Alpha Omega Alpha Honor Medical Society
Founded by William W. Root in 1902

Editor: Edward D. Harris, Jr., MD
Editor Emeritus: Robert J. Glaser, MD
Associate Editor and Managing Editor (in memoriam)
Helen H. Glaser, MD

Managing Editor
Debra M. Lancaster

Administrator
Ann Hill

Art Director and Illustrator
Jim M’Guinness

Designer
Erica Atken

Editorial Board

Jeremiah A. Barondess, MD
New York, New York
David A. Bennahum, MD
Albuquerque, New Mexico
John A. Benson, Jr., MD
Omaha, Nebraska
Gert H. Beier, MD
Baltimore, Maryland
John C.M. Brust, MD
New York, New York
Charles S. Bryan, MD
Columbia, South Carolina
Robert A. Chase, MD
Stanford, California, and
Jaffrey, New Hampshire
Henry M. Claman, MD
Denver, Colorado
Fredric L. Coe, MD
Chicago, Illinois
Jack Coulahan, MD
Stony Brook, New York
Ralph Crawshaw, MD
Portland, Oregon
Peter E. Dans, MD
Baltimore, Maryland
Scott K. Epstein, MD
Boston, Massachusetts
Lawrence F. Faltz, MD
Sleepy Hollow, New York
Faith T. Fitzgerald, MD
Sacramento, California

Daniel Foster, MD
Dallas, Texas
James G. Gambie, MD, PhD
Stanford, California
Dean G. Giankos, MD
Lynchburg, Virginia
Jean D. Gray, MD
Halifax, Nova Scotia
David B. Hellmann, MD
Baltimore, MD
Paschal James Imperato, MD
Brooklyn, New York
Elizabeth B. Lamont, MD
Chicago, Illinois
Kenneth M. Ludmerer, MD
St. Louis, Missouri
James B.D. Mark, MD
Stanford, California
Joseph Marr, MD
Broomfield, Colorado
Stephen J. McPhee, MD
San Francisco, California
Sherman M. Mellinkoff, MD
Los Angeles, California
Robert H. Moser, MD
Madera Reserve, Arizona
Edmund D. Pellegrino, MD
Washington, DC
Eric Pfeiffer, MD
Tampa, Florida
Richard C. Reynolds, MD
Gainesville, Florida
William M. Rogowsky, MD
Stanford, California
Shaun V. Ruddy, MD
Richmond, Virginia
Bonnie Salomon, MD
Deerfield, Illinois
John S. Sergent, MD
Nashville, Tennessee
Audrey Shafer, MD
Stanford, California
Marjorie S. Sirridge, MD
Kansas City, Missouri
Clement B. Sledge, MD
Marblehead, Massachusetts
John H. Stone III, MD
Atlanta, Georgia
Jan van Eys, Ph.D., MD
Nashville, Tennessee
Abraham Verghese, MD, DSc
(Hon.)
Stanford, California
Steven A. Wartman, MD, PhD
Washington, DC
Gerald Weissmann, MD
New York, New York
David Watts, MD
Mill Valley, California

Manuscripts being prepared for The Pharyos should be typed double-spaced, submitted in triplicate, and conform to the format outlined in the manuscript submission guidelines appearing on our website: www.alphomegaalpha.org. They are also available from The Pharyos office. Editorial material should be sent to Edward D. Harris, Jr., MD, Editor, The Pharyos, 525 Middletown Road, Suite 130, Menlo Park, California 94025.

Requests for reprints of individual articles should be forwarded directly to the authors.
The Pharyos of Alpha Omega Alpha Honor Medical Society (ISSN 0031-7179) is published quarterly by Alpha Omega Alpha Honor Medical Society, 525 Middletown Road, Suite 130, Menlo Park, California 94025, and printed by The Ovid Bell Press, Inc., Fulton, Missouri 65251. Periodicals postage paid at the post office at Menlo Park, California and at additional mailing offices. Copyright © 2005 by Alpha Omega Alpha Honor Medical Society. The contents of the Pharyos can only be reproduced with the written permission of the editor. (ISSN 0031-7179)

Circulation information: The Pharyos 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 Middletown Road, Suite 130, Menlo Park, California 94025. E-mail: m.celebi@alphomegaalpha.org

POSTMASTER: Change service requested: Alpha Omega Alpha Honor Medical Society, Post Office Box 2147, Menlo Park, CA 94026.

Officers and Directors at Large
Rae-Ellen W. Kavey, MD
President
Bethesda, Maryland
Edward D. Harris, Jr., MD
Executive Secretary
Menlo Park, California
Donald B. Wilson, MD
Vice President
Baltimore, Maryland
C. Bruce Alexander, MD
Secretary-Treasurer
Birmingham, Alabama
Michael V. Drake, MD
Irvine, California
N. Joseph Esrat, MD
Chicago, Illinois
Ruth-Marie Fincher, MD
Augusta, Georgia
Douglas S. Pauw, MD
Seattle, Washington
Don W. Powell, MD
Galveston, Texas

Councilor Directors
Robert G. Atnip, MD
Pennsylvania State University
Hershey, Pennsylvania
Eric P. Gall, MD, MACP, MACR
Chicago Medical School at Rosalind Franklin University of Medicine and Science
Chicago, Illinois

Student Directors
Natalia Berry
Dartmouth Medical School
Kara Maria Cavuto
University of Miami
Smeeta Sinha, MD
UMDNJ—New Jersey Medical School

Administrative Office
525 Middletown Road, Suite 130
Menlo Park, California 94025
Telephone: (650) 329-0291
Fax: (650) 329-1618
E-mail: postmaster@alphomegaalpha.org

www.alphomegaalpha.org

Δισν πολλαπλασιασμένος αληθείας
"Worthy to Serve the Suffering"
Effective rhyme is invisible, so natural in the flow of words that it is subsumed by the power of the images and emotions evoked. Fine examples of this are in the lines of the ballad, “These Foolish Things.”1 The internal rhymes are easily overlooked by the beauty of the melody and the message of the lyrics, especially when sung by Ella Fitzgerald:

And still those little things remain
That bring me happiness or pain.

A cigarette that bears a lipstick’s traces,
An airline ticket to romantic places,…

A tinkling piano in the next apartment,
Those stumblin’ words that told you what my heart meant,…

In contrast to this example, forced rhyme is a killer of poetry, as the masters of free verse have long recognized. How much better it is to sacrifice rhyme, maintain meter and rhythm, and use each word as a surgical tool, to shape meaning and express feeling. Robert Pinsky, the highly visible poet laureate of the United States, has done more than any contemporary writer to put poetry before the public eye. He writes rhythmically, in clear common language, in sturdy blank verse without rhyme. The power of his ideas and his lucid expression by careful choices of words dominates his work.

We at The Pharos are pleased to receive submissions of poetry from students at many medical schools for the student poetry competition. The numbers received often exceed that of those submissions for the student essay contest. We encourage more students to submit poems. For those just beginning as embryonic poets, I offer the following suggestions. For most of us, it is no easier to write poetry than it is to pick up and play an instrument that we never have held in our hands. Writing poetry is not easy, and requires hard work and practice. Therefore, an important prerequisite for the aspiring poet is to read excellent poetry before putting fingers on the computer keys, or pen to paper. Then there must be a defined message, an idea or an emotion that wants expression. This leads to the need for words to express the feelings. Then it is time to write, keeping in mind that use of rhythm, often with a defined meter, enables the poet to focus his or her message. Then, allow the right brain to take over the process, inserting ambiguity and metaphor to enrich the message.

References
Editorial
It's not a word I can put into feelings
Edward D. Harris, Jr., MD

The physician at the movies
Peter E. Dans, MD
Knocked Up
Juno
Bella
Green for Danger

Reviews and reflections
Reviewed by Elaine Thomas, MD
How Doctors Think
Reviewed by Jack Coulehan, MD
Final Exam: A Surgeon’s Reflections on Mortality
Reviewed by Jay A. Jacobson, MD

Letters

ARTICLES

Affliction is a treasure
Richard B. Gunderman, MD, PhD, and Brandon P. Brown

The Congressional Polio Vaccine Hearings of 1955
A landmark in biomedical research
Samantha Williamson
First month on the wards
Madeline Leong

H. L. Mencken looks at the Johns Hopkins quadrumvirate
William S. Haubrich, MD, MACP

AΩA NEWS
National and chapter news
Richard Bronson, MD, added to the editorial board of The Pharos
Announcing the 2008 Alpha Omega Alpha Robert J. Glaser Distinguished Teacher Awards
Winners of the 2007 Pharos Editor’s Prize
Announcing the 2008 Pharos Editor’s Prize
Centennial celebration at the University of Minnesota Medical School, Alpha Minnesota
2007 program expenditures by the national office
Minutes of the 2007 AΩA board of directors meeting
2007 report of the executive secretary
2007 report of the editor of The Pharos
Leaders in American Medicine

POETRY
Campanology
Shane Neilson, MD

Old Anatomy Textbooks
Shane Neilson, MD

To a Friend at Sixty, Leaving for a New Job
Fredric L. Coe, MD

No Colored Ribbons for Them
Dennis Devereux, MD

Frequent Callers
Helen Montague Foster, MD, DFAPA

Wondering Waves
Steven F. Isenberg, MD

I’m Putting On My Earrings
Beverly Fuchs

Leukemia
Kendall Lane, MD

Night Storm
Steven F. Isenberg, MD
Affliction is a treasure,
and scarce any man hath enough of it.

—John Donne, *Devotions Upon Emergent Occasions*, Meditation XVII\(^{19103}\)
Dust-dry, creaky,
I'm smitten by
your nineteenth-century anatomy:
old beaten-down lungs
too long-effaced by bristly
nicotinic cigarettes that rubbed
black spots through the pulp.
Or a cooked liver marinated
in high spirits, or as you say it,
the owner described as An Over-Imbiber.
Or the poor man with a dislocated
shoulder: well-muscled, grimacing
as the doctor Cokers the humerus
up and back. Up and back,
up and back; so much of medicine
is up and back,
repositioning,
up and back.

You've been replaced, old diagrams,
by the midnight snowstorm of ultrasounds,
the 3-D colour reconstructions of CT scans,
the preternatural sharpness of MRIs,
but the tale is the same,
the whir and hum of technology
the same as blowing dust off an old anatomy text,
the same homage.

Shane Neilson, MD

Dr. Neilson practices family medicine in Erin, Ontario. A book of his medici-
cal essays, Call Me Doctor, was published in 2006, and books of his poetry
will be published in 2008 and 2009. His address is: 63-49 Rhonda Road,
Guelph, Ontario, Canada. E-mail: itchscratch@hotmail.com.
I shall take down my lute from its peg,  
and draw its strings into tune:  
Time is late for traveling,  
my friend, but our carved stones  
in the shapes of animals do not love  
us, and the shifting young,  
who may, smile and move  
on, flattering us in their water  
mirrors. Mollusk, lover of  
old stones, my lute strings stir  
their fanciful rosewood and ivory;  
you lose your hold here, are air,  
a shadow passing over.  
Forgive my song, it means  
no lack of courtesy,  
you, too, could have been  
the name posted for a day  
on the flagpole, the flag  
half high to signify  
what’s finished on this simple stage,  
where all is played, all past  
and what’s to come portrayed  
by honorable craft;  
but we are ordinary guilds  
all prey to ordinary strife,  
and the petty meanness of coarse wills.  
Lift up your roots, this soil  
will not hold you; lift up  
your sum and movables,  
and leave the key in the lock  
on that last morning,  
when everything is in the truck  
that thirty years can bring  
to one place. No lesson  
will be learned from your going,  
my friend, no more reason  
shall I have when time comes due;  
we are creatures of our season:  
may the road be well with you.

Fredric L. Coe, MD
First month on the wards

Madeline Leong
The author is an MD/PhD candidate at Duke University School of Medicine. She plans to be a doctor and a wordsmith.

Sign of the seagull
“The goal is a three. Most people can live with a three.” On my first rotation as a med student, I’m rounding at the veterans’ hospital in Durham. My resident is discussing one-through-ten pain scores: “If you shoot for a zero, you over-sedate.”

“Uh-huh.” I nod, “Guess we all need some pain to know we’re alive.”

He looks at me and chuckles. “Don’t get existential now.”

On call night, we stifle yawns in the workroom. One of our patients has a new diagnosis of lung cancer. My resident is discussing one-through-ten pain scores: “If you shoot for a zero, you over-sedate.”

“Uh-huh.” I nod, “Guess we all need some pain to know we’re alive.”

He looks at me and chuckles. “Don’t get existential now.”

On call night, we stifle yawns in the workroom. One of our patients has a new diagnosis of lung cancer. My resident is discussing one-through-ten pain scores: “If you shoot for a zero, you over-sedate.”

