Alpha Omega Alpha Honor Medical Society
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Revolution is defined in several ways. One is the forcible overthrow of a government or social order in favor of a new system. This type of revolution invariably occurs over a short period of time. “Marat’s Terror” by Jesse Woodard (pp. 17–24) describes the troubled but powerful life of physician/polemicist Jean-Paul Marat and his role in the French Revolution. His fiery doctrines were quenched suddenly when Charlotte Corday stabbed him while he bathed.

Revolutions in medicine and the medical sciences are less radical and follow a second definition: a dramatic and wide-reaching change in the way something works or is organized and in people’s ideas about it, a transition from one paradigm to another. Today’s physicians and scientists are familiar with this type of revolution. We have experienced the discovery of penicillin, streptomycin, and cortisone; the development of vaccines against poliomyelitis and other infectious scourges; the definition of the structure of DNA, the translation of the genetic code, and the establishment of methods to synthesize DNA; the initiation and growth of transplant surgery; the technical advances informing CT, MRI, microarrays, and stem cell biology; and the slower but no less important revolutions in public health. We relish the exploration of the unknown.

Why did it take more than 1500 years, from the first to the seventeenth century, for empiric observations to enable understanding of the circulation? Galen, in the first century AD, adopted the Hippocratic theory of the four humours: blood, phlegm, and yellow and black bile, and the importance of having balance among them to ensure good health. Although reported to be conceited, cruel, and vindictive, he cannot be blamed for the blind allegiance to his teachings that persisted for centuries. Those who followed Galen failed to use the tools they had—eyes, brain, and hands—for at least two reasons: first, human dissection was prohibited, and second, it was philosophers and the clergy who for many centuries determined the truths of life for the people. Most significant among those who led thought was Aristotle. Bertrand Russell writes that “it was two thousand years before the world produced any philosopher who could be regarded as approximately his equal.”1 It was Aristotle who gave science to mankind. He observed, and deduced logical conclusions. Consider his realization that life was growing steadily in complexity and power, with increasingly specialized function. Indeed, he was on the verge of deducing the theory of evolution. Why then was Aristotle not the one to define the physiology of the circulation, that the heart (not the brain) pumped blood through arteries, and that blood flowed back to the pump through thinner vessels, the veins? He certainly had each of the tools—eyes, a brain, and hands—needed to do this.

William Harvey based his theory of the circulation of the blood on a series of simple experiments in which he studied venous blood flow using a tourniquet and digital compression. His famous book, “Ecercitatio anatomica de motu cordis,” published in 1628, illustrates these experiments and elucidates the observations he made and deductive reasoning he used to arrive at this theory. Traditionalists following in the footsteps of Galen attempted to reject Harvey’s conclusions, but uniformly failed to find weaknesses in either his experiments or deductions because to deny a single part of Harvey’s theory would be to reject the whole, and this was impossible. Nevertheless, many tried!

The revolution sparked by Harvey’s new paradigm brought much new knowledge from diverse sources. For example, Antoine van Leeuwenhoek built an instrument, the microscope, that would be a revolution in itself. Leeuwenhoek’s microscope revealed the presence of red blood cells and, more importantly, the hair-thin anastomoses between the blood vessels that he named “capillaries,” a discovery that linked the veins and arteries to complete the elements of the circulation that Harvey had outlined.

Scientific revolutions continue to evolve in both intensity and sophistication, combining the resources of eyes, brains, and hands to bring biological science to the heights it has reached today, with more to be ascended tomorrow.

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The World Is Sleeping
Michael R. Bykowski

I Am the Patient
Suzanne Minor, MD

Significant Other, Late in Life
Eric Pfeiffer, MD

INSIDE BACK COVER
Full Nelson
Jason David Eubanks, MD
Fire engine alarms woke up the stars.
Red lights
Glared on our window panes.
We weren’t sure what to expect,
The sky so bright,
The heat searching for a way into our library.
Over the fence leapt the first firemen—
Axes in hand, superhero helmets
Askance at the sight
Of the spectacle shimmering over their heads.
More sirens, men on the roof and on ladders
Watering the walls, creating a fall
Of liquid ambers.
Once lame hoses snaked over asphalt
Wet with morning dew, distended
Like boa constrictors after a snack.
Their id numbers
Furiously overheated when the building,
Crackling like an immense popcorn bag,
Tumbled noisily into the uneasy silence
Of the morning light.
It fell away from our shattered windows
Redolent of might,
Aided by the cleverness of promethean Physicians with their water rays,
Who saved Cecil, Harrison, Dickinson,
Whitman, Pablo Neruda, Juan Ramón,
And, among many others, Richard Wright
And Richard Bright—
From the burn.

*Manuel Martinez-Maldonado, MD, MACP*
You take me back
To The Sound of Music,
To the yodeling Von Trapps
Orchestrating "The Lonely Goatherd" from above—
marionette in my mind for the first time—
But nothing compared to you,
The C6 quad
Who opens a jar of peanut butter
Between two, once functionless, hands,
Who brushes her golden hair
One deliberate stroke at a time
And lifts the steaming aroma
Of Columbian coffee
Toward eager lips
With arms and hands
That have found a voice again—
*Functional electrical stimulation*—
A fractured, incomplete language
Of electrical words
Running in subcutaneous wires
From the implanted chest stimulator
To the forearm motor,
Brio to the listless,
Like the strings of the velvet marionette
Who dances the dance of the manipulator—
Watching you move,
I can't help but twirl around,
Looking for my invisible strings.

Jason David Eubanks, MD

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Illustrations by Jim M'Guinness
New medical TERMS

James G. Gamble, MD, PhD, Theresa Pena, RN, and Lawrence A. Rinsky, MD

The authors are members of the Packard Children’s Hospital at Stanford. Dr. Gamble (AΩA, University of Maryland, 1974) is professor in the Department of Orthopaedic Surgery. Ms. Pena is a nurse in the Pediatric Orthopaedic Clinic. Dr. Rinsky (AΩA, University of Cincinnati, 1970) is a professor in the Department of Orthopaedic Surgery.

As part of the electronic medical record in teaching hospitals, residents and attending physicians use telephones to dictate notes of their clinical encounters with patients. These dictations are transcribed by voice recognition programs or by transcription services on the Internet. Before application of an electronic signature, physicians have an opportunity to review and correct their notes. However, with the hectic schedule of most residents and attending physicians, it can be difficult to review, in detail, each note before application of an electronic signature. Transcription errors thus enter the permanent medical record. Many of these terms occur repeatedly.

The following list, with the original intent, relates mostly to the musculoskeletal system as the terms were discovered in pediatric orthopaedic clinical notes. The list is certainly incomplete and should be considered a work in progress.

Editor’s note

A paper I once dictated contained the phrase “Cell-free translation,” which came back as “Self retranslation.” I admit that the latter might have been more interesting to discuss.

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New medical terms

- Hell fracture
- Knot knees
- Piggin toes
- Grandma seizures

Illustrations:
- A devil character with a pitchfork and a pig-like figure with toes that resemble a pig's face.
Swirling snow tempest!
Coating the crooked fingers
Of dormant trees.

Cherry blossom youth,
Circle memorial to
Young nation’s founder.

Coneflower cafes—
Serving royal pollen to
Monarch butterflies.

Aspen leaves scatter;
Wind-surfing autumnal zephyrs
Above mountain streams.

*Steven F. Isenberg, MD*
Larry Zaroff, MD, PhD

The author (ΑΩΑ, George Washington University, 1956) is a consulting professor at Stanford University School of Medicine & Program in Human Biology and a senior research scholar at the Center for Biomedical Ethics. He has been a writer for the New York Times science section, and now works one day a week as a volunteer family doctor. In 2006 he was honored as Stanford’s Teacher of the Year.

He had inoperable lung cancer, which had spread to the lymph nodes in the neck, as well as his liver and brain, and was in the city hospital for terminal care.

No hospice was available in the 1950s. I was on the general medical ward, my initial rotation and exposure to clinical medicine. In costume: short white coat, a necklace of stethoscope, jewels of percussion hammer, tuning fork, otoscope protruding from pockets. The Merck Manual for support, making me ready, but with false credentials. Not a real doctor. Yet a thrill, intoxicated by the idea of the act. The days when I knew little but was asked to know everything about everything. As students, we expected to learn from our teachers, obtain the clinical clues that would allow a correct diagnosis and treatment. I thought patients were for
learning on, not learning from. What could they know? I was wrong. Who understands a disease better than the patient?

A first patient. A dying patient. With generosity and tolerance, he answered the many questions medical students were required to ask. When I put my cold stethoscope on his chest, he smiled and murmured, “Doc, you may want to warm that up next time.” The first of the lessons he taught me. He led my hand to the hard nodes above his clavicle, guided me to his swollen liver, and demonstrated the weakness in his left hand.

It is easy to remember the details of that first patient. But after moving to cardiac surgery for twenty-nine years, then dropping out of medicine for ten years to climb mountains, and finally returning to Stanford in 1995 to study humanities and staying to teach medical humanities, I recalled little of general medicine.

It seemed like a full life. I did not miss the operating room but missed the patient contact, the real doctoring that connected with my teaching—the literature that embraces illness. This year when a clinic opened for the low-income and minimally insured population of our town, I volunteered to help the two family doctors who took time from their busy private practices to work there. It was a tsunami of surprises, worse than I expected. I was as lost and confused as King Lear in the forest. I knew little of modern general practice. Fortunately the two doctors in our clinic were willing to teach.

The first patient I saw was a man in his late seventies who was in the clinic for a routine visit and to renew his prescriptions. He was complicated. Not the single problem of a stenosed aortic valve or blocked coronary arteries I had encountered as a surgeon. Back pain, high blood pressure, asthma, elevated cholesterol. And then I noticed he was sitting in a wheelchair. “My leg, Doctor, I had polio.” I had not seen a patient with polio in fifty years. He explained, “Just missed the vaccine.”

