Worthy to Serve the Suffering

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“There is nothing more hostile than water turning into ice”
—Paul Klee, on his Raynaud’s

Edward D. Harris, Jr., MD

Until the early 1970s, the physician’s understanding of his or her patient’s disorder during their first encounter was obtained most often in the form of a highly scripted, dry, verbal questionnaire that the physician confidently expected was complete. The doctor asked, and the patient answered, providing the principal ingredients of the information base about his or her affliction. Then, thirty-five to forty years ago, as Delese Wear and her colleagues pointed out in an insightful essay in The Pharos in 1999, “the postmodern experience of illness begins when ill people recognize that the medical story only tells part of their story.”\textsuperscript{1} The authors drew upon the work of medical sociologist Arthur W. Frank, who provided a useful classification of the ways that patients sense and construct their illnesses, opening the opportunity for physicians to learn (when they listen and ask the right questions) how illness has affected and transformed them.\textsuperscript{2}

Frank described three types of narratives most patients use. The first, the type that doctors want to hear as often as possible, is the restitution narrative. The patient says, “I know I am sick, but I can and will get well again.” The opposite type is the chaos narrative: the patient is despairing, vulnerable, impotent in the face of this crisis, and not at all optimistic about recovery. The quest narrative, more difficult to understand when a patient is moving through it, is the story that the patient wants others to hear. Whether or not a return to normal for herself is possible, she uses suffering to move others forward in ways such as spearheading patient support groups, or being an activist for federal funding.

Wear urges physicians, during their first and subsequent encounters with patients, to look for clues while listening to them tell their stories. Is it a restitution, chaos, or quest narrative that the patient tells? The physician must then seek to enter each patient’s world by listening. Generating almost infinite complexity in this scheme is that the narrative of each patient will be affected by the acuity, pattern, and degree of chronicity of the particular affliction, and the extent to which it is visible or audible to others. The amputee and paraplegic never need to explain to others their principal disorders. In contrast, the man who has had surgery and radiation for metastatic prostate cancer has, generally, no outward signs of his illness. He must make a decision, often with help from his physicians, about how much to let his fear of the future affect his work life, family interactions, and friendships. To whom does he tell his narrative?

A striking essay by James Gamble describes the life and paintings of Frida Kahlo, an artist revered in Mexico and elsewhere, who died at age forty-seven in 1954.\textsuperscript{3} A victim of polio and subsequently of trauma to her spine and pelvis that generated unceasing pain, she painted self-portraits that were non-verbal cries of chaos narrative. Did depicting her nude body split open to reveal a crumbling pillar with nails penetrating her flesh give her any solace or respite from agony? We must hope so. In this issue, Richard Silver gives us another example of how the narrative of illness can be expressed through non-verbal creativity.\textsuperscript{1} Paul Klee developed the first symptoms of scleroderma in his mid-fifties. Put yourself not in the role of a physician listening to Klee’s choice of narrative, but rather into the mind of Klee himself as his disease developed. Imagine his gnawing concern at the first episode of Raynaud’s phenomenon, his fingers turning white and being searingly painful in cold weather. Then one day he feels stiffness in his hands. The stiffness progresses. He finds that he can no longer pinch up the skin from the back of his hand. The skin is becoming leathery and thick. The tips of several fingers turn black and auto-amputate. The skin changes involve forearms and then his face, sparing only the loose skin around his eyes. Several years go by . . . and compounding the skin changes are the insidious onset of fatigue, dysphagia, chest pain, and difficulty breathing with the slightest exertion. There is no relief, only progression to his death.

What other narrative than chaos could Klee express? What could have given comfort? It is unlikely that his physicians had seen many similar rapidly progressing cases. Few, it is likely, could empathize with his verbal narratives, and Silver notes that Klee rarely spoke of his illness. His narrative was expressed by his paintings. He could pour those feelings of chaos into his face, sparing only the loose skin around his eyes. Several years go by . . . and compounding the skin changes are the insidious onset of fatigue, dysphagia, chest pain, and difficulty breathing with the slightest exertion. There is no relief, only progression to his death.

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And then there were eight

Heather Finlay-Morreale

The author is a member of the Class of 2010 at the University of Cincinnati School of Medicine. This essay won second prize in the 2007 Alpha Omega Alpha Helen H. Glaser Student Essay competition.

My medical school class is smaller now because my classmate Mike is not here. Last quarter Mike was in my small problem-based learning group. He stood out when I first met him because he was tall and handsome with dark shiny hair and a cheerful grin. I came to appreciate that he also was charming, curious, funny, and enthusiastic. I noted that he asked questions with a maturity and interest beyond that of most twenty-four year olds. He eagerly shared life experiences and knowledge with our group. He carefully listened while others in the group shared views that were new to him. His enthusiasm made the group meetings fun.

Mike was quieter and more tired than usual as the December exams approached. The whole class seemed to be feeling stress and fatigue and Mike's demeanor was not unusual.

A few weeks after our last problem-based learning session for the fall semester, my class took its biochemistry exam. After I finished and turned in my exam, I was handed a small pink slip of paper announcing a class meeting at 4:15 that afternoon. Once there, it was an utter shock to hear the dean say Mike had "taken his own life through suicide."

"Who?" I asked. "Can you repeat the name?" I couldn't believe Mike had fallen so deeply into depression so quickly. We milled in the lobby, stunned, crying, hugging, and asking questions. Through the torrent of shock, confusion, anger, grief, and fear, I wanted a clear and definite explanation for what had happened to Mike, or someone to blame.

Why? Why? Why?

Now the class has returned from holiday break. The whole school still suffers the loss of Mike. Some students attended his visitation and funeral. His white coat hung near his coffin. The empty coat was a reminder of the great doctor he was supposed to be.

At my first small group meeting after the holidays, I half expected that Mike would be in his regular seat. Instead we had two empty seats at the table. Another group member had decided to take a leave of absence for personal reasons. Her choice was a reminder of the alternative Mike rejected. Out of the ten of us who started in September, now there were eight. The cost of a career in medicine never felt more real.

Mike's death is not my first experience with suicide. When I was a child one of my parents attempted suicide. A few years later a sibling deliberately took an overdose of drugs. All this happened fifteen or twenty years ago. Back then, the tools to treat depression were more primitive than they are today. Mental illness was strongly stigmatized. In those days, I could not talk to anyone about what was going on at home. This was before Oprah Winfrey and others in the media helped to normalize discussions about depression and suicide and brought counseling to the mainstream.

At the time, a family member with mental problems was an embarrassment and shameful. Few people had insurance with mental health coverage. Drugs like Prozac and other antidepressants had not been developed yet. And sometimes, even when people reached out, there were few effective therapies. Fortunately my parent and sibling were able to get professional help.

Since then I am glad to see there have been changes in mental health care. There are new drugs and new treatments. Clinical trials have evidence of proven and effective therapies for many mood disorders. Psychiatric intervention can now prevent suicide in many patients with major depression. Access to care has improved and broadened. Most states now have legislation that requires parity in health plans so that treatment for severe mental illness is covered as completely as coverage for severe physical illnesses.

More and more... students succumbing on anti-depressants

The increasing use of psychiatric services today means less stigma for those seeking mental health treatment in the general population. State governors, professional football players, and business leaders have publicly acknowledged seeking help for mental health concerns. The 2000 Center for Disease Prevention and Control Health Report documented that ten percent of women and four percent of men took an antidepressant medication that year.

Mike was offered the latest tools and therapies for his severe depression. He received emotional support from family and friends, consultation and treatment from personnel in the medical
school, and continuous care from his treating physicians. Our medical school is progressive and proactive about mental health care. During orientation, the student affairs dean described the symptoms of depression in detail. Any medical student can call or go to several places for confidential and professional services, and mental health treatment is provided by professionals who do not teach or evaluate students directly. The medical school has a unique contract with mental health professionals to establish mental health treatment for students, including the proviso that students do not have to wait more than two weeks for an appointment. The cost is covered by student insurance, and any out-of-pocket expense is minimal. Sessions are not limited—students get the care they need to succeed in medical school. A twenty-four-hour helpline is available, staffed by peers on the Student Wellness Committee, as well as confidential counseling, separate from the College of Medicine administration.

Mike was being helped for his depression. A team of caring professionals was actively trying to help him and the best current treatment was offered. All this effort was not enough—he refused treatment that might have saved his life. I struggle to comprehend his final act.

The fact that Mike was a medical student may be part of the answer to my confusion about his suicide. Even though the general population accepts the need for psychological care and treatment, the physician community seems to lag behind. Physicians’ reluctance to seek help is nothing new. It probably has its roots long before medical school. Many medical students are driven, competitive, independent, and confident people. But the characteristics that make a person a successful medical school applicant and student are often the same characteristics that make asking for help difficult.

Data in a study on mental health and help-seeking behavior in medical school indicate that only twenty-two percent of medical students identified by the Beck Depression Inventory as being depressed sought help. Even worse, only forty-two percent of students with suicidal ideation asked for help. Students cited the following barriers to accessing mental health care: lack of time (forty-eight percent), lack of confidentiality (thirty-seven percent), stigma associated with using mental health services (thirty percent), cost (twenty-eight percent), fear of documentation on academic record (twenty-four percent), and fear of unwanted intervention (twenty-six percent). Fear of having stress-related or psychologically-related issues appear on academic records is widespread.

To date there have been limited studies on suicide in medical students. A survey of American medical schools from 1989 through 1994 found that suicide was the second-leading cause of death among medical students. Previously cited studies of medical students found that twenty percent and twenty-six percent of depressed students (or six percent of total medical students) had contemplated suicide. One author reported that physicians are exceptionally successful in their suicide attempts. This observation held true with Mike. He chose carbon monoxide to end his
By and about Heather Finlay-Morreale

I was raised in coastal Massachusetts. My undergraduate training was at Northeastern University where I was an Ell Scholar. My first love was for animals and I spent several years pursuing a career in veterinary medicine.

In 2000 I moved to the San Francisco Bay Area. At this point, I began to explore human medicine. I worked at UCSF on clinical research involving blood transfusion. After living on both sides of the country, I am now living in the middle, attending the University of Cincinnati College of Medicine. I am considering a career in academic emergency medicine and pursuing my interest in clinical research, public health, and underserved populations.

Act quickly and correctly in stressful situations. Both military training and medical school can be overwhelming educational and training experiences. Young physicians and young soldiers are put through stressful periods of intense training coupled with fear of humiliation and failure, and demands for perfectionism. Trainees are taught to be independent and strong. Trainees are pushed to ignore their own discomfort and feelings and focus on the job at hand. Peers and teachers may belittle those who show signs of weakness to try to form an ideal of toughness. At times the medical school experience might foster an environment like boot camp. This ideal of toughness may contribute to a reluctance to seek help, and a disdain for, or fear of, weakness. A common patient complaint about physicians is that they sometimes lack compassion and sympathy, and can be cold or distant. Perhaps training physicians to be tough like soldiers is not the best approach.

Medical regulatory organizations still stigmatize mental illness. State licensing boards and hospital privileges committees question physicians about past mental health treatment. The effect on physicians who disclose mental health treatment is unknown. Among themselves, physicians talk about malpractice rates rising if a physician reveals a history of mental illness. The same hospital credentials committees and malpractice insurers rarely require disclosure of obesity, diabetes, or liver disease. The latter conditions are considered private matters. Why is the confidentiality of mental illness treatment more easily violated than the confidentiality of physical illness treatment?6,7

The differing attitudes toward mental illness and physical illness are illogical. Altering neurotransmitter function is the mainstay of psychiatric medication. In particular, serotonergic medications have helped many depressed people. Serotonergic drugs have also helped people with irritable bowel syndrome. Disruption of the same neurotransmitter causes both a mental and a physical illness. Why is taking a medicine to adjust serotonin levels in the brain a sign of character weakness, when taking a similar medication for bowel problems is socially acceptable?

