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Wrongful death
Edward D. Harris, Jr., MD

Henry was an acquaintance, not yet a friend. He and I served together on the board of a foundation. He regularly flew in for the quarterly meetings, and we chatted idly about summer plans, recent trips, wildfires, and grandchildren. Last fall the board chair announced that Henry had phoned to announce his resignation from the board, that the reason was a personal one, and that he would miss being with all of us. At the winter meeting we learned that Henry had died. A board member who knew Henry well told us that for the past four years Henry had had gradual onset of shortness of breath and progressive swelling of the legs, and died “a natural death” during an acute episode. He added that Henry was a Christian Scientist, and had not seen any physicians for his symptoms. A nurse from the church had tended to him faithfully, visiting him almost daily during the year before he died.

Henry’s death hit me hard. Even though I have tried to resist thinking of it as a “wrongful death,” I have been unable to cool my anger that this good man was denied, or denied himself, access to a physician who would have recommended appropriate therapy for apparent heart failure. The indirect cause of Henry’s death was Mary Baker Eddy.

Born in 1821 in Bow, New Hampshire, Eddy lived in “ill health” until her forties, when she learned of a “medicine-free healer,” Phineas Parker Quimby. She read his works carefully, became one of his disciples, then lifted his material to publish her treatise, Science and Health, in 1875. Quimby’s heirs sued her for plagiarism without success, while she successfully marketed his ideas. Based on some of the fundamentals of Christianity, the “medicine-free” regimen emphasized (1) the removal of fear from the patient and (2) the replacement of fear with faith. Eddy’s extremely long tome is repetitious, constantly emphasizing that all evil, including illness, is not real, but imagined. She wrote: “When . . . faith in God destroys all faith in sin and in material methods of healing, then sin, disease, and death will disappear.”1p385 and “When the condition is present which you say induces diseases, whether it be air, exercise, heredity, contagion or accident, then . . . shut out these unhealthy thoughts and fears.”1p392

Eddy had the instincts and charisma of a true entrepreneur, a field not generally open to women of that time, and in 1879, when she was fifty-eight years old, she founded the Church of Christ Scientists. The magnificent “Mother” Church in Boston speaks to her powers of persuasion and fund raising.

All this is logical and understandable, because in the mid-1800s the pharmacopeia of medicine was very thin. Why not try her method in those days when little else was available that might be effective? But in the twenty-first century, why do logical and well-educated people eschew therapies proven to have curative or palliative effects and, instead, attempt to will away progressive organic disease? This is not to denigrate the efficacy of prayer and positive thinking for affliction created or maintained by connections of brain neurons. Whatever caused Eddy’s ill health when she was younger, her symptoms clearly responded to Quimby’s methods. She lived to seventy-nine.

Perhaps one of the reasons for the successes of Christian Science is that, as with many religions, one cannot accept and implement some of its tenets while ignoring others.

Let us contrast Eddy’s tenets for healing with those of homeopathy. Founded in Germany in the 1700s by Samuel Alway Hahnemann, homeopathy arrived in the United States in 1825. Its first college was established in Allentown, Pennsylvania. By 1900 eight percent of U.S. physicians were homeopaths, and twenty homeopathic hospitals and twenty colleges had been founded to teach its principles. One basic homeopathic principle is that every person has an innate self-healing response, which practitioners must stimulate. Homeopaths hold that a minute (essentially undetectable) dose of substance “X,” which in larger doses would produce symptoms, triggers self-healing.

There are a number of features of homeopathy that are appealing. One is that, like chicken soup, “it can’t hurt.” Another is that homeopaths learn to get a total picture of a patient, not just the “chief complaint,” but lifestyle, emotional status, and mental states. What is more, the best of homeopaths understand that selectivity is appropriate. Their treatments, given together with a lot of time spent with patients, can be effective for some symptoms but not others. Progressive organic diseases such as cardiomyopathy caused by diffuse small coronary arteriole disease need allopathic medicines and procedures. Royal Copeland was a poster boy for homeopathy, and his productive career as homeopath, dean, mayor of Ann Arbor, eye surgeon, wartime surgeon in World War I, and distinguished U.S. senator from New York is well described in Dr. Davidson’s and Dr. Dantas’s essay (pages 4–10). Copeland’s leadership in achieving congressional approval of the 1938 Food, Drug, and Cosmetic Act, was exceptional.

Homeopathic medicine is fading in popularity, due in part to the reality that training of primary care physicians now, more than ever before, emphasizes the holistic approach that homeopathy pioneered. I wish Henry had been seeing a good homeopath when that dyspnea and leg swelling developed.

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Radiology Suite

Hello, back again? We’ve got to stop meeting like this.
You know you’ll miss me when I’m gone
Discharge so soon? Well, let’s get that gown off, shall we?
I am autumn
skin turning like a leaf
red and yellow, fading to brown
Deep breath, now hold it.
holding on was always easy
it’s the letting go
the boundaries won’t hold firm
they collapse whistling and coughing
a flight of geese
That hum, it’s the machine.
the stone wind, ravaging
sweeping away the soft parts
invoking an image
of heart and bone

Well, that’s it, you’re done. I’ll call the ward.
Leaves spinning in dust devils on the asphalt
emulating the wind, whirling
dizzy, venturing in
a brief tug upwards then collapse
And yes, I’ll miss you when you’re gone.

Susan Rakley, MD

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The Pharos/Spring 2008
Quiet places
Our jeep moved cautiously along the muddy trail under the tall forest canopy. Despite the jungle cover, the roads become quite wet and the soil turns to glue that is almost liquid as you slide on it, and then remarkably solid again when the vehicle arrives at its resting place. As we slithered, the monkeys followed above and commented on our progress. Abruptly, the road turned, trees disappeared, and we entered the small village that was our goal. There was a fire pit at the near end of a central clearing and some small fields at the other for growing vegetables, sugar cane, manioc, and whatever products could be gleaned from the fertile but fickle soil. As we came to a halt, the Mayor came out to welcome us and the school bell began to ring—the Acción Cívica team had arrived to provide the episodic medical clinic, consultations about agriculture, and to spread the gospel of democracy. This was the '60s, and Fidel was spreading his own gospel throughout Latin America. Crude dictators were springing up as enthusiastic disciples. We were the counterreformation.

I enjoyed these trips to places where people lived beyond the end of the road, despite the sobering knowledge that medicine was simply the lever to open the door for a political message. Medicine held such a high place in my life that it concerned me to see it used as bait. Nevertheless, we did some good and practiced clinical medicine of a type close to the original sense of that term, in which the five senses served as diagnostic kit and laboratory. Our portable medical box held only basic medical and surgical tools, along with antimicrobials, anthelmintics, antiseptics, antidiarrheals, and topical antibiotic ointment. We were anti most things. Another box contained a (sun)light monocular microscope and Gram and acid-fast staining solutions. We had all we needed. Hyperaldosteronism and apathetic hyperthyroidism were not considerations here.

The schoolmaster's bell brought people from the various
huts and farms and out of the jungle. They were mostly children, herded by their mothers so the Doctor could look into eyes and ears and at rashes, nonhealing sores, and sore throats; listen to coughs and chests; and poke bloated abdomens. Rashes and sores were cleaned and treated. Blood smears were made and quotidian fevers quieted. Pulmonary rales were managed with antibiotics or anthelmintics, as indicated.

The children ran around inside and outside the school that was the temporary clinic, shouting excitedly. This visit made the day special and provided the unexpected benefit of closing the school. Some of the men began to build a fire, and a large pot was placed on it. They filled it with water, and the women brought vegetables and roots for the stew that was to be our payment. Several reluctant chickens came to the party as well. The Mayor made a speech and everyone applauded. The men discussed the issues of the time and the women shouted at their children. One of us suggested gently that the stew be boiled first and then simmered.

As people passed into the clinic and out the other end of the porch, the day evolved into a fiesta. The scene always seemed to me to be the twentieth-century equivalent of a medieval medicine show, but I enjoyed it, since, unlike those shows, we actually did some good. Malarial fevers went away, diarrhea was halted, bacterial infections disappeared, worms were purged, and preventive medicine was explained. Leaflets were given out to teach about parasitic diseases, water-borne diseases, tuberculosis, nutrition, and hygiene. We generally left a village after a visit, bacterial infections disappeared, worms were purged, and preventive medicine was explained. Leaflets were given out to teach about parasitic diseases, water-borne diseases, tuberculosis, nutrition, and hygiene. We generally left a village after a visit.

Nevertheless, I agreed and the schoolteacher indicated a narrow path that led into the jungle and said the walk would be about twenty minutes and her home would be the first hut that I would encounter. I took my small kit and started out.

Jungle is green above and brown below, and all is dim and wet. It swallows sound. Despite the abundance of birds, insects, and animals, relatively little is heard. It is visually rewarding: heliconia flowers grow wild, as do orchids, and wonderful parasitic plants. The smell is fecund and the sight and sense of decay and the evidence for the tenacity of life are pervasive—from the rotting vegetation giving birth to new growth to the parasitic plants in the trees. The wetness makes more of an impression than do the monkeys that follow you through the trees or the bright-plumaged birds that call. The skin is alive with the humidity and hypersensitive to the touch of cloth or leaf. The miracle that makes possible all the varied life in this part of the earth drips down your arms. The quietness aids the mind in its perusal of the surroundings, but the information is processed in a primitive manner. One is confronted with the apparent contradiction of the transience of life and the timelessness of the place. But the real message is the appalling indifference of an enduring system that provides abundant life that goes on to die, apparently casually, to become new life, and has done so for eons and will continue long after you have not. One does not take himself too seriously here.