My first medical patient in twenty-two years had more diseases than I could imagine. I retreated humbly to the conference room and consulted the family doctor working that day. “How do you deal with so many diseases in one patient? How can you know enough? In my first go-around as a student we had few medications for high blood pressure, high cholesterol, asthma.” He smiled and suggested I take my time, go over each problem, then ask what was really bothering him. My patient sat quietly in his wheelchair, did not complain at my tardiness, allowed me to ask the dozens of questions he had answered many times. His blood pressure was slightly elevated, but his lungs were clear. He remarked, “Another cold stethoscope.” I was embarrassed. Twice in one medical life. I reassured him that his problems were well controlled. His last question was a surprise. “Doctor, could I have—I would appreciate some samples of Viagra. Might I have a few tablets?” Another shock. In my era not only did few doctors talk about sexuality, but rarely did a patient bring up the subject. My first patient, once again: enlightenment. That has not changed. Given the opportunity and the time most patients will reveal their complexity, their charm, and will teach us. He deserved samples of Viagra.

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The author is a member of the Class of 2009 at Eastern Virginia Medical School.

It was our sixth week teaching English in rural Costa Rica when my husband Patrick was bitten on the leg by a fer-de-lance, a deadly pit viper. Alone in the jungle, I said a quick prayer before leaving him behind to search for help. Months before, back in the United States, we had dreamt of a journey that would allow us to give of ourselves to others less fortunate—the beginning of a vocation in social justice. Within a split second, our world turned over, and we became the recipients in need.

Patrick, who spoke no Spanish, stood out for his overtly gringo appearance. Still, the elementary school children we taught flocked to him for his lively animations and notable ability to lift seven to eight children at a time. Now, six hours after the snakebite, he lay in the San José Emergency Department almost lifeless from shock, unable to communicate, and at the mercy of the hospital staff.

The hospital was surrounded by armed guards. They kept order in the long lines that trailed around the corner of the building. Inside, where the humidity crept into the open-air hospital, doctors in their long-sleeved coats wiped the sweat from their foreheads.

"They will cut the fascia to treat the compartment syndrome," the doctor stated, nodding as if to indicate agreement. I did not nod back.

"The what?" I replied. He sketched a swollen leg with a scalpel making incisions on either side. I nodded.

I kissed Patrick on the forehead as he was taken to surgery. Afterwards he was placed in the intensive care unit. During the first of several blood transfusions, the surgeon informed me Patrick had a fifty percent chance of survival. The next morning I watched with joy tinged with embarrassment as the nurses struggled to bathe him and administer an asthma treatment. He was more than alive—he was yelling about Snickers bars and Coca-Cola. I began to laugh and to cry at the same time, and even though his eyes were swollen

The half-tico, half-gringo robot

Lindsey Finklea
shut he recognized my voice and began to cry too.

Relieved that I spoke Spanish, one of the nurses lamented briefly over Patrick's obstinace and then left us for a moment. "Coca-Cola" is the same in English as it is in Spanish. Five minutes later she returned with a small glass.

Over the course of two weeks Patrick became proficient at certain Spanish expressions. "I have pain in my leg" and "Can I have Coca-Cola, amigo?" were his favorites. But most important was the language the hospital staff learned to use with him. A reciprocal thumbs up or down meant everything was going well or poorly. Arms stretched out wide with eyes closed followed by adios meant it was time for another operation, seven in all. And tico, the word Costa Ricans use to refer to themselves, was notification that another blood transfusion was coming. The doctors often joked that he was half-tico, half-gringo. But as Patrick suddenly declined into hallucinations and a lung infection, this primitive system of words and gestures crumbled.

Dr. Izaguirre, the head attending, was a thin man and his white coat was stiff with starch. As he grew more frustrated the creases deprived of a home on his coat burrowed thick and ominous into his forehead.

Patrick's most vivid hallucination cast him as the leg segment of a robot. We were merely props in his play, the setting and plot changing by the moment. Like a stagehand laboring to keep the lights on and the curtain from falling, Dr. Izaguirre swooped in and out of the room almost undetected. The rest of us struggled to keep Patrick calm and in bed. The infection was improving, but the hallucinations were not. The doctor was stumped.

Two days went by—no change.

On day three, Dr. Izaguirre entered and stood over Patrick's bed. Like a mannequin from a display window, the doctor remained motionless in thought. Patrick lay watchful from below. After five minutes the doctor raised his hand deliberately, careful not to wrinkle his coat, and scratched the
top of his head. Patrick did the same. The doctor’s forehead creases grew deep as he lifted his eyebrows in surprise. In the same rigid, mechanical way, Dr. Izaguirre put both arms straight ahead. Patrick did the same. The creases moved into the corners of the doctor’s mouth as he began to smile. They mimicked each other’s robotic movements for some time and then began adding machine-like sounds to the narrative. I will never know what they communicated in this intermission, but Act Two had begun.

With the same mechanical gestures and kindness, I watched the staff administer lung treatments, change bandages, and maintain a sterile environment for Patrick’s open wounds. In these moments humanity transcended language and the art of medicine rose above critique.

Dr. Izaguirre ultimately discovered the source of the hallucinations: one of the medications used for pain. Patrick recovered in time for his birthday, which was spent in the hospital dining on cake and Coca-Cola. Two days later we flew home.

We settled back into the comfort of our lives, but remained unsettled by the experience. We were changed. With an appreciative eye, I realized that medicine knows no gender, no age, and no language. I knew this was my calling.

I am a fourth-year medical student. I am the shadow of my intern, the gatherer of lab data, the student baffled, humbled, and challenged by her attending’s knowledge. Tempered by the daily grind of medicine, my naïveté has been tested. Still, I see glimpses of humanity all around.

I have not yet met another half-tico, half-gringo patient who thinks he is a robot—I probably never will. Instead, I see remarkable patients each with their own idiosyncrasies and challenges. The physicians who manage these patients preserve their stories in an imaginary toolbox equipped for the unexpected and extraordinary. For anyone unfamiliar with its therapeutic use, I recommend storing a few cans of Coca-Cola.

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I learned from Dr. Lynn Carmichael that when you make a house call, you excuse yourself to go to the bathroom and peek into the medicine cabinet to check on the pills you've prescribed. And there they all were, in chronological order, unopened.

From Seeing Patients: The Sketchiest Details by Alan Blum, M.D.

From his earliest days as a medical student, Dr. Alan Blum (A.O.A, Emory University, 1965), Gerald Leon Wallace MD Endowed Chair in Family Medicine at the University of Alabama, has captured thousands of patients’ stories in notes and drawings. The sketches and jottings bring back the essence of a conversation, a detail of personality, and the fragmentary clues patients give their doctor about the experience of illness. Dr. Blum’s address is: 26 Pinehurst Drive, Tuscaloosa, Alabama 35401-1148. E-mail: ablum@cchs.ua.edu
Empty memory album discarded by the curb

These poems are the winners of the Winter 2008 contest to write a poem to accompany a photograph of an empty photo album on the curb. Congratulations to contest winners Ben K. Azman, MD, Babette B. Caraccio, MD, James L. Foy, MD, Helene Hubbard, PhD, MD, and Christopher Papa, MD.

Gutted, abandoned
the book with amnesia
lost memories . . . lost lives

*James Foy, MD*

Dr. Foy was elected to AΩA at Loyola University Stritch School of Medicine in 1977. His address is: 3940 Washington Street, Kensington, Maryland 20895.

He loved her more than life
His warm, attractive wife
With her soft, angelic smile
Destined to beguile

The years they spent together
Pledging their love to one another
But then the joy, the laughter
Would not last forever after

One day her lips grew cold
Her words became more bold
And they would fight and fight
Into the emptiness of the night

Give up he would never
Till he found she had a lover
Broken by the hurt, the pain
He felt he lived his life in vain

So he tossed the photos into the fire
Why cling to the memory of a liar?
The empty album went out the window
Lying by the curb, his love a forgotten shadow

*Ben K. Azman, MD*

Dr. Azman was elected to AΩA at the University of Alberta in 1967. His address is: 2435 Kaanapali Parkway, Suite H-7, Lahaina, Hawaii 96761-1980. E-mail: benazman@hawaii.rr.com.
Discarded and but not forgotten
No place for photos or mementos,
His heart is dead to mine.
Icy and unforgiving
Wind will chill the empty pages
No soft breeze will comfort me.
There is not cleansing for my soul
Trapped in love and by love
I live my days and nights alone.
The sight of him pains me,
The thought of him burns
I cast away his image but not his memory.
Who will trample these pages?
Like worthless refuse
As he has done to my heart
Is there healing?
Will the memories fade into peace?
I hope but fear not.
This album is cast away
No more to haunt me
Yet, he haunts me still.
I, too, am a castaway
Adrift in despair and loneliness
Awaiting my end.

Babette B. Caraccio, MD

My Dearest
We shared so much so long
Life bulged with unborn dreams
Unexpected joy grew from gentle sweetness
into hearty robust love
Then you left
And took me with you
Except the plastic cover
That hides my empty space keeping everyone
from seeing I have gone

Helene Hubbard, PhD, MD

Empty memory album, discarded by the curb,
Evokes an image dark, intended to disturb,
But faded and lost photos, we knew would never last,
Have now become the remnants of the techniques of the past.
The albums of today, stored in many bytes and bits,
Are in a fast computer that on a desktop sits,
They’re all stuffed there within, a large and neat selection
Of digital results, to forms just near perfection.
They make their rounds with lightening speed, o’er electronic space,
And unite the far flung family at very distant place,
But there’s that special image which is quite hard to find,
It’s stuck there in the neurons that pass for what’s my mind.

Christopher M. Papa, MD

Dr. Papa was elected to AΩA at UMDNJ—New Jersey Medical School in 1986. His address is: 17 Clover Hill Lane, Colts Neck, New Jersey 07722-1004. E-mail: doxite@verizon.net.

Discarded and but not forgotten
No place for photos or mementos,
His heart is dead to mine.

Empt memory album, discarded by the curb,
Evokes an image dark, intended to disturb,
But faded and lost photos, we knew would never last,
Have now become the remnants of the techniques of the past.

