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

The Pharos of Alpha Omega Alpha Honor Medical Society (ISSN 0031-7179) is published quarterly by Alpha Omega Alpha Honor Medical Society, 525 Middlefield Road, Suite 130, Menlo Park, California 94025, and printed by The Ovid Bell Press, Inc., Fulton, Missouri 65251. Periodicals postage paid at the post office at Menlo Park, California, and at additional mailing offices. Copyright © 2010, by Alpha Omega Alpha Honor Medical Society. The contents of The Pharos can only be reproduced with the written permission of the editor. (ISSN 0031-7179)

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

POSTMASTER: Change of address requested: Alpha Omega Alpha Honor Medical Society, Post Office Box 2147, Menlo Park, CA 94026.
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t upon a time, 1970 to be precise, I returned to Dartmouth Medical School to join the junior faculty in Medicine. Its clinical arm was the Hitchcock Clinic. My motives in going north were several, but one was the superb group of clinicians in the Medicine section (Josh Burnett, the rheumatologist, in particular). Although it seems now even more like a fairy tale, everyone at the Clinic was happy, it seemed. One reason was that everyone was salaried, and salary was based on seniority. The senior pediatrician made a bit more salary than did the only cardiothoracic surgeon. Among other benefits of this payment structure was that free interchange of consultations was the norm, particularly the “curbstone” variety.

Not long after my return to Hanover, a fee-for-service compensation structure with enhanced income for those who performed procedures swept through the Clinic quickly. One unintended outcome was the gradual suppression of curbside consultation. It did no good for the diabetologist to give away management skills about using the new drugs to the general internist. He would say, “Schedule that patient to see me next week.”

Medicare, however, did save consultation for the cognitive specialties* by establishing a different billing code that gave the specialist an additional money for the added work involved in seeing the patient, doing the needed testing, and making the appropriate recommendations to the referring physician. It must be added, however, that the non-cognitive specialists (they reject that phrase!) cared little about the pittance consultation fee. They often saw the patient without charge in return for the opportunity to perform a procedure that was indicated. A new balance point had been achieved.

On November 25, the balance shifted again. A largely overlooked notice in the Federal Register from the Center for Medicare & Medicaid Services (CMS) reads, “beginning January 1, 2010 [it will be policy] to budget neutrally eliminate the use of all consultation codes (inpatient and office/outpatient) by increasing the work RVUs for new and established office visits.”1p61769 It further states, “We support the view . . . that in most cases, there is no substantial difference in work between consultations and visits.”1p61771

Part of the logic for this change in CMS policy were data gathered by the Office of the Inspector General showing that 47% of claims received by Medicare were billed as the wrong type or level of consultation, although more egregious “mistakes,” e.g., claims not meeting the definition of consultation (19%) or lack of documentation (9%), were found as well.

Keep in mind that by 2020 it is estimated that the costs of health care in United States will have doubled, and that despite the spending, the United States ranks (WHO data):

- Thirty-first among countries in life expectancy
- Thirty-seventh in infant mortality
- Thirty-fourth in maternal mortality.

An American woman is eleven times as likely to die in child-birth as a woman in Ireland.

Will doing away with consultations for Medicare patients (private insurers will probably follow suit) disrupt the quality of care that Americans expect and need? One physician blogger says that cognitive specialists are faced with “the Hobson’s choice being (a) do your usual thorough and thoughtful evaluation, and lose money, or (b) streamline your process (e.g., cutting allotted time from 60 mins./new patient to 30 mins.) or (c) having the patient who arrives for consultation fill out a detailed and organized history, followed by an interview with a nurse in your office, who edits the information into an electronic format . . . at which point you come in, all charm, glance at the form, examine the patient as necessary, dictate a problem list and a high complexity plan, and schedule the patient for a series of tests and follow-up visits.”

In the next decade, cognitive specialists may gradually disappear. Or perhaps the new paradigm will be online specialty consultations, such as the one offered by Partners, the combine of Brigham and Women’s, Massachusetts General, and Dana Farber Cancer Center hospitals (econsults.partners.org). The rates are

- Specialist opinion $495.00
- Radiology review $200.00
- Pathology review $250.00

(Additional cost for additional staining)

Whatever direction is taken, the traditional concepts of consultation are gone.

