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Circulation information: The Pharos is sent to all dues-paying members of Alpha Omega Alpha at no additional cost. All correspondence relating to circulation should be directed to Ms. Mara Celebi, Webmaster, 525 Middlefield Road, Suite 130, Menlo Park, California 94025. E-mail: m.celebi@alphaomegaalpha.org

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By focusing on the cost of delivering health care as a percentage of the gross national product of the United States and lamenting this large dollar number, economists and politicians ignore an important reality: Americans expect the most advanced and effective diagnosis and therapies for disease, no matter the cost. This is not a national weakness, but a consequence of our cultural evolution. If we accept this, our focus turns from lamenting our plight to devising a national health system that provides services to all citizens. The remaining challenge then becomes paying for health care while controlling excesses.

How did Americans come to expect only the most advanced and complete system of health care? Part of the answer could be our obsession with "fighting" disease.

At a recent Institute of Medicine conference, "Ending the War Metaphor," the medical war metaphor (e.g., against cancer, bacteria, etc.) was shown to be a sustained by-product of World War II in the United States. Barron Lerner pointed out that this war metaphor in medicine is a product of and a component of our culture, but does not exist in other countries. When we develop cancer, for example, Americans fight—we want as much surgery, as much radiation, as much chemotherapy as possible. Because of this, Americans are unlikely to ever accept less than the most advanced medical care. Despite cogent arguments, the case for arbitrary rationing of medical care has gained little traction in the United States. Quite the opposite. Look at recent examples of the standard of care:

- Zevalin and Bexxar, new radioimmunotherapy anticancer drugs, at the cost of $25,000 per treatment
- Hypothermia for survivors of cardiac arrest, administered at great expense to prevent apoptosis in re-oxygenated cells in the brain, projected to save as many as 100,000 lives each year
- The $20,000 to $100,000 annual costs for one-on-one therapy for our 500,000 (and increasing) autistic children.

But wait! Before botulinum toxin injections of the internal sphincter for refractory constipation in children becomes a mainstream standard of care, we must develop a system for assuring only appropriate therapy for all based upon an appropriate payment scheme.

Arnold Relman points out that commercialization and technological advances “coupled with a largely open-ended fee-for-service insurance payment system are primarily responsible for today’s problems.”

Ezra Klein, in the Washington Monthly, after describing the failed or failing attempts of individual states to achieve universal coverage for their citizens, concludes that, of our many states, only relatively affluent Massachusetts, which had only ten percent of its population uninsured at the outset, can achieve universal coverage without going bankrupt. Klein concludes that, as with national defense, universal health care can be achieved only by a massive federal effort. He writes, “On health reform, the light of reason is clear. We must merely be bold enough to follow it, and not settle for smaller, unsustainable victories because we fear the battle necessary for an enduring triumph.”

Competitive market forces, while desirable for drug and device makers, should not dictate how health care is paid for. This is an impossible dream. The most direct route to universal coverage is a single payer system funded by taxation and administered, as Relman suggests, by a public-private agency.

Once this is agreed upon the cost part of the equation must be addressed by tough measures. Polls indicate that Americans would rather increase taxes than deny a teenager a potentially lifesaving drug with minimal toxicity. In return, medical scientists working with health economists should be given authority to permit coverage of drugs and devices proven effective, while suppressing distribution of the redundant “me-too” therapies that have little demonstrated added value. Insurance companies must trim excess executive compensation, and strategies must be developed to convert them to not-for-profit entities in ways that do not bankrupt them. And, as Robert Moser outlined in the Fall 1999 issue of The Pharos, all the entities that comprise the “peripheral health economy” (i.e., those that make money from health care but are not physicians, nurses, or hospitals/clinics/nursing facilities) must be encouraged to have continued increases in earnings, while contributing a percentage of earnings to lower the gross national costs of health care under the single payer system.

Compounding our problems are human elements. The same forces that shaped America’s expectations for the best of therapy encourage specialization by physicians, leaving inadequate numbers in primary care and insufficient initiatives in preventive medicine. Current moves in the direction of cutting doctors’ take-home pay are not the answer. As Uwe E. Reinhardt writes, “[We would save little money] in return for a wholly demoralized medical profession to which we so often look to save our lives.” The delivery part of health care must revised, suggests Relman, to development of a system of pre-paid medical groups in which physicians are paid largely by salary. The super-specialists would still be paid more, of course, but the primary care physicians could have adequate take-home pay, as well as an acceptable lifestyle.

Forget the health plans of Canada, Great Britain, and Germany—let’s forge one appropriate to our very special culture.

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Would renew my soul once again.

J. Joseph Marr, MD

The Devourer of Things

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Pity. It’s something I used to feel for many of society’s underdogs that I helped care for in free clinics. Recent immigrants with low paying jobs, asylum seekers dehumanized at the hands of torturers, children with AIDS—these people affected me deeply. Pity seemed a natural emotion for me to feel. How bad these people had it, casualties of such unfortunate circumstances! Before long, though, I realized that pity made me see these people as victims, as powerless, as wounded. True, I could see them as somehow disadvantaged, but I also needed to learn to see them as strong individuals. Someday they would be stronger than I. They were not in the clinic to be treated for their pitiful circumstances. They were there as patients.

My best teacher was a seven-year-old boy named TJ, and 4H fairs, basketball courts, and canoeing down the C&O canal in Washington, DC, were my classroom. TJ had been born with HIV, vertically infected by his mother who was addicted to IV drugs. He had been taking antiretroviral medicines since he was about three years old.

Being a big brother in a “little brother, big brother” program was something I had always wanted to do: such a program for children with HIV was even better. I met TJ and his mother one afternoon after work on their front porch. I could hear conversations and occasional yelling from inside the house and wondered why we didn’t go inside. I saw several people pass...
on the street and make eye contact with TJ's mom, then keep walking. I saw trash scattered in the small overgrown front yard. But I also saw TJ smile the entire time I was there, move from his mom's lap to mine, and start calling me "brother."

Over the next two years, TJ and I went out nearly every week. We did things that he had never done before. Eating seasoned crawfish while watching planes take off and land at the airport was something he loved to do. But the activity that trumped all else was bike riding. We would often drive thirty minutes outside the city to some wooded area with trails, and ride bikes “off-road,” all the better when other kids were there. TJ regularly became the leader of the group, and whenever anyone would fall off his bike, he was always the first to jump off his to help. Although I had explained a hundred times over that I worked in a research lab with no patients, he would without fail tell the child that his "brother" was a doctor and everything would be okay.

Taking TJ home was always easy. He slept the whole ride home every time. Dropping him off was never easy. I knew he was returning to a home with a poorly-working refrigerator, that frequently lacked electricity, and routinely had illegal drugs. As I found out over the years, these details, coupled with an endless love for his mother, defined his home life.

I’m not sure when it actually happened, but sometime in the two years we spent together I eventually stopped feeling pity for TJ and his mother. What started as a commitment based on feelings of sorrow for my little brother turned into an experience that forever changed us both. It made me see beyond the disease, his mother, and his home. TJ was a boy who, despite life’s circumstances, still radiated love, happiness, and innocence. Even though his small body harbored a rapidly multiplying virus, he was first and foremost human—as were the patients I had initially pitied in the clinic.

I no longer treat any patient with pity. I have replaced it with heightened levels of empathy, understanding, kindness, compassion, and above all, solidarity. For a long time, though, I questioned myself about this. Was I right in doing so? Doesn’t pity have a role in medicine? Certainly the less fortunate could benefit from pity!

Perspectives

Discharged to the streets: Who cares?

Richard C. Christensen, MD, MA

The author (AΩA, Wright State University, 1990) is professor and associate dean of Students, Admissions and Outreach at Florida State University College of Medicine.

Recall the face of the poorest and the weakest man whom you may have seen, and ask yourself if the step you contemplate is going to be of any use to him. Will he gain anything by it? Will it restore him to a control over his own life and destiny?

Mohandas K. Gandhi

Mr. Ruiz was well known to me from previous psychiatric hospitalizations. This time, however, he was only partially clothed and covered in feces. His rambling speech was so disjointed it was incoherent. The police had brought him to the emergency department after coaxing him from a rain-soaked box leaning against a dumpster behind an abandoned restaurant. In his early forties, Mr. Ruiz looked decades older.

From what I could gather, he had been living in his cardboard shell for nearly ten days following his release from a local inpatient psychiatric facility. When I spoke with the
psychiatrist responsible for Mr. Ruiz’s treatment and discharge, the doctor coolly reported that it really was not part of his “job” to find housing for people. Moreover, he quickly added, Mr. Ruiz “chose” to return to the streets rather than go to a local shelter for homeless persons.

Mr. Lancaster, on the other hand, was an elderly man bearing an uncanny resemblance to a mildly-confused Santa Claus. I met him on my weekly ride-along with a street outreach team attached to our city’s homeless center. On these search-and-find excursions, two case managers and I scour the streets and surrounding woods to locate and engage homeless persons in need of medical and/or psychiatric care. We make arrangements for those with medical needs to be seen in our shelter-based psychiatric or primary care clinic. We always look for ways to bundle shelter and food with the medical services.

In the breaking dawn light of this particular day, we came across Mr. Lancaster lying in a dark, garbage-strewn alley that snaked behind a homeless shelter. His legs were crudely wrapped in dirt-caked gauze dressings and soaked through with urine. On his wrist was the hospital identification band that recorded his name and birth date. He was seventy-seven years old. Prior to our encounter he had been admitted to a local hospital for several days, where he had received inpatient treatment for an angry, oozing cellulitis covering his lower legs. Upon discharge on a late Sunday evening, he had been given a cab voucher with instructions to the driver to take him to the nearest shelter.

After being dropped off by the cabbie, he realized he had missed the admission curfew. When we came upon him he had spent the previous twelve hours lying in the gravel of the alley, unable to stand, calling for help but unheard and unnoticed.

Next to him was a large plastic bag filled with sterile gauze wrappings and rolls of medical tape. Before leaving the hospital the previous night, he had been given written instructions to change his bandages once a day, fill his antibiotic prescription, and be scrupulous about keeping his legs dry and elevated. Once we got him bathed and situated at the shelter, it became painfully obvious that dementia had robbed him of a trustworthy memory and a reliable set of problem-solving skills. The written instructions were not only useless but—tragically—comical in light of his state of homelessness and confusion.

I would like to think that a homeless mentally-ill person being discharged from a hospital unit to a city street is an exception to the norm. I would even like to believe that these particular adverse events are usually the result of administrative oversights that are always seen as serious and humanly painful mistakes. But as a psychiatrist who has worked with homeless persons for two decades, I know better. More times than I care to recount, the “choice” to return the person to the streets arises not with the homeless patient but rather with the treating physician.

I believe we can do better. A covenant of care implies that our moral commitments and professional instincts are singularly “focused upon individualized and excellent care of the patient.” Because our professional positions grant us visible moral standing in society and a clarion voice in medical institutions, we are uniquely privileged to be both the providers of medical care and advocates for needed compassionate services. Homeless persons who enter the health care system with broken minds and damaged bodies invariably need more from their doctors than medical care alone. And physicians who find themselves in the position of caring for those who are “the poorest and the weakest” persons in our communities, may often struggle (as did William Osler) to “maintain an incessant watchfulness lest complacency beget indifference, or lest local interests should be permitted to narrow the influence of a trust.” At the end of the day, however, the “choice” to care deeply, to prevent suffering and to never abandon a patient rests always with us.

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Burial at sea

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Our cruise ship was ten minutes out of port, and my daughter, my niece, and I were in the lounge playing bingo. My sister-in-law, a nurse, approached suddenly. She appeared tense. “Karen needs you right away. The man in the cabin next to yours is having a heart attack and he looks really bad.”

My thoughts raced as I hustled up the decks and forward, wondering what medical equipment or personnel would be available for an emergency. I entered my neighbor’s cabin and saw that there was no shortage of people or equipment and that attempts at CPR were in progress. Unfortunately, the scene was a case of “how many things are wrong with this picture?” A woman was performing what could best be described as mattress compressions. The patient lay in his soft bed, without a backboard. Each downward thrust of CPR was pushing his chest into the mattress, but I didn’t see the sternum descending into his thorax. Our steward, in white uniform, was at the head of the bed using a bag and mask device, but he had failed to establish a seal. He was fanning the victim’s face and oxygenating the room, but not supplying much air to the man’s lungs. A defibrillator and a medicine cart stood in the corner. Several other people were watching silently.

I introduced myself as a doctor and started giving instructions. We immediately put the man on the floor, and I reminded the steward to hold the mask tightly over the nose and mouth while squeezing the bag. As I opened the man’s shirt, I asked for the EKG paddles. Sure enough, he was in ventricular fibrillation. A second woman said she was the ship’s nurse, charged the defibrillator, and applied gel to the paddles. With the second discharge the victim converted to sinus rhythm but remained pulseless. We resumed CPR. I commented that the pulse was strong with each compression and the woman working on the chest appeared relieved and proud. My wife Karen, a pediatrician, entered and told us she had spoken with the patient’s wife. The report: a diabetic, high blood pressure, prior mild stroke, intermittent heart failure, peripheral vascular disease. He had been shaving before dinner when he clutched his chest and slumped to the ground.

I asked a staff member to call the captain to tell him to head back to port. We needed to get the patient to the hospital urgently.

No veins were evident. As a nephrologist I have inserted many femoral dialysis catheters, and it was now gratifying to place a line quickly in the right groin. Epinephrine was given. We administered saline as fast as we could, in the hope of overcoming the patient’s electromechanical dissociation. The staffer told me that we couldn’t go back to port because no tugs were available for an unscheduled arrival. I asked that efforts be made to mobilize a helicopter.

The patient’s rhythm reverted to ventricular fibrillation and failed to respond to defibrillation. I said that I would intubate, and a thin, bearded man in blue scrub attire who had been watching the action now stepped forward and said he was the ship’s doctor—a moonlighting ER physician. He smoothly placed the endotracheal tube and I heard good breath sounds bilaterally.

Nephrologists have to assess patient weights (and fluid status) regularly, and we like to think that we’re as good as carnival barkers at this task. I pegged the patient at 85 kg and we administered lidocaine and bretyllium* at the appropriate doses between shocks. I had the nurse raise the patient’s IV-free left leg in an attempt to attain a partial Trendelenberg position and then realized that I had overestimated his weight, because his leg fell off.

Prosthesis.

The ship’s captain made a brief appearance. He said it would take time and great expense to get a helicopter to the boat and asked if the patient would survive. He quietly stated that he would

*At the time of this event, bretyllium was still part of the ACLS routine for treating ventricular fibrillation.
start making some calls and left. We continued to work. It was humid and everyone was sweating. We used the various drugs and maneuvers in the ACLS algorithms, but ultimately the rhythm was asystole, we had no pacing equipment, and the effort had gone on for forty minutes. We agreed to give up. The ship’s doctor slipped away without talking to the patient’s wife.

Karen and I finally plodded down to the dining room. She was more drained than I was, since pediatric patients rarely suffer such cardiac catastrophes. No one from the ship had thanked us for our efforts and now the waiters chided us for being late and upsetting the seating schedule. I recalled the prophetic words of a medical school professor, who had advised the students that if it was gratitude we desired, we should buy puppies rather than go into medicine. The next morning our cabin steward told us it was common for elderly passengers to die in transit and he had never seen such a concerted rescue effort. They routinely stored the corpse in the freezer until reaching the next port. Karen and I became aware of what should have been obvious earlier. Neither the ship’s doctor, nor the captain, nor the cruise line want heroic interventions. It is more cost-effective to let people die. We had witnessed a perversely extreme managed care philosophy. Burial at sea, indeed.

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Our ultimate salvation lies in that fragile web of understanding that one human being has of the sufferings of another.
—attributed to John Dos Passos

We've got a consult at the VA.” The endocrine fellow paged me at the end of a long afternoon in clinic. “Type 2 diabetes. Five days post-op after a triple-vessel CABG. His name’s Theodore Peters.”

I sighed with fatigue and met the fellow in the surgical ICU thirty minutes later. When I arrived, the fellow was waiting for me at the door of the unit.

