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Being a professional is doing the things you love to do on the days you don't feel like doing them.
—Julius Erving, reported by David Halberstam

A short vignette came to The Pharos from third-year medical student Neelam Vashi at Northwestern University, describing her contact with a fourteen-month-old little girl whose weight and length were at the fiftieth percentile for a two-month-old child, a little girl “who never wondered why.” She describes the girl:

Her skin, an ochre green like the dull yellow-green of unripe olives, was always held taut against the rigidity of her facial bones. Her big, brown eyes staring, always staring. But, oddly, those same big brown eyes never shed a tear. She never wondered why.

She never wondered why she spent day and night in the hospital. Why all her meals were taken through a G-tube. Why, in the midst of life, she was the owner to the labels of failure to thrive and developmental delay.

I have continued to wonder why. Why little girls who have done no harm are forced to live in pain. Why as the world keeps moving forward, day by day, some are left behind with failure to thrive.

I wonder how a little girl who had no voice was able to put thoughts and questions in my mind, who was able to touch my soul.

Ms. Vashi’s soul was touched. The invisible walls that separate us from each other were broken down. It is very likely that from that moment on this young woman, about to be a physician, will readily and promptly form deep associations with, and commitment to, her patients.

I suggest that every young physician must have such an epiphany—a moment of sudden revelation or insight—before he or she is truly able to serve the suffering. A young physician’s epiphany, the time spent with a single patient that makes him or her forever committed to the thoughtful, long-term care of that individual patient and all others, is a major ingredient of professionalism in medicine. Probably most of us who have been out in the clinics and hospitals for more than just a few years experienced our epiphanies when alone with a patient, or a patient and relatives, late at night, when few others were on the wards. Mine came while trying to save a young father who had his similar epiphany forty-three years ago as he titrated administration of intravenous EDTA all night long to a patient with severe digitalis toxicity. His patient lived, although no one would say that giving the chelator was important for his survival.

In contrast to these experiences, the daughter of a colleague, several months into an R-1 year in 2006, stayed on well beyond her prescribed hours to be with a very sick patient. Rather than being commended for her caring, however, she was dressed-down and scolded by a chief resident for violating the week’s eighty-hour maximum.

Turn now to page____ to read the letters from Drs. William Rogoway, Lawrence Faltz, and Kelley Skeff and Lawrence Smith on the subject of duty-hours standards. Rogoway wonders, “Do patients and the educational process benefit from a major focus on whether one has worked too many hours? It seems clear that patients benefit from a continuous relationship with one physician. The more trade-offs there are, the less intimate that connection becomes.” While not mentioning a particular epiphany during his recollections of long hours in training, Faltz notes that, while working those long hours, “One was transformed, marked by the experience with a different perspective on one’s role in society and an intrinsic understanding of what it means to be a professional.” Recognizing that many program directors also have concerns about the effectiveness of these time-on-service rules, Skeff and Smith nevertheless point out that any redesign of residencies cannot focus on hours requirements because “these are sensible from both educational and patient care points of view.” But they do point out that “by emphasizing the integration of patient care and education, we have the opportunity to again foster the commitment of each individual trainee to his or her patient.”

From another direction, numerous educators are designing and implementing the formal teaching of ethics, professionalism and humanism to medical students. David T. Stern and Maxine Papadakis,1 two prominent leaders in this movement, have set out mechanisms for setting expectations for students, the various educational experiences—including formal curricula, role models, community-based education, and patient-doctor courses—that should be available for students, and the ways to evaluate outcomes of these programs. As they point out, “Physicians are asked to deliver professional care in a complex and ever-evolving health care system, and medical educators have a critical role to play in maintaining and enhancing professionalism.” We must hope that the formal curriculum in these subsets of professionalism will help lower the thresholds for students and residents to experience the epiphanies that will forever change them from graduate students who have mastered the basic elements of medical science and clinical diagnosis into true healers.

References

Edward D. Harris, Jr., MD

Editor
Byte

I see too much of words now. An unrelenting flow of electronically expectorated punctuation, exclamation points proliferating in multiple births. Words by hundreds quickly drafted, quickly vanished—insistent contrast on an impersonation of paper.

Can poetry survive such dulling of the senses? Can I remember how to pause, sniff, stalk a word, transform it twenty times and yet rethink it two years later? Live in a page for hours and ignore an Inbox beckoning?

Life now replicates in sequences of browse, open, reply, spellcheck, attach and send. Let’s backup again—listen, speak, tell a leisurely story about living, slow down and ping a muse.

Wynne Morrison, MD

Dr. Morrison is assistant professor of Anesthesiology-Critical Care at the University of Pennsylvania and the Children’s Hospital of Philadelphia. Her address is: 34th Street and Civic Center Boulevard, Philadelphia, Pennsylvania 19104. E-mail: morrisonw@email.chop.edu
To our students

Invaders from Mars, with commentary from Robbie Burns

Martin A. Samuels, MD

The author is chairman of the Neurology Department at the Brigham & Women’s Hospital, professor of Neurology at Harvard Medical School, and president of the Association of University Professors of Neurology. This essay was originally presented as a speech at the annual AΩA banquet at the University of Nebraska and at Indiana University.

Just about a half-century ago, in the mid-1950s, at the height of our paranoia about Communists and the Soviet Union, a boy sees a flying saucer land in the distance. No one else sees the event. The occupants of the mysterious spacecraft prove to be invaders from Mars. Their strategy is to capture people, one-by-one, and to perform brain surgery on them, implanting an electrode controlling device in the victims’ brains and rendering them pawns of the invaders, while retaining their appearance as human beings. The only clue to recognizing one of these unfortunate robots is to look for the telltale electrode at the base of the hairline in the back of the neck.

To understand the profound meaning of William Cameron Merzie’s film, The Invaders from Mars, a little neurology review is needed. There are really two people within each of us, a fact that reflects the two almost mirror-image cerebral hemispheres, each responsible for the opposite side of the body and extra-personal space. Damage to the left hemisphere will cause paralysis and loss of sensation on the right side of the body, including loss of perception from the right side of the world. This loss of perception is more profound than simple blindness. If reflects the fact that anything that the brain does not record is actually not there. We live, after all, in virtual reality. What our brains do not sense is, for us, not there.

Even though the two cerebral hemispheres are roughly symmetrical, there is one striking difference. For almost everyone, only the left hemisphere has the circuitry for language. Millions of years ago, the pressures of evolution selected those of our ancestors who could communicate with each other, an enormous advantage for social animals. The massive amount of computing capacity needed for language could not be duplicated in both hemispheres. The head, already too large for the body, is simply not large enough; so a compromise occurred. Language would only be represented in one hemisphere, while other important functions related to attention would be represented in the analogous structures in the other hemisphere. All right-handers have left hemisphere dominance for language. Even some non-right-handers have substantial components for language in the left hemisphere. Only true left-handers are the throwbacks to our primitive ancestors.

When I talk to someone, I am only talking to the left hemisphere person, because that is the hemisphere with language. When I ask a person: “How are you?” he really responds, “We are fine.” I, the left hemisphere person am fine, and I hear from my mute friend, the right hemisphere, that he is also fine. When the right hemisphere is damaged, the left hemisphere person may well say, “I am fine,” even though the left side is completely paralyzed. This phenomenon is called anosagnosia, meaning denial of deficit.

In 1971 I was asked by my classmates to speak at Medical Class Day on their behalf. They wanted me to tell the faculty about the electrodes in the back of their necks. We students could see them. Though talented, dedicated, hard-working and well-meaning, many of them had gradually been captured by the Invaders from Mars. They had lost touch with our needs, hopes, and dreams, and, worst of all, they didn’t and couldn’t have known it. They had anosagnosia. What had happened occurred outside of their field of vision. My words were met in some quarters by resentment, disappointment, and disbelief, but, in fact, I was performing the most important function of a true friend. People who care nothing about you will not tell you that there is a piece of spinach between your two front teeth just as you are rising to deliver a commencement address.

As you leave here today, you are looking forward, and rightfully so. You have a marvelous education that allows you to become internists, surgeons, psychiatrists, radiologists, neurologists, biomedical scientists, and clinical research-
ers. But as you move forward, find someone to watch for an electrode in the base of your neck. Only your dearest and most trusted friend can and will tell you that you have been captured by the Invaders from Mars.  

Don’t become one of them! We are counting on you to cure pancreatic cancer, to solve the problem of urban blight, to find the treatment for drug resistant tuberculosis, to ameliorate dementia, and to follow any one of an infinite number of other pursuits that will change our world in ways than none of us can currently imagine. The greatest threat of failing to reach your goals is falling victim to prejudices and fears like those of the 1950s, Communism and Soviets. What are the modern analogues of the Soviet Union and the Communists of the 1950s? Xenophobia and blind devotion, ever-present throughout human history, has spawned a new wave of pseudoreligiosity, anti-intellectualism, and blind faith. In 1958 musical satirist Sheldon Harnick wrote “The Merry Minuet,” popularized by the Kingston Trio:

They’re rioting in Africa, they’re starving in Spain  
There’s hurricanes in Florida, and Texas needs rain  
The whole world is festering with unhappy souls  
The French hate the Germans, the Germans hate the Poles  
Italian hate Yugoslavs, South Africans hate the Dutch  
And I don’t like anybody very much!

When some of our friends and allies told us that they didn’t believe there were weapons of mass destruction in Iraq, we denounced them as cowardly, insular, weak, native, and short-sighted. But they were trying to be our best friends. They could see the electrodes in the back of our neck. The problem, of course, is anosagnosia. How can you know? You depend on someone else telling you.

Sitting in church one day in 1785, the great Scottish poet Robert Burns noticed a head louse climbing up the neck and onto the hat of an elegant lady seated in front of him. He says to himself:

Ha! whare ye gaun ye crowlin ferlie?  
Your impudence protects you sairly;  
I canna say but ye strunt rarely,  
Owre gauze and lace;  
Tho’, faith! I fear ye dine but sparely  
On sic a place.

O Jeany, dinna toss your head,  
An’ set your beauties a’ abraid!  
Ye little ken what cursed speed  
The blastie’s makin:  
Thae winks an’ finger-ends, I dread,  
Are notice takin.

He’s done it. He has performed the most valued and rare duty of a real friend, and he and I conclude:

O wad some Power the giftie gie us  
To see oursel as ither see us!  
It wad frae mony a blunder free us,  
An’ foolish notion:  
What airs in dress an’ gait wad lea’e us,  
An’ ev’n devotion!

Once more, in English:

O, would some God that gift to give us  
To see ourselves as others see us!  
It would from many a blunder free us,  
And Foolish notion:  
What airs in dress and gait would leave us,  
And even devotion!

Godspeed.

The author’s address is:  
Brigham and Women’s Hospital  
75 Francis Street  
Boston, Massachusetts 02115  
E-mail: msamuels@partners.org
ALS

An alphabet A,
a trip of the tip of the tongue to the roof of the mouth
and the hiss, like a coiled snake.

When you tell them
their eyes widen, their faces draw back, their mouths O
and the no’s begin;

for your fellow doctors
instantly picture, after all the fasciculations (no tubes,
no trach) the total paralysis,

the choking,
the gurgling; and nothing left, nothing but the blink
and the stare. But you smile and say:

“It’s OK. When the time
comes I’ll show you how it’s done. Remember
when we

were kids at the pool?
You just bounce on the springboard once, twice, then
launch yourself into space.”

George Young, MD

Dr. Young (ΛΩΛ, University of Southern California, 1963) is retired from the
Boulder Medical Center, where he was an internist and rheumatologist. He has
published one book of poetry, Spinoza’s Mouse. His address is: 2315 Hawthorn
Avenue, Boulder, Colorado 80304. E-mail: geopeg63@msn.com.
In the wake of Katrina

An update on the Louisiana State University School of Medicine in New Orleans

Fred A. Lopez, MD
The author (AΩA, Louisiana State University, 1991) is associate professor and vice chair of the Department of Medicine at the Louisiana State University Health Services Center, and the assistant dean for Student Affairs at the Louisiana State University School of Medicine in New Orleans. He is the secretary-treasurer of the AΩA chapter at LSU. His previous article for The Pharos was “In the eye of the storm: Charity Hospital and Hurricane Katrina” in the Winter 2006 issue (pp. 4–10). All photos are courtesy of the author.

August 29, 2006, marked the one-year anniversary of Hurricane Katrina’s arrival along the Gulf Coast. Its epic devastation has been well chronicled, and the city of New Orleans continues to rebuild its infrastructure, including its homes, neighborhoods, schools, and health care system. The losses were enormous and did not spare the academic medical institutions, which have had to sustain their multiple missions of research, health care, student teaching, and postgraduate training while relocating and rebuilding. According to Dr. Larry Hollier, dean of the Louisiana State University—New Orleans School of Medicine and chancellor of the LSU Health Sciences Center (LSUHSC), “With lost revenue streams and property damage of more than two hundred million dollars, we also lost more than twenty percent of our medical school faculty over the past year, as well as about twenty million dollars in research funding.”

