Aξιος ὁφελείν τοὺς ἀλήχωντες
“Be Worthy to Serve the Suffering”

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

Requests for reprints of individual articles should be forwarded directly to the author.

The Pharos of Alpha Omega Alpha Honor Medical Society, 525 Middlefield Road, Suite 130, Menlo Park, California 94025, is published quarterly by Alpha Omega Alpha Honor Medical Society, 525 Middlefield 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 © 2010, by Alpha Omega Alpha Honor Medical Society. The contents of The Pharos can only be reproduced with the written permission of the editor. (ISSN 0031-7179)

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

POSTMASTER: Change of address service requested: Alpha Omega Alpha Honor Medical Society, Post Office Box 2147, Menlo Park, CA 94026.
In his essay on achieving eudaimonia (pp. 26-33), Andrew Radu takes on the challenge of identifying the most appropriate personal philosophy for a physician to embrace. The state of eudaimonia is being in an all encompassing state of happiness, a goal difficult to attain when one is sick and in pain. Thus, it is both the physician’s philosophy and his or her patients’ view of their place in the world that matter.

The alternative philosophies of Epicureanism and Stoicism are available to pursue, of course. Both were founded in ancient Greece in Athens. Epicureanism advocated restrained hedonism, achieving mental pleasure free from anxiety or free of death. In contrast, to be a true Stoic one had to endure pain and hardship without displaying emotion or complaint. Virtue, the highest good, was based on knowledge. For a patient, being hedonistic is easier to grasp than being stoic, but neither is appropriate for a caregiver. As emphasized by Mr. Radu, a doctor who advocates being stoic in face of illness would seem to lack compassion, whereas extolling hedonism is shallow, superficial, and not sustaining.

The existentialist, in contrast, perceives each individual as a free and responsible agent who can determine his or her life’s direction by utilizing an innate free will.

There seems to be little alternative for a physician. He or she must take an existentialist view into the office, combining it with multiple variables of diagnosis, treatment, and the patients’ views of their illnesses into a simultaneous equation. Examples abound. A useful classification system is to consider diagnoses as a function of Difficulty and Urgency (see figure), a constantly shifting balance of existentialism. The less demanding for diagnosis are those in group B, relatively easy to diagnose but in need of urgent care. An example would include an acute anterior myocardial infarction with classic ST elevations on the EKG, high troponin, and CK elevation. Off to the cath lab before or after TPA, and hope for the best, and then deal with the emotional needs of the patient and family.

More difficult are those diagnoses that, once made with surety from sound suspicions, carry a grave prognosis. Such would be the patient with upper abdominal pain, mild jaundice, anorexia, and a CT virtually diagnostic of pancreatic carcinoma. Here there is rarely urgency for immediate treatment, but expect a high degree of difficulty (Group A) in management of the patient’s expectations, fears of death or disability, hopes for survival, and extent of readiness to hear the truth. This situation demands deep insight into that patient’s existence and self-awareness at that very moment in time.

Group C includes those diagnoses that make the doctor’s day easy. A mild upper respiratory infection or poison ivy are examples. Group D includes those unclear diagnoses, the problem cases that present with symptoms that are consistent with complex, unremitting, and progressive illness as one possibility (e.g., lower abdominal cramping with intermittent bloody diarrhea that could be inflammatory bowel disease), as opposed to a less worrisome diagnosis (e.g., irritable bowel syndrome) that would ease the concern to Group C. Understandably, the importance here of making the correct diagnosis is the major concern of the physician, and parallels emphases on the patient’s own deep and frequently changing concerns.

Ironically, there is another group of patients whom we all see. By all indices they have no severe disease but will not accept that possibility. Consider the 45-year-old director of marketing at a Silicon Valley start-up referred for evaluation of a constellation of symptoms labeled by different physicians as SLE, chronic fatigue syndrome, menopausal symptoms, and reflex sympathetic dystrophy. It was immediately obvious that superceding even her desire to be well was her deep need to have a diagnosis. A careful review of her voluminous records and a thorough examination in the office revealed no new insight. I told her what she did not want to hear: “I cannot give you a specific diagnosis, but I assure you that you do not have any serious organic disease.” She left the office unconvinced.

Patients such as she must have a sound personal philosophy, mirrored by that of her physicians. Stoicism is a defeating tactic, while Epicureanism offers symptomatic relief but no firm foundation. The existential approach, accepting reality but knowing that she, and she alone, can dictate the trajectory of her life, is the only logical approach for her to achieve eudaimonia.
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A Simple Walk
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Gaze blurred, happy tears.
A mother’s whisper. A boy. A son.
Hope-born, flame of love.
A freshness flowering.

Now you lie, limp, lean-languid.
More tears, now sorrow-gazing,
   freshness quenched.
A stranger interposed. Unlovely,
   unwanted.
No locks to drench. Love dew falls on skin alone.

Carry me, you cry.
Close, curled, clean.
Now in my weakness carry me.
Let me ride your sorrow.

A love deepened not darkened.
But fear stands in the doorway to tomorrow.
Days are dosed, dreaded, drear.
Anxious pacing, nervous waiting.

Caress through treatment fog,
And hold to tender breast
That life-spring, molded form.
Still a boy. Still a son.

Mark Warren

Rhabdomyosarcoma
If this were the last
day of my life, I wouldn’t be upset
by the mountains of books
and information I have
not yet learned, even though
I hardly ever sleep. No.
I’d sit at my steel desk
watching the wind
turn the pages of the texts,
flipping through chapter
after chapter of pathology and illness,
hematoxylin and eosin stained granulomas
and the cheesy mucoid mess
of tumors. I’d marvel
at the mothers pushing strollers
through the late spring slush
beneath my window, carrying coffee,
wav ing taxis, making little living noises
like the humming of bees. I’d have to hold
myself back from blowing them kisses,
shouting yours is the most beautiful life
that I have ever seen. Or maybe
I wouldn’t. Maybe I would shower them
with paper airplanes
of pharmacology: quaternary structures,
anti-muscarinics and cholinesterases.
Maybe I would read aloud,
study each page in wonderment. That these cells,
red and buoyed like doughnuts in
hot oil are pieces of my being and my body,
are pumping, flowing, flooding into
sinusoids and capillaries, trading gasses,
gathering debris, in the nail beds of my
fingers, just beneath the whites
and in the thin lids of my eyes.
I’d gaze at the print
as though these were the first
words I’d ever read.

Erika Elise Reid

Ms. Reid is a member of the Class of 2011 at
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This poem won honorable mention in the 2009
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Illustration by Erica Aitken
The weather is warm for April. Shorts and sandals, sleeveless, the students drift in for the first class. I suspect they are clothed in the tapestries of biology, chemistry, physics, woven in. Protective gear.

The course, "Novels and Theatre of Illness"—an elective dedicated to premedical students—is small, twenty-two students, juniors and seniors. How many have read Shakespeare, I ask. More hands than I expected, but this is a self-selected group. Romeo and Juliet and Julius Caesar mostly. High school assignments. How many have taken a literature class? No volunteers. Out of some 350 students, mostly premeds, in the Human Biology Program at Stanford, I have captured this small group with the purpose of helping them understand what it means to be a human, what it feels like to be a sick human.

I explain my goal: “To have you become good doctors. The best doctors have gathered knowledge from the sciences and wisdom from the humanities. This seminar is about the impact of illness on the sick and their families, about loneliness and shame, and finding your true self through vicarious encounters with both patients and doctors.” I continue: “This course is an opportunity, while shielded in the classroom, to appreciate the pain and suffering of others as well as the consequences of being a doctor. My wish is that you will not go into medicine for the wrong reasons, that this class will provide some guidance.”

The students seem to sink beneath the surface. They have spent years thrashing through the waves of science, swallowing salt and regurgitating it at every exam for the sole purpose of getting into medical school. Who am I to doubt their purpose?

I describe how the class will function: “Grades depend on class discussions and three papers. During our meetings, all texts and notebooks are to remain closed.” Shock. I have invaded sacred territory. Their faces express disbelief, lose all buoyancy. No notes. “How can we get an A grade without notes?” I explain. “You will forget everything you write down. Listen and join the discussion and you may remember one small point that you will find useful the rest of your professional lives. Perhaps some day when you stand at the bedside of a young woman dying of metastatic breast cancer, you will agree on the importance of empathy, compassion, caring, and generosity. I will be satisfied at that memory. That will be enough to justify the course.”

I clarify how the class works: “I always ask one student to stand and answer endless questions before I open the discussion to others.” Another new invention. When I tell the group that I will, as I learned from my teacher, David Morris, ask no questions for which I know the answer, the shudder...
feels like 4.5 on the Richter scale. Literature is not a chemical equation. Interpretations vary. Eyes bulge, the students slide down as if their seats have suddenly become glaciers. Have they ever had a teacher who had no answers? I expect a few will head for the exit. Surprisingly only one escapes.

**Literature—no correct answers . . . understanding from within**

I go on, ignoring the storm that has replaced presumptions with unclassified debris. “For the writing assignments, I prefer creative work that is related to the readings or to your personal experiences with illness. Names only on the back of the last page. That is as objective as I can be. No curve, no problem sets, no right or wrong, all else is subjective.” Now the students are definitely going under. Oxygen may be required. Or a blood transfusion.

I pass out the syllabus containing the list of books we will read. The class has SPF 50 on their literary skins. No one notices that in addition to novels and plays, nonfiction texts are part of the assignments. Next I hand out the guidelines for writing: two two-page assignments and a final paper of no more than ten pages. I emphasize that I will examine for both content and style. A waving of hands, wind power sufficient to light the room. No one seems to understand “style.” I have stolen their previous lives. The sciences offer no experience with style. The first criticism, expected, comes from a student who later informs me he is planning to join his father in radiology. “Why should style count? This is not a writing class!” For a moment I am speechless. I retreat from the usual explanation that good writing is important even in scientific papers. I reply, “Indulge me, I love a good sentence.” I add that I prefer creative writing, poetry as well as prose. I know the students are definitely going under. Oxygen may be required. Or a blood transfusion.