“Everyone says that he’s really difficult,” she said.

“What do you mean?”

“They say he’s pretty hostile and refuses to take his insulin.”

“Well, is he?”

“I don’t know. He seemed okay to me. At any rate, his pre-op A1c was 6.5.”

I was relieved that the patient’s pre-operative glycemic control was so tight and hoped that we’d be able to keep it that way during his recovery. I was hoping the visit wouldn’t take long.

As we entered the room, I saw an African American man in his early sixties lying in bed. His hair was close-cropped and gray, and he had that drawn and haggard appearance that goes with being in the ICU. With the sheet pulled up to his chin, he eyed us warily. Suspicion and hostility radiated from him, filling the room.

“I introduced myself.

“What do you want?” he asked. “Like I told them, I don’t want to be told what to do.”

“Actually,” I said, “I’m not here to tell you what to do. I was hoping you could tell me what works for you and your diabetes.”

Distrust still hung in the air like a fog.

Feeling awkward and wanting to establish a connection—any connection—to break through the tension, I asked him, “So what branch in the service did you serve in?”

“The army,” he answered.

From his age, I took a guess: “Did you serve in Vietnam?”

“Yeah, I was there . . . for a year . . . a very long year.”

I continued to fumble: “If it’s worth anything, I respect your sacrifice.”

“Yeah, well,” he answered, “it wasn’t voluntary. It was over a pork chop.”

A pork chop?

“What do you mean?”

“I was drafted over a pork chop,” he answered, matter-of-factly.

“I grew up in a little town in Missouri back in the fifties and early sixties. One night, my momma asked me to go down to the corner to buy pork chops for dinner. Well, in the butcher shop they had these thick, juicy, pink pork chops. A whole stack of ’em. And right next to them, there was a stack of grey, spolit meat. Since the price was the same, I asked for the thick, pink, juicy pork chops.

“Well, the lady behind the counter—a big ol’ white woman
with a frown on her face—said to me, ‘Boy, you can’t have those pork chops. Those’re for white people.’ She pointed to the stack of rancid meat, ‘Colored people’s chops is those ones.’

“Well, I refused. There wasn’t any way in hell I was going to pay good money for spoiled meat. I insisted on the good ones. The big ol’ white lady’s frown got deeper, and the more we argued, the angrier she got. Finally, the police got called, and I got arrested and taken off to jail.”

“So how did that end in Vietnam?”

“Turns out, she sat on the local draft board, and pretty soon, here comes my notice.”

Mr. Peters went on to tell me about his year in Vietnam: friends killed, always scared, wanting only to go home.

“Afterwards was no picnic either,” he said. Unemployment, no opportunities, struggles with depression and alcohol, and finally, in his late forties, after his second divorce, diabetes.

We sat in silence for quite some time. He seemed pensive, as memories and loss played themselves out and receded. We began to talk. About growing up. About tastes in music. About things to eat and see and do. As he talked, I glanced at him. He looked full of life and words.

Suddenly, we were interrupted. A young surgeon entered the room, trailing a couple of trainees.

“So, Theo,” he declared, “how are we doing today?” I looked over at Mr. Peters. He squinted with a heavy look of suspicion. I felt the fog again filling the room.

After the surgeon’s cursory visit, I struggled again to find that tenuous thread that had linked us. The fog remained. After a while, after talking to him about his diabetes and thanking him for his time, the fellow and I left.

I saw Mr. Peters again several days later, sitting up and watching TV. I asked him how he was doing and he curtly responded, “Things’re fine.” I asked him whether he needed anything, and he said no. His eyes never left the screen. I said goodbye and left.

Two days later, I left the service. I never saw Mr. Peters again. I later learned that he died some time after we spoke and left no survivors.

For quite a while now, the concepts of compassion, empathy, and social justice have occupied a central place in my perspective on the world and my activities as a clinician and teacher. My encounter with Mr. Peters, however, reaffirmed something that had always lurked at the edges of my idealism: an awareness that seeking justice is, in its essence, the constantly difficult, exhausting task of realizing these ideals in an imperfect world—in what Arthur Kleinman once called “the messy, confusing . . . context of lived experience.” In my visit with Mr. Peters, I saw that my best intentions were met with suspicion, and that my attempts to form a bond between us were no match for the sheer weight of a history filled with unrighted and unrecognized wrongs.

Over the years, I’ve come to realize that achieving justice is not just a matter of simple compassion or sense of fairness. Neither alone is enough. Empathy must cut through the suspicion arising from a lifetime of injuries and indignities, the vast silence of an impersonal, hostile, and demanding system, and my own sense of frustration and powerlessness in response. It is expressed in the effort to slow down and openly affirm the humanity of the person in front of me on the exam table of the clinic or in the bed of the hospital room, to resist the urge to avoid messy social reality by hiding behind technology, lab results, and statistics. It is in the hard work of responding to the hostility of a “difficult patient” and to inequities in the system by striving to understand the causes and work to overcome them, all while caring for the person and addressing everyday clinical needs. It is expressed in listening, amid the discomfort and distractions, to stories of hurt and loss. To seek insight rather than judgment, justice rather than expediency. To weave that fragile web of understanding a single strand at a time.

Acknowledgments

In memoriam, TP. The author would like to thank P. T. Ross, C. B. White, and M. Yoshihama for their thoughtful comments and suggestions.

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The wayward eye

Roger P. Smith, PhD

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Professor Power, sixty-three years old, was of slightly less than median height and more than slightly over his ideal weight. Indeed, the margin by which he escaped the dread category of “obese” of his body mass index was uncomfortably narrow, even for him, and he was never one to be much preoccupied with his physical appearance. Like his father before him, he was fond of lamely joking that he was “too short for his weight.” That was not the only characteristic he had inherited—the male pattern baldness gene had long ago left him with a monkish tonsure, and the hair pattern, coupled with oversize glasses for his myopia, gave him an owlish appearance, which he imagined made him seem wiser than he really was. He therefore cultivated it. He reasoned that for someone in his chosen profession it could do little harm and might sometimes work to his advantage. His students, however, were not fooled.

For someone approaching retirement, Power was in reasonably good shape. In the relatively near future, he would need a cardiac pacemaker. His pulmonary function would come the physiological equivalent of getting by on roughly one lung, the result of thirty years of a pack-a-day cigarette habit. When he finally quit, he had promptly developed asthma, which gradually deteriorated over the years into chronic obstructive pulmonary disease. He had had a very mild stroke, necessitating daily warfarin. Then there were the occasional bouts of gout, eczema, and gastro-esophageal reflux disease. He had recently undergone a prostatectomy, and his internist was starting the long search for an appropriate and effective antihypertensive.

Among a handful of other physicians, Power had for several years been under the care of ophthalmologist Dr. Hasselback. Dr. Hasselback was a brilliant, if somewhat remote, caregiver who managed to maintain a productive and high visibility research program along with his busy practice. That suited Power just fine. He always claimed that he wanted “a physician who knew something, and the heck with the bedside manner.” Hasselback was said to be particularly adept in the surgical suite, where his skill and facility at implantaing artificial lenses was generally admired. Dr. Hasselback had been keeping a careful watch on two small cataracts in Professor Power’s eyes. The one in the left eye was growing, whereas the one in the right eye seemed to be stable. Hasselback was very careful to explain that Power was the sole decider about the course of action to pursue. Hasselback recommended doing nothing so long as Power’s vision was correctable to about 20/20, or until Power himself began to notice some impairment. Perhaps it was the mere knowledge that the cataracts existed, and the vague feeling that something ought to be done about the one that was growing that led Power to decide finally to have the lens in his left eye replaced. The surgery was scheduled for late January of 1995.

It was not an easy decision. The very thought of a surgeon slicing directly through one’s eyeball is enough to make even the most stoic of patients a little queasy, especially since general anesthesia is not usually used. The eye itself, of course, is rendered insensitive to pain with a local anesthetic, but the idea that the patient in theory could look directly at the scalpel as it descended to do its work was more than a little unnerving. Not to mention the needles and sutures that would be used to sew the incisions back together. In brief, Hasselback would cut through the cornea to the capsule that contained the natural lens. That lens would be extracted through another incision and a synthetic one inserted in its place. Both incisions would then be sutured.

The doctor says, “Good surgery.”
The patient isn’t so sure.

The operation went far better than Power could ever have imagined. Although it was true that he was not fully anesthetized, he had been given enough “chemical happiness” in the form of anti-anxiety medication to turn even the meekest of mice into a lion-hearted daredevil. It was completely painless, and the worry about watching the operation through the very eye that was being abused proved groundless. Recovery was a little tedious because of the several types of eye drops administered at frequent intervals. Perhaps the worst part was looking
at the recovering eye in the mirror. It was stomach-churningly bloody and somewhat black and blue, but that was easily concealed from others by dark glasses. The final result, however, as soon as Dr. Hasselback felt that recovery was complete was a little disappointing. Power could tell no difference at all as a result of his new lens. But Hasselback declared the operation an unqualified success, and was extremely pleased with the quantitative examination results. As pointed out by Hasselback from the beginning, the operation would not obviate Power’s need for glasses because of the myopic and astigmatic condition of the other eye.

A touch of ptosis, then decreased vision, then diplopia

About two years later, Power woke up one morning with his right upper eyelid drooping halfway over the eyeball. He was pleased that he knew the name for that condition— ptosis. It can be an early sign of myasthenia gravis, but in that case it is usually symmetrical, involving both eyes. Perhaps, he thought, it is some sort of local infection or inflammation, and he treated it himself with warm compresses. It gradually resolved. At odd moments Power would remove his glasses and focus first one eye and then the other on some photographs at the far end of his office. He still could not discern any improvement in the eye with the artificial lens, but his overall vision seemed completely satisfactory. Certainly, there was no deterioration in his vision that he could tell, until one day about a month later, when he noticed that the vision in his right eye—the one that still had its original lens—seemed to be a little worse than it had been. The next week it was even worse, and a few days later still more deterioration had occurred. Power seemed to be losing vision in his right eye at an alarming rate. He could barely make out the faces in the photographs. He was also experiencing diplopia, at first episodic, and then nearly constant.

The ophthalmology service in his local hospital had been overextended for years. A new patient could anticipate a wait of six to nine months for an appointment. When Power called for one to have his eye evaluated, an appointment six months in the future was suggested. After several more days in which he had further loss of vision, he called and asked for an emergency examination. After some negotiations between the appointments secretary and Dr. Hasselback, the ophthalmologist agreed to see Power over his lunch hour. At the appointed time he entered the examining room carrying a sandwich and soft drink as if to indicate, “This had better be good.” Perhaps he even felt that Power was questioning his professional competence by imagining that the operation on the left eye had somehow caused a problem in its untouched counterpart. Power had reason to believe, however, that the examination itself was every bit as thorough and meticulous as he was accustomed to receiving. The intraocular pressure was checked, and Hasselback spent some time examining the retina. At the end of the exam, Hasselback pronounced judgment: “There is absolutely nothing wrong with your eye.” Power was totally crushed. Hearing that there is nothing wrong with you when you are convinced that you are at death’s door is almost as bad as hearing that you have an unsuspected fatal disease. He slunk out of Hasselback’s office mouthing abject apologies.

Back in his own office, however, Power found to his horror that the vision in his right eye was now almost totally gone. How can that be? And, more importantly, what can he now do about it? There was no use calling Hasselback again. Even if he could get a timely appointment with another ophthalmologist, it was unlikely that anyone in that department would want to put him- or herself in the position of second-guessing a colleague. Then he thought of his genial optometrist, and Dr. Blain promptly made special arrangements to see him.

The wayward eye
told him the whole story. Blain had him read an ordinary eye chart, and the results were clearcut. There had been a very significant deterioration in the vision in Power’s right eye since his last examination. Now it was up to Blaine, a humble optometrist, to convince Hasselback, a somewhat imperious ophthalmologist, that something was definitely wrong with Power’s eye. That must have taken courage, but he did it. Hasselback referred Power to the neurology service that very day, and Power began to rethink his assessment of the value of more cordial and intimate doctor-patient relationships.

Why neurology?

Although he was relieved not to have been referred to psychiatry, Power was somewhat puzzled by why he was handed over to the neurologists. Within hours, however, he found himself being examined by Dr. Hatfield, the neurology chief resident. Many of the tests performed by Dr. Hatfield seemed to have no relevance to his vision, but Power was so pleased to be receiving some attention that he complied without question. Indeed, Dr. Hatfield’s fascination with his case was a little flattering. For a chief resident, he seemed to have little else to do except to take extraordinary personal care of Power. He brought in a constant stream of fellow residents to examine him. By now it was getting rather late in the day on a Friday afternoon, and many hospital personnel were leaving for the weekend. It was then that Dr. Hatfield casually remarked that Power should be admitted at least overnight, and that Hatfield had made emergency arrangements for an MRI image of Power’s head.

As the possible significance of this suggestion slowly dawned on Power, his blood turned to ice water. My God! I’ve got a brain tumor! I’m a goner for sure. All those years of smoking must have resulted in unsuspected lung cancer, and it has now metastasized to my brain. It must be malignant. I wonder how long I have? How are my wife and kids going to think of pain. In addition to the confirmatory MRI results, one of the diagnostic clues was that you are prone to atopic diseases such as your asthma and eczema. The etiology of pseudotumor of the orbit is obscure, but it is believed to have an immune basis. The orbit of the eye is a bony cavity that contains the eyeball. In a pseudotumor, an inflammatory infiltrate accumulates in the orbit to occupy space and compress tissues, including the optic nerve and muscles controlling movement and axis of vision of the eye. Compression of the optic nerve, while usually self-limiting and benign, can in some cases lead to serious ocular damage and possible loss of vision. The mass-lesion effect is similar to a true tumor. Since the condition is external to the eyeball, in the early stages at least there are no visible pathological lesions on the retina.

“But it gets even better. This condition is almost invariably reversed quickly and permanently with a single course of treatment with an anti-inflammatory steroid like prednisone.”

Prednisone, of course, thought Power, beautiful, wonderful, lovely, magical prednisone. The drug that has cured my asthma flare-ups so many times. What better remedy for a disease of unknown etiology than a drug with an incompletely understood mechanism of action? And only thirty-six hours later he was sitting up in bed trying out his newly cured right eye and thinking, Wow, that red-headed nurse across the hall is really hot!

References


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Hold his head still.

Standing at the head of the bed, my hands reflexively spasm at the command, pinning George Bendor’s jaundiced face ever tighter to his hospital bed. He moans.

“Okay, sir. We’re going to put in the tube now. This will help us give you your medications so you can get better.”

Watching the intern approach Mr. Bendor’s head with the 16 French NG tube, generously lubricated, I see from the corner of my eyes the nurse and the senior resident lean forward and anchor themselves over Mr. Bendor’s midsection and legs. I tighten my grip.

He grows still and silent as the plastic tube initially snakes its way into the right nostril, but the stillness does not last long. With the NG tube halfway down his pharynx, Mr. Bendor begins to moan, louder than before, and raises his hands to his nose. The nurse pulls his hands down and to his sides. His attempts at shifting his legs and body are unsuccessful.

The tube advances.

His incoherent groans escalate into hoarse shouts of protest.

Good thing we closed the door.

Opening his unfocused, icteric eyes, he quickly turns his head to the left with a strength his cachectic body ought not to possess. The NG tube falls out—my palms sting as the days-old stubble runs across them.

“Let’s do it again. We’ll get a PCA to hold his head.”

I lock gaze with the senior resident, see regret and pained determination. I step back from Mr. Bendor’s hospital bed as she takes the NG tube from the intern. The intern takes up position with the nurse at the side of the bed as the two hundred-pound patient care assistant steps in to hold Mr. Bendor’s head. I stand and watch.

This time, Mr. Bendor seems to sense the presence of the tube long before it touches his left nostril, protesting with voice and body against the hands that hold him to his bed—the place of rest that is now his prison.

The NG tube travels only through the nasopharynx before his head, thrashing again, pulls out the tube. The PCA is unable to hold Mr. Bendor’s head still. Honestly, I don’t think anyone is overly disappointed.