Recently I spoke at length with a physician who shared his personal experiences of seeking mental health treatment. He diagnosed himself as being depressed with suicidal ideation after reading a pamphlet that outlined for physicians how to diagnose depression in their patients. This man consulted a psychiatrist, who agreed with the diagnosis and dispensed sample medications for depression. The psychiatrist told him that other physician-patients have experienced an increase in malpractice insurance rates when prior mental health treatment was admitted. This was viewed as a double-hit by the depressed physician-patient. Not only could his business costs increase, but his illness would be disclosed to others in his group practice, as they shared a group policy. The physician finished the sample medications, did not return to the psychiatrist, and never filled the prescription for antidepressants at the pharmacy.

Physicians and physicians-in-training who avoid proper care for depression put their lives in danger. Among medical students, depression occurs in fifteen to thirty percent, three times higher than the rate of depression in either the general population or age-matched peers.5,6,9 Measurements of global psychological distress, including depression, found medical students experience greater distress than age-matched peers and the general population.10 Even more alarming is data that reports the chance of dying by suicide is seventy percent higher for male physicians and two hundred fifty to four hundred percent higher for female physicians compared to nonphysicians.11 Given these statistics, untreated depression should be a major concern for all physicians, medical
students, and medical school staff faculty.

When I see fear, anger, and sadness on the faces of my classmates and teachers, I remember my own feelings after my family members attempted suicide. Since then, I have thought a great deal about suicide and depression. I wish I had insights to share at Mike’s memorial that could help my classmates, but I had, and still have, no explanation. Suicide is a terrible tragedy. I know the world would be a better place if Mike was still with us. I do not want to simply mourn Mike and move on. I can only share what I do to make peace with my painful memories. In a deep and personal way I know the serious, insidious, and lethal nature of depression. I will never underestimate depression.

Two days after Mike’s death I was shadowing a physician in the emergency department. A patient presented with medically unexplainable abdominal pain. She attempted to obtain pain and anxiety medications that would essentially keep her in a stupor for weeks. The physician said that she was depressed and he could not help her. He did not call for a psychiatric consult, nor did he share his diagnosis with her. Although she was already on two antidepressants, the physician did not discuss the effectiveness of these medications with her or adjust dosages. My painful memories of family members’ depression gave me the courage to speak up to advocate for the patient and suggest more attention be given to her depression. In Mike’s memory, I promise to continue to speak up through my entire medical career to encourage people who are suffering from mental illness to accept help. I promise to continue to encourage fellow health care providers to address mental as well as physical illness when treating patients.

In addition, on a one-to-one basis I can support my colleagues. Right now that is easy. My medical school classmates and I are very close. We have both celebrated and mourned together. I am comforted knowing that my classmates will look out for me and I will do the same for them. I am comforted knowing that although my teachers push me, they will catch me if I fall. I need to make sure I continue to reach out to those around me as I continue in my training. Even as a busy resident I need to make sure I continue to check in with my peers. If I see someone struggling I will make the effort to take time and listen. I will let him or her know that there is no shame in asking for help. In fact, it is the strong, not the weak, who seek help.

In 2002 and 2005 the American Foundation for Suicide Prevention convened experts in the field to set priorities for research and interventions on physician suicides. A 2003 review article outlined recommendations to reduce physician suicides. This report outlined positive actions that people in all aspects of medicine can take to reduce physician suicides. These resources can be consulted for further information. Physicians and their advocacy groups should work together to reform hospital privileges applications to ensure that those who have sought mental health help are not penalized, and to prevent punitive treatment of physicians who may seek it in the future. Medical schools that do not have a comprehensive plan for medical student mental health should immediately establish one. Physicians can educate their peers when someone makes a disparaging remark stigmatizing people who seek psychological treatment.

Together as physicians and future physicians we must change the ideal of toughness in medicine. The stiff-upper-lip mentality and the perceived weakness of mental distress are harmful to our patients and to our profession. We must stop stigmatizing those among us who seek mental health care and actively remove the barriers to seeking mental health care.

References


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Yesterday we had testicular tumors
but this afternoon we have ovarian ones.

The red laser-dot bounces up and down
over the specimen projected onto the screen in the soporific
lecture hall, back and forth over that pink and red-pied grapefruit
that once had been an ovary, jerking
like conjoined damselflies mating on the wing, cutting the currents and darting over turgid mountain streams.

The professor presses another button to advance the slides of cancerous human tissue that comprise today’s lesson.

Another grapefruit:
*Mucinous cystadenocarcinoma.*

The apple blossoms are bursting like popcorn on the supple boughs which nuzzle the windows of my old bedroom, where my mother has planted tomatoes in half-pint milk cartons on the sill.

Peritoneal carcinomatosis, the professor reads aloud the daffodil-yellow letters which float above an eviscerated middle aged woman, her open abdominal cavity speckled with tumors like gravel among the red mud of a Colorado creek-bed.

Last night the hardware store reeked of lawn fertilizer, citronella and loam. And in fifteen minutes the plaid-skirted school girls with ash-smudged foreheads will flit giggling across the parking lot.

*But this afternoon we have ovarian tumors and tomorrow, gastrointestinal ones.*

James S. Wilk, MD

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The Pharos/Winter 2008
And what brings you in today?
I know, I’ve read the chart.
But I ask anyway.
It’s my job.
But you already know
That it’s not really my job.
Don’t you?
Didn’t you look at my badge
That says medical student?
Or my coat, shorter than all the rest,
Emblazoned with my title?
Well, that’s all right.
I can dance.
I’ve been taking lessons.
I’m sorry that you’ve been feeling this way,
Mrs. So-And-So.
And what about this symptom and that?
Have you had any of those?
I know all the right questions to ask.
I’ve been practicing.
Even if you have bronchitis,
I will make sure that your chest pain
Is not brought on by exertion
And does not radiate to the shoulder.
The first rule of dancing
Is to move with your partner,
But I am supposed to lead.

Mrs. So-And-So,
I’m so sorry to hear about your husband.
It must be really hard for you.
Here’s a tissue.
But now that I have opened up
This Pandora’s box of emotions,
Let me ask you some other questions
So that I can complete the history
And report it back to the real doctor
Who will not listen.

Another thing I learned about dancing
Is to never step on your partner’s foot.
This can be pretty difficult
When you don’t even know
Where the foot is.
Now I’m just going to do
A quick physical exam,
Mrs. So-And-So.
I’m just going to listen to your heart,
And everything sounds normal.
What’s that?
You have a systolic murmur,
Consistent with aortic stenosis?
Now that you mention it,
I can hear it after all,
If I close my eyes and pretend.

But now, a new partner!
My turn for dancing is over.
Hello, Mrs. So-And-So,
I see you have met
The medical student.
It’s good to see you again.
And within a minute
The pertinent positives are elicited.
It turns out there are crackles
In the left lower lung.
Didn’t you hear them?
I am exposed.
Well, it was a pleasure meeting you,
Student doctor.
I thought you were very nice.
Some day you will make a great doctor.
But that day is not today.
I need some more dancing lessons.
Fortunately, my next partner
Is next door.
And I know some new steps.

Jay Augsburger, MD

The first rule of dancing
Is to move with your partner,
But I am supposed to lead.
Belmont and Halsted has always been one of my favorite neighborhoods in Chicago. I used to think it was because I loved the juxtaposition: boutiques next door to sex shops or a Starbucks on the same block as a used bookstore. Later, I thought it was the ten-foot rainbow poles that let everyone know this patch of Chicago belongs to the boys. Perhaps it was the sign in front of a dance club, “Weather forecast: 12 inches.” While I love Chicago, I miss my home in Florida, and the attitude, the vibrancy, and the nightlife of Belmont transports me out of the Midwest and back to Miami. Now I have another reason to love Belmont. It is where I began my third year at a primary care clinic a few doors down from a popular nightclub.

Dr. Green was quick to let me know that his clinic was a little different from other primary care practices. I would see a lot of homosexual men, HIV-positive patients, and a sprinkling of narcotic seekers. Over the next few weeks I would become very comfortable with taking a sexual history and knowing when and how to ask questions I was never taught in my Physical Exam class such as, “Do you rim?”

On my first day, one of my patients was a new twenty-something female patient who complained of kidney
pain on her right side. Review of systems was normal and on physical exam she did not flinch when the doctor tapped her back in a test for pyelonephritis. Again, the doctor tapped her, and she complained of pain on her left side and pointed to the location.

“I thought you said it was on the right—,” said Dr. Green. “I mean the right,” she said on second thought.

The doctor had his doubts, but when he told the patient he would send her for an ultrasound, a strange smile flickered across her face. It was as though she was happy to be getting a test. Later on in his office, Dr. Green asked me what I thought she had.

“Pyelonephritis,” I ventured.

“Factitious disorder,” he responded.

Having been fooled once, I quickly learned that it was okay to approach some patients with skepticism. Before we entered the room to see our next patient, Dr. Green glanced at the chart on the door. He clenched and unclenched his hands several times before taking a deep breath. Then, he whispered to me that the patient had a bad experience with a prostate biopsy a few months ago. Since then, Jon had been to see Dr. Green a few times and always with very vague complaints. Dr. Green gathered himself, pasted a smile on his face, and entered the patient’s room. As soon as I had walked through the door, I heard Jon say.

“I’m not stalking you, Dr. Green. You know, right, that I’m not—” The patient glanced at me. “Dr. Green has been my doctor for fifteen years. Best doctor in town.”

Then Jon began to complain. He had some vague discomfort in his abdomen. Sometimes it was in his chest. Sometimes it was all over his abdomen and chest. It wasn’t really a pain, but it was uncomfortable, and it had begun only after the prostate biopsy two months ago.

“I am not a crybaby. It was an ungodly amount of pain they put me through. No one told me to expect. No one told me anything. And since then, I have not been myself.” Jon gesticulated with his hands as he spoke.

He was a thin, athletic man with gray hair, and he wore a black T-shirt and khaki shorts. His biceps and calves were toned, his veins prominent, and his skin bronzed by the summer sun. He was the most fit, active, and healthy-looking patient I had seen all day.

“Has your partner noticed any changes in you or the way you’ve been behaving?” asked Dr. Green.

“Nooooo,” Jon replied.

Then, Dr. Green asked if Jon was tired, lost weight, felt feverish, had chills, a change in bowel habits? No, no, no, and no. Jon was adamant that he had never felt better about himself, never felt better about life until his prostate biopsy five weeks ago. Again he insisted, “Could what I have right now be related to my biopsy?”

I suppressed a sigh. It was my very first day. I had been told that I would see narcotics seekers, and the female patient I had just seen had factitious disorder, and now this. I had begun to ask myself when was I going to get to see the real patients.

Throughout the interview Dr. Green was silent, typing away on Powerchart. The corners of his mouth were upturned ever so slightly. It was not the smile of a doctor talking to a patient. It was the smirk of a doctor talking to a hypochondriac. The doctor was not buying it. Jon knew it too. He began to fidget and speak with an annoyed tone. The pitch of Jon’s raspy voice went higher and higher.

It is said that for poker players, everyone has a “tell.” A tense jaw, a finger tap, or a cough can give away a player’s innermost workings and thus reveal a particularly good or particularly bad set of cards. For Dr. Green, it was his smirk. It gave away his displeasure and allowed him to suppress his inner laugh. It was a busy day. He had already seen Jon a few times on the same matter. What about today would make Dr. Green more likely to help Jon? Vital signs and review of systems had been normal. Dr. Green gave Jon a gown.

“Lori and I are going to step out for a few minutes. Take off your clothes. The opening goes in the back.”

When we returned, Jon was babbling on and on about his prostate biopsy. Dr. Green listened as best as he could. It was really hard to take this patient seriously, but except for the smirk that kept reappearing, Dr. Green was doing a good job of listening.

On physical exam there were no enlarged lymph nodes and the eyes, ears, and mouth all looked good. Heart sounds were normal. Lungs were clear to auscultation. Now it was time for the abdominal exam. No pain or tenderness was elicited on palpation. No hepatosplenomegaly. However, you could see his upper abdomen pulsating. The patient was a thin man and this is a common and normal finding in thin patients. His abdominal aorta did not feel enlarged. But in the upper quadrant just
right of the midline and adjacent to the ribcage was a pulsating abdominal mass. At least, Dr. Green said it was pulsating. I could see the pulsations in his abdomen upon inspection, but I felt no pulsation in the mass. I sighed. What did I know? It was my first day of my third year, and I couldn't even feel a pulse. I have a long way to go, I thought to myself. We continued the exam. His peripheral pulses were normal. Reflexes and muscle strength was normal. This was to be expected as the patient had been feeling fine. No weight loss, no fever, no sweats.