“Uh-huh.” I nod, “Guess we all need some pain to know we’re alive.”

He looks at me and chuckles. “Don’t get existential now.”

On call night, we stifle yawns in the workroom. One of our patients has a new diagnosis of lung cancer. My resident is discussing one-through-ten pain scores: “If you shoot for a zero, you over-sedate.”

“Uh-huh.” I nod, “Guess we all need some pain to know we’re alive.”

He looks at me and chuckles. “Don’t get existential now.”

On call night, we stifle yawns in the workroom. One of our patients has a new diagnosis of lung cancer. My resident is discussing one-through-ten pain scores: “If you shoot for a zero, you over-sedate.”

“Uh-huh.” I nod, “Guess we all need some pain to know we’re alive.”

He looks at me and chuckles. “Don’t get existential now.”

On call night, we stifle yawns in the workroom. One of our patients has a new diagnosis of lung cancer. My resident is discussing one-through-ten pain scores: “If you shoot for a zero, you over-sedate.”

“Uh-huh.” I nod, “Guess we all need some pain to know we’re alive.”

He looks at me and chuckles. “Don’t get existential now.”

On call night, we stifle yawns in the workroom. One of our patients has a new diagnosis of lung cancer. My resident is discussing one-through-ten pain scores: “If you shoot for a zero, you over-sedate.”

“Uh-huh.” I nod, “Guess we all need some pain to know we’re alive.”

He looks at me and chuckles. “Don’t get existential now.”

On call night, we stifle yawns in the workroom. One of our patients has a new diagnosis of lung cancer. My resident is discussing one-through-ten pain scores: “If you shoot for a zero, you over-sedate.”

“Uh-huh.” I nod, “Guess we all need some pain to know we’re alive.”

He looks at me and chuckles. “Don’t get existential now.”

On call night, we stifle yawns in the workroom. One of our patients has a new diagnosis of lung cancer. My resident is discussing one-through-ten pain scores: “If you shoot for a zero, you over-sedate.”

“Uh-huh.” I nod, “Guess we all need some pain to know we’re alive.”

He looks at me and chuckles. “Don’t get existential now.”

On call night, we stifle yawns in the workroom. One of our patients has a new diagnosis of lung cancer. My resident is discussing one-through-ten pain scores: “If you shoot for a zero, you over-sedate.”

“Uh-huh.” I nod, “Guess we all need some pain to know we’re alive.”

He looks at me and chuckles. “Don’t get existential now.”

On call night, we stifle yawns in the workroom. One of our patients has a new diagnosis of lung cancer. My resident is discussing one-through-ten pain scores: “If you shoot for a zero, you over-sedate.”

“Uh-huh.” I nod, “Guess we all need some pain to know we’re alive.”

He looks at me and chuckles. “Don’t get existential now.”

On call night, we stifle yawns in the workroom. One of our patients has a new diagnosis of lung cancer. My resident is discussing one-through-ten pain scores: “If you shoot for a zero, you over-sedate.”

“Uh-huh.” I nod, “Guess we all need some pain to know we’re alive.”

He looks at me and chuckles. “Don’t get existential now.”

On call night, we stifle yawns in the workroom. One of our patients has a new diagnosis of lung cancer. My resident is discussing one-through-ten pain scores: “If you shoot for a zero, you over-sedate.”

“Uh-huh.” I nod, “Guess we all need some pain to know we’re alive.”

He looks at me and chuckles. “Don’t get existential now.”

On call night, we stifle yawns in the workroom. One of our patients has a new diagnosis of lung cancer. My resident is discussing one-through-ten pain scores: “If you shoot for a zero, you over-sedate.”

“ Uh... do you want a nicotine patch?”

The patient shakes his head.

Mr. Jameson about this.”

I stop yawning. “I’ll go with you.”

He’s staring at the floor, his jaw tight, his eyes vacant. “I hate doing this.”

When he leaves the workroom, he slams the door. We all slam the door. It means something.

“Mr. Jameson, you have lung cancer. One of the consequences of smoking is cancer.”

Patient and doctor look at each other with nearly equal amounts of pain. The resident flushes, but he’s too exhausted, too brain-dead, to take back his harsh words.

“Uh... do you want a nicotine patch?”

The patient shakes his head.

The resident’s pager beeps. He glances at it, hesitates, then strides out of the room.

I hurry to catch up with him. “Yeah, I hate doing that,” he mumbles, “I think you have to tell cancer a couple times, otherwise they don’t get it.”

I refuse to agree.

“Yeah, I’m not the best at it.” He shoves his fist into the wall.

On short call, I admit a patient with pneumonia and present his history to my resident.

“What should we do for him?” he asks.

“I’m thinking IV antibiotics because he failed a Z-pak.”

“Yeah, ceftriaxone and azithro. Plus fluids and a chest X-ray.” He grins, “Good job.”

In two days, my patient has recovered and is ready to go home. “Vitals, sats, everything’s fine.” I double-check my notes. “So. You cured him.”

“No.” He shakes his head, “We cured him.”

I go back into Mr. Jameson’s room.

“How are you doing, sir?”
First month on the wards

“Fine.” He grimaces, “Fine.”
“Any pain, sir?”
“Pain? I’ve always got pain,” he says.

At rounds, the resident asks me what joints look like in rheumatoid arthritis and osteoarthritis.
“I have no idea.”
He frowns and sketches a joint.
“Rheumatoid arthritis eats up the bone so it looks like a rat bite. Osteoarthritis scoops out the bone so it looks like an m, the seagull sign.”
His face brightens, “I go to the beach every year.”
He catches himself and hands me the paper with the seagull sign. “Remember this.”
“Yes,” I promise. In two strokes of a pen, I see birds rise above salt spray and soar to the horizon.

Take it.
“What’s my name?” My resident’s unruly hair makes him look like a teenager. He leans over the patient’s bed.
Mr. Collins’s hair is white, his chest bare, his waist obscured by ripples of fat. His left arm trembles, and his right eye stares. Spittle drips down his chin.
“Mr. Collins, do you remember my name?”
“Chippie.”
“His name is Dr. Davis. And I’m Madeline, the medical student.” I put my hand on Mr. Collins’s shoulder.
“What year is it?”
“Nineteen seventy-four.”
“Are you being funny, sir?”
“I might be joking. It might be two thousand and seven.”
My resident sighs. “Mr. Collins, we need to you to get up and start working with physical therapy. I’ve told you this before. If you don’t get stronger, you can’t get treatment for your lung cancer.”
Mr. Collins groans. “I’m hurtin’, son, I’m hurtin’ in my tail.”
“That’s because you have a pressure ulcer on your backside. You need to get out of bed or the ulcer will get worse, and your cancer will progress. Do you understand?”
“I understand.” Mr. Collins closes his eyes. “Never thought I would see the day.”
We leave the room, which smells of urine and feces. “What’s the plan for him?” my resident asks.
“He’s too deconditioned for surgery or chemo,” I say. “And radiation won’t take him because he’s delirious.”
“Delirious?” My resident shakes his head, “He seems lucid to me. Except if he doesn’t get out of bed, he’s going to die.”
“I’ll ask Psychiatry to evaluate him.”
“Good luck.” He leans against the wall, “So what are the causes of delirium?”
“Uh . . . you told me yesterday, but I don’t remember.”
“Okay, that’s it. You’re fired. Off my service.”
I smile. “You’re a jerk.”

When I call Psychiatry, all the residents are busy so I page the student on the service. “Steve,” I say, “will you get your residents down here to consult on Mr. Collins?”
“Yeah, sure. Collins?” The voice on the other end of the line changes, “Hey, are you Gen Med Team?”
“That’s us.”
“Will y’all quit calling in useless consultations. That guy is delirious.”
“He may be delirious, but he’s also depressed.”
“Why don’t you fix his delirium first, then we’ll fix his depression?”
I slam down the phone. “Psych is useless.”
My resident raises his eyebrows. “Figures.”

Mr. Collins has refused physical therapy week after week. “He’s dying,” my resident says. “We should put him in hospice if he’s not going to get better.”
“Okay, Chippie.”
He frowns, “Don’t call me that.”
“Hey, Chippie!” A day later, I’m reading the nurses’ notes on the computer. “Look at this! ‘Mr. Collins found out of bed on chair. Patient said, “I made it, but my butt hurts.”’”
We rush to Mr. Collins’s room. He is sitting up in bed wearing glasses, his gown tucked around him.
“Hello, hello,” he chortles, “I’m going to work with physical therapy.”
We stare.
“You’ve stopped giving up?” my resident says.
“That’s right. I’ve got a lot to live for. I’ve got a wife and two grandkids. I’m gonna get out of here.”
“What made you change your mind?”
“My wife, my kids, the hospital food.” He raises a wobbly arm, “Goodbye, Chippie. And you, young lady. I appreciate everything you’ve done.”
Outside the room, my resident turns to me. “What did we do?”
“We didn’t do anything.”
He snorts. “I don’t get it.”
“Me neither.” I smile. “Sometimes, you get a second chance.”

On Friday morning, my resident says, “Today, we’re going to Grand Rounds.”
“You mean, we’ll get there half an hour late and stand in the back?”
He tries not to smile. “I’ve had enough of you.”
Standing in the back during Grand Rounds, he leans over and whispers, “I guess it’s inappropriate to write ‘Yippee!’ on Mr. Collins’s discharge summary.”
“Very inappropriate,” I whisper.

The next morning, we stop by Mr. Collins’s empty room, soon to be filled with a new patient. My resident folds his arms, “So what are the causes of delirium?”
I list them all.
“Good. You’re re-hired.” His eyes flick to Mr. Collins’s empty bed.
“Second chance.”
“I’ll take it.”
Sundowning

“Mr. Sams thinks he spent the night at Wal-Mart,” I say, yawning. “He’s confused.” My resident’s eyes track numbers on the computer as his fingers skitter over the keys.

I lean back in my chair, “The hospital is kinda like Wal-Mart. Lots of lights and machines and people trying to sell you stuff.”

My resident gives me the “enough already” look. “Mr. Sams is an elderly patient experiencing a common type of confusion known as sundowning.”

“What do we do about it?”

“Half a milligram of Risperdal at bedtime.”

During attending rounds, my resident hears his pager and dashes off. I run into him half an hour later. “James! What happened?”

“Mr. Sams. He threw a clot in his leg. We’re transferring him to the unit.”

I read his face. “Is it bad?”

“I’ll take care of it,” he says.

Searching for Mr. Sams in the Intensive Care Unit, I pass other lost souls spouting tubes and wires. Their faces droop, their eyes flutter like prisoners in a pirate movie. The hospital becomes a catalog of horrors, the ill and near-dead, so much lost already.

Despite the busy unit, the charge nurse hails me kindly. “Who are you looking for?”

“I’m looking for Mr. Sams.”

“I don’t have Sams yet.”

“Okay. I turn away, a tightness in my throat. After twenty-three years of life, I’m tired of death. I’m sick of the pain on strangers’ faces.

Mr. Sams is on a ventilator in the ICU. His mouth wrinkles around a tube, his chest heaves with each artificial breath. Fresh bruises line his arms, and his left leg is cold and blue.

The leg is lost, the nurse tells me. He’s too unstable for surgery.

Mr. Sams’s eyes flicker, and I smile and wave. His eyes close, his fingers twitch. My white coat feels heavy. Its pockets contain my stethoscope, PDA, pager, cell phone, and copy of The Intern’s Survival Guide; I’m also carrying alcohol swabs, tongue depressors, and bandage scissors. For what?

Usually, I like my white coat. It keeps me warm and soaks up the blood and pus. Today it’s too much to bear.

I hurry upstairs to finish my progress notes and promise myself I’ll check on Mr. Sams soon. For two hours, I type at lightning speed, then troop down the stairs at 4 p.m.

He died at 3:30.

My resident blames himself for Mr. Sams’s death. Mr. Sams was eighty-six, his heart was barely pumping, and he’d been in the hospital for months. Still my resident looks at his chart and says, “If I’d stopped Linezolid, he might have made it.”

At first, I put my resident down as self-destructive in his grief. But later, as weeks pass, I wonder if he was only saying, “The man died on my watch. I’m sorry.”

Crabs and lemonade

For Labor Day, I leave the hospital and drive five hours to southern Maryland, where my family is having a crab feast. We lay newspapers on picnic tables and steam two bushels of crabs. I eat more crabs than I can count, and Old Bay seasoning seeps into my hands, my hair. Afterwards, I sit on the porch drinking lemonade and look out on a sun-crisp lawn. One of my cousins is loading his water gun with Coke, another is dousing his opponents with a hose. A toddler is eating fudge with all ten fingers.