The hut was a surprise in a sudden, small clearing. Of the usual type: it was raised on poles, out of respect for the heavy rains of the wet season, and had a palm thatch roof and a single open floor with a small sleeping room. It was quiet here, too, but quietness of another type; this was not sound smothered but sound absent. Had I not seen the figure standing in the doorway, I would have thought it uninhabited. She was a short brown woman with black hair and the lines of time on a relatively young face. Her feet were callused from harsh use and the loose dress had been washed in rainwater often enough that the floral pattern had withered. The terrible thing was her eyes. In the centers of the surrounding wrinkles were two shining, brown windows through which her soul spoke, and the message was of hope and gratitude that I had come. Everything now would be all right. I was too naive not to have been immediately afraid.

Her story was delivered in a low voice that was insistent and rapid. I stopped her and explained that my Spanish was still a
bit weak and she would have to tell me more slowly. In answer she led me silently to the back of the hut where her husband lay on the floor. One look and I wanted to be almost anywhere else in the world. He had a dense right-sided hemiplegia. She turned to me nervously, smiled slightly, and waited for the magic to begin. He looked at me as well, out of a drooping face.

This was not a neurological game of description of a lesion, nor was it the passing out of nostrums to support the policies of governments. It was a primal human encounter as immediate as the jungle that surrounded the scene: the shaman was here to exorcise the demon that had destroyed this family, and she waited expectantly for the dancing to begin.

I let her talk and describe the story I already knew, and slowly gathered my composure. Then, after the rite of the history, I began the ceremony. The stethoscope was laid on, the reflex hammer applied, and probing done. Strength was tested, motion judged, and bed sores searched for. I talked a bit to him and her as this went on so that the appearance of incantation was met as well. He was neat and clean; this woman had cared for him well. Then the service was over and the moment of truth filled the place.

She had anticipation in her face as I began to explain what had happened to the man she loved and lived with and worked alongside of on the patch of a garden they had coaxed from the forest. We spent time on the blood supply and how it moved; then more time on why it no longer worked. Her eyes grew dimmer as their doors began to close. But they brightened again as she asked how much longer this would last. So I took her hand and explained some more while the life went out of her soul and the body slumped as we sat together on the floor. And I felt the shame and inadequacy of failure that my tools and knowledge were useless, as were the diplomas and various awards I had garnered. Now she understood, more quickly than I, that he would die out in this place where people rarely came; that her small farm would not be worked again. I had changed her from a wife allied with her husband wringing a living from the reluctant earth into a nurse who would now live on the charity of others. And I knew bitter humiliation because I had brought this knowledge to her without the hope that could make it bearable. My current emotional support would fade very soon in the face of the reality of living here.

So we sat a while together saying nothing and then I let go of her hand and made an excuse about returning to my work where I was doing amazing things and went out the front and down the steps and back into the jungle floor into dirt to make the path I followed for a while. I thought about her and of an existence that brought pain and confusion into lives of subsistence sustained by constant work, yet which were complete until this enormity invaded their home. The jungle was very quiet; as quiet as the man who lay back there on the floor; as quiet as the devastated woman who sat beside him. I walked, defeated, in my own cocoon of silence, created not so much by the surroundings as by senses that seemed to have recoiled from the incident and isolated me as a defense against the monstrous unfairness of what I had witnessed. Confusion roiled inside, as I contemplated a long education and a life that had served me well and yet served these people so badly. I had come squarely against a fact of life, a biological event, a social misfortune, a moral horror, and was able to do no more than explain the event and offer well-intentioned support. My good intent, the craving of a young physician to make a bad situation better, had been nudged aside by life saying, “What do you think of this?” Then, partway back to the village I paused abruptly in the path hearing my whispered response, itself a question, that came from far inside: “What will you learn from this?” At that point I think I stopped being a Doctor and began to be a physician.

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Courtesy of the author
The private remonstrance of Doctor Botkin, or Pharaoh's Physician

Andrew J. Schoenfeld, MD

The author (Andrew J. Schoenfeld, MD, Northeastern Ohio Universities, 2003) is chief resident in Orthopaedic Surgery at Akron General Medical Center, and clinical instructor in Orthopaedic Surgery and research instructor in Biochemistry at Northeastern Ohio Universities College of Medicine. He begins a fellowship in spine surgery at Harvard Medical School this year.

July 17, 1918

I tell you, these may very well be the last thoughts that I, Dr. Yevgeny Botkin, personal physician to His Excellency Czar Nicholas II, am allowed to experience on this earth. Better men would think of their families, or beseech the heavens, but I find it appropriate that my ruminations should turn to none other than Levi, the Hebrew physician to the Biblical Pharaoh, Ramesses. The story of Pharaoh's Physician was recounted to me in my youth by some old rabbi, purportedly the descendant of one or another sagacious dynasty. I listened to it intently, like a child considering a lullaby, while administering to his daughter, who was stricken with white fever.

It was a curious, winding tale, spun, I am sure, from the vapid expanse of the rabbit's aged mind. He purported that it was a Biblical legend, but I was unfamiliar with it, even after nearly a decade of rigorous discourse in the Orthodox catechism. The story, as I recall it now, concerns a stalwart Hebrew doctor named Levi, born into slavery as the hereditary surgeon to the Egyptian household. The Jewish doctor never strays from his religion, but remains in Pharaonic employ, even after Moses leads the Israelites from bondage.

The physician has no love for the Egyptians and deeply wishes to enjoy the freedom of his people. Nonetheless, he accompanies Pharaoh's host as they chase the Israelites to the Red Sea. Our physician is no soldier. He is consigned by Pharaoh to the shore, even as the cavalry begins its charge into the parted depths. With indifference he watches as the Egyptian chariots are consumed by the raging tide of the ocean. In but one instant, the physician's world has changed. The surgeon's liege is dead, but the fathoms of the sea now separate Levi from his people. An angel finds Levi and asks: Where goest thou?

The physician responds that he had sworn an oath to care for Pharaoh's body, as his forefathers had sworn before him. His cause for living is now dead and he deserves no better fate. With this, Levi casts himself off a cliff and careens into the obsidian crests of Pharaoh's watery grave.

My name is not Levi, but Botkin and, although I may be no Jew, I am certain that I too am Pharaoh's Physician. My Pharaoh is not old Ramesses but Nicholas II, autocrat of all the Russias. Even as the Bible speaks of the fall of the house of Pharaoh, so too has the modern-day Ramesses been laid low. Just as Levi's fate was intimately entwined with that of his master, I, too, find myself sharing the lot of the former Czar. In the past the royal family and I lived in opulence, inhabiting the palatial microcosm of Saint Petersburg. Now we sit in squalor, under house arrest in Siberia. Once I feasted on roasted pheasant and duck. I can hardly recall those halcyon days. They seem but a dream to me as I find myself barely subsisting on dry bread and porridge, the acrid taste of dust and mold filling my mouth. This place is called
Yekaterinburg. It might as well be Hell. I know that our captors will kill us soon. They allege we have committed crimes against the Russian people. These are sordid accusations, the product of congenitally defective minds. The Romanovs and I are accused of murdering millions of peasants and exploiting workers and their families. It is almost all I can do to control myself when I hear such vile recriminations. The royal family, let alone their humble physician, was responsible for none of these things. They were saddled by a political system that had long grown outdated. Plagued by corruption and greed, they lived in constant fear of the disparate societies and agitators lurking around every corner, waiting to assassinate any member of the aristocracy. The Romanovs are the true victims, a tragic family. It is they who should demand justice and retribution.

But even if the Czar and his wife were murderers, callously plotting the demise of their own people for nothing but grotesque amusement, how can I possibly be culpable? I am a physician. I have saved lives, but never claimed one. On the contrary, I swore an oath,
as my father did before me, binding myself to care for the physic of the Czar and his House. I honorably executed this duty and, even now with no promise of reward but only threats of punishment, I continue to perform my office. The commissars can kill me for nothing save an oath honored and a job well done.

In truth, even with the prospect of death hanging over my head, I weep not for myself, nor for my Pharaoh and his wife. Certainly, we have lived our lives, had our share of caviar and wine. I find myself old and bald, my back gone crooked with age. My legs are wizened, taut stomach long diminished to flab. But the Romanov children, the vivacious Grand Duchesses with their flowing auburn tresses and the Czarevich Alexei, are deserving of a better fate. If anyone can be said to be blameless, surely it is they.

In these final moments I must admit that I remained with the Romanovs solely to care for their hemophiliac son, Alexei. The condition is endemic in his maternal line and should have finished him off years ago, were it not for my attentive mind and skilled hands. We physicians truly understand so little about this malady, it is impossible to prevent the episodes of hemorrhage. Even the slightest tussle can precipitate a life-threatening catastrophe, not to mention the ravages such bleedings work on the joints and muscles. Indeed, only my splints, dressings, and prescriptions for special exercise have kept the boy in the remarkable health he currently enjoys.

