Seeing in the New York Times, or any other newspaper, a photograph of a doctor breaking into tears as he announces that his patient has died, is unusual. Well, there it was . . . Dr. Dean Richardson crying as he spoke at a news conference in a poignant moment after that noble horse, Barbaro, was euthanized. “It is what it is,” said Richardson. “It’s not the first horse I’ve cried over.” Somehow I don’t think that it will be his last. This veterinarian, may well have had multiple reasons for his demonstrative sadness: the loss of a friend, frustration about not being able to save the horse, relief that his suffering was over, and others that we cannot know. My point is that this is compassion, an emotion that should be expressed more freely by all of us who deliver care. Assuming that Dr. Richardson has students, it is likely that he has shown them that a good doctor can be world class, technically competent, and man enough to be moved to tears over a patient’s situation.

Compassion appears in interesting places. For example, in the ACGME list of six competencies that are now required for all residents in all specialties, compassion is set forth as a trait, a quality that can indeed be learned. The six are:

1. Patient Care
2. Medical Knowledge
3. Practice-Based Learning and Improvement
4. Interpersonal and Communication Skills
5. Professionalism
6. Systems-Based Practice.

The leading sentence under the competency of Patient Care is: “Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.” Similarly, under Professionalism is the dictum, “Residents are expected to . . . demonstrate respect, compassion, and integrity.” And under Interpersonal and Communication Skills is the admonition that “Residents are expected to: create and sustain a therapeutic and ethically sound relationship with patients.”

I have observed that there are many who would say that compassion should not be considered as one of the ACGME competencies because it cannot be taught, but rather is an “innate” quality that, similar to a dominant gene, one is either born with or not. “You either are innately compassionate with an emotive spirit . . . or you are not,” some say. Others, and I hear this from trainees and students, feel that expression of compassion by resident physicians must be tightly controlled if it is to escape from repression. The reasons for this include a couple of possible realities: expressing compassion won’t be helpful in getting a fellowship; if you give compassion excessively, it will tear you apart emotionally in residency; and hypothetical objections: being compassionate carries the risk of becoming emotionally involved with your patients. Another reason for restraint is that there remain remnants in many training programs of a “macho” culture that encourages one to brag about “the great case that came in last night with [fill in the blank]” without focusing on the fact that the great case now has a widow and two children who will be fatherless.

Let me push the argument that expression of compassion can be learned, belongs in the competencies of the ACGME, and that it is okay to be emotionally involved with your patients, as was Dr. Richardson. In addition, being compassionate can be a joyous reward for those who can give of themselves in this way. What, then, are the pathways for developing it in those of us in whom it is not innate?

One pathway is to have experienced a great personal tragedy or loss, something, as one dear friend has said, that is “profoundly destabilizing to the point where one is forced to reevaluate one’s place in the world.” I would not wish such loss on anyone, but these events happen and help make permeable the usually dense walls within the mind, enabling the internal sorrow for oneself to flow out to others as support, empathy, encouragement, or tears.

Fortunately, most residents and students do not have to suffer personally to be compassionate. The dense walls within the mind can be made permeable by gentler means. The prescription, in contrast to Sir William Osler who was a great one for compartmentalizing emotions, should be, “Let your mind run free within your brain.” Lewis Thomas had the right ideas: “Perhaps only one or two thoughts should be repressed each day, at the outset. . . . regain the kind of spontaneity and zest for ideas, things popping into the mind, uncontrollable and ungovernable thoughts. . . . There is no delusion more damaging than to get the idea in your head that you understand the functioning of your own brain. . . . If we should give away the capacity for embarrassment, the touch of fingertips might be the next to go, and then the suddenness of laughter, the unaccountable sure sense of something gone wrong.”

I suggest that allowing sadness and melancholy to pervade our senses when sad things happen, such as a patient’s death, is healthy. Melancholy, that gray veil that takes color out of life, can, at the same time, add to the brilliance and value of life, if we feel what it is asking of us. Melancholy and sadness, similar to love, can make those compartment walls in our minds permeable, enabling us to express empathy that is truly felt within. At the least, it will stimulate our awareness of others’ pain or suffering and loss, as well as allowing our true compassion, with or without tears, to be expressed. At the most, providing a mixture of empathy, compassion, and hope to others will enrich our own lives and enable those compartments of our mind to open more easily the next time.

Reference


Edward D. Harris, Jr., MD
Editor
Consumer-driven health care

Implications for the physician/patient relationship

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Public and private sector health care policy and practice leaders in the United States have attempted over the last several decades a variety of approaches to achieve the tripartite objectives of an ideal health care system: high quality care, accessibility, and affordability for the general population. In large measure, these attempted strategies of health planning, command-and-control regulation (often aimed at mandating or restraining specific physician activities), and managed care have come far short of success. In frustration, we are now engaged in a very different sort of national health care financing and delivery experiment: consumer-driven (sometimes called consumer-directed) health care. In his 2006 State of the Union message, President Bush touted this idea as part of his “comprehensive agenda to make health care in America more affordable, portable, transparent, and efficient.” In this experimental model (most commonly entailing a high-deductible health insurance policy, a health savings account [HSA], and a coverage gap in between), the
individual qua consumer is empowered (and indeed required) to exercise a higher degree of personal choice, direction, and control regarding the financial and structural components of his or her own health care. The emerging and controversial phenomenon of consumer-driven health care already has attracted substantial attention from and about an array of potentially affected players in the system. Commentators representing the entire political spectrum have speculated about some of the likely ramifications of the consumer-driven model for employers, insurers, the financial services industry, hospitals, and, of course, consumers. However, relatively little serious discussion has occurred yet about the implications of this new model for practicing physicians, particularly concerning the possible impact of consumer-driven health care on the future of the physician/patient relationship. This essay makes a quite preliminary attempt to identify and sketch out some of the most salient of these implications.

