”

This kindly country doctor summarized his gender-related wisdom in a series of trenchant observations like “The best cure for a neurotic woman is to marry a profligate and drunken husband,” and “The jealous woman nearly always has a
faithful husband." All in all, he wrote, "Unoccupied ladies are very likely to get some sort of complaint." One wonders how Arthur Hertzler would have coped with a world in which women not only occupy themselves, but do so by becoming physicians, lawyers, and corporate executives.

Today’s physicians might also find it difficult to accept Hertzler’s perspective on the equitable distribution of health care. Writing near the end of the Great Depression, Hertzler observed, "There are a lot of tears shed nowadays because one-third of this great ‘American People’ are without adequate medical care." However, in large part, he blamed the victims: "Those without medical care are so because they elect to do without it. Stubborn dumbness stands in their way." To his way of thinking, this "dumbness" consisted of ignorance and improvidence. With regard to ignorance, he claimed many underserved people didn’t realize that doctors and hospitals have a duty to care for needy patients at no charge. Presumably, if they had sense enough to show up at a hospital or doctor’s office, they would receive appropriate treatment whether or not they had money to pay for it. In 2012 this seems like a very naive position, but who knows? Perhaps physicians and hospitals were more committed to altruism and compassion than they are today.

Make no mistake about it, though, Hertzler preferred to be paid. Thus, he also condemned “improvidence,” which he considered the major reason the poor lacked enough money to pay their doctors. Nonetheless, he was willing to accommodate human frailty. For this reason he applauded the concept of health insurance, in its infancy in 1938. How could he have known that seven decades later the health insurance industry would have driven a wedge between doctor and patient and—along with the pharmaceutical industry—come to dominate American health care?

Finally, Dr. Hertzler subscribed to the “bootstrap” concept of character and virtue. Duty, courage, compassion, altruism—these qualities were a matter of moral choice and not subject to teaching, discussion, or dissection. He, of course, approved of humanism in medicine, but considered it a given, not an issue to be addressed in medical training. Unlike urbane, highly cultured physicians like William Osler and Francis Peabody, Hertzler probably represented the mainstream of the profession when he expressed skepticism about the value of the liberal arts and humanities. He disparaged literature and culture in general and heaped particular scorn on attempts to teach the humanities in medical education. He decried the tendency in the late 1930s to introduce “cultural” courses such as medical sociology that “only detract from the things worth while.” He noted sarcastically that “The next course, I predict, will be a course in medical hemstitching or doily making.” His attitude toward the value of arts in general was similarly dismissive, contending for example that real tragedy cannot possibly be conveyed in literature: “The tragedies of literature are silly things; ...” Shakespeare wrote tragedies out of his imagination, not from experience. They are foolish, because he had not seen life in the raw. Tragedies cannot be written.”

As the medical profession searches for ways to reclaim the healer’s touch, Arthur Hertzler serves as a reality check on nostalgia. Is there a Dr. Hertzler in the house? Perhaps not, but maybe that isn’t so bad. We have little difficulty recognizing his integrity, compassion, fidelity, and patient care, but he also reminds us through his prejudices—typical as they may have been of the time—that truthfulness, justice, and respect for patients are very recent manifestations of professional ethics, developed in decades during which both patients and physicians perceived that personal medicine was in decline.

Dr. Hertzler’s most striking characteristic was passion. He was utterly enthusiastic about caring for patients. If they were hurting, he would come. The lesson Dr. Hertzler can still teach us has nothing to do with his dated ideas and social attitudes. His lesson is passion for the art of medicine.

References

An afternoon with the physician-poet John Stone
In November 2003, the president of the Lynchburg Academy of Medicine invited Dr. John Stone to speak to our medical community. He was familiar with Dr. Stone's work as a cardiologist and poet, and he had an ulterior motive—he wanted to improve his own writing skills. He arranged for Dr. Stone to conduct a writing seminar for physicians interested in writing, to be followed by an evening talk on poetry and medicine. I was one of four physicians gathered around a small table in a hospital conference room to hear Dr. Stone speak about his craft.

Walking to the seminar through the parking lot, I watched as Dr. Stone stopped to admire the gingko trees that lined the hospital drive, bright gold in late fall. Those moments in the parking lot were the most memorable of the day. I recall how he suddenly stopped, looked around, and asked me if I had ever noticed the trees. I said, no, I really hadn't. But I did then. After looking closely at the trees, I paused, and then took a good look at him. I noticed his gray beard, slightly hunched back, and bulging stomach. Who was this man in a light brown jacket, standing in the middle of a doctor's parking lot in Central Virginia on a cold fall day, turning in every direction to examine gingko trees as cars and doctors passed by? He notices things, I said to myself. He is easily awed. He later showed me his poem about gingkos and scribbled a line of poetry in my copy of one of his books.

During the seminar, Dr. Stone read poems by William Carlos Williams. His clear, mesmerizing voice reminded me of the importance of reading poetry aloud. He read his own poems. He talked about the medical practice and writing life of William Carlos Williams. He fondly recalled a visit to Williams' home in Rutherford, New Jersey. He gave rules and suggestions for writing poetry: Write it down. Get out of bed. Get a job! Make every adjective earn its way. And most importantly: Know what to leave out.

Since that afternoon, I have enjoyed reading and discussing Dr. Stone's poems, particularly those related to medicine. I frequently use “Talking to the Family” and “Death” when teaching residents about breaking bad news or coping with loss.

I'm always on the hunt for new poems that offer insights into the art of doctoring. Not long ago, Garrison Keillor published in the Writer's Almanac, his electronic newsletter, Whittling: The Last Class

What has been written about whittling is not true
most of it
It is the discovery that keeps
the fingers moving
not idleness
but the knife looking for the right plane
that will let the secret out
Whittling is no pastime
he says
who has been whittling
In spare minutes at the wood
of his life for forty years
Three rules he thinks have helped
Always whittle away from yourself
and toward something.
For God's sake and your own
know when to stop
Whittling is the best example I know of what most may happen when least expected
bad or good
Hurry before angina comes like a pair of pliers over your left shoulder
There is plenty of wood for everyone and you
Go ahead now
May you find in the waiting wood rough unspoken what is true
or nearly true or true enough.
An afternoon with the physician-poet John Stone
Dr. Stone’s “Whittling: The Last Class.” Reading this remarkable poem prompted me to review my notes from Dr. Stone’s visit to Lynchburg, reflect on the poem, and relate some of the things I learned.

“Wood” is first a metaphor for life. Whittling our life, living it, gives it shape. “Make small cuts.” If you don’t, you may create a life you never intended. Go slow, don’t rush into things. Take time to think things through. But don’t idle or obsess, keep moving—“it’s the discovery that keeps the fingers moving.” And remember—time is short. Make wise decisions “before angina comes like a pair of pliers.” Create a career and life that fits your interests, talents, and personality. There is enough wood to go around for everyone.

Making wise decisions is not easy to do. Physicians train for many years, but most of us know it takes many more to become a good doctor—if we are willing to learn from our mistakes, learn from our patients and colleagues, and keep learning our profession and craft. And are we wise enough to be good people? To have time for family, friends, and personal recreation—to prevent burnout, or worse, angina’s grip?

“Always whittle away from yourself and toward something.” If you whittle away from yourself and toward something bigger than yourself, you are less likely to get hurt. Have goals—and makes those goals bigger than you. Physicians understand this: it’s the paradox of altruism. Search for and move toward important things like truth and wisdom, realizing there are limits to your understanding.

“Know when to stop.” Strive to know your own heart and the hearts of your patients, but don’t push too far or strive too hard, lest you lose all you’ve gained. Wisdom is knowing when to stop, knowing when you have arrived at a truth (or a diagnosis!) that is good enough, true enough.

“Wood” is also metaphor for poetry. Whittling is how you write it. Make small cuts. Go slow. Think about every word and punctuation mark. What is really necessary? Write about things outside of you. Good poetry reaches out and resonates with many readers. Find novel ways to express universal truths, understanding that there are limits to your ability to articulate them. Know when to stop writing—the point where you have expressed “what is true or nearly true, or true enough.”

John Stone spent a distinguished career at Emory University School of Medicine, practicing and teaching cardiology to several generations of medical students, residents, and fellows. In his practice and in his poetry he focused his attention on the heart. In a collection of his essays entitled *In the Country of Hearts: Journeys in the Art of Medicine*, he refers to two hearts: the literal heart—the focus of the cardiologist Dr. Stone—and the metaphorical heart, that of the poet John Stone, who wrote, “I am speaking now of the heart as a synonym for sensibility, sensitivity, as the seat of the emotions, if you will—the heart about which Pascal wrote, ‘The heart has its reasons which reason knows nothing of: *That* heart.”

The poems flow from the hand unbidden but there is no need to go into that. There will be dying, there will be dying, and a high tide reflected on the ceiling?

The sun rises in spite of everything and the hidden source is the watchful heart.

How should I not be glad to contemplate the clouds clearing beyond the dormer window and a high tide reflected on the ceiling? There will be dying, there will be dying, but there is no need to go into that. The poems flow from the hand unbidden and the hidden source is the watchful heart.