But I shrug now, recognizing that this small vanity is my sin. I could not bear to abandon the life of poor Alexei, he was my greatest achievement. Frustrated in my limitation to cure him of this horrid disease, I took solace in the fact that I would stand by Alexei until the end. I would not surrender his life to the hemophilia any more than I could hand him over to the Bolsheviks. Therefore, I must now share his fate.

It is all rather an unfortunate turn of events. The Royal Family was always grateful for my efforts, careful to follow my prescriptions and apply my poultices, but they never considered me an equal. My father had served the previous Czar as court physician, my station in life was determined at my birth. I had no say in the matter. I really wanted to be a soldier. No, to the Romanovs I was just an indentured servant. I was on an altered path, but one not so different from the plight of the farmer or factory worker. What choice did I have in any of it? But now I am deemed just as complicit in the Royal Family’s alleged crimes. Never once was I invited to share their regal table; now I find myself their equal, if only equally culpable.

But in this moment of reflection, the question warrants an answer: Why did you stay? Their armies, their empire, their riches were gone. There was no promise of recompense, even the prospect of remaining with them posed a substantial risk. Perhaps in those moments of subconscious reflection, as I resolved to tend to the Romanovs to the last, the tale of Pharaoh’s Physician echoed in my mind. The answer was simple and remains so. Even in my most cantankerous moments, of which you are a witness, I know this to be true. I swore an oath.

I have reflected on my desire to be a soldier. Uniforms, medals, and gallant horses have always appealed to me. I would have made a poor horseman, but I realize what a good soldier I have been in kind. Will you indulge me to say the last good, the one final, loyal soldier? I am prepared to defend my Czar, even if only from microbes and the ravages of gout. I remain the last man standing, I am Pharaoh’s Physician.

Without hope of remuneration, even though it will cost me my life, the health of this family was my charge. Who else knew the Czar’s medical history? What other surgeon could so expertly tend to the Czarina’s nervous liver, the maladies of the Duchesses, the incessant bleedings of Alexei? I pledged myself to tend to their physic, to administer to their ailments, and I will execute my duty to the utmost. This sacred vow will come to an end only with the passing of my life or theirs.

Or both, as the commissars would have it. A surly guard has informed me that we are to be transported once again. The battlefront is moving too close to our lodgings. I may remain here if I so choose. Yet, should I wish to continue ministering to the Romanovs, I must join them in the basement post haste. In these final moments I find it odd that my mind turns not to Heaven, Jesus, or his saints, but to Levi, Pharaoh’s simple Jewish surgeon. It is time to show the Bolsheviks what it means to be a true physician.

The private remonstrance of Doctor Botkin

The tale of Levi, Pharaoh’s Physician, is an extra-Biblical legend told in the tradition of the Jewish Sefer ha-Aggadah (Book of Legends). Dr. Yevgeny Botkin was the last physician to Czar Nicholas II and the Romanov Royal Family. He was shot, along with the Romanovs, on the night of July 17, 1918, by the Bolshevik Lett Guards.

Recommended reading

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Green Shadows Across a Green Lawn

Coming upon the green shadows
Of old trees across a green lawn
On the way to losing my mother,
I look up at mackerel sunrise
Cobbled gold and bronze.
When my brothers and I were small,
We saw a stair-step sunset
And imagined our grandmother
Rising to heaven.
But I am sixty, not seven or eight.
Our grandmother, if living, would be
One hundred eighteen.

When I arrive, I find Mother
Sleeping, breathing beside
A blue-wave frieze
On a monitor, her old heart swollen,
Galloping in sinus waves,
Lubbing so loud
I can hear each beat without a stethoscope
When I speak she labors to awake
And—with a look
That evokes everything—
Swaddles my grief until
My brothers come, and she turns to ivory
In our arms.

Helen Montague Foster, MD

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Edward D. Harris, Jr., MD

They say that General Motor’s Chevrolet Volt, when it debuts in 2010, will go for 150 miles between plug-ins to restore the battery power. GM’s vice-chairman, Bob Lutz, has even stated, “The electrification of the automobile is inevitable.” Toyota has even heard the GM ruckus. Ads for their hybrid Prius occasionally tell us “and it doesn’t need to be plugged in.”
My mother, who died in 1988, would have found these comments amusing. Her father (my grandfather) was a family practitioner in Trenton, New Jersey, in the early 1900s. He owned and drove an electric car that—yes—plugged in. When I finally went through her papers several years ago, I found an essay, “Museum Piece,” that she had typed on her Royal typewriter on onionskin paper, the same typewriter on which I pecked out papers for high school classes.

Father was always generous about offering people rides in his electric car, especially after church. Even though we four children could fit inside the car without discomfort, he would often invite Mr. Dunham, the portly Sunday school superintendent, to ride to his home with us. Rearranging us to fit him into the car put three of us kids facing Father producing a solid barrier to his vision. Mr. Dunham lived on State Street, a wide thoroughfare with trolley tracks down the middle. On more than one Sunday, the solid rubber wheels of Father’s electric car settled into the grooves. There was nothing to do but stay in the tracks for an eighth or quarter of a mile until the trolley switch enabled Father to jump the track, turn around, and deliver Mr. Dunham at home.

One day that propensity for getting wheels caught in the trolley tracks saved us from an accident. It was in a neighboring town. There were no signs to warn us that workmen had dug a vast hole between the tracks that, thank God, had been left intact as a long thin island. Father had inadvertently settled into the track grooves some fifty yards before the hole and was busy peering ahead for a trolley switch when we suddenly came upon the dig. I, sitting in my usual position in front of Father, and half turned to see what was coming saw the potential disaster but was too frightened to utter a word or scream. We rolled silently over the cavern. Father had not even seen it, I’m convinced.

During a family visit to Washington, DC, my mother took me to the Smithsonian, where sits a pristine Rauch & Lang Electric automobile, the same model in which my mother drove. That electric car in the Smithsonian was a curious structure. The electric car had no steering wheel, but rather a bar that when swung forward turned the vehicle left, and would flatten the midsection of the driver when it was pulled inward to turn right.

In place of a horn there was a strident bell that scared people and animals out of the way if they did not see the car coming. They had to see it, because the car made absolutely no noise on a well-paved street. There was no instrument panel, but we guessed that the maximum speed was thirty-five miles per hour. Its symmetrical body design made it difficult to know whether it was going or coming. In spaces reserved for fuel in gas-powered engines and in the trunk there were storage batteries, rows upon rows of them. The batteries were recharged overnight by a huge contraption in the garage called a Rectifier. I remember that it had a huge glass bowl filled with mercury. The bowl was screened by an iron grille, and through the holes shone an eerie blue light. During thunder storms the Rectifier sputtered a great deal and sometimes closed down. However, no act of God did the damage to it that Father himself inflicted. On two financially unfortunate occasions Father started out for the office without disconnecting the cable to the Rectifier. He was reminded of that oversight by the thunderous noise of crashing iron and shattering glass as the charger fell over and the costly mercury cascaded over the garage floor.

All was not as smooth as the ride. Our elderly aunt visited us occasionally and Father would bring her from the train station in the Electric. One day, as one of us helped her out of the car, she surveyed the interior to find something to rest her hand upon. She found something...a short black handle close to the driver’s seat. It was, of course, the driving mechanism, and her pressure upon it put the Electric into a state of “full speed ahead.” The car climbed the curb and was heading for a steep downhill embankment when Father, running beside the car, managed to reach in through the open door and pull the handle to the powerless position.

Perhaps shaken by the twice-fractured Rectifier, or being shaken by the time Mother got her coat sleeve caught on the steering bar and the car ran over the curb and into a telephone pole, or becoming aware of how embarrassed his adolescent children were about our owning this strange vehicle, he turned in the electric car and became a “real car” owner...shortly after breaking the second bowl of mercury.

The plug-in electric car is neither a new concept nor a new reality. How will the latest incarnation of the plug-in electric car be accepted by consumers and automobile manufacturers a century after my grandfather, for reasons perhaps related to his desire to conserve gasoline, bought his in 1914?
Richard Widmark
(December 25, 1914 to March 24, 2008)

Richard Widmark was born in Sunrise, Minnesota, where Wade Olson, a construction worker, opened a museum in his honor in 2002. Widmark's father was a traveling salesman, and his family moved five times before he was six, during which time Widmark bonded with his brother. After graduating from Lake Forest College, he took a bicycle tour of Germany with a friend the year before Hitler invaded Poland. Refused permission to visit Dachau, where political prisoners were being kept, he gained entry to a Youth Camp, where he filmed Nazi indoctrination. On returning to America, he gave talks using the footage, but they generated little interest. Nonetheless, the public speaking experience convinced him to study acting rather than the law and served him well as an actor in radio and on the Broadway stage.

With the onset of World War II, he tried to enlist but was rejected three times because of a perforated eardrum. His brother served as pilot and was shot down over Holland and became a POW. After his repatriation, he became increasingly ill and died ten years later, which devastated Widmark. Described as “quiet, thoughtful and well-read,” Widmark hardly ever drank. He married his Lake Forest classmate Jean Hazelwood, the only girl he said, in a phrase that seems sadly dated, he ever “went steady with.” Happily married for fifty-five years, he cared for her in the years before her death in 1997 of Alzheimer’s Disease. He established the Jean and Richard Widmark Foundation, which has funded Alzheimer’s and cancer research, environmental conservation, and efforts against handgun violence and the use of nuclear weapons, and he donated land and a one-room schoolhouse for preservation in his adopted hometown of Roxbury, Connecticut.