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The physician at the movies

Peter E. Dans, MD

Man on Wire


On August 7, 1974, while the United States was preoccupied by the Watergate controversy that culminated in the resignation of President Richard Nixon the following day, Philippe Petit, a Paris street performer and magician, fulfilled a long-held dream. In 1968, while sitting in a dentist’s office, he had read about the construction of the World Trade Center (WTC) and became obsessed with walking on a wire suspended between the Twin Towers. Based on his book, To Reach the Clouds, this fascinating, fictionalized documentary or docudrama recounts the meticulous planning underlying this remarkable (and illegal) feat. Director James Marsh goes back and forth in time, intercutting interviews with Petit and the other principals. Petit comes across as child-like and self-centered, but also filled with a courageous (or “foolhardy”) passion and radiating a charisma that enables him to get people to help him fulfill his dreams. A climber as a child and blessed with an extraordinary sense of balance and concentration, he was fascinated by wire walkers, not circus performers but those who did daredevil stunts as performance art. The perfect illustration of the French concept of sangfroid, he relates how one to two millimeters of error in placement of his foot or a quarter of a second of inattention can result in losing one’s life. He adds, “If I die, what a beautiful death! To die in the exercise of one’s passion.”
Philippe, who was brought up strictly in a privileged environment, had a “bad boy” side. He enjoyed the aspect of illegality and the feeling that comes with attempting forbidden and “impossible” things. He likened himself to a spy as he reconnoitered entry to the WTC through various subterfuges and kept in character by watching bank-robber movies. He sought out co-conspirators who were not only supportive but had a little larceny in their hearts.

Having walked on wire across the cathedral of Notre Dame de Paris and the Sydney Harbour Bridge in Australia, he was ready to tackle the highest manmade structure. Petit and his co-conspirators made numerous visits to the WTC to determine how to gain entry and to ascend the 110 floors to the top, over 450 meters (1476 feet) from the ground. They enlisted an insider with a top floor office where they could store their equipment. The film takes us back to a time when Americans were more trusting. He gained access to the top floors from the manager of the complex by posing as journalist for a French magazine seeking to interview the construction crew to learn about wind conditions and other potential hazards. While doing so, his two “magazine photographers” took pictures of the site to determine placement of the guy wire; in so doing they learned that the two corners to serve as anchors for the wire did not face one another, but were askew. At one point during his stay, he injured his ankle and had to use crutches, which paradoxically allowed him greater entrée as people were more concerned with holding the door for him than checking his identification.

One of the most ingenious things was how the team got the guy wire or cable across to the conspirators in the other tower, 200 feet away. Petit’s friend Jean Louis Blondeau, who is the most sympathetic character in the film, learned to use a crossbow, and they adapted the wire so that it could be shot the required distance. As they got closer to the event, Jean Louis and the others began to think of being potentially responsible for a friend’s death and of being caught in a litigious America and charged with assisted suicide or involuntary manslaughter. How wrong they were!

The day before the walk, they infiltrated the WTC and got the equipment in place. This, the most exciting part of the film, involved close encounters with the guards and a race against the clock to be able to do the stunt before the WTC came alive. Beginning at 7:45 AM, Petit made an estimated eight crossings which he prolonged to forty-five minutes of theater as he knelt and lay down on the wire while eluding the policemen who were trying to capture him. Finally, as the wind began to pick up and a misty rain began to fall, he was warned that a helicopter was getting ready to scoop him up. He terminated the stunt and was arrested and ordered to be examined by a psychiatrist who pronounced him sane. The initial charges of illegal trespassing and disorderly conduct were dropped in exchange for him giving a show for New York City children.

The most interesting thing was how the event affected Petit and his friends. The celebrity was immediate as he hooked up with a groupie on being discharged from jail, even before he returned to see his girlfriend Annie, Jean-Louis, and the others who had helped make it all possible. They and he admit that it closed a chapter in their lives as they became alienated from his now famous life. He is shown reflecting on how he has done sixty more performances including one on the Eiffel Tower. Vowing never to repeat himself, he follows his “passions,” living life “on the edge,” although admitting that his “life is a mess.” The other beneficiary of the stunt was the WTC, which had been vilified, but now became part of the public imagination and began to fill up with tenants. One wonders how much of this attention influenced the terrorist plotters in 1993 and September 11.
Remaking a forgotten classic Western

While channel-surfing one evening, I got drawn in by the acting in the original 3:10 to Yuma and I thought it might be fun to contrast it with the 2007 re-make to see what it says about filmmakers and audiences separated by half a century.

3:10 to Yuma (1957)

Based on a short story by Elmore Leonard, the film opens with a stirring rendition of the title song by Frankie Laine, known for his recordings of "Mule Train," "Cry of the Wild Goose," and the theme from the television show "Rawhide." Like High Noon, the movie focuses on a man's willingness to do his duty and keep his word, no matter the cost and no matter the enticements to turn his back on it. The protagonist is rancher Dan Evans (Van Heflin), a Civil War veteran who went West with his wife Alice (Leora Dana) and their two children. After four years of hardscrabble existence and six months of drought that threatens the loss of his cattle and his ranch, he is a failure in the eyes of his family. While rounding up his cattle that had been dispersed by outlaw Ben Wade (Glenn Ford) and his gang, Evans and his sons come upon the gang robbing a stagecoach loaded with gold. After shooting a gang member being used as a shield, as well as the guard, Wade takes the Evans family's horses and their canteens of water and heads with his gang to Bisbee.

Passing themselves off as hired hands heading for Mexico, they report the robbery to mislead the sheriff and line up at the bar for a celebratory drink. Meanwhile, Evans and his sons get their horses, which Wade left two miles away, and herd the cattle back to the ranch. Evans decides to go to town to talk the banker into not foreclosing on his ranch, which is now worth more to the bank because of the railroad coming through. Coming upon the marshal (Ford Rainey) and Butterfield the stagecoach owner (Robert Emhardt), he tells them that Wade and his gang were headed to Bisbee. Realizing that they were duped, they return to Bisbee to find that the gang has cleared out, all except for Wade, who has dallied with the barmaid Emmy (Felicia Farr). Although captured and handcuffed, Wade is unperturbed because he knows that his gang will rescue him. The decision is made to pay two volunteers $200 dollars to take Wade to the town of Contention to catch the 3:10 to Yuma where the federal prison is located. Evans, desperately in need of the money, volunteers to do so, as does the town drunk Alex Potter (Henry Jones).

The stagecoach drops Wade, Evans, and Potter at Evans's
homestead, and the sheriff and the rest head off as a decoy as if transporting Wade themselves. There are some excellent scenes around supper, the saying of grace, and Evans cutting the handcuffed Wade’s meat (no fat, please). Wade becomes acquainted with Alice and begins to get some insight into their family. The rest of the film involves their arrival in Contention and the interplay between Evans and Wade in the hotel’s bridal suite as they wait for the train. Two significant events, the saving of Wade by Evans and the arrival of Alice, set the scene for the well-choreographed and dramatic ending in which Evans must get Wade to the train as the gang positions itself to rescue Wade and kill Evans.

3:10 to Yuma (2007)
Starring Russell Crowe, Christian Bale, Peter Fonda, and Ben Foster.
Directed by James Mangold. Rated R. Running time 122 minutes.

The re-make, which is a half-hour longer than the original (and feels it) differs significantly. It opens with the Evans barn being burned by the banker’s hooligan. The elder Evans son William (Logan Lerman) expresses disdain for his father Dan Evans (Christian Bale) because he won’t do anything but simply grovel for more time before foreclosure. While they go to round up the cattle, they come upon the robbery of the stagecoach, this time loaded with paper currency, not gold, and with a lot more shooting and killing. The stage is carrying Pinkerton detectives, one of whom, Byron McElroy (Peter Fonda), is Ben Wade’s (Russell Crowe) nemesis. Wade shoots McElroy in the abdomen at point-blank range. As in the original, Wade spares the Evans family and heads for Bisbee where he is captured after dallying with the barmaid Emma Nelson (Vanessa Shaw). The filmmakers felt compelled to sprinkle in some profanity, which adds nothing to the dialogue, as well as partial nudity. The liaison between Wade and the barmaid was choreographed and dramatic ending in which Wade must get Wade to the train as the gang positions itself to rescue Wade and kill Evans.

The supper at the Evans homestead is more crowded and not as much a family event. Evans still cuts the handcuffed Wade’s meat but this time he’s asked to cut off the gristle. We learn more about Evans’s Civil War record and that he is captured after dallying with the barmaid Emma Nelson (Vanessa Shaw). The filmmakers felt compelled to sprinkle in some profanity, which adds nothing to the dialogue, as well as partial nudity. The liaison between Wade and the barmaid was handled off-screen in 1957. There is a medical sidebar when McElroy is operated on without anesthesia by veterinarian Doc Potter (Alan Tudyk). Simply removing the bullet leads to a remarkable recovery and McElroy joins Evans, Doc Potter, and Butterfield the stagecoach owner (Dallas Roberts) in transporting Wade to Contention.

The supper at the Evans homestead is more crowded and not as much a family event. Evans still cuts the handcuffed Wade’s meat but this time he’s asked to cut off the gristle. We also learn more about Evans’s Civil War record and that he lost a leg (not so in the original). Nonetheless, he is able to run like a deer in some key scenes. From here, the re-make diverges widely from the original as the film covers the trip to Contention, which the original did not. There’s a lot more violence, special effects, and issue-oriented dialogue that the director acknowledges in the DVD commentary was intentional. This includes vilifying the Pinkertons for presumably slaughtering Apache women and children, as well as the railroad’s exploitation of Chinese and Negroes. In contrast to the low-key performance by Richard Jaeckel as Charlie Prince, Wade’s second-in-command, in the original, Ben Foster gives a riveting performance as a vicious psychopath who is dedicated to Wade, although the feeling is not mutual. While I’m not a fan of psychopaths, Foster’s portrayal, which is reminiscent of Richard Widmark’s performance in The Killers, was, for me, the highlight of the movie.

Evans’s wife is no longer involved in the ending, which is much different from the original although the last line is virtually the same. Director Mangold decided to drop her (whose role I much preferred) and made the elder son a main character. Both play the same role in humanizing Wade as he builds an appreciation of Evans and the importance of trying to preserve him for his family’s sake. In this version, Wade quotes the Bible, as many movie villains do these days. He confesses that his mother left him in a hotel room with a Bible and promised to return. He read it in three days, but she never came back for him. His favorite quotations are from Proverbs 13:3 and 21:2. Crowe appears at times to be sleepwalking through the picture, but to give him his due, he does convey menace in ways that Glenn Ford did not in the earlier version. As Wade says to Matthew, who is enamored of Dime Novel western desperadoes like himself, “Kid, I couldn’t last five minutes leading an outfit like that if I wasn’t rotten as hell.” Yet he’s an artist and a philosopher, the prototypical post-’60s anti-hero. His exchange with Evans as to why he doesn’t do good deeds is particularly noteworthy.