Today’s text is Lance Armstrong’s *It’s Not About the Bike*, an exploration of the effect of cancer on a great athlete. My first question is, “How did the disease alter Armstrong’s identity?” I am certain that if my query had been to explain the pathology of testicular cancer, many hands would have been raised. No volunteers—I have not asked a clean question. I call on a student eating a banana in the back row. He sees Lance as perceiving himself as other than a bike racer. A good start. The discussion warms, finally concluding that illness changes people, more than physically. Not bad for a first encounter.

**Brain injury—it damages family too**

The third week we engage *The Mango Princess*, about a young lawyer with a traumatic brain injury. What I want the students to understand is that illness is sticky, affecting not just the patient but others. Caretakers of the chronically ill are especially vulnerable to depression and burn-out. Empathy is ephemeral. A few of the students have had grandparents requiring long-term care. That helps when they tell their stories. We can move on.

The next week we consider mood disorders. Styron’s painful memoir of his depression, *Darkness Visible*, followed by Salinger’s *Catcher in the Rye*, read as a bipolar illness. The lead into the discussion is, “Why do we still blame mental illness on the patient while accepting physical disease as beyond control?” The group warms to the subject, some quoting the long history of mind disturbances as stigma, witchcraft, and devil incarnation. Another student points out, “We accept stuff we can see. Mental illness, the cause not obvious, it’s hidden.” I am elated.

A week later we turn to the theatre, discussing *King Lear* and *Death of a Salesman*. Our most important explorations. One old, the other modern, one about a king, the other a salesman—yet they both teach the same lessons about being human, deal with similar problems, dilemmas that doctors see on a regular basis: relationships and mistakes in judgment, bringing up children, dealing with elderly parents, greed, finding your identity, guilt and shame. Death caused by a broken heart.

The next week we approach Mary Shelly’s *Frankenstein* and Sophocles’ *Philoctetes*. “How are Philoctetes and Frankenstein’s creation alike?” The class needs a clue.

“How are they disabled? What causes their anguish?” I draw out the answer, harder than a breech delivery. “Yes, they are socially disabled, isolated, lonely—made so by their appearance.” A second critical point: “How do their stories relate to the care of patients?” Many hands. The students are with me now. “The sickest patients, the chronically ill, the very old, those that can’t be cured, people we tend to abandon—those are like the characters we have read about.”
Healing powers of the church and of medicine . . . very different

The following week we discuss The Plague by Camus. The conflict/tension in the novel is between Dr. Rieux, an existentialist, and Panloux, the local priest, both engaged with the bubonic plague that is killing vast numbers of the population in Oran. The differences between Rieux and Panloux are easily seen. Panloux at first sees the plague as God’s punishment for sinners—a collective penalty. Rieux believes the plague is a biological event. “But how are the two men the same?” is the question I hope will precipitate discussion. I hint, “Has either cured, brought relief to a single patient?” Now the response is lively. The ability of the church and medicine to provide aid in times of catastrophe, to relieve suffering is compared.

The students are thinking. I am pleased.

“Is there a relation between disease and creativity?” I ask the next week, in a discussion of Saltzman’s Lying Awake, the novel of a cloistered nun who writes brilliant poetry whenever she has a seizure due to a temporal lobe meningioma. The response is vigorous, many students devout, others nonbelievers. We settle: Medicine and religion have much in common. Both can be comforting, healing, but both can fail us.

The shroud of loneliness wrapped tight by disease

I require two novels on aging for the next class: Pouncey’s Rules for Old Men Waiting and Sarton’s As We Are Now. Pouncey’s protagonist is a retired professor of history, Sarton’s is an elderly math teacher. Both have physical ills, but I want to know if other reasons are responsible for their suffering. The answer surfaces when students think of their elderly relatives. “They are lonely.”

“Why do we abandon our elderly?” is the follow-up question. A student quickly points out that the problem is cultural. “Asian families honor their elders. But our society is different, too busy, too many activities to haul children to, earning a living is competitive.” The real answer finally emerges: “We don’t value our elderly.”

Two plays are required for the last class. Whose Life Is It Anyway? is the powerful tale of an English professor who has led a life limited to the study of John Donne. She has avoided intimacy, never showed compassion or empathy to her students, has no friends or family. Dying of ovarian cancer, she is treated by her doctors as she has treated her students. In Whose Life Is It Anyway? a young sculptor become quadriplegic after an accident. In both narratives the doctors are in control, offering no options to their patients. I ask, “Why do the doctors refuse to allow the patients to participate in their own care?” Interesting responses: “The doctors think they know best because they have the knowledge. Medicine is a controlling profession. Doctors tend to be arrogant.”

The final papers are excellent, some worthy of publication. I am happy with the writing, but more important, I am hopeful that the students will be changed from our work together—that their lives as doctors will be altered, that they will remember more than anatomy, physiology, and the other scientific disciplines they must master. That from our readings they will realize the importance of compassion and empathy in the practice of medicine.

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A few days after the fact of it,  
I was invited to see her,  
Everything in good order, prepared.  
And, of course, I accepted  
And entered the room  
Where she, alone, lay waiting  
Resting in near perfection.  
Yet she was not there.  
I don't recall with certainty,  
But believe I spoke a few words  
Of love, of missing and asking forgiveness  
For those occasions, more than one,  
Where I had come up short  
And now had no path for amends.  
I touched her silent cheek.  
Then, hesitant, not wanting to leave  
Without a touch of warm affection,  
Kissed the cheek I knew so well,  
But never knew to be so cold and pale,  
Then left with a full hollowness.  
Not quite alone, for our son  
Spoke the required amenities  
As we walked together from that place  
Into the natural light.  
In that moment, it struck me as ironic  
That the same cold cheek soon would commit to fire.

John C. Wood, MD
Death on call

Alison Wiesenthal

The author is a member of the Class of 2010 at the University of Texas Medical Branch, Galveston, Texas.

I had almost handed the trauma pager off to my fellow student on the day team but decided to keep it in case anything exciting happened before my shift ended. In the rush to the elevator after morning report, I lost my attending and team and was relieved when my pager went off with a trauma call. We would all be reunited in moments. At the ER I found an empty crash room filled with anxious health professionals—doctors, nurses, clinical assistants, x-ray technicians—all gloved, gowned, and ready for trauma: “Seventyish-year-old man in head-on collision. Currently being bagged.”

The patient arrived on a stretcher. As he slid by me, I noticed the pallor of his feet; they looked like they had been stewing in formaldehyde for a few weeks. “He looks like my cadaver,” I told the fourth-year student next to me. She laughed reluctantly.

Suddenly, the roomful of health professionals seemed disorganized and chaotic. “Has he had epi? He needs epi!”

As I scanned the room, it was unclear if this man was getting any help at all or just additional monitoring instruments—a pulse oximeter, leads on the chest. Through my night on call, I had become accustomed to the constant beeping in an ER room—but these beeps seemed more insistent. I looked up at the monitor and saw “–?–.” I assumed the machine had not yet been hooked up.

The man was getting chest compressions from the slight resident, whose body was quickly tiring of the demanding task. A clinical assistant/body builder took over.

My attending was toiling with some sort of kit, trying to put a central line in. After a few tries, he threw the needle down. “I can’t put in a line if I don’t have a pulse! I’m ready to call it.”

I turned and whispered to the guy next to me, “Call it? Do they mean he’s dying? Is he dying?”

“Yeah,” he said dispassionately, apparently unfazed by this unique and scary transition from life to death.

I kept my eye on the patient’s foot, noting that blood was no longer leaking from his wound.

The man’s wife arrived to be treated in the room next to his. She was deaf and we were waiting for an interpreter. I immediately thought of his wife. I asked the ER doctor “Who is going to tell the wife? Do we have an interpreter yet? Should we wait for the interpreter? It seems like a big thing to try to tell without an interpreter.”

She paused as if in awe that a medical student was (again) speaking in the crash unit and walked into the woman’s room.

My attending went to the computer and started intensely looking up another patient’s lab values. I rechecked the name of the chart he was looking at. Surely this must have been our recently deceased patient he was looking up. Surely we had not moved on this quickly.

Alas, we had. As we discussed our plan for the rest of the morning, shrieks of horrific distress came from the wife’s room. She knew. The nurse pulled the curtain of her room closed as if privacy might somehow make this moment better.

“Can we ask her if she wants to see her husband? Maybe she wants to see him one last time.” No one was listening. The nurse pulled the curtain of her room closed as if privacy might somehow make this moment better.

The patient arrived on a stretcher. As he slid by me, I kept my eye on the patient’s foot, noting that blood was no longer leaking from his wound.

I approached the woman, not knowing how I was going to communicate anything that was happening to her or her husband. They were cutting off her pants so I motioned with my hands to mime taking off my white coat and said, “They are taking off your clothes.” She nodded. “Your husband is in the room next door.” Her face lit up as she lifted herself off the stretcher.

“Is he okay?” she asked.

I paused. “We are working on it.” She nodded nervously and clearly had many questions, none of which she could communicate and none of which I would have been able to answer.

I walked over to my attending who was looking at the chest x-ray. “I’m ready to call it. I’m gonna call it.”

“Should we push more epi?” the nurse looked to my attending.

“It’s up to you. I’m ready to call it.”

There was a brief moment of thoughtful silence and the ER doctor said coolly, “All right. We’re calling it. I’m calling it. Time of death: 8:14 AM.”

And with that, this man’s thirty-minute struggle with life and death ended.

I immediately thought of his wife. I asked the ER doctor “Who is going to tell the wife? Do we have an interpreter yet? Should we wait for the interpreter? It seems like a big thing to try to tell without an interpreter.”

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“Can we ask her if she wants to see her husband? Maybe she wants to see him one last time.” No one was listening. The woman’s shrieks became more distant as we walked toward the holding area to see our next patient.

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Health policy

The editors invite original articles and letters to the editor for the Health Policy section, length 1500 words or fewer for articles, 250 words or fewer for letters. Please send your essays to info@alphaomegaalpha.org or to our regular mailing address: 525 Middlefield Road, Suite 130, Menlo Park, CA 94025. E-mail submissions preferred. All essays are subject to review and editing by the editorial board of The Pharos.

The consumer movement in health care

Eric J. Topol, MD

The author (AΩA, University of Rochester, 1979) is director of the Scripps Translational Science Institute, professor of Translational Genomics at the Scripps Research Institute, and senior consultant in Cardiovascular Diseases at the Scripps Clinic.