The School of Medicine pursued a phased return to New Orleans in 2006, after spending much of the prior academic year at the Pennington Biomedical Research Center, a 403,000-square foot research complex located in Baton Rouge, Louisiana. During that time, LSUHSC faculty, fellows, house staff, and students lived on the Finnjet, a Baltic ferry docked along the Mississippi River. According to Dr. Hollier, LSU’s commitment to its students and the health of Louisiana’s citizens is what allows the school to persevere: “As the source of the majority of Louisiana’s health care professionals, we were able to safeguard not only immediate access to care but also future access by reestablishing our academic programs. A testament to the fortitude of faculty and students alike, attendance was ninety-eight percent on September 26, 2005, the day classes resumed in borrowed space in Baton Rouge.” Significantly, the fall 2006 enrollment of medical students was unchanged from pre-Katrina levels, with no notable change in the number of applicants.

While basic science courses are again being taught at LSUHSC’s downtown New Orleans location, clinical experiences for medical students are increasingly diverse, with more community-based rotations within the city of New Orleans as well as at other LSU Health Care Services Division sites in Baton Rouge, Lafayette, and Houma.
Much has changed, including the possible indefinite closure of the venerable Charity Hospital, an icon since 1736 for the public health care system in New Orleans. According to Cathi Fontenot, medical director of the Medical Center of Louisiana-New Orleans (MCLNO), “Prior to Katrina, the Medical Center of Louisiana, comprised of Charity and University Hospitals, as well as upwards of seventy outpatient clinics, provided one hundred thirty thousand emergency room visits and two hundred seventy thousand outpatient visits annually to the citizens of Louisiana. Seventy percent of the patients cared for by this system were uninsured, thus dependent on the safety net for medical care.” She notes as well that “the Medical Center provided training for six hundred house officers on a daily basis from the LSU and Tulane Schools of Medicine, as well as training experiences for medical students from both facilities. Additionally, training programs from the LSU and Charity Nursing schools, Xavier School of Pharmacy, the LSU School of Allied Health, Delgado Community College, and other community training programs for health professions of all types participated in caring for patients in this rich clinical environment.” In addition to the diminishing of health care services for its patients and loss of teaching opportunities for its trainees, the closure of University Hospital impacted the recruitment of residents. Dr. Charles V. Sanders, chair of the Department of Medicine at LSU, notes, “The ramifications of University Hospital’s continued closure on this [past] year’s match were severe for our categorical and preliminary internal medicine and combined programs. The 2006 match was the first time in my thirty-six years at LSU that the Department of Medicine did not recruit a single LSU student to our categorical medicine program.” Many view these developments as an impetus to enhance their teaching programs by diversifying experiences in the community-based hospitals, resulting in exposures that will complement their public hospital experiences. Dr. Sanders also notes that he is very optimistic about the positive impact of University Hospital’s reopening on LSU’s training program.

Indeed, University Hospital’s mid-November 2006 reopening represents an important step in the recovery process, albeit on a smaller scale. In the interim, emergency medicine services for MCLNO were delivered in a former department store in downtown New Orleans. The LSU/MCLNO Level-1 Trauma Center was re-established at the Ochsner Clinic Foundation’s Elmwood Hospital until February 2007, when it returned to the University Hospital campus. In addition, the United States Department of Veterans Affairs and LSU are discussing potential collaborative plans for constructing new teaching hospital facilities in downtown New Orleans. In collaboration with the U.S. Department of Health and Human Services, the Louisiana Recovery Authority’s Health Care Committee has been asked to redesign health care in the New Orleans area and the rest of the state. Rebuilding and recruitment are ubiquitous, but much work still remains. Office space is limited and support staff decreased. The sense of cohesiveness of clinical departments faces the challenge of the scattering of programs and individuals to multiple clinical sites within and outside the city. Students are perhaps the most sensitive to this tangled environment and the most entitled to address its needs. Brad Culotta, president of the Class of 2007, and Jonathan Foret, president of the school’s chapter of Alpha Omega Alpha, comment: “Anxiety and stress levels are increased as students attempt to excel in an already rigorous curriculum with many unknown variables about current and future training. The LSU School of Medicine has traditionally taken pride in the fact that many graduates match to LSU residency programs. We cannot think of a more crucial time for state and local governments to take action in increasing funding and rebuilding of the medical school and its university hospitals.”

This belief, that our mission is not only important but indeed essential, creates a pervasive mood of strength and optimism. Says Dr. Hollier, “Friedrich Nietzsche was right when he said, ‘What doesn’t kill us makes us stronger.’ We are building back smarter, better, and with a heightened strength of purpose forged through the knowledge that we have been tested and we have triumphed.”

Acknowledgment
I appreciate the thoughtful review and editorial suggestions of Michelle Burke, MEd, editor in the LSU Department of Medicine. All photographs in this article are courtesy of the author.

The author’s address is:
Louisiana State University Health Sciences Center
Department of Medicine
Box E7-17
2020 Gravier Street
New Orleans, Louisiana 70112
E-mail: alopez1@lsuhsc.edu
To the medical students who dissect my body:

I am donating my body because I want the end of my life to represent a new beginning for others. I've read the poem in the pamphlet about body donation and it makes sense to me. I want to turn my remains into knowledge for the next generation of healers. I have been bedridden for the last several months—what I know are my final ones—and, as much as I believe in the significance of what I've decided to do, I'm happy just to know that I will be able to do something for others again. It is difficult to look back on the final actions of a lifetime because they will undoubtedly be less profound than hoped: I bathed, I made tea, I complained to my friends and family. But while those may be my final acts before I die, they won't be my final accomplishments—the knowledge that you gain from my body will live on.

I expect your time with me to be profound. I expect you to wonder who I was and what my life was like. I expect you to wonder what finally did me in and what they thought of my decision. I expect you to wonder what it felt like to live in my body, whether I had a kind heart or a fiery temper. I expect you to be delicate: treat me as you would your grandmother. I expect you to be serious and to learn something you did not know each time you touch me.

The day will come when my body will lie upon a white sheet neatly tucked under four corners of a mattress located in a hospital busily occupied with the living and the dying. At a certain moment a doctor will determine that my brain has ceased to function and that, for all intents and purposes, my life has stopped.

When that happens, do not attempt to instill artificial life into my body by the use of a machine. And don't call this my deathbed. Let it be called the bed of life and let my body be taken from it to help others lead fuller lives.

Give my sight to the man who has never seen a sunrise, a baby's face or love in the eyes of a woman. Give my heart to a person whose own heart has caused nothing but endless days of pain. Give my kidneys to one who depends on a machine to exist from week to week. Take my bones, every muscle, every fiber and every nerve in my body and find a way to make a crippled child walk.

Explore every corner of my brain. Take my cells, if necessary and let them grow so that someday a speechless boy will shout at the crack of a bat and a deaf girl will hear the sound of rain against her window.

Burn what is left of me and scatter the ashes to the winds to help the flowers grow.

If you must bury something, let it be my faults, my weaknesses and all prejudice against my fellow man.

Give my soul to God.

If by chance you wish to remember me, do it with a kind deed or word to someone who needs you. If you do all I have asked, I will live forever.

—Robert Test, “To Remember Me”

Ryan M. Zimmerman

The author is a member of the Class of 2009 at the Johns Hopkins University School of Medicine.
To the cadaver I am dissecting:

From the first time I met you, I knew that what has happened to your body is not what you expected. You are naked, in a bag, your head has been shaved and a tag on your ear identifies you. I’ve seen the brochures about body donation. I’ve read the poem on the back of the pamphlet that encourages you to donate your body. I’ve read the sheet that you signed to donate your body. Did you think only of the nobility of donating your body, but never of the reality? Did you donate your body to spare your family the expense of the funeral? Would you have made the same decision if you had known what it meant to be dissected?

I made the first cut into your body and it was both daunting and exhilarating. But within a week, cutting and probing were routine. I skinned your face to examine the muscles that made you smile and frown. I used a saw to cut through your ribs and a chain to hold your ribs over your head like a trapdoor. I found your birth defects. I found what probably killed you. I found plaques of fat in your arteries and scars on your skin. I used a saw and chisel to take out your brain. I held your brain in my hands. I slit your wrists to look at your joints. I leaned on you too hard and accidentally broke a rib.

Older medical students give the younger ones advice about how to deal with the smell in the anatomy lab: cover your head so it doesn’t get in your hair, separate your lab clothes and your normal ones into different lockers, and wear two layers of gloves. Other students bring in air fresheners, the pine-trees tags that dangle from rear-view mirrors. Many students wear masks and one girl had to drop the course because the fumes aggravated her asthma. I know that you hadn’t expected your body to become something against which people protected themselves. You viewed it as a gift, and, in part, we view it as a hazard.

I expect that your decision to donate your body was a very personal one. But here you lie on a hard metal table, one with a hole to drain excess fluid and a bucket underneath to catch it, in an orderly row in a brightly lit room with thirty-two other naked and ear-tagged strangers. I hope we don’t disappoint you. We are all serious about learning and serious about taking advantage of the opportunity and privilege of dissecting another person’s body. But there is also levity and camaraderie. Stories and jokes are told over your body as we work. We’ve given you a name: Ethel.

Why do I feel the need to confess to you? I want to acknowledge what I have done, not that I feel any shame or believe that I have done anything wrong, but just to admit that you have helped me achieve a key step in becoming a physician. Beyond learning human anatomy, I have learned a great deal about myself. As I studied your body, I became more aware of the potential that lies inside me. I always thought that I was capable of taking another person’s life into my hands, making life-altering decisions, acting bravely to face challenges despite great risk. You’ve shown me that I am ready to do those things. As I tell you all that I’ve done, I realize how I would never have believed it myself several months ago. You taught me to become comfortable with death, to probe into new and unknown territory skillfully and meticulously, and to rely on my abilities. Each of us influences others throughout life, but few have such profound influence after death.

Why do I need to acknowledge that what has befallen your body is not what you expected? It is because through this you have taught me another great lesson: You have shown me that the ability to live and work with uncertainty is a crucial part of life and integral to being a successful physician. Each dissection brings uncertainty, which causes some students to grind to a halt and call for the instructor. But when I think about the uncertainty you overcame all through your life, culminating with your decision to donate your body, I realize that anatomy lab is as much about learning to chart new territory for myself as it is learning the anatomical structures. So I press on when I am not sure what I have found. I trust my ability to deduce my way through your body and I discover anatomical relationships that I would have missed had it not been for my uncertainty in searching for them. Only at the end, when I believe the mystery has been solved, do I call for the instructors. I no longer ask them to simply check my work. Now I ask how I should have approached and worked through the problem. You have taught me that uncertainty will be a fundamental part of my life’s work and my personal life. I must acknowledge life’s inherent uncertainty and use it to my advantage by becoming more careful, analytical, and thoughtful.

Despite knowing you so intimately in death, it seems ironic that I can only imagine you in life. If I had known you, I would have wanted to thank you in advance for your unselfish gift. You have given a total stranger one of his greatest experiences and taught him some wonderful life lessons. In hindsight, the poem in the body donation brochure now makes sense: Death can be as much a new beginning as it is an end. Each cadaver passes a torch to its students, imparting knowledge, introspection, and understanding of the challenge and importance of becoming a physician.

The author’s address is:
12 South Ann Street
Baltimore, Maryland 21231
E-mail: ryan.zimmerman@gmail.com
Mentoring

Nurturing clinician and physician scientists in an academic career

Herbert Y. Reynolds, MD

Although it offers some of society’s highest recognition, a career in medicine is arduous. This is especially true for those choosing clinical or basic research at an academic center. But the intellectual rewards and, often, financial security make the effort worthwhile. For a successful and satisfying career, the clinician or physician-scientist needs to be appropriately prepared, must progress through career milestones in a timely fashion, have some luck, and be rewarded at multiple stages in his or her career. Appropriate mentoring often helps sustain the initial enthusiasm present at the beginning of a career, and may help in devising strategies for continued success. It is true, however, that in the twenty-first century a faculty person may require more imaginative, innovative, and individualized help than before.

My thoughts about career guidance are not based on any special insight, other than what I have gleaned during an academic medical career including clinical medicine, education, research, and more than twenty-five years of medical administration. I have always appreciated the opportunity to give advice when asked by specialty trainees and faculty.

I have been immensely helped by and most grateful for the mentoring I have received.1–3 Now, as a senior physician, I want to encourage others who may have special expertise in mentoring to expand on my comments about the best ways to prepare, train, and sustain our replacements on medical faculties, especially physician-scientists.

The early phase

An accomplished subspecialty fellow just joining the faculty may feel capable of performing as a “triple threat”—for a while. Research momentum has begun, probably supported by a National Institutes of Health (NIH) career training grant in the mentored K-series that may phase into the R-series of research awards,4 or with a clinical investigator award obtained from a professional society or private foundation. Spirited teaching ability, possession of current clinical information, and good procedural skills are important currency for aspiring junior faculty. Recognition for teaching from students and house staff may have occurred, providing satisfying personal feedback and enjoyment. But any one of the following may portend problems for the aspiring academic:

- A department’s insatiable need for more clinical work
- A struggle for the protected time stipulated on grants

• Increases in teaching assignments
• The stress of beginning on the tenure track
• Heightened family demands.

Moreover, as young faculty witness the jockeying and competition occurring between more senior colleagues for any number of things, medical politics may become uncomfortable. The burden of educational debts and the greener pastures enjoyed by colleagues who have gone into private practice may compound tensions, and disenchantment with an academic career can develop.