Ironically, this universally acclaimed “nice guy” is most identified with his first screen role as psychopathic killer Tommy Udo in the 1947 film noir Kiss of Death. An ex-con, Udo tears out an electrical cord and ties Ma Rizzo (Mildred Dunnock), the mother of an informant or “squealer” into her wheelchair and, while baring his teeth and giggling, pushes her down a flight of stairs. The role garnered him his only Oscar nomination and led to other “bad guy” roles in noir films like Pickup on South Street and Night and the City. This led James Agee, the author and film critic, to say of Widmark, “Murder is one of the kindest things he is capable of.” The “good guy” roles, which he sought, such as a whaler in Down to the Sea in Ships, a public health officer in New Orleans trying to prevent an outbreak of bubonic plague in Panic in the Streets, a prosecutor in Judgment at Nuremberg, and a police detective in Madigan, never resonated as well with the public. They much preferred roles in which Widmark radiated callousness and moral obtuseness, as in The Bedford Incident and the two films reviewed here, Coma, and No Way Out, in which he plays a megalomaniacal doctor and a malevolent racist. The contrast with Widmark’s real persona is striking, attesting to his extraordinary and vastly underrated acting ability.

References

Coma (1978)

Directed by Michael Crichton. Rated PG. Running time 113 minutes.

Based on a novel by fellow Columbia P&S graduate Robin Cook, and directed by Harvard Medical School graduate Michael Crichton, this farfetched but entertaining thriller makes up technologically for what it lacks in humanity and passion. Genevieve Bujold plays Dr. Susan Wheeler, a surgical resident intent on uncovering the reason for the high rate of unexplained postoperative coma in relatively healthy young people undergoing elective surgery. Wheeler is nothing like most of the previous women doctors in film, as she parks her red convertible in front of Boston Memorial Hospital and runs to rounds. She has a mind of her own and is making it in a
man’s specialty on the basis of talent, hard work, and guts.

The men don’t seem to have changed, though. Even her surgical resident boyfriend, Dr. Mark Bellows (Michael Douglas), patronizes her. Bellows, who is angling for the chief residency in surgery, is caught up in hospital politics. When they return to their apartment, she refuses to get him a beer and to make his dinner. “Get your own beer,” she says, as she proceeds to take the first shower. Bellows mutters, “That’s what I get for becoming involved with a goddamned doctor. I should have fallen in love with a nurse. Dorothy on the eighth floor liked me.” Bellows starts whining about not getting respect, and Wheeler tells him, “You don’t want a lover, you want a goddamned wife,” and walks out of the apartment. The next day at aerobic dancing, she trades confidences with her best friend, pregnant from an extramarital affair and scheduled for a first trimester “therapeutic abortion” listed as a routine D&C.

As they prepare for the operation, the doctors talk about journal articles and the stock market; the nurses discuss their plans for the weekend and other personal matters. There is an excellent sequence involving a Dr. George (Rip Torn) instructing medical students, as well as the audience, on routine general anesthesia (assuming any procedure is routine). As he says, “Anesthesia is the easiest thing in the world until something goes wrong. It’s ninety-nine percent boredom and one percent scared-shitless panic.” His worst fears are realized when the patient’s heart rhythm becomes irregular; despite Wheeler’s friend appearing pink and well-oxygenated, her blood pressure falls. She seems to come around, but never wakes up; her pupils are fixed and dilated. As one doctor describes her to Wheeler, “She’s got complete squash rot—a total gomer. She’s brain dead. EEG completely flat!” Still, George cheerily says that “we can maintain her vital signs for one, two, or three years.”

Wheeler is crushed and tries to find an answer. She learns that a preoperative specimen had been sent for tissue typing (usually done only for transplant donors or recipients), but there is no doctor’s name on the requisition. On gaining unauthorized access to the hospital information system, she learns that there have been 240 postoperative comas that year, ten in healthy adults. Bellows explains it away by citing the law of averages in a hospital that does thirty thousand operations a year. Wheeler attempts to gain access to the charts of the young victim to see if there is a common thread, but is denied.

Unlike most of the coma victims, her friend dies, and during the autopsy, Wheeler learns something that we all learned in medical school in the 1950s: if carbon monoxide is delivered for a few minutes rather than oxygen, the brain suffers, but the tissue remains nice and cherry pink. Her snooping reveals that only one operating room has been involved in all the unexpected comas, a fact that, strangely, no one else has discovered. She is treated by everyone as a hysterical woman, earning her two visits to the office of Dr. Harris, the hospital director and chief of surgery, played with just the right mix of paternalism and menace by Richard Widmark. He spends a lot of time talking to the governor, a United States senator, the president, and the secretary of the Department of Health, Education, and Welfare (now Health and Human Services). Harris tells Wheeler to cool it, saying, “I can protect you because you’re good and, frankly, because you’re a woman.” After she leaves, he says, “Women! Christ!”

STOP READING HERE IF YOU DECIDE TO SEE THE FILM!

Bellows is instructed to take her away for a weekend on Cape Cod to get her under control. After the requisite lovemaking, they head back to Boston, but she can’t resist visiting the Jefferson Institute, where the coma patients are sent after discharge from the acute hospital. Bellows inexplicably stays in the car as she enters this forbidding place. Of course if he had gone in, the movie would have been a lot shorter. There, Wheeler learns that the bodies are in suspended animation, monitored by a computer attached to various lines. Adjustments in vital signs, feeding, and handling of excretion are done automatically, so the staff is lean (one nurse, one doctor on call, two computer technicians, and a lot of security). The staffing is an administrator’s dream. The plan is to house one thousand patients a day, achieving economies of scale that permit charging sixty dollars a day. Visitors are only permitted on Tuesday, when physicians are able to tour the facility. Wheeler overhears a doctor’s name and some auction bidding. A heart is going to San Francisco for $75,000. Bidding starts at $45,000 for a two-hour-old kidney that can be delivered to Zurich with a twenty-three-hour elapsed time.

On her return to Boston Memorial, the maintenance man tells her to meet him in the basement that evening because he knows how the comas are being induced. Any moviegoer worth her salt will know that this is the “kiss of death” for the poor guy. Sure enough, he is electrocuted in a simulated accident by a hitman who has also been stalking Wheeler. Through some pretty energetic detective work, Wheeler follows the line from a carbon monoxide tank in the basement to the operating room. The most exciting part of the picture involves her being pursued by the hitman through the hospital amphitheater, the pathology lab, the autopsy suite, and finally into the refrigerator where the dead bodies are stored. Hanging herself with the others, she manages to bury the blackguard under a ton of corpses. Okay, you say, all she has to do is bring her boyfriend up to see the buried hitman, but no, she goes out to the Jefferson Institute.
for the tour and gets into “another fine mess.” Still, James Bond has nothing on her, and she doesn’t need violence or high-tech gimmicks to outsmart her myriad of pursuers.

Just when you think she is the smartest person alive, she goes unescorted to the hospital director’s office. There she sees “George Harris” on his Alpha Omega Alpha Honor Medical Society certificate and she makes the connection with the name she overheard. Uh-oh! And she took that drink he offered! Turns out it was laced with a drug that simulates peritonitis. Before he has her wheeled to OR 8, he gives an impassioned speech: “When you’re older, you’ll learn that everything is complicated. There is no black and white—only gray. Our society faces monumental decisions about the right to die, abortion, terminal illness, prolonged coma, transplantation decisions. Society isn’t deciding. Congress isn’t deciding. The courts aren’t deciding. Religion isn’t deciding. They’re leaving it up to us, the experts, the doctors. America spends $175 billion on medical care. These great hospital complexes are the cathedrals of our age. Billions of dollars; thousands of beds; a whole nation of sick people turning to us. They’re children. They trust us. We can’t tell them everything. Our job is to make things easier for them, because medicine is now a great social force. The individual is too small.” Wheeler passes out, mercifully ending this megalomaniacal diatribe, which sounds more like Hollywood Doctor Who than AΩA philosophy.

Everyone, even Bellows, is impressed that the chief himself is going to perform the appendectomy. He says, “House staff deserve the very best care in their own hospital.” Finally, when Harris insists on using OR 8, Bellows becomes a believer. Still, he insists on tracking the carbon monoxide line himself. In real life, Wheeler would have been a goner, since she develops an irregular heartbeat and should go the way of her friend. In the end, though, she wakes up and Harris is carted off to the hoosegow. Don’t ask how one man could orchestrate this whole enterprise or how he got admitted to AΩA. Just suspend disbelief and make sure you don’t decide to watch this film before elective surgery, or any other surgery for that matter.

No Way Out (1950)

Starring Sidney Poitier, Richard Widmark, Linda Darnell, Stephen McNally.

Directed by Joseph L. Mankiewicz. Running time 116 minutes.

Although unrated, it would be R for extensive use of the N word.