Consumer-driven health care

Within the health care context, the consumer-driven model is intended and expected to enable consumers to more directly choose health care arrangements according to their own set of priorities. Through defined financial contributions to their personal medical care (by consumers and, frequently, their employers), consumers are able "to control their health care resources and therefore health care decision making" within a competitive, individualized marketplace of competing services and service providers. The elements of consumer choice and control are what distinguish consumer-driven health care from the previous, more confined concept of consumer-centered health care, which focused on satisfaction of consumers needs, but only as defined by health care professionals.

By removing the economic and psychological insulation of first-dollar insurance coverage, consumer-driven health plans make consumers more acutely sensitive to the costs of their own health care, and hence more discriminating purchasers. In essence, the consumer-driven plan makes the individual consumer the agent for rationing his or her own finite health care resources. This approach is "compatible with consumers' desires for control in a world where someone needs to decide which patients will receive which health care services now, which later, and which never," and "many believe that the individual citizen is the most appropriate setter of health care priorities." One of the least controversial mechanisms for rationing could be to allow patients to make their own choices as to which kinds of care they would be willing to forgo. This is appealing because it preserves individual freedom of choice regarding health care in a way that other rationing mechanisms do not.

To pursue its objectives in practice, the consumer-driven health care model may take many particular structural forms. The tangible specifics of the numerous versions of this emerging approach have been detailed thoroughly elsewhere.

The most usual version of the consumer-driven model contains three separate but related parts.

1. A high-deductible health insurance product purchased for the individual or dependents by either a person's employer or union, the government, or the individual. It protects the insured person against the risk of incurring catastrophic health care costs. These insurance policies may vary regarding provider networks, particular services included, benefit packages, and co-payment requirements.

2. An individually-managed, tax-exempt, interest-bearing HSA, usually used to pay for routine and preventive medical, dental, and vision services that cumulatively cost less than the deductible amount specified in the insurance contract. Unused funds may be rolled over into, and accumulated in, various kinds of investment vehicles.

3. The so-called gap or doughnut hole. This component becomes pertinent if an individual uses up all the funds in his or her HSA to pay for medical care and then has to use personal, after-tax income until expenses reach the deductible threshold and the insurance policy begins to pay out.

Impact on the physician/patient relationship

The contemporary American movement toward consumer-driven health care in many respects constitutes a revolution from the status quo ante in health services financing and delivery. Among the most important implications of this paradigm shift are the ways in which this emerging model are likely to fundamentally influence various facets of the physician/patient relationship.

Reduced external regulation

Effective widespread implementation of a consumer-driven health care model will require the development and implementation of a panoply of laws regulating insurance products and HSA financial vehicles, the heart of the model. Additionally, physicians certainly will continue to have their conduct regulated by the traditional legal mechanisms of
contract law, tort (mainly negligence) litigation, and state licensing statutes (Medical Practice Acts). The good news for most physicians is that, under the consumer-directed model, the physician/patient relationship will likely be less subject to the close external oversight and constant supervision that many current financing systems require concerning payment for particular clinical interventions. Rather than relying on direct command-and-control (“Thou shalt” and “Thou shalt not”) conditions of payment for specific services set by government, insurance company, or managed care organization, the consumer-directed model endows consumers/patients with a high degree of discretion in choosing to purchase particular services after consultation with their own physicians. The physician thus deals personally with the rationing agent—the consumer—within the physician/consumer relationship.

More demanding consumers

The obvious other side of the less-external-regulation-of-payment-issues coin is that, if the consumer-directed model actually works as theorized, consumers will become much more sophisticated, choosy, and demanding purchasers of clinical services. Once patients are equipped with the power of the purse and forearmed with appropriate information, they will act as consumers and insist that health care providers deliver high-quality services at reasonable prices and under additional conditions agreeable to the buyer. To the (yet to be empirically tested) extent to which consumer-driven health care succeeds in creating this new lifeform—the financially empowered health care consumer—it will pose several kinds of challenges for treating physicians.

First, the financially empowered health care consumer is likely to shop among potential health care providers, including personal physicians, at least in part on the basis of price. Physicians will need to compete for patients on this basis, just as other sellers of goods and services for which consumers pay directly have always had to do, and just as the purveyors of cosmetic or laser eye surgery have learned to do quite effectively. Competition will consist not only of setting charges at a level the market (rather than the government, managed care organization, or insurance company) will bear, but also making those rates known in advance to the prospective clientele. The medical profession a number of years ago entered the advertising enterprise, and price will, under these conditions, become a larger component of that activity.

