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Memorial
Edward D. Harris, Jr., MD
July 7, 1937–May 21, 2010

Dr. Edward D. “Ted” Harris, Executive Secretary Alpha Omega Alpha and Editor of The Pharos, died on May 21, 2010. Ted was a distinguished teacher, outstanding physician, accomplished researcher and remarkable leader. He was an internationally recognized rheumatologist and former Chair of Medicine at Stanford and Rutgers universities. Through his long battle with a steadily progressing head and neck cancer, he remained committed to his work and the profession he cherished so dearly. He passed away at his son's home in Thetford Hill, Vermont.

Ted was born in Philadelphia, the only son of Edward and Eleanor Harris. He excelled in academics and athletics at the Camp Hill High School and at Dartmouth College. At Dartmouth, an injury curtailed his football career, but his educational experiences and English major kindled an interest in reading, writing, and editing that lasted for the rest of his life.

Ted attended the two-year Dartmouth Medical School and then graduated from Harvard Medical School in 1962, cum laude, as a member of Alpha Omega Alpha and recipient of the distinguished Maimonides Award. Following internship and residency at the Massachusetts General Hospital (MGH) and research training in the Experimental Therapeutic Branch of the National Heart Institute, he returned to Boston as a Senior Resident, Research Fellow, and then Member in the Arthritis Unit at the MGH, working closely there with his beloved mentor, Dr. Stephen Krane.

The call soon came for Ted to return to Dartmouth to head a Connective Tissue Disease Section in the Department of Medicine. His love of the outdoors and northern New England made the call irresistible, so he and his family returned to Hanover in 1973. There Ted organized a Multipurpose Arthritis Center, soon became Professor of Medicine and was recognized as an exceptional clinician, teacher, researcher, and leader. In 1983 he was recruited to be Professor and Chair of the Department of Medicine at Rutgers Medical School and then in 1988 to be Professor and Chair of Medicine at Stanford. Along this pathway he maintained his research program focusing on the natural history and treatment of rheumatoid arthritis, his commitment to teaching, and his engagement with the medical community.

Ted was a major contributor to the American College of Rheumatology, serving as President of the College in 1985 through 1986. He chaired the Rheumatology Subspecialty Board for the American Board of Internal Medicine from 1986 through 1988. Reflecting his broad commitment to the profession, Ted also served sequentially as Governor of the New Jersey and Northern California chapters of the American College of Physicians. He was a member of the Association of Professors of Medicine, American Society for Clinical Investigation, Association of American Physicians, the American Clinical and Climatological Society, and the Royal College of Physicians, as well as numerous other community and professional organization. He received the Class of 1958 Alumni Award from Dartmouth in 1992. The American College of Rheumatology awarded him the Joseph Bunim Medal in 1991 and Presidential Gold Medal in 2007. He is well known throughout the world as co-editor of the Textbook of Rheumatology.

Ted’s friendliness and ease of engagement with others were among his exceptional qualities. I recognized this quality when we first met during our residency days. Dr. Ruth-Marie Fincher, now Professor of Medicine at the Medical College of Georgia recently wrote,

Ted has been a role model and supporter-from-afar for me since 1973, when he taught the musculoskeletal component of our Scientific Basis of Medicine curriculum at Dartmouth Medical School. I remember him as a dashing young professor (assistant, actually) who expected and received respect and undivided attention; he was a marvelous teacher who made collagen and bone come alive. I cherish the opportunities I had through the ACP Board of Governors and AΩΑ Board of Directors to work with Ted. I remember vividly the evening he walked up to the cellist of a string quartet that was playing at an ACP Board of Governors reception. After a brief conversation, the cellist stepped aside and Ted was playing with the quartet. His handling of the end of his life seems typical to me of the strong, “in control” way he handled his career.

AΩΑ selected Ted to be Executive Secretary and Editor of The Pharos in 1997. He served with distinction, reinvigorating the organization through chapter visits, recruitment of new chapter councilors, regional and national meetings for councilors, and in many other ways. He steered The Pharos to a more creative, attractive, and modern format and wrote colorfully about the changing face of American medicine. He selected the articles for and edited Creative Healers, an anthology of memorable articles from The Pharos.

In tribute to Ted, the Board of Directors of AΩΑ has renamed the AΩΑ Professionalism Award the Edward D. Harris Professionalism Award. Donations in Ted’s name will be placed in a fund to support this, with a goal of creating an endowment to support the award.

Friends and family were always very important to Ted Harris. He is missed by his fiancée Dr. Eileen Moynihan, his sons Ned, Tom, and Chandler, and their wives and children, as well as by his former wife, Mary Ann Hayward, the many students he mentored, and medical colleagues around the globe. Ted gave so much of his life and spirit to medicine. We were deeply blessed by his many contributions.

David C. Dale, MD
(AΩΑ, Harvard Medical School, 1966)
President of Alpha Omega Alpha, 1996–2002
Professor of Medicine, University of Washington
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Medical publishing

Michael D. Lockshin, MD, MACR
The author (ΑΩΑ, Cornell University, 1979) is the professor of Medicine and Obstetrics-Gynecology at Weill Cornell Medical College, the editor of Arthritis & Rheumatism, and a member of the editorial board of The Pharos.

For more than 150 years medical professionals have published new scientific data, in paper journals, for an audience of professional peers. Since 1938 Alpha Omega Alpha, for an audience of medical leaders, has published in The Pharos articles on medically-related history, literature, art, ethics, economics, health policy, personal profiles, nonfiction, poetry, photography, and personal essays.

The Internet has changed paper publishing for medical journals and may do so for The Pharos. On the Internet, medical and scientific journals can now offer instant publication (even before or without peer review), hyperlinks, and interactive files. The audience of medical journals is no longer just cognoscenti but is now, potentially,
Will paper live on?

the world. Because of the Internet, editors and publishers of medical journals must re-ask old questions: Why do we publish? Why do we do peer review? Should we edit manuscripts? Is a paper publication better than a digital one? Who are our readers? Who pays the costs? Is there a need for a society-sponsored journal? Will paper journals die?

**Why do we publish?**

Anticipating protests to my assertion, I aver that: the purpose of a journal is not to solicit critique by one’s peers, since personal contacts and research results placed directly online can and do accomplish the same goal. Nor is the purpose of publication solely to disseminate information, since the Internet and public press offer many ways to do this as well. Instead, a journal functions in academia as a means to provide quality validation for both reader and writer. Because of peer-review validation, faculty promotion and grant application review committees use journal publications to judge candidates. The open Internet, lacking peer review, cannot similarly
validate science. Another of a journal’s purposes is to be a filter. While a Google or PubMed search on a topic may yield thousands of citations, a journal offers a narrow, more usable, list of papers relevant to the reader. A journal’s “brand name” guarantees the reader a predictable quality and content, while the Internet does not.

**Why do we do peer review?**

Some argue that peer review is unnecessary, that readers can judge a manuscript themselves, and that manuscripts can be placed online without peer review. The counterargument is that peer review assumes that at least some readers may be unable to make informed judgments on difficult topics and that they do wish an expert’s guidance. All journals offer editorials to explain complex issues or to set context—a fact that supports this view.

As an editor, most recently of *Arthritis and Rheumatism*, I strongly favor peer review: reviewers identify errors and omissions in the original research, suggest better experiments, offer alternative explanations, and explain technical obscurities and priorities. Even for the nontechnical articles published in *The Pharos*, reviewers often suggest better ways of expression or better ways to make an argument, and they suggest priorities for publication as well. Peer review sets a timeline for decision, giving a published paper an address in time and space, while ongoing blogs on the Internet do not. Formal peer review is valid because editors know the skill of the reviewers. In peer review, arbitration is available to resolve disputes, reviewers (and publishers) demand a standardized presentation style, and post-publication comment is possible through a defined process. Public blog review lacks these attributes.

Although peer review is expensive and cumbersome, the hypothesis that open, voluntary criticism results in a better final product than does peer review remains unproved. Conventional peer review is alive and well; there is not a compelling reason to seek an alternative.

**Should we edit manuscripts?**

Once accepted, scientific manuscripts undergo editing for style, format, fact checking, internal contradiction checking, verification of permissions, and evaluation for legibility (both figures and language)—expensive and time consuming work. Copy editors change the original manuscript to

1. Clarify meaning and to make the manuscript harmonious with the journal’s style
2. Identify inconsistencies between table and text and within the text
3. Restructure text to place methods in the methods section and results and conclusions in their respective correct positions
4. Note frank errors, such as pointing out that a figure does not show what its caption claims.