Very much needed, no matter what the outcome of our nation’s strategy for health care reform, is a strong and unified voice of medicine. CMS has found that no matter what changes it suggests, the conflicting comments about them cancel each other out. Medicine needs a powerful group of leaders with whom we can entrust our broad interests and who must speak in unison for the greater good of our profession and our patients.

Reference


* “Cognitive specialties” include those in pediatric and internal medicine such as: infectious disease, allergy, endocrinology, non-dialysis related nephrology, rheumatology, geriatrics, hematology and the components of oncology not related to infusions, and parts of other specialties such as non-operative dermatology.
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Mario Lanza, his mother, Mrs. Cocozza, and Kathryn Grayson. Credit: Photofest.
I went to join the registry
There is out there a need for marrow
It seemed the right and proper thing
Yet I returned back home in sorrow

You cannot join our registry
You’re healthy, that’s quite true, she said
But you are far too old right now
We need a younger man instead

But I’m quite strong from lifting weights
I also run around the track
We’re sure that’s true but we don’t care
Now go way and don’t come back

I make it out of hamburger
To keep the cost of goods quite low
Its lineage is very strong
At least I’m told that this is so

Of quality we have no doubt
She said to me with rueful smile
But seventy is just too old
Care to sit down for a while?

Rules are rules; that is quite true
One must accept the things you say
But I don’t think you understand
I made this marrow yesterday

J. Joseph Marr, MD
Behind a surgical mask, no one can see you smile; hence, surgeons are compelled to seek out other ways of conveying the meanings that a smile conveys. All the alternatives are flawed: winking’s too mild; saying “haha” is too corny. A controlled trial investigating whether a sarcastic phrase achieves more good than harm is in its early days, and yet off-label use is already in style: attending surgeons often fling sardonic quips at residents, med students, nurses, even the patient, using quips as a dubious form of compensation for the fact that no one can see them quirk their lips. As long as masks remain opaque, flesh-cutting docs will likely never cease to make cutting remarks.

Jenna Le

Ms. Le is a member of the Class of 2010 at Columbia University College of Physicians & Surgeons. This poem won second prize in the 2009 Pharoas Poetry Competition. The author’s address is: 630 W. 168th Street, P&S Box 418, New York, New York 10032. E-mail: jnl2105@columbia.edu.
A brief survey of medical literature reveals that the marketing practices of pharmaceutical companies have been under fire for decades. On medical school campuses and in health care policy fora, it is a commonly-heard refrain that “big pharma” spends as much on marketing as on R&D. In fact, a 2008 study published in *PLoS Medicine* contended that pharmaceutical companies spend *twice as much* on marketing their drugs as they do on developing new ones. The FDA’s 1997 rule allowing pharmaceutical companies to advertise prescription drugs directly to consumers is frequently criticized as being wasteful, promoting unhealthy behavior, and—most damning—making the doctor-patient relationship more difficult.

In this environment, physicians find themselves under increasing pressure to resist the overtures of pharmaceutical representatives, to spurn free pens and clipboards and reject the free lunches and “educational” dinners they have accepted for the past fifty years. Academic medical centers are rewriting the guidelines that govern when and where pharmaceutical representatives can contact their faculty and staff, the types of acceptable gifts and payments, and how CME course curricula are created and funded. All these efforts focus on doctors, attempting to change the way they interact with the drug industry, but ignore the powerful incentives driving the industry to continue targeting physicians with their marketing efforts.

Effective solutions require a full understanding of the causes and extent of the problem. Several features of the status quo bear closer attention:

1. The cost of prescription drugs
2. The impact of pharmaceutical marketing on these costs
3. The pharmaceutical industry’s marketing methods.

**Purushottam A. Nagarkar**
The author (AΩA, University of Texas Southwestern, 2009) is a member of the Class of 2010 at the University of Texas Southwestern Medical Center at Dallas. This essay won third prize in the 2009 Alpha Omega Alpha Helen H. Glaser Student Essay Competition.
The cost of prescription drugs

In 2005, the United States spent $1.99 trillion on health care. The analysis of spending, labor, and industry data in Chart 1 reveals where this money is spent.