Everything is going to be all right.

**References**


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The road to healing

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This patient needs a thinking doctor.
—Anonymous Neurosurgeon

Thank God there was one patient who didn’t need me to think. Nineteen others populated a brutally busy general medicine service, and it was my first day to get to know them. Half had been admitted overnight. Two interns, a senior resident, and a medical student did their best to move us through rounds, while I checked on the notes from my predecessor. They were all sick, these patients, and most of them had tough home situations, if they even had homes. “Challenging psychosocial factors,” we like to say. “Rocks,” the residents call them, because they never move from the hospital or from the long team list that becomes the reality of a ward service. If we’re going to teach, or take good care of them, or have room for more, or get some sleep, or have a life, we have to trim that list.

Mr. B wouldn’t help us trim the list anytime soon, but then he didn’t demand much. He was forty-seven and hopelessly demented. That was the first thing I heard, and the second was that if you left his meal tray in front of him for too long he would eat the styrofoam plates and cups. Not only was it the stuff of instant legend, it was the ticket to question-free rounding. Bizarre, not typical, a little threatening. Maintain barrier precautions, stay on guard, move on.

He was quiet, entirely mute, sleeping a lot but always arousable and even...
serene, gazing purposefully at us with no response to our greetings. Neurologically he was intact but for the glaring exception of his mental status. Physically and biochemically, everything else was perfectly fine. The lights were on, but nobody was home. He was “medically stable, awaiting nursing home placement.” The only delay was for Social Security to certify him. That would trigger the nursing home’s acceptance, his removal from our list, and replacement with a more complex and educational patient.

After four or five days of stopping at his bedside, we discovered that he had a fever. Not much, just a degree or two, below the threshold of a “significant fever.” It was a teaching opportunity, the question of what is a “significant fever.” It has to do with the probability of sepsis, blood-borne infection, life-threatening infection. But “significance” is a relative term. The little fever made us stop and examine him a bit more, make sure there wasn’t something serious about him. It wasn’t much, but it might have been what began to change the way we looked at Mr. B.

Eventually the fever went away with no treatment, and we decided he just had the cold that several team members and patients had suffered. It was the first thing we could see that we had in common with Mr. B. After all, he was a lonely black man with no apparent cognitive function: tragic, sad, hopeless. We were healthy white guys, smart and getting smarter, entrusted with the keys to the kingdom of life and health. In our best moments, we acknowledged our humility and humanity.

I felt compassion for Mr. B, at least as much as time allowed, but there didn’t seem to be anything we could do but feed and bathe and clothe him, and hope he could get out of the hospital before he caught something more serious than a cold. But the viral bonding was a start. Bidden or not, we had that in common. I tried harder to talk to him. He nodded yes and no to simple questions in a consistent way. There were rare reports of a few words from his mouth, appropriate to the point, but very simple. Still compatible with severe dementia, but a little more functional than we’d thought. Was he scared, intimidated as demented patients often are in an environment as strange as a hospital? Or had he been pretending some of this?

Then came the call from the Feds. This guy was not at all who we thought he was. He hadn’t grown up here, somehow managing to get lost or estranged or otherwise separated from any human support. He was an immigrant, with an invalid Social Security number, an alien. It fit, his being an alien. Not just from Africa as they said, but maybe not from this planet, this solar system. It would explain why he ate styrofoam, or had that faraway look. Maybe he understood everything and this was part of the invasion strategy. What would be next?

Okay, that was ridiculous, but who was this guy? Earlier I had run the record for proof that he really had a dementia. The multi-infarct diagnosis didn’t fit, because the strokes on his CT were in the wrong places to affect his thinking. But he did have the loss of brain tissue overall, and dementia was the best description of his state. The tests for treatable causes of dementia had been done, with an exception or two that we added, and all were negative—all, that is, but one. He had not had a spinal tap to examine his central nervous system for infection or other strange causes of his mental wipeout. So we did that too, and it was normal.

But who was this guy? How had a solitary foreigner managed to get along in Birmingham, Alabama, and then end up like this? The little fever had started it but the Feds had fanned the flames. The old records showed that a year ago he had been admitted when he showed up saying he was living on the streets and needing a place to stay. He got IV fluids and was sent back out twice. But—this guy surviving on the streets? That took a lot more skill and smarts than he had now. Obviously he’d lost a lot of function in just a year. How did he get here this time, where had he been?

We found he’d been in a boarding home, and his landlord knew things. He had come to this country for graduate study and taught college mathematics. The rest was still a blur, but somehow, whether it was the dementia or something else, he’d fallen on terrible times that now looked like this. Was there redemption for Mr. B? Would the urbane members of the Faculty Club band together and rescue him? Was there a pot of gold at the end of this murky rainbow? Apparently not. We had come full circle.

He was alone, unfunded, and hopeless—if hope is measured in the possibility for recovery of function, autonomous decision-making, or working crossword puzzles. He was after all a problem for the social workers and lawyers, a question of where his disposition for custodial care would be outside the hospital, a “dispo problem.” My compassion could not change that—or could it?

Labels help a lot in medicine. They categorize, prioritize, order our thinking. But they can close us off from the truth. Dementia can be reversible, but not for Mr. B. Dementia can be treatable, even for Mr. B. After all, it turns out he can communicate. What about prejudice: pre-judging—is that reversible? Treatable? We can re-examine diagnoses in our patients, but what if the processes already have gone too far for too long? The tissue damage can be relentless and eventually irreversible. What about the tissue of my own relationships, my own life? I can re-examine my attitudes and assumptions, but what if—like for Mr. B—the tissue of my relationships, the synapses of my connections, are far gone? Just as Mr. B is alone without connections, could I find myself cut off from the humanity that brought me into medicine? Why do this alone? What can I do about lost time? Is there a way for a thinking doctor to think about that?

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You have been a good teacher today. The patients are always our best teachers." The young pediatric resident is ostensibly speaking to a twenty-two-year-old mother whose second child is in the hospital with severe respiratory distress. The six students he is leading around for the morning, acolytes to the altar of medical education, know these stock phrases are for our benefit. The mother smiles back a colorless smile, also mostly for our benefit. I feel as though I am watching an Arthur Miller play, the characters moving through scenes they can't control. There is an awkward pause in the conversation, the insincerity and disingenuousness of the comment taking on a life of its own. That's how you know he's a resident.

The mother doesn't care about being a teacher. She doesn't care about helping to educate the "doctors of tomorrow." She is simply a scared single mother who didn't know how to say no when some pleasant woman came to the room earlier that morning to ask if it would be all right to bring medical students by. All she wants is for her baby to breathe better. Five-month-old Daylon, a beautiful, curly haired child, is enmeshed in the tubes and machines of modern medicine. During our interview with the mother, her eyes flit constantly back to him. I can almost feel her suffering as she watches Daylon's nostrils flare and chest squeeze with each breath. I can see the corners of her mouth fleetingly twitch—a consciously aborted grimace—every time Daylon grunts to breathe.

But maybe my imagination is just playing tricks on me. Maybe she is as calm as she appears. After all this is the third time in Daylon's short life that he has been in the hospital.

I tune in just long enough to hear, "So with vaccinations current and up to date, and given the time of year, RSV would be high on the differential. . . ." I need to focus. This is information I need to know, but somehow I keep coming back to Daylon and his mother. Differential diagnoses and pathophysiology somehow seem less important.

Daylon is big for his age, one of those chubby infants people invariably describe as "cute." His hair is a brown curly mop that stands in all directions, in complete defiance of gravity. He looks healthy, though troubled in his sleep. His mother is thin with light brown skin and bright eyes, beautiful beneath the veil of weary motherhood. Her top is slightly revealing, and I avert my eyes only to notice that among her various tattoos, there are two that claim devotion to two different men. I wonder if one is Daylon's daddy. I wonder if he is worried about Daylon right now, but I doubt it. During the interview, she made it clear that his father was not in the picture.

As medical students, our interviews spare nothing. We are taught to inquire about sex, drugs, money, social relationships—all the juicy details of being human that make for good daytime television. Daylon's mother is on welfare; she has no real plans to ever be otherwise. She lives in an apartment with her two children, and is not worried about finances because, she says with smiling bravado, "It always seems to work out somehow." We smile back, trying desperately to convey that we understand, but we don't. We are bright and well educated people for whom opportunities abound. How could we understand her struggles? She smiles back, understanding the absurdity, but appreciating the good intentions.

Because of Daylon's respiratory problems, we are all wearing bright yellow full-length gowns with masks over our faces—physical barriers that are fitting analogies to the social and cultural barriers in the room. Earlier in the morning we had watched videos that stressed the importance of the doctor-patient-parent relationship in pediatrics, and lectured us on how we needed to "break down the barriers to communication."

The resident continues to talk through the physical exam: "So you can
clearly see the nasal flaring and retractions. This infant is still fairly tachypnic and will remain on oxygen. . . . Daylon lies asleep in the hospital crib, unaware that he is on display. His mother watches the resident intently as he objectively describes her child. The rest of the students and I crowd around the crib, like so many gawking onlookers at a fire.