The cicadas trill in the trees. The grown-ups chatter and drink pineapple rum. The air smells of crab and grass and barbeque chicken. As the day dims, I close my eyes and listen to the lawn speakers throbbing.

Who says you can’t go home?

The author’s address is:

705 Brighton Road
Durham, North Carolina 27707
E-mail: madeline.leong@duke.edu
Crisp, white sheets once comfortable and cool
now the most frightening things in the room.
Her sheets have a story all of their own
that we should hear, that we should know.
Fused to her flesh by proteins that flow
a formidable glue from drying so slow.
Straw colored one time, now brownish and crisp
densely joined to her back and wrist.
Bonding points stronger than duct tape can form
undeservedly painful when broken and torn.

Twice daily she “dances” or “takes a whirl”
requiring a trip to another world
induced by drugs but not really pain free
she needed them strong for what was to be.
The forced separation of sheets and glue
caused her to scream “what the hell did I do?”
“I can’t take this” was her daily refrain
“can’t someone do something to stop my pain?”

The penultimate step in this daily dance
fronted a mirror but she could not glance.
Finally, she looked and she lost her breath
when she saw her chin drawn down to her chest.
A lipless mouth frozen into a frown,
head unable to move up or down.
Ushered back to her bed, back to her sheets
fearing tomorrow, there is no retreat.

This night her guest is the man in the moon
casting a glow and lighting her room.
She stares straight down at her bare oozing chest
red waffled skin grafts lie over her breasts.

If she hadn’t been burned and this were a dream
the sheets wouldn’t stick and she wouldn’t scream.

_Dennis Devereux, MD_
I have four of them now, frequent callers, three-year-old voices piping for help, because long-dead papas stalk in the starlight. Darkling girls cry in their sleep, knot nooses, slice skin, pour pills—lost girls fibbing, lest it all catch up: The incest, the lust, the still neglectful mother—I’m cast in her role nagging: Come here to the now; Stop hurting your soul. Wait for your session. No hitting allowed. Tell me out loud. Would you like to go to the hospital? Of all of my patients, these burden me most. I unfailingly falter, believe, disbelieve. I insist, put them off, urge them on. They lapse into dazes, delve into make-believe, split into toddlers and made-up selves who stalk with razors, poisons, and cars idling in closed garages. “You don’t care if I die,” they accuse. “I don’t call that often,” they lie. Twenty times a week is not too often to them, my incest-cleft girls with their sweet faces and puzzle-piece souls. But it is too often for me. I am their un-rested pretend mother, tending, tiring, waiting for second wind.

Helen Montague Foster, MD, DFAPA

Dr. Foster (AOA, Virginia Commonwealth University, 1981) is a psychiatrist in private practice in Richmond, Virginia, where she serves on the clinical faculty of the Department of Psychiatry at Virginia Commonwealth University. She is a published poet and unpublished novelist. Her address is: 2004 Bremo Road #106, Richmond, Virginia 23226. E-mail: hfoster160@aol.com.

Illustration by Erica Aitken
Knocked Up
Starring Katherine Heigl, Seth Rogan, Leslie Mann, and Paul Rudd.
Directed by Judd Apatow. Rated R. Running time 129 minutes.

The title immediately signals that you shouldn’t expect a classy Astaire/Rogers romance. Made by the director of The Forty Year Old Virgin, this crude comedy, called an “instant classic” by New York Times reviewer A. O. Scott, could have been reduced by fifteen minutes if the F-word and other vulgarities had been deleted from the script. Oddly enough, it is best characterized as a pro-life slacker film. A lovely young lady, Allison Scott (Katherine Heigl of Grey’s Anatomy), gets a big break hosting a local Entertainment Tonight-type show and decides to celebrate at a club with her sister Debbie (Leslie Mann) and Debbie’s husband Pete (Paul Rudd). For some unfathomable reason, except for entirely too much alcohol, she hooks up with Ben Stone (Seth Rogan), a gross, hairy guy who might generously have been called a “schlemiel” and, less generously, a “schmuck” in the old neighborhood.

Ben’s main love is his bong. His dream is to create an economically viable web site where he can record movie star T&A and other sightings in feature films, and that’s not tonsillectomies and adenoidectomies. They have a one-night stand with Allison, and she gets pregnant. In the last scene, she is in a medical office, saying the baby “has a right to thrive.” Following on the heels of these two movies are Knocked Up, Juno, and Bella. The first two are hardly moralistic tales.

The baby boomlet has not gone unnoticed in the media. Michael Currie Schafer in the New Republic doubted that producers were avoiding “storylines featuring abortion because of a political backlash” and instead ascribed it to the fact that “babies add new drama.” Ellen Page, the star of Juno, said “if Juno had an abortion, it would have been a short film,” as if abortion ends the story, which, sadly, is not true in many cases. However, if the post-abortion movie ever gets made, it wouldn’t be a comedy and it would get as much media coverage as Bella, which means practically none.

Reference

The physician at the movies

Peter E. Dans, MD

Abortion in the movies

In November, my good friend Tim Johnson, chair of Obstetrics and Gynecology at the University of Michigan invited me to speak about abortion in the movies in a seminar course he was developing on Contemporary Issues in Women’s Health. Starting with the 1933 film Men in White, I viewed lots of movies. As expected, the trend line followed the evolution of the acceptance of this procedure, which was once illegal and generally considered immoral except when the life of the mother was at stake, to the present when it is legal and the question of its morality is highly contentious. The portrayal of those performing abortions, unsympathetic in films like The Interns (1962), Love with a Proper Stranger (1964) and Alfie (1966), became much more sympathetic, almost laudatory, in Cider House Rules (1999) and Vera Drake (2004). However, that trend may be reversing, as evidenced by a raft of films starting with the misbegotten remake of Alfie (2004), in which the woman involved in the one-night stand with the notorious womanizer, instead of having an abortion as in the original, leaves the abortion clinic and decides to keep the baby. In Waitress (2007), the mother decides to go through with the pregnancy even though she plans to reject the baby, saying the child “has a right to thrive.” Following on the heels of these two movies are Knocked Up, Juno, and Bella. The first two are hardly moralistic tales.

The baby boomlet has not gone unnoticed in the media. Michael Currie Schafer in the New Republic doubted that producers were avoiding “storylines featuring abortion because of a political backlash” and instead ascribed it to the fact that “babies add new drama.” Ellen Page, the star of Juno, said “if Juno had an abortion, it would have been a short film,” as if abortion ends the story, which, sadly, is not true in many cases. However, if the post-abortion movie ever gets made, it wouldn’t be a comedy and it would get as much media coverage as Bella, which means practically none.

Reference
stand during which she rushes him and he fails to use his condom. The next morning, she leaves for work and they presumably will never meet again. Ben goes back to the other creeps with whom he shares a house and brags of his sexual conquest.

When Alison misses a period, enter the new feature in all three movies, the home pregnancy kit. After doing the test multiple times with Debbie as a control, she has to face reality. She telephones Ben, who assumes he is being contacted because he is so irresistible. Stunned at the news, he meets her for lunch and tells her, "My stepsister took care of it and now she has a real baby." When Allison says that she does not intend to have an abortion, he agrees to go with her to Debbie's doctor, Thomas Pellagrino (Tim Bagley), where the second new cinematic feature appears, the ultrasound, which shows the eight-week fetus's heart beating. From that point they visit numerous doctors whom she rejects until she finds one who promises to be there for her delivery. There are more scenes of fetal development on the ultrasound and of Ben continuing to act like an insensitive, pre-adolescent jerk. Finally, when it's time for the delivery, wouldn't you know that the doctor she carefully chose is in Israel at a Bat Mitzvah. The closing credits provide a particularly interesting meta-message in that they consist not only of pictures of the film's characters and their growing family but also of all the children and families of the cast and crew.

**Juno**

Starring Ellen Page, Michael Cera, Jennifer Garner, Jason Bateman, and Allison Janney.

Directed by Jason Reitman. Rated R. Running time 92 minutes.

Juno (Ellen Page), who tells all and sundry that she is not named after a town in Alaska but after Zeus's wife, is a sixteen-year-old pseudo-sophisticated tomboy with a smart motor mouth. She decides that she would like to try out sex with her favorite boyfriend, Paulie Bleeker (Michael Cera), an incredibly naive nerd who runs track and with whom she makes music. She seduces him while he is sitting in a chair and in the best Hollywood tradition, she gets pregnant. After three home pregnancy tests are positive, she tells her best friend Leah (Olivia Thirby), who suggests that she call the local abortion clinic, which she does on her hamburger phone saying, "I'm calling for a hasty abortion." Outside the clinic, she encounters a lone picket, a school friend, Su Chin (Valerie Tian), who tells her that "all babies want to be borned" and that at her stage the fetus has "a beating heart, feels pain, and has fingernails." The receptionist, who is incredibly dense, offers Juno blackberry condoms, which she says makes her boyfriend's stuff smell like pie. Juno refuses the offer and sits down in a chair and, surveying the crowd, which looks pretty squirrelly, she decides to leave, telling the receptionist "to keep her pieballs, I'm staying pregnant."

Leah suggests she check out the Pennysaver insert in the newspaper, where she finds an ad by an affluent, infertile yuppie couple wanting to adopt. Leah convinces her to tell her father (J. K. Simmons) and stepmother (Allison Janney), who are remarkably intelligent and supportive for Hollywood parents. She tells them of her plans to go through with the pregnancy and to give the baby up for adoption. The blue-collar parents join Juno in visiting the palatial home of the prospective adoptive couple, Vanessa (Jennifer Garner), who is somewhat over the top as a woman who believes she was born to be a mother, and Mark Loring (Jason Bateman), a composer of commercials and fan of slasher films. Juno bonds with him platonically (at least on her side) and is pleased that the baby will have a good home. I'll end the story here in case you want to see it.

The film, which was nominated for four Oscars (best picture, director, actress, and screenplay) cost $7.5 million to make and has grossed over $85 million in less than two months, due both to critical acclaim and word of mouth. Page is outstanding, and the rapid-fire dialogue is raunchy, full of "pop" references, and undeniably clever, almost too clever. There are very few moments when Juno, who is constantly smart-mouthing and manipulating all around her, shows any tenderness. The decision to give up the baby is rather facile. Not only does she seem to pay little emotional price for her decision, but she views the whole thing as a chapter to be closed in nine months and never to be re-opened. Screenwriter Diablo Cody (aka Brooks Busey-Hunt), an ex-stripper and phone sex
The physician at the movies

operator, is clearly quick-witted and an accomplished writer who is already involved in other screen projects. She ascribes her facility in writing to the daily blog she kept about her personal life during the year she spent as a stripper. A stepmother herself, she said she made the stepmother nice rather than, as routinely pictured, “monsters and witches.” That’s all well and good, but I wish she hadn’t given the stepmother the following throwaway line: “Doctors are sadists who like to play God and laugh at lesser people’s pain.”

Reference

Bella

Starring Eduardo Verastegui, Tammy Blanchard, and Manny Perez.

The classiest of the three films, Bella won the “People’s Choice” award at the Toronto Film Festival, but had trouble getting a distributor until Lion’s Gate agreed to do so. It was shown in very few theaters despite grassroots support from Catholics and pro-lifers. The Variety critic dismissed it as “a mediocre film that wows crowds” and got appropriately slammed by all four bloggers to his site. Another called it “certainly a sweet life-affirming picture but just not authentic or captivating enough.” Yet another called it “predictable,” as if most films aren’t. Strangely enough, it isn’t predictable, starting with the opening shot at the seashore where one gets an entirely different impression of the bearded protagonist. A flashback then shows a handsome soccer star with Real Madrid, Jose (Eduardo Verastegui), who is on his way to a big payday in his flashy convertible when he strikes a little girl who runs out in the street after a ball. Convicted of vehicular homicide, after his release from prison he is reduced to being a line chef in the restaurant owned by his obsessive-compulsive brother Manny (Manny Perez). When Nina (Tammy Blanchard), a repeatedly tardy coworker learns she is pregnant after getting a home pregnancy test kit on credit, she is fired. Jose leaves the restaurant to console her and Manny fires him, too, setting up a family conflict. Jose accompanies Nina to an abortion clinic, where she also has a change of heart.

There is a great scene with Jose’s warm family on Long Island, one that reminded me of growing up in a home with a mother who was a Spanish/Italian court interpreter and a stepfather who was a Spanish merchant seaman. The rest of the film consists of a reconciliation of the brothers; and Jose helping Nina and her child, Bella (Sophie Nyweide). The whirlwind filming in twenty-three days on location in and around New York City, led one snide reviewer to say that the surroundings upstaged the story.