“With his hepatic encephalopathy he doesn’t have the capacity to understand how getting, or not getting, lactulose will affect him, and his sister wants us to do everything.” The senior resident heaves a loud sigh. “I’ll call the fellow.” The intern and I remain with Mr. Bendor.

Minutes of oppressive silence pass as we are left to our own thoughts, interspersed with low mutterings from the hospital bed.

The door opens, and the senior resident returns with the fellow.

“Okay, let’s try this one more time,” the fellow says. God, this really sucks.

“Mr. George Bendor is a forty-one-year-old man with a history of HIV/AIDS diagnosed in 1984, chronic hepatitis B with cirrhosis, depression with suicide attempt, who was admitted for liver failure and hepatic encephalopathy.”

I pause briefly in my presentation to adjust the progress note on the clipboard.

“Mr. Bendor stopped his HAART medications three months ago, which likely resulted in a flare of his hepatitis B with subsequent hepatic failure and encephalopathy. He was restarted on HAART two days ago and we have been pushing lactulose. However, he only had two bowel movements yesterday, and his mental status continues to decline.”

Glancing through his morning labs and door side flow sheet, I summarized the pertinent findings.

“Patient had decreased PO intake due to altered mental status and is continued on IV fluids. Despite D-5/normal saline at a rate of 150 ml per hour, his urine output is trending down, with less than 30 ml of urine produced over the last eight hours.”

The attending nods after flipping through Mr. Bendor’s door side, confirming my statement and signaling me to continue.

“His creatinine today increased to 3.5, up from yesterday’s 3.1. The differential diagnosis at this point includes pre-renal
azotemia versus hepatorenal syndrome.”

At the attending’s request, I then list the diagnostic criteria for hepatorenal syndrome.

“Very good. Jen, what stage would you categorize his hepatic encephalopathy?” He asked.

“Stage 3.”

“Good. Now since he probably has a hard time taking in PO lactulose, what other options have we tried?”

“We have tried giving him lactulose enemas, but he moves around a lot when they are given, and he has refused it on most occasions. His sister in New Jersey is his power of attorney and would like to have everything done for him at this point.”

“Sounds like he needs an NG tube. Try to put one in him today so we can give him the lactulose. Let’s see if we can get him to have more bowel movements and cleared up.”

The attending replaces the flow sheet in the door side slot and the team moves on to the next patient.

That afternoon, after unsuccessful attempts at NG tube placement, the intern and I mix 40 mg of lactulose in vanilla Ensure and try to cajole Mr. Bendor to drink the lactulose. Standing close to him on either side of his bed, one of us holds the Dixie cup while the other places the straw in his mouth, urging him to drink.

“Mr. Bendor, you have to drink this, or else we’ll have to try to put that tube in you again.”

I nudge the straw against his lips. He puckers his lips around the straw, but it was as if he has forgotten how to suck—the straw just ineffectively falls out of his mouth.

“Mr. Bendor, you have to drink this.”

“I’m trying.”

These are his last coherent words.

The nurse adjusts the IV tubing and silences the alarm on the blue pump.

“Thanks.”

I am sitting across from Nicky, Mr. Bendor’s partner of three years. I silently watch Nicky gently stroking his lover’s ecchymosed left forearm with his right hand, his left hand clutching the jaundiced limp hand in a white-knuckled handshake. I wait for the nurse to leave the room before continuing our conversation.

“Mr. Bendor . . . George has not been doing well.”

I shift in the visitor’s chair.

“Actually, his condition has been getting worse and worse over the past couple days.”


The IV pump starts beeping again. Nicky turns his face towards me.

“From the blood work that we draw every day, we see that his liver is still not doing well, and over the past couple days, his kidneys also started shutting down.”

I look into Nicky’s eyes, see comprehension.

“Yesterday, we tried putting in a tube down his nose and into his stomach, hoping that we can give him more medication that way. We were hoping that would help clear up the toxins that are building up in George’s blood and making him confused.”

“It was . . . ”


“It was . . . uncomfortable for him.”

“I’m sorry we had to put him through that.”

“I’m sorry.”

“A chest X-ray taken yesterday showed that George has a fluid collection around his right lung. That’s why he is now having more problems breathing.”

Nicky turns his head to the right to look at Mr. Bendor—inh and out, in and out.

“He’s breathing fast,” Nicky notes worriedly, “and he’s gurgling.”

“The nurses are suctioning him. If you feel comfortable, you can suction some of that secretion out, too.”


Nicky nods and says, “His sister is driving down from New Jersey today. She should be here in five hours.”

I glance at the clock. Five hours . . . so around two PM.

We sit in silence.


“He’s been through so much in the past. He’s been sick before but always got better. I just don’t understand.” Nicky looks at me with confusion and pain. “He said he needed a break from the medications.” He turns to look at their joined hands. “He was tired.”

“I’m sorry.”

He’s dying. He’s been dying for the past couple days. The IV pump seems to agree.

“He’s now DNR/DNI and comfort care,” my senior resident says after putting the phone back into the cradle. “I explained the situation to his sister, and she said that’s what he would want. She should be here soon.”

We look at each other.

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**About Mok-Chung Jennifer Cheng**

I am a resident in Internal Medicine at Johns Hopkins Bayview Medical Center. My clerkship experiences and my grandparents, with whom I have lived for many years, solidified my interest in geriatrics and palliative care. I hope to continue serving my patients and allowing them to teach me what it means to be a good doctor.
Sitting at the workstation, right next to the hustle-bustle of the nursing staff, I feel oddly alone with my resident. Though I can’t speak for her, I venture to say that we feel quite isolated, like on an island surrounded by endless, unforgiving ocean.

I am a rock, I am an island.

To say that the tension between them (the nursing staff) and us (the doctors) is high would be an understatement. It’s not just high; it’s painful, piercing, and palpable like a punch to the stomach, a slap to the face.

We look at each other.

*Why did you have to force that tube into him. Why couldn’t you let his last days be comfortable, be dignified. Why torture him? Why indeed?*

I am relieved that Mr. Bendor is now comfort care, but there is also a deep sense of loss. I mourn for the man rapidly declining with each passing second. I mourn for the man in the picture, smiling carefree with arms around Nicky. I mourn for the man I will never truly get to know. Most of all, I mourn for the inadequacies of medicine in conquering death, and the fool that I was for ever believing otherwise.

We look at each other.

In that second of eye contact, thoughts and feelings speed through us and between us with an overwhelming need to understand and to be understood.

*And a rock feels no pain, and an island never cries.*

“I need a drink,” I say to my resident.

“I’ll settle for Pepsi,” my resident replies.

We leave our island of computers in search of Pepsi, preferably with crushed ice.

I can hear him moan from all the way down the hall. Listless monotone with every expiration of strangled breath.

We just started him on a PCA with dose and basal.

Although it’s a bit too late for the patient-controlled portion.

“Do you know where I can find a pair of scissors?” I ask the nurse.

*Mr. Bendor’s sister made it in time. Flustered, with tears streaking down her face, she rushed into his room and sat at his bedside until he died shortly after.*

I Am a Rock

© 1965, Paul Simon

A winter’s day
In a deep and dark December;
I am alone,
Gazing from my window to the streets below
On a freshly fallen silent shroud of snow.
I am a rock,
I am an island.

I’ve built walls,
A fortress deep and mighty,
That none may penetrate.
I have no need of friendship; friendship causes pain.
It’s laughter and it’s loving I disdain.
I am a rock,
I am an island.

Don’t talk of love,
Well I’ve heard the word before;
It’s sleeping in my memory.
I won’t disturb the slumber of feelings that have died.
If I never loved I never would have cried.
I am a rock,
I am an island.

I have my books
And my poetry to protect me;
I am shielded in my armor,
Hiding in my room, safe within my womb.
I touch no one and no one touches me.
I am a rock,
I am an island.

And a rock feels no pain;
And an island never cries.

“What are you going to cut?” the nurse asks.

*Though Mr. Bendor had long since stopped going to church, his sister asked for a priest to perform last rites. He died so quickly that the priest did not make it in time, but the hospital chaplain was able to pray with them as he drew his final breaths.*

“Hair,” I reply.

*Nicky said, “He died soon after the chaplain left. The HIV clinic social worker came and visited. We were sharing memories of George when we suddenly realized that he stopped breathing. Like he just fell asleep.”*

The nurse goes and looks for a pair of scissors. Too tired to follow, I wait and try not to think . . . my thoughts race.

*Nicky continued, “At the end, I prayed to God for him. I don’t know if He hears me, but I prayed for his soul.”*
Aunt Molly has a nodule in her lung. It was a grey, cold day in late November when my dad called to give me this news.

“She visited the doctor for a cough. She thought it was some sort of chronic bronchitis, and they saw something on the chest X-ray.”

I felt a chill in my bones and closed my eyes in an attempt to hear him more clearly.

“Do you know how big it is, Dad?”

Since beginning medical school I find I cling to facts like these when faced with emotionally-charged situations. How big is the nodule? Have they done a CT scan? Will she be getting a biopsy? At the time, I reassured him that it was probably nothing serious—nodules are found often, and they usually turn out to be benign. Dad did not seem very comforted, but we talked a bit longer and finally hung up. In the following weeks, I did my best to keep busy. I played with my son. I worked on my thesis. But, like the proverbial pea beneath the mattress, Molly’s nodule continued to intrude upon my thoughts.

A nodule biopsied: cancer

It was another cold, grey day when Dad called again.

“It’s cancer.”

I took a deep breath.

“She has to go back into the hospital soon to get radiation.”

My first thoughts were questions: What kind of cancer is it? Are they considering surgery? Has it spread?

“Are you okay?” I asked my Dad.

I decided to write to Molly, mainly because she does not like talking on the phone and, for the time being at least, did not want visitors. I decided to write because, even if Molly did want to talk, I was too scared to call. She must be frightened, too. What if she asked me questions? I decided to write Molly because I was afraid to talk to her. And I wrote because that is what I do when I feel helpless.

I thought for a while about what to say in my letter. I hiked to the top of East Rock Park. I looked at the bare branches. I lay on my back on the frozen ground, staring at the sky. I watched the ducks and marveled that they didn’t seem cold. I wandered home as it grew dark, moving briskly along Livingston Street, stealing glimpses into warm livingrooms. Finally I sat down to write. I told Molly I was thinking of her and her family and that I loved them all. And then I did what I probably should not have—I offered unsolicited advice.

When you go into the hospital, wear something of your own. A red robe, perhaps.

During my thirty-ninth week of pregnancy, I was kept awake all night by a traveling itch that seemed to leave no inch of my body untouched. I had been itching for over a week, but ascribed it to the dry winter air and the fact that my skin was stretching to accommodate the baby and all the extra fluid a baby brings with it. That night, my itch had been burning up the soles of my feet. They seemed to be on fire and, despite the cool February air (being medical students, my partner Timmy and I are on a tight budget and have managed to survive New Haven winters without once turning on the heat), I let my feet hang off the side of the bed uncovered and was continually scratching the sole of one with the toes of the other. The next afternoon, shortly after a visit to my obstetrician and the subsequent return of elevated liver function tests, I was sent to the hospital to be induced. I had intrahepatic cholestasis of pregnancy.

Upon arriving at Yale New Haven Hospital, I was directed to the tenth floor, led to a room and handed a hospital gown.

“Dr. Farley will be in to see you soon,” the nurse informed me.

No hospital johnny for me!
I thanked her, then stood still. I did not want to sit on the bed, nor did I want to put on my gown. I was not sick. I was pregnant. I had hiked to the top of East Rock that morning and, had I not been sent to the hospital to be induced, that exact moment would have found me contradancing at the monthly barn dance in Bethany. Instead of taking the elevator up to the tenth floor, Timmy and I had climbed the stairs, singing the whole way. Clearly, I did not need to be wearing a hospital Johnny and socks with traction.

The nurse returned, again asked me to change into my “gown,” and told me she needed to place an IV.

“Dr. Farley should be here soon,” she reminded me, and left the room.

I hugged Timmy sideways on account of my large belly, and looked out the window at the New Haven skyline.

Only a few minutes into my hospital stay, and I was already a problem patient. Why did I resist putting on my hospital gown? Why, in a few minutes when the nurse returned, would I tell her I did not want an IV? I realized that, at the very least, I wanted to meet the doctor for the first time while still in my street clothes. I wanted to be standing upright when he entered the room, and I wanted to be wearing my bright blue sweater and my sneakers and my earrings.

As I stood there hugging Timmy, I thought about all this, and about my experience as a medical student on the wards. I thought back to my first medicine rotation, and to Mrs. Lowe, a ninety-two-year-old woman who spent three weeks with us on the geriatric ward. I thought about other clinical rotations and other patients. It was always surprising, after days or weeks of caring for a patient, to see him before departure, having exchanged a hospital gown for street clothes. Mr. Bayer in his motorcycle chaps, Mrs. Pang in her yellow sweatsuit. Somehow the vestments seemed to magically transform these patients into regular human beings who had not always lived in a hospital, who had not always been sick. On the wards, I began to wish that every patient would wear a robe like Mrs. Lowe’s. I found myself collecting details of each patient that would allow me to dress them in my mind, to imagine their lives outside of the hospital’s revolving doors.

The obstetric nurse’s persistence finally overcame my resistance, and I found myself lying in my hospital bed, hooked up to an IV and still awaiting the arrival of Dr. Farley. Timmy ordered a pizza and our friends arrived—they had decided to bring the contradance and pizza, and broke our teeth on some hard cookies brought by Tarka, the vegan. Even my friends, who knew me well, had been fooled by my hospital gown and the tubes running into my arm from the IV bag.

I was surprised to get a letter reply from Aunt Molly only two weeks after sending my letter to Nova Scotia. I had not expected it. She wrote that she appreciated my advice. It seems strange to me, now, to think about it. I did not write to Molly about dying or sickness or hopefulness. I did not write to her about lung cancer, about radiation, or chemotherapy. Even now, I do not know what sort of cancer she has. Molly has not been forthcoming about her exact diagnosis or prognosis. In my letter I did not comment on either. After four years of medical school, my only advice to my aunt dying of lung cancer was this: Wear a red robe.

I’m not sick! Bring in the pizza!

“What are you guys doing?” I asked. “I’m not sick! They just needed to put an IV in because I’m here. I haven’t even been induced yet. Hand me a piece of pizza, please.”

Finally, after more of my urging, they remembered that I was me, and we went on to enjoy an hour or two of dancing and pizza, and broke our teeth on some hard cookies brought by Tarka, the vegan. Even my friends, who knew me well, had been fooled by my hospital gown and the tubes running into my arm from the IV bag.

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This is a film that I very much wanted to like, and there is much to commend it. The couple at its center is so representative of the genuineness of the Indian people, and the scenes in Calcutta (Kolkata, if you prefer) and Agra so vivid, that they evoked warm and nostalgic feelings of my time there in 1963. Yet the filmmakers and I parted company half-way through, when the film hit some inauthentic notes that caused me to stop being an engaged viewer and to become an external critic. Despite its beauty, and the remarkable color for which the director is known, the film seemed to drag to the two-hour mark. If you are going to see the film, STOP READING HERE.

*The Namesake* starts out well enough in the crowded Howrah railroad station, as Ashoke Ganguli (Irrfan Khan), a young student, settles in for his annual summer sojourn with his grandparents in the country. His carriage mate, the quintessential Indian philosopher, assumes an avuncular relationship to Ashoke, who is trying to read “The Overcoat” in his book of the collected stories of Nikolai Gogol. The older man keeps interrupting him with advice that he should see the world rather than read books about it. “Go to London, go to America,” he says. Ashoke replies that, to the contrary, his grandfather told him, “That’s what books are for, to travel the world without moving an inch.” Suddenly, there is a horrific crash and all the passengers seem to be dead until a rescuer sees the book on Ashoke’s chest moving and realizes that he is still alive. We next see him recovering at home with a broken leg and other injuries as a statue of a goddess is lifted outside his window, one of many Indian rituals faithfully pictured by Ms. Nair, the Calcutta-born director of *Monsoon Wedding*, *Salaam Bombay*, and *Vanity Fair*. The accident presumably prompts Ashoke to emigrate to America to study.