Similar editing improves *The Pharos* as well.

**Is a paper publication better than a digital one?**

Advantages of Internet-based publication are that data can be updated, corrected, and manipulated by authors or readers, and that communications can be posted as soon as they are received. A disadvantage is that constant updating of manuscripts results in public availability of several versions, depending on when and how it is accessed. Without arguing the point in detail, the ability to provide an archival paper version of a paper is an important advantage of paper publication. The Internet has not yet proved that it can achieve equal permanence. Electronic publishing also has a risk: today’s technologies may become outdated or non-usable. Who now uses Basic- or DOS-based programs, or 5.25-inch floppy disks? But we can still read the Dead Sea Scrolls.

Print journals format pages, figures, fonts, and other aspects of their brands, place content in sequence, and group articles by theme. These features are less reliably part of Internet publication. Whether they add significant value to the former or detract from the latter will be for the future to judge.

**Who are our readers?**

From ancient times to the present, audiences of medical journals have been other specialists—not nonspecialists, and not the general public. Results of scientific research reach the public through the lay press. *The Pharos* aims for an audience of thinkers and leaders in the philosophy and intellect of medicine.

No one argues that the world at large—a broader audience than *The Pharos* and conventional medical journals target—wants to read basic, clinical, or philosophical science unfiltered by interlocutors. It is appropriate for journals to focus on a narrow group of readers. Scientific journals need not dumb down or popularize their articles to accommodate the wider audience, nor should *The Pharos* change its style to attract an audience it cannot define.

**Who pays the costs?**

Today’s medical journals are financed by sponsors, such as specialty societies including AΩA, by subscriptions, and by advertisements—the user-pays fiscal model. The Public Library of Science charges authors large submission and publication fees. This author-pays model embodies an inherent danger of becoming a vanity press that will favor articles by those with the ability to pay.

The question of who should pay for publication—the producers or the consumers—is open to debate. Publishers of print journals are aware that Internet users expect free access and that user costs may cause publishers to lose market share.

What is not subject to debate is that manuscript receipt, review, editing, formatting, and distribution are costly and that someone must pay. (The actual paper costs of a journal are a small portion of the total cost; mailing costs, however, are high.) While some highly-funded scientists may shrug their shoulders and happily pay author fees through their grants, many clinical papers, and the papers in *The Pharos*, will not thrive in an author-pays world. On-line advertising, society sponsorship, and full or partial access fees will be necessary to support journals whose authors cannot pay publication costs.
Is there a need for a society-sponsored journal?

Society-sponsored subspecialty journals focus topics and prioritize papers to their readers’ interests; give identity to their sponsoring societies; give brand name recognition to authors, papers, and readers; and publish papers that are not sponsored by government and industry. Whether society-sponsored journals will survive in an era in which articles can be easily found by topic search on the Internet is an open question, but if the special interest journals that assemble these articles disappear, the papers that would have been published only in the journals that are now gone will not be found in Google. Subspecialty societies, including AΩA, provide venues for writers for and readers in special audiences.

The technology of how journals do their work—whether on paper or electronically—is a relatively small question, a fiscal one, not central to a journal’s mission. Journals and magazines should constantly reconsider what they do—what they should publish, to whom should they address their content—but to alter their basic missions or to change their target audiences because of opportunities or threats caused by online publishing is wrong.

Will paper journals die?

Everyone I know now reads the New York Times online. My family and I buy our books on Kindle and on the iPhone. Medical students read textbooks on computers, even “dissect” anatomy specimens digitally. Many journals offer podcast versions of their papers. Medical residents and young faculty members download papers to iPods or personal data assistants, upload to desktops and/or print if necessary, and dispense with paper copies of journals altogether. Older readers who favor paper journals point out that printed pages can be torn out and filed, that journals and magazines can be stacked on a desk until read, or carried on an airplane, and that paper journals offer browsing serendipities. But electronic papers can also be downloaded, filed, or carried. Electronic browsing is easy, although qualitatively different from paper browsing; offering hypertext links, it can be more powerful. Paper publication offers permanence as an advantage over electronic publication and convenience in open libraries, but technology will presumably find a way to store readable electrons in perpetuity, if innovative technologies can constantly update disused electronic languages and machines. On the other hand, electronic publication allows interactive data and graphics, motion and sound, accessible links (including conversation between author and reader), worldwide access, and worldwide communication at any hour. Electronic publication must supplant paper. The first question is when. The second is how (not if) contemporary journals will adapt.

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Myron F. Weiner, MD

My molecules
Conquered by entropy
Will mix
With those of parents
And unknown parents past.
I am ready
for infinity
For nothingness
For sleep eternal
Absent awareness,
pleasure and pain
I know the wisdom of Wilder
In Our Town; in
The turning and loosening
of the dead from living.
For their sake
The living bid me farewell.
But I will fare neither ill
Nor well because
I will not be.

Myron F. Weiner, MD

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Hurricane Katrina, New Orleans health care, and the Louisiana State University Health Sciences Center

Fred A. Lopez, MD
The author (ΑΩΑ, Louisiana State University, 1991) is assistant dean for Student Affairs, the Richard Vial Professor and Vice Chair of the Department of Medicine at the Louisiana State University Health Sciences Center, and the secretary treasurer of the ΑΩΑ chapter at LSU.

Introductory notes

Dr. Lopez’s original account of his experiences in Charity Hospital during Hurricane Katrina was published in the Winter 2006 issue (“In the Eye of the Storm: Charity Hospital and Hurricane Katrina,” pp. 4–10, and available on our website). The last sentences of his essay still resonate today, “It is time to launch a new Charity. We owe this to our patients.”

Dr. Lopez recounted the phased return of the LSU School of Medicine to New Orleans in the Summer 2007 issue (“In the Wake of Katrina: An Update on the Louisiana State University School of Medicine in New Orleans,” pp. 22–23, and available on our website) and outlined the steps forward for LSU and the health care delivery system in Louisiana.

In this latest account of the series, Dr. Lopez describes the progress made in the five years since Katrina in rebuilding the health care delivery system in New Orleans. Charity Hospital, for now, remains closed.

Edward D. Harris, Jr., MD, editor

A recent report in the New York Times about the events surrounding Hurricane Katrina and possible euthanasia at Memorial Medical Center in uptown New Orleans, where forty-five deaths occurred in late August 2005, served to highlight the importance of disaster preparedness.1 The article received national attention for the questions it
Almost five years later raises about physician responsibilities during dire situations in which rationing of resources, comfort care, personal safety, physician accountability, and the unpredictability of life converge to create medico-ethical-legal conundrums of which even the most creative writer could not conceive. Conversations centering on such questions are long overdue, and already legal reform to protect health care providers in these situations is being implemented in Louisiana. The rekindling of interest in these ramifications of Hurricane Katrina should also serve as reminders of other significant legacies created in the wake of this disaster.

The 2006 return of the LSU School of Medicine to New Orleans and the reopening of one of its downtown teaching public hospitals (previously known as University Hospital), with state-of-the-art trauma center and intensive care unit services, heralded the recovery of the medical school and health sciences center. Subsequent positive changes include the reopening of a 20,000-square-foot student learning center with both small-group and large-conference facilities and patient-simulation teaching capabilities; the initial construction of a new 175,000-square-foot cancer research center in collaboration with Tulane University Health Sciences Center and Xavier University; replenishment of LSU’s basic science and clinical faculty; and the successful recruitment of residents pursuing medical specialty training. The latter is particularly important for an institution that trains more than seventy percent of the active primary care physicians in Louisiana.

Amidst this momentum, particular attention is being paid to how to best care for a New Orleans population with an uninsured rate significantly greater than the national average, while jumpstarting a downtown medical district renaissance that could provide the economic vitality and an infrastructure to retain our best students, trainees, and faculty, and attract high-quality candidates from elsewhere.2 Historically, the downtown public medical complex (known as the Medical Center of Louisiana at New Orleans—MCLNO—and comprised of University and Charity Hospitals) was a major teaching institution for both the LSU and Tulane Health Sciences Centers, as well as the health care safety net for the underinsured in both outpatient and inpatient settings. In the year before Katrina struck, MCLNO had more than 260,000 outpatient visits, 23,000 admissions, and 119,000 emergency department visits.3

Decentralization of ambulatory services into community settings is one strategy for the improvement of patient care in

Charity Hospital has remained closed since September 2005.
the post-Katrina era. Community-based primary care clinics not only enhance access to preventive care but also allow for exposure of our young trainees to other models of care.