Second, consumers empowered with real (i.e., financial) choice also will expect physicians vying for their business to compete on the basis of quality of care. Physician protestations that quality of care cannot be accurately measured, let alone advertised to or understood by consumers, are falling quickly by the wayside at a time when Medicare and private insurance plans are adopting pay-for-performance methodologies. Indeed, in early 2006 the American Medical Association, encouraged strongly by the AARP, signed a pact with Congress to develop more than one hundred standard measures of performance that individual practitioners will use to regularly report to the federal government. Consumers who are interested in quality, and accustomed to religiously studying Consumer Reports’ comparative scorecards on the relative merits of different brands of automobiles and vacuum cleaners before investing their cash, will soon demand the same sort of medical quality information that physicians will have to provide to the federal government and insurance companies.

Once an economically empowered consumer decides to enter into a contractual relationship with a health care professional, bargaining about the provision and purchase of particular services can be expected. Consumers will likely question not just the need for a recommended diagnostic or therapeutic intervention, but also the expected benefits and risks associated with it, the anticipated financial costs, and the possible alternatives. Physicians should therefore anticipate working harder at explaining to patients why they are or are not making particular recommendations, explicating much more thoroughly costs, benefits (both in terms of likelihood and amount), and physical risks, and the ramifications of choosing alternative procedures or tests. These will all become essential parts of the legally and ethically required informed consent dialogue.

In a similar vein, by forcing individuals to be responsible for their own total health care budgets, consumer-driven health care will impose a corresponding responsibility on physicians to be more aware of their patients’ total health care picture. Physicians may be expected to take a larger role in helping patients, especially those with chronic ailments, to coordinate the necessary services available from an array of different providers, and to do so in a cost-conscious manner. Patients, and hence their physicians, will be much more concerned than in the past about how the previously disparate pieces of one’s health care come together financially.

Counseling patients about health care plans

In the clinical arena, society (acting through the legal doctrine of informed consent) expects patients to make often extremely complex, technical, life-altering decisions about whether or not to undergo specific diagnostic tests and therapeutic procedures. A substantial proportion of patients both accept and demand this right under the ethical principle of autonomy. At the same time, under the consumer-driven health care model, there is substantial reluctance within a segment of the consumer population to take on the same right of self-determination in deciding about competing insurance plans. While both of these contexts call for complex decision making by the consumer, in the former the patient’s personal physician has the opportunity to be an integral participant in providing information, giving recommendations, and helping to guide the patient to a reasonably comfortable choice. In the latter, no such knowledgeable guide is obvious.

14

The Pharos/Spring 2007
But in the emerging era of consumer-driven health care, physicians increasingly may be expected to fill that role. While some of this financially-related counseling task probably can be delegated to others in the physician’s office or outsourced, there is little doubt that most patients thrust willingly or involuntarily into a more consumer-oriented health care role will turn to their physicians to help them with the challenge of identifying the personal priorities through which they must ration in advance their own limited health care resources. Physicians who convince their patients that those patients are capable of managing key aspects of their own clinical care contribute to improved patient health outcomes; physicians must be prepared to seek similar results for patients in managing their own health care finances. Put succinctly, consumer-driven health care will impose on physicians legitimate patient expectations that compel them to become much more health insurance literate, and to use that literacy on each patient’s behalf.

Conclusion
In the United States and abroad, health care resources are finite and therefore must be rationed somehow, by someone. For those who believe that government agencies, private insurance companies, and managed care organizations are best suited to do this in a way likely to maximize the quality, affordability, and accessibility of health care, the concept of consumer-driven health care will be anathema. The concept also will be soundly rejected by those—including perhaps the majority of practicing physicians—who either are threatened by the idea of consumer empowerment challenging traditional physician domination or sincerely disbelieve the capacity of patients to act as intelligent consumers.

For those who truly respect consumers and their autonomy, though, this new paradigm of health care financing and delivery represents a tremendous opportunity. For the positive potential to be realized in practice, physicians will need to embrace the new order and productively carry out the indispensable roles patients and society will expect of them. If physicians sabotage the success of the consumer-driven health care model as they have sabotaged earlier attempts to redesign the health care financing and delivery system, the next major iteration in American health care policy inevitably will consist of some form of socialized medicine. Physicians concerned about maintaining their clinical prerogatives should think long and hard about that consequence and whether undermining the viability of consumer-driven health care really serves best the interests of either physicians or patients.

References

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Commentary

Health savings accounts—the avoidance of solution

Halsted R. Holman, MD

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Dr. Kapp has provided a brief description of what awaits us if some health planners have their way with Health Savings Accounts (HSAs) as the solution to the health care crisis. It is a harrowing prospect: the chronically ill anxiously seeking honest professional advice and a trusting relationship, or the acutely ill in need of urgent care, negotiating with physicians who hawk different services at varying prices for those who are able to pay. Certainly Dr. Kapp does not present the picture this way, but that is what will transpire given the logic and behavior of HSA free-market economics.