We left the room as Jon got dressed, and I questioned Dr. Green. Could it be a triple A? Reversed portal flow? A mass? Dr. Green frowned at each of my hypotheses. He shrugged his shoulders and said he wasn't really sure. He tossed the question out to his colleagues in the shared office.

"A pulsatile abdominal mass in an otherwise healthy patient?" Dr. Green said aloud.

The other doctors thought the location of the mass made it unlikely to be the aorta and then shrugged before continuing with whatever they had been doing.

Dr. Green turned to me. "We'll have to send him for a CT immediately because it is a pulsatile abdominal mass."

Jon was told to go directly to the hospital for an urgent CAT scan.

The next morning, my second day, Sally, the nurse, handed Dr. Green the results. "Oh no, oh no," was all I heard him say as I followed him to the computer.

The CAT scan had been done from the patient's lower lung fields to his pelvis. While his lungs were clear, everywhere else there was tumor. Everywhere. Large masses. Everywhere. Even I could see it.

Dr. Green sat back in his chair and sighed. He had tears in his eyes. I leafed through my notebook and pretended to study.

Dr. Green turned to me. "It's times like these when I pore over a chart. Agonizing, did I miss something? Did I miss something?"

Later in the afternoon of my second day Jon was called in for an appointment to discuss his results. Dr. Green broke the news.

"I knew it was bad when they told me to come see you today. I thought you were going to tell me I had to go to the hospital for an angioplasty or something about my heart. I wasn't expecting this." Jon was silent for a while. "Well," he said softly, "what do we do now?"

Dr. Green explained the next few steps. He would have to go in for a liver biopsy. No, he should not cancel his trip to California for the weekend. Go. Enjoy. They could do the biopsy when he returned.

Then, Dr. Green turned to other matters. He asked if Jon had his affairs in order.

"Didn't think I'd be having this conversation... I guess I should work that out with my partner." Jon looked down at his hands. When he looked up he asked, "How likely is it, Doc, that it's a tumor and not something else?"

Dr. Green bit his lip. "I would say eighty percent chance it's a tumor, twenty percent chance it's something else."

"Wow," Jon rubbed his face. "I appreciate your honesty, Doc. I appreciate you telling it to me straight. That's why I come to you. It's hard to hear, but thanks for being honest."

Later, Dr. Green told me that he thought it was a ninety-nine-to-one odds it was a tumor and that this had been one of the few times he had not been direct with a patient. The rest of the day Dr. Green was very quiet. Every once in a while, as we exited one patient's room and before we entered the next room or when he was sitting at his desk finishing his notes, Dr. Green would tell me a little more about Jon.

"Jon has been so good. He came to me about fifteen years ago. He was a drug user and an alcoholic. I got him to quit. He found a partner he loved and who's loved him. Did you know, the past few years has been the first time ever that Jon has actually liked himself? Felt good about himself. He's exercising. He's in great shape. Good job. A good person. Sure he had hepatitis B, but we've monitored it closely. Normal liver functions every time. Normal liver scan every few years. I could never get him to quit smoking, but he's cut down so much. It was going to be the next thing we would do together."

Earlier, after Dr. Green had broken the news, Jon asked, "Was there any sign of this before? We've been so good."

Dr. Green replied, "Your liver functions have been normal. We had your liver scanned a year ago, and it was normal. Your chest X-ray was normal four months ago. Your prostate biopsy was normal. As far as I can tell, your liver has been okay. There was no indication of this."

"I believe you, Dr. Green. I believe you."

Fifteen years of trust added up and outweighed a smirk. Dr. Green had been exonerated by his patient, but was it was clear to me by his silence and teary eyes throughout the day that he had not exonerated himself. He had missed the diagnosis. More importantly, he had doubted his patient, and it had been obvious to the patient and to me.

A week later a liver biopsy revealed adenocarcinoma. The primary site was the pancreas.

Jon was given less than six months to live.

I always thought it was big moments that a person regret—losing one's temper, speaking words that could not be unspoken, denying a patient's dignity. I had forgotten that it was the quiet moments we could regret as well: a smirk, a disapproving glance, a snub. All of us are guilty of such small moments. In the end, if my admirable moments outweigh my regrettable moments, then maybe my patients will exonerate me. Perhaps then, I will forgive myself.

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Searching for God below the vocal cords

Mani Mokalla, MD

The author (AΩA, University of Minnesota, 2001) is pediatric cardiology fellow at the University of Minnesota. This essay is dedicated to Kerry and Aidan, Dr. Mokalla’s wife and son.

It is Saturday, June 21, 2003, approximately 7:00 AM. I am content, as I have managed to capture a few hours of uninterrupted sleep while on call. I am eager to leave—I was not supposed to take call last night, but the resident in charge had a family emergency and I was summoned to duty.

Between sleep and wakefulness, I rouse to the sounds of the interns leaving their call rooms to perform the ritual pre-rounding work. I start to think about the day ahead. My son, Aidan, turned one month of age yesterday and I am sad to have missed this milestone. We see little of each other, as I am a senior pediatric resident in a demanding program. My mind wanders to my lovely wife, who I am certain has also had a sleepless night entertaining the demands of our son.

Suddenly the speaker next to the head of my bed announces, “Attention, attention, code blue, pediatrics, admission entrance!” My first thoughts are “It can’t be real! It cannot be there. No one codes in the entrance to the hospital!” The message repeats, this time with more emphasis.

I run from the third floor to the first. A nurse crosses my path and shouts, “Go, go!” pointing to the direction of the front entrance. I am the first doctor and the second health care provider to arrive at the following scene.

A Latino boy lies on the floor. I still cannot comprehend why he is here, of all places, in this state-of-the-art children’s hospital. A critical care nurse is performing basic CPR. Bile is coming out of the boy’s mouth, but the nurse works with such intensity and focus that he does not notice my arrival. The boy’s parents are embracing each other, crying silently, watching, and gasping for air between their sobs. My eyes cross paths with two big, almond-shaped brown eyes staring at me—rather, looking through me. They belong to a boy who resembles the one on the floor, only he is older, perhaps four or five years of age. I am stunned, because the gaze of this child reveals that he already knows that what is about to unfold will end only in grief.

“Pediatric resident, what’s going on?” I hear myself say. What a strange phrase, when the answer is obvious and clear: a child is in the active phase of dying. Yet this is the army-like type of communication we are taught in residency: be loud, be clear, be direct. The voice of my critical care professor echoes in my ears, “Always remember the first step is to gather information, regardless of the acuity of the situation.” The nurse looks up and responds in the same cold manner, as if we were not in the company of the dying child. “I am not sure. I arrived here seconds before you, as the parents carried the child through the front door. I think the kid was dead on arrival!”

I take charge and become rapidly aware of how useless I am without modern medical technology. Usually in such a dire situation I am surrounded by medical equipment and ancillary staff. Nonetheless, I am the most senior and supposedly most medically prepared person to handle this situation. I kneel next to the child and instruct the nurse to aid me in two-person CPR as we await the respiratory therapist, the code cart, and other support staff.

A red hued code cart appears by my side and a respiratory therapist provides positive pressure ventilation. The critical care nurse, with his bile-stained beard, continues to press on the child’s sternum. Another resident kneels beside me.

The military song has changed its tone: “One, two, three, four, five, breathe, and one, two, three, four, five, breathe!” as basic life support is implemented. The resident next to me asks, “Are you going to intubate him?” The words lift the fog clouding my reason. For reasons unknown, with absolute confidence I respond yes, and shout for what I judge to be the appropriate laryngoscope and endotrachial tube size.

As a Muslim faces Mecca in his daily prayer ritual, I am bent to the ground. But instead of prayer or meditation to touch God, I am placing a tube into this child’s airway to allow me to breathe life into a dead boy. I am placing a tube into this child’s airway to allow me to breathe life into a dead boy. As in prayer or meditation I become unaware of my surroundings. I focus only on visualizing the vocal cords. I see the glistening white bands I seek, and the tube passes into the child’s airway.

I look up to meet the eyes of my peers. Some look relieved, others impassive. The boy with brown almond eyes still stares at me. Tears run down his face. His father’s right hand is on his shoulder, fingers burrowing into his son’s flesh. I cannot tell if the boy is crying from pain or fear. I bark orders for epinephrine to be placed in the child’s ET tube, breathe, continue chest compressions, no heart rate, more epinephrine, no heart rate, breathe, heart monitor shows flat line, give calcium, another round of epinephrine, give bicarbonate, heart monitor shows flat
line, push normal saline via the peripheral IV line... no heart rate.

I step back from the child. My mind runs over the CPR algorithm. Have I done everything correctly? Is there some other intervention that I am forgetting? I cannot think of any misstep. He was dead on arrival, you have done everything possible, I conclude to myself. The flat line on the cardiac monitor confirms my conclusion.

I tell a fellow resident to take over the resuscitation efforts. I am going to tell the parents that we are going to stop our efforts. I start by introducing myself, "Hello my name is..." only to be interrupted by the father: "Perdón, Doctor, pero nosotros no hablamos ingles." A message difficult enough to provide in English now has to be conveyed in another language. It does not matter, as they likely know what I am about to say. I introduce myself, this time in Spanish. I explain that their son arrived without his heart or lungs working properly. I tell them that we have done everything we can to make his heart and lungs work again. I avoid the older son's eyes, for I know I could not bear to see them. I am about to say, "I think it would be best if we stop our efforts" when a distinct beep sounds behind me. I turn to see a most welcome narrow triangle make its way across the heart monitor. Slow, irregular, and weak at first, then it becomes a steady beat. I embrace the parents, shouting, "His heart is working!" Tears of joy flow from their eyes. Smiles appear on the faces of other residents. More help arrives, and the child is rushed to the critical care unit, where the critical care doctor asks me for the highlights to this point. I declare in less than one minute what seemed like an eternity of efforts. He replies with a cold, "Thank you." Almost as an afterthought he manages to smile and say, "By the way, good job."

I stay at the boy's bedside for a while, observing his care and speaking to the family. Now with monitors in place, lab work in progress, and a team of fully capable providers, this boy's life story begins to unfold. His mother tells me they are from Mexico, now residing in Nebraska, where he underwent palliative cardiac surgery. They came to this center because it was the only place that offered curative surgical intervention. Although the child has been ill for the past few days with coughing and breathing difficulty, they did not seek medical care because they lacked a car and money. "This morning he looked in more trouble," the father tells me, "so we brought him here in a taxi. He stopped breathing when we got here, doctor, and you know the rest." He starts to cry and hugs his other boy.

Later in the day the boy died. Rather, we told the family that he ought to die. The child had suffered enormous anoxic injury to his brain, from which he would not recover, and there was no point in extending his suffering. I felt empty and exhausted. I felt like a failure. Mostly, however, I felt sad for his family.

I went to our hospital's atrium to gather my thoughts and ready myself for my own family. I wanted to get home and hug my little boy and wife. As the sun warmed my face, I saw the child's father. He approached me with tearful eyes. Before I could express my condolences, he hugged me and said, "Thank you for giving us a few more hours with our son. Your efforts were not in vain."

I left the hospital crying that day. I cried for the incredible privilege to cross paths with this family at such a juncture in their lives. I cried because, through their pain, I realized how fortunate I was to have a healthy little boy waiting for me at home. I cried because of the grace this father gave me, the support he extended to me even though his own son had just passed away. I cried because I felt, and still feel, that I have the most meaningful job I could ever hope for.

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White cottonwood tracers perform amidst the warm afternoon sun,
Appearing as fleet acrobats illuminated by the orb’s spotlight.
A white butterfly, camouflaged within daisies, flies erratically,
Dancing with the helicopter flight of beetles with iridescent heads.
Drifting billowy clouds dim the sun’s bright light,
Offering an intermission greeted by a crescendo of cicada cheers.
Lengthening shadows of dreadlocked willows slowly advance,
Gently caressing the moistness of cool green grass.
The sun warms skin cooled in the shade,
Slowly sneaking beneath the floating tarp of a large umbrella.
As angular sunbeams outline the foundation of a spider’s web,
Constructed to provide the catch for an eight-legged gourmand.