The impact of pharmaceutical industry marketing

Thirteen percent of total U.S. health care spending ($260 billion) went to prescription drugs. In comparison, if U.S. per capita prescription drug spending decreased to the average level of other G8 nations,* we would save $80 billion per year.\(^7\) Estimates by global market research companies show that drug marketing in Europe is about 12 percent of European revenue, while in the United States it is about 18 percent ($45 billion).\(^8\) This higher spending on marketing likely contributes to the $80 billion incremental cost by driving inefficient drug prescribing patterns. Thus there are two types of costs associated with pharmaceutical marketing—direct costs (the $45 billion in marketing dollars being passed on as higher drug prices), and indirect costs (the portion of the $80 billion in incremental costs that is driven by inefficient or suboptimal prescribing patterns).

* The G8 provides a good basis for comparison, since health outcomes are comparable to those in the United States. The $80 billion value is arrived at after correcting for purchasing parity. It accounts for lower drug prices in countries that have less spending power. The value would be higher without this correction.
Two questions about the direct costs need to be analyzed:

1. Is the pharmaceutical industry unique in its reliance on marketing?
2. How is the money being spent—on doctors or on mass-media advertising?

The first question can be answered by comparing the pharmaceutical industry to the rest of the economy, shown in Chart 2. The drug industry spends five times more on marketing (as a percentage of sales) than other retailers. As the industry has become increasingly reliant on marketing, it has changed the allocation of its marketing dollars. Between 1996 and 2005, marketing grew from 14.2 percent to 18.2 percent of revenue—a compound annual growth rate (CAGR) of 2.8 percent. The breakdown of this spending by category is shown in Chart 3.

Spending on detailing—visits to doctors by sales representatives—decreased from 5.4 percent of drug sales in 1997 to 4.4 percent in 2005. The increase in spending was mostly on drug samples (CAGR 3.7 percent). The data in Chart 3 counts drug samples at their full retail price. Other estimates use the wholesale price of drug samples, physician surveys, and confidential pharmaceutical industry data to arrive at a different distribution by category, shown in Chart 4.

While there is some disagreement about whether drug
samples or detailing accounts for the bulk of marketing costs, both are marketing activities primarily focused on physicians. Thus, the large majority of marketing budgets—the direct costs of marketing—are spent on physicians.

The drivers of the indirect costs cannot be determined from financial statements, simple market research, and industry trends alone. However, many studies have looked at the effect of detailing and drug samples on prescribing patterns. One study of obstetrician/gynecologists found that more than ninety percent of surveyed physicians thought that accepting drug samples was ethical. More than sixty percent of these doctors admitted that they generally prescribed the brands for which they had samples, primarily because it was convenient and not for reasons of perceived clinical superiority. Another study found that doctors were three times less likely to prescribe generic versions of drugs to uninsured patients if they had access to drug samples. Since the use of generics is linked to lower costs, these findings imply that, in the absence of drug samples, prescribing patterns might shift toward cheaper, clinically-equivalent generics. Thus it is likely that some of the incremental $80 billion of drug costs in the United States compared to the rest of the G8 nations are due to prescribing patterns.

Marketing methods of the pharmaceutical industry

Although detailing is a highly effective marketing technique, it is also labor-intensive and time-consuming. To compensate for this, pharmaceutical companies have developed methods to more efficiently target their detailing efforts. Retail pharmacies sell retail prescription records containing physician identifiers to data-mining companies. The AMA maintains and licenses a “masterfile” mapping these identifiers to detailed information about each physician. These two data sources allow pharmaceutical companies to know—in complete detail—the prescribing patterns of individual physicians. It lets them target their efforts effectively, but even more importantly, it lets them track the impact of their marketing dollars. For example, if a doctor starts prescribing a drug that a sales representative has been pushing, the corporation knows it is getting a good return on its investment. In this way, companies can make intelligent decisions about allocating marketing dollars, choosing marketing strategies appropriate to each physician’s tendencies, spending more on the physicians who provide a return, and less on the ones who don’t.

With these pieces of information in hand, the problem can be summarized simply: Each year, pharmaceutical companies spend $45 billion on marketing (with $40 billion spent directly on doctors), tracking and targeting their efforts with doctor-specific prescription data, resulting in increased health care costs of $80 billion per year.