I don’t agree. Actually, it’s a heartwarming, unassuming story of compassion, selflessness, and redemption, whose premise is articulated early in the film when Jose says “My grandmother always said, ‘If you want to make God laugh, tell him your plans.’”

References

Another vintage doctor film

Continuing the plan to highlight past films featuring doctors, here is a British classic to put on your DVD wish list.

Green for Danger (1946)

Starring Alistair Sim, Trevor Howard, Leo Genn, Sally Gray, and Rosamund John.

There are two signature studio trademark openings that get me in the mood for a movie. The first is MGM’s Leo the Lion, preferably the early one who gave three roars rather
than the later lazier lion who only roars twice. The other is the one that opens this film: the man stripped to the waist swinging the big hammer twice to gong in a J. Arthur Rank Production. Based on a 1944 book of the same name by Christianna Brand, Green for Danger is a murder mystery laced with droll English humor and set in a rural British emergency hospital at Heron’s Park, an Elizabethan manor commandeered during World War II. The principals include two doctors: anesthesiologist Doctor Barney Barnes (Trevor Howard), and surgeon Mr. Eden (Leo Genn). Four nurses complete the primary hospital staff: “Freddie” Linley (Sally Gray), Esther Sanson (Rosamund John), Marion Bates (Judy Campbell), and Nurse Woods (Megs Jenkins). The story is narrated by Scotland Yard Inspector Cockrill (Alistair Sim) as he types his final report.

The first to die is postman Joseph Higgins (Merle Marriott), who is injured by an exploding V-1 bomb, the unmanned buzz bombs the Nazis began launching in 1944 that could go up to 210 miles before the engines cut out and they fell to earth. Higgins has to have his arm repaired and dies of hypoxia before the operation begins. It’s assumed to be an unfortunate event, but the surgeon points the finger at the anesthesiologist, connected to a similar occurrence before the war, although he was exonerated of malpractice. When Nurse Bates interrupts a dance to announce over the microphone that it was murder and she knows who did it, you know that she’s not long for this world. This prompts the appearance of the bumbling, quirky Inspector Cockrill, who dismisses the premise that there’s a simple explanation, saying in his most imperious Simsian style, “Don’t be fatuous. We are dealing with two premeditated murders.” He assembles the staff and tells them that “four of you are in mortal danger from the fifth.”
The picture is like the TV shows of today, little medicine and lots of staff romances and intrigues, especially involving Mr. Eden, who before the war was a Harley Street physician with a Rolls Royce and a practice consisting of lovely ladies who, as Nurse Woods says were “happy to leave their appendices behind” and loved being in the consulting room of a man with “those eyes, the wounded stag look that no woman can resist.” The dialogue is laced with Shakespearean quotes and witty repartee, such as when the hospital administrator Dr. White (Ronald Adam) expresses chagrin when told that Cockrill can’t keep the press out and the inspector responds, “I don’t mind; they always give me a good write-up.” Or when Cockrill calls nitrous oxide “laughing gas,” and is told by Barnes that it is the impurities that cause the laughs and Cockrill replies, “Oh, just the same as in our music halls.” Watching him pull up a chair as the two doctors duke it out is also a hoot. Also watch for his double takes during his bedtime reading and when he hears noises that could be buzz bombs.

There are enough red herrings to keep the viewer guessing right up to the end. The British censors, who were stricter than their American counterparts, temporarily banned the film on the grounds that any wounded soldier seeing it might become so overcome by dread of being murdered in hospital that it might impede his recovery.1 Director Gilliat countered that the setting in the film was no longer a military hospital as in the book and they relented.

Green for Danger was made during the period called the Golden Age of British Cinema, from the 1940s through the early 1960s. The excellence of the films made then was in large part due to actors and directors such as Laurence Olivier, Alec Guinness, David Lean, Carol Reed, and the principals of this film, Sim, Howard, Genn, and director Gilliat. What is particularly striking is their breadth and depth of experience and acting, in contrast to many of the callow and shallow film stars of today. Many had a university background and a long apprenticeship on the stage, as well as a life experience, both in the workaday world and during the war, that clearly enriched their performances. A little about their history will prove my point, for which I am indebted to Ephraim Katz’s The Film Encyclopedia.2

Sim was born in 1900 and educated at Edinburgh University. He was a professor of elocution before becoming an actor at thirty, first on the stage and then in memorable films such as the original School for Scoundrels, with two other comedic actors, Ian Carmichael (who played Lord Peter Wimsey in the Dorothy Sayes mysteries) and the gap-toothed Terry Thomas, who also was in A Matter of WHO. In Scoundrels, based on the Lifemanship and Oneupsmanship books of Stephen Potter, Sim is hilarious as Potter, who runs a school to teach people how to one-up one another. Other Sim classics are the portrayal of Scrooge in A Christmas Carol; the headmistress and her brother the bookie in The Belles of St Trinian’s, and the enigmatic inspector in The Inspector Calls.

Trevor Howard was born in 1916 and educated at Clifton College and the Royal Academy of Dramatic Arts. His performance as the doctor in David Lean’s 1945 film Brief Encounter catapulted him into stardom. My particular favorite is his portrayal of Major Calloway in one of the all-time great films, The Third Man. Those who have seen it will remember the sound of the zither playing the unforgettable theme. Howard was in one hundred other films, including Tom Jones, Von Ryan’s Express, and The Battle of Britain.

Leo Genn, the least known of the three, was born in 1905 and had the most interesting life experience. He studied law at Cambridge and was a practicing barrister when he started in films in 1930. He didn’t give up his day job until 1939 when he debuted on Broadway. During World War II he served with the Royal Artillery, was promoted to lieutenant colonel in 1943, and awarded the Croix de Guerre in 1945. At war’s end, he joined the British unit investigating war crimes at the Belsen concentration camp and served as an assistant prosecutor for the Belsen trial. Among his noteworthy performances were a small role as the sarcastic Constable of France in Laurence Olivier’s Henry V while on loan during his military service in 1944, and Petronius the counselor to Peter Ustinov’s Nero in the 1951 film Quo Vadis, for which Genn earned an Oscar nomination. He was also the doctor in The Snake Pit.

Sidney Gilliat, born in 1908 and a graduate of London University in English and History, made a number of classic English comedies and thrillers with his partner Frank Launder. They include The Lady Vanishes, Night Train to Munich, and the St. Trinian’s series.

Similar things can be said about other English and American actors like Alec Guinness, Donald Pleasance, David Niven, James Stewart, Clark Gable, Tyrone Power, Charlton Heston, Ernest Borgnine, Charles Bronson, Charles Durning, George C. Scott, Eddie Albert, and Lee Marvin, many who served, often with distinction, in the war. When one considers what these people brought to their acting compared to today’s crowd, it’s not hard to understand why many have stopped going to movies.

References

Dr. Dans (AQA, Columbia University College of Physicians and Surgeons, 1960) is a member of The Pharos’s editorial board and has been its film critic since 1990. His address is:

11 Hickory Hill Road
Cockeysville, Maryland 21030
E-mail: pdans@comcast.net
Wondering waves

I want to be a wave reader,
And read the secret messages that are sent
On the rippling water of the seas,
Like the experienced fingers of the blind,
Read the undulating words of Braille.

And I want to understand the sounds
Of the elephants and whales and seagulls,
And know all the languages of this universe and beyond,
Communicated both now and in the past,
By every living organism.

I want to know the names of everything,
Every purpose, disease, fear and cure.
Why is there such a will to survive?
What happens after death?
Where does everything go?

I want to know the string theory and the strings of every
instrument,
Understand the Golden Gate Bridge and the World Trade Center.
And I want to dance in step with wind,
As I circumnavigate the earth, following the stars.

Steven F. Isenberg, MD

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

Illustration by Jim M’Guinness
Reviews and reflections

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


Steven Johnson
New York, Riverhead Books, 2006 (hardcover)/2007 (paperback), 320 pages

Reviewed by Elaine Thomas, MD

When London was struck by cholera in 1854, it was a booming city “drowning in its own filth,” as Steven Johnson describes in a Dickensian opening to this book on Dr. John Snow’s famous investigation of the epidemic. Johnson has studied semiotics and nineteenth-century literature, and has recently achieved renown and controversy with books and commentary on information technology, and popular culture. He thus brings an unusual approach to this important historical episode, using it as a springboard for a wide-ranging discussion of ideas.

Although The Ghost Map is not merely a history of cholera or of Dr. Snow, the story itself is fascinating. In an era of rampant infectious diseases, cholera was new and frightening, brought to England by trade from the Far East. Although it caused copious, humiliating, fatal diarrhea, no one understood that it was spread by fecal pollution of drinking water. The field of medical microbiology was almost nonexistent; Snow made his brilliant deductions without bacteriology. (The cholera bacterium had been described by an Italian scientist, too far ahead of his time to be noticed.) Snow made his living as an anesthesiologist, and studied the cholera outbreak tirelessly in his spare time. His familiarity with the neighborhood, meticulous collection of masses of data, and innovative thinking allowed him to see geographic disease patterns unseen by other health workers, advancing the dawning field of epidemiology.

Johnson’s style is highly readable, and his careful synthesis of primary sources deepens our understanding of the story beyond the usual inaccurate telling. (Snow didn’t end the epidemic by removing the Broad Street pump handle. His compelling analysis demonstrated the waterborne spread of infection, convincing a local health board to shut down the pump, although the outbreak was probably waning on its own by then.) The author skims over some medical details and occasionally uses statistics loosely, but includes a good list of further reading.

Johnson goes beyond details of medical history, however, to explore a set of interrelated societal themes in a fascinating, though occasionally superficial, reflection on the past and future of communities and their health. These themes include:

- The “sociology of error”: the habits of thought that make it easy for people to go on believing the wrong thing, despite the facts—for example, that bad odors cause disease. In an example that should give pause to researchers, a carefully conducted survey by the Board of Health revealed only erroneous conclusions about the epidemic, because it included only questions based on an erroneous model of disease.

- Consilience: the synergistic exchange of ideas across disciplines. Snow’s knowledge of how people inhale anesthesia allowed him to see that cholera could not have been caused by breathing smelly “miasmas,” as most believed. Snow had indispensable help from a local clergyman who contributed key observations from his complementary social connections, served on a health board, challenged Snow’s theory, and ended up helping prove it. Death records compiled and refined by a thoughtful city registrar also contributed to Snow’s deductions. Ideas also mature across time—Snow hatched his theory of waterborne transmission during a 1848 epidemic, but had to wait until 1854 for further data and insight. Johnson compares these synergies in the London cholera story to the role of today’s Internet in facilitating exchange of information and ideas.

The Pharos/Spring 2008
• The rise of the large city, and the benefits and problems of urban density: dense communities can improve public health and encourage consilience between diverse citizens; on the other hand, pathogens, or terrorists, can exploit density to wreak harm. The close-packed population of Soho in 1854 allowed cholera to spread, but also allowed Snow to see patterns that revealed its cause and advanced the science of epidemiology. Despite the horrors of Victorian London's infrastructure, Johnson makes a case for the societal value of urban interactions.

• The representation of information: epidemiologic mapping was a new technique in the mid-nineteenth century. Snow's brilliance lay in both collecting the right data and organizing it in the right way to reveal hidden patterns, leading to the map of the book's title. Johnson cites Edward Tufte, a current expert in this field. Unfortunately, this theme is weakened by the book's only major shortcoming: the illustrations are poorly labeled and credited, and when the author discusses important conceptual differences between three maps of the epidemic, only one unlabeled map is provided. The author would benefit from following Tufte's teachings on information display.

Overall, the book is both an enjoyable review of a seminal moment in the history of public health and a thought-provoking look at how ideas spread like bacteria through communities, causing unanticipated mutations, conjugations, and evolutions. It should be of interest to students of epidemiology, microbiology, urban sociology, and intellectual progress.

Dr. Thomas is an infectious disease specialist at University of New Mexico Health Sciences Center. Her address is:

Division of Infectious Diseases, Department of Internal Medicine, MSC 10 5550
1 University of New Mexico
Albuquerque, New Mexico 87131-0001
E-mail: ethomas@salud.unm.edu

The Pharos/Spring 2008

39
This was largely because of another bias called anchoring: I was so anchored to my initial impression that other possibilities just didn’t make sense. Finally, I had inappropriately applied Occam’s razor, the decision rule that says it makes more sense to account for all the patient’s symptoms with a single diagnosis than it does to posit two or more diagnoses. In this case, I had considered Mrs. Delgado’s dyspnea and chest discomfort to be somatic symptoms associated with her depression.