Steven F. Isenberg, MD

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This rather straightforward film is worth seeing because it’s a true story that highlights both the uncertainty of life and how a community and a university came together in the face of tragedy and conquered despair. In addition, the DVD has a special feature that will resonate with physicians. The film opens at the annual Huntington, West Virginia, commemoration of the November 14, 1970, crash of Southern Airways Flight 932, chartered to transport the Marshall University football team back from Kinston, North Carolina, after a 17 to 14 loss to Eastern Carolina. The film flashes back to Coach Rick Tolley (Robert Patrick) giving a postgame speech about “winning being everything,” and then telling the players that the plane leaves in an hour and that they will be back home by 8:00 so they can do whatever they had planned for Saturday night. The quarterback and his cheerleader fiancée talk about seeing each other soon as he boards the plane and she carpool back.

The scene shifts back to Huntington where loved ones wait expectantly for family members to return. Then, tragedy strikes as the DC-9 crashes into a hilltop one mile short of the runway. All seventy-five on board are killed, including thirty-seven members of the football team, as well as coaches, boosters (including three physicians—Drs. Joseph Chambers, H.D. Proctor, and Ray Hagley—a dentist, and a psychologist), and five airline employees. The crash results in at least thirty-four children losing one parent and twenty-nine becoming orphans (ranging in age from ten days to twenty-one years). As the close-knit community tries to cope, university president Donald Dedmon (David Strathairn) decides to recommend canceling the football program partly because Marshall had been kicked out of the Mid-American conference the year before for over a hundred NCAA violations, and this seems like the fatal blow. This is clearly the wish of the board chairman Paul Griffen (Ian McShane), a widower whose only child was the quarterback. However, Anthony Mackie (Nate Ruffin), one of the players who could not be at the game because of an injury, vehemently protests and energizes the students to call for the rebuilding of the team to play the following year. As the board of trustees meets, a large crowd assembles on campus in opposition and starts chanting, “We are Marshall!” Dedmon decides to go ahead and try to field a team. This sets up divisions within the community. The embittered Griffen, who believes that this is dishonoring the dead, convinces the board to fire Dedmon as he tries to get a coach, and all those with Marshall connections, starting with the assistant coach Red Dawson (Matthew Fox), turn him down. Dawson harbors feelings of guilt for having recruited twenty of the dead athletes and promising their mothers he would take care of them, as well as for urging Coach Tolley to take his place on the plane so that Tolley could be home in time to see his granddaughter’s piano recital, while he returned by car to make the recruiting stop Tolley had planned to make along the way.

Finally, Jack Lengyel (Matthew McConaughey), the coach at College of Wooster in Ohio, calls to say he is interested in the job. When pressed to explain why he would leave an established program for one literally in ashes, he says that he thinks of how he would have felt if his wife and three children had perished and he wants to help with “the hurting.” One of the three remaining seniors refuses to join the team, feeling guilty because he missed the trip to East Carolina by oversleeping. Lengyel suggests that Dedmon request the NCAA’s permission to allow freshmen to play, a practice that did not
become universal until 1972. He visits NCAA headquarters in Kansas City to plead his case and is successful. As the team prepares for the 1971 season, Dawson reluctantly agrees to act as assistant coach for a year. He and Lengyel travel to West Virginia University in Morgantown where the prized in-state recruits preferentially go. WVU coach Bobby Bowden, who had Lengyel and his coaches view their game films and copy their playbook. Before the pivotal game on September 25, 1971, against the experienced (average age twenty) Xavier football team, Lengyel brings his “Young Thundering Herd” team (average age eighteen) to the memorial to the dead players where six athletes who could not be identified are buried. He gives an inspirational talk, not about winning, but about playing for them and the others who died.

The acting is low-key and believable. I especially appreciated McConaughey’s injection of down-home sly humor that respects the seriousness of what happened but is essential for keeping everyone’s spirits up. Paul McHugh, the longtime chairman of Psychiatry at Johns Hopkins had told me he watches films with English subtitles. The film I rented was set up with English subtitles and I did find it very helpful in not missing softly-spoken or clipped dialogue. It also was in widescreen which I also recommend. As for the DVD special feature, it consists of interviews with legendary coaches by director McG. They focus on coaches being teachers, not just about sports but of life and especially in the face of adversity. They all strive to inculcate the idea of the importance of the team, which is so much of what medical care is increasingly all about. The coaches are Lengyel (who moved to Navy), Bowden (who moved to Florida State) Pat Summit (Tennessee women’s basketball coach), Lute Olson (Arizona’s basketball coach), George Horton (UCLA Fullerton’s baseball coach) and best of all John Wooden (UCLA’s basketball coach and English teacher). His interview alone is worth the price of a rental.

Addendum

The Huntington Tri-State airport is sited on a mountaintop, which made the approach especially difficult in stormy conditions such as prevailed that evening. The National Transportation Safety Board report later concluded that the crash resulted from “a descent below Minimum Descent Altitude during a non-precision approach under adverse conditions without visual contact with the runway” either because of pilot error or instrument failure. Since 1970, considerable changes have been made to ensure the airport’s safety, including enlarging the runways and changing the approach, acquisition, and clearing of the hill, better lighting, and state-of-the-art navigational equipment. There have been no commercial airplane accidents since.

Acknowledgment and references

I am grateful to Dr. Maurice A. Mufson, a former NIH colleague and professor and chairman emeritus at Marshall University, Joan C. Edwards School of Medicine, and the kind people of Huntington who helped with fact checking and research as well as the Wikipedia and IMDB websites. More information on the three physicians is available in The West Virginia Medical Journal 1970; 66: 443.

Star turns as movie doctors

Given the dearth of good films, let alone those with a medical theme, I have decided to devote periodic columns to films with movie stars not known for playing physicians and which didn’t make my book on doctors in the movies. I’m starting with one of my all-time favorite actors, Jimmy Stewart, who played a doctor at least twice. In both films the issue of euthanasia was raised.

The Greatest Show on Earth (1952)

Starring Charlton Heston, Betty Hutton, Cornel Wilde, and Jimmy Stewart, and Gloria Grahame.
Directed by Cecil B. DeMille. Not rated. Running time 153 minutes.

Stewart’s first turn as a doctor was in this 1952 Academy Award-winning film, which many critics correctly point out won it for its popularity (it broke box office records) and for sentimental reasons (honoring DeMille for his fabled career). These critics contend that the award should have gone to Singin’ in the Rain or High Noon. What is unfair, however, is the critics’ unrelenting ridicule, which has tarnished the film’s reputation and as a result has made it largely unavailable for rent. It also awaits the special edition DVD treatment that many lesser films have received. Indeed, this is a special film in that Cecil B. DeMille pulled out all the stops in bringing the real Barnum and Bailey three-ring circus in its heyday to the screen. The film represents an archival record of a time when the circus was still being held under the Big Top and traveling from town to town by train. He filmed actual performances with owner John Ringling North, the legendary clown Emmett Kelly, and world-famous acrobats. They cooperated even in the face of discontent about the film lighting, which put the acrobats at risk, as well as a plot in which sleazy grifters were part of the company (something the circus management scrupulously guarded against), and a devastating circus train crash that had not occurred in the twentieth century.

One must look beyond the plot, which is pure soap opera with behind the scenes romances and jealousies, and appreciate the spectacle and the fact that the actors Betty Hutton (Holly) and Cornel Wilde (Sebastian) learned to perform their own stunts at their peril. The film stars Charlton Heston as Brad Braden, circus master, a role that launched his career, with DeMille later casting him in The Ten Commandments. Jimmy Stewart plays Buttons the Clown, who never takes off his makeup in public. It turns out that he is a doctor who went into hiding because he was accused of “mercy killing” in the
death of his terminally-ill wife. At one point, he tries to console Holly, whose romance with Brad has taken a backseat to his desire to make the struggling circus a success, telling her that “people often kill the thing they love most.” Later she sees a magazine article about a doctor who “killed the thing he loved” and puts two and two together. As the principals begin to suspect his identity, they protect him from the police who are on his trail. Like The Fugitive, he can’t escape being a doctor and when the pivotal moment comes and Braden’s life is at stake, he ministers to him, even arranging an on-the-spot transfusion despite risking exposure to the police. It is instructive to contrast the attitudes toward active euthanasia then with those of today, as Oregon and Holland permit assisted suicide. All in all, the film, which is filled with many star cameo appearances common in ’50s movies, is one that the whole family can enjoy. Watch for it on Turner Classic Movies.

The Shootist (1976)

Starring John Wayne, Jimmy Stewart, Lauren Bacall, and Ron Howard.
Directed by Don Siegel. Rated PG. Running time 100 minutes.

It took John Wayne’s sixtieth film Stagecoach in 1939 to make him a star. He went on to make over sixty-nine westerns and 200 films, of which this was his last. It’s considered by many to be one of the top ten westerns of all-time and one of Wayne’s best acting roles. The weakest parts are the opening, where the director chose to set the scene for his character being a killer with clips from Wayne’s shooting bad guys in his previous films, and the Hollywood ending, which deviates from the Glendon Swarthout’s book, regarded as one of the greatest western novels of the twentieth century. However, what transpires in between is extraordinarily well done.

The film opens rather roughly with J. B. Books (Wayne) riding into Carson City to get a second opinion from Dr. Hostetler (Jimmy Stewart), who saved his life after Books was shot in a fight with two gunmen who both perished.
Books, who contends that he never killed a man who didn’t deserve it, has killed thirty men, first as a lawman and later as a marked man sought after by gunfighters who want to demonstrate their prowess and win fame by beating him to the draw. Books is accosted by a highwayman who refuses to put down his gun and is shot by Books, who recites his mantra: “I won’t be wronged, I won’t be insulted, and I won’t be laid a hand on. I don’t do these things to other people and I require the same from them.” It’s 1901 and Carson City already has electricity, a street car and even one automobile. It’s clear that his days as well as those of the shootist are numbered.

Dr. Hostetler greets Books by recalling that they haven’t seen one another for fifteen years. He’s not just referring to their professional encounter, but also to the only other film he and Wayne made together, the 1961 classic The Man who Shot Liberty Valance. Books tells him that he saw “a sawbones in Creede Colorado” ten days before and, without telling him what the doctor said, describes his symptoms, mainly pain in the bottom and up his spine. Hostetler tells him to take his clothes off down to his Long Johns, and to bend over the examining table and to “drop the trap door.” Afterwards he says “Every few days I have to tell a man or a woman something I don’t want to. I’ve been practicing medicine for twenty-nine years and I still don’t know how to do it well.” Books tells him to lay it on the line. Hostetler tells him he has “cancer, advanced” and that there’s little he can do except give him laudanum for when the pain gets too bad and that he has “two months, six weeks, maybe less.”

In a later scene, when asked to describe the expected course, Hostetler is very graphic and then apologizes for being so candid. As Books leaves he tells him something that is neither a directive nor a suggestion but only something to reflect upon while his “mind is still clear.” “The death I just described to you is not the one I would choose—not if I had your courage.” In short, the medical scenes, as in The Greatest Show on Earth, are pure Hollywood and not standard operating procedure, but the interaction of Stewart and Wayne make them memorable.

Hostetler directs Books to a boarding house run by the widow Bond Rogers (Lauren Bacall) where he plans to spend his last days. There are some marvelous scenes with Bacall, whose husband Humphrey Bogart had died of throat cancer, especially when she wants him to leave her house and he tells her, “I’m a dying man, scared of the dark.” Wayne himself had had a pulmonectomy twelve years before for lung cancer and was having some health problems, although the stomach cancer to which he finally succumbed in 1978 didn’t manifest itself until at least a year later. There are many scenes involving Ron Howard as Mrs. Rogers’s son, Gillom, who evolves from hero worship to a more mature relationship with Books. The comic relief is provided by Harry Morgan as Marshal Walter Thibido and Scatman Crothers as the liveryman Moses Brown. Other noted character actors who round out the cast include Hugh O’Brian, Richard Boone, John Carradine, and Sheree North.