Almost all agree that there is a crisis in health care. The crisis has three main ingredients:

1. Declining access to care
2. Poor quality of care
3. Relentlessly rising costs of care.

The crisis has been brewing for fifty years. Costs are the principal driver. No solution has been achieved.

No solutions for a 50-year crisis

Why has there been no solution? Because the critical causes of the crisis have not been addressed. During those fifty years, dominant health problems have changed dramatically from acute to chronic diseases. Chronic diseases are now the major cause of disability and need for health services, and are responsible for some eighty percent of health care costs. Because the current health care system was developed to treat acute disease, the emergence of chronic disease dominance necessitates a different type of health care, in particular, a different practice of medicine.

Care of chronic disease is not the decisive process of precise diagnosis, definitive treatment, and cure typical of acute disease management. In the absence of cure, chronic disease management is an unfolding, lengthy, multivariate process with a different strategy (not cure, but maximizing the comfort and function of the patient) and different tactics (not just medicines or surgery, but behavior change, alteration of social and work circumstances, environmental modification, and emotional adjustment). As a result, chronic disease practice requires different roles for the patient, for the physician and other health professionals, and for health care service forms and financing.

None of these needed changes has been effectively addressed by health policy makers, health professional leadership, or medical educators. Instead, health policy makers have occupied themselves almost exclusively with manipulation of insurance costs; in the private insurance sector (sixty-five percent of the health insurance business), the goal has been capturing market share and short-term profit. Simultaneously, the professional and educational sectors have remained largely oblivious to these developments. Over the years, neither the character nor the production processes of health care were significantly assessed. There has been a genuine failure of leadership.

Had these bodies been attentive to the needs of health care in a rapidly changing era, they would have seen that four critical aspects of care required a new response:

1. The growing problem of chronic disease needed continuous, not episodic, care.
2. Patients were no longer inexperienced and passive but rather observant and critical participants in the care process.
3. Effective physicians were no longer dominant determiners of care but rather partners with the patient in both decisions and treatment tactics.
4. Acute care practices were commonly neither effective nor efficient for chronic disease.

Had there been awareness of these needs, solutions might have been designed and instituted. In their absence, many policy makers have now turned to HSAs, the latest version of solution by avoidance. That is, instead of striving to make health services fit the problems confronting them, they simply seek to shift the cost to someone else, in this case the patient, while increasing business for financial institutions.

Needed: The chronic disease model in care and education
Matters need not be this way. We already have a reasonable idea of how to organize effective and efficient health care in an era of chronic disease dominance without reducing it to vulgar cash transactions. Of course, this will require changes.

- The patient living with the disease and its consequences will take greater responsibility for decisions and care.
- The physician will become more teacher and advisor, functioning as a partner of the patient.
- The system will support the different roles and practices of the physician both structurally and financially.

All of this has been spelled out in the chronic care model. While the model will certainly require more testing and modification, it is based on both experience and experiment. And it does not require expensive new construction or high technology, only changed attitudes and behaviors.

The costs? Current costs are significantly a product of applying acute care methods and structures to care of chronic disease. Substantial evidence indicates that a properly designed and conducted health care system will save as much as forty percent of present costs that are now wasted. Such huge savings would allow us to address the real issues in health care and still reduce expense for each of us.

Dr. Kapp has helped by showing how degrading the latest version of health policy can be. HSAs reduce patients to shoppers, propel physicians away from professional standards and behaviors to meet the demands of free market profit, and make their encounters resemble more those of a supermarket or newspaper kiosk than a meeting of partners to chart a course of action.

Too harsh and unfair a judgment? I don't think so. There are many ways to criticize HSAs but, to perceive the most important, simply recall your everyday experience at the store, follow the logic of HSAs, and make their encounters resemble more those of a supermarket or newspaper kiosk than a meeting of partners to chart a course of action.

References:
On an October morning in 1954, when I was a research fellow in the Cardio-Pulmonary Laboratory at Bellevue Hospital in New York, the nurse called me to the telephone.

“You don’t know me, Dr. Fritts,” the man on the phone said, “but my colleagues and I know a good deal about you, and in the light of what we know, we believe you are uniquely qualified for a job we need to fill.

“I can’t tell you my name or the names of the agencies I represent, nor can I, at the moment, tell you more about the job. I can, however, say that the salary would be around $28,000.

“Please think about whether you would be willing to change jobs, and then, if it’s all right with you, I’ll call again next week. “

As I stood there, trying to grasp what the man had said, I had trouble deciding about a second call. Yet the $28,000 salary had caught my attention. No wonder. My salary, from a Life Insurance Medical Research Fund Fellowship, was $4,200.

I said it would be all right for him to call again.

That night my wife and I considered all the possibilities we could think of to explain the call. Was it a joke? A hoax? A message from some secret group, like one of the Communist cells Senator McCarthy had talked about?

“We shall just have to wait and see what turns up in the call next week,” my wife said.

I had never, since coming to New York a year earlier, considered changing jobs. The laboratory was a happy place, and my work was both interesting and instructive. More importantly, my bosses and mentors, Dr. Andre Cournand and Dr. Dickinson Richards, were fine men and fine teachers. It would take an extraordinary offer to induce me to leave.