Another area of intense attention is Charity Hospital, an icon of indigent care in Louisiana since 1736, which has been closed since its post-Katrina evacuation on September 2, 2005. Charity’s future lies in either restoring the current structure or building a new hospital in a nearby location, proximal to a new VA Hospital. The discussion about Charity has been lengthy and often vitriolic, engendering strong emotions from stakeholders in the residential, medical, business, and preservationist communities. A replacement hospital moved closer to realization when a memorandum of understanding regarding the governance of this new university academic medical center was announced in late August 2009. And in January 2010 a federal arbitration panel awarded the state of Louisiana $474.7 million to cover damages to and the replacement cost of Charity, providing a strong boost to the financing plan for the new teaching hospital. For many of us, it cannot happen soon enough. The future strength of the health sciences center, the state’s supply of physicians, and the health care of so many in our region depend on it.

References

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As I slid the butterfly into the nearly-filled sharps box, the delicate tubing curled back on itself as if refusing to enter, and the business end plunged deep into my ungloved thumb. Stunned, I quickly pulled away and pulled the needle out. I wasn't bleeding, but there had definitely been blood in the needle from the blood gas I had just performed on my patient with DKA. In the ensuing moments I had an out-of-body experience. The Bellevue ER sights, sounds, and smells faded into the distance and all that existed was my throbbing thumb, the guilty sharps box, and my mortality.

In 1990 the beds in Bellevue hospital were filled with HIV infected, IV-drug-abusing, frequently homeless men and women. They came in with PCP and Kaposi's sarcoma, but they also came in with fevers of unknown origin ("shooter with a fever") and lots of bread and butter medicine.

In 1990, as a third-year clerk at Bellevue, my pockets were filled with the paraphernalia of everyday medical ward work. While students at some other schools carried pocket guides of differential diagnosis, Glasgow coma scales, and Snellen eye charts, at Bellevue you carried equipment and supplies or you didn't survive. The words "ancillary services" didn't exist in our vocabulary. We drew all the bloods, put in all the IVs, collected and measured urine and stool, transported patients, checked fingersticks, you name it.

And gloves? They just got in the way. We always wore them for procedures that didn't require fine manual dexterity: a central line or lumbar puncture. But try to find a fluttering radial artery or a tiny vein on the dorsum of an addict's foot with a gloved hand. Perfectly executed "scut" was indispensable if you wanted honors, and no one was going to jeopardize that by wearing gloves for every little thing.

The drawback to Bellevue was that I spent hours every day doing scut instead of learning. My day revolved around the daily labs that had to be drawn and my week revolved around a schedule of every-third-day IV changes for all my patients.

The benefit (far outweighing the drawback) was that I became expert at scut. I could draw blood from a stone, produce clear spinal fluid (the "champagne tap") from the most combative patient, get a Foley past the biggest prostate. Even more important, the scut put me in constant contact with my patients. I spent more time with them, got to know them, cajoled, pleaded, and threatened them on a daily basis for the sake of yet another CBC or a new IV.

How else would I have discovered that "Doc" was my new patient’s street moniker? He came in with fever and not much else, which to him meant a safe, clean bed and three square meals a day, at least until his blood cultures came back negative.
He was calm and cooperative during my admission H&P, letting me attempt the requisite three sets of blood cultures. But this time my painstakingly honed skills actually failed me. I tried the dorsum of his hands, his wrists, his antecubital veins, forearms, feet, and groin. He was scarred down from a lifetime of injecting and skin-popping drugs. I was about to try an arterial stick when he said good-naturedly, “Can I try before you really hurt me?” When I looked at him in disbelief he explained that on the street he was known as Doc because of his ability to find a vein in even the most hardened addicts.

Every clinical and social instinct I had was telling me not to, but I found myself handing him my butterfly needle and blood culture bottles. He looked at the butterfly and said, “Don’t you have a real needle?” When I produced a handful of 10 cc syringes with inch-and-a-half-long 20-gauge needles, he smiled and pointed to a patch of skin midway up his inner right thigh. Not a vein in sight, but I dutifully applied the betadine and prepped the area. He uncapped the needle and without hesitating plunged it deep into his thigh. Pulling back on the syringe he easily filled it, earning him my undying gratitude and admiration.

I was called away to my next admission, a young woman with Type 1 diabetes and DKA. This was what I had been waiting for—a chance to impress my resident and attending, review my pathophysiology, and monitor her acid-base status by performing lots of ABGs (the way things were done in the “days of the giants”). I gloated to everyone within earshot about my new admission but, because I was so excited, did not notice the grins and knowing glances I was getting from the senior residents.

The patient was perfect—sick enough to require careful metabolic monitoring but not so sick that she’d keep me up all night. She was young, attractive, intelligent, and gave a good history. She had been symptomatic for several days, wasn’t sure why she slipped into DKA, and was more than happy to comply with any test or procedure I wanted to perform.

We spent some quality time together over the next six hours while waiting for a bed to open up on the ward, she gradually improving while I reviewed urinalyses and blood gases. When a passing ER attending greeted her with unusual familiarity I realized I might get some valuable past history from him. But when I asked him he looked at me in disbelief, amazed that I had no idea who I was treating.

She was apparently known to every intern and resident in the hospital. Despite routinely maintaining excellent control of her diabetes as an outpatient, she managed to get herself admitted almost monthly for DKA. This was because her only source of income was prostitution, and turning tricks in the hospital was safer and cleaner than doing it in the streets. All it took was a few missed doses of insulin to land her in one of those coveted safe, clean beds. I learned from the attending that she was a model patient on admission, but later would rarely be found in her own bed during her hospital stay. She was typically working other patients’ rooms and counted the prison-ward guards among her clientele.

I was stunned. Now I understood all the knowing looks I had gotten from the housestaff.

The very next blood gas was the one that ended up in my thumb, with subsequent visions of HIV and non-A, non-B hepatitis floating in my head. She had reported being HIV negative when I had taken her initial history, but had also denied any major risk factors for contracting HIV or hepatitis. I didn’t know what to believe.

Was I really at risk? Was I supposed to tell someone what happened? And was I willing to risk looking sloppy and unformed, possibly even incurring the wrath of my resident for (1) not wearing gloves, (2) overstuffing a sharps box, and (3) slowing us down on an on-call night?

In 1990 we didn’t talk about needlesticks and tried not to think too much about contracting anything serious from our patients. This was especially ironic at Bellevue, where practically every patient we cared for either had AIDS or was at high risk for contracting it.

So I told no one except my wife, who accepted it with the quiet fortitude that got us through medical school and residency, and I did nothing except check my patient’s blood for HIV and hepatitis. She was negative for both but somehow didn’t provide much solace in the ensuing months.

My first needlestick was, happily, my only one. It helped me develop a newfound respect for sharps boxes and a more deliberate approach to procedures. Since then I have taught hundreds of students and residents how to do procedures, always insisting that wearing gloves must be their first priority. But I still struggle with the need to wear gloves all the time. Physical contact with patients, not to mention the quest for those tiny arteries, still seems too important to sacrifice to a layer of latex.

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John, a former patient of mine, was a retired television announcer who had worked with a national telecommunications firm for nearly forty years.

John was well groomed and attractive. Appearances were critical to his success. The blend of his oversized, luminous, baritone voice with his gleaming opal eyes was visually overshadowed by his incongruently long, color-enhanced, roan hair and his flawless skin, purified and renovated by the, admitted, nightly application of emollients and creams designed to provide the youth enhancing qualities essential for his career. And they hid well the passage of time.

But John could not hide his aging mind. Over the years he was losing it—his memory. His knowledge of the world, his once-vivid recollection of episodes of his life and family, his worldliness... was gone. But never did he lose the musicality he had acquired during years of professional training in the performing arts and in preparation for live stage performances.

John developed prostate cancer in late 2006. The disease was hidden by the absence of pain and by John’s inability to sense, or report, changes in his body. But it finally surfaced when a blockage to both kidneys caused flank swelling and fever. For years, he needed tubes for drainage and to control infection. And for years he longed to escape definitive treatment for the disease because that might alter his image. Ultimately treatment began and was modified to allow him to maintain his appearance. For three years we were able to avoid rash and hair loss and lower the risk for infection while still being able to shrink the tumor and restore his quality of life.