*How Doctors Think* is full of compelling stories that illustrate the complex panorama of clinical decision making. Why did one doctor conclude correctly that Blanche Begaye suffered from aspirin toxicity, while another doctor ascribed her symptoms to viral pneumonia? Why did doctors repeatedly fail to diagnose Maxine Carlson’s ectopic pregnancy until it ruptured? Groopman’s storytelling gift is so great that he successfully embeds most of these patient narratives in conversations that he had with their physicians, who then go on to describe their decision making processes. Thus, the reader learns through illustration, rather than definition.

Three major themes run through the book, although each is presented with several variations. The first theme is that doctors who don’t listen to their patients are likely to make serious mistakes in diagnosis and treatment. Medical students still learn, as they did fifty years ago, that history-taking is by far the most important clinical skill. However, the communication skills required for effective doctor-patient interaction are too often considered easy or intuitive and, therefore, not taught. Moreover, students promptly forget the importance of history-taking when they enter clinical training, where radiographic images trump talking with patients. Without role modeling and systematic practice, young physicians may never master effective communication with patients.

The second theme is that doctors often function with a lack of self-awareness. This deficiency may occur at multiple levels. As Groopman convincingly shows us, one reason doctors make cognitive errors is simply because they don’t understand how biases interfere with their reasoning. They just haven’t learned how they think. At another level, doctors tend to ignore or minimize the importance of emotions in their thinking, mistakenly believing that feelings don’t influence clinical judgment. A third blind spot has to do with the effect of ambiguity on our ability to function effectively as healers. The traditional medical curriculum avoids dealing with these internal processes and encourages trainees to focus their attention outward. Fortunately, a small, but growing, self-awareness movement has recently appeared in medical education, asserting that doctors need to understand their own beliefs, feelings, attitudes, and response patterns. The more that physicians develop personal awareness, the more likely they will have the resources to listen, connect, and respond to their patients’ experiences.

The final theme is that patients need to be active participants in their own care. This is by no means a new message, but Groopman frames it in a new way. Given the complexity of clinical decision making, and the many cognitive errors physicians may fall prey to, patients can improve their own care by helping their doctors minimize or avoid such errors. Among other things this means asking thought-provoking questions like, “What else could it be?” “What is the worst thing it could be?” or “Is it possible I have more than one problem?”

If *How Doctors Think* has one limitation, it is that in most of his stories Groopman assumes that wrong decisions were necessarily “bad” decisions and discusses them as such. This is a reasonable assumption in many situations. However, throughout the book he is primarily concerned with “false negatives” (i.e., correct diagnoses missed) without giving “false positives” their due. For example, if more doctors spent more time searching for rare diagnoses (thus avoiding “zebra retreat”), what would be the human and economic cost of all the false positives requiring further work-up? Groopman doesn’t pay enough attention to medical errors that result in unnecessary interventions. In today’s medicine this type of error ought also to be understood and communicated to patients, just as clearly as *How Doctors Think* does for other types of error.

Dr. Coulehan is the book review co-editor and a member of the editorial board of *The Pharos*. His address is:
Department of Preventive Medicine
HSC L3-086
State University of New York at Stony Brook
Stony Brook, New York 11794-8036
E-mail: jcoulehan@notes.cc.sunysb.edu

---

**Final Exam: A Surgeon’s Reflections on Mortality**

Pauline W. Chen

Reviewed by Jay A. Jacobson, MD

*Final Exam* is a title that will capture the attention of any physician who
picks up Pauline Chen’s new book. It evokes our feelings of insecurity, uncertainty, and dread. We remember how we asked ourselves, “Am I knowledgeable enough, skilled enough, steady enough to pass a critical and future-defining test alone and without access to the databases and guidelines that I rely on daily?”

Final exams, when they loom ahead of us, motivate most of us to learn, re-learn, practice, and memorize what we expect we will be asked to say or do when we take them. The stress may be so great that we cannot answer a question that we could have the day before. Even when the exam is over, some anxiety and uncertainty remain as we second-guess ourselves and wonder whether we did well enough compared to our peers to pass. We wait and rely on others to tell us the results. When we hear the results and learn that we passed a final exam, we rejoice. We feel justifiable pride in our performance, and relief that we won’t have to repeat the effort and dread again or, at least, not the next trial.

The final exam that Pauline Chen writes about is both similar and radically different from the ones with which we are familiar. The feelings of anxiety, inadequacy, and discomfort, and the behaviors of avoidance and procrastination are common to both. The determination to learn more and to do better is also shared. However, the questions on Dr. Chen’s exam are not multiple choice or evidence-based. We don’t rely on the usual content experts to write that exam or indicate the right answers, and the exam, even if passed, must be repeated over and over again. In some ways, what this book invites us to think about and prepare for is neither final for us nor an exam. It is not an exercise. It is an intimidating, real, and recurring task.

Dr. Chen, however, answers and helps us prepare to answer one very important and troubling question. It does not appear on a test. Dr. Chen does not read it; she hears it from a long-time friend. Erica, also a physician, who recently had to personally manage the otherwise medically-unaddressed suffering of her dying father, asks Pauline, “Why are we so bad at taking care of the dying?”

That question, which we, too, confront in the introduction to the book, frames what follows and echoes the questions that trouble and motivate Dr. Chen. The book’s subtitle, A Surgeon’s Reflections on Mortality, conveys a more revealing picture of its content and style than the provocative, but somewhat misleading, title. Dr. Chen’s very personal, revealing, and moving narrative follows the trajectory of her education, training, and career in three sections entitled “Principles,” “Practice,” and “Reappraisal.” The last one of these reflections aptly ends with “Through the Looking Glass.” The introduction previews the arc of the book. The stages it describes parallel the experience of most physicians, but in the later stages Dr. Chen separates herself from the majority of us when she answers that original question that many of us never ask. She shares personal stories of family, person as cadaver, patients, friends, patients as friends, and friends as patients that revealed her death-related fears, discomfort, and professionally-acquired coping strategies. She uses her experience to rectify her lack of preparation. She uses her insight and reflection to address her fears and to build strategies that shrink the artificial and professionally-maintained distance between her and her dying patients.

Like most of my colleagues, I came into medicine poorly equipped to deal with terminal patients. I had little experience with the dying beforehand, and like many physicians harbored a profound aversion to death. However, during almost 15 years of school and training, I faced death over and over again. And I learned from many of my teachers and colleagues to suspend or suppress any shared human feelings for my dying patients, as if doing so would make me a better doctor. These lessons in denial and depersonalization began as early as my first encounter with death in the gross anatomy dissection lab and were reinforced during the chaos of residency training and practice.

As I learned and eventually even mimicked these coping mechanisms, I found myself wrestling with disturbing inconsistencies that only multiplied over time. There was a dying friend I could not call, a young patient’s tortured death that I could not forget, and even the sense of shared humanity with a corpse that I could not cast aside when I was asked to saw her pelvis in two. These small but powerful moments, magnified every time I encountered death, would finally give me insight into how my own fears and trained responses had, in the end, incapacitated me. In acknowledging the painful consequences and paradoxes of my behavior, I began to extricate myself from those learned responses. Amid the pain of losing patients, I learned that I might be able to do something greater than cure. I could provide comfort to my patients and their families and, in turn, open myself to receive some of their greatest lessons.

Stories give this book the power and motivating force absent from reports that document our inadequacies in the care of irreversibly ill and dying patients. Dr. Chen tells her stories, almost parables, in a simple, clear, direct, and compelling fashion. She doesn’t, however, depend solely on the stories and her personal responses to them to help readers prepare for the “final exam,” which is really the obligation to repeatedly and consistently provide better informed, more skillful care at the end of life.

The book is much more than a personal narrative. Chen has extensively annotated her chapters. She does a real service for readers unfamiliar with
Reviews and reflections

literature about the culture of medicine, about contemporary practice, and expert recommendations for end-of-life care. The notes add background and depth, but are wisely grouped at the end of the book to avoid interrupting its smooth flow and informal tone. The notes can almost be read independently and serve as a mini-course or survey of the intersections between death, American culture, and American medicine. For those who want to go even deeper, there is a very extensive bibliography as well. Chen doesn’t limit her sources to the standard medical literature. She draws on related work from sociologist Charles Bosk’s Forgive and Remember: Managing Medical Failure; cultural anthropologist and psychiatrist Arthur Kleinman’s The Illness Narrative: Suffering, Healing, and the Human Condition; social commentator Studs Terkel’s Will the Circle Be Unbroken, Reflections on Death, Rebirth and Hunger For a Faith; novelist Leo Tolstoy’s The Death of Ivan Ilyich; and contemporary popular physician authors Perry Klass, Jerome Groopman, Abraham Verghese, and Sherwin Nuland.

When we take our usual final exams, we get a score. If we pass, we are done. When we take care of dying patients, we rarely get a score, and we are obliged to do it again without knowing how well we’ve served our patients.

Pauline Chen was lucky enough to receive one of her scores. When her beloved college mentor, Dorrine, faced the prospect of liver cancer, Chen, despite her fear, called on all she had experienced and learned to stay supportive, engaged and honest with her friend. Dorrine later wrote:

I can’t thank you enough; you’ve been instrumental in helping me get back my life. If anything, this has taught me how precious friends are. Thank you for the inexpressibly touching and life-giving gift of your friendship. It’s wonderful to have friends who, as they say in Japanese, “do me the honor of worrying about me.” p. 217

Chen writes to us:

That honor of worrying—of caring, of easing suffering, of being present—may be our most important task, not only as friends, but as physicians too.

And when we are finally capable of that, we will have become true healers. p. 218

Pauline Chen attended Harvard University and the Feinberg School of Medicine at Northwestern University. She trained in surgery at Yale University, the National Cancer Institute, and UCLA, where she also joined the faculty. Her previous work has won prizes for nonfiction and creative writing. This book will justifiably win well-deserved recognition and acclaim from physician readers and others who wish to understand their own fears and attitudes about mortality and who aspire to help or shepherd others through life’s most difficult journey.

Dr. Jacobson is Professor of Internal Medicine and Chief of the Division of Medical Ethics and Humanities at the University of Utah School of Medicine and LDS Hospital in Salt Lake City, Utah. His address is:

LDS Hospital
8th Avenue and “C” Street
Salt Lake City, Utah 84143-0002
E-mail: jay.jacobson@intermountain-mail.org

Letters to the editor

Is any measurable blood lead level harmful?

Drs. Dunavan and Mellinkoff wrote an excellent article about lead poisoning in the Autumn 2007 issue of The Pharos (pp. 17–22). I would like to elaborate on two of their points.

First: Lead is such a useful element in so many industrial and manufacturing processes that there has been a long history of skepticism and worse directed against those who raise concerns about its toxicity.

The authors describe the calumnies or ridicule visited upon George Baker because of his concerns about the ways in which the lead-contaminated production of apple cider contributed to lead poisoning in Devonshire, England, in 1767. Other physicians studying lead toxicity have also had to face opposition.

Herbert Needleman (referenced in the article) is one of the scientists in the forefront of studies of the influence of lead on the intelligence of children. His article of almost three decades ago about the effects of lead poisoning as measured by elevated lead in dentine is a classic. But this work has been the subject of heated criticism. There was an unusual investigation by the Office of Scientific Integrity. During a course of hearings at the University of Pittsburgh he was eventually cleared of any charges of scientific misconduct. One of the scientists who raised questions about Needleman’s work later received funding from the International Lead Zinc Research Organization.

The work of other researchers has vindicated Needleman, with a slight modification. In Needleman’s 1979 study, twenty-three subjects had had their blood lead levels determined several years before the tooth study. The
mean blood lead levels were 35 micro-
grams per deciliter for the subjects with
high dentine lead and 24 micrograms
per deciliter for the subjects with low
dentine lead. Blood lead levels even
at concentrations as low as 5 or 10
micrograms per deciliter are associ-
ated with decrements in intelligence.
Furthermore, there is surprising and
alarming evidence “that the effects of
lead on IQ are proportionally greater at
lower lead concentrations.”^34^22 Many
experts believe that there is no level of
blood lead that is harmless. When we
look back at Needleman’s 1979 paper, it
is probable that even the subjects who
were classified in the low dentine lead
group were still being lead poisoned.

Second: Dunavan and Mellinkoff
write that the removal of lead from
gasoline occurred because it was seen
as a “major public health threat” (p. 18).
But, in fact, the story is slightly more
circuitous. The impetus to remove lead
from gasoline came in part as an un-
intended consequence of the effects of
smog. Catalytic converters are devices
that reduce carbon monoxide, nitrogen
oxides, and hydrocarbons (unburned
fuel). They were added to cars to de-
crease these smog forming emissions.
Lead fouled these converters, and it was
this problem, along with concerns about
the health hazards of lead, that finally
caused it to be removed from gasoline.4

The effect of taking the lead out of
gasoline has been dramatic and, no
matter how this was actually achieved,
has been described as a “triumph for
public health.”^51^51 But nothing is simple.
The catalytic converter decreased
pollution by converting carbon monox-
ide to carbon dioxide. Carbon dioxide
in tailpipe emissions is thought to be
a major contributor to “greenhouse
gases. And leaded gasoline continues to
be sold in some developing countries
where many children are exposed to
lead toxicity.6

The interactions between lead, in-
dustry, and public health continue to be
complicated and contentious.