Medicine is remarkably resistant to change. That may be a good thing when there is a new medication or device that is approved and marketed but not adequately tested in the real world. Or when physicians are asked to type into a PC during an office visit instead of looking the patient in the eye and communicating in a fully committed fashion.

Too many things have happened in recent years to change the dynamics and challenge the resistance of the medical community to undergo transformation. In the United States in 1997, for the first time, pharmaceutical companies were permitted to market drugs direct to consumers (DTC). Over the course of the next decade, pharmaceutical, device, and biotechnology companies came to realize an extraordinary return on investment. One can hardly turn on a television today without watching a flood of drug commercials. Why was this new strategy so effective? Because it empowered the consumer to ask his or her physician for a medication that otherwise would not have been prescribed. Did anyone ever know of the term “erectile dysfunction” before the era of DTC advertising?

Right around the same time as DTC marketing of drugs became commonplace, there was the jump in use of the Internet. Whereas in the early years the information on medical diagnoses and treatments was sporadic and often unreliable, over time the accuracy has greatly improved, with many trusted websites that are “go to” places for consumers to get educated about their (or loved ones’) symptoms, conditions, or treatments. Now the typical consumer is not only getting information pushed to her via the media, but more than sixty percent of the American public is frequently going to medical web sites to get educated. The education now extends to research hospitals, clinics, and individual physicians, and in some states where such data are widely available, such selection can be markedly enhanced by searching the web.

The “third wave” of consumer empowerment is the most recent, related to genome-wide scanning. In late 2007, multiple companies began offering a research-grade test of more than 500,000 to 1 million genotypes of variant markers across the genome. Via a saliva specimen or buccal smear, a consumer can order the kit over the Internet and mail it in, getting the genomic data results in a few weeks at a cost now ranging from $200 to $1000 (originally $1000 to $2500). The output for each individual has information on susceptibility to (or protection from) over fifty complex traits, including most common cancers, cardiovascular conditions, immunologic diseases, neurodegenerative, and metabolic diseases. While controversial because of the question of actionable data, consumers are ordering these scans and own the data. The DTC genomics era has been instructive since it gets around the concern of having genetic data entered into the medical record (unless the patient decides to make that available). Even more striking is that individuals who get their genome scan and read the materials on the web site and their personalized reports often know more about genomics than most physicians.

While there are many uncertainties about the genetics of common polygenic (non-Mendelian) diseases, more has been learned about the genes and pathways underpinning diseases over the past few years than during the entire history of man. There has hardly been a week since April 2007 when there was not a major disease genetic association published in Nature, Science, or Nature Genetics. Many key pharmacogenomic discoveries have also been made for commonly prescribed medications like clopidogrel for arterial disease, or tamoxifen for breast cancer. Since the pace of discovery has been truly unprecedented and breakneck, and physicians are generally quite busy with limited training in genetics in medical school (even recent graduates), an imbalance has been established favoring consumers. The concerned, motivated individual is apt to spend considerable time researching his or her condition and be much more knowledgeable than the physician. Yet surveys indicate that over eighty percent of consumers trust their physicians more than anyone else for interpretation of their genetic data, while ninety percent of physicians feel uncomfortable about making decisions based upon genetic data!

Next up: whole genome sequencing of the diploid 6 billion base pairs with need for interpretation at the individual level.

Now that medicine is going digital with personalized health records (albeit with very limited adoption to date) and genomics, the next frontier is wireless sensors and imaging devices. For example, diabetics can have continuous glucose
monitoring via a subcutaneous sensor that provides a highly accurate reading of glucose every five minutes. Smart "band-aids" and non-invasive sensors are being developed that monitor all vital signs including continuous blood pressure, heart rhythm, oximetry, respiratory rate, and temperature. A recently released cell-phone-sized device can be used to acquire high-resolution two-dimensional echocardiography and color flow. It is just a matter of time until consumers will learn how to acquire their own echocardiograms, fetal ultrasounds, or breast ultrasounds, and transmit the images for their physicians for real-time interpretation.

If one reflects on the biggest life-changers of the past decade, it clearly was the mass adoption of digital devices that transformed the way we listen to music, communicate via e-mail and texting, engage the web via mobile computing and smartphones, and the way we read. With this precedent and the cell phone as the primary platform, it is interesting to speculate how much further consumers will be empowered in the coming decade by digital wireless medical devices. Having patient records, biologic, physiologic, and imaging data all digitized and eminently portable creates an exceptional opportunity for consumers to drive the next phase of evolution of medicine.

The digital innovation that is already here and will soon ramp represents extraordinary potential for unparalleled progress in medicine. The bottom-up consumer movement may well be the best thing that ever happened to push this front along and force the desperately needed jump forward. Working with consumer groups and patient advocacy organizations may be an ideal way to assimilate the flood of technology and innovation that is coming. This can be in the form of clinical trials to validate the improvement of outcomes and reduction of costs in such approaches as genome-wide scanning or wireless sensors for continuous blood pressure monitoring. As more emphasis is placed on comparative effectiveness, testing novel strategies that put consumer empowerment front and center would be appropriate. As the medical community fully acknowledges that consumer driven health care is like a high-speed train that has already left the station, it will be positioned to catalyze a great inflection for medicine's future.

This article was received 12/23/09, revision accepted 2/9/10.

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Expanding physician supply—An imperative for health care reform

Richard A. Cooper, MD

The author (AΩA, Washington University, 1961) is professor of Medicine and Senior Fellow of the Leonard Davis Institute of Health Economics at the University of Pennsylvania.

A midst intense discussions about health care reform, too little attention is being paid to the fact that the United States is entering an era of physician shortages.1,2 Never before have shortages of the magnitude now developing existed, nor was the United States ever so far behind in responding. Most remarkably, although shortages in nearly every field of medicine are recognized by political leaders,3 health care planning is proceeding as though no serious problems exist.

Two decades of complacency

One reason for this complacency is that surpluses, not shortages, dominated policy planning for three decades.2 The last shortages were fifty years ago. In response, forty new medical schools were developed, existing schools were expanded, and the number of entry-level residency positions was doubled.4 While this fixed the problem, the vigor of the respon-fueled fears of an overshoot, and federal support for medical schools ended abruptly in 1976. It took another twenty-five years before medical schools grew again.5 However, residencies continued to expand throughout these years, with support from Medicare and an influx of international medical grads.6

In 1997, certain that the long-anticipated surpluses would soon materialize, academics and legislators joined to cap the number of residency positions funded by Medicare,7 and that stemmed the tide. Yet by then the problem was exactly the opposite. While a temporary bulge in supply was unfolding, it was clear that “the nation would soon confront shortages in relation to the potentials of medical care, the desires of the public and the capacity of the economy,” and I cautioned that, “although the long duration of this projection insulates current educators and planners, it is incumbent upon them to prepare for these future needs.”8

But they did not, and shortages soon appeared, initially among specialties in which technology had created new beneficial services.9 For a time, primary care was spared, in part because more medical grads had been encouraged to enter primary care in the 1990s and in part because nurse practitioners and physician assistants were playing larger roles, but ultimately shortages emerged there. And it is these shortages in primary care, rather than the overall shortages of physicians, that have garnered the most attention.
Antipathy to expanding specialist supply

One reason for the focus on primary care is that, although shortages there are roughly proportional to overall shortages, they are more prominent, since most patients have a primary care physician, whether or not they are ill, while relatively few depend on specialists. But more importantly, health care reformers believe that specialists cause health care spending, that perverse incentives lead them to provide unnecessary care, and that if only there were fewer doing less there would be enough for everyone, which would be better and cheaper. As the Queen told Alice, “Sometimes I’ve believed as many as six impossible things before breakfast.”

The impossible notion that fewer specialists would be better was hatched fifty years ago by Max Shain and Milton Roemer, two health economists who observed that the number of hospital admissions correlated with the number of hospital beds. This was extended to physicians by Victor Fuchs, who found a correlation between the number of surgeons and the amount of surgery. But, in like manner, David Dranove and Paul Whener found that more obstetricians practiced where there were more births, just as more snow plow drivers live where there is more snow.

Nonetheless, policy makers have pondered the idea that, if eight more physicians were produced than the 800,000 needed, health care spending would increase by 0.001%, which translates into $20 million, and that’s a lot of money. Even applying what economists term “elasticity,” which they peg at about 0.35, spending would be $7 million more. And, moreover, it’s to no good purpose. Proof is no further than services abound where supply is abundant, ignoring the simultaneous abundance of poverty and the even greater abundance of disease, and totally ignoring the link between health care spending and economic capacity.

These perceptions have stimulated legislation to increase the number of primary care trainees, increase reimbursement for primary care physicians and provide other economic inducements, with the belief that more medical graduates would choose primary care, as occurred in the 1990s. But times have changed. Then, there was an abundance of physicians and a widespread view that surpluses were developing. Now, most specialties are in short supply and deepening shortages are predicted. It’s a zero-sum game. With too few physicians overall, more in primary care simply means fewer surgeons, oncologists, and other needed specialists. Recognizing this, the AAMC and other major organizations have called upon Congress to lift the caps on graduate medical education.

Realities on the ground

Faced with the reality of too few, most physicians are concentrating their efforts on elements of care that they must necessarily provide, while delegating more routine tasks to others. As a result, the average acuity and complexity of physicians’ practices is increasing, while pressure to provide more services to more patients continues to increase. Some primary care physicians have opted for concierge practices. Others have limited their patient care hours. Many younger physicians are carving out defined roles as hospitalists, intensivists, nocturnalists, or emergency physicians. And most specialists are narrowing the spectrum of care that they provide. At the same time, fewer physicians are choosing to practice in rural and inner-city areas, and more are closing their practices to patients with poor health insurance coverage—even Medicare.

While some of these adaptations may aid in getting the job done, some clearly won’t. Sadly, few will help physicians to “lavishly dispense time, sympathy and understanding,” as Francis Peabody urged they should. Indeed, surveys show the opposite. Nor will most foster the personal bond that, in Peabody’s words, “forms the greatest satisfaction in the practice of medicine” and that, in Paul Starr’s words, “gives the profession of medicine its special place in society.” And tragically, some adaptations will contribute to a further marginalization of society’s poorest and most vulnerable members.