During that period, John needed only brief hospitalizations for stents, slightly longer hospitalizations for infections, but no hospitalization for problems related to treatment itself. Treatment was selected to avoid what could be a disorienting discrepancy between what his eyes might see and what his dementia might expect after decades of image enhancing cosmetics. Such a disconnect would only be further disorienting. He was lovingly cared for by his wife of forty years.

During one of John’s last hospitalizations, I witnessed a curious event. John was singing. He was singing love songs. He sang complete songs from start to flourishing finish with proper phrasing, beautiful intonation, and remarkable expression and emotion. “Moon River,” “Black Magic,” “Crazy for You,” “Always on My Mind” poured forth perfectly, filled with the eloquence and baritone quality one might expect from a performer. But John did not know the names of any of these songs. John did not even know where he was when his rendition of these songs was prompted by a request. It was like pushing a button on a jukebox: out came a song. No cognizance existed beforehand, and none followed. But while singing John seemed to be filled with a great sense of accomplishment, happiness, and joy. He came alive and was at peace. There was salvation.

A few weeks before he died, John came to my office. He was preoccupied and seemed in deep thought. I had never seen him like this before. He was slightly dysphoric and not the least despondent. His eyes were thoughtful. His disposition was introspective. His body language was less open than usual, as his shoulders shrugged and his head weighed heavily upon his neck as though bearing down on him. He looked up. I asked him what he was thinking. He said, “Doc, it is coming, I know it is coming, I can feel it, and I just want to tell you thank you for making my life a joy. Thank you for giving me happiness. Thank you for loving Sonya, and for guiding her.” His arms then lifted from his knees and embraced my shoulders, hugging me tightly, and ending with a soft, gentle kiss on my left cheek. He seemed at ease. He relaxed.

Only a few days later, I received a call from Sonya. John had been singing. He had been singing a love song. And in the midst of an aria of love,
devotionally bequeathed to his wife and children, he died. The words of love were on his lips when, in full voice on that night, the grandeur of love swept him away.

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The winning photos from our web site photography contest began appearing on our web site on April 1, 2010. The purpose of the contest: To encourage photography that illustrates A’s motto: “Be Worthy to Serve the Suffering.” The winning photos are profiled on the following pages.
April 2010—Charles Timothy Floyd, MD
An injured Iraqi boy is examined at a U.S. Army Forward Surgical Hospital near Baghdad, April 2003.
Dr. Floyd’s e-mail address is: timfloydmd@mac.com.
May 2010—Heather Michael

I recently volunteered with a mobile clinic in Kenya. We journeyed far and wide to reach patients who would otherwise have no access to medical care. I don't know which part of our work was more difficult: the process of getting to our patients, or our medical duties. No matter where fate took us, the paths were ridden with obstacles. From flat tires to washed-out roads, we encountered daily roadblocks. Yet our determination always prevailed. Neither mud nor engine failure could thwart our efforts to reach our patients. Our resilient clinic brought new meaning to the word “mobile.”

Ms. Michael's e-mail address is: heather.c.michael@gmail.com.
July 2010—**James D. VanHoose, MD**

Young Haitian refugee Effie Pierre is greeted by her new foster mother Sandy Tucker as she arrives in Lexington, Kentucky, for medical treatment. Mrs. Tucker and her husband have taken in more than one hundred disadvantaged and medically-needy children into their home in Casey County, Kentucky, over the last twenty-five years. More information about their mission at: www.galileanhome.org.

Dr. VanHoose’s e-mail address is: jdvhmd@yahoo.com.
August 2010—Ebby Elahi, MD

While visiting one of the villages in Western Burundi on a medical mission in 2008, I came across a little shack where this little girl lived with her parents, four other siblings, and their livestock. Their mother had been called a witch and had fled from another village in fear for her life. The family clearly had no income and ate only occasionally. I found the little girl's expression very telling of the trauma she had suffered during her short life. Sadly, her case was far more the norm than the exception.

Dr. Elahi's e-mail address is: ebbyelah@gmail.com.
September 2010—Sarah Abdulla

During a stop on a train in Thailand, I looked to my right and saw that the window perfectly framed a striking tree. At the base of the tree were bright pink flowers. The strong tree and beautiful flowers contrast with the seemingly helpless women. The bright light of the window contrasts with the darkness inside the train. Capturing the picture was also a symbol of chance: if the train had stopped only a couple of feet ahead or a couple of feet behind, the picture would not have been possible.

Ms. Abdulla’s e-mail address is: sarah1abdulla@gmail.com.
October 2010—Felicia Jinwala

I composed this photo using a double exposure method, in which one roll of film was shot twice, each time at half the exposure. The primary image captures a solitary man walking his dog, confronted by a “fork in the road” at the local park. The overlapping image, randomly imposed on the first, is a close up of blossoming daffodils, their search for the sun conveying a sense of hope. In medicine, individuals are often challenged with making difficult choices, but I think there is a guiding principle of patience, worthiness, and knowledge that shapes the path of treatment.

Ms. Jinwala’s e-mail address is: jinwalfn@umdnj.edu.
November 2010—Kavya Reddy

In loving memory of my grandfather

“Be Worthy to Serve the Suffering”

Lend a hand,
A hand to heal,
To heal those who suffer,
Who suffer every day,
Everyday . . . somewhere.
Somewhere,
There is someone
With endless compassion for humanity,
Who strives to be worthy,
Worthy of serving,
Serving those in need,
In need of a hand,
A hand that can heal.

Ms. Reddy’s e-mail address is: kreddy815@gmail.com.
December 2010—Brittany Solar

Cabaret, Haiti, summer of 2009: Located in the side of a mountain, Grace House is home to ailing Haitians and children of sick mothers and fathers. The woman on the left is screaming with abdominal pain while the man works to comfort her. The children are eating fresh mangos from the market, the first food they have eaten in days. Scenes like this are reminders that health care takes on many faces and sometimes the only medicine available is nutrition and comfort.

Ms. Solar’s e-mail is brittany.k.solar@uth.tmc.edu.
January 2010—Alison Freeman

I took this photo while working in a refugee camp in eastern Kenya. Walking through the “blocks” one day, I turned around to find a dozen kids following me around; they would giggle and scatter, only to start following me again when I turned my back. This is my favorite photo of that day. The smiles on their faces seem to exemplify the very innocence and happiness of childhood, even those that grow up in such poverty. I find it very hopeful and it reminds me why I continue to pursue a career in international medicine.

Ms. Freeman's e-mail address is: freeman.alison@gmail.com.
February 2011—Warren “Jay” Huber III, PhD

Even in the most dire circumstances, a mother’s love is unconditional. Her hands of comfort work in concert with the light of life and modern medicine to support the will to live. My daughter, Maryn Alice Huber, was born April 14, 2009, at twenty-six weeks and four days gestation. Weighing only one pound thirteen ounces, and at twelve inches in length, Maryn endured countless nights of uncertainty. This photograph was taken during her second night in the Neonatal Intensive Care Unit. Throughout the eighty days in the NICU, Maryn was treated by a number of selfless nurses and one physician in particular who portrayed a comforting level of passion and empathy.

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March 2011—Justin Palmore

I fervently believe that everyone is “worthy to serve the suffering.” It is not a matter of worth, it is a matter of heart, a matter of passion, and as this picture so candidly portrays, a matter of willingness to progress—to progress in a way that best serves the human condition, in every aspect. Therefore, “worthy” is not the word, “willingness” is.

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April 2011—Ajai Sambasivan
An elderly man carrying his grandson on his back through a market in Xian, China. The child’s expression captured my attention for many minutes that day, and continues to draw me in months later.
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Today I saw my final patient.
Fifty years ago I saw my first.
What did I feel? Triumph?
Sorrow? Emptiness?
Only this: One door closes,
one door opens.
Endings are beginnings.
I begin again:
A whole generation left to live,
failure ruled out by definition,
all possibilities are open,
nothing more to prove.
I get in my car and drive home.
Rain is starting to fall.
Today I saw my final patient.
My dog welcomes me just the same.

Eric Pfeiffer, MD
When I gets big
and my mama gets little,
I'm gonna put her
in that car seat
so tight
she can't move

From *Ladies in Waiting* by Alan Blum, MD
The inadequacy of legislative procedures and the infirmity of physician organizations

Dan F. Kopen, MD

The author (AΩA, Pennsylvania State University, 2000) practices general surgery in Forty Fort, Pennsylvania.