Striking down data mining

Most current efforts at resolving this problem focus either on asking the industry to spend less on marketing or on setting guidelines for physician interaction with pharmaceutical representatives. But moral imperatives and ethical guidelines have never proven effective at changing behavior. As long as there is a strong incentive to engage in unethical—but legal—activity, it will continue. The better solution is to change the incentives and make unethical behavior unrewarding. While it is probably not possible to make pharmaceutical marketing unrewarding without mandating behavioral changes from physicians, the linchpin of the marketing machine is the ability to assess the return on marketing dollars. Without access to physician-identifiable
prescription data, pharmaceutical companies would be unable to efficiently target their marketing efforts.

This approach is already being pursued by several states. New Hampshire, Vermont, and Maine have passed laws that prevent the transmission or use of prescriber-identifiable prescription data, effectively short-circuiting the pharmaceutical marketing mechanism. The New Hampshire law was challenged by two data-mining companies, and was initially struck down by a federal district court judge as a violation of the First Amendment. However, in November 2008 a three-judge panel of the moderate First Circuit federal appeals court reversed the district court decision and upheld the law, arguing that it only regulates conduct and therefore is not a First Amendment violation. This bodes well for the Vermont and Maine laws. The advantage of this approach is that it only changes the incentives: new guidelines don’t have to be written and doctors don’t have to be persuaded that their clinical decision-making is affected by marketing pitches. Without data to track the effectiveness of their marketing dollars, pharmaceutical companies might voluntarily reduce their spending on detailing. This would weaken the pharmaceutical/physician relationship, resulting in a reduction of the overall spending on drugs through greater use of clinically equivalent generics.

More importantly, regulating the use of prescription information is justifiable within a framework of individual privacy protection. Apart from state licensing boards, the FDA, and the DEA, no other entity needs access to physician-specific prescription data. This approach does not create complicated and unenforceable ethical guidelines for physicians, and does not require public corporations to behave in a way out of keeping with their fiduciary duties.

Can there be health care reform without pharmaceutical company regulation?

The long-term effects of such laws are unpredictable. Will pharmaceutical companies find other ways to track the return on their marketing dollars? Will they start spending more on direct-to-consumer advertising? Will doctor/patient interactions suffer as a result? Will companies spend even more on detailing because they cannot efficiently allocate their current budgets? Will doctors who have come to rely on detailers to provide them with information on new drugs find themselves behind the curve? These claims will no doubt be made by industry spokesmen. In the next few years it will be necessary to look at prescription and market research data from states that have successfully implemented these laws. If these data show that the direct and indirect costs of marketing have indeed been reduced as a result of prescription privacy laws, it may be time for other states to follow suit.

References


The author’s address is:
2610 Allen Street #1202
Dallas, Texas 75204
E-mail: nagarkar@alumni.rice.edu

By and about Purushottam Nagarkar

I am planning on pursuing a career in Plastic and Reconstructive Surgery. I have a longstanding interest in health care policy, with a special emphasis on its economic aspects. I earned my BS in Electrical Engineering from Rice University in Houston, and worked as a management consultant with the Boston Consulting Group.
The ethics of cosmetic enhancement

Anna Raphael, MD
The author is a resident in Internal Medicine at Montefiore Medical Center in the Bronx. This essay won first prize in the 2009 Alpha Omega Alpha Helen H. Glaser Student Essay Competition.

The burgeoning use of cosmetic procedures and the potential ethical implications of this trend have been on my mind since I came face to face with these issues as a medical student rotating through the dermatology and surgery departments. I had already seen shows like *Extreme Makeover* and knew that going under the knife wasn’t for me. However, now that I was going to be a physician, I not only had to consider what I would do for myself, but what I could do and would do for others. The struggle to define the boundary between treatment and enhancement is not unique to the fields of plastic surgery and dermatology. Many specialties, from psychiatry to medicine, raise the possibility of making us “better than well,”1 offering drugs for social anxiety or erectile dysfunction, for example. Still, plastic surgery and dermatology remain the two fields with the most potential for enhancing the healthy rather than simply treating the ill.

Over the past few decades, cosmetic plastic surgery and dermatology procedures have been democratized for the public and adopted with great enthusiasm by physicians. In 2007, board-certified physicians performed 11.8 million cosmetic procedures in the United States.2 The top four surgical procedures—breast augmentation, liposuction, nose reshaping, and eyelid surgery—accounted for 1,175,500 of these procedures,2 up from 443,728 of the top four surgical procedures combined in 1997.3 Annual expenditures have increased from an estimated $1 to $2 billion in 1996 to $12.4 billion in 2007.2,3

1975–The FTC permits physicians to advertise. The flood gates open.