In the next scene we see a lovely young lady, Ashima (Tabu), returning from school to find that her parents are entertaining Ashoke and his parents during his three-week return to arrange a marriage. On the way to the living room where her presence has been requested, she tries on Ashoke’s wing-tip shoes, which fascinate her. When she recites a stanza from a Wordsworth poem, Ashoke’s father finishes it, sealing the deal. On arriving in America, the couple settles into a cold apartment in what appears to be Queens. Ashima is freezing and unhappy as Ashoke immediately leaves for a faculty meeting at a local college. Parenthetically, the book of the same name by Jhumpa Lahiri on which the film was based was set in Cambridge, with Ashoke teaching at MIT; it’s not clear why the venue was changed. Ashima tries to do the laundry in his absence, shrinks the clothes, and begins crying when Ashoke scolds her. She locks herself in a room before yielding to his apologies. She watches her husband go off to his world each day, leaving her in isolation. There is little time for these two strangers to get to know one another. So as not to alarm her family, Ashima sends them letters telling them how wonderful life is.

I began to stop suspending disbelief at the point when Ashima gives birth to the couple’s first child. The sequence was filmed in a hospital on Welfare (now Roosevelt) Island with the 59th Street Bridge in view. I was okay with the couple’s delay in naming the child (which must be done before babies are discharged). Our twins were Baby Boy A and B for a number of days while they were in intensive care at the Boston Lying-In. I was also all right when Ashoke suggests they name the baby Gogol as the formal name, and later will give him his “good” or “pet” name, Nikhil. What troubled me was the absence of the woman’s mother. Since both their families are decidedly middle-class and very traditional, I would have expected that either Ashima would have gone to India to have the baby or that the mother would have flown to the United States (which the family could afford) to help her care for the first-born, especially since it’s a boy. Indeed, this maternal presence is common in almost all cultures. It seemed that the filmmaker was making a conscious effort to show the competition between American and Indian cultures, rather than the couple blending with American culture. Ashima says, “I don’t want to raise our son in this lonely country.” Later the film
shows all the cultural downsides of living in a "foreign" land. 
There's a beautiful scene at the shore as Ashoke takes the young Gogol to the water's edge, while Ashima stands next to the car holding their newborn girl Sonia and tells them to be careful. Realizing that he forgot his camera, he tells Gogol that they will just have to "remember the time we came so far that we could go no further." 
The children turn into intelligent adolescent brats treating their parents contemptuously. Gogol smokes pot with his friends, and in a particularly jarring scene he's doing a wild dance while playing air guitar to blaring music in his room after his graduation. His father looks in at the door, stupefied. Finally, Gogol sees him and tells him that he's all right, but makes no move to turn down the volume. Ashoke says that he has come to give him a present of Nikolai Gogol's stories. Gogol finally lowers the volume, takes the book, and throws it on the desk. Ashoke quotes Dostoyevsky: "We all came out of Gogol's Overcoat," and recounts the story of the accident. Gogol wants to know if that's all Ashoke thinks about when he sees him. Ashoke assures him that he reminds him of all that came after: "Every day since then has been a gift." 
Gogol becomes infatuated with a WASP girl when he matriculates at Yale, and spends the Christmas holidays with his parents at the Hamptons and in their posh New York apartment, while Ashima decorates her house with Christmas trimmings. This sets the scene for the most improbable events. Ashoke is set to go to Ohio to teach a six-month semester and asks Ashima to go with him. She refuses. This made no sense to me given that they have grown together for over twenty years and their love is palpable. We see Ashoke enter a barren apartment. Then we see him calling her from a phone booth in a hospital to say he's got indigestion and that he's been waiting for two hours and has yet to be seen, but he's okay. Why call and worry her? Especially since any self-respecting moviegoer knows that he's not long for this world, which Ashima learns much later, and becomes hysterical.

After Ashoke dies, Gogol goes to the apartment and has an epiphany. He goes all Bengali, shaving his head, dumping his WASP girl friend, having an Indian wake in America, and going back to Calcutta to scatter Ashoke's ashes in the Hooghly, a tributary of the Ganges. He even follows the advice of his mother and her family that once he's "had his fun," he should marry a Bengali. Only the one he chooses is someone he appropriately turned up his nose at during his rebellious American period. She turns out to have become more Westernized and sexually liberated than even he, as she continues an affair with her Parisian boyfriend after their marriage and is insensitive to things he considers personal between them. Sonia also does an almost 180 as she becomes a dutiful daughter but marries a non-Indian, which is okay with all.

There were particular scenes that resonated with me. The first was when grandma tells the servant to get only BATA brand shoes for Gogol when the family makes its sole trip to Calcutta; that was the brand preferred by the middle class in 1965 as well. The second was when grandma sends her servant to run after Gogol when he decides to take a jog through the crowded streets (the former being credible, the latter; not). Mrs. Dut, who administered our program, was equally solicitous to us "boys" (we were junior residents), even though she said we spoke "American," not English. Also evocative were the many scenes of the very prominent Howrah Bridge; the people going down to the Hooghly River to pray and bathe: the incomparable Taj Mahal, and the contrast with the Victoria Memorial, which can't hold a candle to it, and where I watched a snake charmer orchestrating a battle between a mongoose and a cobra. Ashoke's name reminded me of taking a picture of a doctor named A. Ganguli standing proudly in front of his home office next to a sign indicating that he was a "gold medalist." Finally, I could empathize with Gogol, who refuses to get into a rickshaw with his mother and sister because he can't think of himself being pulled along by another human—which was my reaction. However, in City of God, the protagonist, a rickshaw driver, makes the case that this is how he can afford to raise his family and many middle- and upper-class Indians had no such qualms.

Maybe I'm being too Pollyanna-ish or just identifying with Ashoke, but I don't think that, as much as the first generation Indians acculturated in America, they would be allowed to be so patronizing to their parents even if they were so inclined. I'd be interested in the take of readers of Indian descent.

Waitress


Like Sideways, Waitress is another film over which the critics gushed, calling it "a little slice of heaven" (Chicago Sun Times) and "close to perfection (Wall Street Journal)." A glowing review in the "Family Filmgoer" section of the Washington Post noted that it is "not for middle schoolers." That's not much of a concession, given that it's rated PG-13. To my mind, the most appealing things about this picture are the actress who plays the central role and the pie concept. But like those high-calorie showy desserts that are enticing until you take the first bite and come up with air and a cloying sweetness, the movie soon left me disappointed. The waitress Jenna, played by Keri Russell, best known as the star of the television show Felicity, is perky, attractive, and well-coiffed. I mention the latter because Russell was told to cut her hair at the beginning of Felicity's second season, which was blamed for the series falling ratings.

Jenna makes to-die-for pies to which she gives names like "Kick in the pants" and "I hate my husband." My first reaction was what is this pie genius doing playing a harassed waitress in...
Joe's Diner in the middle of nowhere? My second was how can this woman, who could have had her pick of the crop, marry an abusive creep like Earl (Jeremy Sisto), who drives up to the diner to take her home and honks the horn expecting her to run right out? He is a jealous control freak who takes the money she earns and knocks her around. When Jenna skips a period after Earl gets her drunk to have sex, she goes to her female OB-Gyn only to find that she has taken on a new locum tenens, handsome Dr. Pomater (Nathan Fillion), who confirms the pregnancy and congratulates her. She doesn't want Earl's baby or congratulations. “This is not a party,” she says; so he “un-congratulates” her. She tells him she wants maximum drugs and complains that they never tell you about the downsides of pregnancy like “being nauseous.” (This is one of my pet peeves. She meant “being nauseated” rather than “being nauseous” which means inducing nausea, but maybe this was a subtle commentary on the picture.)

Although she decides to carry the child, she has angry conversations with the poor thing, calling it an “alien” and a “parasite.” In between vomiting, she makes “Damn you child”, “I don't want Earl's Baby,” “Pregnant, miserable, self-pitying loser,” and “Baby screaming its head off in the middle of the night and ruining my life” pies. At the second visit, she hops on the clueless but more than willing Dr. Pomater and they begin a torrid affair. When they are about to run away together, she breaks her water and has an unconvincing delivery. She refuses to look at the baby at first but finally does so and has an epiphany and says “Oh, my God” and decides to keep her. She tells Earl to hit the road and after meeting Pomater's very nice wife who came to do a residency at the hospital (that's why he came there in the first place) and seeing how much the wife adores him, she rejects his offer to run off with her and the baby, and dumps him too. She gets discharged prematurely when Earl refuses to pay the bill and goes off with her two waitress friends. Her pie-making came from being bonded with her genius pie-maker single mother and she replicates that with the daughter.

I'm not much into labels but it is fair to call this a feminist picture. The women are all strong and the men are all weak. Besides creepy Earl and the doctor who cheats on his sweet wife, the other men in the picture include Old Joe (Andy Griffith), the diner owner. Griffith makes the most of a small part as a cantankerous, dirty old man who stops by each day for a regimented lunch featuring Jenna's pie. He is especially good in the scene in which he describes his favorite pie. Then there's Cal (Lew Temple), the obnoxious diner manager, who is married but having sex in the kitchen with Becky (Cheryl Hines), Jenna's hard-boiled sidekick and adviser. Becky is also married and explains her affair by her inability to have sex with her husband, who presumably has been out of it for years from Alzheimer’s. Finally, there's Ogie (Eddie Jemison), a nerd who is sweet on Dawn (Adrienne Shelly), the klutzy waitress of the trio. Jenna and Becky advise her to reject his requests for a date because he's a tax auditor, spouts terrible “spontaneous” poetry, is ugly, and has few social skills. He persists and marries Dawn in the diner. Ogie is the best of the lot; his support and Old Joe's legacy to Jenna after he dies during surgery help the three women establish their own diner.

My greatest disappointment with this picture is its trivialization of a very important issue, sex with patients. I became energized about this issue after hearing a family doctor, who was responsible for some of the babies he delivered in rural Maryland, tell the Board of Discipline that he had never heard in medical school that sex with patients was a no-no. I made sure that we included this subject in the required first-year course Ethics and Medical Care that I directed at Hopkins from 1983 to 1991. Some students later told me that it was not really covered in their clinical years, when, whatever their sexual orientation or gender, students found themselves attracted to their patients. Admittedly the subject is uncomfortable and one that no one likes to talk about, but it’s important. Maybe medical schools and residency programs need the equivalent of those radio spots that advise parents to talk to their children about sex.

Addendum: One sad note about this film is that Adrienne

Keri Russell in Waitress.
Credit: Alan Markfield

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Shelly, the screenwriter, director, and actress (Dawn) was murdered in her New York office/apartment shortly before the film opened. Because she was found hanging in the bathroom, it was thought to be suicide at first, but a shoeprint on the toilet led to an illegal immigrant from Ecuador whom Shelly had confronted about noise from his renovation of the apartment below. The five-foot-two Shelly apparently slapped him and he knocked her unconscious. Fearing that he would be deported, he carried her up to her apartment and because he was only five feet tall had to climb on the toilet to hang her from the shower rod. Talk about truth being stranger than fiction.

Reference


La Vie en Rose

Starring Marion Cotillard, Sylvie Testud, Gerard Depardieu. Written and directed by Olivier Dahan. Rated PG-13. Running time 140 minutes.

This is a maddeningly confusing picture because of the extreme use of flash-forwards and -backs. It’s also too long by twenty minutes. That said, it’s worth seeing for the extraordinary performance of Marion Cotillard as Edith Piaf and, of course, for the music. Both my guest and I unknowingly had the same reaction after seeing the film as the Wall Street Journal critic Jon Morgenstern, when he wrote: “In the spirit of Edith Piaf’s signature song, I regret nothing about La Vie en Rose—not the narrative confusion, not the sketchy details, not the lack of historical context or the music-video editing.”

In some respects it’s better than many of the straight-ahead biopics downplaying a star’s seamier side. If anything, this film wallows in it. There’s Piaf’s mother, who begs for money and neglects Edith (named for the heroic nurse Edith Cavell), finally dropping her off at her mother’s house. Her father returns from the front in World War I to find Edith full of sores, and takes her to his mother’s house, a bordello in Brittany, while he pursues his career as a contortionist in the circus. Edith develops severe conjunctivitis in both eyes and is temporarily blinded. The prostitutes chip in for her to go to the shrine of Therese of Lisieux and she is cured (although her taking off the bandages over her eyes in broad daylight should have been accompanied by marked photophobia). Interestingly, this devotion to St. Therese continued throughout her life, as the film shows.

Her father comes back for Edith, and she joins him in the traveling circus and later on the streets of Paris. As a teenager, she and a friend, Momone (Sylvie Testud), sing for money in Pigalle under the auspices of Albert the pimp, who threatens them with being put to work as prostitutes if they don’t bring in
enough money. Meanwhile her daughter, Marcelle, born to her and a local delivery boy, dies of meningitis. She is discovered by Louis Leplee (Gerard Depardieu), who convinces her to change her outfits and gives her the new name of Piaf (“sparrow”) because of her four-foot-eight stature, the genesis of her nickname “Little Sparrow.” When Louis is murdered, ostensibly by Albert, she is accused of being an accessory to murder but is released. All this is packed into only twenty years.

Edith is fortunate to come under the tutelage of Raymond Asso (Marc Barbe), who polishes her singing and diction, while his colleague, Marguerite Monnot (Marie Armelle Deguy), writes the songs that make her famous. Her affair with Marcel Cerdan (Jean-Pierre Martins), the Algerian boxer and married father of three who beat Tony Zale for the world middleweight title in 1948, is the only one that the film focuses on, ignoring other celebrity lovers like Charlie Chaplin, Charles Aznavour, Yves Montand, etc. This is probably because Cerdan is said to have been “the love of her life”; a picture entitled Edith and Marcel was made in 1983 by Claude Lelouch, starring Marcel Junior. Cerdan’s death aboard an Air France plane that crashed in the Azores in 1949 was largely responsible for her subsequent despair, which, along with injuries in an automobile accident, led to her descent into morphine addiction and alcoholism.

Cotillard is remarkable in portraying the stooped-over hag-like Piaf, a transformation that took almost five hours of makeup artistry to achieve. As for the songs, she convincingly mimics Piaf, most of whose “greatest hits” are included. If you like Piaf, see the film, but be ready to be turned off by some scenes. It’s mostly in French with subtitles.

La Vie en Rose brought to mind the stories of Judy Garland and Billie Holiday, who also kept singing to the end with severe debilitating addictions. It raises the old question, “Does one have to go through all that depravity, drug and alcohol addiction, consorting with lowlifes, and having multiple lovers to live the lyrics or to be successful an artist?” When we had this conversation in another context, my wife Colette pointed to the happily married and certified genius Felix Mendelssohn, whose life, though short (he died at thirty-eight), mirrored his first name. Then again, he may have been the exception that proved the rule.

References


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Wynne Morrison, MD
Reviews and reflections

The Biology of Cancer
Robert A. Weinberg

Reviewed by Thoru Pederson, PhD

There is a dangerous zone of writing that some physicians and biomedical scientists dare to enter, with results ranging from feckless folly to enchanting erudition. This zone lies between standard texts on the one hand and books for broader audiences occupying ever-expanding shelf space in the biomedical and natural sciences sections of bookstores.

An author trekking into this zone seeks to reach the educated lay public and yet properly hopes not be seen by peers as having left the guild. Astronomer and astrophysicist Carl Sagan paid dearly for the sin of reaching out to the lay public, getting blackballed at the final stage of his candidacy for the National Academy of Sciences. He lives on as one of the most eloquent champions of the ethos of Sciences. He lives on as one of the known, occupying a position in another kind of academy—the pantheon sitting alongside Lewis Thomas.