The future course

It is difficult to know what the practice of medicine will become. Most of the adaptations mentioned above were not predictable, and it is hard to predict what will follow. What seems certain is that, if efforts are not begun to expand physician supply, the practice of medicine will become intolerable for many physicians and many patients. All of this may seem quite distant from the daily machinations surrounding health care reform, but it is much more important, because physicians have a more pervasive impact on health care than anything now being debated.

If Medicare’s funding of residencies had not been capped in 1997 and entry-level positions had continued to increase by 300 to 500 annually, there would be no shortages today. But now, more than a decade later, residencies cannot be increased quickly enough to meet the current demand, let alone the added demand if access to insurance is expanded. If residency growth at about 500 annually resumes over the next few years, a further deepening of shortages could be averted but no real increases in supply will occur. If, in addition, nurse practitioner and physician assistant programs are expanded, the shortages of physicians could be further mitigated, but probably not enough to accommodate the expansions in technology and utilization that are contemplated. Remember that, even with expenditure cuts deeper than those proposed in health care reform legislation, health care spending will grow more rapidly than the economy overall for decades.

Despite this reality, some planners continue to see an expansion of physician supply as fueling the unnecessary use of technology, which is strange, since virtually everyone wants more, the NIH spends more than $30 billion annually to produce more, the growth of jobs in our economy depends on having more, and no credible model of social progress exists without creating more. It is difficult to contemplate deploying more without having a sufficient supply of highly-skilled physicians.

Planners also recoil from the likely persistence of geographic differences in physician distribution. But Mississippi will not resemble Manhattan any time soon, nor will Detroit resemble Des Moines. As I have noted, regional differences in health care will exist as long as differences in economic
status persist, and health care will distribute accordingly. Physicians can soften the edges, but greater social equity requires less income inequality.

Finally, planners express concern that, despite technological progress, primary care is languishing. This brings into focus an image of the inchworm meeting Florence Nightingale. As technology has stretched the range of physician services, physicians have looked up, seen valid partners, and pulled in their tails. It was not until the late 1940s that nurses performed venipunctures, and not until the 1960s that they were permitted to take blood pressures. Both were painful for the medical profession. The future promises more pain.

Our nation now has a choice. Will it allow the current shortages of physicians to deepen, with the hope that fewer will hold back the march of technology but more will serve primary care roles? Or will measures be taken to train enough to make a technologically-advanced, socially-equitable health care system possible. I favor the latter. I believe that our patients do, too.

This article was received 12/24/09, revision accepted 2/16/10.

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An invitation

March 22: Last night the House of Representatives passed the administration’s Health Reform and reconciliation bills over the united opposition of the Republican minority. The pundits will now analyze how this happened and try to predict the effects of the new legislation.

Pharos editor Ted Harris and I encourage members of ΩΩΑ to join the analysts by writing about the significance of the new legislation for the Health Policy section of the journal. How do you think health care reform will affect the health of our patients, the practice of primary and specialty medicine, the policies and operations of medical schools and academic and community hospitals, and the finances of the federal and state governments?

John A. Kastor, MD
Individually who have contributed substantially to medicine and fields related to medicine, but who are not eligible for membership in AΩA as graduates of a medical school with an AΩA chapter or as a faculty member of a medical school maintaining an active AΩA chapter, may be nominated for honorary membership by any active member of the society. In 2009 Alpha Omega Alpha’s board of directors extended invitations to the following distinguished physicians and scientists.

Edward D. Harris, Jr., MD
Executive Secretary

Martha N. Hill, BSN, MSN, PhD
Dean Martha Hill has led the Johns Hopkins University School of Nursing since 2002 and has been a member of the faculty since the school was established in 1983. As an educator, she is known for her mentorship of students and junior faculty members; as a researcher, for her investigations in preventing and treating hypertension and its complications, particularly among young, urban African-American men. Her expertise in community-based participatory research focuses on the integration of multi-professional health care to improve treatment and outcomes for vulnerable and underserved populations. She has been an active investigator, mentor, and consultant on numerous National Institutes of Health-funded clinical trials and is recognized around the globe for her research projects including Comprehensive HBP Care for Young Urban Black Men, Barriers to HBP Care and Control in Black South Africans, and Research Training in Health Disparities in Underserved Populations.

Dr. Hill is a member of the Institute of Medicine and serves on the IOM Council and the Board of Directors of Research! America. From 1997 to 1998, Dr. Hill served as president of the American Heart Association, the first of two non-physicians to be named to that position.

It is generally agreed that during the present decade she has moved the Johns Hopkins Nursing School into the top tier of American schools of nursing.

Albert R. Jonsen, PhD

Dr. Jonsen is an emeritus professor of Ethics in Medicine at the University of Washington School of Medicine, where he was chairman of the Department of Medical History and Ethics from 1987 to 1999. After earning a BA and MA in Philosophy at Gonzaga University he received a PhD in Religious Studies in 1967. Prior to his years at the University of Washington, he was president of the University of San Francisco and subsequently was chief of the Division of Medical Ethics at UCSF. He has published fifteen books on varied topics including patterns of moral responsibility, ethics of newborn intensive care, academic dishonesty in medical education, ethical decisions in clinical medicine, the impact of human genome mapping on the doctor-patient relationship, and history of medical ethics. He has collaborated with leaders of American medicine in discussing the many ethical problems that have evolved within medical education.

After his retirement from the University of Washington, Dr. Jonsen became co-director of the Program in Medicine and Human Values at the California Pacific Medical Center in San Francisco.

He has served twice on the Council of the Institute of Medicine, to which he was elected in 1980. He served on the President’s Commission for the study of Ethical Problems in Medicine. He has worked tirelessly for ECFMG, ABMS, and the NBME. His awards has included the McGovern Award of the American Osler Society, the Annual Award of the Society for Health and Human Values, the Davies Award of the American College of Physicians (for writing excellence in topics of humanism), and the Lifetime Achievement Award of the American Association of Bioethics and Humanities.
Prof. Dr. med. Dr. h.c. Gerd Plewig

Dr. Plewig is professor and chairman emeritus of Dermatology at Ludwig-Maximilian University in Munich. His initial medical training was at the University of Hamburg in Germany, with additional accreditation at Graz and Kiel universities. In 1965 he came to the United States for a rotating internship at the Thomas M. Fitzgerald Mercy Hospital in Darby, Pennsylvania. This was followed by a research fellowship with Albert Kligman at the University of Pennsylvania. He returned to Munich for his clinical training in dermatology. Named to the faculty there in 1963, he became an expert in the pathophysiology and treatment of acne and rosacea. From 1982 to 1991 he was chair of the Department of Dermatology at the Heinrich Heine University of Düsseldorf, and then he returned to Munich as chair of Dermatology at Ludwig-Maximilians University.

Beginning with his first peer-reviewed paper in the Archives of Dermatology in 1969, he has been a prolific contributor to clinical and investigative dermatology as author of more than 280 peer-reviewed papers on multiple dermatological entities and their treatment, as well as an additional twenty-four papers on cellular dynamics in their pathophysiological development. Referred to as author of “legendary” books such as Acne and Rosacea, the third edition in English of a full textbook of dermatology, his expertise has helped in educating scores of dermatology trainees in this country and others.

Dr. Plewig was elected to fellowship in the Royal College of Physicians (London) and has received honorary doctorates from the universities of Prague, Wroclaw (Poland), and Bratislava (Slovakia). He is an international honorary member of the American Dermatological Association.

Snapshot

You are a fresh-wrought photograph of life—
The quickening lines: a mouth inclined to smile,
Secret dark eyes—snapped at a chance uniting,
Conceit of guideless and defining time.
What colors will detail your final form?
Although my arms enclose you, soft unknown,
I know you will for me some sorrow hold—
My small weakness, the pathway to my core.
In order you will crawl, speak, disobey;
The old unfailing pattern. Yet maybe
We’re less strict pattern than a recipe?
The elements unique, mixed the same way,
Each yielding a new whole. Glimpse of these days—
You could not be in any other age.

Wynne Morrison, MD

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Gifted Hands: The Ben Carson Story

Starring Cuba Gooding, Jr., Kimberly Elise, and Aunjanue Ellis. Directed by Thomas Carter. Rated TV-PG. Running time 90 minutes.

This made-for-TV movie won the Epiphany Prize from Movieguide as the Most Inspiring TV Program of 2009 (the award is sponsored by the John Templeton Foundation). Based on the autobiography of Dr. Benjamin Carson, chief of Pediatric Neurosurgery at the Johns Hopkins University School of Medicine,1 it is faithful to the book, with some noteworthy exceptions that I will discuss later. Cuba Gooding, Jr., is an excellent choice to play Carson, not just because of the uncanny resemblance, but also because of the low-key persona he projects. As the movie opens, Carson is seen scrubbing as Mozart plays in the background.

On the DVD special feature, Carson commends the moviemakers for their remarkably accurate portrayal of the various operations he undertakes. This is especially the case for the successful separation of the craniopagus conjoined Binder twins, both of whom survived. Their story begins the film, with a call to Johns Hopkins from Ulm, West Germany, leading Carson and three others to be dispatched to examine the twins. They are aware that the previous failures to separate such twins successfully were due to sharing of organs and exsanguination because of a shared sagittal sinus. Indeed, when the Binders had been informed of the malformation, the mother had wanted to kill herself, but realized that if she did so she would be taking three lives. After the children’s successful delivery, the parents bonded to both, as each twin did to the other. The parents ask Carson’s team that they not have to choose which one would survive. The preliminary evaluation reveals that they don’t share internal organs, although it is not clear whether the vision centers are completely separate. The operation is scheduled for four months hence, during which an extraordinary team is configured and a battle plan developed, with a number of rehearsals to make sure that the timing of the intricate maneuvers is flawless.