And what in my background made me “uniquely qualified” for the job? I thought back over my life: in college I had earned a degree in electrical engineering; during World War II I had served on an LST in the South Pacific; and following my discharge from the Navy, I had entered medical school. After graduating and then completing an internship and residency, I had come to Bellevue for training in heart and lung disease. I couldn’t see anything in this record that made me “uniquely qualified” for a job of any sort.

On the other hand, I saw no reason to turn the man down before learning what he had in mind. So when he called the next week, I told him there was an outside chance I might be willing to change jobs.

“I’m pleased,” he said. “And as a first step, I would like you to come to our home base in Philadelphia next Thursday for a two o’clock appointment. The people there will be expecting you, and will be glad to answer your questions.”

So the next Thursday I rode the train to Philadelphia, hailed a cab, and handed the driver the address the man had given me. As we drove along, the neighborhoods became seedier and seedier. I began to wonder whether coming to Philadelphia on such a mysterious errand had been wise.

We pulled up in front of a huge building that, in its prime, must have been a warehouse. As I walked up the steps, I saw a Marine colonel guarding the door. He was six feet tall, and had four rows of battle ribbons. When I gave him my name, he picked up a phone, spoke to someone, then turned to me and said, “A messenger will come pick you up.”

The messenger led me through a labyrinth of narrow, temporary hallways to a small, windowless room containing a table and two chairs. Shortly afterward, a young man stepped into the room, introduced himself, and invited me to take a seat.

“You may wonder who we are,” he said. “That’s easy. We are the General Electric Company and the federal government.”

Harry W. Fritts, Jr., MD

The author (AΩA, Boston University, 1951) is professor and chair emeritus of the Department of Medicine at Stony Brook School of Medicine. He is the author of On Leading a Clinical Department, published by the Johns Hopkins University Press in 1997, and is a previous contributor to The Pharos.
“You may also want to know why we chose you to come for an interview. That’s easy, too. It’s because you have degrees in both medicine and engineering, and the job we have in mind requires a knowledge of both.

“That job centers on putting men in space. Hence, whoever takes the job will have to know about the effects of altitude on the human body, and also about rockets and rocket ships.

“Since you would be in charge, you wouldn’t need to know all of this yourself. Instead, you could tell us who the experts are, and we would recruit them for you. Your job would be more administrative, which means you would assign tasks, supervise the way the project is going, and most important of all, help instill a spirit of competition, because we are going to beat the Russians in putting a man on the moon.”

A man on the moon! Should I believe this? If he was telling the truth, it would be Buck Rogers and my childhood all over again.

I listened carefully to what the young man said, and realized that the job, in addition to paying a lavish salary, was probably a marvelous opportunity. Yet as he had ticked off the talents they were looking for—assigning, supervising, whipping up a spirit of competition—I knew they had invited the wrong person. I had little interest in any of these things, and I told him so.

“I understand,” he said, “and I nevertheless thank you for coming. Now, is there anything I can do for you?”

“Yes,” I said. “I would be grateful if you would reimburse me for my train fare.”

A few weeks ago, as I was clearing out an old file, a piece of paper fell out. It was a travel reimbursement voucher, written on the stationery of the General Electric Company.

It read:

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Commentary

What a wonderful story! Ted Harris asked if I would like to comment on this gem-like essay, since it seemed to have some commonalities with my own career. Indeed it does, from two aspects: Dr. Fritts’s brief exposure to the American space effort, and the intellectual and emotional conundrum imposed by a potentially seismic career decision.

I was unaware that the United States was contemplating such a program in 1954. Among other events, it was the year we tested the H-bomb on Bikini, the USS Nautilus was converted to atomic power, and the demagogue Joseph McCarthy was brought to earth. It was four years before NASA became an entity. Obviously, some visionaries in GE and the federal government were thinking well ahead of their time. It was only in the early 1960s that John Kennedy issued his epochal challenge to achieve a manned lunar landing.

My “invitation” to become a NASA medical flight controller came much less gently—as a military order in 1961. I was involved with NASA and the space program in a rather desultory fashion in various capacities for the next eighteen years.

I empathize with Dr. Fritts’s anguish. To be working in a laboratory with the celebrated Cournand and Richards must have been cardiovascular research paradise. I am not sure what I would have done under similar circumstances, but I suspect the lure of being offered the power and resources to be a pioneer in investigating the physiological and psychological aspects of prolonged weightless flight might have won the day. I have made a few admittedly less momentous decisions in a lifetime a career choices—and luckily have never regretted taking the leap.

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**ONE** stark red neon “Gym” sign reflects on my windshield as I park in the predawn darkness.

My gym is neither an elegant lifestyle spa nor a yuppie sports club or a new age brain gym. Not the high school gym reeking of old vomit and sweaty singlets after wrestling practice. Not the gritty gyms of punching bags inhabited by the down-and-out contenders for the heavyweight championship portrayed in *Cinderella Man*. The bodybuilders and the body sculptors do congregate here at more populous periods of the day; audience adulation is essential. In the morning, only the old and the hardcore inhabit the gym. We struggle for physical rehabilitation and maintenance of function rather than work toward marathons and matches. We choose predawn for reasons of professional schedules and personal pride. We prefer the privacy of invisibility.