In medical school, there are never enough chairs. In the patient rooms there is usually only one or two, often occupied by family members. Any available chairs go to the attendings or the residents; the medical students stand. I never know exactly how to hold my arms. Crossing them seems too stern, hands in pockets seems too casual, and behind the back makes me think of decrepit old high school science teachers walking between the rows of desks while proctoring exams. Most of the rest of the students have opted for the behind-the-back pose, hovering over the crib. I pray that Daylon stays asleep. I pray that he doesn’t awake to see a ring of yellow mouthless specters peering down on him.

“So do you have any further questions?” The resident is looking at us. He has decided not to examine Daylon any further because he might wake him. The mother looks relieved.

“Have they told you how long you will be here?” one student asks the mother.

Daylon’s mom looks pleadingly at the resident and says, “I am not sure yet, they haven’t really told me.”

The resident replies that he thinks Daylon will likely be able to go home in a day or two. He adds that he feels comfortable sending Daylon home so soon because he is confident that his mother knows how to watch him and will be quick to bring him back if his health deteriorates.

In other words, she is a good mother, so we will release Daylon; if she were a bad mother he would have to stay longer. At that, the mother smiles her first genuine smile of the day. I see pride in her face.

“Well, if there are no further questions, shall we move on?” the resident says.

I want to scream, “Wait! I don’t want to move on.” I have questions, millions of them: Who are you? What do you want for your son? What does this all mean to you and Daylon? Tell me the poetry that is your life. Give me the words to say to the tortured soul of a mother at three o’clock in morning when her dreams and aspirations live on the fragile breaths of a dying infant. How do I be a good doctor to you and to Daylon?

But I don’t ask. I don’t know how to ask. Anatole Broyard in his essay “Doctor, talk to me,” says his ideal doctor would be Virgil, leading him through his purgatory or inferno, pointing out the sights as they go. Though I have always liked the idea, somehow I don’t think Daylon or his mother need a Virgil. Perhaps the Virgin Mary would be a better guide for them—the consummate compassionate maternal deity. Who better to understand their suffering? Who better to share their burdens? They don’t teach that in medical school. I want to ask Daylon and his mother to teach me, but I don’t. It is time for us to move on to the next specimen.

We thank her as we leave the room. She asks us to turn down the light. As the room goes dark, I look back one last time at Daylon and his mother, bathed in the light of the monitors surrounding the crib. Her head is bent toward her child, our intrusion already forgotten. In the dim light, I see her kiss Daylon on the forehead to ease his sleep and assuage her own worries. For the first time I see her for who she is, a modern Madonna caring for the light of her world.

Reference


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It was like fate, if I believed in fate. I don't believe in fate, but I do believe in tacky Hawaiian hotel gift shops. Here I am, at the zenith of my self esteem, newly graduated from college with a mountain of ribbons, sashes, and various honors named after dead people who did something for science. I am about to start medical school at the Mayo Clinic and I have an inappropriate level of appropriate anticipatory anxiety. For my last hurrah, my parents have brought me to Hawaii to remind me of what I'll be missing for the next four years (relaxation, sunlight, and enough blissful ignorance to eat raw oysters without worrying about Vibrio vulnificus).

Anyway, the gift shop. I see her there, hanging on the wall. She gives me that look, the one that says, “You should purchase me with your parents’ money since you’re a Big Girl now...”
and they’re about to cut you off financially."

She’s the most beautiful ukulele I have ever seen. Surrounding her are instruments professionally crafted from the finest spalted woods, resplendent in lustrous shades of tan and deep brown. She reminds me of myself showing up to all twelve of my medical school interviews wearing a hot pink suit jacket. I love the red of her front, the green and black of her sides. She is painted like a watermelon, and I want her. I wipe nervous sweat from my brow, still pale even after five days under the hot Hawaiian sun.

My inner voice chimes in: Linda, what are you going to do with a ukulele?

I’m going to play it.

But you don’t play any instruments and your hand-eye coordination is about as good as a snake’s—and snakes don’t have hands.

I want that ukulele. It is painted like a watermelon and I don’t own any watermelon things.

That is the worst reasoning I’ve ever heard. You could spend that money on a textbook.

That’s it. Now I’m definitely buying this ukulele. I’m going to strum my way through medical school.

A few days later I arrive at the Mayo Clinic in Rochester, Minnesota.

After three months I can play some chords. Clumsily. Like a surgical intern tying air knots, I know the motions but have not come close to perfecting them. Luckily there is no attending to stand behind me and remind me that I am but a flea on this institution’s backside.

One year later. One year of dissecting the hearts, heads, and hands of our silent teachers; one year of reading about normal form and function and disease, only to discover how little pathology PowerPoints prepared me to gaze into the eyes of a Stage 4 cancer patient who has allowed a pack of medical students to file into her room and steal knowledge from her body.

It’s Friday afternoon, and I know nobody will be here. I sidle through the Mayo Clinic, my nondescript black case hiding my secret. Any normal person would assume the case holds a sensible instrument like a violin. I approach the revered grand piano at the center of the main lobby and set up my tools (Ukulele: check. Water bottle: check. Confidence: —). I notice that my not-so-grandstand is stationed right underneath a giant statue of a naked man. I really hope he enjoys this, because nobody else will.

I adjust the ukulele under my arm and my nervous fingers strike the first chord. I begin singing “Walking in Memphis,” and the slow trickle of Friday passersby puddles into a human pond. I will my fingers to go to the right frets; I will my voice not to give out; mostly, I will the statue not to fall on me in an attempt to shut me up. But the naked statue stays in his spot, requisite loin leaf securely in place, and my audience nods its approval. Success? Well, at least not defeat. I slink off reflecting on how maybe I should have been studying instead of making a spectacle of myself and my little watermelon ukulele.

I gown. I glove. I don one of those infuriating face masks that stick to your mouth when you try to talk. I can tell I’ve picked an especially effective mask since it is especially infuriating—I feel it sticking to my mouth, and I haven’t even tried to talk yet.

I’m not sure this is the right room. When the pediatric nurses heard that I was hanging around the children’s hospital today with my extensive second-year medical student knowledge base—and my ukulele—they asked me to visit a ten-year-old boy with a shaky prognosis and a thing for country music.

I peer through the doorway. Sunlight in pale yellow slits falls gently through the blinds onto the white walls of the hospital room. My audience doesn’t resemble any ten-year-old boy I’ve ever seen. He is small, too thin and bald, and his pale skin almost matches the white of the walls. I begin to ruminate on the profound tragedy of pediatric cancer, one of the most devastating diseases in existence. Knee-deep in my mental pity-party, I jolt back to attention when my skeletal friend-to-be abruptly interjects in a Cajun twang:

“Ah’l lahk it if you played a coun-treh song. They don’t got no good musek in this dang hospital.” His parents look at me.
expectantly. My gown feels even hotter than usual.

“Well, I am from the Northeast. Maybe I won’t be up to your standards when it comes to country music.”

“Ah don’t care. And what is that thing you got there, a little gee-tar?”

“It’s a ukulele. People in Hawaii play them. And me. I play them, too.”

“All right.”

I pick up my uke, trying to adjust to the feel of the fretboard through the barrier of my size medium hospital-approved gloves. I take a huge breath to begin the song, sucking not only hospital-approved air, but part of my face mask into my mouth. I begin again. I play the country-est song I know, full of fried chicken and red-white-and-blue. I suppress everything I’ve ever learned about diction from classical voice training and add an artificial twang to my voice.

There is something desperately intimate about performing for a tiny audience. I am not just singing for a distant, faceless crowd; I am communicating, up close and personal, close enough that my listeners can hear the small mistakes and fluctuations in my voice and see me struggling to breathe through the face mask. I see both fear and appreciation in the parents’ eyes; I notice the boy’s fatigue as he slowly works through swallowing his thirty morning pills while I slowly work through the song’s verses.

When I finish the song, my face mask sopping wet from repeated encounters with my mouth, my three-person audience claps. I wish them luck with the remainder of the cancer treatments.

“I’m back in the Mayo lobby. I denied my addiction at first—I mean, I don’t need to play my ukulele and sing every week. I just choose to. But now it’s twice a week, an hour each time. There are some compulsions that overtired medical student-musicians cannot control. No longer confined to the shyness of a late Friday afternoon, I have claimed two lunch-time slots per week for my personal version of music therapy. I notice that some of my regular listeners—patients who are stuck at Mayo Clinic for extended treatment regimens—have claimed their usual listening posts.

“Which subject are you procrastinating studying this week, Linda?” one asks.

“Pulmonology. It’s okay—I mean, ‘breathe in breathe out.’ What’s there to learn? I have time to play.”

I begin to play “Hey, Soul Sister,” my voice echoing through the clinic and punctuating the rhythm of life, death, and bad hospital food. I have noticed that some thing in popular bad music seems to connect women of every age and type, and “Hey, Soul Sister” definitely has that thing, whatever it is. I watch the serious, focused faces of female physicians soften into half smiles as the nonsense verses of the song roll out: “The way you can cut a rug, watching you’s the only drug I need!”

I strike the last chord. Applause. Out of nowhere, an adolescent boy walks up to me.

“Can you play ‘Chickin Frahd?’” A heavy, heavy Southern accent.