As one might expect of someone who came of age in the 1950s, I much preferred the original, which features straight-ahead storytelling with a powerful performance by Van Heflin, who specialized as the solid second male co-star, most especially in Shane. Leora Dana’s role, though smaller, is essential in conveying the importance of character and family. Still, as noted, there are some excellent scenes and standout performances in the re-make, especially by Ben Foster, as well as Peter Fonda. I was also grateful for the re-make in that it led me to watch the older version. There are some interesting features on the DVD, especially the one that shows how the picture was made. Another, an altogether too brief survey of the Western outlaws gangs like the James Brothers, the Youngers, the Daltons, and the Earps, discusses how many of them walked the fine line between being lawmen and outlaws, periodically falling to one side or the other.

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Reviews and reflections

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

Geriatric Bioscience: The Link Between Aging and Disease

David Hamerman
The Johns Hopkins University Press, Baltimore, Maryland, 2007, 279 pages
Reviewed by Denise Zwahlen-Minton, MD

Get ready to clear out the cobwebs everyone! Geriatric Bioscience will take you back to the days of biochemistry and pathophysiology lectures and add in a couple more details. Dr. Hamerman describes the molecular process of multiple diseases associated with aging, including osteoarthritis, diabetes, osteoporosis, and more. The depth of knowledge presented is astounding. I found myself reading in small sections so I could fully process the information covered and I realized just how much our knowledge of aging and diseases has exploded due to research.

This book is not meant to tell you how to treat your patient, but how to understand your patient’s illness and why certain treatments are recommended and, further, how to avoid the disease in the first place if at all possible.

In the preface, Dr. Hamerman expresses his desire to pass on his vast knowledge and theories on aging by presenting a new term he calls “geriatric bioscience.” Dr. Hamerman defines geriatric bioscience as “the interrelations of the biology of aging and disease.”

His goal with this book is to “promote greater awareness of the biological basis of aging and related diseases; introduce the relevance of early origins of disease as part of overall development; and encourage geriatricians to be aware of assessing risk factors to permit timely interventions.”

As a young geriatrician, I especially enjoyed the chapter covering the evolution of geriatrics, and that Dr. Hamerman calls on future geriatricians to continue the quest for knowledge in aging and prevention of disease. I have recommended that our geriatric fellows read Geriatric Bioscience to develop an appreciation of the history and future of geriatrics, as well as to increase their knowledge of aging, the chronic disease process, and how closely related these entities are.

In the body of the book, Dr. Hamerman conveys the knowledge he has gained in the science of aging, spanning his half-century career in medicine and geriatrics. He covers the basic science of many common geriatric syndromes, and discusses how the normal aging process contributes to the development of disease and how common pathways lead to different disease processes.

The covered geriatric syndromes were described individually, which made it easy to go back to find a disease process; but the discussion of common pathways between diseases could be better referenced to other chapters. It would be interesting to try fitting a patient with multiple co-morbidities into the pathways Dr. Hamerman presents and then discuss how the patient got to be in the shape he or she is in, as well as the key points for intervention that were missed by the patient or the physician.

Overall, I enjoyed reading Geriatric Bioscience. I feel it is a must-read for young and in-training geriatricians. It will help to build knowledge on the molecular basis of the aging process and how aging affects chronic disease and its management and prevention. Geriatric Bioscience also inspires one to pursue knowledge in aging and chronic disease management through research. Dr. Hamerman has truly fulfilled his goal of conveying his knowledge, as well as inspiring future geriatricians to keep the torch of understanding of the aging process burning.

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Life in the Balance: A Physician’s Memoir of Life, Love, and Loss with Parkinson’s Disease and Dementia

Thomas Graboys, MD, with Peter Zheutlin
Union Square Press, New York, 2008, 224 pages

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

Once upon a time, pathographies (i.e., illness narratives) and physician memoirs were few and far between. Undoubtedly, the experience of illness raised existential questions for sufferers then as now, but the only people moved to communicate their encounters with illness for public consumption were those whose business it was to do so; clergymen and creative writers, for example. Likewise, while the occasional doctor published his memoirs, the public in general wasn’t consumed by a passion for reading about medical exploits. This state of affairs is difficult for us to imagine today because for several decades now pathographies and medical memoirs have been hot items in the publishing world. In the 1970s and ’80s, many such books concentrated on anger, exposé, and condemnation, with physicians telling the terrible truth about medical training and patients documenting the inhumanity of American medical care. More recently, many doctor- and patient-writers have shifted their attention to the existential and spiritual dimensions of medical experience.

Life in the Balance and The Light Within are interesting, and in some ways surprising, examples of this recent “greening” of medical nonfiction. In both, health care professionals and medical institutions come across as good guys rather than villains. And in both books the major theme is interior growth. Life in the Balance is the story of a cardiologist who develops progressive, disabling illness while at the peak of his profession. Speaking from the perspective of patient and doctor, Dr. Thomas Graboys struggles not only with the meaning of illness in his own life, but also with its impact on his patients and colleagues, and the difficult decision of when to retire from practice. The Light Within is co-authored by a gynecologic oncologist and an ovarian cancer patient with whom she established a close personal relationship. This “extraordinary friendship,” as described in the book’s subtitle, leads both women to discover deeper meaning in their lives and work.

An eminent Boston cardiologist, Harvard professor, and protégé of Bernard Lown, Dr. Thomas Graboys developed Parkinson’s disease while still in his late 50s. Shortly after his wife died of cancer in 1998, Graboys noticed unusual fatigue and physical and mental sluggishness. He naturally attributed these symptoms to grief. But they continued, and a couple of years later he experienced episodes of stumbling, falling, and syncope. Despite receiving a permanent cardiac pacemaker, these symptoms recurred in 2002 around the time of his marriage to Vicki, a woman he had met a year or so after his first wife’s death. During 2003 Graboys confided to his diary that it was “increasingly difficult to express concepts.” He also noticed tremor, problems with dictation, and frequent loss of his train of thought, symptoms “typical of Parkinson’s.”

While Graboys recorded these concerns in his diary, outwardly he denied that anything was wrong, even to family and close friends. He courted and married Vicki without revealing his symptoms or explaining their implications. When a long-time nurse colleague questioned him about his health, he replied, “I'm just tired.” In fact, his denial remained intact until the day in 2003 when the chair of Neurology at Harvard accosted him in the parking lot and pointedly asked, “Tom, who is taking care of your Parkinson’s?”

Despite some improvement with treatment, Dr. Graboys faced an even more difficult challenge in 2004 when he developed the vivid, violent dreams and memory lapses that led to a diagnosis of Lewy body dementia, a form of progressive dementia sometimes associated with Parkinson’s disease. With the cat out of the bag at last, the author finally began to confront the issue of professional impairment. But initially the confrontation was indecisive. He wrote a letter telling his patients about his illness, cut back on his practice, and even had his neurologist certify that he
“will be able to continue as an effective physician” p34

Finally, in mid-2005 Graboys’s colleagues had to seize the initiative themselves. “I was told, gently but firmly, that it was the unanimous opinion of my colleagues that I was no longer fit to practice medicine.” p36

Writing now with the assistance of journalist Peter Zheutlin, Graboys reviews these events with unblinking honesty. He acknowledges his betrayal of Vicki and the subsequent tension and distrust in their relationship. He confronts his anger over being ill and the prolonged denial that led to personal and professional isolation. At the same time, however, the author reveals the thoughtful, generous, and passionate side of his character: good friend, loving husband and father, a man determined not to give up. At one level he approaches the challenges of declining physical and mental ability with Stoic-like equanimity, while at another level he maintains fierce determination to fight as long as he can.

“What will become of me?” This is the question that now lies at the center Dr. Graboys’ personal world. He knows that his loss of mental and physical control will worsen. With almost superhuman effort and his family’s strong support, he has been able to adapt to his limitations and maintain a sense of meaning in his life. Will that continue? In a chapter entitled “End Game,” he addresses the question of suicide. Reflecting on his condition, especially the dementia, Graboys asks, “Will I lose myself, my very essence, to this disease?” p161 Yet what end-of-life instructions should he give to his surrogate decision makers? “Who is to say how much dementia is too much to live with? Who will know what really goes on in my head when I lose the ability to communicate?” p166

In the last chapter, Graboys acknowledges that he has no “simple prescription that will help you or someone you love live a life beyond illness, or tell you how to tap the hope that lives within.” p181 Unfortunately, he then goes on to make several suggestions of the superficial advice-manual variety: “Use your family and friends as motivation to live life with as much grace as you can muster.” “Find a safe place . . . to unburden yourself of anger.” “Acceptance is key to defusing anger, stress, and self-pity.” “Use your faith in God, if you believe in God.” pp181–82

I found the last comment dispiriting. Up until that point (six pages from the end of the book), Graboys says nothing explicit about the role of spirituality in coping with progressive illness. I use the term “explicit” here because in my opinion the kind of existential work the author describes qualifies as implied spirituality. So I don’t mind the absence of transcendent language or revelatory experience. No, I found the bland God-comment disappointing because with it the author introduces a new character (God) who plays no role in his plot. Why toss belief into your recommendations, if you immediately dispose of it with such a truism? As noted in the previous paragraph, perhaps my major complaint about Life in the Balance is the disconnect between the engaging personal story that occupies most of the book and the advice manual last chapter. I guess Dr. Graboys felt that he owed his readers a summary take-home message. However, he didn’t. Trust me, his story speaks eloquently for itself.