Now into this dangerous métier comes Robert Weinberg with a book on the biology of cancer. It is neither a clinical oncology text nor a Scientific American treatment. Rather, the author has managed by the sheer dint of his mastery of the subject and brilliant expository skill to come up with a true manifesto, a work that I believe will remain sui generis for decades. Even beyond then, it will be always looked back upon as a defining epistemological milestone in our knowledge of cancer.

How did the author pull this off? First, Weinberg holds an unusually broad command of cancer biology. His initial scientific fame resulted from his lab’s discovery of the bladder cancer-causing segment of mutated human DNA called the ras oncogene (a discovery chronicled beautifully by Natalie Angier for a lay audience and by Weinberg for a hybrid peer/“really interested” non-peer readership). But Weinberg’s interest in cancer originated much earlier, both from a seminal familial influence (a cousin who was a prescient cancer researcher) and from his training in cell biology at MIT. He wisely chose to do postdoctoral work at the Salk Institute with Renato Dulbecco, who had earlier developed a quantitative assay for studying tumor viruses, while also possessing deep insight into how tumor viruses influence the cell division cycle.

But the innate gift of formidable intellect, coupled with his powerful training and succeeding prescient research on the ras oncogene is not the only backdrop for this book. Along the way, on a thirty-seven-year path, Weinberg was in his study at all hours reading and amassing virtually everything that was known about cancer. Unlike many molecular biology-oriented cancer researchers, he did not look down on pathologists and oncologists, understanding that their knowledge base constitutes a treasure. All through the years, one can track Weinberg’s research through the eyes and mindset that this broader reach of oncology has provided him.

This book has been designed as a “hyper-engageable” entity, combining superb graphics with Weinberg’s extremely lucid and lively writing style to create powerful didactic punch. However, because this review is appearing in a publication whose readership includes many practicing physicians, a warning must be issued: the author’s treatment of the biology of cancer will not be easy going. Readers who are not cancer research scientists will have to steel themselves to “stay with the program” and read on. Oncologists, surgeons, and other physicians dealing with cancer in the clinic may want to set aside two hours or so every weekend for careful reading. The bad news is that there is a necessary level of information that will be unfamiliar. The good news is that Weinberg makes it as enjoyable a ride as can be imagined. In addition, some chapters will be more relevant to oncologists who are keen to know how tumor gene expression analysis by “microarrays” can enable prognosis and treatment (perhaps one of the most exciting dimensions in oncology today), while other chapters will especially engage cancer surgeons or chemotherapy and immunotherapy practitioners. The result will be a deep and extremely accurate picture of cancer as a science of causation, a science of precision, and a science of opportunity. I know of no other book about a major disease that meets these criteria so well.

From the epistemological point of view, Weinberg’s most commanding central doctrine is the notion of a genetic schedule of events as a cell becomes malignant. Although oncologists and pathologists might at first read this central tenet as simply a restated version of “tumor progression,” Weinberg is on to something deeper. It turns out that cancer is an extremely episodic phenomenon and that signature changes in gene expression and cell behavior have become now well-recognized milestones, each one of distinctive biology and no one of which...
is quite the same as the ultimate, frank metastatic state. Amazingly, some of these stages are not florid disease, and even vexing clinical phenomena such as tumor indolence can now be understood in this context. Weinberg also brings readers up to date on perhaps one of the most frequently deployed ways that a premalignant cell avoids becoming a tumor progenitor cell, namely to undergo senescence. The book is remarkably up to date and, although some issues are still uncertain, the author makes clear what is well grounded versus what is still unknown.

As is now evident, I am enthusiastic about Weinberg’s book. Beyond its didactic power, it has the all-too-rare quality of style. The authoritative material on each page enables the reader to know more about cancer as biology than can be learned so pleasurably anywhere else. An accompanying CD has all the illustrations in PowerPoint slide format with engaging narrative by the author, adding to the combined value of this body of scholarship.

References

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Letters to the editor

“Looking south to find the medicine of my heart”

I am glad that Ms. Rebecca Trotzky Sirr found the medicine of her heart in Venezuela (Spring 2007, pp. 18-21). I am only sorry that she left her brain at home. Citizens and medical practitioners in the United States can certainly learn methods of improving public health by observing successful initiatives abroad; however, we must remain aware that these initiatives come at a price beyond the financial in some countries. Although citizens of Venezuela may receive a basic level of health care under the Chavez regime, they have lost many of the freedoms that we as Americans hold dear, such as freedom of assembly, freedom of speech, and freedom of the press. Most Americans would not trade our Bill of Rights for free housecalls.

M. Boyd Gillespie, MD
(ΩΩΩ, Medical University of South Carolina, 2006)
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Resident duty hours and professionalism—limits and opportunities

In 2003, the ACGME instituted common standards for resident duty hours. Since then, a number of articles noted that residents today are “less professional” than earlier cohorts and have offered duty hour limits as the cause. If we accept a cause-effect relationship between duty hour limits and allegations of lower professionalism, are we certain which is cause and which is effect? It seems equally plausible that residents in the early twenty-first century, like their contemporaries in other occupations, seek a different balance between their professional and personal lives from that pursued by the generations that make up their faculty and that this contributed to the interest in limiting resident hours.

The U.S. public places a high value on continuity of care and the professionalism of their physicians. However, its members do not universally equate professionalism with their physicians’ working long hours, and it has been difficult to persuade them to accept the eighty weekly and up to thirty continuous hours allowed under the current duty hour standards as safe for patients or residents, and as the only approach to ensure continuity of care. Many physicians in academic practice who espouse a traditional view of continuity of care as the responsibility of the individual live this belief in a system in which residents provide much of the care on nights and weekends, and in which their own weekly work hours often do not approach those worked by residents. One may question whether continuity of care in the nation’s “best hospitals” should rely on learners in a formal program of education, and whether making the youngest members of the profession responsible for continuity represents the appropriate manifestation of professionalism at the level of the department, institution, or profession. Evidence that there are other ways of ensuring continuity comes from specialties and settings with an expectation of 24/7 availability of faculty, many of which have restructured faculty work patterns to follow a shift model, even in specialties with high patient expectations for continuity like obstetrics. At the same time, continuity in residents’ educational exposure to patients, to allow them to see progression of illness, responses to treatment and to appreciate complications that may arise, could be a victim of the limits on resident hours. This suggests a need to study the effect of limits on residents’ learning and acquisition of competence, and to develop alternative approaches that ensure effective education at the bedside within the current system constraints.

Four years after the institution of limits on resident hours, the ACGME and the medical community have begun to appreciate there may be a dearth of evidence for the patient safety effects of the duty hour limits, despite ample scientific data of the effect of sleep loss on resident performance. This may be because patient safety is not “created” at the level of the individual resident or faculty member, but results from the efforts of a clinical microsystem, in which a group of medical, nursing, and other professionals collectively maintain patient safety and continuity of care. Such systems still can fail if duty hour limits are instituted without other staffing or other changes, resulting in a compression of work or an inadequate number of professionals to perform the work. The consequences often are indistinguishable from those of long hours worked by residents in isolation and without adequate supervision. At the heart of the case of Libby Zion and many of the anecdotes about consequences of duty hour limits is not the success or failure of an individual resident’s professionalism. Rather, the events are instances of “failure to rescue,” defined as inadequate attention and a lack of a system of care around a given patient as the cause or contributing factor in an adverse outcome.

It is worth noting that the regulation prompted by the death of Libby Zion included both limits on resident hours and strengthening faculty supervision and coordination of care in the academic inpatient setting, though the latter has not garnered as much of the medical community’s attention in the past nearly two decades.

A real danger of equating limits on resident hours with loss of professionalism comes in the selection of remedies. If eighty hours per week is insufficient for continuity of care and socializing residents to their professional responsibility for patients, would ninety weekly hours be adequate, or would it require one hundred hours or more? This suggests that the solution likely will not come from adding back hours to residents’ work weeks. Duty hour limits are blunt tools and cannot by their absence or presence promote or obliterate professionalism in residents.
It is important to socialize resident physicians to the demands of continuity of care and the importance of putting their patients’ needs above their own. Promoting professionalism under limited resident hours will benefit from dialogue between teaching faculty and residents about professional obligation to one’s patients that seeks to balance the views of residents and junior and senior faculty. Promoting professionalism also requires exploring the benefits of continuity of care held by a group of individuals, facilitated by technology and from conceptualizing, teaching, and assessing professionalism in ways that permit viable forms of “group and team continuity” to emerge across a wider range of clinical disciplines, in response to changes in patient care practices that place responsibility for care at the level of the group. The goal is to create a new construct of professionalism that is not dependent on long hours spent and that bridges the differences in the approaches of a work and personal life balance of the multiple generations of physicians involved.

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Endangered species indeed

It was disconcerting to read Dr. Edward D. Harris’s editorial in the Winter 2007 issue of The Pharos (p. 1). Dr. Harris writes of two separate problems in medicine today: increasing specialization, creating the “endangered species” of family practitioners, and the problem of the uninsured.

Increasing specialization has at least three causes. First is the ever-accelerating pace of change in medical knowledge. The ability of physicians to learn it all and keep up to date with it is strained to the maximum. In order to master it with any degree of confidence, more physicians are specializing.

Secondly, patients are demanding specialists. If your child has a broken arm, whom would you prefer to set it: a family practitioner who may have applied plaster three or four times during his residency, or an orthopedist? If there were no demand for specialists, a lot of doctors would be out of work. That is not the case. Supply has risen to meet the demand.

And the third cause for specialization is monetary. It requires several additional years of hard work and study, beyond the three years of a primary care residency, to specialize. These years mean thousands of extra hours spent taking care of patients, rounding, reading, and acquiring a larger body of knowledge. In addition, those who specialize further postpone the gratification of earning a living in practice. The economy rewards these extra years, and this additional knowledge, with increased compensation. Medical specialists have earned it.

Dr. Harris proposes to attract more physicians to primary care by improving reimbursements. His solution is a good one: billing by the hour, based on one’s level of training. In addition to direct patient encounters, physicians in all specialties spend countless hours reading about their cases, returning patients’ e-mail and phone calls, arranging referrals and care with other health professionals. Why shouldn’t doctors be compensated for their hard work and grueling hours? Attorneys have long utilized billable hours. Most psychiatrists bill by the hour. This is a workable solution to the problem for many doctors (not just those in primary care) who spend many, many hours at work for which they receive no compensation.

However, rather than billing patients and their insurance companies by the hour, Dr. Harris suggests “a small tax” on the profits of drug companies, insurance companies, manufacturers of medical devices, and hospitals! By what right would such a tax be collected? Dr. Harris is clearly looking for the deep pocket here, and implying that earning a profit in the health care industry justifies dipping into that profit to compensate doctors. The cost of this lost profit would ultimately be borne by patients in the form of higher costs for health care products and services.

The second problem Dr. Harris addresses is the uninsured. He advocates “a well-designed single payer system” for the uninsured, created by “true will and determination among our elected officials.”

Who would pay for this? “Society,” say those who advocate such a system. “Society” is nothing more than the 130 million taxpayers in this country, who would then be paying for health care three times over: once for themselves, once for Medicare and Medicaid, and once for the uninsured. By what right do the uninsured (or the elderly or the poor) lay claim to the income of others?

Health care does not grow in nature. It is a man-made commodity of goods and services in our economy. There is no “right” to health care. There is only the right to seek health care by trading one’s own goods or services for it, or by availing oneself of the charity of others. A need for health care does not mean that one is entitled to it.

Should “our elected officials” determine that “people need food, therefore everyone in this country is entitled to food”? Should people be told they may buy whatever groceries they want, in whichever store they choose, as often as they please, with “society” picking up the tab? What would that do to the price of food? How long do you think grocery stores could stay in business if government payments to grocers are decreased because costs have gotten out of control?

If the government nationalizes health care, the consequences will be devastating and far-reaching for everyone who gives or receives medical care in this country. Demand for care will increase, and costs will follow, as has happened with Medicare and Medicaid. There will then be the multiple rounds of ever-decreasing reimbursements to physicians and hospitals. In an effort
to rein in spiraling costs, doctors will become essentially government employees. And where will the best and brightest students in this country go? Into fields other than medicine. And slowly but surely, progress in medicine will decline. There will be no new drug therapies, no new medical devices, no new surgical techniques, in a system that rewards conformity and penalizes innovation. Is this what the advocates of “a single payer system” have in mind?

Those who propose government-funded health care for the uninsured (or the elderly, or the poor) are attempting to project their own benevolence and compassion onto others. In a free society, those who feel compassion for the uninsured are permitted to act on that feeling, for instance by donating time at a free health care clinic, or donating money to a hospital. But they are not free to impose their compassion on the rest of the individual people that make up society.

It surprises me that Dr. Harris can advocate physicians’ billable hours on the one hand, and national health insurance on the other, in the same editorial. Physicians who agree that government-funded health care must be avoided at all costs, must be prepared to speak up about this issue, to defend our profession from those who would enslave it.

If one is to keep a covenant, one should know with whom the covenant is made. Do we make this covenant with our own conscience, our profession, our patients, or our God? Who or what exactly is coming together when this covenant is undertaken? Does a covenant have meaning if we do not know with whom or what we have an agreement? Does the moral authority of the covenant vary with the moral, scientific, or political authority of the entity with whom it is made? If this covenant is made with the medical profession, does a suitable body of practitioners who truly live by its tenets exist? If so, where may this community be found?

In requiring that a practitioner diagnose and treat all persons who want or need care, the second sentence of the covenant implies an omniscience, omnipotence, and omnipresence that earlier oaths, in particular, that of Hippocrates, forbade. In the Hippocratic oath, the practitioner is obliged not to cut for a stone, but to send the patient to practitioners of that art. With the advent of the eighty-hour work week, physicians have self-imposed limits on our ability to care for all when we are faced with this unscientific, arbitrary definition of fatigue. Personal beliefs, religious customs, previous psychological traumas, illness, substance abuse, work hour restrictions, and physical handicaps may prevent the practitioner from giving optimal care to all patients. A valid covenant should recognize that a physician has the responsibility to identify when these barriers to optimal care occur, and should oblige the physician to personally decline care to an individual when care cannot be given safely and ethically.

A primary mission of caring for patients demands that the physician be reimbursed for the work of this mission. If the physician must find other means of support in order to care for patients, then this mission of caring for patients is no longer primary. Monasteries have long recognized the need to form self-sufficient communities to raise food and manufacture goods for sale abroad to support the life of prayer and solitude that the called have chosen. If we truly believe that our practice of medicine should not be influenced by promise or acquisition of personal reward, then it is incumbent upon our profession to develop communities (monastic or otherwise) that allow us to practice medicine as a pure offering of love, while bearing the burden of our own support through other means. If sentence three is a valid declaration of our professional covenant, we have failed miserably because we are approaching the problem in an inherently contradictory way.

Lastly, the final sentence of the covenant subtly validates the neglect many physicians create for themselves and their families. No other line of the covenant merely “strives” for anything. This line should simply read, “I will maintain physical and emotional health in myself and my family.”

In spite of these attempts at its deconstruction, this covenant has served as a useful tool for personal examination of conscience. Rather than view my career as a covenant between my profession and myself, I believe my career in surgery to be a vocation whose mission (a sending forth) is and will be fulfilled by the actions of my life and

Reference


Deborah K. Miller, MD
(AOA, New Jersey Medical School, 1980)
Great Falls, Virginia

Covenant

While clearing my desk of journals, I encountered the covenant inscribed on the cover of the Summer 2006 Pharos. The resulting introspective examination of my twenty-year surgical career led to a more critical analysis of the tenets of the covenant and their validity in light of the current state of medical practice.

The word “covenant” comes from Middle English, and is derived from the present participle of the Old French verb, “covenir”, literally a coming together, or an agreement. In western theology, the term is associated with the agreement between God and His people, as expressed by the Hebrews and their relationship with God through Abraham, Moses, and David, and in the Christian tradition, as a new covenant between Christ and the Christian church. In law, covenant refers an agreement between two parties drawn up by a deed, or a specified clause within a contract.