“Oh. Oh my gosh! It’s you!”

After months of remission, good Southern food and a little bit of burgeoning activity on the part of his pituitary gland, my formerly cancer-laden Cajun audience-of-one has transformed into a robust pre-teen. He is taller, thicker, standing and smiling. One hug later, I am belting out “Chicken Fried.”

I do not yet know how to run a code. I haven’t learned the dosages of common medications, and I can’t insert an IV. If I took all of the time that I spend practicing and performing and devoted it to studying, I know I would do a point or two (or five) better on my exams. But that doesn’t matter. What I can do, with the help of a flamboyant little instrument, is bring a little bit of life and music to the institution that is shaping me into a physician.

This is the point in the essay at which I’m supposed to close with profound words and solemn thoughts. Instead, in honor of my in-remission buddy, I give you the words to “Chicken Fried”:

You know I like my chicken fried
A cold beer on a Friday night . . .
And the radio up.

References

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The physician at the movies
Peter E. Dans, MD

War Horse

Starring Jeremy Irvine, Peter Mullan, Emily Watson and David Thewlis.

Based on a children's book and later a play of the same name by Michael Morpurgo,1 this is an old-fashioned film with an almost unheard-of 5800 extras. It opens in the rolling hills of England with the dawn of a beautiful sunrise. Filmed on location in and around Dartmoor in Devon, it has an authentic rustic feel. A flute solo ushers in a very well-crafted soundtrack. The camera then focuses on teenager Albert Narracott (Jeremy Irvine) hiding behind a tree and watching a mare give birth. After much straining, the mare delivers a colt who is soon on his feet and gamboling with his mother in the field (an incredible sight when one considers how long it takes newborn humans to accomplish that). When the horse becomes a yearling, he is auctioned off in the town square. The boy's father, Ted Narracott (Peter Mullan), a hardscrabble farmer who needs a workhorse to plow his rocky fields, falls in love with the horse and decides to bid on him, even though his bloodlines are those of a thoroughbred,

When his landlord Lyons (David Thewlis) bids against him, his pride is challenged and he gets the horse at the exorbitant price of thirty guineas. The farmer, who was crippled in the Boer war, can hardly afford to pay the rent, let alone the cost of the horse. The landlord is pleased because if the farmer doesn't make the rent by October the farm and the horse will be his. As the landlord climbs in his fancy car full of himself, he is chased by the family goose in a scene that is reminiscent of the goose Samantha in the film Friendly Persuasion.

As predicted by their neighbors, the farmer's wife, Rose Narracott (Emily Watson), a hard-working practical sort, sees this as yet another disastrous judgment by her husband, who is rarely seen without his flask of whiskey to help him cope with the pain in his leg. When it's time to plow, the farmer tries to harness the horse to the plow. When the horse resists, the farmer is so angry that he gets his shotgun and levels it at the horse, vowing to kill him. The boy stands between his father and the horse and the farmer relents and stomps away; the boy tells him that he can get the horse to do the plowing. His mother backs him up in a poignant scene in which she sits down with the boy and shows him a box with medals and ribbons that his father earned during the war for saving his mates. When he returned home, he was so angry at what the war had done to him and his comrades that he threw the box away. His wife retrieved it and hid it, and now opens the box to show the boy what a hero his dad was. She gives the boy a ribbon that will appear as a talisman throughout the film.

The boy names the horse Joey and begins to train him and break him. As they bond, the boy is able to get him to submit to the harness. After many false starts during which the boy collapses as a crowd watches, Joey responds to the boy's

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1 The original work was published in 1982.

Jeremy Irvine and Joey (horse) in War Horse, 2011. © Walt Disney Studios Motion Pictures.
urging and plows the rocky fields, dragging the boy through the mud. Despite this success, the turnip crop that the farmer had planned to use to pay off his debts fails. Shortly thereafter war is declared with Germany. A rider cries out, “We will ring the bells and will not ring them again until the war is over.” Young men sign up for what they think will be a very quick victory, promising that they will be home by Christmas. In the background, we hear strains of “The Roses Are Blooming in Picardy.” The town’s horses are commandeered and Joey is bought for thirty guineas by Captain James Nicholls (Tom Huddleston), who promises the boy that he will take good care of the horse and to keep in touch. The performances of the actors, especially the young boys, are excellent, but the star of the show is Joey. We see him budding up with a fellow equine as they train to execute a cavalry charge before embarking for France in 1914.

There is a Pickett’s type charge in which the British emerge from the tall grass into the open to try to surprise the Germans; unfortunately the Germans are ready for them and mow them down. As the camera pans over the dead men and horses, a German officer expresses amazement to a British officer for believing that his men would be left undefended. Most horses are shot, but Joey and his buddy survive. They are cared for by two German brothers who desert but are caught at a French farm and shot by their compatriots. The farmer and his daughter are the new owners; their brief story provides a pleasant interlude before the film turns grim and the cinematography gray, as the war deteriorates to trench warfare of attrition with episodic charges and retreats. A harsh German orders all horses including Joey and his buddy to pull artillery, and predicts that they all will be dead in a month. Joey’s buddy dies and Joey tries to escape. There is a very striking scene in which the Germans and the Brits with no man’s land between them call a cease fire while they work to free Joey from barbed wire.

The film brings home the futility of World War I, so starkly shown in All Quiet on the Western Front and The Grand Illusion. It reminds us of the consequences of both World Wars I and II, with the loss of two generations of the best young men profoundly altering the demographics of post-war Britain, France, and Germany, as well as, to a lesser extent, North America. The demographic effects go a long way to explaining what we see today in terms of the transformation of European countries. The film also shows the hardscrabble existence of farmers who remain loyal to one another and to the land. It’s a generation back from the life pictured in All Creatures Great and Small. Those who liked that particular TV series should enjoy this film. It was nominated for an Academy Award for Best Picture. While not a great film, it tells an interesting story about people one can care about. If you decide to watch it and, like me, have lost some hearing and have difficulty with foreign accents and dropped words, I suggest you turn on the English subtitles option on your DVD.

Addendum: Joey was played by fourteen horses. The main one, named Finder, also played Secretariat in the recent movie. Spielberg used almost no digital effects so what you see filmed was live action. The barbed wire was rubber so as not to injure the horses.²

References

To Rome with Love
Starring Woody Allen, Penelope Cruz, Jesse Eisenberg, Alec Baldwin, and Ellen Page.
Directed by Woody Allen. Rated R. Running time 102 minutes.

Recently I reviewed Midnight in Paris and found it to be so enchanting that I rashly said that Woody Allen was back. The movie was an imaginative, funny, and beautifully filmed paean to Paris, opening with a stunning kaleidoscopic tour that evoked many happy memories of the City of Lights. To say that his follow-up film is terrible is an understatement. How could such a talented director and cast make such a bad film with the eternal city as a backdrop? Think of all those wonderful scenes in Roman Holiday and you will know what I mean. This film is clichéd, unfunny, pretentious, and populated with people you wouldn’t want to spend ten minutes with, let alone 102 minutes. I almost bailed on the film, but I kept hoping it would get better and didn’t want to disturb the guy next to me.

Okay, let’s start with “unimaginative.” In contrast to the beautiful opening of Midnight in Paris, this film opens in front of the monstrosity popularly called “the wedding cake,” a tribute to King Victor Emmanuel. The next image is of the balcony where Mussolini pompously held forth. I did like seeing the policeman (Pierluigi Marchionne) who stands on that pedestal and directs traffic through the circle with élan, but soon I was overwhelmed by the first vignette, a clichéd tale of a dippy American girl, Hayley (Allison Pill), stopping a handsome Italian Michelangelo (Flavio Parenti) to ask for directions to La Fontana di Trevi. He offers to take her there and before you know it, they are planning marriage. Cue up the Four Aces singing “Three Coins in the Fountain.”

How about “unfunny?” Allen’s obsessions are sex and death (see Everything You Wanted to Know about Sex: But Were Afraid to Ask and Love and Death). The death part comes with his stressing over the turbulence during the flight to Rome to meet his future son’s family, as well as his reaction to the fact that the young man’s father, Giancarlo (Fabio Armiliato), is a mortician and he’s not sure whether to shake his hand or eat anything in his house. It turns out that the father’s hobby is

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singing in the shower, where he sounds like Pavarotti. Allen's character Jerry is an impresario who specializes in producing avant-garde operas that nobody wants to see. He immediately concocts a plan to get the mortician to translate his singing ability from the shower to the stage. I'll leave it there.

The second vignette involves a southern Italian couple who have come to Rome for their honeymoon, thinking that they may stay in the big city—even though the bride clearly prefers to go back home. Allen uses a weak contrivance to separate them, during which time they manage to have sex with others before they consummate their own marriage. In the groom's case it's with Anna, a bombshell prostitute played by Penélope Cruz in a dress that leaves little to the imagination. In the bride's case it is ostensibly with a fat Italian movie star for whom she has always had a crush. The entry of a burglar and the film star's jealous wife pushes the vignette beyond farce. Indeed, I found this to be the most far-fetched and offensive of the film's vignettes.