At this early career point the young faculty member needs a good advisor, one with experience in guiding young investigators. Such a mentor should be identified to address issues and possibly intervene with a division chief or department chair. Once a comfortable relationship has developed, a sage mentor can save his protege's fledgling academic career by negotiating for better protected time, keeping research on track, helping to unload some committee assignments, or advising on family or personal problems. Unfortunately, a plentiful supply of versatile and willing mentors may not exist in most departments. Moreover, trying to link up a senior faculty member with one just joining the faculty, in the hope of establishing an ongoing mentoring relationship, may be ineffective. While the spontaneous choice of a mentor by a young faculty person can occur, that choice may not necessarily be the ideal one. Regrettably, a division chief or a chair can neither undertake to do all of the needed mentoring, nor expect to be successful with every challenge. Each unit of a department should devise a strategy to identify mentors and offer training to make them become more proficient.

The impact of mentoring on recruiting physician-scientists to pursue an academic career was assessed in a survey about career development of subspecialty fellows and junior faculty in U.S. and Canadian pulmonary and critical care medicine and neonatology divisions. Results compiled from one study showed that both fellows and junior faculty gave the highest rating to a mentor's availability to critique scientific work, and not to the mentor's availability to give advice about other components of an academic career. Most of the 531 respondents identified four to five persons as important mentors, including at least one mentor holding a PhD degree. Another survey of 122 junior faculty about their perceptions of mentoring found that fewer than half of them felt adequately mentored. Thus, all junior faculty may benefit from improved mentoring. However, although mentoring is perceived to be important in an academic career, a recent review concluded that the evidence to support this perception was not strong.

### Mid-academic career

Faculty members who have progressed well into mid-career may not seem to need further advice or guidance, but changes in circumstances and professional interests may be unnoticed and remain undetected until something unexpected occurs.

A desire to change career focus may affect even the most successful faculty person at the peak of prominence. Several examples illustrate the spectrum:

• A top clinical investigator wishes to switch into more departmental administration or into dean's office affairs
• A successful general internist, who is well published in evidence-based medical research, wants to fulfill an unrequited desire to train as a proceduralist and enter a demanding subspecialty fellowship
• A physician-scientist with good success in basic research, but whose likelihood of achieving tenure is uncertain, decides to leave a medical faculty and seek a different career path at the NIH in extramural program management.

Others may switch to industry, seek an administrative position in a medical society, or join an editorial office. Excellent, but very busy, clinical faculty may opt to leave for private practice, and a few may even choose to decompres a heavy clinical caseload into more manageable time and effort by seeing only selected patients in a "boutique" practice for retainer fees. Thus, at mid-career some faculty dropout is inevitable. Key contributing factors are anxiety about continuation of research grant support, becoming overextended, bitterness about academic fairness, or developing a sincere desire to change direction and do something different. At this point, what can a savvy mentor offer to disillusioned faculty, particularly those in research tracks, to prevent them from abandoning academics? Perhaps nothing, if the decision has been made and is irrevocable, but the mentor must continue to be supportive and encouraging.

For faculty who are physician-scientists, a mentor must offer realistic advice about how to balance all the academic demands and still find the time to remain active in research. Maintaining research funding, building a research team, remaining on the “cutting edge,” publishing in high-impact journals, and attracting trainees are important issues. As the NIH budget decreases and grant pay lines are lowered, obtaining federal funding is becoming more difficult. This pressure is causing more medical center investigators to weigh alternatives. To counter these pressures and the draining away from faculty positions, a mentor might petition a division chief or other administrative leaders to use discretionary funds to sustain research productivity during a period of grant application resubmissions. While becoming a "Young Turk" by election to the American Society of Clinical Investigation is no longer the mandatory scientific attainment that this society and others like it signaled in the past, this recognition may help with early promotion in the academic research track and indicate tenure potential. A mentor should make certain physician-scientist faculty are nominated for appropriate professional recognition.

A mid-career faculty member may try to take on administrative duties prematurely. Receiving a leadership position early in a career can be tempting. Some will want to position...
themselves for senior administrative leadership by pursuing an MBA or other advanced leadership training. These strategies are often encouraged by many institutions and some institutions consider them a requisite for departmental or school leadership. The goal should be supported, but timing needs to be considered. Such extra educational pursuits might be better undertaken earlier in a career when other responsibilities were less.

Mentors must also be aware that faculty members may be diluting their chances for recognition by the home institution by excessive travel. Too much traveling to present research, to do consulting, and to attend meetings can hurt an academic career, even if the extra income from honoraria seems important. Although it is exciting to be in demand, peripatetic faculty members can get distracted, lose research focus, or fail to maintain their medical skills. Lack of personal availability to see patients can cause poor continuity of medical care and can require other colleagues to pick up the slack. This often causes resentment and can affect morale in the department.

A mentor, while cautioning about some of these common pitfalls, might prefer to concentrate on urging the faculty member to maintain a successful clinical research career. Ways to collaborate with colleagues in a less competitive or intense local environment or to seek new scientific partners might be suggested. Taking a short, focused sabbatical to learn new research techniques is often desirable and perhaps a necessity for any investigator. Creeping clinical demands often have to be revisited. Clinical duties can often be better organized to create periods of unfettered time to think about research, write new applications, or assemble data, and write papers. Seeking a different academic job, which might involve a faculty promotion as an inducement, might seem to be either a solution or an escape. A promotion would be a positive, as would more money and space, yet many deterrants must be considered, such as the downtime of getting research started at a new place, and the effect on other careers in the family. This prospect of going elsewhere usually needs the mentor’s best advising effort. A mentor can be helpful in working through any of these scenarios that can snare mid-career faculty.

Later stage

The reality of attaining senior faculty status and the decisions it prompts require yet another perspective. Good health, continued vigor, joyful enthusiasm, confident self-image, new interests, and keeping up with developments in one’s field may delay the inevitable. Except for restrictions on holding certain administrative leadership positions, age is not a determinant in forcing retirement in academics or research. However, overstaying in a position can be a problem. Either or both colleagues and family members should give the word; unfortunately, they may not. A tough and frank mentor may be needed. Retirement can offer the prospect of many things that have been postponed, such as pursuing new educational interests, returning to neglected hobbies, traveling, or participating in community service and helping others. Continuing some medical and educational activities may be feasible. For example, one may continue to teach as a preceptor in physical diagnosis courses. Others give back to the community in different ways. Volunteering in a free medical clinic is a wonderful experience for many, especially for retired physicians. A final piece of advice: stay active and engaged, and cultivate a mentor whom you respect and who understands you. One is never too old to be a mentor or need one.

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The author’s address is:
DLD/NHLBI
Two Rockledge Center
6701 Rockledge Drive
Bethesda, Maryland 20892-7952
E-mail: Reynoldh@nhlbi.nih.gov
After the flesh was gone
they say her bones burned violet
before they crumbled.

Toad-eyed Diego wept
and warned the world, “She’ll clump into
your heart
and then she’ll eat it. She ate mine.”

And on the heap of white ash that had
been her
a steel rod of spine glowed red.

George Young, MD

The Cremation of Frida Kahlo
I almost engaged in fraudulent medical research. As a third-year pulmonary fellow, I conceived of a study while taking a research methods course. The design was flawless, accounting for all possible sources of bias. The experiment was randomized, controlled, and double-blind by natural design. Randomized controlled trials, especially blinded ones, are revered in the ivory tower of academia as the highest level of experimentation. Results are trusted and considered least subject to bias and mistakes.

Using statistical tables and newly-learned epidemiologic concepts, I realized that my sample size was going to be in the thousands. I needed help—a lot of it. I recruited twenty undergraduate students from various colleges in the area, whose primary responsibility would be subject recruitment. Soon, I had an army of eager pre-meds, willing to do my bidding. This came with a lot of unexpected heartache. Not only did I have to collect and interpret my data, I had to manage and contain a group of busy, pre-medical, pre-occupied, and over-committed kids. As the study gained momentum, I expended enormous amounts of energy motivating, organizing, and inspiring my research assistants to continue to collect reams of data, usually from uninterested, unwilling subjects. Qualified subjects were few and far between. It was grueling work. The data dripped in like honey from a cold fridge.

Although I praised each of the research assistants when they brought in their daily kill, they quickly became discouraged and unenthusiastic.

Even with our focus on team effort, it was hard not to notice who the “stars” were. My most productive research assistant was a pre-med student from a local high-tier university, who was hoping to be accepted to the medical school where I worked. He seemed always to be willing, even eager, to take the least desirable and largest number of shifts, and his data collection rate was significantly higher than all of the other research assistants put together. Over spring break, he enlisted his brother, home from an East Coast prep school, for data collection. The brother’s subject response rate was similarly impressive.

One night, about nine months into data collection, I was making follow-up calls for some of the research assistants who were on spring break. I went through a pile of The Star’s questionnaires and noticed some irregularities. Most telephone numbers were not in working order, and the occasional subject I did reach had no idea who I was and why I was calling. Shaking, with my husband at my side, I began a random audit of The Star’s subjects: Thirty out of thirty of his latest batch of questionnaires had been fabricated. They were fraudulent. This type of situation had not been covered in my textbooks.

I was devastated, enraged, panicked. My study had been violated, to what degree I did not know. Two years of painstaking work, my first attempt as a researcher, and nineteen young people’s commitments potentially wasted. I called the culprit, who initially denied my accusations, but then blurted out his confession with tears and threats of suicide. I remained on the phone with him for several hours until he finally agreed to go to the student health center. After hanging up with him, I was left with my binders of three thousand subject questionnaires. My husband and I stayed up much of the night trying to chart next steps. I alternated between deciding to abandon

Jessica Nutik Zitter, MD
The author (ΩA, Case Western Reserve University, 1992) is an assistant clinical professor at the University of Medicine and Dentistry of New Jersey.

Unintentional fraud
An oxymoron?

Data dripping in like honey from a cold fridge
any attempts for a career in academic medicine, to blaming the pre-med student, to blaming myself for my naivete and inexperience.

One bad apple did not ruin the entire basket

Over the next six months, I completed large random audits of all of the other researchers’ work, telephoning hundreds of subjects to ensure that they had truly participated. Luckily, there had only been one bad apple. I discarded all of The Star’s “subjects,” and filed a complaint with his university’s ethics committee. I called his brother’s school on the East Coast and alerted them to his behavior. We continued data collection and ended up with an exciting study that was later published in *JAMA*.

Who’s to blame? The student for his unethical, amoral behavior? Me for my naivete and inexperience? My training program for focusing on study design and methodology before data management and ethics? Society for over-trusting the word of science and physicians? Medical journals for not performing their own quality assurance and accepting manuscripts on the honor system?

This student clearly had an underdeveloped ethical foundation, which allowed him to cross the line of professionalism. His goals were purely opportunistic and he put his own advancement above the goal of discovering truth through science. This type of person can be found in all walks of life, taking advantage of weaknesses in systems for self-advancement. However, we need to make sure that our systems are designed to prevent this type of practice. We need to discourage and punish this type of behavior in all academic institutions, from elementary school through masters programs. If The Star and his brother had known that they could be prevented from graduating or that their records would be forever blighted by this behavior, they might have been deterred. They both graduated with honors several months after these events, the ethics committees of both schools claiming that these projects were not under their purview for oversight.

Training programs for new investigators must teach data management and quality assurance techniques alongside strategies for sample size and power calculations. If I had planned and publicized weekly random audits into the protocol, or had required subject signatures at the bottom of the questionnaires, this disaster might have been avoided. If I had required that all data collection sessions be attended by at least two researchers, it might have been nipped in the bud. There are countless other safeguards I would have taken if I’d been prepared for the possibility of fraud.

The unprofessional Star gets an MBA

The story does have a happy ending. The study was published. The Star, although allowed to graduate from college, was apparently dissuaded from pursuing his dream of being a cardiac surgeon. He got an MBA instead. I’ve continued a career in academic medicine and have learned firsthand how to provide real quality control for my data. I have taken a personal interest in ethical conductance of research, and I talk to residents and medical students about my experience.

Fraudulent research, although hopefully rare, weakens the institution as a whole. We can and should hold individual researchers accountable for their lack of morals, but we bear a responsibility as an academic community to make sure that systems are in place to discourage fraud at all levels. Although I obtained an MPH and took a series of advanced courses on research design and epidemiology, I received no formal training regarding data management and ethics in research. Managing a lab or research assistants complicates matters, because you have other people’s motivations, organization, and ethics to account for. External review and audits of data should be built into every research protocol, for everyone’s protection, but mostly for maintaining the integrity of our research compendium.

The author’s address is:
65 N. Wyoming Avenue
South Orange, New Jersey 07079
E-mail: zitterjn@umdnj.edu

*The Pharos* / Summer 2007
Recent article by Ellen Frank and her colleagues reports on the efficacy of Interpersonal and Social Rhythm Therapy (IPSRT), a therapy that attempts to limit the number and extent of clinical regressions of individuals with bipolar illness by regularizing their daily routines. Derived largely from interpersonal psychotherapy, IPSRT "focuses on the links between mood symptoms and quality of social relationships and social roles, the importance of maintaining regularity in daily routines, and the identification and management of potential precipitants of rhythm disruption." It also emphasizes attention to "grief for the lost healthy self," a mourning for the compromised healthy functioning caused by the illness. The therapy educates patients about the manifestations of bipolar illness, suggests behavioral interventions to alleviate specific symptoms (e.g., sleep hygiene to minimize insomnia), and provides help in addressing adverse events caused by the disease. It is administered both acutely and as a maintenance treatment.