The United States has just commenced another in a century-long sporadic series of national health care initiatives with passage of the 2009 Senate Bill included in H.R. 4872, The Health Care and Education Affordability Reconciliation Act of 2010. This legislation represents the product of a highly turbulent politicized process driven by special interests. It is both expansive and expensive and will result in increased governmental and special interest control over approximately seventeen percent of our GDP at a cost of nearly a trillion dollars.

For the people of our nation the results will be mixed. The bill consists of well over two thousand pages of legislative language containing hundreds of line item issues addressing an impressive array of health and education related concerns. Some mandates will take effect immediately, others intermittently over the next several years extending through 2018. Presently no one can accurately predict the ultimate outcome of this reform effort, but there are two critical yet-to-be-addressed issues that bear directly upon the likelihood that increased government oversight will be successful in improving access to quality care for the public.

Legislative procedural inadequacy

While difficult for many in Washington to openly admit, it has become increasingly apparent that our national political processes are not up to the task of effectively dealing with the complex realities presented across our nation’s health care landscape. Legislation driven by special interests is not capable of advocating for the overarching and ethically proper goal of universal access to quality care for our nation’s inhabitants. What has emerged is a mishmash of legislative resolutions targeted at individual concerns. While almost all of the issues are legitimate, each section has been drafted against a backdrop of special interest agendas. The result is that many persons will gain access to care, others will see access more difficult to maintain or attain, and many will remain without access. The actual quality of the care accessed at the provider-patient interface has in large part been disregarded. Financial considerations have dominated the legislative product. Quality of care issues have been relegated to secondary status.

The more complex the issues addressed by our political machinery, the greater the opportunities for the agendas of special interests to trump the public good. Our political processes are inadequate in advocating for the public good when asked to effectively address the complexities of our health care economy. The emergence of calls for revision and repeal represent a predictable consequence of the procedural processes embraced by our political leaders in forging the legislative product. In the long run, major change in our political machinery will be a necessary element of effective advocacy for universal access to quality care. This will include replacing the business-as-usual deal-making by special interests, typically conducted behind closed doors, with open and transparent drafting of legislation guided by those who possess an understanding of the broad spectrum of issues that need to be addressed. The leaders of our nation’s academic health
centers must be involved to effectively address the need for reform in the public interest.

Physician organizational infirmity

More participation by physicians is the second critical issue upon which ultimate success of health care reform depends. By education, training, experience, and professional mission our nation’s physicians and physician associations represent the special interest that is best positioned to advocate for public access to quality care. Sadly, this cohort was neither afforded a seat at the table of reform, nor did it actively seek such a role. Indirect participation both as testifiers before committees and letter writers to those in positions of political leadership was not effective in realizing the goals advocated by physicians throughout the reform process leading up to the enacted legislative product.

The influence of our nation’s physicians and the many general and specialty societies has been stifled as drivers of health care policy over the past half century. Because of the massive infusion of taxpayer dollars and increasing influence of state and federal governments generated by the Medicare and Medicaid programs introduced in 1965, potent special interests now dominate control of the national health care agenda.

In 1998 the Sustainable Growth Rate (SGR) formula was introduced to further control the reimbursement of physicians for services provided. As a result of the gradual increase to the currently proposed draconian twenty-one percent across-the-board cut in physician Medicare reimbursements, physicians have been further silenced by a top-down self-imposed policy of reticence regarding health care issues. Private payers use the Medicare reimbursement schedules as a base to determine how much they will pay for physician services. From the solo practitioner to the largest academic health centers, leaders of physicians and physician societies have become supplicants in health care discussions. The huge financial axe wielded by Congress threatens physicians who would otherwise openly and outspokenly advocate for the public good.

The powers, both governmental and special interest, that control these purse strings are not going to permanently loosen the manacles that bind physicians in servitude to the agendas of special interests. The increasingly burdensome overlay of financial considerations has decreased the influence of physicians, extending from bedside care of individual patients to national legislative agendas. The result is that the special interest best positioned to advocate for universal access to quality care has been muted.

Conclusion

If we as a nation are to achieve meaningful and effective health care reform, we must overhaul legislative procedural machinery and increase the ability of physicians to advocate to provide better access to quality care. Special interests have for too long trumped the common good. Absent the willingness to confront these two issues, the current legislative attempt to reform the health care landscape will be marginally effective at best, and will result in unintended adverse consequences. We remain a nation of tremendous potential and a profession with a great mission of service to the public good. If we willingly commit to an open-minded and vigorous approach to these two issues, we can successfully achieve better health care for our nation.

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Direct-to-consumer advertising

Francis J. Haddy, MD, PhD

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Most of us in the United States are familiar with direct-to-consumer advertising (DTCA), in which pharmaceutical firms encourage patients to ask their doctors to write a prescription for their brands of drugs. This is accomplished by repeated enthusiastic television messages beamed directly into the living rooms of consumers. The technique is effective. Prescription drug sales grew sixty-eight percent from 1994 to 2004, even though the U.S. population grew only twelve percent in that time. Similar growth has been occurring since 1985, when the Food and Drug Administration (FDA) relaxed DTCA regulations. While only the United States and New Zealand allow DTCA now, it is possible that the practice will spread to Canada and European nations.

The practice is harmful in several ways. Opponents of it argue that the ads mislead consumers and prompt requests for products that are not needed and are more expensive than
equally effective drugs or nonpharmacologic treatment. Many physicians are opposed to DTCA because they feel it leads to inappropriate use of expensive brand name drugs.\(^1\,\!^,\!^5\) In one study, seventy-one percent of physicians reported inappropriate pressure from patients to prescribe unneeded drugs.

Physicians should not be influenced by patient pressure to prescribe certain drugs, but in the real world they clearly are. The Center for Disease Control and Prevention has noted that “tens of millions” of antibiotics are prescribed annually for viral infections,\(^5\) and that physicians cite patient demand as one of the primary reasons.\(^5\) Hope motivates sick people to believe that there is a “pill for every ill” and to overlook potential side effects or increases in bacterial resistance. Certainly DTCA has contributed to growth of prescription drug use and consequently to costs and side effects.\(^6\)

We need to reconsider the distinction between selling soap or other consumer products and selling prescription drugs.\(^5\) Poor judgment among soap brands may have few health consequences. The influence of DTCA on drug preferences is a much more substantial concern.

The enforcement of current and future laws rests with the FDA. At present, FDA regulatory action typically occurs long after an ad has begun airing on television. This should be remedied. DTCA is not in the best interest of physicians and patients. We should return to the regulations in force prior to 1985. Organized medicine and the public should make their feelings known with resolutions from groups and individuals to the FDA and the Congress.

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Ode to a Jaundiced Eye

Clinicians and Pathologists are most benevolent,
At a clinical pathologic conference are at times malevolent,
The conference Pathologist practiced one-upsmanship
Through the medium of unilateral jaundiced-eyemanship.
The Clinician diagnosed the cause of a single yellow eye,
The knowledgeable Clinician had an eye for a yellow eye.

Paul L. Wolf, MD

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Reviews and reflections

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

A Second Opinion: Rescuing America’s Health Care: A Plan for Universal Coverage Serving Patients Over Profit
Arnold S. Relman
Reviewed by Robert A. Chase, MD
(ΑΩΑ, Yale University, 1947)

Doctor Arnold Relman has published extensively on the health care crisis in the United States. Together with Marcia Angell, he is credited with lucid, insightful, and reasoned approaches to the present crisis. This review joins many others that compliment Relman for this excellent summary of the ever-changing U.S. health care system over the last six decades. He has packed his review of the system with personal experiences from his own career in health care as clinician, research investigator, teacher, author, and critic. In general, his expressed feelings about the sequential changes in health care organization over his sixty years of experience match my own. Disturbed by the commercialization of medicine, Dr. Relman points out that, as an industry, profit dominates patient care needs and physicians have become tradespeople, which has resulted in the loss of their professional status. Market theory has prevailed in the economic definition of “managed care.” The advent of Medicare and Medicaid has created a major incentive for development of private and industrial-based health insurance. The positive and negative effects are clearly expressed by the author with staunch personal determination.