The third vignette features the omnipresent Woody Allen alter ego. Now that he can't play the role himself, the presumably "lovable" schnook Jack is Jesse Eisenberg, whom I found to be obnoxious. An architectural student, he is in a live-in relationship that seems strong until his significant other, Sally (Greta Gerwig), while studying for an exam, throws him togethers with her visiting friend Monica (Ellen Page), a failed actress. Despite his protestations that he is not attracted to this man-eater, they have a steamy affair, all the while lamenting that they are doing this behind the friend's back.

The fourth vignette focuses on how reality television makes ordinary people celebrities who become famous for being famous. When the famous one is used up, he or she is replaced by another loser. Roberto Benigni, whose only claim to fame is his Academy Award performance in Life Is Beautiful, is insufferable as the nebbish Leopoldo who is married with two children. As his every waking minute is chronicled, his fame results in women lining up to go to bed with him while his family is ignored. He enjoys the ride until the bitter and pathetic end.

Topping off this mess is Alec Baldwin at his most pretentious and obnoxious best as John, an architect who, like the schnook, lived as a student in Rome decades before. He pops up periodically and tries to tell Jack not to get involved with the man-eater, while predicting what's going to happen—as if we need him to tell us. My favorite scene was shot from the balcony of one of those hotels where one can enjoy a morning colazione while soaking up a spectacular view of Rome. If you have time to kill (and I do mean kill) see this movie; otherwise resist the temptation to view it at all costs.

**The Lost Weekend (1945)**

**Starring Ray Milland, Jane Wyman, Phillip Terry, and Howard da Silva.**

Directed by Billy Wilder. Rated TV/PG. Running time 101 minutes.

In the 1930s, following the repeal of Prohibition, drinking alcohol was portrayed in movies as relatively harmless and ubiquitous. Just think of the Thin Man films, where Nick Charles is rarely seen without a martini in his hand. After World War II, films turned dark (so-called film noir) and became grittier and more realistic. Based on Charles Jackson's semi-autobiographical novel of the same name, this film was the first to deal seriously with alcoholism. It also has the distinction of being one the many films of the time that were filmed on location in New York City—Naked City, A Double Life, Kiss of Death, On the Town, and Pickup on South Street among others—which added to the air of realism. Many scenes were filmed on Third Avenue, which was perpetually dark because of the Third Avenue EL or Elevated Line, which last ran on May 12, 1955, and was later dismantled. The EL's shadow, especially in the southern section of the Avenue called the Bowery, was the home of many homeless. This film shows that alcoholism wasn't restricted to the lower social economic classes; it includes a scene in which the narrator points out a rich person, now a hopeless alcoholic.

In the opening scene, the camera focuses on a bottle of whiskey hanging from a cord outside the apartment window of an alcoholic writer, Don Birnam (Ray Milland). He is being ushered off for a weekend in the country to cure his writer's block by his solicitous brother, Wick Birnam (Phillip Terry), and girlfriend Helen St. John (Jane Wyman), but he wants no part of it. He has been dry for ten days and desperately wants...
to stay in the city and drink that bottle and have a weekend bender. He succeeds in getting rid of them by promising to meet his brother at the station. He then heads for his favorite watering hole, Harry and Joe’s, “where good liquor flows.” The exterior bar scene was filmed at P. J. Clarke’s on 55th Street and Third, and the interior in an exact replica on a Hollywood stage set. It was one of New York’s many saloons like McSorley’s alehouse where writers, journalists, and others went to wind down after work.3,4 Don shows the many sides of the alcoholic: by turns manipulative, charming, gregarious, witty (quoting Shakespeare), self-absorbed, inconsiderate of others, and finally nasty when unable to get alcohol.

After many rounds, Nat (Howard da Silva) tells him that he has missed the train and Birnam goes home to sleep it off. When he wakes up, he finds that the bars, liquor stores, and pawn shops are closed by mutual agreement because it’s Yom Kippur.2 He desperately searches his apartment to locate another carefully hidden bottle. The scene in which he finds it is a classic. Another disappointment occurs on Sundays when liquor stores are closed and bars don’t open until one. The bartender stops giving him credit and he begins a downward spiral.

As narrator, he then tells viewers how he got together with such a loving woman as Helen. At a matinee of La Traviata while watching the “Drinking Song” (“Libiamo” or “let’s drink”), he gets excited as they lift the champagne glasses and begins to crave a drink. He starts to perspire and goes to get his coat, where he has hidden a bottle. He finds out that his ticket is for the wrong coat and is told that he must wait for the woman who has his check. He gets angrier and angrier as he realizes that he has to wait until the opera is over for the woman to reclaim her coat. When she does appear, he strikes up a conversation with her and they plan to see one another again, but as he turns to go, the bottle drops out of his pocket and breaks. He accepts her invitation to join her at a party in an apartment on Washington Square.

They develop a very good relationship during which he is sober, but when her parents come to meet the boy friend he is scared off and goes back to drinking. Helen goes to his apartment to find out where he is. His brother, a classic enabler, lies, saying he is in Philadelphia. As she turns to leave, Don comes out of the room where he had been lying in a drunken stupor and says, “I’m not a drinker; I’m a drunk. I had to be brought down after first getting published, only to find that he wasn’t such a hotshot. He took refuge in alcohol. There’s a powerful scene of the DTs filmed at Bellevue. To get ready for that scene, Ray Milland spent a night at Bellevue and cut down on his food as alcoholics are wont to do.2 The only disappointing part of the film is the resolution; it seems facile, but a more realistic ending was probably believed to be unacceptable to the audience. As it was, the preview audiences were not enthusiastic, but the critics were.1 The film won Oscars for Best Actor, Best Picture, Best Director, and Best Screenplay. It was nominated in four other categories including for Best Score by Miklos Rozsa, who went on to write over a hundred film scores, including those for Ben Hur, El Cid, Quo Vadis, and Double Indemnity, as well as the Dragnet theme. The soundtrack has a spooky resonance. Apparently, it was the first film to feature a theremin, a musical instrument that produces a strange wailing sound, later used extensively in sci-fi films.2

For another picture dealing with addiction and showing a very harrowing scene of going cold turkey you might want to rent the 1955 film The Man with the Golden Arm, starring Frank Sinatra as a heroin addict.

Addendum: Wilder claimed that the liquor industry offered Paramount $5 million to not release the film. They refused, but he said he would have taken the money.2

References

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Reviews and reflections
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The Immortal Life of Henrietta Lacks
Rebecca Skloot
Crown Publishing Group, New York, 2010
Reviewed by R. Stephen Griffith, MD (ΩΛ, University of Missouri-Columbia, 1977)

I remember lectures in medical school in which HeLa cells were discussed. The professor named the source of the cells: a cancer from a woman named Helen Lang. The cell line was unique: the cells grew well in culture—the first human cells to do so—and had been used in countless experiments as a model for the biology of human cells. My professor was not alone in using the wrong name—others called the woman Helen Lane or Helen Larson. These misattributions are among the many injustices associated with this invaluable cell line and the woman from whom it was taken. The story of Henrietta Lacks and the cell line rising from a single tissue sample is wonderfully explained in The Immortal Life of Henrietta Lacks by Rebecca Skloot. A book about science and a biography of Ms. Lacks and her family, it is also a memoir by the author, who spent over a decade in untangling the story and gaining the trust of the skeptical family.

Henrietta Lacks’s life was tragically brief. She was born in 1920 in a shack in rural Virginia. Her mother died four years later and Henrietta was raised by her grandfather, a poor sharecropper. Raised with her cousin, David Lacks, they had their first child when she was fourteen. In 1941, they moved to Baltimore. After the birth of her fifth child, Ms. Lacks began bleeding. She went to John Hopkins, the only hospital in the region that accepted black patients, where a physician found a mass on her cervix that had not been present three months earlier. A biopsy showed carcinoma of the cervix. She had the standard treatment at the time—a tube of radium was twice sewn into the cervix, followed by a month of external beam radiation. She was declared free of disease, but pain soon returned, the tumor spread, and she died seven months after the cancer was first discovered. It was a tragic ending for this young woman who was reputed to be beautiful and vibrant. Her cousin Sadie expressed it well: “Hennie made life come alive—bein’ with her was like bein’ with fun.”

She was buried in an unmarked grave near her original home.

Before the doctors placed the radium, samples of the tumor had been taken without Ms. Lacks’s permission and given to Dr. George Gey, who had been trying unsuccessfully to grow human cells in vitro. The tissue was placed in tubes with media, labeled “HeLa” (for Henrietta and Lacks), and incubated. Unlike any previous attempts, these cells grew with “mythological intensity,” becoming the first “immortal” cell line. Soon Dr. Gey proclaimed that cures for cancer and other illnesses were imminent, that the HeLa cells were to be the keys to unlocking the mysteries of the cell. The amazingly resilient cells were distributed around the world. Skloot writes,

Her cells were part of research into the genes that cause cancer and those that suppress it; they helped develop drugs for treating herpes, leukemia, influenza, hemophilia, and Parkinson’s disease; and they’ve been used to study lactose digestion, sexually transmitted diseases, appendicitis, human longevity, mosquito mating, and the negative cellular effects of working in sewers.