IPSRT is based on the "social zeitgeber hypotheses." Zeitgebers are environmental cues (e.g., light) that help regulate the biological clock of an organism; zeitgeber events (e.g., the light-dark cycle of a twenty-four-hour day) keep circadian rhythms normalized. Cindy Ehlers, Ellen Frank and David Kupfer suggest that loss of social zeitgebers, such as one's routine responsibilities and contacts, can distort biological rhythms and, in turn, promote affective instability in vulnerable individuals. Studies of rhythm-disrupting life events support this theory, suggesting that the zeitgeber hypothesis may represent a crucial link between psychosocial and biological events.

In conjunction with pharmacologic management, adjunctive treatments such as cognitive therapy and psychoeducational programs have long proven beneficial to patients suffering from bipolar illness (e.g., by increasing medication compliance, decreasing the incidence of clinical episodes and hospital admissions, and enhancing psychosocial functioning). Frank and her colleagues suggest that their randomized study of IPSRT also qualifies it as a useful treatment for bipo-
lar disorder. Their findings demonstrate that patients in the acute phase of illness who received IPSRT “experienced longer survival time without a new affective episode and were more likely to remain well for the full 2 years of the preventive maintenance phase.” They assert in support of the zeitgeber hypothesis that the benefits were “mediated by the substantially increased regularity of social routines among subjects receiving IPSRT.” Moses Maimonides (AD 1138–1204) would likely have concurred.

Maimonides's two treatises on the regimen of health

The extraordinary scholar Moses Maimonides was regarded as the wisest physician in medieval Spain. His writings include ten medical treatises addressing such diverse topics as asthma, poisons and their antidotes, hemorrhoids, sexual relations, and the classification of hundreds of drugs and medicinal herbs. The eighth and ninth works in this series are Regimen of Health (circa 1193–1198) and Discourse on the Explanation of Fits* (circa 1199). Regimen of Health was written at the behest of the eldest son of Saladin the Great, Sultan al-Malik al-Afdal, who sought Maimonides's guidance for symptoms that included “feeble” digestion and constipation, as well as “the occasional occurrence of melancholy, evil thoughts, desire for solitude, and foreboding of death.”

Discourse on the Explanation of Fits, written in response to a later request by the sultan, is a compilation of highly detailed answers to specific questions posed by the chronically ailing sultan. The title is generally believed to refer to fits of melancholy because al-Afdar's various complaints are consistent with the neurovegetative changes common to chronic depression. Seemingly he had not adhered to the directives in Regimen of Health, which Sherwin Nuland attributes to the fact that he was too “wedded to habits that were physically, emotionally, and politically hazardous.” Fred Rosner shares the opinion, describing the sultan as a “frivolous and pleasure-seeking man” who “persisted in his indulgences” of “wine and women and warlike adventures against his own relatives and in the Crusades.”

Regimen of Health

Regimen of Health is a general discourse on health. The first two chapters discuss standard methods of medical treatment that were set forth in the teachings of Hippocrates and Galen. Chapter one reviews practices generally “applicable to all men” about such issues as diet (e.g., what and when to eat; the quality of foods), as well as what activities should or should not be associated with the taking of food (e.g., bathing, sexual intercourse, exercise). Chapter two presents a regimen for the sick when “there is no physician, or when, if available, the physician’s knowledge is not to be trusted.” It describes when “it is proper to relinquish the sick to Nature,” and when to apply “strong remedies” (e.g., phlebotomy or purgatives), how medications are not to be used if the sick can be managed by “regulating nourishment alone,” and why herbs, as opposed to “complex medicaments,” are the drugs of first choice when medication is required.

Chapter three specifically addresses the sultan’s complaints and presents a curative regimen. It contains a great deal of discussion about improving digestion, including directions for a proper diet and indications for the use of medications. Significantly, Maimonides emphasizes the importance of emotional issues in health maintenance. Noting that “passions of the psyche produce changes in the body, that are great, evident and manifest to all,” he advises they “be kept in balance.”

The physician should make every effort that all the sick, and all the healthy, should be most cheerful of soul at all times, and that they should be relieved of the passions of the psyche that cause anxiety. . . . It is the same for someone

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* Also known as the Treatise on Accidents, it is considered by many to be the fifth chapter of the Regimen of Health. The reason for the ambiguity about the title remains unclear.
who is overcome by grief and obsessions, or by terror of whatever is unnatural to fear, or by the diminution of satisfaction in what is natural for him to enjoy. In all of these, the skillful physican should place nothing ahead of rectifying the state of the psyche by removing these passions.\textsuperscript{9p325}

Suggested means for “restraining the passions” include “studying books on morals, [and] the disciplines of the Law” as well as “contemplation” to dispel distressing thoughts, such as the loss of wealth.\textsuperscript{9p26} Maimonides tells us that “thought regarding what has come and passed is of no value at all, and that sorrow and gloom about things that have come and passed are the occupation of fools.”\textsuperscript{9p26}

**Chapter four of *Regimen of Health* presents ‘advice that is beneficial in general,’\textsuperscript{9p27} and reviews recommendations of common matters associated with health such as diet, drinking wine, bathing, sexual relations, and the effects of climate. Additionally Maimonides emphasizes the importance of habit, which he views as “fundamental in the conservation of health and in the cure of ailments.”\textsuperscript{9p31} He warns against rapidly changing habits:

> whatever is customary should be maintained. Even if the accustomed thing is contrary to the principles of medicine, one should not leave it for what is determined by these principles except gradually and over a long time, so that one does not perceive the change. If one alters any of his habits all at once he will perforce fall sick.\textsuperscript{9p31}

**Discourse on the Explanation of Fits**

*Discourse on the Explanation of Fits* consists of twenty-two paragraphs, the first eighteen of which review treatments contained in *Regimen of Health*, and additionally support some recommendations suggested by other physicians. For example, Maimonides agrees that “steeping twenty drams of oxtongue in one Syrian ounce of wine and ten drams of rose water”\textsuperscript{9p33} is an excellent bedtime draught, noting that as “sleep deepens, anxiety departs, the digestion improves, and the superfluities are repelled.”\textsuperscript{9p33} And he concurs that “the use of ozymel of quince an hour after the meal, is correct; it is a good regimen to improve the digestion.”\textsuperscript{9p33}

But, strikingly, the twenty-first paragraph prescribes hourly activities for the sultan to be followed daily. The detailed instructions seem designed to relieve al-Afdal’s symptoms by regularizing his daily routine:

> I declare that one should always aim to awaken from sleep at sunrise or a little before that. Two or three ounces of syrup of hydromel should be taken at that time. He should wait thereafter for an hour and then go riding. He should ride leisurely, and then, without stopping, gradually quicken the pace until the members are warmed and the respiration alters. Then he should dismount, and rest until none of the changes caused by exercise remain on the skin of the body or in the respiration. After that, he should partake of one of the dishes mentioned previously. He should take some of the astringent fruits as has already been said . . . Then he should recline for sleep, and the chanter should intone with the strings and raise his voice and continue his melodies for an hour . . . until he sleeps deeply. . . . Physicians and philosophers have already mentioned that sleep in this manner, when the melody of the strings induces sleep, endows the psyche with good nature and dilates it greatly, thereby improving its management of the body. Upon awakening, he may be engaged for the rest of his day in reading whatever he wishes, or be attended by someone whose company he chooses. The best is the attendance of someone whose company is desirable because of his virtues, or the delight in beholding him, or his lightheartedness. All these dilate the psyche and remove evil thoughts from it.\textsuperscript{9p36}

Rosner points out that the sultan’s behaviors, such as his excessive drinking, reflect the fits of melancholy of the treatise’s title.\textsuperscript{7p127} However, he also notes other indulgences, such as womanizing and heightened aggressiveness in military campaigns. Like Nuland,\textsuperscript{8p209} I believe the spectrum of these behaviors suggest bipolar illness rather than major depression. (At a minimum al-Afdal suffered from recurrent depressions, often a prodromal pattern of bipolar disorder and sometimes representative of a clinical presentation in which hypomanic episodes go unrecognized.) Even granting that the position of sultan conveys a contextual basis for profligate behavior, *Discourse on the Explanation of Fits* provides some support for the bipolar hypothesis. At one point Maimonides discusses the use of different draughts for treating individuals with “hot temperaments” and “cold temperaments,” noting that “some who follow the same course as kings suffering from melancholia” can also have “a disorder that tends toward mania, that is rage.”\textsuperscript{9p36} Cognizant of the dangers of diagnosing “from minimal evidence provided in text from long ago,”\textsuperscript{8p210} Nuland nevertheless concludes that the substance and context of these two treatises by Maimonides support the belief that the sultan suffered from bipolar illness.\textsuperscript{9p329} I am inclined to agree.

**Maimonides—still worth reading**

*Regimen of Health* and *Discourse on the Explanation of Fits* offer a fascinating glimpse into the mind and character of Maimonides. His clinical acumen, breadth of medical knowledge, and meticulous attention to detail are evident—and still worthy of the reader’s appreciation. The treatises also reflect his well-recognized understanding of the importance of the mind-body interaction. Whereas the tradition of Hippocratic and Galenic medicine contained an unsophisticated grasp of the concept, noting indistinct influences of bodily fluids on temperament, Maimonides clearly articulated it. For example,
relating how “passions of the psyche” can produce bodily changes “that are great, evident and manifest to all,” he presents an unmistakable appreciation of psychosomatic issues:

you can see a man of robust build, ringing voice, and glowing face, when there reaches him, unexpectedly, news that afflicts him greatly. You will observe, that all of a sudden his color dims, the brightness of his face departs, he loses stature, his voice becomes hoarse, and even if he strives to raise his voice he cannot, his strength diminishes and often he trembles from the magnitude of the weakness, his pulse diminishes, his eyes sink, his eyelids become too heavy to move, the surface of his body cools, and his appetite subsides. The cause of all these signs is the recall of the natural heart and the blood into the interior of the body.9p25

More relevant to this discussion is Maimonides’s similar understanding of somatopsychic issues, as reflected in his detailed prescription of a daily routine designed to promote the sultan’s health. Viewed in the context of the findings of Frank and her colleagues,1 I believe that *Regimen of Health* and *Discourse on the Explanation of Fits* comprise an early articulation of the zeitgeber hypothesis, as well an appreciation of its relevance to the treatment of bipolar illness. There is a striking parallel between the process of IPSRT and Maimonides’s instructions to the sultan. It supports Nuland’s observation that Maimonides’s aim was “clearly to regulate the day so carefully that the patient is always occupied, distracted from the obsessive thoughts” that may aggravate his emotional state.9p209 In fairness, Maimonides’s treatment is not concerned exclusively with social zeitgebers; his was a biopsychosocial approach to medical care.10 Nevertheless, the coincidence of his advice to al-Malik al-Afdal and IPSRT underscores a long understood need for broadly-based care of individuals with bipolar illness, and the aphorism that plus ça change, plus c’est la même chose.

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The author’s address is:
5410 Connecticut Avenue, NW, #109
Washington, DC 20015
E-mail: sgreen.georgetown@verizon.net
Lunch time means different things to different people. Some virtuously do without lunch altogether, pretending that this somehow both contributes to health and bolsters the ego, while freeing up time for other things. Some choose to eat in the hospital cafeteria, partaking of the customary sumptuous delicacies.

Among this latter group there are those who choose to dine alone, often with the morning newspaper or the current issue of The Pharos. Some choose to eat sitting among the students or young house officers on the assumption that we instructors and mentors will be democratically and generously sharing our knowledge and experience with them. (Actually, our presence often makes them uncomfortable.)

Many of us, however, choose to spend this hour or so in the faculty dining room, where we can chat amiably with our peers and share stories, ask questions, propose what may be absurdities to be shot down or—rarely but occasionally—get a possible clue to a problem which has been perplexing.

Some fifty years ago I was recruited from high academia at Columbia University’s College of Physicians and Surgeons to start up a Division of Rheumatology and a research laboratory at Mount Sinai Hospital in New York City. While much of my research effort was devoted to the mechanism of action of the recently discovered cortisone, my major concern was with what we called “rheumatoid factor.” The science of immunology was a toddling infant. Nevertheless, I was determined to discover what there was in the serum of seventy percent of patients with rheumatoid arthritis that had the capacity to agglutinate sensitized sheep cells (first reported by Waaler in Norway in 1943 and later by Rose, Ragan, Pearce, and Lipman in 1946).

The process of “sensitizing” the sheep cells involved going to a large-animal center and bleeding a sheep, then injecting a horse with the blood, waiting six weeks for the horse to develop antibodies, then bleeding the horse to collect its serum, bleeding a sheep again to get fresh erythrocytes and coating them with the antibody-laden horse serum.