The Light Within

The same is true, although in a much different way, for The Light Within. Dr. Lois Ramondetta was a fellow in gynecologic oncology at the M. D. Anderson Hospital in 1998 when she was called one night to the bedside of Deborah Rose Sills. Sills, a professor of comparative religion, had undergone surgery for ovarian cancer the year before and was now admitted for small bowel obstruction. Scheduled for surgery the next morning, she had refused to drink her laxative on the basis of being “already empty.” p3

Dr. Ramondetta’s verbal intervention was successful. So, too, was the surgery, during which no recurrent cancer was found. Ramondetta and Sills hit it off well from that moment on. Their relationship developed over the next seven or eight years from doctor-and-patient to close friendship and eventually co-authorship of this intriguing memoir.

In the early part of the book, the women’s stories remain largely independent, except for medical contacts. Dr. Lois writes about her early marriage to a medical classmate, its rapid unraveling under the stresses of residency, their infant daughter Jessica, and subsequently the complexities of her life as a single mother. (The women almost immediately begin referring to one another as “Dr. Lois” and “Deb,” a practice I’ll adopt here.) Deb’s sections, printed in italics, tell of a highly regarded university professor adopting a strange new life as an cancer patient. She struggles against reinterpreting herself as sick. As Dr. Lois writes, “One of the first things I learned . . . was how much she disliked to be defined by her illness.” p31 The women also reflect on their developing relationship. Deb writes, “the two of us [are] still dancing our way around each other.” p79 In a companion section, Dr. Lois observes that Deb considers friendship “an ongoing conversation.” p80

The stories converge as the two become close friends. Some of their interactions take place at M. D. Anderson, as Deb first returns for a phase II clinical trial that requires a seven-month treatment protocol, highlighted by a bone marrow transplant, and later for management of recurrences and complications. Their friendship also blossoms in nonmedical settings, both in Houston and at Deb’s home in Santa Barbara. Among the stories they share is that of Dr. Lois’s courtship and marriage to Nuri, a local disc jockey. Another is the rock-solid support of Deb’s family. In addition, the friends begin to collaborate, first on a lecture and then on an academic paper about spirituality and ovarian cancer. This dialogue eventually leads to the book itself, completed only after Deb’s death in 2006.
Dr. Lois relates one sobering incident in the realm of medical ethics. Toward the end of her life, when cancer had obstructed her ureters, Deb decides against having nephrostomy tubes inserted to prevent renal failure. "I'm not going to be medicalized," she explains.\textsuperscript{168} Deb's choice comes as a surprise to Dr. Lois, who by that time had already been practicing medicine at least six years: "That conversation was a real eye-opener for me. With most patients, I had never thought of this as a choice."\textsuperscript{168} Not a choice? Hadn't she ever discussed forgoing life-extending therapy with one of her cancer patients? I would hope that Dr. Lois had done so before Deb's case, which occurred after she had completed several years of gynecologic oncology practice. Fortunately, Deb is then offered a stent rather than an external tube, an option she accepts, thus making her earlier decision moot.

Although I found \textit{The Light Within} interesting and competently written, I was disappointed because through most of the book the spiritual dimension—so often referred to by its protagonists—doesn't come alive. Early in the text Deb introduces Dr. Lois to Buddhism and Ram Dass's teaching, "Be here now." Much later, Nuri, her fiancé, is helping her learn the same lesson: "to enjoy the present—to be in the now, as Deb had put it."\textsuperscript{156} In the chapter entitled "Spirituality and Cancer," Deb's ovarian cancer recurs and the question "How long do you think I have?" arises. Dr. Lois observes, with regard to their friendship, "I began to notice that some of my fellow oncologists were also being drawn—sometimes against their will—into similarly deep and spiritual relationships."\textsuperscript{157} Yet the narrative contains few reflections on human dignity, suffering, or the meaning of illness, and no attempt to evoke in words the spiritual experiences the authors refer to.

Thus, I was taken by surprise when on page 197 I came to the episode where Deb reads a passage from the biblical book of Isaiah to Dr. Lois: "The voice said, Cry. And he said, What shall I cry? All flesh is grass, and all the goodliness thereof is as the flower of the field." My reaction to this passage was immediate and visceral. I burst into tears. Not just a single sob or two, not just a crinkling of my eyes. No, I literally burst into tears, feeling a sense of loss and a deep yearning seemingly unattached to any specific object. As I read on, a quieter version of the same reaction occurred at page 218 where Abby, Deb's adolescent daughter, thanks her dying mother for being her mother and for fighting so hard to stay alive. I'm not sure how to interpret these reactions, and it is probably unprofessional for a reviewer to cite tears as data in a book review. Nonetheless, I acknowledge them because the spirituality I was looking for all along seemed to "click" for me in the last chapter of \textit{The Light Within}. The authors' stories may appear for most of the book to promise more than they deliver, but in the end they come together powerfully and, at least for me, they triggered a revelatory experience.

Life in the Balance and \textit{The Light Within} are two very different, but complementary, memoirs. Neither is stale or routine. Each is fresh and surprising in its own way. Both are tales that deserve our attention.

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Office Hours

A search for disease
Amidst innocent chatter.
Anxious eyes.
Hidden fears.

Disease selects a stranger,
And merges our lives.
Adding me to the broth,
That sustains a life.

Each subsequent visit;
A sip of sustenance,
Cratered in a bowl
Of hope.

Cupped by trembling hands,
The bowl touches lips.
Eyes speak,
"OK to drink?"

Eyes that occupy
My pensive moments.
My morning drive.
My sleepless nights.

\textit{The Pharos}/Spring 2009

45
The World Is Sleeping

3:03 AM. The world is sleeping.
Skin stretched over bones,
her weight pretends to depress the hospital mattress.
These waking hours are unbearable pain.
Writhing and worming in bed,
she digs her own grave.

An exhaust fan sounds like tiny hands clapping.
It makes a wind to kiss the sweat of her hairless skull.
Tumors devour her.
Mitotic spindles dance wildly
a choreographed mayhem.

Her body is indifferent to a half-empty syringe.
Blood vessels protrude from her arms,
calling Morpheus to ease her through—
memories of 96 years need more than minutes to pass.

Neon lights buzz to reveal her.
A steady pulse barks out to the stethoscope.
A needle prick, a rose blooms—
a red flash hardens to crimson.

Her heart is now a blood-soaked sponge.
Each contraction rattles and cracks her crusted ribs.

Minutes pass. Time slows.

3:17 AM. The world is sleeping.

Michael R. Bykowski

Mr. Bykowski is a member of the Class of 2011 at The University of Pittsburgh School of Medicine. His address is: 2158 Fairland Street, Pittsburgh, Pennsylvania 15210. E-mail: bykowski.michael@medstudent.pitt.edu.
Announcing the 2009 Alpha Omega Alpha Robert J. Glaser Distinguished Teacher Awards

These awards are based on a national competition conducted annually through the offices of the deans of U.S. and Canadian medical schools, and are designed to recognize distinction in medical student teaching. Each school may submit one application. Recipients are selected by a committee jointly appointed by AΩA and the Association of American Medical Colleges (AAMC).

Up to four faculty awards of $10,000 each are made. In addition, each award winner’s nominating institution receives $2,500 for teaching activities. If that school has an AΩA chapter, a $1,000 stipend is awarded toward its activities.

Nomination materials for 2009 have been sent to every medical school by the AAMC, which administers all aspects of the competition. The deadline for nominations is May 1, 2009. Information and nomination forms are available at www.aamc.org/about/awards/aoa.htm. Queries regarding nominations should be addressed to Henry M. Sondheimer, MD, at the AAMC, 2450 N Street, NW, Washington, DC 20037-1127; telephone (202) 828-0680; e-mail: hsondheimer@aamc.org.

The awards will be presented during the annual meeting of the AAMC in Boston, November 6–11, 2009.

Minutes of the 2008 meeting of the board of directors of Alpha Omega Alpha

The meeting in Menlo Park, California, was convened at 8:30 AM by President Rae-Ellen Kavey, MD.

Present were: Secretary-Treasurer C. Bruce Alexander, MD; member at large N. Joseph Espat, MD; President Rae-Ellen Kavey, MD, MPH; member at large Douglas S. Paauw, MD; councilor member Robert G. Atnip, MD; medical organization member John Tooker, MD; Executive Secretary Edward D. Harris, Jr., MD; Assistant Treasurer William F. Nichols; and national office members Mara Celebi, Ann Hill, Debbie Lancaster, and Carol Wong. Participating by conference call were Vice President Donald Wilson, MD, and student member Natalia Berry.

Absent and excused were: members at large Michael V. Drake, MD, Ruth-Marie Fincher, MD, Don W. Powell, MD, and Joseph W. Stubbs, MD; councilor members Eric P. Gall, MD, and Amy Goldberg, MD; student members Sneeta Sinha and Kara Cavuoto.

The minutes of the 2008 meeting of the board of directors were reviewed and approved.

New board and honorary members

Nominations for the 2008/2009 board of directors slate were reviewed and voted upon. Elected to a three-year term as member at large: Robert Atnip, MD, Pennsylvania State University. Re-elected to three-year member-at-large terms: C. Bruce Alexander, MD, University of Alabama at Birmingham; Donald B. Wilson, MD, Director, Minority Health & Health Disparities, Owings Mills, Maryland. Elected to a three-year term as councilor member: Anne Mancino, MD, University of Arkansas School of Medicine. Elected to a three-year term as student member: Cason Pierce, University of Texas Southwestern Medical School at Dallas.

Honorary member nominations were reviewed and voted upon. Elected to honorary membership were: Lihadh Al-Ghazali, MBChB, MRCP, FRCP, FRCPC, United Arab Emirates University, Al Ain, United Arab Emirates; Rodolfo A. Armas-Merino, MD, MACP, University of Chile, Santiago, Chile; Kai-Ming Chan, MBBS, FRCS (Edin.), FRCP (Glas.), FHKCOS, FACS, The Chinese University of Hong Kong, Hong Kong Special Administrative Region, People’s Republic of China; Ronald Dorfman, MBChB, FRCP, emeritus professor of Pathology, Stanford University School of Medicine, Stanford, California; Ogabara K. Doumbo, MD, PhD, University of Mali, Bamako, Republic of Mali; Torello Lotti, MD, University of Florence, Florence, Italy; Prof. Dr. med. Dr. H. C. Thomas Ruzicka, Ludwig-Maximilian University, Munich, Germany; K. V. Thiruvengadam, BSc, MD, FRCP, FAMS, DSc, FCCP (US), FCAI, Madras Medical College, Chennai, India; Nuria M. Greenfield Tortosa, MD, University of Panama School of Medicine, Panama City, Panama.