By 2009 over 60,000 scientific articles had been published about research using HeLa cells. It is estimated that over 50 million metric tons of her cells have been produced over the decades.

The story of the Lacks family is one of poverty and mental and physical illness, made worse by the mental torment the family suffered because of their fragmentary understanding of what the cell line was and how it was used. Henrietta’s youngest daughter Deborah felt a part of her mother’s spirit was in each cell, and thus the experiments done with them could cause her mother perpetual pain.

The more Deborah struggled to understand her mother’s cells, the more HeLa research terrified her. . . . When she found out scientists had been using HeLa cells to study viruses like AIDS and Ebola, Deborah
imagined her mother eternally suffering the symptoms of each disease. p196

The family’s religious background also influenced how they were able to perceive the “immortality” of the HeLa cell line.

In that moment, reading those passages [in the Bible], I understood completely how some of the Lackses could believe, without doubt, that Henrietta had been chosen by the Lord to become an immortal being. . . .

For Deborah and her family—and surely many others in the world—that answer was so much more concrete than the explanation offered by science: that the immortality of Henrietta’s cells had something to do with her telomeres and how HPV interacted with her DNA. The idea that God chose Henrietta as an angel who would be reborn as immortal cells made a lot more sense to them than the explanation Deborah had read years earlier in Victor McKusick’s genetics book. p296

Ms. Skloot wrote the book for the lay public and integrates the science with the stories so that, while basic, it is never tedious.

The book underscores the contradictions inherent in the benefits derived from a cell line developed from an uninformed patient without her consent. Even more reprehensible, HeLa was used in many further experiments on uninformed subjects. Like many doctors of his era, Henrietta’s surgeon, Dr. TeLinde, often used patients from the public wards for research, usually without their knowledge. Many scientists believed that since patients were treated for free in the public wards, it was fair to use them as research subjects as a form of payment. Most subjects, in keeping with the accepted racism of the time, were African American. In one notorious example out of many others, Chester Southam of Sloan-Kettering Institute for Cancer Research performed a number of studies to find out whether investigators of the cell line were at risk themselves of developing cancer from working with HeLa:

In February 1954, Southam loaded a syringe with saline solution mixed with HeLa. He slid the needle into the forearm of a woman who’d recently been hospitalized for leukemia, then pushed the plunger, injecting about five million of Henrietta’s cells into her arm. Using a second needle, Southam tattooed a tiny speck of India ink next to the small bump that formed at the HeLa injection site. That way, he’d know where to look when he reexamined the woman days, weeks, and months later, to see if Henrietta’s cancer was growing on her arm. He repeated this process with about a dozen other cancer patients. He told them he was testing their immune systems; he said nothing about injecting them with someone else’s malignant cells.

Such blatant ethical breaches contributed to efforts to create the requirements for informed consent and research oversight that now protect experimental subjects.

The story of the author’s involvement with the family is a saga of incredible dedication. Skloot learned about HeLa at age sixteen in a community college biology class. Years later, when she contacted the family, she encountered great resistance. Once the identity of the donor of the HeLa cells had been revealed (twenty years after Ms. Lacks’ death), the family was bombarded by requests for family details, blood samples, and information that could contribute to a good story. They had been victimized by some, and felt that someone had made a fortune from their mother’s cells and that they should have a share. Skloot’s perseverance and personal sacrifice eventually won their trust.

Read this book. It is a riveting story, a reminder of how far we have come and how far we have to go. It is not just about science or the life of a woman who died at such a young age. It is about truth and trust and breaches in professional responsibility. Deborah summarizes the conflict:

“Truth be told, I can’t get mad at science, because it help people live, and I’d be a mess without it. I’m a walking drugstore! . . . But I won’t lie, I would like some health insurance so I don’t got to pay all that money every month for drugs my mother cells probably helped make.” p256

Dr. Griffith is an associate professor in Community and Family Medicine at the University of Missouri—Kansas City School of Medicine. His address is:

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A CELEBRATION OF POETS

Reviewed by Jack Coulehan, MD (ΩΩΩ, University of Pittsburgh, 1969)

Everyone is aware of the dramatic advances in medical science that have occurred over the last few decades, but relatively few people realize that the medical profession has also experienced a parallel explosion of poetic creativity. Medicine has a long tradition of distinguished physician-poets, including, for example, Thomas Campion, Tobias Smollett, Oliver Goldsmith, John Keats, Oliver Wendell Holmes, Silas Weir Mitchell, Robert Bridges, and William Carlos Williams, the early twentieth-century bard of Rutherford, New Jersey. Today’s American medical poets generally look to Williams as their godfather. His no-nonsense language, accurate observation, and privileging of experience over ideas meshes well with the ethos of...
Reviews and reflections

contemporary medicine.

A number of superb post-Williams poets (e.g., Drs. Robert Coles and John Stone) established themselves in the 1970s, but it was only in the late 1980s and 1990s that doctor poets began springing up like wildflowers in an Alpine meadow. By now they blanket the continent. Why has this phenomenon occurred? An interesting question, but one I can't attempt to answer here. For whatever reasons, we now have a whole new cadre of medical “specialists,” who, for all their differences in focus and style, bring a medical sensibility to their ancient art. A number of recent anthologies celebrate this burgeoning poetic movement. For this review I've selected a handful of books published in the last few years just to suggest the range of contemporary physician-poets.

Secret Wounds

Richard M. Berlin
BkMk Press, University of Missouri—Kansas City, Kansas City, Missouri, 2011

Psychiatrist Richard Berlin's Secret Wounds, which won the John Ciardi Prize for Poetry in 2011, acknowledges the woundedness of a medical life, while affirming the possibility of healing. In “How a Psychiatrist Writes a Poem,” Dr. Berlin relates his method:

I begin by remembering my hours as a patient and Freud’s “Fundamental Rule”:

Say Whatever Comes to Mind

In “Wounds,” he shows that he understands that “Each wound contains/its own beauty” and “speaks/its own language.”

In an accessible narrative style, Berlin discovers revelatory moments in his life, from the drudgery of internship (“Interned”) to a seemingly rash act with a dialysis patient: “It was a headlong act of love/when I kissed her.”

“Medical Education” summarizes the irony of our curriculum,

What they taught in school was not what we needed and what we needed (they said) could not be conveyed.

In “Whores” the poet turns his ironic eye toward health insurance.

But every month, when we devour another round of sessions, I fill out forms for insurance pimps who won’t pay unless I reveal the private parts.

Richard Berlin transforms the wounds of a life in medicine, a life on the line, so to speak, into affirmation, not with fancy language or heroic gestures, but with the eloquence of directness and honesty.

Poems from Both Sides of the Fence: A Disabled Physician’s Experiences in Medicine

Beryl Lawn
Texas Review Press, Huntsville, Texas, 2011

Another psychiatrist, Beryl Lawn, writes from the perspective of a physician whose wounds are not so secret. Paraplegic as a result of a childhood accident, Dr. Lawn, in Poems from Both Sides of the Fence, offers tough wisdom from the perspective of both patient and healer. Unlike Richard Berlin's poems, Dr. Lawn's are very short, explicit, anecdotal, and sometimes gnomic. They resemble clinical “pearls.” Far from being limited by her seeming disability, the poet proclaims,

I believe I am set free by my wheelchair.

In one poem she reveals the secret of generating patient satisfaction:

For the patient it was time spent, attention given (not experience) for which he was most grateful.
Beryl Lawn’s work also contains a strong element of social commentary. A friend is batted back and forth among several specialists without an accurate diagnosis. In frustration, he went to his veterinarian, described his symptoms, gave a urine specimen, and was promptly diagnosed as having diabetes.19

In “Assumptions IV” another friend, an African American psychiatrist, is asked for his Medicaid card when he shows up at an Emergency Room. With great insight, Dr. Lawn concludes,

As often as I sweep, the garage never stays swept and clean for long.

Like my inner life.79

Six Rivers
Jenna Le

Six Rivers is Jenna Le’s first collection. Dr. Le, the youngest in this group of physician-poets, is also the most devoted to traditional poetic forms, ranging from the European sonnet and villanelle to the Japanese tanka and haiku-bun. The poet divides her book into six sections, each named for a river important in her life, beginning with the Perfume River, near her family’s home in central Vietnam. The fifth “river” is the human aorta, around which are clustered her medical poems. Among these are the lovely villanelle, “Caesarian Section,” which celebrates a healthy new life, and “Elegy,” which mourns the death of an elderly Nepalese woman. The latter poem also reveals how physicians can become hardened and detached, as the radiologist comments on the difficulty in visualizing the woman’s intestinal parasites—since they “have no bones,” 55—seemingly unconcerned about the patient herself. The ultimate river is the Styx, where the book ends appropriately with poems that celebrate characters from myth and history.