This was a daunting and dangerous task and I needed a research fellow who would be willing to “learn” the process by doing it for me. I recruited a senior microbiologist from Israel, Jacques Singer, who for family reasons wished to relocate to New York. I taught him the sheep-cell test and set him to do the blood collection.

Jacques didn’t like the process any more than I did. The two of us would sit in the laboratory and analyze just what it was that we were doing. The easy part would be to eliminate some of the animal steps. One day at lunch in the faculty dining room, one of the infectious disease specialists asked if any of us had any use for some outdated Red Cross pooled human gamma globulin (which was used at the time for polio prevention). Singer and I grabbed it and found that it coated sheep cells admirably, making the step involving the horse unnecessary, much to the relief of our
The late night dinner

As I reviewed Dr. Plotz’s manuscript, my thoughts immediately turned to what was possibly the most important learning experience of my days as a house officer at Yale over fifty years ago, the late night meal in the hospital cafeteria. The fact that it was free is not relevant now, but was important then.

The late night meal at Yale was served from about 10:00 PM to 12:30 AM. Nurses coming on the 11:00 to 7:00 shift and those going off the 3:00 to 11:00 shift attended in some abundance, a fact of social importance at the time. Most important, house officers from all clinical disciplines were there. Since we were in the hospital every other night and every other weekend, roughly half the house staff was there every night. Not only did we indulge our appetites for food, we exchanged important medical, intellectual, and scientific information. There were informal consults and follow-ups, pearls passed on from attending rounds in many specialties, and reference to articles recently read in medical journals, most often the New England Journal of Medicine, everyone’s gold standard of up-to-date medical information, then and now. The latter was, in a way, a form of upmanship and to those of us who were residents in Surgery with little time to read, evidence that the information dropper, most often a resident in Internal Medicine, did not have enough to do. More likely, it was just an early separation of the cognitive from the noncognitive types.

These informal get-togethers, when added up over the years, were sources of medical information important in both quality and quantity. They are gone and have not been replaced. Our (Stanford’s) hospital cafeteria opens at 7:00 AM and closes at 7:00 PM. That may be suitable for the eighty-hour work week, but provides no opportunity for the important exchanges that took place at the late night meal in the bad old days. How ever do house staff learn in the modern era?

James B. D. Mark, MD
(AQA, Vanderbilt University, alumnus, 1974)
Stanford, California
Doctors have not been featured very much in recent movies, and when they appear have been mostly portrayed harshly. This is in sharp contrast to earlier times. Richard Malmheimer estimated in 1988 that doctors were characters in half of about eight hundred films made in 1949 and 1950 but in only twenty-five cases were they portrayed as bad persons.\(^1\) Revisit with me two previously lost 1930s RKO films in which doctors are the central characters. Like Meet Doctor Christian, both are unalloyed paean to the selfless country doctor who goes out in all kinds of weather and gets paid in potatoes, thus setting the stage for paying primary care doctors peanuts compared to their specialist brethren. Dennis Millay, the programming director at Turner Classic Movies (TCM), was part of a team that found and preserved them. Not yet available, they will be shown on the TCM network throughout 2007. The films show the growing importance of specialists and big medical centers, as well as the devastating effects of epidemic diseases and the hazards of childbirth. They can be seen as sociologic equivalents of archaeological digs, showing how far we have come in the provision of medical care, good antidotes for those who like to whine about how bad things are today. They are also affirmations about the need not to forget the human aspects of our patients amid all our scientific progress.

**One Man’s Journey (1933)**

Starring Lionel Barrymore, Joel McCrea, May Robson, Dorothy Jordan and Frances Dee.


Lionel Barrymore, who later played Dr. Gillespie while wheelchair-bound with rheumatoid arthritis in the Doctor Kildare films, is Dr. Eli Watt, who has returned with his six-year-old son Jimmy (Buster Phelps) to his old hometown. Once considered the most likely to succeed, he is now a destitute widower, whose wife died in childbirth. He borrows $250 and hangs up a shingle. His dinner is interrupted by McGinnis (David Landau), who asks him to go and deliver a baby in return for two sacks of potatoes. Dr. Watt delivers the baby, but when told that it’s a girl, McGinnis complains that girls are no good on the farm. Dr. Watt tells McGinnis that his wife was too far gone to save, and the farmer tells the doctor to get out before he kills him, gives him the baby, and throws his bag out the door. With the help of Sarah (May Robson), an older widow, Dr. Watt raises his son and Letty, but on her fourth birthday, the father comes back for his daughter.

Dr. Watt continues to serve the indigent, although his son wonders why patients don’t call during the day. The doctor gives patients money to pay for X-rays even though he doesn’t have enough to pay the mortgage. Then smallpox appears. Saying that “smallpox thrives on dirt,” the doctor tells people to scrub everything down, including themselves, and vaccinates everyone in the town, using a church as his clinic. Jimmy now grown (Joel McCrea), says he wants to be a doctor. Dr. Watt replies, “Be a specialist; don’t be an old country hack like me. I wanted to do research work in neuropathology but I couldn’t afford it.”

A few years later, Letty’s (Dorothy Jordan) drunken boyfriend Bill (James Bush), the son of the banker, crashes his car after she had reluctantly agreed to have sex with him. Dr. Watt administers first aid to the young man’s broken arm, then sends him to the nearest hospital where Jimmy is interning and Dr. Babcock, a general surgeon (Sam Hinds), comes from New York to do the surgery. Afterwards, they have a smoke (as they usually do after operations in ’30s movies) and Jimmy commends the surgeon, who deflects the praise, saying that it was the quick work by his father that saved Bill’s “arm and his life.” Watt says he’s just been a backwoods doctor for nineteen years and that every doctor should go back to school every five years. Dr. Babcock invites him to go to New York to study general surgery and neuropathology but Dr. Watt says that he’s too old and, besides, he is sending his son to Vienna for two years. As I note in my book, Vienna was a favorite place for doctors to go to for postgraduate medical training in ’30s and ’40s films (see Men in White, Dr. Monica, King’s Row and Miss Susie Slagle’s).\(^2\)

In a minor subplot, young Dr. Jimmy Watt returns to the hometown and falls in love with Joan Stockton (Frances Dee). She becomes tired of his always going to meetings to advance his career and tells his dad that she can’t marry him “because he isn’t kind, like you. He’s like a machine and it’s hard to love someone like that.” The elder Watt says that Jimmy never had a mother and asks her to reconsider. In another subplot, as is the case in films of that era, Letty’s one night of passion leads to a pregnancy. So when the banker balks at paying Watt a fee, the doctor tells him that he must permit Bill to marry Letty or he will have to report the circumstances of the accident to the police.

Years later, Letty gets sick and faints after seeing her husband flirting with another woman at a New Year’s Eve party. Jimmy operates, but Letty remains unresponsive, and he calls Babcock and another specialist from New York. Both declare that there is nothing they can do. Jimmy says, “I hate to lose this case.” His father replies, “It isn’t just a case. It’s Letty. She doesn’t want to live.” He then asks permission to see her and tells the distraught Bill, “This has nothing to do with doctoring. She has something that hurt her in the heart. She loves you so much.” Bill admits that he was having an affair and that Letty knew. Dr. Watt takes their daughter into the room and she says, “Wake up, Mommy, I love my Mommy” and wouldn’t you know, Letty wakes up and Bill tells her how much he loves her and how sorry he is, which restores her will to live.

The capper is that the son asks the renowned visitors to stay for the county medical society dinner and Dr. Babcock,
whose books Watt used, is introduced by Jimmy as the chief of the largest medical center who has honored them by attending. Babcock says, “The real guest of honor is a greater physician than I have ever been. He has labored without glory, without profit, in an obscure nook in our vast American scene preserving the one thing that modern medicine with all its scientific advances has woefully neglected, the wisdom of the human heart, the greatest therapeutic force at the command of a physician.”

Dr. Watt is stunned. “I’m just an old country plug trying to do the best I can. I had to use horse sense.” Jimmy finally gets it, and goes over to his Dad saying, “I too want to honor my father. I learned something from my father today. He is a great physician.” Finally Dr. Watt gets to take time off to marry Sarah and they are off to Niagara Falls, mimicking another 1933 film, Doctor Bull, directed by John Ford and starring Will Rogers as a veterinarian turned selfless country doctor who also is led to the altar at the end.2

Jimmy also gets it with regard to neglecting Joan and they marry. This mirrors the real life of Joel McCrea, grandson of a stagecoach driver and a gold prospector. Called Mr. Nice Guy by all who worked with him, McCrea avoided Hollywood glitz and followed Will Rogers’s advice to save half of whatever he earned,3 managing to become a multimillionaire. McCrea and Frances Dee, who played Joan and whom he had met on a previous film, were married one month after the release of One Man’s Journey. McCrea died at eighty-five on their fifty-seventh anniversary,3 and she lived to be ninety-four, a real-life Hollywood ending.

References


A Man to Remember

Starring Edward Ellis, Anne Shirley and Lee Bowman.

The only known surviving copy of the film was located in the Netherlands, so the preserved print has Dutch subtitles. A remake of One Man’s Journey, and also adapted from Failure, the novel by Katherine Haviland-Taylor, it deviates enough to have been named one of the ten Best Films of 1938. This one opens in Westport, with the flag at half-mast. A funeral procession led by a band winds down Main Street lined with people who remove their hats. A visitor asks “Did somebody die? Was he important?” “It all depends,” someone replies. It turns out to be the dedicated family doctor.

The scene shifts to a lawyer’s office, where three people to whom the doctor owed money are gathered to review his estate, contained in a small strongbox. One says that, even though he gave the town $40,000 to build the only hospital it ever had, he wouldn’t get the kind of recognition the doctor had. Another says it just goes to show the more shiftless you are, the greater the public likes you. The other says let’s open the box; Doc would have wanted us to get our money. As the lawyer does, each letter or note tells a story. The first involves the return of Dr. Abbott (Edward Ellis) in 1919 with his son Dick to his hometown, which the chamber of commerce calls the Paris of the Midwest. The next few scenes are the same as in the original leading up to the doctor delivering a girl and...
the farmer, here named Johnson (John Wray), saying "girls are for people who can afford them." When Dr. Abbott tells him that his wife died, Johnson slugs him and throws his bag out the door even though the doctor tells him that his own wife died in similar circumstances. In this film, the father places the baby on the doctor's doorstep and leaves town. Dr. Abbott cares for the indigent and gets paid in potatoes, a pig, and promissory notes. When he saves the wife of rich banker Howard Sykes by performing an appendectomy in their home he submits a bill for one hundred dollars. Sykes calls it "good pay for four hours work," and says that he knows that the doctor has different rates for the poor and the doctor settles for two dollars.

As in The Citadel and Meet Doctor Christian, the doctor fights for a public sewer and safe water supply, as well as for a hospital. Sykes's son George (Granville Bates) gets drunk and takes Dr. Abbott's foster daughter Jean (Anne Shirley) for a joy ride and when she tells him to be careful, he stops and playfully takes out a gun, which goes off, wounding her in the arm. Dr. Abbott saves the arm, and tells the elder Sykes that the price for him not reporting it is for Sykes to donate money for the hospital. The hospital dedication scene, as Dennis Millay points out, seems to have influenced Orson Welles in Citizen Kane. Sykes gets back at the doc by saying that only doctors who have had postgraduate training in the past twenty years can practice there. So young Dr. Dick Abbott (Lee Bowman), who was sent by his father to study neurology for three years in Paris (the second favorite movie postgraduate site), gets appointed to the staff.

Dick tells his father to go to Paris to study for a year, but the elder Dr. Abbott is looking forward to adding his son's name to his shingle. However, Dick has an offer to be a partner with another doctor and make money. Doc tells him, "Money never bothered me very much, neither the money I owed nor the money that was owed to me." Dick says he wants to make money to help him, and not for its own sake. "Neurology is a new line. People will go for it." Dr. Abbott asks, "What about those who can't afford it?" Dick replies, "I'll take any patient you send, for nothing."

Dick moves out of his father's house because appearances matter. Then he gets invited to go to New York and asks his father to look at his new car saying, "If you're going to succeed as a doctor these days you have to put up a little front." When the son leaves, the father goes to lie down on couch with "heart trouble." He rebounds quickly when Mr. Johnson returns, not to claim Jean, but to give the doctor three thousand dollars. He has turned his life around, "got hitched again, had two more kids, both girls," and figures he owes the doctor that much for taking care of Jean. Dr. Abbott only takes it because he needs it, and decides to apply to go to Paris for training.

The most interesting part of the film begins when Doc examines four children and, after looking in their throats and checking his textbook, diagnoses infantile paralysis and orders a quarantine and the cancellation of the county fair. Sykes, concerned about losing the revenue the fair will bring, says Doc can't prove it, and that if he were an ordinary man, it would be a "hunch," but because he's a doctor it's a diagnosis. The newspaper editor won't let Doc warn the citizens, so he recruits kids to bike around town with flyers. When he returns home, it's crowded with kids and mothers. He sprays their nostrils (see below for rationale), quarantines the sick, and tells the others to stay home.