Swarthout’s son Miles, who co-wrote the screenplay, said that his father wrote the book after reading an article about there being a higher incidence of prostate cancer in long-distance truckers and assumed the same would be true for cowboys. I could find no evidence for either association, which was confirmed by noted Hopkins Professor of Urology Patrick Walsh. The character of J. B. Books is based on John Wesley Hardin, the only known gunman to have a college and law degree. He was killed at the Acme saloon in El Paso in 1895. The titles “shootist,” “gunman,” “man-killer,” and “assassin” are what such killers were called rather than “gunfighters,” as Hollywood has called them. The term was popularized in the 1950 film The Gunfighter, starring Gregory Peck as a similarly ill-fated man who can’t escape his paparazzi, who used six-shooters rather than cameras.

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He brought her flowers
Overflowing bouquets of soft petals
She smiled
The way she smiled
The time she found him as a child
Pounding rice flour until his
shiny black hair was white.
She rested her head
now coated white
and
Forgot to tell him
About the doctors
And the words they thought she didn’t understand
About the nurses
Frantic about her
Weaving tubes and wires through and around her
Connecting her spidery veins with machines
About asking the prayer-woman
To go home and many thanks for her efforts
About throwing up
About chills not beaten with blankets
About moving within and without herself.
She was so pleased to see him
So tall, so straight-backed
She decided to forego chastising him and herself
For missing the lesson that white flowers are meant for
the dead.
She was so pleased to see him
She held his hand tightly
And lay quietly
As the excited nurses
contacted the solemn doctors
who found him
Sitting by her side
Holding her hand
And they talked to him with their foreign tongues
About foreign medicine
For a familiar illness.
She smiled knowingly
Closed her eyes
and lay quietly
So pleased he was finally there.

Jade B. Tam

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Class of 2010 at the University of
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mizzou.edu.
Serendipitous discoverers have certain traits in common. They have passionate intensity. They insist on trying to see beyond their own and others’ expectations and resist any pressure that would close off investigation. Successful medical discoverers let nothing stand in their way. They break through, sidestep, or ignore any obstacle or objection to their chosen course, which is simply to follow the evidence wherever it leads. They have no patience with dogma of any kind.

This is the principal message of this splendid book that for me struck a sharp note of déjà vu. Many years ago in conversation with that magnificent intellect Alvin Feinstein, I used almost the same words to describe what I called “the Intellectual Imperative,” but I was speaking of all scientific endeavor and its creative disciples.

Later the author offers this observation, as a qualifying corollary to his principal thesis—and in seeming paradox.

Despite all the examples given, mainstream medical research stubbornly continues to assume that new drugs, and other advances, will follow exclusively from a predetermined research path. Many, in fact will. Others, if history is any indication, will not. They will not come from a committee or a research team but from an individual, a maverick who views the problem with fresh eyes. Serendipity will strike and be seized upon by a well-trained scientist or clinician who also dares to rely on intuition, imagination and creativity.

But this issue is quite complex. The author makes frequent reference to the stultifying atmosphere of most contemporary “organized research” beset with the bureaucratic realities of seeking grant money, pursuing the party-line, team effort at “goal oriented” research, and enduring formidable peer review by referees (often intellectually myopic or hostile). This is the eternal lament about The Establishment with its built-in resistance to new, innovative ideas, especially if they are iconoclastic and challenging to the “prevailing wisdom.” It has almost become a tiresome truism.

In reality, most of the Eureka! moments described in this book came from science-disciplined “plodders” laboring in the vineyards of the establishment, but blessed with the brilliance and virtuosity to recognize the serendipitous thunderbolt when it struck. I believe it takes a disciplined scientific mind to appreciate this grand event. But I am also convinced that there should be research funds dedicated to encourage those rare individuals who come up with the revolutionary idea, quite outside the mainstream, to enable them to pursue their heart’s desire. I feel that medicine has learned enough from the historical contribution of serendipity to allow the occasional brilliant maverick some free rein.

Also, I have always felt (as expressed in Meyers’s earlier statement) that the intellectual imperative of the “iconoclast” will ultimately prevail, and the scientific community, after perhaps initial reluctance—especially if the idea borders on the bizarre—will review the data. If it bears up under steely-eyed scrutiny, it will be embraced. Alas, for each serendipitous Eureka! there are many others that are simply useless, off-the-wall concepts. It is an obligation of The Establishment to assess these as well. And this latter group is often quite vociferous in condemning the perceived stone-walling they encounter from the established scientific discipline. I really don’t believe that very many truly worthy new medical ideas have been sacrificed by this methodology. I will concede some unfortunate delay and much frustration by some worthwhile (even Nobel laureate-quality) innovators, but new concepts must pass rigorous muster; the process isn’t perfect, but it is the best we can do. Perfection is an elusive ideal.

Also I cannot agree with the author that “Eventually, once the breakthrough becomes part of accepted medical wisdom, the insiders will pretend that the outsider was one of them all along.” This is unduly cynical. Most of the “outsiders” were disciplined “insiders” before their great moment. As Pasteur said, “Chance favors only the prepared mind.”

Aside from a rather tiresome repetition of the issues stated above, and too-frequent references to the reluctance of some discoverers to admit the serendipitous nature of their discovery, the book is an absorbing read. Meyers is a wonderful storyteller. He has explored letters, texts, articles, and other materials to provide a series of fascinating anecdotal chapters of medical history that we all know about, superficially. In this exciting book he provides details that were previously unknown to me; they bring the historic events to brilliant, vibrant life.

He begins with infectious diseases and how they unfolded (Leeuwenhoek,
Pasteur, Koch), the contribution of chemistry (Ehrlich), and the remarkable evolution of antibiotics, featuring the work of Domagk, Fleming, Florey, Chain, and many others. He describes the Lætretile hoax, the thalidomide paradox, and devotes many pages to the dramatic 1943 attack on allied shipping at Bari that ultimately led to the identity of nitrogen mustard as a chemotherapeutic agent. The story of prefrontal lobotomy in World War II reads like a novel by the other Fleming. To describe all the characters and events depicted in each of the thirty-nine chapters would not be feasible here. In addition to the historic breakthroughs in cancer chemotherapy, Meyers explores psychotropic drugs, cardiac physiology (the remarkable story of the evolution of the ECG), and much else. Each chapter contains gem-like adventures in medicine.

But I must relate another especially déjà vu moment stimulated by this book. For several pages Meyers relates the unsavory history of prefrontal lobotomy. When I was a third-year medical student, in an effort to pick up some “disposable income,” I worked after class in several private, nonuniversity hospitals doing “menial” tasks: laboratory, surgical assist, cleaning glassware, etc. Thus in 1946, I found myself working in the emergency room of the now-demolished Casualty Hospital in downtown D.C.; we handled most of the trauma and walk-ins in center city. As one of three not-yet-dry-behind-the-ears “externs,” I worked Saturday nights from six to six and was expected to do everything—most often with minimal or no supervision. It was nonstop chaos.

Then I met Dr. Walter Freeman.255 I had heard of him peripherally; he was the “ice-pick lobotomy” doctor, a distinguished professor of Neurology at George Washington. One Saturday evening, he encountered me in the lobby at Casualty and asked if I would be willing to “assist him at surgery” the following morning. He offered to pay me more than I made working twelve hours in the ER. I had no time to read about prefrONTAL lobotomy, but he was a well-known professor! And so I became his head-holder. We did three or four patients in rapid sequence. I was frankly terrified and horrified. On Monday, back in school I walked over to our hospital and spoke to a surgical resident I knew. He chastised me for being so gullible and “stupid.” I retired as a head-holder.

I trust Dr. Meyers will indulge me this bit of reminiscence, but it was provoked by his writing. Happy Accidents should be required (happy) reading for every medical student.

Too Soon to Say Goodbye
Art Buchwald
Random House New York, 2006, 181 pages

Reviewed by Robert H. Moser, MD (ΩΩΩ, Georgetown University, 1969)

In January 2006, when I read that Art Buchwald had died, I felt like I had lost an old friend. I am sure that millions of others felt the same way. Buchwald was a contemporary, and during my time in Washington, D.C., I read his column in the Washington Post with great anticipation. He was the quintessential American humorist. By all estimates he was unique—a gentle political satirist, engagingly self-effacing, never taking himself too seriously. He had a style sparkling with good humor. Reading his light, warm, easy stuff always produced a smile. I never recall any of the acerbic rhetoric and malevolent malice that has come to characterize so much contemporary political satire.

This modest book is a remarkable testimony to Art’s prevailing philosophy of life and an eloquent paean to hospice care. He writes, “The purpose of the hospice is to help you pass away gently when all else fails. You are supposed to do it with as little pain as possible and with dignity. It didn’t work out that way for me. . . . I never realized that dying could be so much fun.”p144–45 The book is remarkably free of political hyperbole; the word “Iraq” does not appear, although the sense of some disenchantment with the current political establishment does manage to creep in.

Buchwald was admitted to hospice when he suffered renal failure, and was advised that without hemodialysis he would probably last just a few weeks. He elected to live out his remaining time in his own fashion. “After surgery [below knee amputation after an arterial occlusion in his right lower leg], I tried dialysis twelve times and decided I didn’t like it. ‘That’s it,’ I said, ‘I don’t see a future in this and I don’t want it any more’ I had discovered the idea of the hospice by then, and I knew I had an alternative.”p145 But he went into an unanticipated partial remission and survived for another five months.

This book was written during this interval; vintage Art Buchwald—part diary, part personal history—laced throughout with humor, yet candid reflections on many of his experiences and incredible coterie of friends—a veritable Who’s Who of American literature, art, theatre, and politics—those who made the pilgrimage to the Washington Home and Hospice to pay homage to their dying friend (albeit later than sooner).

Mulling over these pages, one is obliged to reflect on how medicine has been transformed in the span of life embraced by Art Buchwald (and me). His final personal decision to forego life-prolonging dialysis, over the mild protests of family and friends, might not have been so easy fifty years ago (albeit it was before dialysis, invented in Holland
during the Second World War, had come into widespread use!). When I was a student and house officer, I do not recall any discussions about “shared decision making” or “quality of life.” Success in medicine was measured by simple criteria: prevention of death (mortality) and attenuation of disease (morbidity). I suspect that was due to our sorely limited (often incorrect) information base and so few diagnostic and therapeutic options. We practiced benign paternalism as an accepted way of life. As I recall, the first “controlled trial” was published in about 1950 (streptomycin in tuberculosis). Our “evidence” for evidence-based medicine was strictly empirical, anecdotal, and “what the Herr Professor says.”

The larger issue that permeates these pages, while not addressed directly, is the determination by the patient to take control of his own end-of-life decisions.

When I entered the hospice I was under the impression it would be a two- or three-week stay. But I was wrong. Every day I sit in a beautiful living room where I can have anything I want; I can even send out to McDonald’s for milkshakes and hamburgers. Most people have to watch their diets. No one can believe that I can eat anything I want.97

As eloquently expressed in this book, end-of-life need not be all sadness and darkness. Art briefly discusses his formal will, his living will, and durable power of attorney (mandating careful selection of like-minded-to-the-patient surrogates and totally empathetic physicians), and describes in tongue-in-cheek detail how he envisions his elaborate burial ceremony.

The epilogue consists of light-hearted eulogies (requested pre-mortem by Art) by Tom Brokaw, Mike Wallace, Ben Bradlee, George Stevens, Jr., Ken Starr, Dr. Michael Newman, and the author’s son and daughter, Joel and Jennifer. The words of a song written for Art by Carly Simon, “Too Soon to Say Goodbye,” fill the concluding few pages.

In his final column, published following his death in the Washington Post in January 2007, he wrote:

I know it’s very egocentric to believe that someone is put on Earth for a reason. In my case I like to think I was. And after this column appears in the paper following my passing, I would like to think it will either wind up on a cereal box top or be repeated every Thanksgiving Day.

So, “What’s it all about, Alfie?” is my way of saying goodbye.9

Not a bad way to go!

Reference

Dr. Moser is executive vice president emeritus of the American College of Physicians. He is retired. He is a member of the editorial board of The Pharos, and a frequent contributor to the journal. His address is:

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Green Valley, Arizona 85614
E-mail: rhmoser@earthlink.net

Exposed, and in white I collect their stories with a new tongue, solicit pentameter to create poems that might immortalize a moment.