During this preparation, the film flashes back to Detroit,
where Ben is doing poorly in fifth grade and is called “dumb,” which he begins to believe. His mother, Sonya Carson, played movingly by Kimberly Elise, married at thirteen and was deserted ten years later when Ben was eight, after the revelation that his father had another wife and children. Though Ben and his older brother Curtis miss their father, they are sustained by their mother, who keeps the family solvent by cleaning houses and some child support. She instills in them the belief that they can do anything they want to do and pushes them to do well in school. Ben’s poor performance is ascribed to his needing glasses to see the blackboard and his watching television rather than doing homework. His mother, who never went beyond third grade, limits the brothers to two shows a week after homework is completed. This generally consists of the quiz show College Bowl, which introduces him to classical music and a broader world, and Father Knows Best. His mother makes them take two books a week out of the library and submit a book report to her, and they become avid readers; only later do they learn that she is illiterate. She also takes them regularly to church, where Ben is inspired to become a missionary doctor. Ben gets so good in school that he wins the class spelling bee, leading a racist teacher to chide the white students for letting a black student beat them. Later on in high school, he falls in with a crowd that is more interested in how they look, and he gets a knife. After one of his buddies changes schools for letting a black student beat them. Ben rushes home devastated and prays to God for help with his bad temper, a “darkness” he can’t control.

After obtaining a scholarship to Yale University, Ben begins to be interested in the brain. He also discovers, through his facility at playing foosball (see below), that he has incredible hand/eye coordination, the “gift” of the film’s title. Overwhelmed because his fellow students are much more advanced, he skips classes and his grades suffer. Fortunately, he meets Candy (Aunjanue Ellis), a triple-major fellow student and his future wife. She, like Ben’s mother, instills confidence in him and helps him develop a successful work ethic, culminating in a crucial chemistry exam in which he averts failure. He ultimately does well and matriculates at the University of Michigan Medical School, then applies for one of the two coveted neurosurgery residency positions at Hopkins. He is interviewed by George Udvarhelyi (Yasin Peyankov), a Hungarian neurosurgeon and Renaissance man, who asks him why he decided to become a neurosurgeon. Ben says that the brain is a miracle and that doctors are capable of performing miracles, like Handel who composed The Messiah in three weeks. Their shared interest in classical music cements their relationship.

Ben is accepted in the residency program, but when he diagnoses a patient with Von Hippel Landau disease and challenges the attending’s plan, he is told, “Don’t think you’re special because there’s no one like you in the department. If you don’t change your attitude, I’ll get you kicked out of surgery faster than you can say, ‘Yassuh’” (see below for corrections). This agitates him and he doubles his efforts to conform. His breakthrough comes when no attending is available and he has to do an emergency lobectomy, which he has never done before without supervision. He prays, “Lord, thy will be done.” The operation goes well. In 1985, he is named chief of Pediatric Neurosurgery and is confronted with an epileptic who has Rasmussen’s syndrome and is on thirty-five different medications. After consulting with pediatric neurologist John Freeman (Geoffrey Beauchamp), he agrees to do a hemispherectomy, which he has never done before. The patient requires nine pints of blood, more than double the normal blood volume, and the operation is a success.

Candy’s loss of twins in a miscarriage sets up the operation on the conjoined twins. Once again, his mother buoyed his confidence by saying, “You can’t be able to bring back your twins by saving these, but at least you can try.” The team consists of about fifty professionals, including anesthesiologists, cardiac surgeons, thoracic surgeons, plastic surgeons, nurses, and Dr. Donlin Long (Ele Bardha), chief of Neurosurgery, as well as Dr. McCall, neurosurgeon of the Detroit Medical Center, in an incredible exhibition of teamwork. The parents ask him what they should do during the operation and are surprised when he says, “Pray,” and he prays with them. The procedure, which lasts twenty-two hours, has many moments of tension, especially with regard to the amount of time the heart could be stopped to allow a relatively bloodless field. Its success has led him to perform many more such operations.

Reading Carson’s autobiography, one can’t help but conclude that two important things were deemphasized in the film. The first is his Christian faith. It is abundantly clear that since his baptism as a Seventh-Day Adventist Carson...
has been a deeply devout man who calls on God repeatedly. There are many times in the book when he talks about God entering his life in addition to those cited in the film. They include for example that Yale chemistry exam, a car accident that was almost fatal to him and his then-girlfriend Candy, and even during the operations. He not infrequently gives parents assignments to say their prayers, as shown in the film. He believes that the Lord never gives him something that He cannot get him out of. His mother told him that if he asks “the Lord for something believing He will do it, He will do it.” One interesting episode not covered in the film is the story of a safe that was stolen from his house just before he was to go abroad to assess the conjoined twins. It contained his important papers including his passport, which would have taken weeks to replace. The safe was “miraculously” discovered by a policeman with everything intact in a pile of garbage a couple of days before he was to leave.

I asked him why there wasn’t much about Christianity in the film, and he said that the sponsors wanted to cut what was left in, saying that it was not a Christian film. Carson told them, “If you take it out, you can take me out because it won’t be true to who I am.” This shows the pressure to airbrush religion, especially Christianity, out of feature films. An excellent example of this is the film Amazing Grace, which relates William Wilberforce’s decades-long fight to get England to abolish the slave trade. Director Michael Apted, who replaced Hugh Hudson, the director of Chariots of Fire, one of the most unabashedly favorable treatments of Christianity, said that he purposely downplayed Wilberforce’s main motivation as an evangelical born-again Christian, and portrayed it as a legislative and political victory.\(^2\)

The other thing that was not talked about was Carson’s ROTC training in high school, a remarkably good story. Carson joined the ROTC, following in the footsteps of his brother, who had risen to the rank of captain, quite an achievement for a black in Detroit at the time. Carson decided that he wanted to be the commanding officer, a colonel. Placed in charge of one of the worst companies of undisciplined students, he turned them into a crackerjack outfit and earned the top rank. I can’t say that the reason it was omitted was because of Hollywood’s current unwillingness to honor the ROTC and the military, but there’s no doubt the experience was very important in his growth, as it was in my own. As Carson said, this and other important issues were probably left out because of time constraints in producing a ninety-minute made-for-TV movie. Those who read the book will learn about his emphasis on rapport with clerks and aides, whom he considers part of the team and who have been very helpful to him over the years. Also left out was his year-long fellowship in Australia, where he gained invaluable experience in neurosurgery and where the local Seventh-Day Adventist community welcomed him and his family with open arms.

When I asked him about the racist encounters, he said that the incident on rounds involved a resident, not an attending, and while it was substantially accurate, the physician did not say “Yassuh.” On the other hand, the eighth-grade assembly scene was even more blatant than portrayed. He verified that neither the principal nor anyone else in authority spoke out, and that the students looked at him sympathetically and rolled their eyes signaling that the teacher was crazy. His extraordinary hand-eye coordination was first recognized not with foosball but during a summer job in which he was allowed to operate a crane despite being inexperienced, and handled it skillfully. Finally, it was chief of Anesthesiology, Dr. Mark Rogers, not Carson, who broke the news to the Binders of the operation’s success.

Addendum: Dr. Carson continues to do about 300 operations a year despite increasing claims on his time, which he tries to protect for his family’s sake. In addition to his medical lectures, he gives many motivational speeches on the importance of education, one of which my wife had the privilege of attending at her school many years ago. He and his wife have used their good fortune to set up a foundation funding Carson scholars and has also provided money to more than forty schools for Carson reading rooms. Another project called Angels of the OR helps families who can’t afford to get care.

References

Valkyrie

Starring Tom Cruise, Kenneth Branagh, Terence Stamp, Tom Wilkinson, and Carice van Houten.


Valkyrie, which recounts the conspiracy to kill Hitler and take over Germany, is well worth seeing despite the fact that it was savaged by many critics, principally because of their distaste for Tom Cruise now that he’s into Scientology and his tendency to make wacky comments during interviews. Although Cruise is quintessentially American, his profile bears a striking resemblance to that of Colonel Claus von Stauffenberg, whose attempted assassination of Hitler on July 20, 1944, failed. He does a commendable job in the role, as do the excellent British actors who play the co-conspirators, and the largely German supporting cast. The film’s main asset is that, unlike most Hollywood fare, it deals with a real event about which many in the current generation have no knowledge, although they should. Memory of the German resistance, such as it was, like that of the Holocaust, is worth preserving.

Indeed, this film only scratches the surface of that movement. The attempt is said to have been the last of fifteen
known attempts on Hitler’s life, although there were many more. Many had to be aborted or failed either because Hitler changed travel plans or SS Chief Himmler was absent, and the conspirators believed that his survival would have perpetuated Der Fuhrer’s policies. Himmler once boasted, “If Hitler should say I should shoot my mother, I would do it and be proud of his confidence.” In his book Killing Hitler, Roger Moorhouse discusses about twenty of the so far forty-two uncovered plots to assassinate Hitler, beginning in 1939 and culminating in this complex conspiracy involving mostly high-ranking military officers who, despite their strong aristocratic and religious backgrounds, nevertheless served in key positions and carried out orders. Although not members of the Nazi party, they originally rallied to Hitler’s cause of resurrecting the glory of Germany, which had been humiliated after World War I, but became disillusioned by the reports of brutality by the SS and by the inept prosecution of the war by Hitler. This intensified after the devastating losses during the invasion of Russia and the entry of the United States into the war, which presaged defeat. The large number of people in high places who risked their lives to rid the world of a madman who was sacrificing so many lives to his megalomania was especially noteworthy because, as the circle of conspirators grew, shown almost to the point of confusion in the film, the danger of their discovery increased.

The movie begins when von Stauffenberg is injured in battle in Tunisia and loses his left eye, his right hand, and two fingers on his left hand. He is shown writing a letter to his wife (Carice van Houten) expressing his disillusionment with Hitler. The film then moves to the conspiracy, with the introduction of one of principal architects, Major General Henning von Tresckow (Kenneth Branagh), smuggling a bomb disguised as a gift of brandy on the Fuhrer’s plane. When the bomb fails to detonate, he is able to retrieve it before the intended recipient discovers the contents. After one of the key conspirators is arrested by the Gestapo, another of the leaders, General Friedrich Olbrecht (Bill Nighy), recruits von Stauffenberg, who has direct access to Hitler, to join the conspiracy after he promises that he would not flinch at killing Hitler even though he had been given the Iron Cross and been lavishly praised by him. Von Stauffenberg is surprised that no coherent plan for the aftermath has been developed, and he and Olbrecht draw up a sophisticated plan to seize control of the country after Hitler’s death. The complex plan to mobilize the reserve army, capture military headquarters, and neutralize the SS is well shown in the film. The director picks up the pace in the second half of the film, and though we know the outcome, the movie keeps its hold till the last major conspirator is shot or commits suicide. Each is given his say:

- Dr. Carl Goerdeler (Kevin R. McNally) says, “The people will know that we put our principles above personal gain.”
- General Ludwig Beck (Terence Stamp) shoots himself after thinking of earlier times.
- General von Tresckow says, “We had to show the world that not all of us were like him.”
- Lieutenant Werner von Haeften (Jamie Parker), von Stauffenberg’s aide de camp, is killed as he tries to prevent the general from being shot.
- Before von Stauffenberg dies, he says, “You may hand us over to the executioners, but in three months the disgusted and harried people will bring you to book,” and cries out, “Long live sacred Germany!” before the guns are fired.
- Although General Friedrich Fromm (Tom Wilkinson), the head of the Reserve Army, refuses to join the conspirators, he is executed on March 12, 1945, shortly before the war ends.