Dick takes issue with his father, saying "If you're wrong, it will destroy our reputation and destroy the confidence of our patients. It's unethical. You're spraying children who are not your patients. The county medical society is stirred up about
it.” The son goes off to a meeting where the board is going to discuss suspending Doc’s license. After he leaves, Doc tells Jean, “He’s right about the ethics. I’m hoping in spite of myself that it is infantile paralysis.” When the board votes to suspend his license, Dick defends him saying “The foundation of the profession was built on mistakes. Some of the greatest doctors made the greatest errors and learned from them.”

Suddenly a doctor comes in to announce that six cases of infantile paralysis have been diagnosed in a nearby town. While the surrounding jurisdictions pile up cases, Doc’s town gets no further cases. When the epidemic is over, Dr. Abbott gets his long-anticipated letter from Paris, which turns out to be a rejection because he doesn’t have two years of post-graduate training. A large crowd comes to his house, led by a minister who brings a scroll with four thousand signatures acknowledging that although Doc didn’t make money, he earned his patients’ love. Dick says, “You have taught us all something not just about medicine but about humanity,” which was big in ‘30s films. He also announces that Doc has been elected president of the board of medicine. Dick decides to move back in and takes his evening house call. Jean joins him and makes him take his dad’s car, not his fancy one.

The scene reverts to the lawyer’s office where he opens an envelope containing the three thousand dollars that Johnson gave him, and read the accompanying note: “I knew you three vultures would be the first to crawl over the carcass. There’s $473.63 left for Richard and Jean, and they know how much is coming to them. Until I see you all in eternity, I am your humble servant, John Abbott, MD.”

Addendum

I had no idea what Doc Abbott was doing with the spray until I read the following excerpt from an article by Christopher J. Rutty, PhD, of the Health Heritage Research Services in Toronto entitled “The Middle-Class Plague: Epidemic Polio and the Canadian State, 1936–1937,” originally published in the Canadian Bulletin of Medical History 1996; 13: 277–314. [Reference numbers have been removed from the article excerpt. You can read the entire article, with references, at: www.healthheritageresearch.com/MCPlage.html#Prevention%20&%20Treatment%20Methods.]

Prevention and Treatment Methods in Canada—“Paralysis Nose Spray: Just Squirt and Smile”

During the polio season of 1936 widespread enthusiasm developed around the prophylactic potential of nasal sprays based on the prevailing idea that the portal of entry of the poliovirus was the olfactory nerves of the nose. Interest in the chemical blockade of the nasal mucosa first emerged in 1934 with attempts to protect white mice against an intranasal inoculation of equine encephalitis virus with a tannic acid solution. Similar experiments were conducted with as many as 150 different solutions on mice using the St. Louis type of encephalitis as a “feeler” for polio research with monkeys. A picric acid solution was eventually settled on, and in the summer of 1936, Dr. Charles Armstrong of the U.S. Public Health Service advocated that such a spray be given a human field trial based on monkey experiments and the repeated spraying of himself “and a small group of volunteers without apparent ill effects.” That summer a serious polio epidemic in Alabama presented an opportunity for such a field trial. Federal and state health officials had hoped it “would be a test by and under the [medical] profession,” but it soon became, “largely through the activity of the people themselves . . . a test by the masses, largely uninstructed, with all the many variations of method which such a procedure implies.” The U.S.P.H.S. issued a statement on the nasal spray which stressed that “home-made concoctions are not favored.” Also, “early applications at least should be administered by a physician.” This statement was published in the Manitoba Medical Association Review in September 1936 during the peak of the province’s polio epidemic.

The most significant problem noted in the [1936] Alabama nasal spray trial seemed to be technical, with the spray not reaching high enough into the nose to be effective. A long special tip was thus needed on the atomizer which could only be inserted by a professional nose-and-throat specialist. Furthermore, experiments using a zinc sulphate spray on monkeys reported in June 1937 suggested that this was more effective than the picric acid spray and was worthy of a human trial. In Ontario, parents grew desperate for any kind of preventive measure as the 1937 epidemic spread and news of the potential value of the nasal spray generated increasing demands that it be given by private physicians. Such demands were stimulated by widely-quoted press statements from American spray enthusiasts, such as noted virologist Dr. Thomas Rivers. In August 1937 he recommended: “If I had a child in an area where poliomyelitis appeared, I would take my child to a good otolaryngologist and ask him to apply the spray in the manner set forth by Dr. [Max] Peet,” who had developed the newer treatment. Despite the caution of some MOHs, doctors began offering the spray and considered it “both safe and cheap.” A London, Ontario doctor provided the press with the spray’s formula and application procedure. Newspapers quickly picked up the spray story and even reported that some desperate parents were spraying their children’s noses with salt water. Other physicians were not so sure about the spray, one warning that “until we have definite proof that children contract the disease through the nose,” there was “no point in using the spray, which [was] difficult to administer, uncomfortable and possibly dangerous.” Despite such controversy, physicians were soon overwhelmed with calls from parents wanting the children treated with the spray.

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

11 Hickory Hill Road
Cockeysville, Maryland 21030
E-mail: pdans@comcast.net
Reviews and reflections

David A. Bennahum, Book Review Editor

Narrative Matters: The Power of the Personal Essay in Health Policy
Fitzhugh Mullen, Ellen Ficklen and Kyna Rubin, editors
Baltimore, Johns Hopkins University Press, 2006, 293 pages
Reviewed by Eva Orlebeke Caldera, JD

In accepting the 2006 Nobel Prize in Medicine, Turkish novelist Orhan Pamuk described the writer’s vocation this way: “A writer is . . . a person who shuts himself up in a room, sits down at a table, and alone, turns inward; amid its shadows, he builds a new world with words.”¹ In the essay collection Narrative Matters, thirty-eight different authors with varying experiences and perspectives in the world of American health care shut themselves up in a metaphorical room, sit down at the writer’s table, and bear witness to the challenges and frustrations of giving and receiving medical care in today’s health care environment.

Through their personal narratives, these writers seek to share hard-won insights into the complex world of medicine, and through the power of their personal testimony, they aspire to alter perceptions and policies—to build a new world with words. Unlike the writer of fiction, however, the contributors to this book (many of whom are already familiar names to readers of medical journalism and memoirs) are engaged in building a world that is not fictional but real—the world of health care and health policy. The narratives they offer are intended both to identify gaps and failures in our current approaches to health care delivery and to advocate practical solutions to a wide range of pressing problems—from racism to health care disparities to end-of-life decision making.

What unifies this book, despite the wide range of issues covered and the diverse voices of its many contributors, is the earnest and soul-searching quality of so many of the pieces. Each of the essays conveys a sincere effort to shine light on a difficult issue that its author has personally struggled to understand and to solve for himself or herself, for a patient, or for a loved one. In documenting their struggles, these writers reveal themselves as human beings—parents, friends, children, spouses—who directly experience the frustrations of what Abraham Verghese, in his foreword to the volume, labels the “mess” of health affairs in America today.

Tying these various essays together is the editorial vision of Fitzhugh Mullen, Ellen Ficklen, and Kyna Rubin, who in 1999 oversaw the launch of the column in the journal Health Affairs that is the source of the essays in this book. Likewise entitled “Narrative Matters,” that column was premised on the insight that “the personal narrative could bring light on a difficult issue that its author has personally struggled to understand and help focus policy deliberations.”² In selecting the forty-six pieces (including three pieces of short fiction) to be published as “narrative matters,” the editors looked for writing that both conveyed a clear message and told a compelling story that would be representative of the experience of many others. The success of the column inspired the publication of this book, which includes a selection of pieces organized around recurring themes—“The Maddening System: Frustrations and Solutions,” “Trouble in the Ranks: Professional Problems,” and “Drug Resistance: Battling Undue Influence,” to name several of these thematic chapters.

The editors are clearly committed to harnessing the power of individual stories to shape and enliven health policy debates. At the same time, they worry about the “human hazards of subjectivity.”³ The book opens with a cautionary chapter pointing out the risks associated with policies shaped by anecdotes as opposed to evidence. An essay by former Massachusetts state legislator John E. McDonough discusses his experience with “Using and Misusing Anecdote in Policy Making.” Another piece, “Out of the Closet and into the Legislature: Breast Cancer Stories,” by communications professor Barbara Sharf, celebrates the role of women’s stories in changing the politics of breast cancer, while cautioning that stories can also interfere with objective assessment of treatment options.

Although these concerns about legislating by anecdote are legitimate, they are not necessarily the most important lens for viewing the narratives that follow this opening chapter. The real strength of this book lies in the editors’ choice of many pieces that in the words of the writing instructor, “show, not tell.” The best of these narratives are persuasive not because they marshal evidence and arguments for a policy position, but because they give voice to an impulse to humanize medicine and to find honest ways of talking about its daunting challenges.

To that end, many of the authors in this collection share candid and soul-searching stories of providers and patients confronting limits—their own and those of the larger health care system.
Jerald Winakur’s brilliant and wrenching essay, “What Are We Going to Do with Dad?” examines systemic issues in caring for the growing elder population through the intensely personal lens of his love for his aging father. Winakur’s willingness to pierce the physician’s professional veneer, revealing his own vulnerability—as physician, as son, as member of the aging Baby Boomer generation, makes this piece stand out, both as a compelling narrative and as a highly effective piece of advocacy. He offers up unforgettable images of himself spending long nights in the hospital trying to protect and calm his ill, agitated, and disoriented father—“Finally, so that he could get some rest, I got in the bed with him and held him, comforting him as he once—in a long-ago life—did for me.” p271 Later, Winakur even allows himself to fantasize, if only briefly, about how he might use the physician’s tools to bring closure to his father’s (and his own) suffering.

Also impressive in their honesty about difficult—and often unspoken—societal issues are several of the pieces included in the chapter, “Disparity Dilemmas: Stories on Race and Ethnicity.” One physician, Neil Calman, describes his struggle to admit and to overcome his racial prejudices and preconceptions in treating minority patients in an urban clinic; his essay, entitled “Out of the Shadow,” is a personal meditation summed up by the quotation from Pearl S. Buck that serves as an epigraph to his piece: “Race prejudice . . . is a shadow over all of us, and the shadow is darkest over those who feel it least.” p196 Two other physicians, African American Vanessa Northington Gamble and international medical graduate Alok Khorna from India, write of the shadowy mix of visibility and invisibility that they experience as minority physicians. Titled “Subcutaneous Scars” and “Concordance,” respectively, their stories offer very different perspectives and personal strategies for thinking through the obstacles of race and racism in health care.

Not all the pieces in Narrative Matters dwell on the dilemmas of doctors facing intractable social problems. The voices of patients, families, nurses, and other providers are heard here as well. Patients and families recount their experiences on the receiving end of a seemingly illogical and dehumanizing system that repeatedly stands in the way of obtaining a much-needed wheelchair (Andrew Batavia in “Of Wheelchairs and Managed Care”), or appropriate long-term care (Deborah Stone in “Shopping for Long Term Care”), or adequate mental health treatment (Paul Raeburn in “Acquainted with the Night”). Several nurses reflect on the untenable position they occupy between needy patients and the unrelenting pressures of cost-cutting and bureaucracy; their frustration is abundantly clear in titles like “Accountable but Powerless” (Barry Adams) and “Leaving Nursing” (Ray Bingham).

Still other stories are noteworthy because they offer positive and affirming stories of health care professionals in the role of sincere and committed problem solvers. Janette Kurie’s “Where’s David?” tells of a team of family practice providers in a small community clinic who observe a strong correlation between frequent no-shows for pediatric appointments and cases of child abuse and neglect. This observation, which begins with a chart review and follow-up for one child with a string of missed appointments, becomes the impetus for a new program at the clinic in which daily chart reviews are used to identify children and families in need of help. Told in a straightforward and unassuming manner, this story of a seemingly simple chart review process is a story of hope—hope that health professionals can develop creative solutions to problems and make a difference in individual lives. Likewise, Darryl Williams’s “La Promotora” describes the improving outlook for health care along the impoverished U.S.-Mexico border, achieved through a program to empower local women to serve as health outreach workers in their communities.

This kind of hope—that positive change is possible and that stories like these can spur such change—is found throughout Narrative Matters. As the title announces, stories do matter. Even when some of the contributors express frustration and disappointment, it is seldom because they have given up. Rather, they are writing because they believe that sharing their experiences in this way will contribute to bettering the health care system. As Verghese, himself a noted physician-author, aptly observes in his foreword, they write “to bring about a healing,” so that “even when writing can’t change the root causes of our malaise (an aging population, rising health care costs, decreasing reimbursement . . .), what it can do is acknowledge the disquiet.” ppx–xi Through their stories, these medical professionals and others involved with health care grant us the privilege of sharing their experiences and perspectives. They invite us into the rooms where they turn inward to reflect, to nurture their own humanity, and perhaps to build a new world with words.

References

Dr. Caldera is associate director of the Institute for Ethics and research professor at the School of Law at the University of New Mexico. Her address is:
University of New Mexico
MSC11 6095
Albuquerque, New Mexico 87131-0001
E-mail: ecaldera@salud.unm.edu
What are we to make of it?—
syphilitic spirochetes
spinning in his brain, creating some wild delusion,
or a moment of clarity.

Turin, Italy, 1889. Cold, brilliant day.