I arrived here uneasily but claim these clumsy words now, aware that in the pocket of my clean white coat there is room for a new anthology.

Hilarie Tomasiewicz

Ms. Tomasiewicz is an MD/PhD candidate in the Class of 2012 at Mount Sinai School of Medicine. This poem won first prize in the 2007 Pharos Poetry Competition. Ms. Tomasiewicz’s address is: 50 E. 98th Street, Apt. 9D3, New York, New York 10029. E-mail: hilariet@gmail.com.
A doctor’s a person, some short and some tall,
Some have brown hair or blonde hair or no hair at all.
Some are black, some are white, some are Vietnamese,
Some allergic to nuts, some intolerant of cheese.
Some doctors are nice and some doctors are mean,
And a whole bunch of doctors are right in between.
But stereotypes do exist, and I’m not an apologist—
There’s a distinct type of person for each type of -ologist.
Orthopods are jocks, and nephrologists nerds,
GI guys are for some reason interested in turds.
Endocrinologists are very cerebral, OB-GYNs, enough attitude to fill a cathedral.

Psychiatrists have issues, and write really long notes.
Dermatologists like sunscreen and buy really fast boats.
Radiologists and pathologists are an interesting bunch,
They either don’t like windows or patients too much.
Pediatricians are kooky, but patient and warm.
ER docs are crazy, but serene in a storm.
Surgeons are pompous, but talented, too.
So, you medical students, which stereotype are you?

Daniel Shumer
2007 Alpha Omega Alpha
Robert J. Glaser Distinguished Teacher Awards

Each year since 1988, Alpha Omega Alpha, in cooperation with the Association of American Medical Colleges, presents four faculty members in American medical schools with the AΩA Distinguished Teacher Award. In 1997, AΩA named the award to honor its retiring executive secretary Robert J. Glaser, MD. Nominations for the award are submitted to the AAMC each spring by the deans of medical schools.

Nominations were reviewed by a committee chosen by AΩA and the AAMC. This year’s committee members were: Andrew L. Chesson, MD; Arthur F. Dalley, II, PhD; Richard D. deShazo, MD; Steven L. Galetta, MD; Joel Felner, MD; Charles H. Griffith, MD, MSPH; Virginia M. Miller, PhD; Louis N. Pangaro, MD, FACP; Gary O. Rankin, PhD; Jeff M. Sands, MD; Steven Spitalnik, MD; Michael Vergare, MD; Robert T. Watson, MD; Jeffrey G. Wiese, MD.

Winners of the award receive $10,000, their schools receive $2,500, and active AΩA chapters at those schools receive $1,000. Schools nominating candidates for the award receive a plaque with the name of the nominee.

Brief summaries of the accomplishments in medical education of the 2007 award recipients follow.

Edward D. Harris, Jr., MD
Executive Secretary

Robert M. Klein, MD
Associate Dean for Professional Development and Faculty Affairs, and Professor of Anatomy and Cell Biology, University of Kansas Medical Center School of Medicine

Dr. Klein earned both a MS and PhD (1974) at New York University, and did postdoctoral work at the Medical College of Wisconsin and NYU. After joining the faculty at the University of Kansas as an assistant professor he has been an active advisor of PhD and MA students, and since 1979 he has been advisor to fourteen medical and undergraduate students. He has served as course director of four basic science courses at the medical school as well being a member of twenty-three doctoral dissertation and twenty-four PhD preliminary examination committees, as well as serving on more than forty-five additional committees at UKMS. His research activities have focused on autonomic nervous system effects upon blood vessels and cell lines, and more recently, genetic and molecular studies of neuronal degeneration, particularly during aging.

Dr. Klein has been awarded seventeen Student Voice awards, and he is the only faculty member to have been recognized twice with a Kemper Teaching Fellowship. His teaching books in anatomy, histology, and cell biology have been used by multiple medical centers in this and other countries.

Dr. Klein enjoys and has been extremely successful with innovative approaches to the integration of clinical and basic knowledge for medical students, a number of which have been converted to useful peer-reviewed publications. In a wonderful example of a turnaround, one of his students wrote, “I thought I would hate his course, but Klein’s enthusiasm and energy made me learn and enjoy mastering the material.”

John (Jack) Nolte, PhD
Professor of Cell Biology and Anatomy, University of Arizona College of Medicine

Dr. Nolte earned his PhD at the Massachusetts Institute of Technology in 1971 with a thesis investigating electrophysiology of brain nuclei of the horseshoe crab. After two years of postdoctoral work at the University of Colorado he joined the faculty there and remained for sixteen years, moving as a full professor to the University of Arizona in 1990. After receiving numerous teaching awards at Colorado, including the honor of being asked to give the commencement address in his last month on the faculty, he has received several awards for innovative creativity in teaching. The first-year class at the University of Arizona selected Nolte to receive the Basic Science Educator of the Year in 1996, 1997, and 1999. In 2000 he received the Basic Science Educator of the Year Lifetime Award. Graduating classes awarded him Basic Science Educator of the Year seven
times. His six publications in the field of neuroscience include a survey of human neuroanatomy titled Stalking the Wild Asparagus. He uses technology in teaching, producing fifty-one videotapes on neurologic syndromes, several videodiscs, a CD-ROM (Electronic Image Collection to Accompany the Human Brain) and twenty-five interactive computer programs for medical students. The Human Brain, best known of his books and now in a sixth edition, has been used in neuroscience courses in this and other countries for twenty years and has been translated into three other languages.

"Put simply," wrote the dean, "Dr. Nolte is our finest classroom teacher." At the University of Colorado he was the first to introduce problem-based learning, the first to implement college-wide faculty development programs, and was instrumental in developing student support services. His positive indirect influences upon his colleagues has led to a generalized scholarly approach to instructional activities throughout the College of Medicine.

Richard M. Schwartzstein, MD
Faculty Associate Dean for Medical Education and Associate Professor of Medicine, Harvard Medical School; Executive Director, Shapiro Institute for Education and Research at Beth Israel Deaconess Medical Center; and Vice President for Education at Beth Israel Deaconess Medical Center

After earning his MD at Harvard Medical School, Dr. Schwartzstein was intern through Chief Resident in Medicine (1983–84) at the Beth Israel Hospital. He served as Medical Director of the Emergency Unit and Director of Advanced Life Support System at Beth Israel, and from 1998 to 2005 he was Clinical Director of the division of Pulmonary and Critical Care Medicine there. In 2000 he was a Rabkin Fellow at the Carl J. Shapiro Institute for Education and Research at Harvard and in 2005 he joined the Harvard-Macy Institute program for leaders in medical education. From 1993 to 2006 he was nominated for the Harvard Medical School prize for Excellence in Teaching (years 1 and 2). He won the S. Robert Stone Teaching Award at Harvard in 2002. From 1998 to the present he has received thirteen teaching awards at Harvard, including the Robert C. Moellering, MD, Award for recognition of excellence in teaching, research, and clinical care at the Beth Israel hospital, and the Clinical Educator Award of the American Thoracic Society.

Dr. Schwartzstein directed the integrated physiology course for first-year Harvard students. He and Michael Parker received the 2006 Frank Netter Award for Special Contributions to Medical Education for their computer-based text on respiratory physiology. Since 2001 he has directed graduate medical education at Harvard. In 2003/2004 he directed a strategic review of the educational mission at Beth Israel. He continues to teach Harvard students as course director of the Integrated Human Physiology. He has also been involved in educational ventures of the American Thoracic Society.

His dean writes, "Over the past ten years Dr. Schwartzstein has set a new standard for teaching at Harvard." His excellence in teaching is in both basic and clinical arenas, and plays a major role in curriculum reform at Harvard. As director of the Shapiro Institute for Education, he has led (in collaboration with AAMC) national conferences addressing issues in medical education. His dean concludes, "In summary, Dr. Schwartzstein is the consummate teacher. He has an uncanny ability to transform complex concepts into principles that become intuitive to the learner. He provides a framework for what otherwise seem like isolated facts. He takes his students on a wonderful journey from 'knowing' to 'understanding.'"

James Sebastian, MD
Professor of General Internal Medicine, Medical College of Wisconsin

After receiving his MD at Indiana University, Dr. Sebastian was an intern through chief resident in Medicine (1982–83) at the Medical College of Wisconsin, and subsequently, a fellow in cardiovascular medicine. He joined the faculty in 1982 and was promoted to professor in 1999. Since 1990 he has been the director of the Department of Medicine student teaching programs and director of the medicine subinternship program. From 1994 to 2003 he directed the M2 Introduction to Clinical Examination course. Between 1988 and 2006 Dr. Sebastian has received twelve teaching awards in the department of Medicine. In 1992 he received the Edward J. Lennon Endowed Clinical Teaching Award at MCW established to honor a junior faculty who is recognized as a superb teacher and a "clinician's clinician." In both 2002 and 2006 he received the Ernest O. Henschel Clinical Teaching Award for the outstanding teacher on the clinical faculty by vote of senior medical students. In 2006 he received both the Distinguished Service Award at MCW and the Standing Ovation Award and Certificate of Recognition from the MCW Student Assembly.

In a major accomplishment, Dr. Sebastian was awarded a four-year grant as co-project director to build educational capacity through faculty development from the Advancing a Healthier Wisconsin Program Development Fund. This supplements the thirteen separate grants to enhance educational programs at MCW that he has received since 1991. The majority of his twenty-four peer-reviewed papers are focused on educational efforts, hypotheses, and projects.

Dr. Sebastian was elected by the Class of 1992 to Alpha Omega Alpha, and is currently the chapter councilor.

His dean's nominating letter says, "Jim is the consummate role model for our developing physicians, demonstrating compassion for patients and a curiosity about health and disease on a daily basis. . . . He makes certain that our physicians in training understand how basic science concepts and the clinical world of medicine interact to guide the care of patients. . . . Blending humor and pedagogical principles, Jim identifies the key issues and gently leads his colleagues towards change."
Re “Consumer-driven health care”

Marshall Kapp’s article in the Spring 2007 issue (pp. 12–15) strongly advocates a failed utopian economic ideal as the solution to medicine’s current problems. Consumer-driven health care is the most recent snake-oil nostrum of the “free market” people. The serious shortcomings of free market ideology have become increasingly obvious over the past twenty-five years. Complexity, huge unnecessary administrative expense, and health care fraud on a previously unimaginable scale have characterized the free market approach. The Canadian John Ralston Saul has dissected the idiocy of multiple repetitions of a failed idea while expecting different results. The conclusion section of the article has a badgering and hectoring tone common to many of the free market people, with the injection of the fear factor and denigration of anyone who might have other ideas (implied dumb, slow, or misinformed). Yes, the boogie man appears at the end: socialized medicine. Probably at least fifty percent of U.S. physicians now favor a single payer system much like an updated Medicare. Patients’ care and well-being should be at the center of our medical system, not some abstract and failed idea.

Robert J. McElroy, MD
(AΩA, Indiana University, 1965)
Empire, Michigan

Meeting Holly Smith, through two generations of his disciples

Marvin Sleisenger’s beautiful account of Holly Smith’s extraordinary career (Spring 2007, pp. 32–39) reintroduced me to an iconic figure, one I had at one time almost known for real but for an antigen. In 1970, the biochemist Gordon Tomkins invited me to interview for an assistant professor position at UCSF, in the newly formed Department of Biochemistry and Biophysics. After receiving his MD from Harvard, Tomkins had rapidly become a world-renowned enzymologist during his years at the NIH. In the first minutes of my interview, without me even raising the question, he volunteered his reason for leaving NIH for UCSF. He said, “You want to be at a place where the dean is smarter than you are.” He continued, “Holly Smith came out here and it has changed everything.”

As my interview day continued, all I could think about was this man Smith, whose name had been mentioned in such glowing terms (his—unlike mine, a name instantly remembered), whose talent not only was remaking UCSF, but had magnetized the attraction of such a brilliant star as Tomkins. But after lunch I became ill and was admitted to the Moffett

Colonel Harold W. Glascock (deceased), a Regular Army physician, commanded the 11th Evacuation Hospital, Wonju, Korea, in 1951 during the Korean War. When Holly Smith proposed dialysis treatment for acute renal failure complicating extensive battle injuries, Colonel Glascock made the request through usual Army channels within the Far East Command. As I recall, this initial request was denied.