This enormous growth in cosmetic procedures results from changes in the law, technology, attitudes, and finances. In the past, cosmetic surgery was a well-guarded secret of mostly wealthy and upper-middle-class clients. At the same time, physicians were prohibited from advertising their services. In
The ethics of cosmetic enhancement

1975, the Federal Trade Commission lifted its ban on physician advertising, and physicians began promoting cosmetic services. The introduction of less invasive procedures such as Botox injections and injectable wrinkle fillers fueled much of the more recent growth, and nonsurgical cosmetic procedures accounted for eighty-five percent of total cosmetic procedures in 2007. Botox injection is by far the most common, with 4.6 million treatments given by board-certified physicians in 2007, an increase of 488 percent from 2000. The visual nature of cosmetic procedures made them well-suited to exposure on television and in women's magazines. Not surprisingly, the American public became more aware and accepting of cosmetic procedures. Finally, health care reform in the 1990s that reduced reimbursement for reconstructive and medical procedures prompted many physicians to start offering cosmetic procedures or expand existing cosmetic practices. Physicians partnered with financial agencies so that more people could secure cosmetic surgeries with credit or monthly installments. Today, more than two-thirds of American cosmetic surgery patients earn less than $50,000 per year.

While cosmetic procedures have boomed in number, there has been a simultaneous shortage of reconstructive plastic surgery and medical dermatology services. Evidence for this relative workforce shortage is not as clear-cut as the evidence of the increase in cosmetic procedures, but it is still highly compelling. It is suggested anecdotally within the specialties and by surveys of residency faculty, physician practice mix, and patient wait times for noncosmetic appointments. A study using physician data from the American Medical Group Association and Medical Economics magazine showed that between 1992 and 2002 cosmetic procedures as a percentage of plastic surgery practice increased from twenty-seven percent to fifty-eight percent, and the average number of cosmetic procedures per surgeon annually increased from fifty-two in 1994 to 105 in 2002. In a recent survey of burn centers, thirty-eight percent anticipated needing to recruit a new burn surgeon in the next five years and eighty-nine percent expected it would be difficult to do so.

In dermatology, the reported amount of cosmetic work is also significant. According to a 2007 American Academy of Dermatology (AAD) practice survey, fifty-four percent of dermatologists reported that cosmetic procedures made up about ten percent of their practice. Regardless of whether media exposure and the popularity of cosmetic procedures make the proportion of cosmetic work done by dermatologists seem higher than what it actually is, surveys of patients show problems with access and patient dissatisfaction. Surveys reported in 2006 and 2007 showed that patients were more likely to get a timely appointment with a dermatologist when they requested Botox injections than when they reported a changing mole, with an average wait time of six to eight days for the former and twenty-six to thirty-eight days for the latter. Doctors themselves note that specialists in pediatric plastic surgery and dermatology are harder to find. Pediatric dermatology and plastic surgery practices are less lucrative than those treating adults, which get higher insurance reimbursements and often incorporate out-of-pocket cosmetic procedures into their practices. One dermatology resident professed an interest in pediatric dermatology to me, but acknowledged that pursuing it would decrease her future income by $100,000 per year.

Beyond the practical dilemmas that a relative workforce shortage creates for the medical profession and patients in need of noncosmetic services, we need to consider the ethics of the burgeoning availability and use of cosmetic procedures. Key to the ethics of cosmetic and reconstructive procedures are these questions:

- What is normal?
- What does functional impairment mean?
- What are the goals of medicine?
- What is the morality of medicine?
- What official position, if any, should the specialties of plastic surgery and dermatology take on cosmetic procedures?

The line dividing cosmetic and noncosmetic procedures is often difficult to define. However, when public resources are used to finance procedures along this continuum, as in certain countries with national health insurance, a distinction must be made. People generally agree that reconstructive surgery for disfigurement due to burns, trauma, surgery (e.g., mastectomy for breast cancer), or congenital abnormality should be covered by government-financed health care. On the other hand, surgery to correct unattractive appearances due to age or heredity is more difficult to justify when public funds are used.