Like many of its hospital-based predecessors, No Way Out opens with a harried switchboard operator directing ambulances in a county hospital. When we first meet Dr. Luther Brooks (Sidney Poitier), the first black intern at County Hospital, he has just taken the state medical board examination and is agonizing about whether he should go into practice or stay on at the hospital. He meets Dr. Wharton (Stephen McNally), the chief resident, and they discuss the boards. “The boards can’t be too tough—that’s what all doctors agree on after they have passed. They want it to be tougher on the next group.” Dr. Wharton tells him that he can stay on another year, and the happy Brooks proceeds to the ward to admit two shooting victims. On the elevator, Lefty (Dotts Johnson) the black elevator operator tells him, “The boys are saying that the test is just for colored doctors” and that “they probably want to make it harder on you.” Brooks responds that it is no harder for him than for other doctors.

The film’s voltage is about to go sky-high with the entry of Ray Biddle, played by Richard Widmark with the same maniacal viciousness that he brought to Kiss of Death. As Brooks begins to examine him, Ray spits at him, and recalls the many times he and his white hooligan friends from the equally impoverished “Beaver Canal went over to clean up Niggertown.” Lefty reminds him, “You’re talking to a doctor,” prompting Ray to say, “I don’t want him; I want a white doctor.” The policeman says, “We’ll turn the lights out, so you won’t know the difference.”

The next sequence sets up the dramatic tension that will carry the film, but does so at the expense of medical accuracy. Brooks learns that Johnny and Ray were caught robbing a gas station. When Johnny ran away, he appeared confused, and ran into the gas pump. On observing the young man, he appears to have abnormal breathing and a lack of sensation when a lighted cigarette burns down to his fingertips. Then using an ophthalmoscope, Brooks detects papilledema. That it has nothing to do with the gunshot wounds is only a minor distraction. The main problem is what Brooks does next, that is, prepare to do a spinal tap. As medical students in the ‘50s, we were taught not to do one if one suspected increased pressure and a brain tumor, because the brain might herniate, causing pressure on the brainstem that could be immediately fatal. Furthermore, he’s all
by himself and doesn’t call for an attending physician backup, reasoning that this is an emergency. This is hard to fathom, given that Johnny only came in because he got shot and must have been walking around like this for a while. Anyway, Brooks goes down the hall to ask the orderly for a procedure set. The orderly says, “I don’t recall anyone using that thing before.” Brooks does the tap and the boy suddenly dies. Ray screams out, “He took it out on Johnny. He wanted it to be me. I’ll get you for that, you black rat.”

Ray’s “deaf and dumb” brother, George (Harry Bellaver), visits, and the policeman says, “Get the dummy out.” This insensitive line is as important as the depiction of raw racism in exposing the fallacy of another uneducated belief that needed exposure. It turns out that George “can read lips a block away,” He has deciphered that Brooks wants an autopsy to prove the man had a brain tumor. Ray taunts Brooks, saying “Beaver Canal is full of Johnny’s pats. Wait till they find out how he got killed and by what. I’d sure hate to be living in Niggertown.” Ray then tells Brooks that George told him everything and that there won’t be an autopsy.

The hospital director, Sam Moreland (Stanley Ridges), calls Wharton into his office and tells him of a brief article on the back page of the newspaper, saying that “one of the brothers suffering from a superficial wound in his leg, died shortly after admission to the hospital.” Cause of death was not revealed.” He’s scared to death that the press will blow the story up and find out that the doctor was black. He would rather let it go away and refuses to authorize an autopsy without family permission. “Don’t go reading into it that I’m anti-Negro. Why if anything I’m pro-Negro,” he says. Wharton replies, “I’m pro good doctor—white, black, or polka dot.” Moreland tells Wharton that getting public funds is not easy. He says that in his present position, M.D. means “something different now—Master of Doubletalk.”

Wharton agrees to accompany Brooks to visit Johnny’s widow, Edie (Linda Darnell), to request an autopsy. Wharton introduces Brooks as the doctor who “tried to save your husband.” She says “You mean Johnny died in a colored hospital?” Wharton replies, “Doctor Brooks is on my staff at County Hospital. He couldn’t have had a better doctor.” It turns out that Edie hates the Biddle brothers and is divorced from Johnny. She agrees to think about visiting Ray to persuade him to agree to the autopsy.

Brooks returns home, where his brother is studying for an exam to be a mailman and his mother and sister are preparing dinner. They have invited a local physician to dinner to convince Brooks to join him in practice so that they can begin to get some money into the house. When Brooks’s wife returns home from her job, he collapses on the bed and tells her that “I’m not sure of myself in so many ways. I need another year with Wharton. With Clark and his big, fat practice I’d never know when I’m a good doctor.” As he drifts off to sleep, his wife comforts him saying “You’ve got a right to be tired. You worked so hard, harder than anybody to get where you are. Shoes you shined; dishes you washed; garbage you dumped; the food you couldn’t buy because you needed books. Remember how you studied? How I asked you questions over and over? Questions I couldn’t even pronounce. Coffee, coffee, and more coffee. Slapping you to keep you awake and when you told me A was your passing mark, not for the others, just for you. You got them—all A’s.”

**I’LL STOP HERE TO LET YOU SEE THE REST OF THE PICTURE WHICH DEPICTS A RACE RIOT AND AN INTENSE BATTLE BETWEEN RAY AND BROOKS.**

Of the many remarkable things in this film is the consistent performance of Widmark as a hate-filled racist. The interplay with Poitier is electric and, indeed, Widmark apologized to Poitier for being so bitter and menacing as well as for the racist language he spewed. In his marvelous autobiography, Poitier recalled that this was the first movie his Bahamian parents had ever seen. When Widmark’s “beating the crap out of me with his pistol, my mother jumps up in the theater and yells, ‘Hit him back, Sidney! Hit him back! You never did nothing to him!’”

The film also portrays the deprivation in Ray Biddle’s background that gives insight into, without in any way excusing, his anger and hatred. This balance between “in your face” dialogue and subtlety is what elevates the film from being merely a soap opera to the level of a classic. Also ringing true are the family scenes documenting the sacrifices for Luther Brooks to get where he is, as well as his struggle to overcome racism as he tries to minister to his patients. The side commentary involving the supporting cast is also interesting, such as Brooks’s brother studying for a difficult postal examination or Ray’s impaired brother who is far from “a dummy.” There’s also an excellent scene where Wharton’s black maid asserts that no one can take away her pride in what she does for a living—an attitude I heard from my immigrant grandmother who also worked as a cleaning woman until her retirement at age sixty-five. Then, there is the smoldering resentment of black men who, after fighting for their country, weren’t being accorded respect. In short, the film provides enough material for a whole course in sociology.

**Reference**


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More than scientific racism, more than heroic purges, bleedings, and cathartics, and more than the punitive use of therapeutics, involuntary medical experimentation was the scientific personification of enslavement. Violence, pain, and shame joined as physicians forced the enslaved body into medical service, not to cure, but for profit. Medical experimentation was profitable in terms of recovered health and life for whites, who benefited once the medical process had been perfected. It was also a profitable source of fame, and sometimes fortune, for physicians.94

With eloquence and courage, Ms. Washington cuts to the chase and illuminates the truth that racist philosophy has been a binding thread throughout the history of science, medicine, and ethics in the United States. Shattering accounts of unethical physician practice are thematic throughout the text. Some of the accounts are well known, such as the U.S. Public Health Experiment in Tuskegee. Other accounts are less well known; one in particular lends itself to a display of the level of ignorance that held grasp of the medical profession. It is an account of Dr. Clinton Hamilton of Clinton, Georgia, and his experimental subject, a slave called "Fed," who later claimed John Brown as his rightful name.95

Hamilton had a deep pit dug, and built a fire in it that he damped so that the burning embers remained; these were retained until the doctor, using a thermometer, ascertained that the pit was sufficiently hot. He then made Brown sit naked on a stool in the pit and covered the opening with a wet blanket to retain heat. Only Brown’s head was exposed while temperatures routinely exceeded one hundred degrees. Hamilton then administered his various heat remedies until, Brown recalls, “though I tried hard to keep up against its effects, in about half an hour I fainted. I was then lifted out and revived, the Doctor taking note of the degrees of heat when I left the pit.

After each day’s work in the fields, Brown was given some nostrum and made to repeat the ordeal. . . .

After a few days’ rest, Brown was subjected to a new set of experiments, for which he was bled every other day. But still worse was to come: “He set to work to ascertain how deep my black skin went. This he did by applying blisters to my hands, legs and feet, which bear the scars to this day. . . . He also tried other experiments on me, which I cannot dwell upon.”

After Brown’s matter-of-fact account of being poached to the point of fainting and of his repeatedly burned and flayed skin, one wonders what other experimental horrors he “cannot dwell upon.” When he could bear the surgical torture no longer, Brown fled to England.96

Ms. Washington’s dedication to unraveling myths and exposing the truth in her book brings to light the unsavory history of medical education and the infamous “Night Doctor.” If you have lived in the Southeastern region of the United States, the term “Night Doctor” may be familiar. They were feared for their role in the scrounging of bodies and organs, in particular those of black Americans. The chapter “The Restless Dead” brought to mind vivid memories of my childhood in rural Alabama in the 1950s. The thought of being out after dark evoked a fear, in men and women, of both the Ku Klux Klan and the “Night Doctor.”