The colonel then issued orders, on his own local authority, directing that Holly proceed to Washington, procure the Kolff artificial kidney then at Walter Reed Hospital, and bring it back to Wonju together with all needed chemicals, tubing, and other supplies. Surely, the “liberation” of all that equipment required the intelligence, energy, and diplomacy which make Holly Smith the force of nature described by Marvin Sleisenger in the Spring 2007 Pharos (pp. 32–39).

While Holly was away on his mission, Colonel Glascock ordered the construction of a small building, with its own electric generator, to house the dialysis unit. Holly’s project was eminently successful. The 11th Evac became the Army’s renal/dialysis center in the Far East—the first place dialysis had ever been used in a wartime military setting.

Colonel Glascock, probably because he issued orders outside the chain of command, was passed over for promotion to brigadier general, and had to resign his commission in the regular Army. He thus lost his chance to become Surgeon General, which had been his lifetime ambition. However, in exchange, he mightily helped to establish, in a combat zone, a dialysis service that saved hundreds of lives.

I’m certain the colonel considered it a good swap.

Colonel Harold Glascock, Photo courtesy of Dr. Hoffman

Holly Smith performing first dialysis in Korea, 1952. Photo courtesy of Dr. Hoffman.
Hospital emergency room. I had been so busy talking with the faculty during lunch (talking too much is among my many flaws) that I hadn't noticed the sliced almonds in my sandwich. I have a severe nut allergy. Tomkins took me to the ER and was suddenly cast as a physician, conferring with the staff on my status (which was not life-threatening, though, very touchingly, Gordon thought it might be) and demanding that all the top medical people come and make sure I was okay. And during the afternoon and evening, several of the postdocs in his lab came to look in on me. Like Tomkins, they too were MDs, and the job candidate had become a somewhat interesting case for observation. And like Tomkins, they also had impeccable bedside manners. Of course, they were training descendants of Holly Smith.

Years later I realized that Holly Smith had known Tomkins as a brilliant Harvard medical student and had recruited him to UCSF from the NIH. Thus, in that Moffett Hospital ER bed, I was seen not only by someone mentored by Smith, but as well by some of his “academic grandchildren”—Tomkins’s postdocs. Marvin Sleisenger’s article evoked these memories, and while I regret not knowing Holly Smith personally, I now feel I do know him, through his disciples.

I have, as an amateur historian, looked a bit into the origins of America’s greatest institutions of science and medicine. There can be no doubt that Holly Smith was the key catalyst for the extraordinary institution UCSF became. How good that he has lived to see it, and how good of Marvin Sleisenger’s article evoked these memories, and while I regret not knowing Holly Smith personally, I now feel I do know him, through his disciples.

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An essay award prize winner writes

I was awarded the second place prize for the 2007 Helen H. Glaser Student Essay competition (see page 4). I want to tell you about the project that I partly funded with the award money.

I am studying urban interpersonal violence as it relates to women. I spend nights in the emergency room Level 1 trauma center in Cincinnati. During the day I study nine years worth of data from the Trauma Center registry and the coroners office. I am pulling together a compelling story of violence in the city as it affects women. My focus is on the narratives of assaults and determining whether the assaults are domestic violence related, drug related, “innocent bystander,” community violence related, or some combination. I am digging into the psychosocial cause and risk factors for exposure to firearm and stabbing injuries. I have found some surprising results.

I am presenting this work at an international conference in Ghana in August, and then spending time in an emergency room in a city in Accra, Ghana.

Heather Finlay-Morreale
Cincinnati, Ohio

Carlos Chagas

I read with great interest Dr. Natalie McCarter Bowman’s short article published in the Spring 2007 issue (pp. 24–29) on Professor Carlos Chagas and the disease he discovered that was appropriately named after him.

It was my honor to have known and worked with his son, Dr. Carlos Chagas, when he was president of the Pontifical Academy of Sciences (PAS) at the Vatican in Rome. At the time he was also serving as the director of the Neuroscience Institute in Rio de Janeiro, Brazil. Dr. Chagas was highly instrumental during his presidency at the PAS in arranging for many of the major bioethical issues that have arisen in contemporary medical research and practice to be considered and discussed by the membership of the PAS (for example, brain death and in vitro fertilization).

To a very large extent, all of this was accomplished when he agreed to form a special subcommittee to deal exclusively with moral and ethical issues that were continuing to arrive within human biology. Following papal approval, this group was named the Advisory Commission on Biotechnology Applied to Man, and placed under the jurisdiction of the PAS. This all grew out of a number of discussions on bioethical issues that I had discussed with Pope Paul VI and Pope John Paul II. On one occasion with John Paul II, I suggested to him that perhaps the Vatican should have its own bioethical committee. He vigorously agreed and requested that I prepare a position paper on the subject. I was asked to return to the Vatican to present the document a year following the assassination attempt on him. The position paper was then sent to the PAS to become the basis for the formation of this historic committee.

I will always be beholden to Dr. Chagas, for it was through his efforts that I became a member of the PAS. Professor Chagas’s son became a distinguished physician and scientist in his own right, although he never gained the worldwide reputation his father did. Nevertheless, his impact on world health through the auspices of the PAS has truly been outstanding.

Robert J. White, MD, PhD
(AQA, Harvard Medical School, 1953)
Cleveland, Ohio

Re “Gout, an American Revolutionary War Statesman, and the Tower of London”

It was a pleasure reading Dr. Martin Duke’s well-written article in the Spring 2007 issue (pp. 42–47). Two of the items in the title immediately brought to mind Sir William
S. Gilbert, the librettist of the enduring Gilbert and Sullivan operas.

In her authoritative text on Gilbert’s life, Jane Stedman details the many times the famous man suffered from gout, and how it affected his work output, lifestyle, and relationships.\(^1\) Gilbert himself inserted the following lines into the Grand Inquisitor’s first act song in *The Gondoliers*, which explains why there is some uncertainty about who is the King of Barataria. It seems that the father-guardian of the two boys, one of whom is the king, cannot help to solve the riddle because he is dead.

A taste for drink, combined with gout,
Has doubled him up forever!
Of that there is no matter of doubt,
No probable, possible shadow of doubt,
No possible doubt whatever!

The reference to the Tower of London is the subject of the single Savoy opera that both Gilbert and Sullivan, who frequently had differences, agreed was their best. This was *Yeoman of the Guard*, the most serious of all the operas, both in text and music, which unfortunately never reached the popularity of *H.M.S. Pinafore*, *The Pirates of Penzance*, and *The Mikado*.

Reference


Christopher M. Papa, MD

(AΩA, UMDNJ—New Jersey Medical College, 1986)

Colts Neck, New Jersey

**Re “Well, death’s been here for a long time”**

Thank you for your thoughtful commentary (Spring 2007, p. 1) on compassion and its role in the six competencies of the Accreditation Council for Graduate Medical Education (ACGME). The American Board of Medical Specialties (ABMS) supports your opinion and requires the same six competencies as part of its Maintenance of Certification Process.

Maintenance of Certification ensures that these competencies and professional qualities, such as compassion, are not only learned by residents and students, but also reinforced and practiced by physicians with years of experience. Thus, the competencies deemed necessary for students and residents are equally necessary for those in the practice of medicine. Concern for the emotional needs of patients is as important to the practicing physician as it is to the student of medicine.

ABMS Member Board certification has always been widely recognized as the gold standard for specialty physicians. As research and technology continue to advance medicine, ABMS will continue to set high standards for doctors who choose to specialize, and for patients who deserve to be treated by the most highly skilled professionals, who are also caring and compassionate.

Stephen H. Miller, MD, MPH

(AΩA, University of California, Los Angeles, 1964)

President and CEO, American Board of Medical Specialties

Evanston, Illinois

**Re “An epiphany—requisite for all physicians”**

Regarding your editorial in the Summer 2007 issue (p. 1), Ms. Vashi’s touching description of her epiphany and your expansion of the idea that the truly compassionate physician should “form deep associations with and commitment to, her patients” caused me to wonder why so few doctors disclose their home telephone numbers to their patients. The security and comfort they and their families derive from this knowledge establish a valuable bond which can solve many problems. I perhaps can understand why movie stars and other entertainers would want to cut themselves off from the hoi polloi, but physicians and house officers insulating themselves from their patients doesn’t seem ethical or sensible.

When I started practice in 1960 I put my home phone number on my business card and made sure it was also in the phone book. I have never regretted it and very few patients abused the privilege. In fact, I know that over the years I have avoided several medical disasters and lawsuits by early direct communication in the middle of the night.

It is easy to mouth platitudes about compassion and caring, but all patients know all their friends’ home or cellphone numbers; I like my patients to consider me one of their friends as well as their doctor.

Louis R. M. Del Guercio, MD, FACS

(AΩA, New York Medical College, 1982)

Larchmont, New York

Many compelling subjects have been presented over the years in *The Pharos*. None have been more important than your editorial, “An epiphany—requisite for all physicians,” and the accompanying letters in this summer’s issue. I have been a member of AΩA since my graduation from medical school in 1978 and have had the enjoyment of twenty-nine years of *The Pharos*.

This is my request: I would like to ask your permission (or the editorial office to grant permission) to reproduce your editorial for my faculty (>275 pediatric faculty), house staff (>100) and pediatric subspecialty fellows (35 to 40) as well as the associated letters.

Thank you for your consideration and know that many of us appreciate your important work.
Re “The faculty dining room”
Can you explain to me why only men appear in the illustration for “The faculty dining room” (Summer 2007, pp. 36–37)?
Oh, well. I guess I should be grateful that there wasn’t a concurrent story bemoaning the supposedly inexplicable dearth of women in academic medicine.

Kathryn O’Connell, MD, PhD
(AΩA, Emory University, 1984)
Sykesville, Maryland

Dr. Harris responds to Dr. O’Connell
When Charlie Plotz was in that doctors’ dining room in 1954, it is sad but true that there were no women there. The sad thing is that in recent years there are no doctors’ dining rooms in many hospitals for either sex!
Edward D. Harris, Jr., MD
Editor

Dr. O’Connell responds to Dr. Harris
It strikes me as fortunate indeed that Dr. Plotz was able to share the dining room with what appears to be a male of color on the 1954 day depicted in this illustration.
The cartoon illustration in question was not a historical archive photograph. If the point of the 2007 story was the value of doctor dining rooms in fostering community of physicians, then the accompanying cartoon needed to reflect the welcomed diners of the twenty-first century, women included.
Kathryn O’Connell, MD

Dr. Plotz responds to Dr. O’Connell and Dr. Harris
Dr. O’Connell and Dr. Harris are both right. Times have changed—and for the better. There were four women and one hundred men in my graduating class from medical school. Of eight PGY-1s in my group at New Haven Hospital, there was only one woman.
During the twenty or so years I served as faculty advisor to AΩA at Downstate there was a steady increase in the number of women making AΩA, and they currently seem to be outnumbering in percentage their male counterparts. When I became a department chairman, I appointed the two best-qualified people I could find as my deputies. As it happens, one was a black male and the other a Latina female. The current and extremely capable chair of my department is female.

So, Dr. O’Connell, real life is amply proving what mere illustrations cannot!
Charles Plotz, MD
(AΩA, Downstate Medical Center, 1968)
Brooklyn, New York

Re “Paralysis Nose Spray”
Dr. Peter Dans’s review of 1930s movies and his commentary on the use of nasal spray in an attempt to prevent polio-myelitis struck a memory note with me.
In the 1930s, I was in elementary school and students in our class subscribed to My Weekly Reader, a publication for children containing news and features. I distinctly remember an article about joining the “Yellow Nose Club,” which advocated spraying the nose to prevent polio. Because it turned the inside of the nose yellow, they were probably using picric acid, as mentioned by Dr. Dans.