In a free society, the covenant implies an omnipotence, and omnipresence that earlier oaths, in particular, that of Hippocrates, forbade. In the Hippocratic oath, the practitioner is obliged not to cut for a stone, but to send the patient to practitioners of that art. With the advent of the eighty-hour work week, physicians have self-imposed limits on our ability to care for all when we are faced with this unscientific, arbitrary definition of fatigue. Personal beliefs, religious customs, previous psychological traumas, illness, substance abuse, work hour restrictions, and physical handicaps may prevent the practitioner from giving optimal care to all patients. A valid covenant should recognize that a physician has the responsibility to identify when these barriers to optimal care occur, and should oblige the physician to personally decline care to an individual when care cannot be given safely and ethically.

A primary mission of caring for patients demands that the physician be reimbursed for the work of this mission. If the physician must find other means of support in order to care for patients, then this mission of caring for patients is no longer primary. Monasteries have long recognized the need to form self-sufficient communities to raise food and manufacture goods for sale abroad to support the life of prayer and solitude that the called have chosen. If we truly believe that our practice of medicine should not be influenced by promise or acquisition of personal reward, then it is incumbent upon our profession to develop communities (monastic or otherwise) that allow us to practice medicine as a pure offering of love, while bearing the burden of our own support through other means. If sentence three is a valid declaration of our professional covenant, we have failed miserably because we are approaching the problem in an inherently contradictory way.

Lastly, the final sentence of the covenant subtly validates the neglect many physicians create for themselves and their families. No other line of the covenant merely “strives” for anything. This line should simply read, “I will maintain physical and emotional health in myself and my family.”

In spite of these attempts at its deconstruction, this covenant has served as a useful tool for personal examination of conscience. Rather than view my career as a covenant between my profession and myself, I believe my career in surgery to be a vocation whose mission (a sending forth) is and will be fulfilled by the actions of my life and

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the lives of the patients and families with whom I have been blessed to intersect. In giving, I also receive from my patients, if only I have the insight and humility to recognize these gifts for what they are. It is a work in progress, a life in service to others, a living organism whose remaining acts have yet to unfold. It is to this calling that I have dedicated my life. It is to this vital mission, rather than an abstract covenant, that we are bound as physicians worthy to serve the suffering.

James J. Hamilton, Jr., MD, FACS (AΩA, University of Kansas School of Medicine, 1981) Topeka, Kansas

Intelligent design

Gerald Weissmann may hardly realize that his rebuttal to W. McA. Davis in the Spring 2007 issue of The Pharos (pp. 67–69) is a representative example of dogmatic naturalism—a belief system that fits every definition of a religion, and that threatens the pursuit of truth as much as any of the religious beliefs he claims are “endarkening” science.

However, beginning in his original article and continuing into his response to Davis, Weissmann persistently resorts to ignoratio elenchii. Instead of responding to the thrust of Davis’s letter—some salient points of the intelligent design argument—he chooses to focus on the most easily refuted element of the letter: a single introductory sentence in which Davis expresses doubt that Weissmann is familiar with the substantive works of intelligent design. Unfortunately, this is merely a continuation of the theme of the original article, in which Weissmann never actually addresses any of the assertions made by proponents of intelligent design and instead chooses to promote the contrived dichotomy between science and theism by resorting to ad hominem attacks. If intelligent design has merit, concede it; if it does not, refute it. Personal attacks are not necessary.

A hardly less disappointing feature of Weissmann’s rebuttal is his appeal to authority in the form of reputable journals. Fallible though appeals to authority are by nature, Weissmann’s version also resorts to circular logic, the premises of which could be read as follows:

A. Intelligent design does not stand the test of scientific peer review.

B. No scientist believes in the viability of intelligent design.

If premise B were predicated on premise A, then Weissmann’s overall argument might have merit (assuming we could establish a good argument for why intelligent design does not stand up to peer review). However, in Weissmann’s argument, premise A is also predicated on premise B! It is not hard to see that his position degenerates into infinite regression. The only way to break this regression is to actually address the features of the intelligent design argument rather than bias oneself against it without tackling any of its assertions.

The latter part of Weissmann’s rebuttal illustrates a phenomenon in science that is, unfortunately, not new: the priority of the paradigm. History shows us that revolutionary ideas in science are often met with a hail of criticism because they defy or challenge the existing paradigm. Charles Darwin met with such hostility when his tenets of natural selection were first presented; now a variant of his theory is the popular model. In the last two decades, scientists and nonscientists alike have questioned the sufficiency of the theory of evolution as it is currently presented, based on a cogent set of arguments. Some of these arguments are outlined in Davis’s letter, and some lie outside the traditional realm of science and fall into the realm of philosophy. Many proponents of evolution have responded to this challenge by rushing to “protect” evolution, much as scientists in the latter part of the nineteenth century tried to protect their existing paradigm from the perceived threat of Darwin’s ideas. Never mind that intelligent design is not the sinister chicanery its opponents insist it is. It questions the existing paradigm and is therefore “dangerous.”

Miles Otto Foltermann, MD (AΩA, The University of Texas-Houston, 2005) Nashville, Tennessee

Bioethics and Armed Conflict

Perhaps because today is the anniversary of the Allied invasion of Normandy in 1944, I feel obliged to respond to Mr. Franklin Hunt’s review of Bioethics and Armed Conflict: Moral Dilemmas in Medicine and War (Spring 2007, pp. 63–65). I enjoyed (and for the most part agree with) his comments until his last few paragraphs: “But in World War II, believing Britain could only be saved by ‘an absolutely devastating, exterminating attack by very heavy bombers . . . upon the Nazi homeland,’ [Churchill] supported a protracted carpet-bombing campaign against German cities and civilians. As intended, it was horrible and murderous, and in retrospect was probably of little military value. The British, however, were and remain unapologetic.”

This is true. And it reminds me of the words of irate German civilians in 1952 when I was stationed in Wurzburg. Neither Mr. Hunt nor those folks had words to speak of the 1940 blitz (around-the-clock bombings and the V1 and V2s) of London and other English cities. I don’t think Dresden or Leipzig suffered any more than Coventry or Manchester. But then, who started this debacle? It was an ugly chapter in the history of man, but I am weary of so-called experts on military ethics who cite the British as being “unapologetic,” while conveniently omitting any mention of the violence against humanity initiated by the Nazis and Japanese. Unfortunately, Mr. Hunt is not alone in this unilateral vision of history.

Robert H. Moser, MD, MACP (AΩA, Georgetown University, 1969) Madera Reserve, Arizona
The Alpha Chapter, Rhode Island, held its first induction of student members on May 15, 2007. New members in attendance included twelve of the sixteen students, three house staff, and two faculty. Over one hundred members and guests enjoyed the celebration. Keynote speakers were Eli Y. Adashi, MD, Dean of Medicine and Biological Sciences of the Warren Alpert Medical School of Brown University, and Charles Carpenter, MD, original chapter councilor and Professor of Medicine at Brown University.

Charlotte M. Boney, MD
(AΩA, University of Tennessee, 1988) Councilor

Brown University’s 2007 AΩA inductees. Front row: Jennifer Yates, Peter Vezeridis, Dr Francois Luks, Madhavi Parekh, Nancy Brim, Lauren Geller, Stacy Croteau, Dr. Michelle Lombardo, Dr. Corey Ventetuolo, Elizabeth Wallace. Second Row: Dr. Charles Carpenter (former councilor), Sarah Taylor, Nicole Herschenhous, Charlene Hooper, Michael Kurtz, Courtney Voelker, Dr. Edward Feller, Dr. Charlotte Boney (current councilor), Dr. Mike Connors.
Alpha Omega Alpha Medical Student Service Project awards, 2006/2007

Begun in 1993 as the Chapter of the Year award, this program was intended to recognize outstanding contributions made by an AΩA chapter. In 1997, the program became the AΩA Chapter Development Awards, aimed at encouraging ongoing original and creative programs being carried out by AΩA chapters. In 2003, the program again changed to the AΩA Medical Student Service Project awards, which became an award available to any student or group of students at a school with an active AΩA chapter.

Funds of up to $2000 per year, renewable for a second year at $1000 and a third year at $500, are available to students to aid in the establishment or expansion of a medical student service project benefiting a school or its local community. One application per year per school is allowed, selected by the school's AΩA councilor and dean from the proposals submitted.

Medical Student Service Projects funded by AΩA during the 2006/2007 school year were:

**CALIFORNIA**
University of California, Irvine, School of Medicine
CampMed at UCI
Keck School of Medicine of the University of Southern California
KSOM Program in Patient Education
Loma Linda University School of Medicine
Reach Out and Read at SACHS (Social Action Community Health System) Clinic

**ILLINOIS**
University of Illinois at Chicago College of Medicine Urbana-Champaign campus
HerMES Clinic Third Year
University of Illinois at Chicago College of Medicine Chicago campus
The Vision Mission
Chicago Medical School at Rosalind Franklin University of Medicine and Science
New Life Vocational Society (NLVS)
University of Chicago Division of the Biological Sciences/Pritzker School of Medicine
Multicultural Community for Academic Advancement in Medicine (MCAAM)
Loyola University Chicago/Stritch School of Medicine
Community Health/Loyola Primary Care Clinic

**MARYLAND**
Johns Hopkins University School of Medicine
Community Based Tuberculosis Program (CBTP)
University of Maryland
Community Health Advocacy Team (CHAT)

**MASSACHUSETTS**
Boston University School of Medicine
Helping Adolescents to Live Tomorrow Healthy (HEALTH)

**MINNESOTA**
Mayo Medical School AΩA Association
Harvest Classic Road Race Second Year

**NEVADA**
University of Nevada School of Medicine
Student Outreach Clinic (SOC) Second Year

**NEW YORK**
New York Medical College
Elementary Health Education Outreach Project
Mount Sinai School of Medicine of New York University
Mount Sinai Community Health Fair
University of Rochester School of Medicine and Dentistry
Journal of the University of Rochester School of Medicine & Dentistry (JURSMD)

**NORTH CAROLINA**
University of North Carolina at Chapel Hill School of Medicine
Health Fair for Hispanics
Wake Forest University School of Medicine
Share the Health Fair, Third Year

**NOVA SCOTIA**
Dalhousie University Faculty of Medicine
Everest Project

**OHIO**
Ohio State University College of Medicine
MD Camp 2007
University of Cincinnati College of Medicine
MEDVOC: Expanding and Improving Medical Education Out of the Classroom and Into the Community
Northeastern Ohio Universities College of Medicine
Improvement of Health Awareness in the Asian Adolescent Population of Northeast Ohio
Ohio State University College of Medicine
Columbus Free Clinic, Third Year

**TENNESSEE**
Vanderbilt University School of Medicine
Healthcare for Teens in Crisis

**TEXAS**
University of Texas Medical Branch University of Texas Medical School at Galveston
Teen Medical Academy & Teen Health Camp

**WASHINGTON**
University of Washington School of Medicine
Students in the Community (STIC), Second Year

**WEST VIRGINIA**
Joan C. Edwards School of Medicine at Marshall University
Let's Get Moving: Childhood Obesity Community Awareness and Intervention Project
West Virginia University School of Medicine
West Virginia University Health Sciences Center Recycling Project

Alpha-male giraffes have learned to get carotid ultrasound by age 17.

Dr. Spudis is emeritus clinical professor of Neurology at Wake Forest University Health Sciences (School of Medicine), and a consultant at the Veterans Administration regional office in the Compensation and Pension Division. His address is: 1215 Yorkshire Road, Winston-Salem, North Carolina 27106. E-mail: spudis@msn.com.
Alpha Omega Alpha members elected in 2006/2007

Chapters are listed alphabetically by state, province, or country, then in order of charter

**ALABAMA**

University of Alabama School of Medicine at Birmingham—Alabama


Alumni: Brian A Perry, R Edward Varner

Faculty: William D Jordan Jr., Tarak Vasavada

House staff: Sarah Wood Atkins, Runci Toms, Robert Bradley Troxler

University of South Alabama College of Medicine—Beta Alabama

Students: Amy L Bowden, Benjamin A Davidson, Joseph B Eason, Marianne D Grammas, Thomas Lake Lee, Amanda J Mularz, Christy Gautier Humphrey, Nicholas G Papajohn, Karen Anne Raduaco, Kashi H Tufafque, Holly Wimppe, Elizabeth Duett Wood

Alumni: Anthony N Galanos, William Kevin Green

Faculty: Errol D Crook, Susan P LeDoux

**ALBERTA**

University of Alberta Faculty of Medicine and Dentistry—Albta Alberta

Alumni: None reported

**ARIZONA**

University of Arizona College of Medicine—Arizona


Alumni: Stephen W Coons, Kerilynn Morgan

Faculty: Ronald C Hansen

House staff: Reta Arsanjani, Carlos F Barajas, Brad Alan Friedman

University of Arizona College of Medicine—Arizona

Students: Amanda Michelle Bailey, John Carlo Barr, Montianna Sherrell Bingham, Mary Joan Burgess, Adam Avery Carver, James Edward Cassat, Stephen J Davis, Michael Lawrence Flick, Tiffiny M Gillam, Brandi Elizabeth Guthrie, Christian Cardell Hester, Michael McKinley Hussey, Jennifer Lynn Jacks, Andrew Callaway James, Susanne K Jeflfs, James Cooper Keane, Michael Gregory Kendrick, Justin Hale Long, Richard Grant Morschedi, David Bryan Nelson, Dawn Marie Reeves, Christopher C Ross, Stephen Gandy Routon, Lisa Gayle Poudnor Sajivovic,9, Sament Trent Snipes, Erin Joyce Vaughn, Daniel Young Woodruff

Alumni: Billy Ray Thomas

Faculty: Sara Tariq, Puri Thapa

House staff: Leah Annulis, Matthew W Jaeger, Tobias Jay Vancil

**CALIFORNIA**

University of California, San Francisco, School of Medicine—California

Students: Carina Heather Baird, Ami Siddharth Bhatt, Rohy Paul Bhattacharya, Erin Michelle Brock, Emily Buck, Rebekah Anne Burns, Danielle Andrea Carlin, Carolyn Marie Hendrickson, Kevin Chung-Kai Huo, Veronica Anne Jordan, Robin Alison Lamar, Christina Audrey Lee, Annie Katherine Lim, Charles Chia-Hong Lin, Katherine Casey Lion, Sarah Elizabeth Little, Deirdre Alumae Martines, William Martin, Glen Elwin Michael, Jonathan Matthew Raser, Robert Carlston Sprold, Luisa Maria Stamm, Margaret Hancock Sullivan, Vanessa Victoria Thompson, Aaron Daniel Tward, Michael Robert Wilson

Alumni: Ralph Gonzales, Todd Anthony May

Faculty: Jack Partridge, Lowell Dean Tong

House staff: Nobu Barazangi, Brian L Shaffer, Harisrman Sachdeva Singh

Keck School of Medicine of the University of Southern California—Gama California

Students: Amy Allman, Laura A Bower, Meredith Ashley Brower, Angela Giron Covington, Braden J Criswell, Paul Clement Drury, Michelle Renee Fleurat, Donald Hannoun, Jennifer Anne Hertz, Elliot M Hirsch, Paul Sanghun Jhun, Grant Michael Kleher, Monihan J Lappati, Josh Meier, Andrew L Merritt, David George Rubin, Chad E Sarver, Adam Sassoon, Mark Alan Schumpf, Aaron C Spicer, William Ryan Spiker, Ashley Erin Starkweart, Kristine Tate, Ryan Samuel Jacobson Vitali, Jeffrey Kuoitin Wang, Ernestine Wen, Talley Bhan Yang Whang

Faculty: Kenji Inaba

House staff: Ryan Smith

David Geffen School of Medicine at UCLA—Delta California


Loma Linda University School of Medicine—Epsilon California


Alumni: Richard H Hart

Faculty: David M Swope

House staff: David Justin Dows, P Bertil Weldon Smith, Tang Henry Tang

University of California, Irvine, School of Medicine—Zeta California

Students: Mahsa Abdollahi, Megan Boyerson, Scott M Bradley, Taylor DeFelice, Christina Hernandez, Alison Kim, Michael Zachary Koontz, Jon-Paul Pepper, Conor Regan, Mark Russell, Joline Shu, Eric Silman, Sarah Elizabeth Smith, Jeanette M Waller, Rebecca Yeastad