The history presented in this book captures the ugly facts of experimentation in the prison system and other horrendous revelations. Thumbing through the August 27/29, 2007, issue of JAMA, I was struck by a photo on page 927, taken in 1909, depicting a male of apparently African descent lying on a table beneath an X-ray machine. After reading Medical Apartheid, the photo raised many questions about the photographed man’s rights and his role in
the situation portrayed.

This is a well-written historical exposé; it has the potential to evoke a multitude of emotions, including pain, sadness, anger, and validation. History of this sort is reminiscent of an abscess, a painful pocket of pus that requires lancing and debridement, following which it should remain exposed and allowed to heal by secondary intention. *Medical Apartheid* has lanced the abscess, and I, for one, am willing to move forth with the pain of debridement and the process of healing.

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**The Cancer Treatment Revolution: How Smart Drugs and Other Therapies Are Renewing Our Hope and Changing the Face of Medicine**

David G. Nathan
John Wiley & Sons, Hoboken, New Jersey, 2007

**Reviewed by Thoru Pederson, PhD**

Many of us were motivated to consider particular professions by books we read in elementary or high school, or college. The one that snagged me was *In Vivo* by Mildred Savage, which, despite its uninformative title, was an engaging look at biomedical science in a setting I hadn’t known existed—the research institute. But for many students who were pondering medicine the hook was *Arrowsmith* by Sinclair Lewis or its nonfiction counterpart, *Microbe Hunters* by Paul De Kruif. Academic and private practice physicians identify these two books more consistently than any others as having been factors in their attraction to the profession. (Sinclair Lewis in fact never viewed himself as a mentor or proponent of the medical profession, but rather considered himself mainly to be a social critic of America. He even believed that the official citation on his 1930 Nobel Prize was somewhat mis-stated.)

In another corner, we have biography as a form, like René Dubos’s masterful *Louis Pasteur, Free Lance of Science* or Louis and James Thomas Flexner’s classic biography *William Henry Welch and the Heroic Age of American Medicine*—the latter about a man whose dizzying organizational talents and prodigious energy seemed to have been almost unbelievable. And less well known but a favorite of mine, there is *Snatched from Oblivion* by Mary Cannon Schlesinger (the daughter of Harvard’s famed physiologist Walter B. Cannon). And then, for better or worse, there is a wide zone of autobiographical writing that includes works like Robert Gallo’s *Virus Hunting: AIDS, Cancer and the Human Retrovirus* and Joseph Murray’s *Surgery of the Soul*—let’s just say as great a contrast in style as can be imagined. In all, this is a vast, difficult terrain of literature and few such works are covered in the *New York Review of Books*, although two Boston physician-writers, the infectious disease expert Jerome Groopman and the surgeon Atul Gawande became darlings of the *New Yorker* magazine prior to their book deals (“darlings” and “book deals” are not meant pejoratively—I am a fan of the general audience writings of both).

I recite these bibliophilic perspectives to simply say that it’s a heterogeneous domain. And there is always the issue of whether, in writing for a general audience, a professional might lose some points with peers. Dubos and the Flexners were of course writing mainly for the profession, but writers like Lewis Thomas didn’t care if peers thought their writings were outside the union. (His enduring importance as a writer stemmed precisely from the fact that his essays and books were outside the shop, just as were Loren Eiseley’s and Carl Sagan’s in their respective domains.) I suspect David Nathan probably went through this series of considerations, yet decided to push on. For his effort, we have a remarkable book on the new era of cancer treatment that is distinctive both in content and form.

If one had the privilege, and Nathan would be the first to term it that, to have been on the front line as the modern era of cancer treatment came to be, especially chemotherapy, and if (and this is a big if) one were willing to stop everything else and devote hundreds of hours in one’s office and study to writing the story, how should it best be told? The standard model goes something like this: There were early ideas that certain chemicals might kill tumor cells, and maybe even that a parasite (“Spiroptera carcinoa”) might cause cancer (this misguided observation leading to the 1926 Nobel Prize in Physiology or Medicine to Johannes Fibiger, one of the Karolinska’s few real blunders). Then, as the story is usually told, the gene arrived, so there were drugs to beat back DNA replication (recognized by a richly deserved Nobel to the non-doctoral-degree-holding Gertrude Elion and her collaborator George Hitchings) and Sidney Farber’s anti-folate chemotherapy (more on this to follow). This is then typically followed by describing the increasing recognition from the 1950s onward (led by Charles Huggins, Elwood Jensen and others) of the hormonal influences in certain cancers, leading eventually to estrogen receptor-modulating drugs (tamoxifen, raloxifine) or hormone synthesis inhibitors (finasteride,
Reviews and reflections

reviews and reflections

These chronicles typically then move on to the 1960s through 1980s and the advances in education and prevention, in detection, the zenith and then nadir of the concept that viruses are a major factor in the pathogenesis of human cancer, with President Nixon’s 1971 War on Cancer and the National Cancer Institute’s Viral Carcinogenesis Program providing no cancer breakthroughs but making it possible, from studies of a human T-cell leukemia virus, to relatively quickly understand the genome and replication of HIV when it came upon the scene. These are all conceptual (if not scientifically linear) antecedents of where we are today and there would be nothing wrong with an author presenting them in a “time’s arrow” motif, as several have.

But, although he knows this lore as well as anyone, Dr. Nathan resisted the temptation to paint the story in a narrow history of science métier. His device is instead to give us (and he indeed gives them to us, with their permissions and collaboration) a trio of patients and their loved ones, not as viewed on rounds or as written up in the New England Journal of Medicine, but as stories of how the diagnosis and discussion of available treatment regimes interconnected with the patient, and the dialogue between the team and the patient and family. The focus is not solely on chemotherapy, but conveys the interactive matrix of diagnostic and treatment tools. The three cases are different in pathology and treatment regime, but of course share the common dimension of human drama. The author omits nothing about the science behind the treatment options but, in this reviewer’s opinion, it is his successful reach for the human dimension that makes the book. Dr. Nathan’s obvious goal was to educate the reader about the new era of cancer treatment, as the book’s title justifiably conveys. This is the first time the subject of cancer treatment has been conveyed both as the scientific antecedents and the human dimension of the bedside encounter. An abiding humanism lies at the core of Dr. Nathan’s being, and is hinted at in the book’s subtitle: How Smart Drugs and Other Therapies are Renewing Our Hope.

The author persistently keeps his general readership in mind. When a relevant scientific discovery needs to be told, he refrains from technical shoptalk. Dr. Nathan also displays the humility to not interject himself into every nuance of these cases, presenting engaging expository detail and appropriate praise of the treatment teams’ members and advisors. On other fronts, the author isn’t shy about conveying his authoritative knowledge and, for this reviewer, his description of Sidney Farber, not always the charming, avuncular gentleman of legend, and the advent of anti-folate therapy, warts and all, was one of the most engrossing, and in many respects disturbing, segments of the book. I suspect too few practicing oncologists are aware of the brave and eventually successful stand Dr. Nathan took against the imperious Farber at an absolutely pivotal and epochal moment in the modern era of cancer chemotherapy.

Today there is talk of not just gene-targeted drugs but “genome-tailored” medicine that will interface with a patient’s distinctive genotype including, in the theater of oncology, not only the specific DNA mutation of a cell cycle progression-related gene a patient may have but also the patient’s now increasingly predictable response to a drug or drug combination. Meanwhile, David Nathan has written a most engaging account of how we have come to this good place. He pays respect to the past, properly applauds current successes, and yet soberly and honestly points to defeats and what they might mean as science. And he offers a realistic glimpse of the future. That he conveys all this with both great style and deep insight is no surprise to those of us who know him and his writings. This warm appraisal of his book might be faulted as coming from a nonphysician reviewer. Therein lies the book’s added value, both within the profession and for the knowledge-hungry general audience that the author had primarily in mind.

The autobiography of the aforementioned Walter B. Cannon was titled The Way of an Investigator. In his career and by this book, David Nathan lives up to the Olympian ideal Cannon set as a scientist, teacher, and author. And one can happily ponder the many students who may read this book and be propelled into oncology careers, in the Arrowsmith tradition.