Silent Music
Richard Bronson

In Silent Music Richard Bronson reminds us that, although we live in a world of ambiguity, we can discover beauty and meaning in our lives by becoming aware of “notes/at the edge of perception—/. . . a new sensibility/. . . a silent music.”26

Dr. Bronson, a reproductive endocrinologist, brings a medical sensibility to memories of childhood, especially in such poems as “Father’s Day,” “Imperfect Knowledge,” and “The Pill Closet,” poignant tributes to his father, a general practitioner who worked himself, “black bag in hand,” to an early death. Having become a facilitator of life, Richard Bronson celebrates its mystery, as he writes in “Laboratory-Assisted Reproduction”:

I have often probed that fecund place, And in the dark vista of my sonic vision, Sought the motion of a nascent heart Bearing witness to life.51

But Dr. Bronson’s narratives also cry out for justice and deplore violence and cruelty, as in his eloquent “Cry, Oh Cry Darfur!” and the touching “Terminal Velocity.”

Primitive Mood
David Moolten
Truman State University Press, Kirksville, Missouri, 2009

The last selection is the T. S. Eliot Award-winning Primitive Mood by David Moolten, a Philadelphia transfusion medicine specialist. Moolten’s distinctive style presents the reader with finely wrought narratives, each telling a small human story with deep empathy and compassion, and often with a palpable sense of gratitude. Whether he writes of his Jewish grandfather’s response to Wagner’s music on the radio, or observing “The Girl Without Hands,” or about a Native American activist who “drank herself out/Of a smashed marriage,” Moolten transforms our world by evoking theirs.

Dr. Moolten’s poems are, in a
Less woman enters “one long swoon/Into loathsomeness,” suffers a cardiac arrest, and someone “saves” her, “the story’s still not over.”⁸⁸ On observing a mass grave in Rwanda, he also knows that “It takes a year for a body to purge itself/ Down to bones.”¹²¹⁹ Nonetheless, he approaches the human condition with tenderness and hope. The reader finishes Primitive Mood with the feeling, “Even now I’m greedy to hear more.”

Technology is thriving in medicine today and, fortunately, so is poetry. This situation is neither strange, nor paradoxical. Rather, it’s an affirmation that art and science are not only compatible, but inseparable, in the practice of healing.

References

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Letter to the editor

After reading the editorial in The Pharos on mentoring and coaching by R. L. Byyny (Winter 2012, pp. 1–3), mentors and coaches emerged from the shadows of my memory. First was grandfatherly John Jennings, who had a farm near our house where he kept six or eight horses. Mr. Jennings befriended our family and took a special interest in me, an only child. He taught me to ride and proudly followed my progress in medicine. Another mentor was a neighbor, Edward Cannon, who took me to Sunday school. I now mentor youth at church even as others mentor me spiritually.

In school, I was too introverted and shy to actively seek mentors. Faculty during college and early medical training did not relate to me personally in the ways Byyny lists. But later I met Dr. Harold May in the Community Medicine unit at Brigham Hospital in Boston. Dr. May invited me to his home for dinner and starting me down the road to community medicine/public health. After joining the U.S. Public Health Service, I met Dr. Manning Feinleib in an evening statistics class. He gave me a job in his epidemiology unit at NIH, launching my career as a cardiovascular epidemiologist. Later in my career, I had the opportunity to work again with him and Jack Feldman in an ideal research job at the Centers for Disease Control and Prevention.

So thanks to Dr. Byyny for his sage advice to mentors, coaches, and their protégés, and to my mentors, whom his editorial brought to mind. Perhaps others will find it useful to list their mentors and share their stories with friends and protégés. Now as I continue to mentor young people from second grade through assistant professor, I hope I can return with interest what my mentors have given to me.

Richard Frank Gillum, MD, MS (AOA, Northwestern University, 1969)
Silver Spring, Maryland
The Board of Directors of Alpha Omega Alpha is pleased to announce the winner of the 2012 Edward D. Harris Professionalism Award. The award emphasizes AΩA’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 AΩA Professionalism Fellowship, the award was renamed in 2010 to honor the late Edward D. Harris, the longtime executive director of the society. Applications were open to medical schools with active AΩA chapters or associations. 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 2012 Edward D. Harris Professionalism Award is:

**Anthony Back, MD**
Professor, Division of Oncology, Department of Medicine, University of Washington School of Medicine

Professionalism is central to training physicians who can meet the challenges of medical care that the United States currently faces. Responding to these challenges, the Accreditation Council for Graduate Medical Education (ACGME) has recognized that training programs must develop methods that enable physicians in training to “develop a therapeutic relationship with patients and families,” and “use verbal and non-verbal skills,” while acting with “integrity and honesty,” “accept[ing] responsibility,” and “act[ing] in the best interest of the patient.” The ACGME has recently identified “the ability to run a family meeting” as a milestone for postgraduate residents that requires them to combine communication and professionalism in complex clinical situations that require integration of communication skills with professional integrity, honesty, and nonabandonment. Over the past decade, with funding from the National Cancer Institute, we have developed a small group learning method for trainees that demonstrates behavior change, and developed a faculty train-the-trainer program that improved teaching behaviors by faculty and improved communication outcomes by learners. In this proposal we aim to disseminate this evidence-based train-the-trainer facilitation model by developing a novel video-based train-the-trainer intervention that will improve learner communication behavior by using the family conference as a focal point.

### 2012 Postgraduate Awards

In 2011, the board of directors of Alpha Omega Alpha established the Postgraduate Award to encourage and support AΩA residents or fellows from programs or institutions with an active AΩA chapter or association to pursue a project in the spirit of the AΩA mission statement. Project applications were accepted in the categories of:

1. Research: Support for clinical investigation, basic laboratory research, epidemiology, or social science/health services research.
2. Service: Local or international service work, focusing on underprivileged or immigrant populations or those in the developing world, as well as patient and population education projects.
3. Teaching and education: Research, development, or implementation of education academic curricula, with the focus on postgraduate education.
4. Leadership: Leadership development.
5. Humanism and professionalism: Projects designed to encourage understanding, development, and retention of traits of humanism and professionalism among physicians, directed to physicians in postgraduate training.

Eight applicants received $2000 awards to support their work. The recipients of the 2012 awards are:

**Julie Balch Samora, MD (AΩA, West Virginia University, 2009)**
The Ohio State University College of Medicine
Project category: Teaching and education
*Microsurgery Instruction in an Orthopaedic Residency*
Ryan D. Klinefelter, MD, mentor
Sheryl A. Pfeil, MD, councilor

**Steven Bishop, MD (AΩA, University of Virginia, 2010)**
Virginia Commonwealth University School of Medicine
Virginia Commonwealth University Health System
Project category: Teaching and education
*Team-Based Learning in In-Patient Ward Teams: Does It Improve Resident Learning?*
Stephanie A. Call, MD, MSPH, mentor
Gordon L. Archer, councilor
2012 Postgraduate Awards

Michael O’Neill, MD (ΑΩΑ, Temple University, 2009)
University of Miami Leonard M. Miller School of Medicine
Jackson Memorial Hospital/University of Miami, Department of Diagnostic Radiology
Project category: Research
Follow-up Yttrium-90 Internal Pair Production PET/CT Imaging in Patients with Primary or Metastatic Liver Tumors as Compared with Bremsstrahlung Imaging: A Prospective Case Series
Jason Salamendi, MD, FACP, councilor
Alex J. Mechaber, MD, councilor

Andrew Ross, MD (ΑΩΑ, Oregon Health & Sciences University, 2009)
University of Vermont College of Medicine
University of Vermont, Fletcher Allen Health Care
Project category: Research
Benefits of a Pre-Natal Ultrasound Program in Rural Uganda
Kristen DeStigter, MD, mentor
Jeffrey Klein, MD, councilor

Shawna Ruple, MD (ΑΩΑ, Michigan State University, 2010)
University of South Carolina School of Medicine
Greenville University Hospital Systems
Project category: Research
A Pilot Study Comparing the Pregnancy Rate of Clomifene Citrate and Raloxifene in Infertile Polycystic Ovarian Syndrome Patients
Bruce Lessey, MD, PhD, mentor
Joshua T. Thornhill IV, MD, councilor

Mary Temple Sale, MD (ΑΩΑ, Marshall University, 2010)
University of New Mexico School of Medicine
Project category: Research
Improvement for Contraceptive Access in Methadone-Using Women
Tony Ogburn, MD, mentor
Tony Ogburn, MD, councilor

Noam VanderWalde, MD (ΑΩΑ, University of Maryland, 2009)
University of North Carolina at Chapel Hill School of Medicine
Project category: Research
Utility of the Comprehensive Geriatric Assessment in Predicting Tolerance to Radiation Therapy in Older Adults with Cancer: A Prospective Blinded Study
Bhishamjit S. Chera, MD, mentor
Amelia Drake, MD, councilor

Breelyn Wilky, MD (ΑΩΑ, University of Medicine and Dentistry of New Jersey—Robert Wood Johnson Medical School, 2005)
Johns Hopkins University School of Medicine
Project category: Research
The Role of RNA Helicase DDX3 in Ewing’s Sarcoma
David M. Loeb, MD, PhD, mentor
Peter E. Dans, MD, councilor

2011/2012 Visiting Professorships

Beginning in 2002, Alpha Omega Alpha’s board of directors offered every chapter and association the opportunity to host a visiting professor. Sixty-seven chapters took advantage of the opportunity during the 2011/2012 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
Stephanie D. Reilly, MD, councilor

Victor Strasburger, BA, MD, University of New Mexico School of Medicine
University of South Alabama College of Medicine
T. J. Hundley, MD, FACP, councilor

Molly Cooke, MD, University of California, San Francisco, School of Medicine

ARKANSAS
University of Arkansas for Medical Sciences College of Medicine
C. James Graham, MD, councilor

Kevin Krane, MD, Tulane University School of Medicine

CALIFORNIA
Loma Linda University School of Medicine
Sarah M. Roddy, MD, councilor

Thomas J. Nasca, MD, MACP, Accreditation Council for Graduate Medical Education
University of California, Davis, School of Medicine
Regina Gandour-Edwards, MD, councilor
Jerome Hoffman, MD, FACP, University of California, Los Angeles David Geffen School of Medicine

University of California, Los Angeles David Geffen School of Medicine
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George Karam, MD, Earl K. Long Medical Center

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University of California, Los Angeles David Geffen School of Medicine

Neil H. Parker, MD, councilor

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The PharoS/Autumn 2012
The Alpha Omega Alpha Volunteer Clinical Faculty Award is presented annually by local chapters or associations to recognize community physicians who have contributed with distinction to the education and training of medical students. AΩA 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 2011/2012 academic year are listed below.