Frank B. Norbury, MD
(AΩA, Washington University School of Medicine, 1948)
Jacksonville, Illinois

Dear Peter [Dans],
As a regular reader of your movie columns in The Pharos, I was especially pleased by your research into the practice of nasal sprays to block polio transmission.
About 1937 I was a sophomore at a prep school in Connecticut. The school physician, also our family physician, decided to spray all the students because of a polio scare. I have always thought he used a tannic solution, and the length of the atomizer tube remains memorable. While not one of Ted Harris’s epiphanies for me, Dr. Pratt, knowing that even then I wanted to become a physician, when the tube was well past a turbinate, smiled and asked whether I was sure. I was.
Your eclectic reviews are wonderful successors to those of my Portland friend, Ralph Crawshaw.

John A. Benson, Jr., MD, MACP
(AΩA, Oregon Health & Science University, 1968)
Omaha, Nebraska

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Kids who live by the railroad track
Live a life that dates way back.
It’s "kill or be killed, eat or be eaten,"
Or they might escape with just being beaten.

Oh, yes, it’s mean, it’s rough, and it’s tough,
But their daily existence is filled with that stuff.
Their elders faced reality long, long ago—
They “will never succeed” and this they know.

So they look for warmth, shelter, and food,
Sometimes a joint, cigarettes, or booze.
Perhaps to forget their unfulfilled dreams,
But also to stifle the urge to scream.

Dennis Devereux, MD

Encourage Their Children

Dr. Devereux (A.O.A, Robert Wood Johnson Medical School, 1986) practices general surgery at FirstHealth of the Carolinas. His address is: 522 Allen Street, Suite 202, Troy, North Carolina 27301. E-mail: dfdev@aol.com.
Medical Student Service Project Award, The Chicago Medical School at Rosalind Franklin University—Health care: A right that must be shared by all

Everyone should have access to health care. Countries like Australia, France, Denmark, and the Netherlands provide universal health care to all their citizens regardless of their ability to pay.¹ Sweden takes care of all residents regardless of nationality. In the Netherlands, individuals who fall below the statutory income ceiling (EUR 30,700) are insured under the Sickness Fund Act. France has the highest insurance rates of any European country, but more than ninety-six percent of the population is insured by one of three available insurance schemes. Interestingly, France has been able to achieve such high percentages by placing taxes on the yearly revenue of the pharmaceutical, tobacco, and alcoholic beverage industries.

In contrast, the U.S. Census Bureau estimated the number of uninsured in the United States in 2005 as approximately 44.8 million, more than fifteen percent of the population.² A steady ten percent per year increase in health care costs since the 1960s means that those in lower brackets have become increasingly uninsured.³,⁴ While only six percent of families with income above $75,000 per year are uninsured, almost thirty-five percent of families with income below $10,000 per year have no medical insurance.⁵

Health care polls conducted by the Wall Street Journal in 2003 revealed that more than sixty percent of the 2,078 adults interviewed were projected to go without prescription medications and health care based on the steady rise in health care expenditure.⁶ Given a choice between getting medical insurance or receiving a pay increase, more than sixty percent of the 2,299 interviewed subjects reported that, in light of rising health care costs, they would forego a pay increase to maintain their current health insurance benefits.⁷

Ethnic minorities and foreign nationals constitute the largest demographic division within the uninsured.³ They are three times as likely as white U.S. citizens to be uninsured because they typically have low-wage jobs without insurance.⁸ Since 1996, all legal immigrants have been barred during the first five years of their residency from enrolling in Medicaid and State Children Health Insurance Program (SCHIP), adding to the discrepancies noted between immigrants and natives.⁹

Interestingly, a recent study done at the University of Southern California refuted the widespread belief that immigrants constitute a large financial burden on the U.S. health care system.¹⁰ Expenditures for immigrants were shown to be fifty-five percent lower than those for non-immigrants. Similarly, expenditures for uninsured and publicly insured immigrants were shown to be twofold lower than for U.S. citizens. However, expenditures for emergency department usage were more than three times higher for immigrant children than U.S.-born children despite a lower frequency of visits, implying that a lack of adequate comprehensive health care for immigrants results in a growing proportion who seek help only when symptoms reach an emergent point.

The New Life Volunteering Society (NLVS) free health clinic

In 2003, through the combined efforts of medical students from five medical schools in the Chicago area, the New Life Volunteering Society (NLVS), a secular not-for-profit organization started in the University of Illinois at Chicago in 1999, pioneered a new project aimed at fulfilling the need for adequate health care for the uninsured. With the support of the Indian American Medical Association Charitable Foundation (IAMACF), NLVS opened a free health clinic in West Ridge, Chicago, an area in which a third of the population lives below the poverty level. As an entirely student-organized endeavor, the NLVS free health clinic serves as a unique collaboration between students from Loyola University, Northwestern University, Rosalind Franklin University, Rush Medical College, and the University of Illinois at Chicago. Funding is provided through both intra-school and inter-school fundraiser events, including membership dues collection, T-shirts sales, silent auctions, date auctions, and social mixers. Grants are sought for various events, including the Alpha Omega Alpha Medical Student Service Project Award, to fund the Second Annual NLVS Health Fair, and scholarships from Better World Books to fund the Annual Books for Africa Drives at each school, while the IAMACF helps to pay for medications. The NLVS free clinic is the first step in consolidating the efforts of student bodies from different schools in the joint struggle against poverty in Chicago.

Clinics are held on Saturdays and Sundays from 10:00 AM to 2:00 PM, and are staffed by volunteer attending physicians, nurses, phlebotomists, pharmacists, health educators, translators, and medical students. While Saturday clinics are organized, run, and staffed primarily by NLVS medical students, Sunday clinics are run primarily by IAMACF volunteer physicians. On average, twenty-five

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to thirty patients are seen each session. Patients are predominantly South Asians between the ages of eighteen and sixty-five years. The clinic provides the following services: routine blood tests (complete blood count, basic and comprehensive metabolic panels, fasting lipid profile, hemoglobin A1C, thyroid function test, and liver function test), urinalysis, 12-lead EKG, and general physical exams. Monthly cardiology and dermatology clinics were recently added. X-rays and ultrasound are offered through collaboration with Swedish Covenant Hospital. The clinic also provides some free medications to treat allergies, infections, diabetes, hypertension, hypothyroidism, urinary tract infections, joint pain, gastritis, GERD, and dyslipidemias. Patients requiring further medical attention are referred to the Cook County Bureau of Health Services, which offers free health care to all residents. With over 2500 visits to date, NLVS plays a proactive role in the care of its uninsured patient population.

The Second Annual NLVS Health Fair

NLVS has striven to diversify and expand its patient population since its inception by organizing annual health fairs in different communities of Chicago. On January 27, 2007, we hosted the Second Annual NLVS Health Fair, with four goals:
1. Screening for chronic diseases such as diabetes and hypertension
2. Education for a high-risk population of poor Caucasians, Hispanic Americans, African Americans, and South Asians on the benefits of proper diet and exercise in the prevention of chronic disease
3. Identification of patients without insurance who need a primary care facility for health care management
4. Education of medical students on proper history-taking, obtaining vital signs, and identifying and managing patients at high-risk for developing chronic diseases.

The health fair consisted of five stations manned by teams of medical students: registration, vitals I (blood pressure and temperature), vitals II (heart rate and respiratory rate), blood sugar, and physician consultation and patient education. During registration, participants were assessed for their risk factors of developing hypertension, diabetes, and hyperlipidemia based on medical, family, social, and substance-abuse histories. Blood pressure, temperature, heart rate, respiratory rate, and blood sugar were checked and recorded during the patients’ visits to the next three stations. Finally, a physician, assisted by fourth-year medical students, discussed the results of tests, placing specific emphasis on prevention of chronic cardiovascular diseases through proper diet and exercise. Participants identified for further treatment were referred to our free clinic (if they lacked health insurance) or to their primary care physicians. All volunteer participants were given a copy of their test results and a concrete plan for management of their health. Before leaving, they were requested to fill out a survey assessing their satisfaction with the fair and the effectiveness of our educational approach in helping them with managing their health.

Results of our study

Over a three-hour period, we screened fifty-one patients, thirty-four women and seventeen men between the ages of nineteen and eighty-five. Approximately sixty percent had health insurance, and within this group, almost sixty percent had seen their primary care physicians in the last twelve months. We also identified twenty patients without insurance who qualified for free health care follow-ups at the NLVS health clinic. Most had not seen a physician within the last twelve months. All participants were extremely satisfied with the caliber and quality of the services and education provided by the health fair.

In assessing the potential for future health abnormalities, two risk factors, systolic blood pressure and random blood sugar, were recorded and analyzed. Approximately sixty-four percent of insured participant volunteers presented with systolic blood pressure greater than 120 mmHg, while fifty-five percent of uninsured participants
did so. Forty-eight percent of insured and thirty-five percent of uninsured patients were prehypertensive (121 to 139 mm Hg), while fifteen to twenty percent qualified as stage I hypertension and fewer than ten percent had stage II hypertension. Because these figures represent singular, random measurements of blood pressure, diagnoses were not made, nor were inferences about causation constructed. Volunteer participants with higher blood pressure readings were strongly advised to follow-up for management of their blood pressures either with their primary care providers or at the NLVS health clinic. Ninety percent of participants had blood sugar less than 200 mg/dL and hence did not meet criteria for intervention. Nevertheless, these individuals were educated on the benefits of diet and exercise in controlling blood sugar levels and preventing insulin resistance. The remaining ten percent uninsured with measurements above 200 mg/dL were immediately referred to the NLVS free health clinic for management of their hyperglycemia.

The effectiveness of the health fair
All patients received a plan for management of their health. We identified twenty patients lacking insurance who needed basic, regular health care. They were referred to the NLVS free health clinic for follow-up. The health fair was judged effective in addressing patients’ health concerns, in educating patients about risk factors, and in establishing concrete plans for follow-up management for their conditions. The medical students thoroughly enjoyed interacting with patients and providing necessary health screening tools, while learning how to appropriately use and assess the results of these tools.

To find out how you can get involved, contact sidharth.mahapatra@rfums.org. For more information on NLVS, visit www.nlvs.org.

References

Sheena Maharaj
Class of 2009, Rosalind Franklin University of Medicine and Science

Sidharth Mahapatra
Class of 2009, MD/PhD program, Rosalind Franklin University of Medicine and Science
Chicago, Illinois
We talk about mortgages now, instead of cleaning your plate.
Stock tips and management discussions, instead of how to hold a bat.

We discuss the existing evidence
Whether a treatment plan might work.
And we share the lessons of parenting,
Rather than how to tie a tie.

You call me from airports far away,
Instead from your friend’s next door.
I speak with you like friend to friend,
And find myself listening to your advice.

You question if you should buy or lease,
Rather than be home by eleven.
You dry the tears of your children’s frustrations,
As you fight to hold back your own.

I still want to comfort you
Just like when you skinned your knee.
I feel hollowed by your struggles,
As you search for answers I never found.

There will be a moment
When you will take my place.
Worrying more about me,
Than I will be able to worry about you.

Steven F. Isenberg, MD

Dr. Isenberg is assistant professor of Otolaryngology—Head and Neck Surgery at Indiana University School of Medicine. His address is: 1400 North Ritter Avenue, Suite 221, Indianapolis, Indiana 46219. E-mail: sisenberg@good4docs.com.
I remember it clearly even today
The shouting, the screaming, the soldiers
retreating
Brilliant and explosive shone the night sky
Just one quick glance up, I often wonder
why
So fiercely it hit, like the pounce of a tiger
So quickly I fell, not much of a fighter
Back to black I recall now
But no lights, no fireworks somehow
Like the flash of a camera so suddenly
The horrible war stole my eyes from me

My Own Two Eyes

I remember it clearly even today
As I hold my child, a boy, they say!
His smell so pure it intoxicates
His touch so soft it debilitates
I dream of the day, the light that went
The years of darkness, how many I’ve spent!
But all is different as I touch his face
The darkness has flown, only sunshine
pervades
Like nascent flowers on a spring afternoon
My life has begun, started anew

Clutching him close and lifting him high
Promises that he shall never cry
And in that moment it occurs to me
I’ve lost my eyes and can finally see

Madhu Iyengar

Mr. Iyengar is a member of the Class of 2010
at the University of Kansas School of Medicine.
This poem won an honorable mention in the
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Erica Aitken. Photo courtesy Liam Ruderman