And Nietzsche,
bushy-haired, deep eye-wells red, with a huge mustache,
walking through the Piazza Carlo Alberto, hears
hoof beats on the cobblestones,
sees an old horse, eyes wide, head thrown back,
being whipped by a coachman,
and runs,
throwing his arms around the arched neck of the horse
(like a new moon embracing the old)
and, weeping, whispers something in its ear.

There are birds of light in the air

and irony:
this Greek scholar, the most arrogant of men whose credo
is “the will to power,”
who has preached that sympathy is weakness—
saves a horse.

Then he collapses
and they carry him back to his room
(the beginning of eleven more years of a life of insanity).

Was it madness?
or perhaps something else more human,
which even he could not hide:
the gift of the fire of comprehension (stolen for us from the
gods
by Prometheus)
for which we pay by enduring the pain of all horses.

That day the distant Alps burning like white candles.

George Young, MD

Dr. Young (ΛΩΛ, University of Southern California, 1963) is retired from the Boulder Medical Center, where he was an internist and rheumatologist. He has published one book of poetry, *Spinoza’s Mouse*. His address is: 2315 Hawthorn Avenue, Boulder, Colorado 80304. E-mail: geopeg63@msn.com.
Letters to the editor

Re “The tradition of the gold-headed cane”

I read with interest the article entitled “The Tradition of the Gold-Headed Cane” (Winter 2007, pp. 42–46). At the end of the article were listed medical organizations that present a gold-headed cane. Left off this list is the Oregon Health & Science University, formerly the University of Oregon Medical School, which has awarded the Edward S. Hayes Gold-Headed Cane Award to a senior medical student at graduation for more than thirty years.

This is a wonderful tradition and the history of the gold-headed cane is obviously part of that. The Edward S. Hayes Gold-Headed Cane Award states, “This cane with the trust it symbolizes, after a vote by peers and teachers, is given to the recipient to carry henceforth because of compassionate, devoted and effective service to the sick and with a conviction that its holder will forever epitomize and uphold the traditions of the True Physician.”

As a former recipient of this award, I continue to feel extremely honored and humbled by it. Reading the article in The Pharos about the gold-headed cane reminds me of this.

John R. Lobitz, MD
(ΩΩΑ, University of Oregon Medical School, 1973)  
Portland, Oregon

Re “Endangered species”

In the Winter 2007 issue of The Pharos, Dr. Harris raises important concerns about the decline of primary care and the impact on the nation’s health (“Endangered species,” p. 1). On a personal note, I recalled an editorial Claire Maklan and I wrote twenty years ago in response to the then perceived “primary care crisis,” and we noted our anticipation of the improved outlook for health care the emerging practice of geriatrics would bring. Yet it has become apparent, as Dr. Harris points out, that geriatricians cannot and should not meet the health care needs of the rapidly growing segment of the population over sixty-five years of age. Others have also raised concerns about the very “survival” of primary care, which is “facing a confluence of factors that could spell disaster.” Yet primary care survives because it is clearly the practice mode that best meets the diverse health needs of persons of all ages. Indeed, an especially vocal demand for primary care practice is likely to arise from those over eighty years of age (and from their representative organizations) who most need it, require less intensity, more “value” for less cost, manifest multiple chronic age-related conditions, use many medications, and ultimately seek restorative function rather than cure.

Specialists and generalists alike, and their patient constituencies, realize the essential place primary care holds in the spectrum of health care in this country. The political outcry that is emerging about the current limitations in meeting patient needs will reaffirm the necessity for enhancing primary care, and is likely to promote remedial action by future administrations.

References


David Hamerman, MD
(ΩΩΑ, New York University, 1948)  
Bronx, New York

A new patient to the clinic, Mr. O. calmly describes his story as a worker for a carnival, injuring his leg as the season drew to a close. Awaiting spring in an unfamiliar city, his wound has worsened, now obviously infected and requiring debridement. Continuing his story, he explains that he is homeless and alone, spending the unusually cold nights in an abandoned building nearby. “I can go back to the shelter if you want me to,” he adds, “but I’d rather be by myself.” For a moment, I allow myself to be moved by his sadness, and then, together, we make a plan.

Ten years ago, knowing little about the practice of medicine, I joined the National Health Service Corps. Entering medical school, I shared the hopes of my peers . . . to somehow help people. Over the next four years I watched as others competed for the most specialized residency positions, ultimately won over by obvious incentives and discouraged by the ever-present challenges of primary care. As a resident of internal medicine, I watched again as the striking advantages of subspecialty care eclipsed the less apparent rewards of outpatient general medicine. Eight months ago, I nervously began working in an urban community health center, and since then I have found unexpected challenges and rewards each day.

As a trainee, I recognized that I would face trials as I left the security of residency, and these are frequently apparent. Without the luxury of working in a tertiary center, standing on the front line remains intimidating, and becoming comfortable with uncertainty is a necessity. Resources, once taken for granted, seem in short supply. As underinsured patients wait months for consults or face overwhelming bills for testing, diagnosis is no longer simple. Furthermore, I am challenged daily to earn patients’ trust and to communicate clearly. I struggle with overwhelming disparity of resources, the demand for productivity, the presence of the pharmaceutical industry, and the need for continuing education. And as I look back on my first year in practice, I realize that through such struggles, I have changed.

In addition to these obvious struggles, I have found unexpected rewards, centered in relationships. I remember wondering if, as a primary care provider, I would fix problems, or
would this be left to the surgeons and specialists. In fact, I help my patients face life-changing challenges daily, and their perseverance is inspiring. Clinic practice involves frequent diagnostic challenges as well. From breast cancer hidden within a screening exam to polymyalgia rheumatica masquerading as chronic fatigue, pathology is frequently present and rarely apparent. In addition to the developing relationships with patients, our clinic team has grown together as well. Faced with limited resources and the daily challenges of patient care, we share our frustrations, hope, and often laughter. And from different backgrounds, clinging to diverse beliefs, we continue to grow closer.

Residents and students often hear of the challenges unique to the practice of primary care, however little emphasis is placed on the many unique rewards. My short experience so far has been surprising, eye-opening, frustrating, and invaluable. Laughing, crying, celebrating, and grieving with my patients, I have experiencing the human condition much more honestly and completely than I can convey. I have become a more interesting and understanding person, and gained perspective which will help me throughout my career. My faith is now deeper, more firmly grounded in realities of inequality, suffering, and perseverance, and I am becoming a better doctor. This vocation is not for everyone, but as far as me, I feel at times overworked, often undervalued, and above all, happy.

Steven M. Hegedus, MD
(ΩAΩ, Ohio State University, 2004)
Memphis, Tennessee

Dr. Faith Fitzgerald comments on Dr. Hegedus’s letter

When older doctors get together, their conversations almost invariably turn to patient stories, vying with one another for the finest they each have to tell. The content of these stories are generally not centered around the labs, the images, nor the procedures these patients underwent, but rather the puzzles they presented, the tragedies and triumphs they experienced, the touching or humorous events of their lives—in which their doctors participated, and from which these doctors learned more, and more vividly, than ever they could by lecture or text, syllabus, standardized patients, CD-ROM, or Internet search. If endurance in memory and effect upon the joy of our profession are a measure of the value of curricula, it is the patients for whom we care, and the vast kaleidoscope of the human experience they manifest, that are the best of the curriculum in lifelong medical education.

Young people enter medicine now fully aware that they may no longer assume a future of high status, high pay, or autonomy of judgment. They have been told before application to medical school, even by many physicians, to go into something else, that medicine is not what it was. And these students have answered: “Nonetheless, I want to be—a doctor.” They enter as the most promising of our generations, vocational and idealistic, most promising in terms of the future and society. They are the best students, the best of the curriculum in life, and the vast kaleidoscope of the profession are a measure of the value of this education.

What stories will the now young doctors tell thirty years from now, I wonder. Will they compete for pride of place in swiftest and best colonoscopies performed? Will some proudly present their outstanding echocardiograms in competition with others? Perhaps “most exciting anesthetic induction” will be the topic of some exchanges at class reunion dinner tables. Dermatologists could joust in a “dermatopathology derby,” radiologists pit their best films one against another.

None of them, I think, will have the same richness, broadness, completeness, and true satisfaction in the stories of their lives as doctors as does the author of this piece.

Faith T. Fitzgerald, MD
(ΩAΩ, University of California, San Francisco, 1969)
Professor, Internal Medicine
Assistant Dean of Humanities and Bioethics
University of California, Davis, School of Medicine

Re Intelligent Design

In his essay, “Intelligent Design and the Age of Endarkenment” (Autumn 2006, pp. 4–8), Dr. Weissmann portrays intelligent design theory’s challenge to Darwinian evolution as a threat to post-enlightenment thinking.

Intelligent design as theory has both merit and valid criticisms. In reality, however, Dr. Weissmann’s piece was not directly about intelligent design, but about his sense of “anti-science” in our current society. To me, the author’s saber rattling against the forces of “endarkenment” appears reactionary and unwarranted. I propose that this is a misreading of modern society that is, if anything, centered on technological and scientific progress. Indeed, if the question did not involve the Darwinian sacred cow, it is likely that the issue would never have surfaced. Moreover, Dr. Weissmann errs in calling intelligent design a euphemism for creation science. Intelligent design makes rather modest claims. Thoughtful proponents of intelligent design do not deny the evidence for evolution per se. Rather, inferring design argues against a materialistic form of evolution founded on the accumulation of mindless chance events.

A closer look suggests that the real
Conflict is not between faith and science, but between faith and materialism, the latter regarding matter as the only reality in the world, thus denying the existence of spiritual realities such as God and the soul. Science is an empirical endeavor that relies on observation and experimentation to explain the physical world. It has resulted in great progress, especially in medicine. But isn’t there a degree of arrogance in believing that man’s observations and experiments are the sole source of truth?

Readers of The Pharos know that there is more to life than laboratory experiments and double-blind placebo-controlled studies. Good physicians routinely acknowledge the importance of our patients’ emotions, relationships, and spirituality to their overall health and well-being. Are we to banish discussions of these “non-scientific” factors from medical classrooms, journals, and clinical wards? Rather than a call to arms, may we be called to celebrate together the awe and wonder of all creation.

Stephen J. Smart, MD
(AΩA, Washington University, 1988)
Peoria, Illinois

Resident duty hours—second thoughts

Physicians in training have historically worked long hours. Public awareness was heightened in March 1984 when Libby Zion, an eighteen-year-old college student, died shortly after admission to New York Hospital. Her father charged that her death was a result of poor care by overworked residents. While no criminal indictments came from a Grand Jury investigation, recommendations included limiting resident working hours. This ultimately led New York to become the first state to codify regulations governing resident hours.1 As public concern about sleep-deprived residents grew, the Accreditation Council for Graduate Medical Education (ACGME) formulated new duty-hours standards for residency program accreditation in 2002 that became effective on July 1, 2003.2 There is some documentation that long duty-hours are harmful to patient care.3 The regulations include a limitation of eighty hours per week averaged over four weeks, one day in seven free, in-house call no more frequently than every third night and continuous on-site duty not to exceed twenty-four consecutive hours with an additional six hours allowable for continuity of care, etc., and a ten-hour rest period provided between all daily duty periods and after in-house call.

The institution of these mandates has led to detailed monitoring. In our institution, medicine work rounds occur with only portions of the team involved at any one time. This makes possible early departure of the on-call resident and frees up time for the other residents to carry out tasks that otherwise might extend their hours beyond those allowable. There is some documentation that preventable adverse events are associated with physicians covering who have less familiarity with the patient.5 When hour constraints lead to fragmented rounds and the disappearance of the team approach to continuity of care, not only does care suffer, but also lost is the opportunity to learn from colleagues and patients. On surgical services, operating experience, particularly with emergency cases, suffers.

The complexities of modern medicine and reimbursement limitations have led all practicing physicians to compress more in the time we have available. Physicians seem increasingly attracted to the defined hours of hospitalists and emergency room physicians. Now residents are developing a “shift-mentality.”

The molding of a physician that begins in medical school and goes through residency training has as much to do with responsibility, compassion, and devotion as it does with actual knowledge. Do patients and the educational process benefit from a major focus on whether one has worked too many hours? It seems clear that patients benefit from a continuous relationship with one physician. The more trade-offs there are, the less intimate that connection becomes.

Some have argued that forced regulation affords an opportunity to create new paradigms.6 In contrast, a recent survey of pediatric surgery training programs including both program directors (PD) and fellows highlights the discomfort and uncertainty that the hour regulations have created.7 Neither the trainees nor PD give a ringing endorsement to the new standards.

Medical education should move forward, but those of us who teach have an obligation to foster attitudes that are immutable. An obsession with the time clock, however well intentioned, can produce physicians who have lost the sense of personal responsibility to patients. Boutique practices shouldn’t thrive just because they offer the kind of personal attention that was once commonplace.

After four years, it seems time for the ACGME and program directors to reassess the hours issue, to reflect on the pros and cons of the change, and perhaps to become more flexible and creative in balancing educational rigor and responsibility in training with the need for time away.