**CALIFORNIA**
University of California, San Francisco, School of Medicine
Margaret Chen, MD

**GEORGIA**
Medical College of Georgia at Georgia Health Sciences University
James Hotz, MD
Morehouse School of Medicine
Douglas S. Ander, MD, FACEP

**HAWAII**
University of Hawaii, John A. Burns School of Medicine
John Cogan, MD

**ILLINOIS**
Chicago Medical School at Rosalind Franklin University of Medicine & Science
Barbara Brotnie, MD, FACMP
University of Illinois College of Medicine
Michael Werckle, MD

**INDIANA**
Indiana University School of Medicine
Fred Frick, MD

**KANSAS**
University of Kansas School of Medicine
Michelle Pope, MD

**KENTUCKY**
University of Louisville School of Medicine
Jeffrey T. Omer, MD

**LOUISIANA**
Tulane University School of Medicine
Henry Evans, Jr., MD
Louisiana State University School of Medicine in Shreveport
Charles D. Knight, Jr., MD

**MARYLAND**
University of Maryland School of Medicine
Danielle Robertshaw, MD

**MICHIGAN**
University of Michigan Medical School
Daryl Tanski, MD

**MINNESOTA**
University of Minnesota Medical School
Megan McEllistrem, MD

**NEBRASKA**
University of Nebraska College of Medicine
Mark Woodruff, MD

**NEW JERSEY**
University of Medicine and Dentistry of New Jersey—New Jersey Medical School
Roger Harrison Brodkin, MD
University of Medicine and Dentistry of New Jersey—Robert Wood Johnson Medical School
Barbara Marroccoli, MD

**NEW YORK**
Mount Sinai School of Medicine
Danielle Milano, MD
New York Medical College
Danny Hirsch-Kaufmann Jokl, MD
New York University School of Medicine
Bruce Raphael, MD
State University of New York Downstate Medical Center of Medicine
Alla Shapiro, MD
State University of New York Upstate Medical University
Patsy Iannolo, MD
University of Rochester School of Medicine and Dentistry
Peter Van Brunt, MD
Weill Cornell Medical College
Patricia Yarberry-Allen, MD

**NORTH DAKOTA**
University of North Dakota School of Medicine and Health Sciences
Mathew Iwamoto, MD

**OHIO**
University of Cincinnati College of Medicine
Ronna Schneider, MD

**PENNSYLVANIA**
Drexel University College of Medicine
Robert Massaro, MD
Jefferson Medical College of Thomas Jefferson University
Matthew J. Burday, DO, FACP
University of Pittsburgh School of Medicine
Deborah Gilboa, MD

**SOUTH CAROLINA**
University of South Carolina School of Medicine
Ada D. Stewart, MD

**TENNESSEE**
Vanderbilt University School of Medicine
Timothy Eidson, MD

**TEXAS**
University of Texas Medical School at Houston
Fernando Levaro Pano, MD
University of Texas Southwestern Medical Center at Dallas
Southwestern Medical School
Stephen W. Lacey, MD

**VERMONT**
University of Vermont College of Medicine
Jennie Lowell, MD

**VIRGINIA**
Virginia Commonwealth University School of Medicine
Mitchell Miller, MD, FAAFP

**WASHINGTON**
University of Washington School of Medicine
Emily Transue, MD
2011/2012 Administrative Recognition Awards

This award recognizes the AΩA chapter administrators who are so important to the functioning of the chapter or association. 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 2011/2012:

ARIZONA
University of Arizona College of Medicine
  Bonnie Marshall

CALIFORNIA
University of California, San Francisco, School of Medicine
  Sara Campillo

MINNESOTA
Mayo Medical School
  Judith Kaur, MD

NEW HAMPSHIRE
Geisel School of Medicine at Dartmouth
  Pauline Moran

NEW YORK
State University of New York Downstate Medical Center College of Medicine
  Carol Wolintz

      PENNSYLVANIA
University of Pittsburgh School of Medicine
  Erika Miller

      PUERTO RICO
Universidad Central del Caribe
  Liza Cintron

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

      TEXAS
University of Texas Medical Branch School of Medicine
  Elisabeth Sanders
  University of Texas Medical School at Houston
  Patricia Caver
  University of Texas Southwestern Medical Center at Dallas
  Southwestern Medical School
  Holli Holbert

WASHINGTON
University of Washington School of Medicine
  Trish Zander

What my student research fellowship meant to me

As a first year medical student, I was interested in not only learning the basics of medicine in the classroom but also exploring the many factors that play into health care delivery and access.

The fellowship let me pursue that opportunity to be a "student-researcher," to examine medicine and health care both in and outside the classroom. It funded research supplies that I used in the field for data collection as well as preparation of numerous abstracts and posters. It funded my travel to both regional and national conferences where I was able to present, defend, and distribute my findings as poster and oral presentations, something I had never done before. The conferences were especially exciting because I could not only share my work with like-minded colleagues, but also meet many people in the field of research, medicine, and global health who I very much admire. Lastly, I was able to fund a submission and therefore publish a first-authored manuscript of my work in the *International Journal of Family Medicine*.

Together, those experiences inspired, challenged, and shaped me profoundly as a student. They gave me skills and confidence to continue to pursue research through my career. In fact, the project I started with the help of the fellowship is still ongoing. We presented my findings to the local government in Yoro, Honduras, which helped inform changes to our mission that will better target the community health needs. How inspiring to see my research make change in a community's access to health care! I am planning my next trip to Honduras for this January, to continue expanding on our findings from my last project. This work has shaped my experience in medical school tremendously. I have no doubt it will continue to shape my education and future profession in a positive way, as well.

Kate Pearson
Class of 2014
Virginia Commonwealth University School of Medicine

Feedback from students like Ms. Pearson shows us how important it is to support programs like the AΩA Carolyn L. Kuckein Student Research Fellowships. Besides the financial support of your dues, we need volunteers to help us review the dozens of applications we receive each year for the program. If you are qualified to review applications for student research fellowships, please send us an e-mail to info@alphaomegaalpha.org. Include a paragraph about yourself and your research interests, and attach your NIH biosketch or equivalent. The fellowship applications are sent to reviewers in February, with a deadline of mid-March.

Help us support student research
I pass behind her as she maneuvers an empty grocery basket into its slot in the parking lot. There is no spring in her heels like other eight-year-olds. Her hair is curly but thin, as if growing anew. Delicate legs carry her in Deliberate steps, Unsteady steps. Measured steps, as if she is on a mission to return that basket to its safe home. The mother watches from the car door. As the basket clangs into its nest, the child turns on wobbly legs and pulls a baby doll from under her arm.

Holding it to her chest, she carefully steps toward her mother. I cannot see the child’s face, but in the mother’s there is a mutual agony. She brushes back the defiled hair and smiles at the child clutching her doll—as if she, too, aches to clutch her child right there in that parking lot.

Douglas H. Forsyth, MD

Dr. Forsyth (AΩA, Tulane University, 1960) is retired from private practice in Internal Medicine and Cardiology in Atlanta. His address is: 6660 Weatherly Drive, NW, Atlanta, Georgia 30328. E-mail: douglasforsyth@comcast.net.
Illustration by Erica Aitken.
AΩA’s new scarf highlights the society’s insignia, based on the shape of the manubrium sterni. The center medallion feature the Pharos lighthouse of Alexandria, one of the seven wonders of the ancient world, for which AΩA’s journal is named. The borders are stylized DNA strands.

Alpha Omega Alpha neckties or freestyle bowties are fashioned from fine silk by Vineyard Vines of Martha’s Vineyard, Massachusetts.

Scarf design by J&J Designs of San Francisco (jnjdesigns.biz).

To order, send a check for the appropriate amount to: Alpha Omega Alpha, 525 Middlefield Road, Suite 130, Menlo Park, CA 94025. Or order online at www.alphaomegaalpha.org/store. Price includes shipping and handling.