Courts have applied antitrust laws to medicine, making health care organizations very cautious about setting ethical standards. Physicians themselves have become investors in and purveyors of products and services for profit under the influence of manufacturers of such products and pharmaceuticals. All of this with little or no attention to the social and health effects of this growth of investor influence and profit orientation. These changes and more represent the gestation for the birth of today’s “Medical Industrial Complex.” Relman points out that such commercialization has not occurred in nations with universal publicly-supported health insurance systems. He expresses the opinion that our business-oriented health care model is substantially responsible for its current high cost, more than fifteen percent of the gross national product. His opinion is that health care improvement has not been worth the inflated cost. Inequity of access to care is one more result of medical commercialism. This appears to be a clear basis for the current revolt of those responsible for payments for health care, be it industry or individual.

In this book, Relman proposes radical major reform as the best solution to the multiplicity of problems in our current health care crisis. He agrees with the notion of a single-payer national insurance system, but feels that to control costs while simultaneously improving the quality of care there must be reform of the way physicians are organized in practice. Properly organized reforms could solve many of the present problems at no increase or even a decrease in the overall cost of health care. The extra cost of management and shareholder profits in commercialized medicine should be going to care of patients. To achieve this, Relman favors prepaid medical groups with physicians on salary. Salaries could be supplemented with reasonable bonuses defined by multispecialty group management. With such a system, the enormous overhead cost of billing and possible billing fraud would be eliminated.

In this period of serious discussion of U.S. health care change it is of great value to have a crisp, detailed evaluation from one of the nation’s health care experts. Physicians should involve themselves in the ongoing debate and thus they should read and understand this excellent Second Opinion.

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The Language of Life: DNA and the Revolution in Personalized Medicine
Francis S. Collins
Reviewed by Thord Pederson, PhD

Francis Collins was an icon in pedi-

The Pharos/Summer 2010
name became known in the genomics field. Getting big things done requires exceptional people and Collins was a major force in getting something very big done, the Human Genome project—not as a scientist making a key breakthrough à la Watson and Crick, but as a passionate physician-scientist with the position and innate gifts to rise as a needed leader. He and a great opportunity found each other, in time and space.

This book is aimed at two audiences at the same time: on the one hand an educated lay readership, especially patients and their families, and on the other those who work on genes, gene products, and cells. The author charts out the territory with a clear didactic style. To engage both audiences simultaneously is not easy, but is something that true masters of their subjects can do (indeed, this is as good a definition of a master as I know). One of the most riveting impressions that comes across is that Collins has never stopped being a physician, but has also not ever stopped being a basic scientist. He clearly loves his patients first, but the lab is a very close second.

Collins covers the basics of gene expression and genome sequencing, then moves into the various aspects of how genomics can be used to detect or anticipate disease. He addresses these challenging frontiers as they apply to cancer in a particularly insightful and circumspect way. In contrast, in the arena of single gene-based pathology he uses his expertise in cystic fibrosis as a case in point: the number of mutations is large and carrier detection is generally successful but misses some.

His exposition of the gene therapy field is expert and wise, as expected. It is now twenty-six years since a four-year-old girl, Ashanti DeSilva, had her white blood cells transfected ex vivo with the gene for adenosine deaminase at the U.S. National Institutes of Health—she is prospering today, proving that it can be done. The subsequent era, involving retroviral insertion of hopefully corrective genes directly into patients, has been checkered by less impressive outcomes and tragedy, and Collins is objective in weighing these against the promise of success, now at hand given the safer adeno-associated viral vectors and some impressive clinical achievements recently.

A particularly poignant vignette Collins presents concerns progeria, a premature aging syndrome caused by mutations in a protein called lamin A that surrounds the nuclear genome. The discovery by Collins’s lab of the gene underlying one form of progeria is a spectacular example of how human genetics and basic cell biology can come together in wonderfully catalytic ways. Within weeks after this discovery, Collins and his team became aware of a recently developed foundation of incisive work on this protein by cell biologists who had not been thinking about disease but were just trying to figure out how the cell nucleus is built. This is an especially engaging part of the book, providing a case for the support of both basic and clinical research, and the peril of ever steering funds into either at the expense of the other. In closing sections Collins looks forward to the time when at least single gene-based diseases will be recognized and genetically defined at the first onset of symptoms, or even earlier in carrier detection. As a major theme of the book, he develops a strong case for the advent of “personalized genomics,” when very subtle zephyrs lurking in a patient’s DNA will be part of the diagnostic tree and treatment.

In its clarity of exposition, sobriety of promise, and engaging vision, this is a book that should be read by every physician whose practice interfaces with the genetics of disease, or whose broader intellectual fabric seeks to gain a sense of what is to come.

Interviewing a hopeful MD/PhD applicant to my medical school recently, I mentioned to her that she might, as a third-year student on the wards, see a chart with the entire genome of the patient. She replied, “I think that is a real possibility.” I wrote down “Good answer.” Then I added to my notes “Send her a copy of Francis Collins’s book when it comes out in January.”

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One Breath Apart: Facing Dissection

Sandra L. Bertman

Reviewed by Robert A. Chase, MD (ΛΩΑ, Yale University, 1947)

In this book, Sandra Bertman shows and discusses the changes in teaching and learning of human anatomy by human cadaver dissection. She comments on the history of human dissection, from pre-Roman, medieval, and Renaissance, to modern times, including its benefits to great artists as well as medical practitioners. The remarkable changes in the teaching and learning of human anatomy in the last half century are described in detail.
Psychological preparation of students anticipating laboratory dissection of a dead human being has become a standard for anatomy departments around the world. Support and open discussion of the effect upon students during the laboratory experience is now an important part of the process of preparing students to learn to care for living patients. During the entire period of concentrated study of human anatomy, psychological support, including discussion among students and faculty continues. The whole process has an important dimension beyond learning gross human structure, anatomical relationships, and the language of medicine. It introduces students to an understanding of death and dying, as well as an understanding of professional relationships with colleagues in medicine.

Through letters from donors and their families, students understand the desire of donors to help them become truly competent and caring professionals. This book outlines and effectively displays one technique for introduction of students to human dissection, initiated by a thoughtful faculty at the University of Massachusetts School of Medicine at Worcester. Appropriately, the author has dedicated the book to one such teaching innovator, Dr. Sandy Marks, who before his untimely death was well known to the worldwide community of teaching anatomists.

At the University of Massachusetts, students are invited to draw on a blank sheet of paper an image that depicts the student’s own feeling as he or she faced the prospect of dissecting a dead human being. They were also to write a short explanation of the feelings that helped them to generate the image. Selections from this thirty-year tradition are illustrated in One Breath Apart, including both the images and explanations showing the wide range of feelings of students anticipating the opening and exploring of a dead human being, a process that has been referred to as a “rite of passage” into the fraternity of medicine. The drawings are interesting and often revealing, and many of the explanations are poetic and touching. There are bits of humor, evidence of concern and fear, expressions of gratitude, thoughts of understanding of the relevance to patient care, and the development of a relationship to each student’s own cadaver. The juxtaposition of religious beliefs and emotions related to dissection come through in several of the examples shown.

During the period of dissection itself, students describe the variety of emotions they feel when first uncovering the face or observing fingernail polish, details that remind the disectors that they are working with someone who was human like themselves.

At the end of the anatomy course at the University of Massachusetts, and now in many of the world’s medical schools, a memorial service is held to honor and express thanks to the body donors. Student-produced music, poems, and thoughtful reflections are presented to a wide audience including students, donor families, and the public at large. Letters of appreciation from attendees, including donor families, are quoted in the book.

As students reach graduation years later, they regularly receive a note from the Anatomy faculty, including some of the drawings and comments made earlier, to congratulate the graduates and to wish them well.

This book will appeal to students about to embark on the study of medicine or any medically-related discipline in which human dissection is a requisite element and opportunity.

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**Doctors in Fiction: Lessons from Literature**
Borys Surawicz and Beverly Jacobson

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

**Doctors in Fiction: Lessons from Literature** is a fascinating collection of short essays about fictional physicians by Borys Surawicz and Beverly Johnson. The authors, one a cardiologist and the other a freelance writer, discuss a wide variety of doctors drawn from novels, short stories, and drama, and representing a fictional time frame from the late twelfth century to the early twenty-first. In each chapter the authors present one or more of these physicians in context, briefly introducing the work, the writer, and a précis of the social context.