References
Dr. Lawrence Faltz comments on Dr. Rogoway’s thoughts

To suffer woes which Hope thinks infinite;  
To forgive wrongs darker than death or night;  
To defy Power, which seems omnipotent;  
To love, and bear; to hope till Hope creates  
From its own wreck the thing it contemplates;  
Neither to change, nor falter, nor repent;  
This, like thy glory, Titan, is to be  
Good, great and joyous, beautiful and free;  
This is alone Life; Joy, Empire, and Victory!  
—Percy Bysshe Shelley, *Prometheus Unbound*

To undergo trials and make sacrifices in pursuit of great rewards is an elemental human theme. It’s the subject of mankind’s oldest book, the *Epic of Gilgamesh*. Odysseus had twenty years of challenges before he could get home to his wife and kingdom. Tamino must undergo trials of temptation, silence, water, and fire to win Pamina in Mozart’s *Magic Flute*. And so for Don Quixote. Robin Hood. Rocky. Luke Skywalker. Dr. Kildare.

Residency, in its former 110-hour week format, was often unpleasant, and there were casualties, but something profound was achieved by giving one’s self over fully to the world of medicine. One was transformed, marked by the experience with a different perspective on one’s role in society and an intrinsic understanding of what it means to be a professional.

What society offered in return was that the newly minted doctor would have a future of high societal standing, personal and professional independence, and substantial income. During the 1980s, economic, social, and political pressures began to erode medicine’s special place. That decade saw the rise of HMOs, the imposition of Medicare fee freezes, a marked rise in liability cases, increased regulation, and a drastic fall in the public’s opinion of physicians. For residents perceiving limited prospects, every second or third night rotations and 110-hour weeks were no longer a reasonable investment. Even without the Libby Zion case and the Bell Commission, residency as a total immersion experience was doomed.

I was a program director in New York in 1989 when the Bell Commission rules went into effect. As we redesigned our staffing and call systems, we worried about how to preserve continuity, responsibility, professionalism, effective teaching, and the balance between service and education, things implicit in the total immersion paradigm. These are now threatened, or have been completely lost.

I agree with Dr. Rogoway that we have to consider what has been given up in exchange for more rested physicians-in-training. But it’s not only a matter of cleverly designing training programs. Is the objective to have residents alert enough to flawlessly interpret that 3:00 AM EKG, or to develop a professional persona that lasts a lifetime? The two goals may not be compatible. If there is truly value in professionalism in medicine, and that’s what’s being lost, society will have to make changes in the health care system that make an epic quest again worthwhile.

Lawrence L. Faltz, MD  
(A2A, New York University, 1971)  
Senior Vice President for Medical Affairs and Medical Director, Phelps Memorial Hospital Center  
Sleepy Hollow, New York  
Associate Clinical Professor of Medicine (Rheumatology), Mount Sinai School of Medicine  
New York, New York

Drs. Kelley Skeff and Lawrence Smith comment on the thoughts of Drs. Rogoway and Faltz

The comments by Drs. Rogoway and Faltz are understandable and worrisome, as they are both concerned about losing some of the core values of the profession. Although the eighty-hour workweek receives a great deal of attention, that concept, in and of itself, should not be the daunting one. We should be able to deliver an effective learning experience for residents and fellows within this time allotment. However, addressing these requirements has been a significant challenge for program directors, residents, faculty, and institutions. Compressing a 110-hour week into eighty hours of frenetic patient care is not the answer. For residents, the result is a loss of time to reflect on doctoring, to have collegial discussions, and to grow personally and professionally into the social culture of physicians and medicine. For faculty, the result is inadequate time for teaching and far less a “sense of team.”

In attempting to create approaches that respond to the requirements, many have understandably moved to models of overlapping care, e.g., night float and physician extenders. Yet in implementing these methods to enhance goals of efficiency, we can have the unplanned consequences of separating patients from residents, thus diminishing residents as caregivers. While incorporating new shifts for residents and physician extenders, we must be careful that we do not abandon the physician role of healer by giving the
The comments and attitudes of program directors at the most recent APDIM meeting indicates widespread concern regarding the effectiveness of many recently applied methods, echoing agreement with Drs. Rogoway and Faltz of the need for a re-examination of our approaches. However, the re-examination cannot be one focused on the hours’ requirements, since these are sensible from both educational and patient care points of view. Rather, the redesign must focus on two issues: (1) re-emphasizing the values of physician responsibility and patient ownership, something desired by faculty and residents alike, and (2) collaborative redesign by both educational and hospital administrators. The latter point is critical, as the accomplishment of the educational goals also and ultimately must accomplish the goal of the hospital, effective delivery of patient care.

Collaboration between educators and administrators has great potential in improving both current and future patient care by simultaneously emphasizing patient care outcomes and education, via redesign of the system. By emphasizing the integration of patient care and education, we have the opportunity to again foster the commitment of each individual trainee to his or her patient throughout training. Moreover, we can foster an evolving new professional behavior, the collective responsibility of all practitioners toward the improvement of the health care system, both locally and nationally. In sum, we have the opportunity to re-examine our current methods, looking beyond the eighty-hour workweek to our major goal as a profession: excellent care for all patients now and in the future.

Kelley M. Skeff, MD, PhD, MACP (ΔΩA, University of Colorado, 1970)
George DeForest Barnett Professor of Medicine
Residency Program Director
Stanford University Department of Medicine

Lawrence Smith, MD
Chief Medical Officer
North Shore-LIJ Health System
Great Neck, New York

### The 2007 Pharos Poetry Competition winners

The Pharos Poetry Competition was held for the first time this year. Sixty-eight poems were submitted, and the winners were selected in April. First prize and three honorable mentions were awarded:

First prize, $500: Hilarie Tomasiewicz of the Class of 2012 at Mount Sinai School of Medicine of New York University for her poem, “New Art.”
Honorable mention, $100 each:
Jay Augsburger of the Class of 2007 at the University of Cincinnati College of Medicine for “Dance of the Student Doctor.”
Madhu Iyengar of the Class of 2010 at the University of Kansas School of Medicine for her poem, “My Own Two Eyes.”
Jade B. Tam of the Class of 2010 at the University of Missouri—Columbia School of Medicine for her poem, “She Lay Quietly.”

The winning poems will be published in future issues of The Pharos.

Judging the poems were members of the editorial board of The Pharos: Henry Claman, MD; Jack Coulehan, MD; Dean Gianakos, MD; J. Joseph Marr, MD; Eric Pfeiffer, MD; Richard C. Reynolds, MD; Bonnie Salomon, MD; Audrey Shafer, MD; John H. Stone III; Jan van Eys, PhD, MD; David Watts, MD; and Editor Edward D. Harris, Jr., MD.

### 2007 Alpha Omega Alpha Helen H. Glaser Student Essay Awards

The twenty-fifth annual Alpha Omega Alpha Helen H. Glaser Student Essay awards were made in April of this year. This year’s winners are:

Second prize, $750: Heather Finlay-Morreale of the Class of 2010 at the University of Cincinnati College of Medicine for her essay, “And then there were eight.”
Third prize, $500: Lori K. Soni of the Class of 2008 at Northwestern University’s Feinberg School of Medicine for her essay, “Hypochondriac.”

Honorable mentions, $250 each: Lara Devgan of the Class of 2007 at Johns Hopkins University School of Medicine for her essay, “What Does a Doctor Look Like?”; Mok-Chung Jennifer Chow of the Class of 2007 at the University of Virginia School of Medicine for her essay, “Things Remembered”; and Phoebe Este Koch of Yale University School of Medicine’s Class of 2007 for “Wear a Red Robe.”

Winning essays will be published in future issues of The Pharos.

Judging the essays were members of The Pharos editorial board: John A. Benson, Jr., MD; Lawrence L. Faltz, MD; Robert H. Moser, MD; Marjorie S. Sirridge, MD; Editor Edward D. Harris, Jr., MD; and Managing Editor Debbie Lancaster. Also judging was Natalia Berry, ΑΩΑ student at Dartmouth Medical School.
Annual induction ceremony at New York Medical College (Iota New York)

The New York Iota Chapter at New York Medical College had a very special annual induction ceremony on March 28, 2007, to celebrate the fiftieth anniversary of the founding of the chapter. William H. Frishman, MD, chair of Medicine at NYMC, is the councilor of the active chapter there, following many years as councilor at Albert Einstein University School of Medicine. The annual ΑΩΑ lecture was given this year by ΑΩΑ Executive Secretary Dr. Edward D. Harris, Jr.

Dr. Harris was honored to be asked to present the talk. The annual dinner was exquisitely arranged by Elizabeth Ashlie Darr, president of the chapter. In addition to the student members inducted, two alumni (Oliver Pacifico and Fran Kaiser) and two faculty (Richard G. McCarrick and Canan K. Gucalp) were elected to membership in the society. George P. Liakeas was awarded the 2007 ΑΩΑ Volunteer Clinical Faculty Award. Presenting the awards was Susan A. Kline, executive vice dean of Academic Affairs.


Photo courtesy of Lori Ann Perrault. Identification diagram by Ashlie Darr.
Addition to the Pharos editorial board

We are pleased to announce that Stephen J. McPhee, MD, is joining the editorial board of The Pharos. Dr. McPhee is professor of Medicine at the University of California, San Francisco, and was inducted as a faculty member to AΩA in 1984. His research interests have been in cancer control programs, particularly for Vietnamese in the San Francisco Bay Area. A published poet, he brings appreciation and evaluative skills to this growing segment of manuscripts sent for review to The Pharos.

More National and Chapter News can be found on our website: www.alphaomegaalpha.org

Alpha Omega Alpha visiting professorships, 2006/2007

Beginning in 2002, Alpha Omega Alpha's Board of Directors offered every chapter the opportunity to host a visiting professor. Forty-four chapters took advantage of the opportunity during the 2006/2007 academic year to invite eminent persons in American medicine to share their varied perspectives on medicine and its practice.

Following are the participating chapters, their councilors, and their visitors.

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University of Alabama School of Medicine, University of Alabama at Birmingham
C. Bruce Alexander, MD, councilor
Rita Charon, MD, Columbia University

ARKANSAS
University of Arkansas College of Medicine
Anne T. Mancino, MD, councilor
Lewis First, MD, University of Vermont

CALIFORNIA
Loma Linda University School of Medicine
Sarah Roddy, MD, councilor
Stephen J. McPhee, MD, University of California, San Francisco

ALABAMA
University of Alabama School of Medicine, University of Alabama at Birmingham
C. Bruce Alexander, MD, councilor
Rita Charon, MD, Columbia University

ARKANSAS
University of Arkansas College of Medicine
Anne T. Mancino, MD, councilor
Lewis First, MD, University of Vermont

CALIFORNIA
Loma Linda University School of Medicine
Sarah Roddy, MD, councilor
Stephen J. McPhee, MD, University of California, San Francisco

GEORGIA
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Clarence Joe, DMD, MD, councilor
Norma Wagener, PhD, University of Colorado at Denver and Health Sciences Center

HAWAII
University of Hawai'i at Manoa John A. Burns School of Medicine
Mary Ann Antonelli, MD, councilor
Kevin J. Soden, MD, MPH, national medical reporter, NBC News

ILLINOIS
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University of Illinois at Chicago College of Medicine
N. Joseph Espat, MD, councilor
Donald P. Francis, MD, DSc, Global Solutions for Infectious Diseases
Loyola University Chicago Stritch School of Medicine
John A. Robinson, MD, councilor
Daniel R. Salomon, MD, Scripps Research Institute

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Peter Densen, MD, councilor
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Amy O'Brien-Ladner, MD, councilor
Jeremy Greene, MD, Brigham & Women's Hospital

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Charles Griffith, MD, councilor
Karen DeSalvo, MD, Tulane University

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Jerome Kassirer, MD, Tufts University
Louisiana State University School of Medicine in Shreveport
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Uniformed Services University of the Health Sciences
Robert Goldstein, MD, councilor
Barry J. Maron, MD, Minneapolis Heart Institute Foundation

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Ameena Ahmed, MD, Highland Hospital, Oakland, California
West Virginia University School of Medicine
Melanie Fisher, MD, MSc, councilor
**Robert Keith Minkes, MD, PhD, Houston Pediatric Surgeons**
Another sleepless night of quiet flight in some small plane to some small town, each one unique and everyone the same with their own short tale of unthought tragedy and I—the arbiter of this exchange of organs from dead to dying quietly wait. Bitter and unhappy to be awake when the world lies sleeping guilt makes me think who else lies sleepless tonight, regretting some then unknown last word or promise unfulfilled. This process of saying dying is now death but not yet dead disturbs the certainty of pulseless forms so much easier to declare, to walk away from convinced that nothing else remains. But here, here is something more—brain dead we say, no person here—just blood and bone and organ waiting now as some full ship for Ahab’s beckon call. And the child—alone with bandaged head and swollen face lies broken and unrecognized. She bears the silent cut to find a quiet heart. Betrayed by death and unaware the child is gone, the heart persists. But not for long—a simple clamp, a cut—the heart bleeds out and comes to rest. Like some new age resurrectionist or sanctioned Burke and Hare my harvest is complete and I come home.

Charles Hoopes, MD

Dr. Hoopes (ΛΩΛΩ, Duke University, 1991) is assistant professor of Surgery at the University of California, San Francisco. His address is: University of California, San Francisco, Cardiothoracic Surgery, 350 Parnassus Avenue, Suite 150, San Francisco, California 94143. E-mail: hoopesc@surgery.ucsf.edu.