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The Soul of a Doctor: Harvard Medical Students Face Life and Death

Susan Poires, Sachin H. Jain, and Gordon Harper
Algonquin Books, Chapel Hill, North Carolina, 2006

Reviewed by S. Ryan Gregory, MD

One hundred years ago, celebrated humanist-physician Sir William Osler wrote of medical students, “Except it be a lover, no one is more interesting as an object of study than a student.” Although dramatic changes in medical education ensued during Osler’s lifetime, it was not until the 1960s and ’70s that residents, followed soon by students, began to publish accounts of their transformations into physicians in their own words. Now, well over thirty such narratives have been published as books, all of which share at least three features: introspection on the personal transition from layperson to physician, critical candor on the educational process, and a focus on the hopes, fears, and lives of patients encountered early in the authors’ training.
In the introductory chapter of this newest addition to the genre, student editor and contributor Sachin Jain captures the essence of these narratives. Medical students, he argues, are ideal critics of the profession because they are already firmly imbedded, yet able to critique with external values. "Knowledgeable about medicine but still idealistic, the medical student has not yet been changed by the norms of practice. He may be more able than others to reflect thoughtfully on the health care system and uncover defects in care—and more sensitive to the effects that these defects have on patients." pxxi

Another hallmark of this genre is the vivid description of learners' encounters with seriously—often terminally—ill patients, and such accounts are particularly prominent in nearly every one of forty-four essays (by thirty-nine authors) in this volume. The first section focuses on students' struggles and successes in mastering the art of communication. Disappointed with an encounter overly focused on note-taking, one first-year student worries that "in only a couple of months I had gone from Mr. Empathy to Dr. Jerk," and a third-year bristles over the terseness of patient interactions in the ER when she realizes, "I had already begun to place my efficiency, interests, and performance ahead of the patient's feelings and questions." p207 Another student on clerkships contemplates the art of listening as his patient "constructed an eloquent soliloquy of loss and its toll on health. Hearing this patient communicate intimate emotions and concerns was a privilege surpassed by little else." p40 Yet before the encounter is over, she feels conflicted: "as even as he detailed the final weeks of his wife's life, I remember feeling anxious about how long our interview had taken." p40

In the second section, titled "Empathy," one student uses her pen to apologize beyond the grave for several painful, perhaps pointless, procedures performed on a dying woman, and another eulogizes her "first patient" (a cadaver) in poetic verse wondering, "Who did you love? Who loved you?" p76

The penultimate section, "Easing Suffering and Loss," features students in end-of-life discussions with families reluctant to let go in the face of imminent mortality, dealing with the harsh realities presented in experiencing a first "code," and watching a patient slowly expire, alone. As an ICU patient takes his last breath, a nurse suggests that someone should hold his hand, "But we didn't. We hadn't the courage. Instead we stood as spectators, separated from the action as if by a thick glass, discussing his junctional rhythm and his loss of blood pressure when the silence grew too long." p152

"Finding a Better Way," the fourth and final section, finds students reflecting on their transformation, or "rewiring" as one puts it, from "highly educated individual to physician." They also anticipate, with many reservations, the duties of their fast-approaching roles as future residents. One student laments the shattering conciseness of her resident's feedback for a grueling rotation—"strong work"—and promises that she will do better. p210 Another resists the detachment thrust upon him when a patient has prescription issues after discharge from the hospital. "I know you wanted to take good care of him," the resident explains, "but you have to learn to let go. He's not our patient anymore." pp201–02

These stories not only illustrate the emotional and intellectual challenges of students becoming physicians, they articulate the thoughts and feelings of compassionate people who are aware of the process they are experiencing. As one of the two attending-editors of this compilation explains in the epilogue, these essays break with the "anti-reflective" tradition of medical training that frequently discourages students from discussing and learning from this transformation. While much of the material in this book centers on difficult—sometimes frustrating—scenarios encountered in training, the overall view of the book is hope for a better way. "The message, finally, is that doctors have to study themselves as well as disease," p236

Indeed, looking over the history of similar narratives, evidence of positive change can be seen in the content (even in the titles) of narratives written by Harvard students in the 1970s and '80s, such as Gentle Vengeance and A Not Entirely Benign Procedure. The environment for residents has seen dramatic change as well. While House of God (1969) and Complications (2001) could hardly be more different stylistically, they also paint a picture of change in the postgraduate environment that is more protective of resident well-being and self-awareness.

The Soul of a Doctor is an excellent compilation of well-written essays that, in essence, are student-and-patient case histories revolving around one complex concept in caring for sick persons: how to balance empathy and clinical detachment. A more nuanced and contemporary discussion of Osler's controversial watchword, aequanimitas, is hard to imagine. This attention to student introspection in developing their sense of clinical balance, particularly in cases involving death, dying, and palliative care, is extremely timely and represents a new and welcome direction for the genre of narratives by physicians in training.

Reference


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Letters to the editor

Re: “Jack London’s Chronic Interstitial Nephritis”

Dr. Andrew S. Bomback and Dr. Philip J. Klemmer’s excellent article on the final illness of an American literary icon raises as many medical questions as answers. My wife Eleanor M. Imperato and I worked for many years in some of the same scholarly quarries as the authors of this article in preparing our biography of Martin and Osa Johnson.

Martin Johnson was a young man from Kansas when the Londons chose him to sail with them on the Snark as their cook. Even though he had never cooked in his life, he quickly read cookbooks and took a few lessons at a local diner in his hometown of Independence, Kansas. He was the only member of the original crew to complete the voyage, and later went on to become an internationally renowned wildlife and ethnographic filmmaker, together with his wife, Osa. Her 1940 biography, I Married Adventure, was the bestseller of the year. Evidence of their enduring fame is found not only in reprints of their books and CDs of their films, but also in the current new chain of Martin + Osa clothing stores.

Like Jack London, Johnson assumed that he had yaws. While on board The Snark, he regularly treated the single lesion on the mid-to-lower anterior surface of his right tibia with corrosive sublimate (mercuric chloride) and blue vitriol at London’s urging. Johnson’s single lesion is documented in a photograph taken of him in the Solomon Islands close to the end of the voyage. In this photograph, he is naked except for a G-string and bandaging around his right lower leg.

The differential diagnosis of primary yaws includes tropical phagedenic ulcers that often occur on the ankle and the lower third of the leg. The anatomic location of Johnson’s lesion and the fact that neither he nor London went on to develop secondary yaws, for which there was ample time, tilts the diagnosis in the direction of tropical ulcers. Johnson’s tropical ulcer was eventually treated with caustic potash (potassium hydroxide) by a Dr. Deck in Sydney, Australia.

On December 8, 1908, he again wrote to London from the Sydney Homeopathic Hospital, where he was surgically treated for a hydrocele that was probably secondary to filariasis caused by Wuchereria bancrofti.

Drs. Bomback and Klemmer present an excellent analysis of London’s other dermatologic illness that they reasonably ascribe to mercury toxicity due to excessive use of mercuric chloride. However, there is another diagnostic possibility here, namely pellagra, which can cause much of the same symptom complex as mercury toxicity. Johnson pretty much stopped cooking early on the voyage. He, the Londons, and the crew had been subsisting on “canned foods and salted meats” for most of the trip. “Fresh fruits and vegetables and fresh meats,” were prescribed by...
In the final analysis, was it mercuric chloride poisoning that caused London’s skin lesions, pellagra, or both? Was it yaws or tropical phagedenic ulcers, or both? Perhaps we will never know for sure because our surmises are based on less than complete medical evidence. What is more certain is that London may have developed interstitial nephritis secondary to excessive mercuric chloride exposure. Here, Drs. Bomback and Klemmer have made a unique and important contribution in providing new and convincing evidence for London’s probable cause of death.

References

Pascal James Imperato, MD, MPH

A new member writes
I would like to express my profound gratitude upon induction into the Alpha Omega Alpha National Honor Medical Society as the 2008 Boston University faculty selection. I normally subscribe to the Groucho Marx aphorism about not wanting “to belong to any club that will accept me as a member.” However, that is absolutely not the case in this instance. I deeply appreciate this honor that has been bestowed by the Boston University AΩA students, and I shall certainly try to sustain a strong dedication to our medical students. This award is a vindication for all students who sit in the back row, and I truly cherish it.

I suspect that my election is based on hard work and devotion to patient care, rather than an intellect on par with most in attendance this evening. Therefore, I implore the students to strive to provide the best care for your patients and to treat each patient with the dignity that you would wish for your family. (The corollary of this is to regard each medical student with the respect that you would expect for your daughter or son.)

David McAneny, MD, FACS
Associate Professor of Surgery
(AΩA, Boston University, 2008)
Boston University

REAL doctors in the movies?
I love reading your “The physician at the movies” section in The Pharos.

I wondered if you have ever featured a review of movies in which actual physicians played a role?

Brian B. Adams, MD, MPH
(AΩA, University of Cincinnati, 2007)
University of Cincinnati
Cincinnati, Ohio

Thanks for your kind words.

I have not. Are you aware of any doctors who were cast in feature films, not documentaries? If so, let me know.

Peter E. Dans, MD
(AΩA, Columbia University, 1960)
Cockeysville, Maryland

Of course, people often only comment when they have personal experience though I am sure that your readership has several others who have had similar roles as I. It might be interesting to query the readership to ascertain the roles that they have played.

For instance, to cheer myself up after my grandfather’s (to whom I was very close) death, I went to a casting call at the Millennium Hotel in Cincinnati for a film to be shot partially in Lexington, Kentucky (Seabiscuit). I was cast as a reporter. I had a splendid morning of going to “make-up” to get my hair cut yet again (my hair had been cut two weeks before by their staff as they initially fit my “costume”), and to wardrobe for my final fitting. We spent almost two hours filming our less than ten-second scene, but spending this time with the six other extras and Jeff Bridges was priceless. It turns out that one of Jeff Bridges’s publicity photos for the movie was the one in which I appear and proudly now adorns the wall in our home.

I also learned that lunches on the set for actors can be amazing. We enjoyed a fabulous buffet. I had done some theater in high school where ad libbing was not encouraged. However, I found it interesting that Jeff Bridges never said the same lines twice during all of our takes. The idea and theme was the same but what he actually said never said the same lines twice during all of our takes. The idea and theme was the same but what he actually said was different words.

Also I found it interesting that for about one to two minutes or so before the shot begun, Jeff started talking to us in character. I’d love to hear other physicians’ experiences.