Reports of officers and programs

Reports of the president, executive secretary, and managing editor were presented, followed by reports on the programs the national office administers.

Ms. Celebi and Ms. Wong presented the report on online registration of new members. The board decided in 2006 to require registration of new members on-line:

- To familiarize nominees with their obligation to pay dues to support ΑΩΑ programs.
- The ΑΩΑ Constitution states that “Elected candidates
may only be inducted into the Society after the membership fees to the local chapter [if any] and to the national AΩA office have been paid.

- The new process familiarizes new members with the AΩA web site, which the national office will use increasingly for communication with members.

The new registration procedures resulted in 96 percent of all nominees having paid dues as of August 2008, compared with 38 percent at the same point in 2007, before the new registration procedures took effect.

The board unanimously approved the following statement regarding nonpayment of dues by students elected to AΩA:

As established in the AΩA Constitution (Article IV, Section 2f), a student chosen for membership in AΩA “. . . may only be inducted into the Society after the membership fees to the local chapter and to the national AΩA office have been paid.”

The AΩA Board of Directors established at its annual meeting in October 2007 that all new member dues must be paid through a process of online registration using the AΩA website, effective with all subsequent chapter elections. This process has been successful at enrolling 97% of new members over the past 12 months. Students who do not initially pay their dues receive reminders from the National Office, both in person and through their AΩA Councilor.

By unanimous vote, the AΩA Board now reaffirms that AΩA membership will not be granted to any student, who after a reasonable process of notification, has failed to satisfy the dues requirement prior to September 1 of the year of graduation. After that date, a final letter of non-election will be sent to the Councilor and to the Dean of the medical school. It is expected that the Councilor will then make appropriate efforts to notify the candidate of his/her status.

This action of non-election as a student will not preclude any candidate from future election to AΩA in other defined membership categories.

Dr. Alexander and Mr. Nichols presented the financial review. AΩA’s financial health continues strong in spite of the problems in the stock market. The change in registration procedure resulted in a small improvement in dues income. National programs accounted for $1.27 million in actual expenses for the 2007/2008 fiscal year.

New initiatives

The proposal for the Professionalism Fellowship was discussed and approved. Announcement of the fellowship was sent to all chapter councilors and deans of schools of medicine having active AΩA chapters.

A survey of medical students was completed. The survey sought to determine:

1. Student awareness of AΩA as an organization: Is the student familiar with AΩA? Does the student understand its function as a medical honor society?
2. Student understanding of AΩA: Does the student know about AΩA opportunities within chapters and nationally?
3. Student perception of AΩA: Is the student associated with AΩA? Is AΩA a negative or a positive influence? Should honor societies exist in medical training?
4. Visibility of AΩA on campus.

The survey was designed and conducted by student member Natalia Berry of Dartmouth Medical School with the input of marketing professor Jackie Luan at the Tuck School of Business at Dartmouth. Two groups of students were surveyed: junior AΩA students and a broader group of AΩA and non-AΩA students.

Almost 200 third-year students, elected as juniors, completed the survey, as did an additional fifty senior students. Names and medical schools remain anonymous. Most reported first hearing about AΩA from elected students. Those reporting recognized scholarly achievement (95%) and professionalism/leadership/service (82%) as the primary functions of AΩA. Forty-seven percent listed help in obtaining a residency as a primary function. Of these elected students, 41% believed that AΩA was active and visible at their school. Of the small number of elected students (2% of those responding to the survey) who felt that there was no appropriate role for a honor medical society, the principal reasons were that it increased stress and pressure and competition. The attributes of membership most important to recently elected junior students were help with residency match (77%) followed by prestige. A number of written comments indicated that the lack of visibility of AΩA on campus resulted in the organization appearing as if it were a secret society.

Presentation by Stanford Alumni Consulting Team

AΩA’s board of directors decided at its 2007 board meeting to investigate ways to increase AΩA’s visibility, both in medical schools and generally, to enhance existing programs, and to generate revenue for additional important programs. A group of alumni from the Stanford University Graduate School of Business, the Stanford Alumni Consulting Team (ACT), provides pro bono management consulting services to nonprofit agencies. The group presented its report to the AΩA board of directors at this meeting. The board has taken ACT’s proposals under advisement and will implement selected recommendations over the next several years.
I Am the Patient

I give my name,
Take a seat.
It feels odd from this vantage.
They call me Ms., ask me in.
This is my turf, but I'm not in charge.
Today I am the patient.

My vitals taken,
I sit, ill at ease not being in charge.
There's a reason I sought that degree.
The doctor comes in,
Asks my complaint.
I try to be helpful, descriptive,
Though I don't enjoy being vulnerable,
Or asking for my needs to be met.
I need to be the patient.

My visit almost complete,
I recheck—did I miss anything?
"I hope you feel better," my physician offers
And I thank him for seeing me as a walk-in.
God, I just hope the cough will ease tonight
And I can get some rest.

I pay my copay,
Get my prescriptions and note for work.
"Oh, you're a doctor," the receptionist notes.
I smile.
Not today.

Suzanne Minor, MD

Dr. Minor (ΛΩΛ, University of Miami, 2001) lives in Florida. Her address is 16555 NW 25 Avenue, Opalocka, Florida 33054. E-mail: suzieminor@aol.com.
Letters to the editor

Locked-in syndrome

I enjoyed the review of *The Diving Bell and the Butterfly* by my friend and classmate Peter Dans in the Autumn 2008 issue of *The Pharos*. I would agree with his characterization of the film as outstanding and, as a neurologist, I found the depiction of a patient with the locked-in syndrome quite accurate. The protagonist showed remarkable inner strength and intelligence despite his desperate condition, being unable to move or speak and only able to communicate with eye blinks. Bauby, the patient, had a contract to write a feminine counterpart to *Monte Cristo*, presenting a powerfully ironic situation, as its author, Alexandre Dumas, père, penned the first literary depiction of a person with the locked-in syndrome in this novel. Whether or not the screen writer knew this is not clear.

The description of “the paralytic,” who was in this state for six years, is as follows:

M. Noirtier, although almost as immovable and helpless as a corpse, looked at the new-comers with a quick and intelligent expression . . . . Sight and hearing were the only senses remaining, and appeared left, like two solitary sparks, to animate the miserable body which seemed fit for nothing but the grave. The speaking eye sufficed for all. He commanded with it; it was the medium through which his thanks were conveyed.1

As in the movie, there were several people who learned to communicate with Noirtier by attempting to interpret his eye blinks. His granddaughter Valentine, however, worked out a system much like that used by the speech pathologist in the film. She first recited the letters of the alphabet until Noirtier indicated that the first letter of the word he wanted was reached. The second letter of the word was then determined the same way. Valentine then held up a dictionary and ran her fingers down the columns until her grandfather signaled that she was at the word he wanted.

Although rare, the locked-in syndrome occurs often enough that it needs to be considered in the differential diagnosis of any patient who has no voluntary movements but seems to have some level of wakefulness. These patients are individuals with whom reliable communication can be achieved, unlike patients with coma, the chronic vegetative state, or conditions associated with minimal consciousness. The same careful assessment needs to be applied to children, as the syndrome has been reported in pediatric patients. Patients with amyotrophic lateral sclerosis and some other neuromuscular conditions can eventually become locked-in, but this does not occur calamitously as in the case of a stroke or traumatic brain injury.

References


Gerald S. Golden, MD
(AΩΩ, Columbia University College of Physicians & Surgeons, 1961)

Anatomy—with or without a cadaver

I read with great interest the article, “Bring out your dead?” by W. Roy Smythe (pp. 10–15). In Nepal, dissection is a necessary component of the gross anatomy curriculum for medical students. Students dissect certain regions of the body and are shown prospected specimens of other regions. During the practical examinations, students do not have to dissect the human body but are shown prospected specimens and identification of individual structures followed by a *viva voce* with the examiner.

In Nepal, the basic science subjects of anatomy, physiology, biochemistry, pathology, microbiology, and pharmacology are taught in an integrated organ system-based manner during the first two years of the undergraduate medical (MBBS) course. A survey was carried out in a medical school in western Nepal to study the emotional impact of cadaver dissection using the appraisal of life events (ALE) scale.1 The loss, challenge, and threat scores were compared initially on first exposure to dissection and at the time of the study. The loss and threat scores declined over the course of study. The loss and threat scores were lower than that reported previously. The challenge scores were higher. Majority of students considered anatomy dissection as a significant positive life experience.

The December 2004 issue of the magazine *The Clinical Teacher* had an interesting article about how a new medical school in the United Kingdom teaches anatomy without cadavers.2 The department decided that they would rely on living anatomy and medical imaging. Peer examination, life models, body projection, body painting, digital surface anatomy atlases, computer models, and simulations are among the various methods used. A major disadvantage of dissection ac-
According to the authors is that the color, texture, and smell of a cadaver is not like real life and cadavers cannot be auscultated, palpated, or usefully asked to change position.  

I am a medical educator and the medicine program coordinator in my medical school, and am interested in strategies to deal with the knowledge explosion in medicine. These days knowing "what not to teach" according to me is as important as knowing what to teach. A possible problem is that anatomists and anatomy teaching have concentrated on the requirements of surgeons and surgical specialties. The majority of medical graduates will not be surgeons and the anatomical knowledge they need and the way they approach the body may be quite different.

During my undergraduate days I was taught the detailed relations of various nerves and blood vessels. I do not remember any of that now and also did not find it useful in practice. I personally feel that the procedures like peer examination, body projection, and other methods adopted in the U.K. school will equip students with a more relevant knowledge of anatomy. A doctor while doing a physical examination (palpation) should be able to visualize what structures lie underneath the examining hand and should also know about the surface anatomy of different organs. With the widespread availability of CT scans and MRIs cross-sectional anatomy is becoming more important.