Faculty: Jishin I Wu

University of California, Davis, School of Medicine—Eta California


Faculty: Roberta Springer-Loewey

**COLORADO**

University of Colorado School of Medicine—Alpida Colorado

Students: Erin Marie Arthur, Melissa Caroline Austin, James Frederick Cromie, Maureen Ann Cunningham, Margaret Mary DiGeronimo, James Benjamin Earl, Daniel Eric Forsba, Shiloh Virginia Gilbert, Shay Krier, Damien James LaPar, Kari L Lauridsen, Ryan Lipmansion, Benjamin David Marvin, Laura Allison Newberry, Sajal Sharma Pokharel, Cara Catherine Prideaux, Brian Liem Roethschild, Andrew Lewis Samuelson, Tianjie Shen, Jill Michelle Stovall, Eric James Thorson, Rebecca Susan Vogel, Gary J Witt, Michael Gregory Zieske

Faculty: Bruce W Evans, Frederick L Grover

House staff: Daniel D Matlock, Robert T Stovall

**CONNECTICUT**

Yale University School of Medicine—Albta Connecticut

Students: Karen Lorraine Archambald, Nana Akua A Asafu-Agri, Aaron J Berger, Sean Ryan Christensen, Farrah Mikhail Dato, Matthew Chandler Egalka, Hassana Aisha Ibrahim, Christopher Michael Janson, Lucy Kalandini, Paul Sudhir Arul Kalainithi, Jennifer Melissa Kalish, April Robin Levin, Rajesh Chalamalasetty Rao, Sally D Roman, Oren S Rosenberg, Stephen Lawrence Shiao, Kristen Tomiko Soreoka, Lara Kim Suh

**DISTRICT OF COLUMBIA**

The George Washington University School of Medicine and Health Sciences—Alpha District of Columbia


Alumni: Alan E Greenberg

Faculty: Allan Goldstein, Matthew Mintz

House staff: Fred Ko, Rachel Seaman, Kshahayat Yazi

Georgetown University School of Medicine—Beta District of Columbia

Faculty: Maria Marquez, Deborah Topol
House staff: Peter Nathanial Ram Ramsey
Howard University College of Medicine—Gamma District of Columbia
Students: Reginald A Alexander, Laura K Chesoni, Lana M De Souza, Neil W C Gibson, Ahmad R Hossani-Madani, Naima B Jacobs-EL, Stephanie Jean-Noel, Michael A McCall, Oreolu O Odejide, Julius K Oni, Lawrence B Oresanya
Alumni: Steven N Singh
Faculty: Chiledum A Ahaghotu, Thomas A Mellman, Oge C Onwudiwe
Howard University College of Medicine—Delta Georgia
University of Miami Leonard M Miller School of Medicine—Alpha Florida
Alumni: Charles A Owens
Faculty: Norman G Lieska, L J Sandlow
House staff: Ulf Henning Beier, Yasser Mohammad Said, Adam Joshua Schwartz
University of Chicago Division of the Biological Sciences Pritzker School of Medicine—Beta Illinois
Students: Richard Alan Anand, Patrick Ryland Burnett, Matthew W Colman, Walter Dante Coneval, Sarah Newbold Cross, Adam D DeVore, Diana Doeing, Melissa S Dunagan, Patrick O Connor Lang, Jeffrey R Lewis, Griffin Robert Myers, Eric Kane Nordquist, Priot Roman Obara, Jacqueline Oguma Ogutha, Amber Talyn Pincavage, George Richard Schade, Tiphanez Phillips Vogel
Alumni: Anthony F Cutillleta, Eric E Whitaker
Faculty: Javad Hekmatpanah, Kevin Roggin
House staff: David Brush, Chad El Zayat, Keith Naylor
Northwestern University, The Feinberg School of Medicine—Gamma Illinois
Alumni: Harold J Pfizer, Vera Helen Rigolin
Faculty: David Brock Neely, Amy S Paller
House staff: Omobolaie Campbell, Farzad Jabangari, Amy Lin
Chicago Medical School at Rosalind Franklin University of Medicine and Science—Delta Illinois
Alumni: Lori Moss, Fred C Rothstein
Faculty: Hugo A Alvarez, Ernest John Sukowski
House staff: Saravanam Balambusamy, Bhargavi Devineni, Paari Dominic
Swaminathan
Loyola University Chicago Stritch School of Medicine—Epsilon Illinois
Alumni: Daniel R Salomon
Faculty: Erik K Muraskas
House staff: Elizabeth Borges Harstad, Brian Keith McNeil
American University of Beirut School of Medicine—Alpha Lebanon


Faculty: Patrice Delafontaine

House staff: Chad Stephen Miller

Louisiana State University School of Medicine in New Orleans—Beta Louisiana

Students: Erin R Alesi, Sudig Bhandari, Blake Booth, Christina Chen, Lori Michelle Cook, Clifford A Courville, Brad Anthony Coulotta, Robyn Deranger, Bennett Boutenstyn Fontenot, Adam Neil Foreman, Duncan Aeestun Friedman, Jessica Gautreaux, Kristal Bourgeois Guidorizo, George N Guild III, Christopher Michael Johnson, Kristy Roper Kennedy, Jarrod D Knudson, John Kristian Lindsay, Nicholas D McKinnon, Grant William Robichaux, Erik Soin, Jeremy Speeg, Akila Subramaniam, Rebecca Elaine Whiddon, Megan N Wilson, Lauren A Zatarain

Alumni: James Leonard, Lee J Monlezen Jr

Faculty: Paul Joseph Failla, Gary E Lipscomb

House staff: Jesse Michael Corbello, Mary Coenen Raven, Fred H Rodriguez III

Louisiana State University School of Medicine in Shreveport—Gamma Louisiana

Students: Erin F Dauterive, Brad James Hymel, Brett Michael Hymel, Catherine Caldwell Parker, Sarah Grace Stringer

House staff: Pritesh Patel

MARYLAND

Johns Hopkins University School of Medicine—Alpha Maryland


Alumni: Edward Paul Shapiro, Michael G Worthington

Faculty: Michael Andrew Chotz, Gregory Paul Prokopowicz

House staff: Trinity Jade Bivalacqua, Hans Adrian Puttgen, Alisha Nicole Wade

University of Maryland School of Medicine—Beta Maryland


Alumni: Christopher Welsh

Faculty: Richard Colgan, Bart Griffith

House staff: Yosef Joseph Greenspon, Brian Salter, Christopher Stephens

Uniformed Services University of the Health Sciences F Edward Hébert School of Medicine—Gamma Maryland


Alumni: David E E Holck, James L Esperance

Faculty: Robert A DeLorenzo, Vincent Miyulic

House staff: Kenneth Spencer Bode, Mark D Johnson, Joseph W May

MASSACHUSETTS

Tufts University School of Medicine—Beta Massachusetts

Students: Catherine Afdalianid, David Burt Blonder, Nichole Elizabeth Bosson, Catherine Celler, Jordan Chase, Louis Cohen, Joseph Donroe, Kevin Dwyer, Jennifer Goldberg, Kimberly Hanley, Matthew Kruger, Matthew Kutsch, Kristen Laraja, Jeremy Matlof, Timothy Mitin, Robert Osterhoff, Deborah Rin, Robert Rix, Jocelyn Robinson, Alexander Ropper, Alison Schwartz, Molly Senn, Sachin Shah, Steven Sobey, Megan Tramontozzi, Himanshu Verma, Adam Weston, Brian Walk, Tony Wong

Faculty: Arthur Rabson

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Boston University School of Medicine—Gamma Massachusetts
Faculty: Robert C Low
House staff: Gracelwa M Bauza, Satyam Saras, Judith A Siegel
University of Massachusetts Medical School—Delta Massachusetts
Students: Jennifer Bartkus, Emily Hopp-Long, Rebecca Botelho, William Burke, Mary Connolly, Kate Dorney, Jacob Drew, Jesse Fotte, Anne Garrision, Julie Herlihy, Samuel Klempner, Erin Mahoney. Gary Mendese, Heather Smith, Jesse Winer, Michael Zachcilli
Alumni: Celentia Higano, Charles R Taylor
Faculty: Francis Emits, Jeffrey Stoff
House staff: Jeremy Bordeaux, Steven Hatch, David Jones

MICHIGAN
University of Michigan Medical School—Alpha Michigan
Faculty: Sandro Cinti, Douglas J Gelb
Wayne State University School of Medicine—Beta Michigan
Alumni: Munirah A Curtis
Faculty: Donald P Levine
House staff: Cristal Adler
Michigan State University College of Human Medicine—Gamma Michigan
Students: Corinne Peimer Cohen, Timothy Michael Ehle, Corie Michelle Eklov, Nersha E Fournier, Lindsay Louise Fox, C Matthew Hawkins, Katrina Wils Hopper, Jennie Honol Law, Michael L McConnon, Lauren Waldad Metlos, Angela Ic Joyce Noble, Kami G Palmer, J. Eric Payne, Jennifer Michelle Powsawski, David R Ross, Matthew Daniel Schmitz, Jacob Phillip Scott, Katherine Michele Scott
Alumni: Barbara A Conley, Karen L Gilhoolly
Faculty: Mark Charles Delano, Padmani Karna
House staff: Rannie Alsamkari, Nicole Marie Tocco, Mary Ann P Tran

MINNESOTA
University of Minnesota Medical School—Twin Cities—Alpha Minnesota

MISSISSIPPI
University of Mississippi School of Medicine—Alpha Mississippi

MISSOURI
Washington University in St Louis School of Medicine—Alpha Missouri
Students: Courtney Amor, Katie Amos, Kevin L Arld, Rebecca Ann Barvolek, Jennifer Y Chu, Denise Debra Deward, Kimberly Jane Evanson, Katherine Elizabet Fleming, Timothy Justin Gillenwater, Heba Iskandar, Benjamin Charles Kramer, Gina Nicole LaRossa, Bryan S Lee, Sameer Jagan Lodha, Scott Benjamin Lovitch, Gita Nawar Mody, Elizabeth Channing Reed, John Edward Reuter, Justin Samuel Seddu, Bajiju Shah, Yelizaveta I Shev, Anna Terry
Alumni: Alan P Lyss, Bernard L Shore
Faculty: Michael Simon Avidan, Susan M Culican
House staff: Meredith Ann Brisco, Nupur Goshal, Rashindra Mamidi Reddy

Saint Louis University School of Medicine—Beta Missouri
University of Missouri—Columbia School of Medicine—Gamma Missouri
Students: Kevin Nance Bartow, Christina L Byron, Daniel Lawrence Christiansen, Sara L Cross, Scott David Culbertson, David Felleke, Jennifer Horst, Kara Marie LeFevre, Kathleen Shawn Martin, Kerry Massman, Alexander McCvoy, Sarah E Smitherman, Emily Elizabeth Smith Vogel, Angela K Walker, Eric Daniel Wirtz
University of Missouri—Kansas City School of Medicine—Delta Missouri
Students: Patrick S Kim, A Keith Rastogi, Emily A Van Trump, Danielle Lindsay Webster
Alumni: Dee Anna Glaser
Faculty: Bradley A Warady
House staff: Douglas A Coe, Laura A Ornmann, Zachary Douglass Post

NEBRASKA
University of Nebraska College of Medicine—Alpha Nebraska
Students: Mark Paul Bazant, Jonathan Steven Black, Jesse L Chrestal, Colleen Diane Christensen, Brendan D Connealy, Justin A Cramer, Judd D Davies, Laura Kathleen Donigan, David W Iantzent III, Scott Koepsell, Kathryn E Lazure, Eugene Katherine Maziarcz, Michael Kelly McCarthy, Gregory Thomas Peters, Tiffany Brooke Peterson, Carrie Riha, Hadley J Sharp, Marc A Sintek, Christopher Jay Smith, Benjamin M Solomon
Alumni: Jeffrey D Harrison, Bill Liydatt
Faculty: Charles Arthur Enke, Phyllis Irene Warkentin
House staff: Michael Gray Feely, Tony Yammen
Creighton University School of Medicine—Beta Nebraska
Faculty: Freddie Petty
House staff: Lori Beth Brunner-Buck, Kiran Kalyan Turaga

NEVADA
University of Nevada School of Medicine—Alpha Nevada
Students: Michael J Cascio, Jeremy M Gonda, Carly S McAttee, Jarrod Mosier, Jennifer L Stafford, Carrie N Stair, Travis R Torngren, Jason A Webb, Kate M Young
Faculty: Philip Holden Goodman, Mark R Hall, Raman Chaos Mahabir
House staff: Daniel Ranich

NEW HAMPSHIRE
Dartmouth Medical School—Alpha New Hampshire
Students: Stacey Fletcher Crawford, Salma Dabiri, Bjorn I Engstrom, Julianne Anderson Mann, Meghan M McCoy, Gregory A Sawyer, Theodore H Yuo

NEW JERSEY
University of Medicine and Dentistry of New Jersey Robert Wood Johnson Medical School—Alpha New Jersey
Faculty: Dalya Leviant Chefitz, Aida Finkielstein
House staff: Lena Lucy Merjanian

New members, 2006/2007
University of North Carolina at Chapel Hill School of Medicine—Gamma North Carolina

None reported

The Brody School of Medicine at East Carolina University—Delta North Carolina


Faculty: Paul J Schenarts

NORTH DAKOTA

University of North Dakota School of Medicine and Health Sciences—Alpha North Dakota

Students: Rebecca J Bakke, Richelle M Blanchard, Aaron J Chalmers, Laura M Duty, Megan S Johnston, Jill M Klinemint, Scott R Maanum, Sarah E Miller, Jessica M Titus

Alumni: John Donald Opgrande, Lori A Sundrol

Faculty: James J Kolars, Dennis Lutz

House staff: Vijay Lakshman Kovimilli, James A Schmidt

Dahlhouse University Faculty of Medicine—Alpha Nova Scotia

Students: Gillian Bethune, Dylan Paul Vincent Blacquaire, Beau Blois, Andre Daniel Boudreau, Samantha Gray, Jill Hudson, Andrea Kermaek, Fiona Liston, Ryan Francis MacDougall, Ashley McCormick, Mike Ripley, Peter Sullivan, Edward Ashley Wiley

Alumni: Michael Fleming, John Steeves

Faculty: Karen V Mann

House staff: Chris Gray, Emily Shaw

OHIO

Case Western Reserve University School of Medicine—Alpha Ohio

Students: Maryrose Patricia Bauschka, Ramona Behboud, Joshua Francis Coleman, Anand Bharat Desai, Michael Joseph Ebert, Katie Rose Ellerbrock, Matthew Richard Garrett, Matthew Lee Hanson, David Edward Karol, Nadia Khoury, Joshua Gabriel Kubit, Gregory Blair Martin, Jennifer Gutierrez McCarthy, Stacey Lynn Milunic, Christine Elizabeth Mullowney, David Kwan Rhee, Amy Katherine Ricke, Marwa A Sabe, Amelia Louiseemaple Sutton, Christopher Joseph Utz, Virginia Miralidi Utz, Hamilton Jason Wells

Faculty: George Richard Dubyak, Stephen A Weirich

University of Cincinnati College of Medicine—Beta Ohio


Faculty: Brian Burke Adams, William F Balistreri

House staff: Yvette A Neirouz, Jeffrey Robert Strawn, Ryan Michael Thomas

Ohio State University College of Medicine—Gamma Ohio


Alumni: M Michael Wolfe

Faculty: Douglas Danforth

House staff: Richard Ipsen, Marty Meyer, Subahd Pal

University of Toledo College of Medicine—Delta Ohio


Faculty: Krishna Mallick

Wright State University Boonshoft School of Medicine—Epsilon Ohio


Alumni: Dennis Brown, Julie P Gentile

Faculty: Arthur S Pickoff, Brenda B Roman

House staff: Pritam Polkampally

Northeastern Ohio Universities College of Medicine—Zeta Ohio

Students: Wendy V Andanajaya, Jason R Axt, Allison A Beyer, Brittany N Bohinc, Ryan A Frederiksens, Sinimel James, Hannah R Kerr, Britni L Lookabaugh, Himabindu Mallineni, Joshua B Nethling, Alisha N Plotner, Stephanie J Robertson, Kamal O Shemison, Brandon M Smith, Erica J Stovisky, Jason C Tank, Megan E Terek