Brian B. Adams, MD, MPH
The Centennial Celebration of Alpha Omega Alpha at the University of Michigan Medical School

On March 5, 2008, Alpha Chapter of Michigan, the twelfth chapter chartered in Alpha Omega Alpha, celebrated 100 years at the University of Michigan Medical School.

The celebration started with an afternoon symposium hosted by the Dean of the Medical School, James O. Woolliscroft, MD. Dr. Joel Howell, Professor of Internal Medicine and Professor of History, gave a historical overview of the chapter at Michigan. Photographs of original documents, including minutes of the chapter’s first meeting, the original constitution of AΩA, and correspondence between the university and the AΩA national organization around the time of the institution of the chapter at the University of Michigan were displayed. Alpha Michigan was one of the first chapters to admit women to its ranks, in accordance with the principles set forth by founder William Webster Root that the organization is open to all students, without distinction as to race, sex, or social position. Dr. Howell noted that Miss Placida Gardener was approved for membership in AΩA on January 27, 1911.

Two long-time faculty gave a faculty remembrance of AΩA at Michigan. Dr. Gerald Abrams, Professor Emeritus of Pathology, was inducted as a student in 1953, and Dr. Robert Bartlett, Professor Emeritus of Surgery, was inducted as a student in 1962. Steve Gross, an M4 student and new initiate into AΩA, presented a student perspective after polling his classmates about what AΩA means to them. His presentation focused on professionalism and duty to patients.

The symposium concluded with an address by AΩA Executive Secretary Edward D. Harris, Jr., entitled, “Getting Into the Flow.” Dr. Harris reviewed the ideals of AΩA and emphasized the role of mentors in the lives of the students and in their development as professionals.

Following the symposium, there was a festive banquet held in the atrium of the Biomedical Science Research Building. The five-story atrium in this newest building on the medical campus provided a spectacular setting for the banquet. The names of all previous 2,180 members inducted by the Alpha Michigan chapter were presented on a continuous loop over a twelve-foot area behind the podium. Approximately 170 people attended the banquet, comprising student inductees, with their guests and parents, and AΩA faculty members. AΩA Councilor Dr. Cyril Grum presented the AΩA Root Student Fellowship. The Michigan Chapter of AΩA is unique in that it has an endowment to fund a $20,000 one-year student research fellowship. The 2008 recipient was Wajd Al-Holou, who will spend a research year in the Department of Neurosurgery. The AΩA Volunteer Clinical Faculty Award was presented to Dr. Mac Whitehouse, a beloved surgeon who has done a remarkable job educating students over the past two decades. Following dinner, the Class of 2007/2008 was inducted into AΩA. The students all joined Dr. Grum on the stage to the acclamation of parents and faculty. The students then were delighted to induct into the society Dr. Valerie Castle, Chair of the Department of Pediatrics, based on her strong commitment to medical student education and support of her outstanding department faculty. The culmination of the evening was the induction of
Dr. James Woolliscroft, our current Dean and a nationally-acclaimed educator. Following closing comments by Dr. Harris, the wonderful evening concluded.

**Patient encounters—The American University of Beirut: Volunteer Outreach Clinic at Shatila Refugee Camp**

Encounter one: Fattoum Ali has sharp, penetrating, green eyes, surrounded by wrinkles, on a frail body. I saw her in clinic today; she is one of the “regulars,” and for the first time, I had few minutes to ask her more about herself, and to hear part of her story. I am sure she has much, much more she can tell me.

She did not know her age, so handed me her identity document (which Palestinian refugees living in Lebanon possess). On it, there was the year and place of birth, and her mother’s name, Zahra, meaning “flower.” The year was 1930, so I asked her, “You are seventy-five?”

She answered, “Forty-five?”

I said, “No, I think it is seventy-five!” That thirty-year leap did not seem to affect her.

She was coming to follow-up on abdominal pain and osteoporosis. I asked her if she had any family.

She said, “No one, my husband is dead.”

“No children?”

“No, my husband could not.” So now she is all alone, taking care of her whole self and issues.

She volunteered, “Sometimes, when there is nothing to eat, I find an apple.”

About her pain, she showed me a scar from a sniper’s bullet (during the war days), which had penetrated her right flank, and exited from her left shoulder, very narrowly missing her spine. She said she had been in so much pain that she was crumpled over for three months, and the blood “has just gathered in the stomach,” where she now hurts. She also said that during those three months, her husband would walk her and give her physical therapy. I could imagine this couple, a bit unusual in such a society because of being childless, and I could imagine the bond uniting them.

There were vestiges of this love remaining in Fattoum.

If she were to think about possible “go-wrongs” and uncertainties of the future, she would have many reasons for sleepless nights of worry.

Instead, she was quite happy about the three boxes of laxative and calcium/vitamin D supplements that I handed her. She walked away as if she owned the world.

Encounter Two: Hadieh Abou-Harb came to clinic because of pain and burning in both of her hands, from the wrist on. She also had some swelling around the interphalangeal joints, compatible with osteoarthritis.

She said the pain becomes so severe that she soaks her hands in cool water, and sometimes just hits them against the wall.

When I knew she had come all the way from Sidon (a city one hour away from Beirut), I asked her, “How did you know about the clinic?”

She said, “I am a daughter of the camp. I grew up here.”

“Yes.”

“During the massacre?”

“Yes—and during the ten-day hissar (siege), and the twenty-day hissar, and the forty-day hissar . . . ” She had left the camp at the end of the war, about fifteen years ago.

“I lost one son in 1982.”

“Yes?”

“He was killed at the American University Hospital.”
“How do you mean?”
“He was in the militia, and got wounded during a fight and was transferred to AUH. While there, a militant from the other party went after him and shot him in bed.”
“What? That’s unbelievable!”
She stared at me with quiet sadness, for it was much too believable for her, and she wished reality were different.
“How many children do you have?”
“I have four daughters and four sons. . . . I had five sons.”
That was our conversation, interspersed with silence and sadness.
My impression was that she had carpal tunnel syndrome in both hands, with osteoarthritis. However, I will keep an eye on her cervical spine, in case she does not respond to medicine. I gave her an NSAID for the pain.
Before she left, I shook hands with her, a little longer and a little warmer than I normally do for patients. I also looked in her eyes a little deeper.
I wanted to take away some of that pain from her hands, and from her heart.

The Volunteer Outreach Clinic is located in the Palestinian refugee camp of Shatila in Beirut, Lebanon. It was set up and has been run solely by volunteers since 2001. I began working there upon my return from the United States in 2003. The project was partially funded by an AΩΑ Medical Student Service Project Award in 2005. It was profiled in National and Chapter News in Winter 2006, pp. 56–58.

Mona Nasrallah
(AΩΑ, American University of Beirut, 2005)
American University of Beirut
Beirut, Lebanon

A Summer Sum

2 compound eyes
3 body parts: head, thorax, and abdomen
4 iridescent wings
5 fingers of my hand tickled by
6 prickly legs on this
7th day of the
8th month equals
1 dragonfly

Joan B. Lehmann, MD

Dr. Lehmann (ΑΩΑ, Marshall University, 1990) is a family practice physician working in the Emergency Department at Baltimore Washington Medical Center. Her address is: 1841 Fox Hollow Run, Pasadena, Maryland 21122. E-mail: lady-doc9@msn.com.

Douglas McDonough, the creator of the photograph that accompanies this poem, is a senior photographer/videographer with the International Imaging Center at Aberdeen Proving Ground in Aberdeen, Maryland. His e-mail: doug@dougmcdonough.com.
I visit after the seven-to-four nursing assistants have left for their little ones at home. The streets are so dark that car lights reflect like spills on tile. Warm wind flows between buildings, soft as the night I feel breathing all around me.

I’m stopped by doors, which fold back and let me into a glassed space, where I am trapped in stale air until more doors retract, admitting me. I sign my married name in a book for visitors. I have neglected to bring the grandchild pictures I intended, but Mother won’t remember.

I pass a woman with cement features. She sits, stiff, unhinged as a propped doll in her wheelchair. “Mama,” she calls. “I want a drink of water.” She must have been beautiful before her face froze. Her eyes are blue as nightlights, her hair the color of corn silk. When her husband, a former Marine, was still alive, I heard him tell her, “All the Mothers are busy.”

The nurse pushes her cart, bringing balms for the hour of sleep, capsules in pleated cups, thickened water, concerned glances. A nursing assistant pulls diapers from plastic packs. My heart has been folded for years, padded with absorbent layers to prevent seepage, but now I’ve come unwrapped. I remember standing near my mother’s tanned young legs, seeing her tennis dress, and knowing she was everything, the universe, love, everything true. She came to the side of my bed each night and filled my dark room with sounds gentle as running water, the whoosh and splash, the last trickle into the plastic cup that she would bring while car lights cast tree shadows through the white blinds. Her presence lingered past our partings, but I have been busy mothering others. Here is what I did not know when my mother visited my bedroom, tending me and my brothers, bringing cups of night water: Love so deep is difficult to know when you are occupied, your children grown and sleeping beside their spouses, but in the evening, the nursing home becomes a nursery, and if you visit and sit in the dark on the side of your mother’s bed, while outside lights flicker through blinds, making striped shadows, your mother may look up at you with a look of pure love, and that is all you need.

Helen Montague Foster, MD

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