**Two** is the number of knees hobbled by degenerative osteoarthritis, or “bone on bone” as the orthopedists say, which keeps me from running down lobs on the tennis courts and charging up the hospital stairs. Two knees battered from decades of running on asphalt in Virginia and skiing on ice packed snow in Vermont. Two knees with only ratty remnants of shredded cartilage left over for padding. A combination of football knee and housemaid’s knee and jumper’s knee, all euphemisms for chronic abuse and aging knee parts that ache and click and grind and sometimes just lock up tight.

**Three** is the number of times each week I arrive at the red neon “Gym” sign in the pitch black with my sweats and my sneakers. The early crowd costumes are grungy gray and black, rarely the faded navy and orange of a Cavalier T-shirt, certainly not the fit couture of racing stripes and spandex featured on the ’Net. The one early morning fashion sighting to date involved a matching sweater and sweatband in sky blue and pink.

**Four** o’clock is the time I set my alarm clock. Then, I feed the cat, brew my coffee, pack my L. L. Bean canvas bag with work clothes fit for an academic presentation, and perform an abbreviated personal toilet to color lips and brows and, sometimes, a touch of Chanel CoCo just for the sheer insanity of it. Four o’clock rising predicts a 5:15 AM departure, if I resist the temptation to open a novel or fuss with Florrie the cat.

**Ten** pounds mark the transition from the periwinkle, soft-edged dumbbells piled in a basket next to the big-boy, steel-gray iron weights ordered on racks by weight up to one hundred pounds. The big boys and girls pump iron with them, usually with groaning and straining. I have finally worked my bicep curls up to the iron range, but just barely at twelve pounds. I am strengthening my biceps because the strategic fallback position, the dreaded knee replacements, requires a strong upper body for crutch walking.

**Twenty-one** different machines are lined up in front of three televisions in one half of the gym: regular old stationary bicycles, lifecycles, recumbent bicycles for oldsters like me, treadmills, Stairmasters, elliptical trainers, and mountain climbing contraptions. Thirty unique, ungainly Nautilus machines, each designed to stress a specific isolated muscle group, are arrayed on the other side of the gym. The posted line drawings identifying the targeted muscles are not sufficient for me to remember where to hook the weights, the direction of the activity, and what to do with my body parts. I use only sixteen of the assorted fifty-one machines and that is enough.

**Twenty-three** years old is the age of Clarence, who has contracted for $40 a session to remind me how to get onto the same machines every other day, demonstrate the desired movement, establish the target, sometimes to coach...
along with “bring those shoulder blades down into your hip pockets,” and finally, to record the weights and the number of repetitions after each activity. In exchange, I dispense advice on the local housing market (limit search to properties with fenced yard for Bella the Great Dane and a good resale value in two years), desirable honeymoon destinations in the Caribbean (all inclusive couples resort now reserved) for July, a special restaurant (C&O upstairs) for the birthday celebration of Sarah the bride, and what are the rituals of conversion to Judaism anyway? I remember being twenty-three years old, and I avoid being a sixty-six-year-old grouch.

One hundred pounds is the resistance on the torture machine, indistinguishable from a medieval rack, named the horizontal leg press. I am not sure which worries me more, the indignity of my contortions entering and exiting the device or the terror of eternal entrapment once ensconced. My attempts to bond with it, even imagining it as a “hug machine” à la Temple Grandin, have failed. My quadriceps seem to be growing bigger and stronger as the weight of the resistance increases . . . the better to protect my knees from grinding it seems. And so one hundred pounds seems effective in spite of the indignity of the exercise.

Sixty is the number of morning sessions at the Gym before one of the other early morning crones offered the gift of a personal comment: “So, you’re a baby doctor?”

“Yup,” I muttered as I gripped the upright bars to the rotary torso machine (forty pounds resistance).

“Do you ever see old guys in their second childhood?”

“Only at the gym,” I retorted, trying to maintain the rotations.

“Happy New Year, Doc.”

“You too.”
After sixty sessions over five months, I was no longer a transient.

Six months is how long I have complied with the strengthening routine developed by Phillip the tight-assed, tennis champion-therapist after my health insurance denied his physical therapeutic ministrations. Before then, Phillip had been directing the aides to apply heat, ice, and ultrasound to my knees while he cavalierly spooned Brancusian-shaped blades around my old swollen knee joints. The insurance company apparently had abandoned all therapeutic hope and approved costly surgical operations to replace those worn-out babies. Phillip, a therapist of little chatter and even less body fat, proposed an alternative philosophy: “Join the gym and work the ‘no pain, no gain’ program.” Strengthen the muscles around the knees to reduce the bone-on-bone destruction and . . . maybe the pain will ease . . . and maybe your function will improve. So six months I have been off the tennis court and in the gym on Mondays, Wednesdays, and Fridays before sunrise. After six months, Phillip swaggered over while I was working on the glute press (now up to fifty pounds) for a brief commentary, “Hmmmmm, you seem to be getting into a routine. That’s a beginning.”