Faculty: Steven M Kelly, George J Litman

House staff: Dean M Frate, Andrew J Schoenfeld, Insi Kurtz Euan Tu

OKLAHOMA

University of Oklahoma College of Medicine—Alpha Oklahoma


ONTARIO

University of Toronto Faculty of Medicine—Alpha Ontario


Faculty: James M Edwards, Gregory J Magarian

House staff: Sarah Elizabeth Scott Andrus, William L Hills, Vojin K Patel

OREGON

Oregon Health & Science University School of Medicine—Alpha Oregon


Faculty: James M Edwards, Gregory J Magarian

House staff: Sarah Elizabeth Scott Andrus, William L Hills, Vojin K Patel

Pennsylvania

University of Pennsylvania School of Medicine—Beta Pennsylvania


Faculty: Gerald A Isenberg, Javad Parvizi

House staff: David Mark Otternbuch, Bridget Jennings Seymour, Timothy K Williams

University of Pennsylvania School of Medicine—Beta Pennsylvania


Faculty: Pablo Tabes

University of Pittsburgh School of Medicine—Gamma Pennsylvania


Alumni: Dennis Brown, Julie P Gentile

Faculty: Arthur S Pickoff, Brenda B Roman

House staff: Pritam Polkampally

Northwestern University Feinberg School of Medicine—Gamma Illinois

Students: Andrew A Andres, Matthew Reid Armstrong, Laima Kautz, Sydney M Kus, Matthew D Kynett, Janet Ann LaPiec, Michael D Kynett, John C Conley, Paul J Schenarts

None reported
**House staff:** Galen Wachtman

**Drexel University College of Medicine—Delta-Zeta Pennsylvania**


Alumni: Endia Katalin Ander, Pamela Elaine Pette

Faculty: William Clark Meyers, Donna M Russo

**House staff:** Michael Stuart Green

**Temple University School of Medicine—Epsilon Pennsylvania**

Students: Amanda A Cannarozzo, David J Casper, Nicole Eustace, Mary Nichole Fontanella, Megan M Graybill, Vinay Ullal Kini, James Hyunsoo Lee, Deborah Yvette Chao Lim, Sandeep R Pandit, Sarah M Peman, Stephanie Marie Pouch, Laura Hope Rothkopf, Nima Salari, Matthew Francis Sandusky, Naomi Schwarz, Katya Silpilberg, Todd Steven Stafford, Renee Danielle Straub, Nelson Tang, Lindsey Price Lichtman

Weinstein, Benjamin R Winders

Alumni: Woodrow William Wendling

Faculty: Benjamin Krevsky, Joel E Richter

**Pennsylvania State University College of Medicine—Eta Pennsylvania**

Students: Brian Blasiale, Craig Gerald Brooksby, Andrea Anpei Chan, Jennifer Lee DeLutis, Lisa Anne Franczato, Rebecca Lepke Hein, Jeffrey Robert Iglowinski, Curtis Jeffrey Kehprt, Amy O'Gurek Kokinda, Emily Marie Kowalik, Laura Beth Lewandowski, Rebecca Mary Lombel, Barbara Peterson-Cramer, David Calvin Plitt, Rebecca J Roller, Scott Lawrence Runyon, Heather Leanne Salvaggio, Andrew Joseph Thompson, Collin Michael Tokor, Bridgett A Trulove, Elizabeth A Valentine, Jennifer I Westhafer, Lance Douglas Wood

**PUERTO RICO**

**University of Puerto Rico School of Medicine—Alpha Puerto Rico**


Alumni: Walter R Frontera Roura, Milagros Martin de Pumarejo

Faculty: Belinda Beauchamp Baez, Maria A Sosa Llorens

**State school of Medicine—Beta Puerto Rico**

Students: Vanessa Baute, Fernando J Cabrera Piquer, Carlos J Gonzalez, Maryliz del C Gonzalez Santos, Carmen J Holmes, Alba del Mar Miranda Rijo, Juan Manuel Ramos-Acevedo, Steven Matthew Sharatz, Dennis J Yang Wu

Faculty: Georgina Aguirre Melendez, Ivonne E Galarra

**Universidad Central del Caribe School of Medicine—Gamma Puerto Rico**

Students: Nicolas Lopez Acevedo, Pedro R Cox Alomai, Elizabeth Noriega Cruz, Beatriz Eugenia Garcia, Ana Cristina Toro Ortiz, William James Rahe, Raouf Beshara Rodriguez, Jessica Gutierrez Santiago, Raquel M Mercado Sepulveda, Olga Maria Tufela

Faculty: Nereida D Diaz-Rodriguez, Cecile Marques-Goyoco

**RHODE ISLAND**

**The Warren Alpert Medical School of Brown University—Alpha Rhode Island**

Students: Nancy Michelle Brim, Stacy Emily Croteau, Melissa J Donovan, Lauren Elizabeth Geller, Nicole Herschensohn, Charlene Hooper, Michael Philip Kurtz, Marianna Merino, Mathavi Parekh, Adam A Rojan, David Allen Sears, Sarah Ann Taylor, Peter Statz Vezeridis, Courtney C J Voelker, Elizabeth Mary Wallis, Jennifer Ann Yates

Faculty: Edward R Feller, Francois I Luks

**House staff:** Michael J Connor Jr., Michele Lombardo, Corey E Ventetuo
New members, 2006/2007

Faculty: William H Nealon
House staff: Juan G Martinez, Nicole Nemeth, Vu Tran

Baylor College of Medicine—Beta Texas
Faculty: Florence F Edlin's Folio
House staff: Nicole Cotter, Peter Nguyen

University of Texas Southwestern Medical Center at Dallas Southwestern Medical School—Gamma Texas
Alumni: Joseph N Fisher
Faculty: Robert R Rege

University of Texas Southwestern Medical Center at Dallas—Delta Texas
Students: James G Bulfanz, Kathryn Elizabeth Ban, Cary J Bosworth, Susan M Cameron, Sheila M Eyre, Matthew C Fox, Thomas A Gehrband, Paul H Graham, Amy D Graham-Carlson, William Hartman Harvin, Alicia A Henry, Benjamin O Hooker, John W Jaco, Ida Juarvez, Marianne E Nash, Travis R Newberry, Jill M Olson, Brian S Phelps, Patricia Sims Poole, Amy E Shackay, Justin K Smith, Christopher G Stockton, Nowice A Trexler, Mark E Usrey, Sarah M Weakley, Stephen B Winter

University of Texas Medical School at Houston—Epsilon Texas
Students: Jaideep Uday Barge, Codí D Beam, Adam John Bruggman, Matthew V Chauvriere, Brooke Alison Chidgey, Maria de la luz Villegas, Maria del Socorro Rayas, Kelly Holliday Foster, Sarah Elizabeth Goodpaster, Alan Scott Hamilton, Ross Aubrey Harper, Russell Jason Hicks, Josephine Huffman, Kristyn Becker Ingram, Sindhu Liz Joseph, David Jackson Levin, Rebecca D Mahan, Casey Wade Pollard, Alison L Radford, Corrie Elizabeth Roehm, Margaret Elizabeth Rogers, Jeffery S Russell, Dan Shaked, Ashley Summers, Edward Davis Tarnawa, Denise Marie Tavana, Ian Murchie Thompson III, John W M Tindall, Robert Daniel Tunks, John A Walker Jr., Stanley E Winters
Faculty: Antoinette F Hood, Susie Eager Kelly Sayegh
House staff: Heathar Melelani Justice, Muhammad Ali Khan, Michael S Lofgren

Texas Tech University Health Sciences Center School of Medicine—Zeta Texas
Alumni: W Tom Fogarty
Faculty: Mukbarz Naqvi
House staff: Nicole Davis, Sunanda Ghosh, Amy Thompson

The Texas A&M University System Health Science Center College of Medicine—Eta Texas
Students: Robert K Bour, Matthew S Brown, Charles Simpson Grimshaw, Chad D Housewright, Dip S Jaday, Ervin Lee Lougher, Tare N Rice, Erin Qamarani, Ellen Wear Smith, Kelly Nicole Wright, Eric Matthew Zavaleta
Alumni: John Paul Chiang
Faculty: Christopher Dennis Chaput, John D Myers
House staff: Rocky David Billhardt, Paul Lee Dillson, Parviz Keikhosrow Kavousi

University of Utah School of Medicine—Alfa Utah
Students: Brandon Mitchell Barney, Don Kent Davis, Jacob Brent Ekins, Kathryn Elizabeth Gibson, David Alexander Kelly, Luke Luther Linscott, Wes Young Madsen, Jotham Charles Manwaring, Jason Hudson McQuillen, D Anderson Miller, Matt Walker, Jacob Oman, Matthew Reeves Simmons, Logan Cole Sundrump, Jonathan Nicholas Warner, Nicole Suzanne Winkler

University of Vermont College of Medicine—Alpha Vermont
Students: Matthew D Coates, Audrey Collins, Leah Costello, Miki Fujiwara, David Michael Gordon, Joe C Huaing, Kelly Thii Huynh, Gabrielle Andrea Jacquet, Sahir Kalim, Kevin Keet, Kurt Hammond Kelley, Suezie Kim, Monica Kwan, Ryan Douglas Peterson, Justin John Sanders, Kelly Weirather, Jennifer Williams
Faculty: Masatoshi Kida
House staff: Krish Bhadra

University of Virginia School of Medicine—Alfa Virginia
Students: Parag Mahendra Amin, Heidi Flora Anderson, Christopher John Arnold, Kalyth Anne Reisecker, Shannon Elynn Brim, Adam Quincy Carlson, James Bryan Carmody, Christopher James Elmer, Andrew Weidner Ertel, Brian Thomas Fowler, Bridget Marie Bryer Goff, Terrence Colton Keaney, William Allen Kwan Jr., Richard William McClain, Michael Drew McCulloch, Sarah Reynolds Nassau, Wayne Douglas Ormsby, Benjamin Reed Ostrhine, Clinton Scott Pease, Colin Christopher Quinn, Jk John Raasay, Kelli Anne Beardon, David Hallmark Ryan, Lisa Beth Sandstrom, Sarah Marguerite Stamps, Nicholas Gregory Stowell, Laura Lee White, Matthew Thomas Wittmer
Faculty: Mark J Mendelsohn
House staff: Amy E Cool

Virginia Commonwealth University School of Medicine—Beta Virginia
Alumni: Pamela S Douglas
Faculty: Gonzalez Bearman, Andrea Hastillo
House staff: Nicole Kelleher, Emily Rudnick, Michael Patrick Stevens

Eastern Virginia Medical School—Gamma Virginia
Alumni: Marissa Caganap Galicia-Castillo, Gordon John Iiams
Faculty: Antoinette F Hood, Susie Eager Kelly Sayegh
House staff: Heathar Melelani Justice, Muhammad Ali Khan, Michael S Lofgren

Washington University School of Medicine—Alfa Washington
Students: Paul D Anderson, Lindsay R Barclay, Elizabeth L Brown, Jacob R Calvert, Bryan J Chow, Samuel O Clarke, Lilian DiGiacomo, Michelle J Dossett, Kevin C Gilbert, Deepi Gupta, Brian S Kim, Samuel W Linford, Kerry L Loveland, Brendan J McCullough, Jeffrey L Peckingshaw, Francisco A Perez, Benjamin A Pinsky, Tor H Slaugenhaug, Erik D Schroeder, Anna R Shope, Emily S Showman, Elise Jenner Simeron, Gretchin J Smith, Kyle J Tubbs, Alisa C Van Cleave, Brian M Waldschmidt, Pandora L Wander

West Virginia University School of Medicine—Alpha West Virginia
Students: Elizabeth Alexis Bragg, Carrie Marie Cantrell, Christopher M Carter, Ian Patrick Conner, Melanie Jane Evans, Stephen Charles Haferter, Collin Christopher John, Lesli M Lucas, Kevin York Marra, Daniel Everett Miller, Jeffrey Kyle Mullins, Anna Skold, Shari Jean Twigg, Timothy Aaron VanHoose
Alumni: James G Arborgast
Faculty: Barbara S Ducatman
House staff: Sadia Ali, Jeff Lancaster, Anthony J Van Norman

Joan C Edwards School of Medicine at Marshall University—Beta West Virginia
Students: Jeffrey K Harris, Lara Mae Hourani, James C Kitchen, Christy L Robinson, Craig D McCafferty, Eric Beth Shaver, D Paul Turley, Anne Kathleen Shirley Williams
Alumni: William M Mitchel Shaver
Faculty: Bruce S Chertow, Joseph B Touma
House staff: Tiras Soleiman Almashaeheb, April E Kilgore, Yih-Dar Nien

University of Wisconsin School of Medicine and Public Health—Alpha Wisconsin

Wisconsin
I look forward to nine holes of golf at day’s end, when others are absent and there is only the course and me. Score card and pencil remain in the bag. Camaraderie and competition are in the past. The grass is soft and easy on the feet, a verdant welcome mat. My swing has gone, but not the challenge.

If I par I walk off rejuvenated by silent applause. A shank doesn’t hurt and no alibis are needed. A good shot goes unnoticed except by insects hit by this meteor. With no pressure to win, distance is less important than accuracy. On the ninth, hazards are avoided and I feel like I’ve climbed a mountain.

H. Harvey Gass, MD

Dr. Gass (AΩΑ, University of Michigan, 1941) is retired from practice as a clinical professor of Neurosurgery at Wayne State Medical School. His address is: 6155 E. Longview Drive, East Lansing, Michigan 48823.

Trauma. Poem. Turgay K. Winter, inside back cover.


Visit to Apollo’s Temple. A. Poem. Wassersug JD. Winter, 27.

Warm nights in Oaxaca. Poem. Winter, 52.


Well, death’s been here for a long time. Editorial. Harris ED Jr. Spring, 1.


Building like a ladder out of the mire
Winding around, bound by finger-like extensions
holding one to the other.

Until, by inexorable forces, they part.

This double helix,
one segment the pattern for the other
Who is to say one side,
God-like,
is not the tool which the creator uses
to construct his beings,
in his image?

Jules S. Shapiro, MD

Dr. Shapiro (AOA, University of Illinois at Chicago, 1961) is associate professor of Orthopaedics (emeritus) at Rush University and senior attending physician (emeritus) at Rush University Medical Center in Chicago. Dr. Shapiro’s sculpture and poetry also appeared in the Summer 2005 issue. His address is: 1116 Calle Conejo, Santa Fe, New Mexico 87501. E-mail: marju@worldnet.att.net
Still, no one has a god's-eye view
not philosophers not physicians not pastors
what transpires when we die
If a bolt from nowhere stuns us with no time for good-bye
Or the death blow cruelly lingers, half-choking breath for weeks stuck atop a Ferris wheel scared to cause the slightest bounce (the brat beside me might then pounce and rock my car, with fiendish zeal) my limbs snap-frozen, I feebly gasp for far-down solid ground; tachycardic, cowed, aghast, by drawn-out panic downed
Regardless of the death blow's source—the lightning, the long ride—we finish up our doomed life course unknowingly, wide-eyed nothing gives a gut-felt clue not tomes not prognoses not sermons
Still.

Mary E. Knatterud, PhD

Dedicated to Dr. David Goldblatt.
Dr. Knatterud is an associate professor and senior research associate in the Department of Surgery at the University of Minnesota Medical School in Minneapolis. Her work on medical communication has appeared in the Annals of Emergency Medicine, Archives of Surgery, and Science Editor, among others. Her address is: University of Minnesota Medical School, 11-135 Phillips-Wangensteen Building, MMC 195, 420 Delaware Street SE, Minneapolis, Minnesota 55455. E-mail: knatt001@umn.edu.

Illustration by Marvin Plummer