References
1. Needleman HL, Gunnoe C, Leviton
A, et al. Deficits in psychologic and class-
room performance of children with elevated
dentine lead levels. N Engl J Med 1979; 300:
689–95.
2. Palca J. Panel clears Needleman of
3. Canfield RL, Henderson CR Jr, Cory-
Slechta DA, et al. Intellectual impair-
ment in children with blood lead concen-
trations below 10 microg per deciliter. N Engl J Med
4. Warren C. Brush with death: A social
history of lead poisoning. Baltimore: Johns
5. Rogan WJ, Ware JH: Exposure to lead
in children—how low is low enough? N Engl
6. Kitman JL. The secret history of lead:
Frances Frankenburg, MD
(AΩA, University of Toronto, 1977)
Bedford, Massachusetts

Thanks to Dr. Dans

Dr. Peter Dans’s review of Miss
Potter in the Spring 2007 Pharos
(pp. 58–59) was such a delight that I
straightway hustled out to purchase the
DVD. My wife’s parents came to the
United States after World War I from
Burnley in Lancashire, not far from the
Lake District; she and I watched the
DVD last evening and were enchanted.

I hope that you also came upon
the essay concerning Miss Potter in the
May-June issue of the American
Scientist (pp. 210–12). It serves as a
worthwhile sequel to the film, I believe.

Additionally, Linda Lear’s new biog-
raphy: Beatrix Potter: A Life in Nature
(St. Martin’s Press, New York, 2007).

Russell M. Lane, MD
(AΩA, University of Rochester, 1955)
Sunderland, Massachusetts

I’ve enjoyed your perceptive reviews
of the movies in The Pharos, and was
delighted with your discussion of La
Vie en Rose until I read the last line.
A statement attributed to Albert
Einstein states the meaning of “the ex-
ception that proves the rule” most con-
cisely: “No amount of experimentation
can ever prove me right; a single experi-
ment may at any time prove me wrong.”

With rare exceptions, keep up the
good work.

Kenn Hubel, MD
(AΩA, Cornell University, 1954)
Iowa City, Iowa

Dr. Dans responds to Dr. Hubel

Thanks for your kind words and for
sending Einstein’s deciphering of the
meaning of the phrase used in the con-
cluding sentence of my review of La Vie
en Rose. I used the phrase in the sense
I was taught, with “prove” meaning “to
test.” The second definition of “prove”
in the 181 Webster’s New Collegiate
Dictionary (after an archaic meaning)
is said to derive from the Old French
“prover” and the Latin “probare, ” i.e.
“to test the quality of: try out (the ex-
ception proves the rule),”52 In other
words, the exception challenges (tests)
the universality of the rule. An analo-
gous usage is in the phrase “the proof
of the pudding is in the eating.” Clearly,
as Einstein and you point out, an excep-
tion hardly proves the rule in the sense
of confirming it.

My research did turn up a mean-
ing that hinges on “proverb,” meaning
“to confirm.” It relates to a medieval
principle of the law “exceptio probat
regulam in casibus non exceptis)” or “the
exception confirms the rule in cases
not excepted.” A common example is
a parking ordinance where the sign
“No parking between 7 AM and 9 AM
and between 4 PM and 6 PM” is said to
prove (confirm) the rule that parking is
allowed at all other hours (the excep-
tions).

Thanks again for sending your
thought-provoking comment.

Best regards and keep that sharp eye
out for ambiguity.

Peter E. Dans, MD
Cockeysville, Maryland

The Pharos/Spring 2008
Putting a cost on extra days given by drugs

Although I strongly concur with the overall message of the Autumn editorial, “The American culture and health care” (p. 1), regarding the need to consider cost of new therapies as part of making them generally available, I strongly take issue with the appropriateness of one of the examples used to argue that the cost of new therapies is too high—that of Zevalin and Bexxar for relapsed or refractory indolent lymphoma. Although the cost of a single administration of these radio-immunotherapeutics is approximately $25,000, that single dose frequently produces durable multiyear remissions in patients with relapsed or refractory indolent lymphomas, whose other options are at least equally costly, more toxic, and probably less effective. A recent Phase III study in over four hundred patients reported at the American Society of Hematology by Hagenbok et al1 in December 2007 showed that a single dose of Zevalin given to patients with indolent lymphomas in a complete or partial remission from any first-line chemotherapy increased progression free survival from thirteen to thirty-seven months. To patients and society, the value of two productive years of life far exceeds this cost, as an expensive targeted monoclonal antibody that is standard-of-care in the United States was used only in a small minority of cases. Although cost must be part of the overall health care equation, benefit must be considered as well, particularly for therapies for which there is compelling evidence of clinical benefit. It is of note, that both Bexxar and Zevalin are approved for use in the European Union despite their review process which includes a cost/benefit analysis. Two recent articles in the lay press specifically address the importance of keeping these drug available: www.newsweek.com/id/70301 and www.nytimes.com/2007/07/14/health/14lymphoma.html?pagewanted=2&_r=1.

Reference

Jack W. Singer, MD
(ΩΩA, Downstate Medical Center, 1967)
Disclosure: Dr. Singer is Chief Medical Officer of Cell Therapeutics Inc., which is in the process of purchasing the rights to market and further develop Zevalin.

Dr. Harris responds to Dr. Singer
My point is exactly the one that is implicit in your comments: The citizens of the United States will not accept not receiving a medicine or other therapy proven to be effective just because of its cost. Other ways to stabilize expenditures must be found.

Edward D. Harris, Jr., MD, editor

Remembering Alvan

In addition to an astonishing array of interesting and insightful articles, I thought it was an exceptionally nice touch with the “Found in a filing cabinet” piece featuring a poem by Alvan Feinstein. He was an exceptionally talented individual, and I vividly remember him playing his guitar at clinical scholars meetings and singing a tune he wrote about achieving success in academic medicine (something about putting a shield on the spleen of a rat).

I also appreciated your editorial and the need to find something that uniquely works for the U.S. culture. In that light, you might be interested in a podcast I recorded a while ago about the need to change the psyche if we are truly going to change the system: www.aahdc.org/audio/Episode_2_The_Psyche_and_the_System.mp3.

[Editor’s note: The podcast is well worth a listen.]

Steven A. Wartman, MD, PhD
(ΩΩA, Johns Hopkins University, 1970)
President/CEO, Association of Academic Health Centers
Washington, DC

The captain is the master of his ship

Dr. David Goodkin’s article, “Burial at sea” (Autumn 2007, pp. 28–29) is interesting, readable, and has pleasantly sly touches of humor. Dr. Goodkin obviously lives up to his name. He does, however, present a rather one-sided philosophy, and some comments need to be made.

First, the captain of a ship (or the pilot of a plane) has the ultimate say on just about everything. That may come as culture shock to physicians, who are accustomed to writing orders and having nurses carry them out. Thus, when Dr. Goodkin tells the captain to turn the ship around, it sounds—we can be blunt here—simplistic. The captain/pilot, who is trained for all contingencies, makes his decisions based on many factors. And, yes, one of those factors is—as it should be—cost.

Secondly, these costs of an evacuation or emergency rescue can be astronomical. And usually, unless the traveler has taken out special insurance, the costs are the responsibility of the patient (or the estate, if the patient dies). To blindly ignore costs is a bit naive.

Finally, and in a more general vein, some physicians simply cannot grasp the fact that death (like birth) is a normal part of life. In the great majority of cases, there is no one to blame. Death is not a failure.

A reasonable attempt was made at defibrillation, and failed. Quiet and dignified acceptance of death, at this point, would have been entirely appropriate.

John U. Buchman, MD
(ΩΩA, University of Maryland, 1962)
Studio City, California
Caveats re Walter Reed and James Carroll

As the co-author of a recent book on yellow fever, I read with great interest Dr. Charles S. Bryan’s article, “Gloria in Absentia: Walter Reed, James Carroll, and the ethics of authorship,” in the Autumn 2006 issue of The Pharos (pp. 16–22). I have corresponded and spoken with Dr. Bryan about his paper. Due to space limitations imposed on a letter to the editor, I will not address the many subtle issues discussed by Dr. Bryan that are open to much discussion and speculation by students of these events but will confine my comments to known historical facts that he seems to have missed.

The most significant is found in the article’s first paragraph and repeated later on page 19. Dr. Bryan says that in early August 1900 Walter Reed returned to Washington, DC, “allegedly to complete a report on typhoid fever.” On page 19, again referring to Reed’s work on the typhoid report, Bryan says “Although the whereabouts of the material [Reed] submitted to Sternberg is apparently unknown, the report was indeed published.” This statement could be a bit confusing to the casual reader. The “report” referred to is the complete typhoid fever report published in two volumes of 1600 pages total in 1904, two years after Reed’s death.

The statement that “the whereabouts of the material [Reed] submitted to Sternberg is apparently unknown” is simply not true. The publication may be unknown to Dr. Bryan but it does exist as the Abstract of Report on the Origin and Spread of Typhoid Fever in U.S. Military Camps During the Spanish American War of 1898,” by Reed, Vaughan, and Shakespeare.3 This abstract was published by the U.S. Government Printing Office, Washington, DC, that same year, 1900. The abstract, 239 pages in length, carries the names of the three board members. It is not possible to know exactly who wrote what, but Reed is generally credited with at least the final 45-page summation chapter of the abstract, as Edward Shakespeare had died in June 1900 and Victor Vaughan was back at the University of Michigan. It was also probably Reed who pulled it all together into final form for publication.

Another factual error occurs in Dr. Bryan’s statement on page 18 that “Neither Reed nor Carroll had published a scientific paper before their collaboration began in 1895.” This statement is incorrect and could be taken to imply that without Carroll, Reed was unable to produce his own work. A list of Reed’s publications can be found in the first edition of Howard Kelly’s book, Walter Reed and Yellow Fever, page 281.2 Reed’s first publication was in 1892 in the Boston Medical and Surgical Journal, the forerunner of the New England Journal of Medicine. Reed had four more publications before 1895, one of those again published in the Boston Medical and Surgical Journal.

Dr. Bryan writes on page 21 regarding Reed’s whereabouts during the mosquito experiments at Camp Lazear, “to be sure, Reed was nowhere on the premises when the decisive experiments were actually performed.” This statement appears to unfairly malign Reed and is not factually correct.

According to John Moran, a former Army hospital corpsman, who was one of the first along with John Kissing er to volunteer for the experiments at Camp Lazear, Reed actually had an office tent at Camp Lazear. There are at least two documents in the on-line version of the Philip S. Hench Walter Reed Yellow Fever Collection at the University of Virginia that detail Moran’s time at Camp Lazear.4,5 Moran served as Reed’s clerk typist and provides details about Major Reed’s office tent used by him when he visited and inspected Camp Lazear twice daily. Moran also says that Reed was in Building #2, the mosquito house, when loaded mosquitoes were released on Moran’s side of the room.

Dr. Bryan’s statement on page 18 that in the Spanish American War, “thirteen [soldiers] died from yellow fever for every combat death,” is not supported by any authoritative document. There were about 315 combat deaths in Cuba during the Spanish American War, which would mean an additional 4,095 (315 x 13) would have died from yellow fever if Dr. Bryan numbers are correct. The number of typhoid deaths among soldiers, which was considered scandalous, was almost 1,600. The total number of deaths from disease nonbattle injury was about 2,500, significantly below the 4,000 plus that would had died from yellow fever alone if Dr. Bryan is correct.

Finally, it is a bit nit picky, but on page 17 Henry Rose Carter is referred to as being in the Public Health Service. Carter was actually in the Marine Hospital Service, the forerunner of the Public Health Service. The Marine Hospital Service became the Public Health Service in 1912.

While the main thrust of Dr. Bryan’s article is to discuss the issues of first authorship, maintenance of mutual respect between and among investigators, and public attribution of credit for major scientific discoveries, he has missed significant historical facts. These first three facts discussed above, if included, could have provided a different tone to his article.

References

The Pharos/Spring 2008 45

John R. Pierce, MD, Colonel, U.S. Army (retired)
Rockville, Maryland

Dr. Bryan responds to Dr. Pierce

Accusations of hagiography constitute an occupational risk for physicians who write about their role models, and one with which I am not unfamiliar. I thank Dr. Pierce, longtime historian of the Walter Reed Society, for identifying my several oversights but am surprised by the tone of his letter, suggesting as it does the Shakespearean “nothing is but what is not.” My paper, based primarily on the newly-available James Carroll papers, helps exonerate Reed from three damaging innuendos including the one about the typhoid report. My paper rebuts, for example, some of the charges made by Lawrence K. Altman in his essay “The Myth of Walter Reed.”