One is the number of reconstructive orthopedists I will disappoint in July if my newly toned gluteus maximus, medius, and minimus, and the quadriceps and the hamstrings and the gastrocnemius muscles shape up around the knees and slow down the deterioration of the last few shreds of cartilage. Two biceps, two triceps, and two rotator cuffs unnecessarily prepared for crutch walking may put a little extra zing in my overhead, that is if the knees allow shuffling around on the clay court come spring. In the meantime, I sometimes take only one ibuprofen a day. Well, maybe two when I climb the hill to the University of Virginia grounds and then mount the Rotunda steps for conferences. My bladder now wakes me at night but not my knees. One is the orthopedist who will develop a smaller, jazzier knee joint to implant when eventually I acquiesce to the inevitable surgery, just not this year.

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A man whose temple-hair was becoming gray bragged to me recently that he had graduated MD at Ohio State in 1990. He was momentarily nonplussed when I told him that I had received my MD degree at Western Reserve University in 1935. His eyes mirrored the spinning of his mental calculator. That long-ago day, so difficult for him to imagine, is engraved in my memory. I hope the occasion of graduation is a precious day to remember for all physicians. It is more than a once-in-a-lifetime event for each of us. For me it represented both achievement and challenge. Everything that preceded it made the achievement all the more unforgettable. The challenge was how I was to get home to California from Cleveland after graduation.

Remember, this was seven decades ago. My medical school era, 1931 to 1935, encompassed the deepest, darkest days of America's Great Depression. Few physicians remain who struggled through it. Interestingly, my memory of the period is not clouded by recollections of hardship. I had my premedical education in San Diego, where my father served as minister in a local church. I marvel, even now, at his faith and fortitude, with three other younger children to provide for, in encouraging me in my plan to venture far away to medical school. Of course, neither he nor I had any idea what the next four years were to be like.

During my first year in Cleveland I lived in a fraternity house where room and board were $45 a month. Medical school tuition was $350 a year. At the time, to meet these expenses was a breeze financially. My prospects brightened when I scored one hundred
percent on the first major biochemistry examination, a test that caused two or three of my fellow freshmen to flunk out. It was my good fortune to have previously taught organic chemistry for two years at San Diego State College.

After that first year, the financial crunch began to squeeze my family’s resources, as it did for so many others. It was necessary that I move out of the fraternity house. I managed to get a job, along with three more advanced medical students, manning the dispensary at Cleveland’s Wayfarers’ Lodge. As compensation, we were permitted to live at the lakefront Lodge in our own large room and to subsist on the house diet. In return, we tended to the ailments of the two thousand transients who annually filtered through the lodge. These itinerant men could stay three days, then had to move on, to be replaced by newcomers, each of whom had to be examined the evening of their arrival for “seam squirrels” and “crotch pheasants,” epithets given to prevalent clothing and body lice. We had a twelve- to fifteen-bed sick bay. Lobar pneumonia was rampant. The practical medical experience for me was invaluable, although it took time away from my studies. Nursing care of bed patients was provided by selected long-term residents of the place, but we played the role of doctors. A physician employed by the city dropped by in the daytime to check on our work. It was a maturing experience for a young medical student, a task I performed for my last three years at the university.

There was still tuition to pay and other expenses to worry about, since this job paid no money, only room and board, such as it was. To help solve my financial problems during my last two years I also manned the dispensary at the nearby Otis Steel Mill from midnight to 7:00 AM, seven days a week. The job paid seventy-five dollars a month. Because of the economic depression, steel production was shut down much of the time. Usually my only duty was to answer and record the calls of the watchmen every half-hour. Employee injuries and minor complaints were infrequent. This gave me time in the early morning hours to study, catch up on my assigned homework, and occasionally to doze. Income from this job enabled me to pay my tuition, as well as to meet other expenses, including an occasional date. Also, I managed to buy a 1929 Ford coupe for eighty-five dollars. Personal transportation was necessary to fulfill my obstetrical service during the summer months between my junior and senior years. We were required to perform home deliveries of approximately twenty babies born to indigent mothers. An obstetrical resident and nurse were called to observe and assist when delivery became imminent. This sometimes required a bit of “holding the head back” while waiting for the resident to arrive, an unkind thing to have had to do. One irate husband threatened to throw me down the stairs if I did not let go.

With graduation day approaching I began to realize that the only way I would be able to get back to California to begin my internship at the Los Angeles General Hospital was in my so-far trustworthy Ford. The terrifying question of how I was going to pay for gasoline and oil (one quart of oil every fifty miles at ten cents a quart) was keeping me awake nights at the “Bum’s Rush” (as the Wayfarers’ Lodge was commonly called). I had exhausted my meager savings. Enter the AΩA prize.