Surawicz and Johnson intend this book to be read by physicians, medical students, and other health professionals.
who don’t have “much time to read fiction, except perhaps on vacation.” By introducing literary works that explore the great themes of medicine, *Doctors in Fiction* may “hook” these individuals into further reading. The authors begin each chapter by listing several themes suggested by the works and characters covered in that chapter and, in many cases, discuss these themes as they relate to contemporary medical practice, thus making the book a potential adjunct to teaching literature in medicine.

As a high school student, the first fictional doctors I encountered were Andrew Manson in A. J. Cronin’s *The Citadel* and Martin Arrowsmith in Sinclair Lewis’ eponymous novel. These two were ideal role models for an aspiring physician in that they committed themselves to excellence in patient care and research. Sure enough, they appear prominently in *Doctors in Fiction* as examples of highly ethical physicians; other such examples of truly “good” doctors include Tertius Lydgate (*Middlemarch*), Bernard Rieux (*The Plague*), and Thomas Stockman (*The Enemy of the People*).

At the other end of the spectrum are failures and burnt-out cases, like psychiatrist Dick Diver, the protagonist in F. Scott Fitzgerald’s *Tender Is the Night*, who succumbs to weakness and alcoholism, and the debauched abortionist Dr. Harry Ragin in *The Wild Palms* by William Faulkner. Some of the best examples of “fallen” doctors appear in the two chapters that deal with characters in Anton Chekhov’s stories and plays. Chekhov, a practicing physician himself, had an inside track in understanding the triumphs and tragedies of the medical experience.

One chapter focuses on Dr. Andrei Ragin, the dispirited medical director of Chekhov’s “Ward #6.” Ragin has withdrawn from his provincial hospital and sits at home all day reading and drinking beer, while his assistant takes care of the patients. Ragin justifies his *anomie* because he believes the hospital system is so corrupt that any effort on his part would be futile. During an unexpected visit to the psych ward, Ragin becomes fascinated with an articulate patient who challenges his self-justification by claiming that Ragin has never suffered, so he can’t empathize with his patients’ suffering. Ragin becomes obsessed with gaining the ability to suffer, an obsession that eventually leads to his own incarceration on Ward #6. Surawicz and Jacobson characterize this doctor as an essentially good man, but I tend to view him as a nonreflective, narcissistic person who never developed a mature professional identity. In either case his story is depressing.

The authors also touch briefly on several other doctors in Chekhov’s fiction: Dymov, an idealistic physician who dies as a result of the diphtheria he contracted from a patient (“The Grasshopper”); Korolyov, a young doctor who develops an empathic bond with a woman who suffers from chronic anxiety (“A Doctor’s Visit”); Startsev, a practitioner who grows to love money more than his patients’ welfare (“Tonitch”); and Astrov, the dedicated proto-environmentalist physician in *Uncle Vanya*.

Two of the most striking figures in *Doctors in Fiction* arise from contemporary popular fiction, but Surawicz and Jacobson also draw their doctors from recent works of a more literary bent, like the novels of Robertson Davies, Ian McEwan, and A. B. Yehoshua. All in all, *Doctors in Fiction* acquainted me with some old favorites and introduced me to several works with which I was unfamiliar. The book is by no means a comprehensive survey of physicians in literature—witness the absence of *Madame Bovary, The Magic Mountain* and, of course, Sherlock Holmes’ friend, Dr. Watson—nor is it a deep analysis of the works included. Rather, *Doctors in Fiction* is just what the authors intended it to be: a generous selection of physicians that illustrates “how the medical profession is viewed by prominent writers and how their writings may affect the judgment of the medical profession by readers.”

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

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The murmurs grew, my bow would not respond
The delicately sweet was all but lost
Notes tumbled smearing in a sludge
Of music drowned

My eyes were smarting from the salted sweat
Cascading from my devastated brow
My fingers stiffened as they touched
Unyielding gut

But then “good luck,” a pat upon the back
A handkerchief and “What would Heifetz do?”
I strode across the stage becalmed
And assayed Bach.

Emanuel E. Garcia, MD

Dr. Garcia (AΩA, University of Pennsylvania, Hutt Valley District Health Board, Lower Hutt) is clinical director of Mental Health Services at the Hutt Valley District Health Board in Lower Hutt, New Zealand. His address is: Hutt Valley District Health Board, Lower Hutt, New Zealand. E-mail: emanuelegarcia@gmail.com.
The Candidate

Having to answer the
inquiries
from each
interviewer
in every
city
is exhausting and
can be intimidating.
The relentless sniffing,
prying,
posing,
posturing,
pestering,
can create doubt and erode
confidence.

Is the process easier for those who try
to choose between souls without ever
knowing them?
A perfect process,
no—but better than—no
face.
Committees read vitas,
letters,
television colleagues and friends,
argue with each other about reliability, potential, virtue,
but rarely
do they ask directly of their
prey,
“pray tell us, who are you;
what do you love?”

Herbert T. Abelson, MD

Dr. Abelson (AΩA, University of Chicago, 2000) is senior associate dean for Admission and Student Affairs at the University of Chicago Pritzker School of Medicine. His address is: 935 East 59th, BSLC 321U, Chicago, Illinois 60637. E-mail: habelson@uchicago.edu.

Illustration by Erica Aitken
The board of directors of Alpha Omega Alpha established five student research fellowship awards in 1982. Since then, the awards have grown in number and dollar amount. As many as fifty $5000 awards are made, and $1000 is available for travel to a national meeting to present the research results. In 2004, the name of the fellowship program was changed to the Alpha Omega Alpha Carolyn L. Kuckein Student Research Fellowship awards in honor of Carolyn L. Kuckein, AΩA’s longtime administrator, who died in January 2004.

Evaluations of the fellowship proposals were made by reviewers C. Bruce Alexander, MD; Robert G. Atnip, MD; Jeremiah Barondess, MD; John A. Benson, Jr., MD; Natalia Berry, MD; John M. Boltri, MD; John C.M. Brust, MD; N. Joseph Espat, MD; Ruth-Marie Fincher, MD; Faith T. Fitzgerald, MD; Daniel Foster, MD; James G. Gamble, MD; Mary A. Gerend, PhD; Amy Goldberg, MD; Edward D. Harris, Jr., MD; Suzanne Leonhard Harrison, MD; David B. Hellman, MD, MACP; Joseph A. Hill, MD, PhD; Monica M. Jablonski, PhD; Rae-Ellen W. Kavey, MD; Zhongyu John Li, MD, PhD; Tara A. Lindsley, PhD; Michael D. Lockshin, MD; Mirjana Maletic-Savatic, MD, PhD; Anne T. Mancino, MD; Francis A. Neelom, MD; Douglas S. Paauw, MD; Thoru Pederson, MD; Suzann Pershing, MD; Sheryl Pfeil, MD; Don W. Powell, MD; Sarah M. Roddy, MD; William M. Rogoway, MD; Shashi K. Salgar, PhD; Gerald Weissman, MD; Donald E. Wilson, MD, MACP; Michael Zawada, PhD.

Checks should include a notation indicating that the funds are for the Edward D. Harris Professionalism Award.

Memorial donations

The AΩA Professionalism Award, initiated last year, was conceived and developed by Executive Director Edward D. Harris, who was passionately committed to excellence in every aspect of the practice of medicine. In his honor, the award will be renamed the Edward D. Harris Professionalism Award. Donations to AΩA in Dr. Harris’s name will be used to support this award. Please send donations to:

Alpha Omega Alpha
525 Middlefield Road, Suite 130
Menlo Park, California 94025

Interim editor

The board of directors of AΩA has appointed Pharos editorial board member Dr. Eric Pfeiffer interim editor of The Pharos. Dr. Pfeiffer is emeritus professor of Psychiatry and the founding director of the Eric Pfeiffer Suncoast Alzheimer’s Center at the University of South Florida College of Medicine in Tampa, Florida.

The board of directors and Pharos staff deeply appreciate Dr. Pfeiffer’s willingness to serve as interim editor.

2010 Carolyn L. Kuckein Student Research Fellowships

In 1982, the board of directors of Alpha Omega Alpha established five student research fellowship awards to encourage and support student research. Since then, the awards have grown in number and dollar amount. As many as fifty $5000 awards are made, and $1000 is available for travel to a national meeting to present the research results. In 2004, the name of the fellowship program was changed to the Alpha Omega Alpha Carolyn L. Kuckein Student Research Fellowship awards in honor of Carolyn L. Kuckein, AΩA’s longtime administrator, who died in January 2004.