Despite the failure of the conspiracy, one marvels at how close they came to succeeding.

Von Stauffenberg’s wife and children survived the war; she died in April 2006. Outside the Bendlerblock, the conspirators’ headquarters on the re-named Stauffenbergstrasse, is a German Resistance Memorial in Berlin honoring the conspirators. It reads, “You did not bear the shame, you resisted, sacrificing your life for freedom justice and honor.”

Reference

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Reviews and reflections

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

Dancing at the River’s Edge: A Patient and Her Doctor Negotiate Life with Chronic Illness

Alida Brill and Michael D. Lockshin, MD
Schaffner Press, Tucson, Arizona, 2009

Reviewed by Ralph C. Williams, Jr., MD (ΑΩΑ, Cornell University, 1953)

This is a very good book written jointly by Alida Brill, a patient who has suffered almost all her life from chronic autoimmune disease—finally diagnosed when she was middle-aged as Wegener’s Granulomatosis—and her doctor, Michael Lockshin, a distinguished rheumatologist at the Hospital for Special Surgery in New York City. The book’s alternating sections or chapters are written either by the patient or by her physician and provide fascinating insight into the thoughts, fears, and interpretations of symptoms and flare-ups of the disease, first from the patient’s viewpoint, and then similar, sometimes not mirror, views of what seems to be happening from the attending doctor’s vantage point.

During the course of constructing the framework of this ongoing narrative concerning the pattern and manifestations of the disease, which begins when Ms. Brill is a teenager and finally is correctly diagnosed when she is in her fifties, Ms. Brill (an accomplished author and social scientist herself) and Dr. Lockshin become good friends as well as patient and doctor. Their negotiations about treatment represent the core thread of this book.

The book deals with material that is very important but often overlooked or unconsciously given short shrift by many attending physicians, including desention of patients who are hopelessly ill by marital partners or other family members, as well as patients’ reactions to being dropped or discarded because they are and will continue to be chronically ill.

For her appointments with Dr. Lockshin, Ms. Brill rides up in elevators often packed with other patients and their relatives on their way to see their particular physicians. When she sees children with deforming arthritis or other physical malfunctions, she has many memory flashbacks of her own times with similar problems as a child or teenager. Her tempered observations of these children’s plights are quite moving and memorable.

One feature of this book that provides a good deal of entertainment is the often quite different interpretations of various actual happening or flare-ups of the patient’s disease from the patient and doctor perspectives. After her diagnosis has been established, Ms. Brill reads in the Merck Manual that her disease is invariably fatal. Naturally, this information sets the stage for her and clearly influences her choices and plans for continuing work and her relationship to her aging parents.

One of the most remarkable elements of this book is that we are presented with situations that many practicing physicians or former active doctors have to deal with every day: that patients do not tell us the things that are foremost in their minds or what their expectations are of us as their doctors.

This book is a moving account of a patient and her doctor’s relationship during the course of a chronic, often fatal, disease. Moreover, it provides an entertaining point of view for many of us who have to deal with medical and psychological care for such patients.

All physicians who treat patients with serious types of autoimmune disorders, such as systemic lupus erythematosus, scleroderma, or rheumatoid arthritis, have observed the only-too-common phenomenon of husbands or wives of such seriously ill individuals at some point throwing up their hands and saying that they have had enough, then leaving the marriage or relationship for good. This sort of fearful desertion may be more likely to occur in patients with autoimmune diseases that often wax or wane repeatedly over a lifetime, as compared with patients who have far advanced or inoperable cancer, when the spouse knows that death soon to come will end the relationship. In this book, Ms. Brill faces this very difficult crisis herself as her husband leaves her. Instead of being embittered, she chooses remarkably to analyze what has happened and to attempt to define what actually motivated her husband to leave. This section of the book was for me an eye-opener and an education in the fact that some people are big enough and sufficiently honest with what has happened to them to accept it as a given and then move on. All physicians are accustomed to dealing with their patients’ personal tragedies; in this case Mr. Brill’s reaction to her partner’s leaving was an uplifting insight into what a brave person can muster in spite of her circumstances.

I recommend this book highly.

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Worried Sick: A Prescription for Health in an Overtreated America
Nortin M. Hadler

It is impossible to read this monograph and remain complacent with the current medical model. Dr. Hadler states that “I have written this book for the general audience to foment debate and thereby open minds.” This tome will certainly engender debate even if it fails to open minds. Dr. Hadler posits a number of provocative tenets based on his evaluation of the medical literature.

1. The American public is at “grave risk” from Type II Medical Malpractice, what Hadler defines as doctors doing the unnecessary very well, as opposed to what he calls Type I Malpractice, doctors doing the necessary very badly.

2. Health Promotion, Disease Prevention is an “Orwellian banner” that medicalizes dying. We medicalize normal biologic parameters by making them more restrictive (such as defining a metabolic syndrome for which there is more conjecture than proof).

3. Since all of us will die approximately at our biologically programmed time because “it was her time,” proximate cause epidemiology, which looks at the disease condition operating at the time of our death is meaningless.

4. Seventy-five percent of our mortality risk is related to socioeconomic factors and satisfaction with our employment. Therefore, we should ignore all associations with mortality in any given study, if not stratified by socioeconomic status (SES).

5. Surrogate measures are not important. Very few studies measure actual death rates, rather than surrogate measures (change in blood glucose, cholesterol, and blood pressure, etc.). Studies have not demonstrated that influencing surrogate measures influences mortality.

6. Only study results that spring from primary a priori hypotheses can be considered valid. All other results are termed “data torturing.”

7. Most symptoms (back pain, diarrhea, weakness) that we ascribe to medical causes (medicalize) are instead related to “SOOS—the syndrome of being out-of-sorts.” SOOS, instead of being related to illness, represents the inability of a person to cope.

As a result of these postulates, Dr. Hadler rejects most forms of health maintenance. This includes colonoscopies, mammograms, PSA screening, treatment for osteopenia, lowering of cholesterol, “healthy” diets, etc. He rejects acute care such as coronary angioplasty or stents. He proposes that seventy-five percent of health care dollars be spent on improving SES and job satisfaction. Twenty-five percent of insurance monies should go to disease insurance. Interventions that reduce “hard outcomes” such as death, stroke, heart attack, and renal failure would be completely covered if one out of twenty patients was advantaged. For treatments related to “soft outcomes” (feeling better, functioning better), indemnification would occur if the number needed to treat was five or less. If a “clinical interface” does not meet these criteria, insurance plans would pay nothing. This is a radical concept, indeed, one that turns the medical model on its head. In the current health debate, no one seems interested in compromising at all on their extant medical “entitlements,” much less agreeing to pay for their own care if this care helps fewer than five percent. Statistics may apply on a policy level, but no one individual thinks it should be applied to him or her.

In the introduction, Dr. Hadler writes, “I am very uncomfortable asking the reader simply to accept my arguments. I need to provide the detailed, rigorous support for the exercise.” The author’s audience is the lay public and it is a difficult task to debunk the accepted medical model while providing “detailed, rigorous support.” He attempts to provide this support by accompanying each chapter with a “shadow chapter” that provides more details for his arguments. I found this arrangement very cumbersome and difficult to follow. I tried two approaches: one, reading the entire chapter and then the shadow chapter, and two, reading one topic in the main chapter and then reading the pertinent portion of the shadow chapter. Each method failed. The first failed because the chapters dealt with too many studies; in reading the shadow chapter, I could no longer relate it to the point made in the primary chapter. In the second tactic, I couldn’t tell from the shadow chapter when the author had moved on to a new topic in the primary chapter. If this system was difficult for an experienced medical professional, I imagine it to be much more so for a lay person.

I find Dr. Hadler’s assertion that his positions are the result of only personal critical evaluation of the literature suspect. The concept of this book—that most symptoms relate to an inability to cope—is central. However, Dr. Hadler specifically states, “My psychosocial
and sociocultural theory has not survived formal testing either and indeed such testing is difficult to design and perform. How can the author reject most of the medical literature and the entire current medical model, when his position cannot be supported by the type of analysis of his choice? Some of Dr. Hadler’s positions appear nonsensical such as, “one of the most dangerous acts a physician undertakes is to take a history.” On occasion, when the author strayed into an area of my expertise, I recognized a few statements as simply inaccurate.

This volume holds other frustrations for the medical professional. Dr. Hadler is not a dispassionate voice. He is an advocate for his position. This leads him to use hyperbolic phrases such as “violence to the coronary arteries,” the “trigger happy FDA,” the “anguish of a cardiac cath,” and “give me a break—let my polyps go.” The studies Dr. Hadler chooses, of course, advance his position. Much of the “detailed, rigorous” support in the shadow chapters is still colored by judgment. For example, instead of giving the absolute numbers in a study, he reports that the difference was “minimal” (what difference constitutes minimal?).

This monograph meets Dr. Hadler’s goal of fomenting debate. He very clearly states a series of provocative tenets which deserve serious consideration. I have taken to questioning many medical interventions I perform and viewing many of my patients as presenting with SOOS. The caveat is that the author does not substantiate his own positions with the rigor he requires from others. This volume, like almost all literature, should be read with a critical, inquiring mind.