During my freshman summer vacation I could not afford to return to California for a visit with my family. Instead, I applied for a George Crile Research Scholarship and received a grant of three hundred dollars. This supported me while I spent the summer working in a laboratory at the Cleveland City Hospital (now MetroHealth). My project involved determining the influence of carotenemia on the validity of the icterus index (then a commonly used measure of jaundice). During the latter months of my senior year, as I whiled away the night hours at the steel mill, I put the results of my research into a paper I submitted in competition for the annual Alpha Omega Alpha prize. My day of graduation in 1935 was doubly memorable for me when it was announced that I had won the AΩA prize, and with it an honorarium of fifty dollars. I had my MD degree along with the wherewithal for my return trip to California. During the four days and nights of the drive home (at forty-five miles per hour, maximum), I pulled to the side of the two-lane road for a few hours of sleep in my car when I was overcome by fatigue.

If it had not been for the AΩA prize, and the gods that look after such things, I might have ended up a permanent resident of Cleveland’s Wayfarers’ Lodge.

Editor’s note
Helen Conger of the Case Western Reserve University Archives provided this information about the AΩA prize:

The Western Reserve University chapter of Alpha Omega Alpha (the Alpha of Ohio chapter) did award a prize annually for many years. The prize began in 1917. In the 1920s, the chapter did some fundraising, and in 1923 established the Alpha Omega Alpha Endowment Fund—the income to be used for the annual prize essay competition or lecture expense.

In 1935, two students won: Earl Fay Nation won the fifty-dollar first prize and Franklin Alois Benes won the twenty-five-dollar second prize award.

Acknowledgment
Thanks to Dr. William S. Haubrich (AΩA, Western Reserve University, 1947), who submitted this article to The Pharos on behalf of Dr. Nation.

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Mohannad al-Azawi was his name, a Sunni, just twenty-seven. Pigeons were his trade, canaries too—but nightingales his passion. And in his shop on afternoons, he would often tell the tale of the wonderful Oiseau that warbled in its gilded cage, while the Emir of the East bowed low, oh so slow, in his scarlet pantaloons, crooned “Araaaabaha, baazoom!” And the Wazir of the West danced to the chant, in his very pointed shoes, played duet on his oud, cried “Wallazoon, Aa’arooon!” Men dressed in black dragged him away, his body found next day, his skin, a map of bruises, drill holes in his face and legs. He died in a world where an ancient rift (who would be Caliph at the Prophet’s death) can touch a lover of nightingales, where flagellants whip themselves bloody in frenzied prayer to commemorate a martyrdom—a land of visitations by angels and broken promises made by Gods.

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(highwire.stanford.edu), where seventy of the highest cited journals have been archived since 1948 lists Darwin’s “natural selection” in 271 titles, almost all experimental, whereas “intelligent design” appears in the title of but a single effort, a review published in the Journal of Theological Studies. Alas, ID loses out to another system of alternative science: “Mesmer” or “Mesmerism” appears in twenty titles devoid of experimental promise. Dr. Davis asks for open discussion: I ask for peer-reviewed evidence of creationism under another name.

References

Gerald Weissmann, MD
(AΩA, New York University, 1965)

You complete your daily coneflower rounds at a pace dictated by your brief existence. Your soft dance hardly moves the proud flower; the genesis of sweet nectar that fills your proboscis. Your tiger-striped wings are finished with cerulean strokes, and tipped with deceptive eyes to fool birds of prey. You are another reminder of nature’s perfect design, and the beauty of a midsummer day. The brevity of your life and your dedicated mission Serve as subtle reminders to your admirers.

Steven F. Isenberg, MD

Dr. Isenberg (AΩA, Indiana University, 1975) is assistant professor of Otolaryngology—Head and Neck Surgery at Indiana University School of Medicine. He also took the accompanying photograph. His address is: 1400 North Ritter Avenue, Suite 221, Indianapolis, Indiana 46219. E-mail: sisenberg@good4docs.com.

Tiger Swallowtail

The Pharos/Spring 2007
An Inconclusive Autopsy

Death, unexpected, rolled in on a cot, demanded explanation, so I got a warrant for my court of last resort to grill the newly dead, file a report.

From sternal notch to pubic symphysis I whipped my blade, his overalls unzipped. Then Duschka crossed the T, flayed back the flaps, down to the pectoralis and the lats.

Then clutched his cutters, crunched each helpless rib, revealed, beneath that corrugated bib the thorax triptych’s splendid symmetry: tall sentry lungs, a rufous heart—lust-free.

We slit the belly fascia down the seam. A coiled boa, his intestines gleamed. Esophagus to rectum splayed that snake: sans tumor, tear, congenital mistake.

The liver was a smooth brown stone. The spleen was plush with purple pulp, a prosperous bean. From beds beside the backbone bulge we plucked two renal oysters—clean, both whole and shucked.

We gathered nuggets, nuts and sweet viands: the testes, thyroid and adrenal glands. Duschka held them close to hear the hum those dynamos unwinding softly spun.

Across the top I sliced from ear to ear, then peeled the scalp skin fore and aft to clear his downy crown so Duschka could bear down and buzz the bone saw all the way around.

Those convoluted gyres! each mortal sore deposits there its band of bitter ore. Thus full of hope, we set to mine those lobes, carved down wide walls, but just dull clay exposed.

In sum, we found no flaws—no gross disease, nor any microscopic subtleties. His parts just stopped—no reason they did so. But then, we’ve never figured out what makes them go.

Kenneth R. Lee, MD

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