Dr. Pierce and his co-author, Jim Writer, indeed point out in their well-researched and highly readable account that on 21 December 1900 Reed looked on from “the mosquito-free side of the screen” while John J. Moran exposed himself to 15 loaded mosquitoes. Also, Reed later offered to undergo a blood injection experiment from which Carroll tried to dissuade him. However, had Reed vigorously volunteered for the mosquito experiments, surely this would have been known to Carroll and Aristides Agramonte, mollifying their bitterness. Number me not among those who fault Reed for not self-experimenting. As the forty-nine-year-old senior investigator, and with men less than half his age willing to volunteer, it would have been more appropriate for Reed to submit to a loaded mosquito than for the general of an army to lead the bayonet charge. But here’s what Reed earlier wrote his wife about the pending experiments at Camp Lazear:

Don’t worry about any exposure on my part, for I shall do nothing in connection with the camp. My work is to get the station completed and properly equipped, & then I shall confine myself to Laboratory work.

And here’s what Reed later wrote his sister:

Dr. [Jesse] Lazear, of Baltimore, and Dr. Carroll, my assistant here, went with me—Both contracted the disease, & my dear friend Lazear, died of that disease! As for myself, I suppose that I was hardly worth killing & so escaped, although coming into the most intimate daily contact, but I never permitted a mosquito to bite me!! [The underlining is Reed’s]

I’m a bit perplexed that Dr. Pierce and Mr. Writer omitted from their book these and certain other choice passages that would have afforded a more nuanced portrait of Reed. I’m also puzzled by their undocumented statement that “Reed probably either cabled or wrote Lazear instructing him to stop human experiments until [Reed] could get back to Cuba.”

On the other hand, Dr. Pierce and Mr. Writer make the breathtaking suggestion that Lazear was almost certainly “Guinea pig No. 1,” as recorded by his own hand in a laboratory notebook. This makes sense, especially since there were no ongoing animal experiments at the time. Moreover, this suggestion supports the widely-held opinion that Lazear designed the crucial self-experiment that nailed down the conditions for mosquito transmission of yellow fever to humans (namely, the mosquito must feed on an infected person before the onset of jaundice and must incubate the virus for at least a week before feeding on its next victim). Many observers through the years have sided with Carroll and Agramonte to the effect that if any of the four investigators deserves to be singled out, it should be Lazear.

Walter Reed left Cuba on 2 August 1900 uncommitted to the mosquito hypothesis and returned on 6 October 1900 to find data that allowed him to present just seventeen days later a paper concluding that the mosquito was the intermediate host. Reed was a good and honorable man, but credit and posthumous fame should be distributed more evenly than Dr. Pierce and Mr. Writer convey in the subtitle to their book (How Yellow Fever Ravaged American and Walter Reed Discovered Its Deadly Secrets). However, and as Dr. Pierce knows better than I, this matter will remain highly controversial until or unless Jesse Lazear’s notebook, last seen in Reed’s possession, somehow finds the light of day.

References
3. Letter from Walter Reed to Emilie Lawrence Reed, November 18, 1900. Philip S. Hench Walter Reed Yellow Fever Collection. etext.lib.virginia.edu/etcbin/fever-browse?id=022406001.
4. Letter from Walter Reed to Laura Reed Blincoe, March 26 1901. Philip S. Hench Walter Reed Yellow Fever Collection. etext.lib.virginia.edu/etcbin/fever-browse?id=LVAF0010.

Charles S. Bryan, MD, MACP
(AQA, University of South Carolina, 1992)
Columbia, South Carolina
I'm putting on my earrings;
I'm going for my chemo.

Once a week, from nine to noon,
Poison kills my cancer cells.
I read. I doze. I smile at Vic.
We hold hands.

Cancer comes like a cobra's strike,
Life-limiting, dream-destroying.
Realist or optimist?
I am both.

I'm wearing my earrings;
I'm getting my chemo.

More than anxiety, I feel hope.
More than fear, transcendence.
Better to pray for strength
Than for results.

Loving friends predict:
"Now that you have cancer
You will treasure every day."
I always have.

I love my earrings;
Is my chemo working?

Beverly Fuchs
Richard Bronson, MD, added to the editorial board of The Pharos

Richard Bronson, MD (AΩA, New York University, 1965), Professor of Obstetrics, Gynecology & Reproductive Medicine and Director of the Division of Reproductive Endocrinology, has been appointed to editorial board of The Pharos. Dr. Bronson has this to say about himself, writing, and poetry:

Some say that the reading and writing of poetry is an acquired taste. There may be some truth in this, as a “prepared mind” is frequently required to appreciate the nuances of poetry. Looking back to my teens, when I began to write, my only goal was to let others know what I was feeling. It seemed the way to go. Now, I have come to learn that poetry teaches the writer introspection, skills of observation, expression, and self-awareness. It keeps one in touch with oneself. These are all skills of importance in the macrocosm of Life and the microcosm of our medical profession. Writing also leads to catharsis, has therapeutic value for oneself and others. In the end though, my initial premise remains true.

I am a poet, but also consider myself an educator. How could I not, as I have lived an academic medical career? I am on the editorial board of Xanadu, the literary magazine of the Long Island Poetry Collective, and have run its weekly workshop over the past decade. Interestingly, our working group is mostly made up of people who have careers in education. The giving and acceptance of criticism in an incisive, gentle, nonjudgmental way are signs of an expert teacher. We watch with satisfaction the maturation of abilities and are happy to see a poem develop a stronger form. I have given and learned from this group and now am happy to use these skills as a reviewer for The Pharos.

Announcing the 2008 Alpha Omega Alpha Robert J. Glaser Distinguished Teacher Awards

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

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

Nomination materials for 2008 have been sent to every medical school by the AAMC, which administers all aspects of the competition. The deadline for nominations is May 29, 2008. Information and nomination forms are available at www.aamc.org/about/awards/aoa.htm. Queries regarding nominations should be addressed to Robert F. Sabalis, PhD, at the AAMC, 2450 N Street, NW, Washington, DC 20037; telephone (202) 828-0680; e-mail rsabal@aamc.org.

The awards will be presented during the annual meeting of the AAMC in San Antonio, October 31 to November 5.

Winners of the 2007 Pharos Editor’s Prize

The 2007 Pharos Editor’s Prize has been awarded to Doruk Ozgediz, MD, MSc (AΩA, University of California, San Francisco, 2002), Julie E. Adams, MD (AΩA, University of Vermont, 1999), and Rochelle A. Dicker, MD (AΩA, University of Vermont, 1995), for their excellent essay, “Trauma on trauma: Lessons from the tsunami and civil conflict in Sri Lanka” (Winter 2007, pp. 28–33). The Editor’s Prize is awarded yearly to encourage younger authors (those under forty-six years of age) to submit essays to the journal.

Doruk Ozgediz writes: I am of Turkish origin but mostly grew up in the United States. I went into medicine partially for the possibility of promoting positive social change. I recently completed training in general surgery and am interested in the broader aspects of clinical medicine and health care for vulnerable populations. I am currently living and working in Uganda, specifically on research and training initiatives in surgery. We were all disheartened to hear of the escalating unrest that developed in Sri Lanka in the year after the tsunami, since there seemed to be an opportunity for some reconciliation that we sensed while there on the ground. We would be very excited for an opportunity to return there to work with our colleagues there who continue to work in tremendously challenging circumstances.

Rochelle Dicker tells us about herself: I am currently an Assistant Professor of Surgery and Anesthesia at the
University of California, San Francisco. I was born in Los Angeles and went to medical school with the intent of practicing primary care. I caught the "surgical bug" and now practice in a city hospital specializing in trauma, acute surgical care, and critical care. San Francisco General Hospital is not only the trauma center for the city, but it is a hospital of last resort. I run a program in violence prevention serving youth and young adults from disenfranchised communities. I have taught ultrasound in Uganda to surgeons and the need to continue to strive for excellence throughout a medical career.

Julie Adams has this to say: I am currently a full-time vascular surgeon at Fletcher Allen Health Care/University of Vermont. My clinical interests are abdominal aortic aneurysms, carotid disease, and percutaneous vascular intervention. I was attracted to vascular surgery as a medical student and enjoy it for many reasons. I enjoy the continuity of care our specialty provides to a primarily older population and the diversity of treatment options that we have to offer. I am married to Thomas Lahiri, a pediatric pulmonologist, and we have one son, Kevin, and another child on the way. In our free time, we enjoy trips to Montreal. My trip to Sri Lanka with Rochelle and Doruk really opened my eyes to the plight of those suffering from civil war, poverty, and natural disaster. I encourage all physicians to participate in supporting endeavors to bring medical care and cost-effective solutions to the burden of injury both here and abroad.

2007 Pharos Editor’s Prize winners Doruk Ozgediz, MD, Rochelle A. Dicker, MD, and Julie E. Adams, MD. Photo courtesy of Dr. Dicker.

Announcing the 2008 Pharos Editor’s Prize

For the eleventh year, Alpha Omega Alpha is pleased to offer up to three prizes of $1000 each to the author(s) of original nonfiction manuscripts published in The Pharos. Authors need not be members of ΑΩΑ, but must be forty-five years old or younger as of December of the calendar year in which the paper is submitted. To be competitive for a prize, the paper submitted must be in the standard format of The Pharos (see www.alphaomegaalpha.org/pharos/NoticeToContributors.htm), and not published previously in any form. Content should be in the areas emphasized by The Pharos—medical history and biography, ethics, professional issues, and personal essays. Essays submitted to the ΑΩΑ Helen H. Glaser Student Essay competition are not eligible for this prize, nor are previous winners of the Editor’s Prize eligible to compete. All manuscripts are subject to review of Pharos editorial board members. Judging will be on the basis of style and composition, originality, scholarship, and interest and relevance to medicine.

Centennial celebration at the University of Minnesota Medical School, Alpha Minnesota

On December 5, 2007, the University of Minnesota chapter of Alpha Omega Alpha celebrated its one hundred year anniversary with the induction of twenty-five new senior members. The event took place at the McNamara Alumni Center, on the University of Minnesota campus. There was an impressive turnout for the event, including medical school Dean Dr. Deborah Powell, Chairman of Medicine Jonathon Ravdin, and many other prominent faculty. The ΑΩΑ visiting speaker for the evening was Dr. Edward Harris, Jr., Executive Secretary of Alpha Omega Alpha and Editor of The Pharos, who spoke about an eclectic variety of topics, including the mentor relationship and the need to continue to strive for excellence throughout a medical career.

The evening opened with a welcome address from chapter President Aaron Tande, who recognized prominent attendees and gave an outline for the night's program. Next, chapter Councilor Dr. James H. House gave an excellent overview of the history of Alpha Omega Alpha nationally and at the University of Minnesota. Then chapter Vice President Tony Anderson spoke about three prominent ΑΩΑ alumni. The first was Dr. S. Marx White, who was one of the eight members of the 1908 inaugural class at the University of Minnesota. The period during which Dr. White served as chief of Medicine at Base Hospital No. 26 in France during World War I was discussed in detail. In only five months of operation, the hospital took care of over 5700 patients with astounding low mortality. Also discussed was Dr. C. Walton Lillehei, a member of the 1942 class of ΑΩΑ. Dr. Lillehei was a pioneer of cardiothoracic surgery at the University of Minnesota. At a time when the options for open-heart surgery were limited by an inability to maintain blood flow to the brain during the procedures, Dr Lillehei would not be discouraged. He implemented a novel approach to this problem, using cross-circulation,
which was the controversial method of running the patient's circulation through a donor (usually a parent). Not satisfied with the limitations of this technique, Dr. Lillehei continued his innovations with the development of the bubble-oxygenator. This development ultimately established Lillehei’s legacy and led to the successful treatment of countless patients throughout the world.

The third prominent alumnus was ΑΩΑ Councilor Dr. James H. House, who is stepping down this year as faculty leader of the Minnesota chapter after twenty years. With the help of several accomplices in Dr. House’s family and faculty at the University of Minnesota, we were able to surprise Dr. House with several meaningful photographs and anecdotes. It was a special and well-deserved recognition of both Dr. House’s outstanding career and service to ΑΩΑ. The one-hundredth anniversary program finished with a discussion of the chapter’s ongoing service activities and financial situation by Treasurer Dr. Sarah Cooley.

Tony Anderson
(ΑΩΑ, University of Minnesota, 2007)
Vice President of Academic Outreach, Alpha Minnesota
St. Paul, Minnesota

and on what dues are spent. Below is a listing of ΑΩΑ’s national programs, and their 2007 actual expenses.