Dr. Brillman is Associate Dean of Continuing Medical Education and a professor of Emergency Medicine at the University of New Mexico School of Medicine. She fancies herself a critical reader of the medical literature for almost 30 years and appreciates this opportunity to opine. Her address is:

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On Apology
Aaron Lazare
Oxford University Press, New York, 2004

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

A aron Lazare, a professor of psychiatry and former dean of the University of Massachusetts School of Medicine, presents a comprehensive overview of apology and forgiveness in his highly readable book, On Apology. Although published in 2004, the book’s contents remain fresh and are increasingly relevant to physicians because of the recent focus on apologizing to patients for medical error. Based on many years of study, On Apology presents a framework for understanding the basic requirements for an effective apology, including its process, timing, motivation, and content, as well as sociolinguistic and cultural variations. The text is chock-full of examples drawn from the author’s experience, historical narratives, and the world of public affairs. Lazare covers the complete spectrum of apologies from private interactions between individuals to public apologies by a government to a minority group for present or past injustices. Examples of the latter include Abraham Lincoln’s apology in his Second Inaugural Address (1864) to black Americans for the evil of slavery, and the lesser known apology by Kevin Gover (2000), an assistant secretary of the Bureau of Indian Affairs, to Native Americans for the long history of treachery and humiliation federal agencies had perpetrated upon them.

According to Lazare, successful apologies always fulfill one, and often several, of seven specific psychological needs of offended person(s): restoration of self-respect and dignity; assurance that both parties have shared values; reassurance that the offense was not the offended party’s fault; a promise of safety in the future; the experience of seeing the offender suffer; reparation for harm; and a meaningful dialogue with the offender. Restoration of self-respect is an especially potent and prevalent need, since humiliation can lead to long-term psychic dysfunction, as is the case with grudges, which serve as bellows that reenflame the embers of anger. As Lazare illustrates in the first chapter, people nowadays frequently have a very low threshold for “being dissed,” and this may in part be responsible for the growing thirst for apologies in our culture.

The first and most important part of a successful apology is to acknowledge the offence. This seems straightforward, but there are many considerations involved and, therefore, many ways of missing the target. Sometimes, apologizers try to hold back by making vague or superficial acknowledgments, or by trying to share the responsibility with others. In other cases apologizers may imply that the offensive behavior was understandable, given the circumstances in which it occurred. Examples
of unsuccessful apologies in these respects include Arnold Schwarzenegger’s public apology for mistreating women, Cardinal Edward Egan’s apology for reassigning pedophile priests to new parishes, and President Richard Nixon’s resignation speech, in which he regretted only “any injuries that may have been done.”

After the acknowledgment of a specific offence, the remaining parts of an effective apology are: communicating remorse, giving an explanation for the behavior, and making reparation. Remorse may include expressions of guilt, forbearance, shame, humility, and sincerity. Aggrieved individuals also want an explanation for the offensive incident, including whether the slight was intended or accidental. Such an explanation, however, can’t take the form of “explaining away” or justifying the act. As an example of failed explanation, Lazare tells the story of Latrell Sprewell, a professional basketball player who became angry during practice and tried to strangle his coach. Afterwards, Sprewell apologized by explaining, “I think it’s fair to say I had a bad day... That’s not me. I don’t have a problem.”

Although reparation can be an important part of an effective apology, simple monetary reimbursement without the acknowledgment of guilt may be unsatisfying and even lead to enhanced anger. Lazare quotes the reactions of a victim of clerical sexual abuse, who said, “plaintiffs feel almost like prostitutes now that they’ve been compensated for having been sexually violated.” In such cases the financial compensation had resulted from settlements that did not include honest apologies.

One of the most fascinating sections of this book deals with gender, language, and culture as they relate to apology. Lazare reports that among those attending his lectures on apology, women outnumber men by a ratio of three to one, which tends to support his belief that women apologize more often than men. From a cross-cultural perspective, the English verb “to apologize” has a lighter, less serious feel than equivalent verbs in many other languages. Our verb is derived from the Latin apologia, which means an explanation of one’s beliefs, or a defense against an opponent’s charges. On the other hand, the German equivalent of apologize, entschuldige bitte, has no such ambiguous roots. It translates roughly as, “Please take away my guilt.”

Lazare’s discussion of public apologies, especially those dealing with national guilt for historical injustice, is enlightening. Lazare argues convincingly that national identity is the key to understanding such apologies. As humans we see ourselves in the context of our history, culture, and political system. The symbolic heft of national (cultural, ethnic, racial) identification is just as important for the victimizers as it is for the victims. In that sense we share in social guilt for atrocities once perpetrated by our nation. Therefore, according to Lazare, symbolic apologies can be emotionally satisfying to aggrieved peoples, even though those now apologizing did not actually perform the acts for which they avow guilt.

What seems at first to be a simple human response—apologizing for harm we’ve caused another person—turns out to require a complex excursion into social psychology, ethics, and communication skills. Aaron Lazare expertly guides the reader through this territory with his keen analytical mind, his understanding heart, and a great gift for storytelling. On Apology is a valuable book for physicians to read, as well as for anyone else who cares about maintaining good relationships with others.

Dr. Coulehan is a Book Review Editor for The Pharos and a member of the journal’s editorial board. His address is:

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The Procedure

Eyes dim, breath ceases
Sweat trickles down my forehead
Vocal cords appear

Seth Ilgenfritz

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Illustration by Jim McGuinness
Letter to the editor

Doctors and pharmaceutical promotion

I read with great interest the review of the book *Our Daily Meds* by Michael B. Bevins, MD, PhD, in the Summer 2009 issue (pp. 46–47). Being involved in promoting rational use of medicines and teaching undergraduate medical students about rational prescribing for many years in Nepal, the review raised a number of interesting issues. Creating new diseases or disease mongering is a topic which has garnered attention and also generated controversy. Disease mongering can include turning ordinary ailments into medical problems, seeing mild symptoms as serious, treating personal problems as medical, seeing risks as diseases, and framing prevalence estimates to maximize potential markets.¹

In an article, I and a colleague found this phenomenon to be common in South Asia.² Pharmaceutical companies, cosmetic companies, complementary medicine practitioners, and even beauticians were often guilty of “disease mongering.” Fairness creams are aggressively promoted in the media. They exploit the historical preference of South Asians for a fair complexion and promote the concept that “dark” skin is a “disease” which can be cured through the use of fairness creams.³ PLoS Medicine (www.plos.org) has devoted an entire issue to disease mongering.

Recently I watched a video produced by the Citizen’s Commission on Human Rights (www.cchr.org) about psychotropic medicines in the United States that raises disturbing questions. Psychotropic medicines, according to the documentary, are increasingly being used for non-psychiatric indications. In Nepal access to medicines remains a problem among rural populations and the urban poor (though the situation is improving), but medicines are aggressively promoted in urban areas.

At both the Manipal College of Medical Sciences, Pokhara, and at KIST Medical College, I and my colleagues have been teaching students about pharmaceutical promotion and rational use of essential medicines. Medical representatives (pharmaceutical details in the United States) play an important role in promotion. Using role-plays students were taught to optimize time in promotion. Using role-plays students were taught to optimize time in promotion. Using role-plays students were taught to optimize time in promotion. Using role-plays students were taught to optimize time in promotion. Using role-plays students were taught to optimize time in promotion. Using role-plays students were taught to optimize time in promotion. Using role-plays students were taught to optimize time in promotion. Using role-plays students were taught to optimize time in promotion. Using role-plays students were taught to optimize time in promotion. Using role-plays students were taught to maximize potential markets. They learn to analyze drug advertisements and promotional material against the WHO Ethical Criteria for Medicinal Drug Promotion.

KIST Medical College has an active and functioning Medicine and Therapeutics Committee which has taken steps for promoting rational drug use.⁴ Medicine information services have been established to provide prescribers access to independent, unbiased sources of information about medicines. Medical representatives are not allowed to meet doctors individually and can only present their products to doctors in a group at a designated time each week. Certain other Nepalese hospitals are also regulating pharmaceutical promotion within their premises. The draft guidelines formulated by the national drug regulatory body recommend regulating promotion in hospitals. A possible problem could be that most doctors are engaged in private practice outside the hospital working hours and medical representatives may have unrestricted access to doctors at these locations. Teaching doctors about dealing with aggressive promotion may be helpful though certain authors have cast doubt that doctors can ever gain more good than harm from visits by sales representatives.

In South Asia there is wide variation in the prices of different brands of the same medicine. We are making available the cost of various brands to doctors so that they can make rational prescribing decisions. Also the hospital pharmacy stocks not more than four brands of a particular generic based on criteria of efficacy, safety, cost, and convenience. I personally think the suggestion that FDA produce a brochure for every drug available in the U.S. market is a good one. Independent information about medicines is widely provided in countries like Australia and New Zealand. In Nepal due to resource constraints and other problems we have not been able to make much progress in this direction.

In our interactions with students we stress the importance of maintaining a “proper” relationship with the industry. The industry has over the years produced useful medicines and has done much to reduce human suffering. An article in the BMJ likened the relationship between doctors and the pharmaceutical industry to dancing with porcupines.⁶ The trick is not getting stung!

References


P. Ravi Shankar, MD
Associate Professor Clinical Pharmacology, KIST Medical College
Kathmandu, Nepal
On Wrinkles
(Hiding the Evidence)

They're seen as a badge of advancing maturity,
Arriving with checks from Social Security

While the zits are gone, the terrain is now sprinkled
With spots and with lesions where it's folded and wrinkled.
They have names like squamous, and almost as famous,
Are melanoma and keratosis if the tissue is shrunkled.

You don't have to urge on the diligent surgeon,
He'll carve the incision and line up the scar.
(To compensate for the scalpel's incursion,
It's invisibly placed where those wrinkles are.)

But if it's not possible yet to remove them,
Perhaps there's a way that might improve them.

If a car wreck is called a crinklefender,
Is treatment with Botox—a wrinklemender?

Henry N. Claman, MD

Dr. Claman (AΩA, University of Colorado, 1979) is Distinguished Professor of Medicine and Associate Director of the Medical Humanities Program at the University of Colorado, Denver. His address is: Allergy/Immunology B164 RC2, 12700 E. 19th Avenue, Room 10100, Aurora, Colorado 80045. E-mail: henry.claman@ucdenver.edu.

Winner of the Submit a Photo contest

Shown here is the winning photograph of the Submit a Photo for the Next “Write a Poem for This Photo Contest.” The photographer is Dr. Anthony Shaw (AΩA, University of Virginia, 1980) of Pasadena, California. The judges were impressed with the sheer fun and eloquence of the photograph. Congratulations to Dr. Shaw and good luck to all the poets hoping to write a winning poem to go with this winsome photograph!