In my undergraduate days, anatomy was taught in a traditional manner and was not clinically oriented. Dissection may be useful in that it is a group activity and learning takes place in consonance with adult learning principles. Students can also be introduced to death in a sensitive manner. However, this objective was not fulfilled during my undergraduate days. Most medical schools in South Asia do dissections as a mechanical activity which is mandatory as it has been included in the curriculum. I feel medical educators and doctors other than anatomists and surgeons should also be engaged in the important issue of curriculum design. This may also be required for other basic science subjects. Their broader and more holistic viewpoint can have a significant impact on the narrower viewpoint of subject experts resulting in a more relevant curriculum.

Anatomy describes the setting of events, as rightly pointed out by the author. The questions are what methods to use to teach and learn about the body and to what depth to teach and which details are necessary and which are irrelevant and may be omitted. The guiding principle I feel is that the undergraduate course in most parts of the world prepares the student for a career as a primary care physician. The teaching of all subjects should keep in mind this important fact. Facts and details needed for various postgraduate courses can be better taught during the particular course and not during the undergraduate days!

References

Dr. P. Ravi Shankar
Department of Medical Education
KIST Medical College
Lalitpur, Nepal

AΩA membership—more than high GPA
In recent years, the Gamma AΩA chapter at UT Southwestern had been making student nominations based strictly on GPA, and individuals were only nominated during their senior year of medical school. Last year, the chapter leadership made two important changes in its selection process. First, selection criteria were changed to incorporate leadership, research, and service activities as outlined in the AΩA Constitution. Second, for the first time in over a decade, members were nominated from the junior class.

The benefits of making these two minor changes in the selection process have been tremendous. Weighing leadership, research, and community service in the selection process better insures that student members have the skill set and commitment necessary to foster a dynamic organization. By selecting a small group of members and student officers prior to the fourth year, the organization’s leadership has had more time to identify and organize projects that serve the community and that boost the visibility of the organization and its ideals on campus.

After their selection last spring, the student officers met with the chapter council, executive committee, and outgoing student officers. Following this meeting, the new officers together came up with ideas for several new programs designed to improve the university community, serve the community at large, and strengthen the ties of its faculty and former student members. The officers then organized a meeting with the newly-selected junior AΩA members to discuss these project ideas, identify those ideas with the most member support, and delegate responsibilities for development and implementation.

The AΩA student leadership and members identified several opportunities to provide service to the university community. The organization made one of its goals to encourage a collegial atmosphere among medical students. To achieve this goal, AΩA worked with the university administration to create a program where each of the forty AΩA members serves as a mentor to the small groups of first- and second-year students within the newly-created UTSW Colleges. These mentors provide support by assisting with instruction in performing different components of the physical exam, working with students to improve their patient
write-ups, providing encouragement and advice regarding Step 1 preparation and the residency application process, and by hosting their small groups of students for dinner. AΩA plans to make this partnership a cornerstone of its service activities and is working to improve the overall experience for all of the involved parties.

In addition, the chapter leadership felt that, given the academic success of its members, the group was in a unique position to offer advice on study habits and exam preparation to first- and second-year medical students. Several AΩA members developed a survey instrument and polled their fellow members to determine those study methods and resources most consistently utilized. They then incorporated this information into several Powerpoint presentations and shared it with first- and second-year medical students during a series of lunch workshops. Several other members are still working to create a similar resource for second-year students related to Step 1 and wards preparation.

The chapter community service project involved partnering with a local nonprofit organization to provide free sports physicals for the school-aged children of north Dallas. AΩA student members advertised the event, helped with patient intake and discharge, and conducted physicals with appropriate faculty supervision. Physician volunteers were recruited from the local AΩA faculty. In total, the group saw sixty-nine patients during a single Saturday morning in early September. AΩA plans to make this community service activity an annual event.

Moreover, the officers felt it important to strengthen the relationship between AΩA faculty, former student members, and current members. They contacted all current AΩA faculty members and asked for responses from those willing to serve as mentors to student members. They then compiled this list of mentors, organized it by area of medical specialty, and made it available for all of its student members. The organization is also working to acquire contact information for alumni members so they can be made aware of the various chapter activities.

To further improve visibility and communication within the organization, the student leadership has made a significant effort to update and improve its chapter website. The new website features information about the various AΩA activities, a list of all current faculty AΩA members, those faculty members willing to serve as mentors for AΩA members, and all recent student members. It also contains downloadable copies of the “study tips” documents, the current selection process, and the AΩA Constitution. The chapter has also produced the first edition of what it hopes will become a biannual chapter newsletter for distribution to faculty, student, and alumni members.

Several forces are responsible for this rapid and significant revitalization of the UT Southwestern Gamma Chapter. Strong faculty and administration support has been crucial. However, the main driving force for these recent changes has been greater opportunity for student leadership and greater student member involvement. This enhanced student involvement stems directly from the recent changes in member selection. We encourage other chapters to re-examine their selection processes and the organization of their student leadership so that they may better contribute to their local institutions, better serve their local community, and better promote the ideals of the national organization.

Cason Pierce, Chapter President, Gamma Texas
(AΩA, University of Texas Southwestern Medical School, 2008)
Dallas, Texas

Editor’s note
Prior to receiving Mr. Pierce’s letter, we sent out a reminder of AΩA selection principles to each chapter councilor, and requested responses from each about his or her own chapter processes:

Most chapters do indeed follow the guidelines in the constitution (Article IV, section 2) that stipulate that from the upper 25% of the class expected to graduate, one sixth of the total number may be nominated for membership. Up to one half of the total may be nominated in the spring of the junior year. Those chosen for nomination from the upper quartile by the following guideline (IV.2.c): “Scholastic achievement should be the primary but not sole basis for nomination of a student. Leadership capabilities, ethical standards, fairness in dealing with colleagues, potential for achievement in medicine, and a record of service to the school and community at large should be criteria in addition to the academic record.”

There are several important points to stress: One is that “nomination/nominated” replaces “election/elected” because students (or faculty, residents, alums) nominated are not full members until they have registered online and paid first-year dues or lifetime dues. Another is that within the context of the constitution, each chapter is free to weight these less objective criteria (perhaps best summarized by the term “professionalism”) as it chooses.

The message is a simple one: Those chapters that choose nominees for membership using only the Grade Point Average are in violation of the constitution, and must change. The evaluation of the subjective criteria does not sit squarely on the shoulders of the councilor. Fellow students (e.g., when elected juniors are considering seniors) and, most important, faculty member assessments, are very important to gather. Members
of numerous chapters have noted that the selection meetings have been very rewarding interactive experiences when input from many voices is heard.

Edward D. Harris, Jr., MD
Editor

Poetry—perhaps best read aloud

I enjoyed reading your editorial, “It’s not a word I can put into feelings,” in the Spring 2008 issue of The Pharos.

My older brother, Professor John Pick (born September 18, 1912), graduated maxima cum laude from the University of Notre Dame in 1933. He then earned his PhD at the University of Wisconsin under tutelage of Helen C. White, PhD. He was editor of Renaissance, the Catholic Literature Critique, for at least twenty years.

He taught graduate students various branches of English, but always insisted on teaching one undergraduate course in grammar, rhetoric, etc., so that he might keep up with any changes in punctuation, rules of paragraphing, etc., which helped him as an “editor.” He enjoyed teaching poetry, but his specialty was the Victorian novel.

My reason for writing was to point out that John always insisted his students read poetry aloud, as a recitation, and I note your various editors have also emphasized this. It makes sense, and emphasizes the real fundamentals of poetry by the auditory sense of the rhymes and rhythms of any language. All readers need to be reminded of this essential, because it leads to a greater appreciation of poetry as a means of communication.

I have been leafing through my collections of The Pharos from over the many years, and have been surprised at the variety and frequency with which you have promoted poetry. Thanks.

James W. Pick, MD, MS
(AΩA, Northwestern University, 1938)
Shorewood, Wisconsin

Dr. Pfeiffer (AΩA, Washington University in St. Louis, 1960) is a member of the editorial board of The Pharos. His address is: 3120 W. Hawthorne Road, Tampa, Florida 33611. E-mail: epfeiffe@health.usf.edu.

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Significant Other, Late in Life

We came together late in life
two rivers mingling
where each had been apart and unaware
now flowing as one
our bond holier than holy
impossible to rend
bound for
a common sea

Eric Pfeiffer, MD
Individuals who have contributed substantially to medicine and fields related to medicine, but who are not eligible for membership in AΩA as graduates of a medical school with an AΩA chapter or as a faculty member of a medical school maintaining an active AΩA chapter, may be nominated for honorary membership by any active member of the society. In 2008 Alpha Omega Alpha’s board of directors extended invitations to the following distinguished physicians and scientists.

Edward D. Harris, Jr., MD
Executive Secretary

Lihadh Al-Gazali, MBChB, MRCP, FRCP, FRCPCH
United Arab Emirates University, Al Ain, UAE

Dr. Al-Gazali, a British citizen born in Baghdad, Iraq, is Professor in Clinical Genetics and Paediatrics in the Faculty of Medicine and Health Sciences at Al Ain, United Arab Emirates. She graduated from Baghdad Medical College and went on to receive pediatric and genetics credentials in England and Scotland. Her goal in research is to identify and delineate genetic disorders that are prevalent in the UAE and Arab populations. Her group and collaborators internationally have identified more than a dozen recessive genes and has mapped four of these. Crucial for her research has been her establishment of a Registry for Birth Defects in the UAE. Her teaching expertise benefits both pediatric clerks and sub-interns, and she was honored with the Distinguished Performance Award at UAE University. She is a Fellow of the Royal College of Physicians of Ireland and the Royal College of Pediatrics and Child Health, United Kingdom. She is the winner of the 2008 L’Oréal-UNESCO award for women in science for Africa and Arab States.

Rodolfo A. Armas-Merino, MD, MACP
University of Chile, Santiago, Chile

Dr. Armas-Merino is a Professor of Medicine at the University of Chile, and a gastroenterologist at the Hospital San Juan de Dios in Santiago. He served as the Chairman of the Department of Medicine at the University of Chile from 1984 to 1994, and has been a Member of the Council of the Faculty at the University of Chile. In addition, he has been a member of the Editorial Board of the Revista médica de Chile and of Gastroenterología y Hepatología (Barcelona, Spain).