All programs are funded entirely by the member dues and contributions, supplemented by investment income.

<table>
<thead>
<tr>
<th>Program</th>
<th>2007 $ Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Pharos</td>
<td>438,000</td>
</tr>
<tr>
<td>Carolyn L. Kuckein Student Research Fellowships</td>
<td>295,000</td>
</tr>
<tr>
<td>Visiting Professorships</td>
<td>130,000</td>
</tr>
<tr>
<td>Robert J. Glaser Distinguished Teacher awards</td>
<td>62,000</td>
</tr>
<tr>
<td>Medical Student Service Project awards</td>
<td>110,000</td>
</tr>
<tr>
<td>Helen H. Glaser Student Essay awards</td>
<td>5,000</td>
</tr>
</tbody>
</table>

Minutes of the 2007 ΑΩΑ board of directors meeting

The annual meeting of the board of directors of Alpha Omega Alpha was called to order by President Rae-Ellen Kavey on Saturday, October 27, 2007.

Attending

Directors at large: C. Bruce Alexander, MD, University of Alabama School of Medicine, Birmingham, Alabama; N. Joseph Espat, MD, Roger Williams Cancer Center, Providence, Rhode Island; Ruth-Marie Fincher, MD,
Alpha Omega Alpha continues to operate effectively, offering a variety of programs to students at our 124 chapters in the United States, Canada, Puerto Rico, and Beirut, Lebanon. This is the sub-text of our mission, supporting not only the activities of students that foster excellent teaching, scholarly accomplishments, and the opportunity to render service to underprivileged populations, but, as well, supporting high ethical standards and professionalism. AΩA is privileged to have a board of directors that brings expertise, good long-range perspectives, varied backgrounds, and compatibility to our deliberations. Never has it been more important for the society.

**The importance of AΩA membership**

Membership in AΩA continues to be a substantial added value to professional life. There is little doubt that AΩA membership is an important credential for attaining students’ goals for postgraduate education, despite the concern of many of us more advanced in years who want membership in the society to represent a capstone rather than a stepping stone in careers. I remain particularly impressed, however, with e-mails that I receive regularly from faculty elected by students with presentation of their pins at award dinners, showing that their selection by students to become members of the society means very much, for all the right reasons.

Very important, but easy to overlook, is that AΩA sits in the context of a changing landscape of medicine and health care. It has become more difficult to be both a doctor and a patient. The ranks of uninsured are increasing without any vision for creating a national health plan. Reimbursement insufficiency is an increasingly common syndrome afflicting all physicians, particularly for those providing primary care. Along with all this goes a decrease in disposable income and, unfortunately, the sad fact is that requests for support to an honorary society that cannot enhance the bottom line of one’s practice often sit at the bottom of paper piles on desks. Special requests for funds that I am likely to respond to positively come these days from my subspecialty society fighting the battle for diminishing funds from NIH, CMS, and private insurance.

**AOA’s role in the twenty-first century**

What then, should be the continuing valid and appropriate role of AΩA? The answer to this has been crystallized for me by reading the responses to me of Yale AΩA graduates upon learning that the Deputy Dean for Education at Yale University School of Medicine, Richard Belitsky, MD, has requested that the chapter there be disbanded. In the words of these Yale members, elected as students or faculty, AΩA is prized, first, for its recognition of excellence in the areas of scholarly achievement, but also for the commitment of individuals to service, as well as their possessing the qualities of leadership and professionalism. AΩA membership is not perceived as an elitist conquest (as would being tapped for Skull and Bones at Yale), but rather as unapologetic and justifiable recognition of the achievements and qualities outlined above.

**The chapters and their councilors**

The keystone to success of AΩA is having active, committed chapters at our medical schools, and the key to having active and thriving chapters lies outside control of the national office. It is the chapter councilors who hold the key. It is councilors who pass on to the elected students the spirit of AΩA and the energy to give back to others, as well as receiving recognition to themselves. It is the councilors who put energy into programs and into organizing events such as the annual banquet. It is the councilors who lobby deans for staff help and money for chapter management.

There is great variation among chapters in use of national programs that have been designed over the years to enhance scholarship and teaching, service commitments, and good feelings for both the medical school and the chapter. In my analysis, the greatest challenge to our society, along with that of fiscal stability, is the effective nurture and support of councilors by helping them with relationships to their deans and students, energizing them with enthusiasm for use of national programs, and recognizing their accomplishments. Visits to the chapters by me or board members are the most valuable mechanism that we currently use to energize chapters, but the challenge is there to conceive of additional ones.

Edward D. Harris, Jr., MD
*Executive Secretary*
Perhaps it is ingrained within editors, but there is a certain yearning for controversy among readers in response to publications. I confess to being part of that genre, and have been interested over the years to note how few riled up readers are sufficiently upset to write strong letters to the editor of The Pharos.

Exceptions over the years have been papers that directly, or more often indirectly, support abortion. And this year we received some excited responses to Gerald Weissman's paper that suggested our country was heading into domination by a conservative theocracy that disbelieves Charles Darwin's postulates of evolution. In contrast, the editor has received many kind references to various papers, including some that are hardly deserved. We welcome more of both kinds!
The stability of The Pharos is recognized. Readers want, for the most part, more of the same. We in the editorial office will continue to be rigorous in review, to encourage good authors to submit more papers in the future, and to continue with the ever-popular “Physician at the Movies” and the growing excellence of the Book Reviews section. We hope that the National and Chapter News section will be read with more enthusiasm as Medical Student Service Projects are defined, with photographs, and frequent pictures of those elected at awards dinners being recognized. I promise not to become too radical in my editorial topic selection, and will not do back-to-back diatribes about the dysfunctional health care system that we in the United States labor under.

Edward D. Harris, Jr., MD
Editor, The Pharos

Medical College of Georgia; President Rae-Ellen Kavey, MD, National Institutes of Health, Bethesda, Maryland; Maxine Papadakis, MD, University of California, San Francisco, California; Treasurer Donald B. Russell, MD, Victoria, British Columbia; Vice President Donald Wilson, MD, University of Maryland, Baltimore, Maryland.

Councilor directors: Robert G. Atnip, MD, Pennsylvania State University, Hershey, Pennsylvania; Eric Gall, MD, Chicago Medical School at Rosalind Franklin University of Medicine and Science, North Chicago, Illinois; Douglas S. Paauw, MD, University of Washington, Seattle, Washington.

Student director: Justin Wasserman, University of Florida, Gainesville, Florida.

National office: Administrator Ann Hill, Managing Editor of The Pharos Debbie Lancaster, Assistant Treasurer William Nichols.

Absent
Student Director Kara Marie Cauvoto, University of Miami, Miami, Florida; Director at Large Michael V. Drake, MD, University of California, Irvine, California; Director at Large Don W. Powell, MD, University of Texas Medical Branch at Galveston, Texas; Student Director Smeeta Sinha, UMDNJ—New Jersey Medical School, Newark, New Jersey.

Minutes of 2006 meeting
The minutes of the 2006 board meeting were reviewed in detail, with emphasis on follow-up of items designated for planning or implementation, and were approved without corrections or additions.

Retiring members
Donald B. Russell retired from the board after serving twelve years. Maxine Papadakis was granted an indefinite leave of absence. Justin Wasserman retired after three years of service.

New members
Natalia Berry of Dartmouth Medical School was elected to a three-year term as student director. Douglas S. Paauw was elected to a director at large position from his position as councilor director. C. Bruce Alexander was elected treasurer to replace retiring member Donald B. Russell. N. Joseph Espat was elected to a second three-year term as director at large. Rae-Ellen Kaven was elected to a third three-year term as director at large.

Candidates for the open councilor director position are being discussed by the nominating committee. The committee is also considering a nominee to take the slot opened by the departure of Maxine Papadakis, with the view to finding candidates outside of academic medicine.

Honorary members
No eligible candidates were nominated this year. A special effort to gather nominations from councilors, board members, previous recipients of honorary membership, and other members will be made.
Report of the treasurer

Mr. William Nichols, assistant treasurer, reported that the financial status of the society is strong, primarily due to solid investment return over the past five years. AΩA revenues in the next year should cover expenditures without drawing on investments.

The proposed budget showed a small surplus, primarily from the investment portfolio.

The board approved retaining independent investment managers for the society.

Dues: The number of dues payers has increased slightly, but the percentage of dues payers continues to decline. Lifetime dues payers represented 28.6 percent of dues payers, up from a year ago. The last dues increase was in 2003. A future increase may be warranted, but is not necessary for 2008.

The AΩA constitution states in Article IV, Section 2f:

Elected candidates may only be inducted into the Society after the membership fees to the local chapter and to the national AΩA office have been paid.

The board last year directed that all registration of new members be moved to the AΩA web site (www.alphaomegaalpha.org). This was implemented during 2007, and is now being phased in for all chapters. A letter was sent to all AΩA councilors in December regarding the changes and the reasons for them. The welcome letter sent to all new members informs them of this change and includes directions about how to complete their registrations.

The board approved the reduction of annual dues for members over 70 years of age to $25, effective in the 2008 dues notice.

The importance to the society of lifetime dues members was emphasized. Programs to benefit and further involve these AΩA supporters will be developed.

The board approved a category of "inactive" for those members who have not paid dues for ten years or more.

New business

Yale University has informed the national office that it wishes to cease electing student members. This was accepted. A five-year period of discussion will be instituted to determine whether the chapter’s charter should be withdrawn, an AΩA association instituted, or full chapter status reinstituted.

Proposed new programs

AΩA Foundation for Research: A subcommittee was established to explore the idea of establishing a foundation for research in aspects of medical education.

Funding research in education and medical professionalism: Maxine Papadakis, Douglas Paauw, and Robert Atnip will form a subcommittee to explore ideas for research in professionalism.

AΩA Sabbatical Fellowship: A postdoctoral sabbatical funded for as much as $50,000 for six months to a year. This idea will be examined during the year ahead.

Edward D. Harris, Jr, MD
Executive Secretary

Leaders in American Medicine

In 1967, as a result of a generous gift from Drs. David E. and Beatrice C. Seegal, Alpha Omega Alpha initiated a program of one-hour videotapes featuring interviews with distinguished American physicians and medical scientists.

The collection has been donated to the National Library of Medicine, which will maintain it for permanent use by scholars visiting the library. Videotapes continue to be available for loan from AΩA. A listing of available tapes can be found on our web site: www.alphaomegaalpha.org, or by contacting Ms. Debbie Lancaster at d.lancaster@alphaomegaalpha.org or (650) 329-0291. Please also contact Ms. Lancaster to borrow tapes. Those wishing to purchase copies may do so by contacting Ms. Nancy Dosch, manager, Historical Audiovisuals, History of Medicine, Building 38, Room 1E-21, 8600 Rockville Pike, Bethesda, Maryland 20891. Telephone (301) 402-8818, e-mail nancy_dosch@nlm.nih.gov.

<table>
<thead>
<tr>
<th>Programs</th>
<th>Award winners were announced in the Winter 2008 issue of The Pharos</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robert J. Glaser Distinguished Teacher Awards</td>
<td>52 applications</td>
</tr>
<tr>
<td></td>
<td>51 approved and funded, 1 rejected</td>
</tr>
<tr>
<td>Carolyn L. Kuckein Student Research Fellowships*</td>
<td>30 submissions</td>
</tr>
<tr>
<td></td>
<td>6 prizes awarded</td>
</tr>
<tr>
<td>Helen H. Glaser Student Essay Awards*</td>
<td>29 proposals accepted, including three second-year awards and three third-year extensions</td>
</tr>
<tr>
<td></td>
<td>55 professorships were funded</td>
</tr>
<tr>
<td>Pharos Poetry Competition*</td>
<td>4 prizes awarded</td>
</tr>
<tr>
<td>Medical Student Service Project Awards*</td>
<td>36 awarded</td>
</tr>
<tr>
<td>Visiting professorships*</td>
<td>2 awarded</td>
</tr>
<tr>
<td>Volunteer Clinical Faculty awards*</td>
<td></td>
</tr>
<tr>
<td>Administrative Recognition Award</td>
<td></td>
</tr>
</tbody>
</table>

* Recipients/award winners were announced in the Summer 2007 issue of The Pharos
Embryonic mushrooms
Awaken.
Progeny of earth
And spring.

Evanescent puddles
Assemble.
Tempest’s bounty
Children’s footbaths.
Infant leaves
Amputated.
Savage prey
Embracing newborn grass.
Fury becalmed
Pierced.
Desperate pleas of
Homeless birds.
Angry sky
Dissipated.
Cautious sun dissects
Lingering clouds.

Steven F. Isenberg, MD