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Interim editor

The board of directors of AΩA has appointed Pharos editorial board member Dr. Eric Pfeiffer interim editor of The Pharos. Dr. Pfeiffer is emeritus professor of Psychiatry and the founding director of the Eric Pfeiffer Suncoast Alzheimer’s Center at the University of South Florida College of Medicine in Tampa, Florida.

The board of directors and Pharos staff deeply appreciate Dr. Pfeiffer’s willingness to serve as interim editor.
Jennifer Bunch  
Southern Illinois University School of Medicine  
Prevention of Cisplatin Otoxicity by Transplantin  
Leonard P. Rybak, MD, PhD, and Vickram Ramkumar, PhD, mentors  
Andrew J. Varney, MD, councilor

Wayne Chen  
Wake Forest University Health Sciences School of Medicine  
Impact of age on Schwann cell dedifferentiation following PNS injury  
Zhongyu J. Li, MD, PhD, and Jonathan C. Barnwell, MD, mentors  
K. Patrick Ober, MD, councilor

Constantin Chikando  
Morehouse School of Medicine  
Effects of the amplification of the Bmal1 gene expression on the mammalian sleep-wake cycle  
Ketema Nnamdi Paul, PhD, mentor  
Frances J. Dunston, MD, MPH, councilor

Brittany Clark  
University of Rochester School of Medicine and Dentistry  
Validation of New Self-Paced Online Dermatology Curriculum Method  
Arthur Papier, MD, mentor  
Heidi Schwarz, MD, councilor

James Crawford  
New York University School of Medicine  
The Role of Local Reactive Oxygen Species in Diabetic Wound Healing  
Pierre B. Saadeh, MD, mentor  
Steven Abramson, MD, councilor

Chardan Das  
University of Arkansas for Medical Sciences College of Medicine  
Intraoperative peritoneally delivered MMP inhibitors for the prevention of ovarian cancer seeding and metastasis  
Timothy J. O’Brien, PhD, mentor  
C. James Graham, MD, councilor

Nicholas Do  
Dartmouth Medical School  
Immunohistochemistry Analysis of Tissue Hypoxia in Laryngectomy Patients in Relation to Fistula Development  
Eunice Y. Chen, MD, PhD, mentor  
Susan Harper, MD, councilor

Gregory Eckenrode  
University of Pennsylvania School of Medicine  
Characterization of residual neoplastic cells in a mouse model for Herz/neu-driven breast cancer  
Lewis A. Chodosh, MD, PhD, mentor  
Jon B. Morris, MD, councilor

Adriel Fajilan  
Loma Linda University School of Medicine  
CXCL12 May Provide Significant Neuroprotection Against Neonatal Hyoxia-Ichemia of the Brain  
John H. Zhang, MD, PhD, mentor  
Sarah M. Roddy, MD, councilor

Nina Gazanfari  
Rosalind Franklin University of Medicine and Science/Chicago Medical School  
The Effect of Rab5 GTPase Protein Knockdown in Papillomavirus Cell Trafficking and Infection in Human Keratinocyte Cells  
Patricio I. Meneses, PhD, mentor  
Cathy J. Lazarus, MD, FACP, councilor

Matthew Geeslin  
University of Minnesota Medical School  
Thermochemical Ablation of Ex Vivo Liver Using Sodium Hydroxide and Acetic Acid to Produce Heat in Situ  
Erik Cressman, MD, PhD, mentor  
Charles Billington, MD, councilor

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Creighton University School of Medicine  
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Laura A. Hansen, PhD, mentor  
William Hunter, MD, councilor

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University of California, San Francisco, School of Medicine  
Fertility Desires and Family Planning Among HIV-Infected Couples in Nyanza Province, Kenya  
Sara J. Newmann, MD, MPH, mentor  
Steven Z. Pantilat, MD, councilor

Nicholas Horen  
The University of Toledo, College of Medicine  
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Andrea L. Nestor Kalinoski, PhD, mentor  
L. John Greenfield Jr., MD, PhD, councilor

Yen Hsia  
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Role of Dectin-1 and TLR2 in Candida abicans Keratitis  
Eric Pearlman, PhD, mentor  
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Washington University in St. Louis School of Medicine  
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University of South Florida College of Medicine  
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SU1R-regulated NC(Ca-ATP) channel—a novel therapeutic target in perinatal hypoxia and germinal matrix hemorrhage  
J. Marc Simard, MD, PhD, mentor  
Yvette Rooks, MD, councilor

Yuna Larrabee  
Columbia University College of Physicians and Surgeons  
Noninvasive detection of phosphatidylinositol 3-kinase, catalytic subunit p110a(PK3CA) mutations in patients with known head and neck squamous cell carcinoma  
Gloria H. Su, PhD, mentor  
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David J. Fink, MD, mentor  
Cyril M. Grum, MD, councilor

Karen Li  
Drexel University College of Medicine  
Receptor selection in mouse bone marrow B cells  
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Allan Tunkel, MD, PhD, MACP, councilor

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University of Hawaii at Manoa John A. Burns School of Medicine  
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Mary Ann Antonelli, MD, FACP, councilor
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Ohio State University College of Medicine
Cardioprotection of critical Ca\(^{2+}\) handling proteins in super antioxid-

dant mice
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University of California, Irvine, School of Medicine
Evaluating the Effects of Pancreatic Protease Inhibitors on Multiorgan Failure in a Porcine Model: A Step toward a Mechanistic Explanation for a Fatal Syndrome
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Albany Medical College
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A Clinical Comparison of Successful and Failed Repeat Microdissection Testicular Sperm Extraction in Men with Non-Obstructive Azoospermia
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University of Nevada School of Medicine
Reversed Camera Task Training
Shawn Tsuda, MD, mentor
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Michelle Scerbo
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Reliable Reduction of Trauma Overtriage Based on Serial Prehospital Data: A Conservation of Scarce Health Care Resources
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Deana Shenaq
University of Chicago Division of the Biological Sciences Pritzker School of Medicine
The Differential Effects of Cellularity Engineered BMP-2, BMP-2, and Runx2on Bone Healing in Murine Critical-Sized Calvarial Defects
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University of Texas Southwestern Medical Center at Dallas, Southwestern Medical School
Predicting response to therapy of diabetic foot infection utilizing \(^{99m}Tc\) labeled white blood cell high resolution SPECT-CT imaging
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Russell Steele, MD, councilor

Alaa Tahan
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Use of retinoic acid in treatment of the childhood tumor rhabdomyosarcoma
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Ibrahim S. Salti, MD, councilor

Kathleen Turek
University of North Carolina at Chapel Hill School of Medicine
Influence of Government Food Program in Rural Mexico on Childhood Obesity and School Performance
Philip D. Sloane, MD, MPH, mentor
Amelia Drake, MD, councilor

Pranita Vemulapalli
Wayne State University School of Medicine
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Jonathan Yun
University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School
Intratumoral convection enhanced delivery of topotecan in a mouse model of glioblastoma
Jeffrey N. Bruce, MD, FACS, mentor
Geza Kiss, MD, councilor

The Pharos/Summer 2010
You go
with the fragrance of the departing dark
clinging softly to you.
Even your eyes hold their silence.
A clear wind blows gently through your hair
multiplying the stillness with a single sound
a whisper, barely heard
enshrined in a veil of shadows.
Turning to me
your eyes tell it all.
A gaze that reaches
to my heart’s core.
Suddenly
memories and dreams leap from our looking
taking me to the end
of my silence
finding again the love that began
so long ago.

Blair P. Grubb, MD

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Medicine and Pediatrics at the University of Toledo Medical Center. His address is: College of
Medicine, University of Toledo Medical Center, 5050 Arlington Avenue, Toledo, Ohio. E-mail:
blair.grubb@utoledo.edu.
When my winter’s cold is not warmed by the sun of length’ning days,
When the buds and blooms I faintly see are in my bedside vase,
When breath taking describes my gasp, not the wonder of my view,
When all my lust is minimized to the touch of one I knew,
When I can’t taste arugula nor smell the rosemary,
When I can’t hear the coming storm,
It's time. Declare the death of me.

Raymond C. Roy, MD, PhD

Dr. Roy (ACS, Wake Forest University School of Medicine, 2005) is professor of Anesthesiology at the Wake Forest University School of Medicine. His address is: Wake Forest University School of Medicine, Medical Center Boulevard, Winston-Salem, North Carolina 27157-1009. E-mail: rroy@wfubmc.edu.

Illustration by Jim McGunness