2010 Write a Poem for This Photo Contest

Write a poem to accompany this photograph. Submit it by June 1, 2010 to:

2010 Poem/Photo Contest
Alpha Omega Alpha
525 Middlefield Road, Suite 130
Menlo Park, CA 94025

Prizes: First place, $500; second place, $250; third place $100.
Requirements:
1. One single-spaced page.
2. One poem per author.
3. Four copies, each with poem title (required), author's name, address, and e-mail address.
4. Poem must be original and must not have been submitted elsewhere. The Pharos will have the right of first refusal.
5. Author need not be a member of AΩA.

The winning poem will be published in a future issue of The Pharos. The winner will receive two copies of the issue and a color PDF in addition to the cash prize.
Minutes of the 2009 meeting of the board of directors of Alpha Omega Alpha

The meeting in Denver, Colorado, was convened at 7:48 AM by President Rae-Ellen Kavey. Present were:

- President Rae-Ellen Kavey, MD, MPH
- Secretary-Treasurer C. Bruce Alexander, MD
- Members at large Robert G. Atnip, MD; N. Joseph Espat, MD; Ruth-Marie Fincher, MD; Douglas S. Pauw, MD; Don W. Powell, MD; Joseph Stubbs, MD
- Councilor members Eric P. Gall, MD; Anne T. Mancino, MD
- Student members Natalia Berry, MD; Kara M. Cuvuoto, MD; Cason Pierce, MD
- Medical organization member John Tooker, MD
- National office staff: Executive Secretary Edward D. Harris, Jr., MD; Assistant Treasurer William F. Nichols; Records Administrator Mara Celebi; Managing Editor Debbie Lancaster; and Administrative Assistant Carol Wong.

Absent and excused were: Vice President Donald E. Wilson, MD; councilor member Amy Goldberg, MD.

The minutes of the 2009 meeting of the board of directors were reviewed and approved.

Recognition of retiring members

The board acknowledged retiring directors Eric P. Gall, MD, and Kara M. Cuvuoto, MD.

New board and honorary members

Nominations for the 2009/2010 board of directors slate were reviewed and voted upon. Re-elected to a three-year term as member at large: Ruth Marie Fincher, MD, Medical College of Georgia; Don W. Powell, MD, University of Texas Medical Branch at Galveston. Elected to a three-year term as councilor member: Sheryl A. Pfeil, MD, Ohio State University College of Medicine. Elected to a three-year term as student member: William C. Bynum IV, University of South Carolina School of Medicine.

Honorary member nominations were reviewed and voted upon. Elected to honorary membership were:

- Martha N. Hill, BSN, MSN, PhD, dean of the Johns Hopkins University School of Nursing; Albert R. Jonsen, PhD, emeritus professor of Ethics in Medicine at the University of Washington School of Medicine; Prof. Dr. med. Dr. h.c. Gerd Plewig, professor and chairman emeritus of Dermatology at Ludwig-Maximilians University in Munich, Germany. See the announcement and brief biographies of honorary members on page 38.

Reports of officers

Reports of the president, executive secretary, and managing editor were presented. Of note:

- "The Pharos" will now be available on AΩA's web site in its entirety six months after publication. As usual, the table of contents and excerpts from each new issue are available immediately. PDFs of back issues of "The Pharos" will be added to the web site gradually.

- In the Autumn 2009 issue, "The Pharos" initiated a new Health Policy section, to which we solicit contributions. Contact us at info@alphaomegaalpha.org for more information. The kick-off article by Dr. Robert Moser is available in the excerpts PDF for the Autumn issue, noted below.

Reports of programs

Programs funded during the 2008/2009 year are listed in the Autumn 2009 "Pharos," which is available on our web site at: alphaomegaalpha.org/pharos/AOA-ThePharos-Autumn2009.pdf.

- The Carolyn L. Kucin Student Research Fellowship: This program, designed to support a minimum of eight to ten weeks of research for students and providing $5,000 for the student and an additional $1,000 for presentation of a paper based on the research at a national scientific meeting, continues to be underutilized. It was agreed that, to facilitate use of the program by students in other than the first year, carrying out the research throughout the school year would be acceptable.

- The Professionalism Fellowship: Three fellowships were awarded this year. Further discussion for refinement of the program is detailed later in these minutes.

- Visiting Professorships: This program is often linked to the annual AΩA banquet. Fifty-one chapters used this program in the 2008/2009 year.

- Medical Student Service Project Awards: Twenty projects were funded this year.

- The Robert J. Glaser Distinguished Teacher Award: The board voted to disallow nominations for three years from any school whose nominee wins an award in a given year. The name of the award was changed to the Alpha Omega Alpha Robert J. Glaser Distinguished Teacher Award. The announcement of the awards was made in the...
Winter 2010 issue (pp. 30–31), and is available at alphomegaalpha.org/pharos/AOA-ThePharos-Winter2010.pdf.

- The Helen H. Glaser Student Essay Award: Six prizes were awarded in 2009. Winning essays began appearing in the Winter 2010 issue.
- The *Pharos* Poetry Competition: Ten poems won prizes. Winning poems can be found beginning in the Autumn 2009 issue.
- The Volunteer Clinical Faculty Award: Fifteen chapters presented this award to community physicians contributing to the education and training of medical students.
- Administrative Recognition Award: Eight chapters recognized their chapter administrators with this award.

**Enhancing the visibility of Alpha Omega Alpha**

Based in part on recommendations by the Stanford Alumni Consulting Team made to the board in 2008 (see the minutes of the meeting of the board of directors in the Spring 2009 issue), a consulting group was retained to present suggestions for enhancing recognition of the society and its programs to medical schools and the general public. Ms. Marilyn Saltzman of Schoolhouse Communications gave a presentation that emphasized the importance of clearly defining the goals and objectives for increasing awareness of the society. Target audiences were defined and common strategies used by nonprofit organizations were also enumerated.

Following discussion, negotiation for a working contract with Schoolhouse Communications was approved. A Public Relations committee was established to interact with Schoolhouse and make recommendations for moving forward.

**Residency initiative**

Responding to the suggestions by the board at the 2008 annual meeting, Dr. Suzann Pershing presented background and proposals for developing programs for residents to help them to continue their interest and commitment to AΩA, and to improve AΩA’s visibility at schools.

The board elected her to a newly-created position, Coordinator, Residency Initiatives, for a three-year term. A committee on Resident Initiatives was formed to work with her.

**The Professionalism Project**

Dr. Harris presented the recommendations of the reviewers of applications for the Professionalism Fellowship, now renamed the Professionalism Project:
- To continue the funding of $50,000 for the 2010 year
- To request applications for research projects, not sabbatical use
- To target faculty in the context of creating the appropriate learning environment for professionalism as well as applications for developing projects for teaching residents and students.

The board voted to accept the recommendations.

**The new AΩA web site**

The new web site was launched earlier in September for a total cost of $15,000. It includes a searchable member database. Nominations and many program applications can now be submitted on-line. Members who have not paid dues in the current year will be labeled “inactive”; non-members of the society can access the membership list and see whether the individual is listed as “active” (current on annual dues) or “inactive.”

Data on registration, after the difficult transition to the online process in 2007, has been very encouraging. Very few students and a smattering of faculty/alumni nominees have failed to register and thus become elected members of the society. The new procedure has resulted in initial increases in dues paid and in those choosing to pay lifetime dues.

![The new AΩA web site](http://alphaomegaalpha.org)

**Financial report**

Treasurer C. Bruce Alexander, MD, and Assistant Treasurer William F. Nichols presented the summary of the Investment Committee meeting and the financial report for the 2008/2009 and 2009/2010 years. A dues increase was proposed, and approved. The new dues structure may be seen at: alphomegaalpha.org/dues_contributions.html#paydues.

The meeting was adjourned at 4:05 PM.

Respectfully submitted,

Edward D. Harris, Jr., MD, Executive Secretary
A solitary walker
Listens to the symphony
of each step.

Dry winter leaves,
Loose gravel,
Cracking sticks.

Hawk, crow
Squirrel with a nut.
Forte. Pianissimo.

Barren trees
Fallen, upright.
Mid-morning apricity.

No revelations.
A simple walk.
A beautiful day.

Steven F. Isenberg, MD
Announcement

Executive Director of Alpha Omega Alpha

After many years of distinguished service as Executive Secretary of Alpha Omega Alpha (AΩA) and editor of The Pharos, Edward (Ted) D. Harris Jr., MD, has indicated his desire to retire. Accordingly, AΩA is interested in receiving inquiries from those who might be interested in fulfilling these important roles.

The Executive Director (ED) of AΩA has dual responsibilities as chief administrative officer of the society and as Editor of The Pharos. The AΩA Board of Directors is seeking preferably one person who is a member of AΩA to fulfill both of these functions. The ED must have a strong belief in and commitment to the mission of AΩA and have a record of active service to the organization. She/he must have excellent leadership and management skills, the ability to interact with a diverse group of professionals in medical academia, and excellent literary skills. Currently, the ED devotes approximately 65% of his time to AΩA administration and programs with the remaining 35% devoted to The Pharos. Administrative support for the ED includes 4.25 Full Time Equivalent (FTE) employees.

The ED serves as an ex officio member of the Executive Committee of the AΩA Board of Directors. As such the ED must be in close contact with the Executive Committee and the Board. The ED is responsible for implementing the shared vision of the Board and the ED.

- The ED oversees AΩA programs and periodically evaluates their effectiveness and relevance with the Board.
- The ED serves as the external spokesperson for AΩA; corresponds with chapters; serves as the contact person to provide information and clarify AΩA policy, programs, and chapter responsibilities; and adjudicates chapter disputes where possible. She/he will be expected to visit chapters periodically, meeting with councilors and deans to provide support and promote AΩA.
- The ED interacts on a regular basis with AΩA’s financial manager to recommend budgets and with the investment team to insure appropriate oversight and reporting to the Board of Directors.

As Editor of The Pharos, the ED oversees the work of the full-time managing editor who is primarily responsible for handling accepted manuscripts, managing journal production, and interacting with the publisher and outside contractors.

- The Editor reviews each manuscript as it arrives and designates those for review.
- The Editor determines who on the editorial board will review each manuscript.
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