Professor Armas-Merino has held many other academic and administrative positions in his career, including the Presidency (1986 to 1996) and Vice Presidency (1982 to 1987) of the Superior Council of the Chilean Corporation for Certification of Medical Specialties; membership in the Council for the Technological Development of the Chilean Commission for Research in Science and Technology; a member of the Chilean Council for Research in Health since its foundation in 2003, and Vice President since 2007.

He has served on a number of International Committees and belongs to many professional societies, including the Sociedad Médica de Santiago (President from 1983 to 1985); Colegio Médico de Chile serving as a Member of the Santiago Regional Council from 1969 until 1973, and the National Council from 1973 until 1975. In 1982 he became a Fellow of the American College of Physicians and served as the Governor of the ACP Chile Chapter from 1996 until 2000, and has been a member of the Chapter Council from 1994 until 2008. He was made a Master of the ACP in 2001. He joined the Chilean Society of Gastroenterology in 1968 and was the Director from 1975 until 1990, he has been a member of the Chilean Academy of Medicine since 1989, was Treasurer from
2001 to 2008, and became the Academy Secretary in 2008. He was President of the Chilean Society of Medical Societies since its foundation in 2000 until 2007. Professor Armas-Merino is held in the highest professional esteem in Chile and internationally.

Kai-Ming Chan, MBBS, FRCS (Edin), FRCPS (Glas), FHKCS, FACS
The Chinese University of Hong Kong

Dr. Chan is Professor and Chair of the Department of Orthopaedics and Traumatology at the Chinese University of Hong Kong, and director of both the Hong Kong Centre of Sports Medicine & Sports Science and the WHO Collaborating Centre for Sports Medicine at his university. As a mentor/teacher he has overseen thirty graduate students, and his funded grants during his career have, to date, totaled almost $14 million. He has written 196 papers published in peer-reviewed journals, been an editor or co-editor of twenty-five books, written fifty-two book chapters and assembled 570 conference proceedings. International recognitions of his energy and accomplishments have included membership on the International Steering Committee of the WHO-endorsed Bone and Joint Decade, and being elected president of the International Federation of Sports Medicine (2002 to 2006). He is a Fellow of the American College of Surgeons and a member of the American Academy of Orthopaedic Surgeons and the American College of Sports Medicine. In 1995 he was honored by being named an OBE, Officer of the Most Excellent Order of the British Empire.

Ronald F. Dorfman, MBBch, FRCPath
Emeritus Professor of Pathology, Stanford University

Ronald Frederick Dorfman is an Emeritus Professor of Pathology at Stanford University School of Medicine and one of the most noted hematopathologists in the world. He is a South African graduate of the University of the Witwatersrand and Medical School in Johannesburg. His pathology training was at the South African Institute for Medical Research in Johannesburg. His major interest for nearly fifty years has been in diseases of the lymphoid system, making early major contributions to the role of enzyme histochemistry in the understanding of Kaposi’s sarcoma and, after moving from South Africa to Washington University in St. Louis in 1963, reporting the first case of Burkitt’s lymphoma outside of Africa. During the same period, he and his colleague Juan Rosai described what has become the well-recognized entity of sinus histiocytosis with massive lymphadenopathy commonly referred to as “Rosai-Dorfman Disease.” He was recruited to Stanford University in 1968 and, for thirty-five years co-directed the Laboratory of Surgical Pathology. During this time, he was a major participant in seminal clinicopathologic studies of Hodgkin’s disease and other lymphomas carried out at the University. He was, as well, one of six expert pathologists involved in a worldwide study that eventuated in “The Working Formulation of non-Hodgkin Lymphomas for Clinical Usage.” He is the author of over 170 peer-reviewed publications and many book chapters and has trained more than a generation of hematopathologists including Dr. Roger Warnke who is the current Ronald F. Dorfman, MBBCh, FRCPath, Professor of Hematopathology at Stanford University.

Ogabara K. Doumbo, MD, PhD
University of Mali

Dr. Ogobara Doumbo has been the Director of the Malaria Research and Training Center in Bamako, Mali, since its inception. He is also Chair of the Department of Epidemiology of Parasitic Diseases at the University of Mali. Awarding him honorary membership in ΩΩΩ recognizes his excellence in service through the Malaria Research and Training Center (MRTC).

The MRTC is a collaborative effort between the staff of the Faculty of Medicine, Pharmacy and Odonto-stomatology (FMPOS) and the National Institutes of Health (NIH) in the United States. This program has also received significant support from a number of USAID programs including the USAID Mission in Bamako. This is a uniquely African operation in which the work is planned, directed, and executed by the local staff.

In March 1998, President Clinton recognized the MRTC and made a promise for continued support. A site visit in October of 2007 clearly demonstrated that the MRTC presence and its protocols in the treatment of malaria have upgraded the health of the region under the leadership of Dr. Doumbo. Dr. Doumbo has contributed greatly to the health of the citizens of Mali and the success of the MRTC. The basic tenet of ΩΩΩ is to be “Worthy to serve the suffering,” and Dr. Doumbo certainly fulfills this mission.

Torello Lotti, MD
University of Florence, Florence, Italy

Torello Lotti graduated from the Universita di Firenze and specializes in Dermatology. He is a Professor in the Faculty of Medicine at the University of Florence. He embodies the spirit of ΩΩΩ. In addition, Torello is a force in organized dermatology in America and worldwide. He is acknowledged internationally as an expert clinician. He has the titles of Visiting Professor at three American medical schools (Bowman Gray,
Medical University of South Carolina, and the University of Louisville), and is an honorary member of eight international dermatology societies. He is the founding editor of *Journal of the European Academy of Dermatology*.

**Prof. Dr. med. Dr. H.C. Thomas Ruzicka**  
*Ludwig-Maximilian University, Munich, Germany*

Prof. Dr. med. Dr. H.C. Thomas Ruzicka, Professor and Head of Dermatology at Ludwig-Maximilian University in Munich, exemplifies the attributes we expect of AΩA honorary members, being a respected leader in academic medicine who cements with towering leadership the academic excellence of what may be the finest dermatology department in the world. Professor Ruzicka is an internationally renowned authority on atopic dermatitis with more than 500 full articles and a number of highly regarded books. He has led world dermatology with aplomb, beginning a new Munich tradition that has attracted English speakers in the same way that the Fortbildungswoche für praktische Dermatologie und Venerologie has been a magnet for German-language physicians to update their medical knowledge. His life exemplifies academic excellence, clinical acumen, and inspirational teaching at all levels with a warmth and graciousness that marks him in the first order of wonderful human beings.

**K. V. Thiruvengadam, BSc, MD, FRCP, FAMS, DSc, FCCP (USA), FCAI**  
*Madras Medical College, Chennai, India*

KVT, as he is popularly known, is in his eighty-second year, having enjoyed an outstanding academic record as Professor and Head of the Department of Medicine at Madras Medical College in Chennai. Earlier he had a distinguished academic career at the Stanley Medical College, Chennai, India, as the best outgoing student of the college and also of the University of Madras in 1950.

KVT’s primary areas of expertise have been clinical allergy, infectious diseases, and occupational medicine.

For the past nearly fifty-three years he has focused his attention on teaching undergraduates and postgraduates—for nearly thirty-one years in the State Medical Service and later in private medical institutions for nearly twenty years to date. Indeed, KVT is a legendary teacher at the bedside, in small groups, and the lecture hall, and was recognized by the Medical Council of India with the Dr. B.C. Roy award for eminent medical teacher. His medical school alma mater, Stanley Medical College, honored him with the Star of Stanley Medal. Many of his former students have distinguished themselves in India, the United States, the United Kingdom, and elsewhere.

A prize in his name was established at Stanley for the senior student graduating with the highest GPA in both physiology and medicine. Lectureships in his name were instituted at Madras University and Madras Medical College. An award in his name was established by the Rotary Club of Chennai.

Along with his teaching efforts, KVT has published more than 100 peer-reviewed papers. He has given a number of prestigious lectures on chest diseases, allergy, and internal medicine. He served as Regent of the College of Chest Physicians of India, and is a Fellow of the Royal College of Physicians, Edinburgh.

KVT has been Honorary Physician to the President of India. The government of India bestowed on him the honorific “Padma Sri” in 1981.

**Nuria M. Greenfield Tortosa, MD**  
*University of Panama School of Medicine, Panama City, Panama*

Nuria M. Greenfield Tortosa just completed four years as Governor of the American College of Physicians for Panama and has done a remarkable job as advocate for outstanding patient care and raising the level in quality of care in her country. She went to medical school at the Faculty of Medicine at the University of Panama, graduating in 1969. She did her internship at the Hospital Santo Tomas in Panama and then a rural internship at Area Sanitaria de David, Panama, followed by her residency in Internal Medicine and a residency in Nephrology. She has served as a Clinical Professor at the University of Panama since 1993 and an Adjunct Professor in Internal Medicine at the University of Guadalajara. She served as the president of the Panamanian Society of Internal Medicine from 1995 to 1997, and as governor for the American College of Physicians, Panama Chapter, from 2004 to 2008. It is hard to convey the importance of this person to her country’s medical establishment. Dr. Tortosa has an energy that lifts everyone around her.
Full Nelson

Under the state tournament banner
He wears a wrestler’s
String bikini helmet
And a singlet whose leg holes
Reveal two stumps
Emerging like wary prairie dogs
From their underground dens
As he balances his torso
On truncated arms
That lost necrotizing hands
Twelve years ago.

To me he seems half a man
Until I see him in his circle
Where he escapes my limiting hold—
Reversal—
Just as he did the nights of tears
And the endless days of “stumpy” and “freak”
To place me beneath him
Like the struggling wrestler
Wrapped in his twitching elbows,
Twisting on the mat
Whose painted circle
Belies the geometry of this man,
Complete in his abridgement,
A four limb amputee
Who is both beast and being
In his victorious, gymnasium roar,
A mouth stained red
In the invigorating blood
Of a long-awaited kill.

Jason David Eubanks, MD

The author (ΔΩΑ, Case Western Reserve University, 2003) is a Spine Fellow in the Department of Orthopaedics at the University of Pittsburgh. His address is: 36901 Beech Hills Drive, Willoughby Hills, Ohio 44094. E-mail: jdeubanks2002@yahoo.com.
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