In the 1980s, the Netherlands established objective appearance criteria for cosmetic procedures to be covered by national health insurance. These included women having breasts whose nipples were at or below the level of their elbows, women with greater than four dress sizes difference between their upper and lower bodies, and people who looked...
at least ten years older than their chronological ages.¹⁴ The seemingly arbitrary nature of these criteria leads us to wonder how they were decided. At the same time, such standards illustrate that large variations to “normal” appearance must be present before intervention can be considered. No other national insurance program I examined provided coverage for the type of cosmetic procedures once subsidized in the Netherlands.

The philosopher John Rawls spoke of the virtue of equal opportunity for individuals, which would require eliminating social disadvantages caused by racism, sexism, or lower socioeconomic status.¹⁵ Norman Daniels interprets equal opportunity as it relates to health care as the ability of individuals to remain as close to “normal functioning” as possible and thereby enjoy their “fair share of the range of opportunities reasonable people would choose in a given society.”¹⁵ The economic and social advantages of being tall and good-looking are well-known. Tall men and attractive men and women have higher incomes and are more likely to find desirable mates (i.e., similarly tall, attractive and/or wealthy) than their short and unattractive counterparts. Thus, even if shortness and unattractiveness are part of the range of human variation, one could argue that such people are functionally impaired in their ability to reach the highest strata of society.

It is no surprise that women comprise the vast majority of patients undergoing cosmetic procedures, making up approximately ninety percent of cosmetic patients in 2000 and 2007.²⁻¹⁴ The pressure on women to conform to stereotypical Western notions of beauty results in Asian woman having eyelid reconstruction surgery and Jewish or Iranian women growing up with the expectation of getting a “nose job.” When a mother takes her teenage daughter to the mother’s plastic surgeon, a new kind of family resemblance is perpetuated.¹⁴

The American Society of Plastic Surgeons (ASPS) distinguishes between cosmetic and reconstructive surgery on its web site in an extensive section for “Patients & Consumers.” It makes a distinction between cosmetic and reconstructive surgery on its web site, nor in its 2006 code of ethics. Its explanation that cosmetic surgery is not usually covered by health insurance “because it is elective”¹⁶ seems incomplete, however. Many reconstructive surgeries, such as reconstruction following mastectomy or the autotransplantation of a toe for an amputated thumb could also be considered “elective” because they do not improve patient survival, and patients still have to choose to have them done. It would be more appropriate to say that cosmetic procedures are not usually covered by insurance because they are performed on normal, instead of abnormal structures. Noncosmetic procedures still better serve what we traditionally view as the goals of medicine.

The goals of medicine, like the morality of medicine, have been described in various ways. Daniels takes a Rawlsian approach to propose that the goals of medicine are to keep all individuals as close to normal functioning as possible, to create “normal competitors” for the world’s opportunities, even if not equal ones.¹⁵⁻¹⁶ But with limited health care resources, physicians are not obligated to do everything possible to normalize people’s functions, let alone enhance them.¹⁵ We cannot create a world of “normal competitors” because even assuming an ideal situation in which everyone has the ability to pay for health care (i.e., universal health insurance), geographic disparities in the numbers of health care providers and the availability of technologies will still exist. Moreover, care itself is imperfect. This nevertheless leaves the door open for people to privately purchase cosmetic procedures.

In the Aristotelian essentialist position of Edmund Pellegrino, the goal or “end” of clinical medicine is a healing good intimately bound up in the physician-patient relationship.¹⁷ This internal good is distinct from external goods such as physician fees for consultation or treatment. The good is comprised of a “medical good” (technical skills or knowledge); the patient’s perception of good; the “good for humans as humans,” rooted in common principles of autonomy, beneficence, nonmalfeasance, and justice; and the spiritual good that
respects the patient as a divine or spiritual being and is the highest good that must be served. Cosmetics procedures fit these different "goods" to varying degrees. They certainly involve technical competence and knowledge. Something seemingly as simple as a Botox injection is done in a systematic way, taking into account facial muscle and nerve anatomy and titrating to a proper dose of the toxin over time. Many patients and surgeons testify to how a cosmetic procedure radically changed a patient's life for the better. The availability of cosmic procedures is consistent with the principles of patient autonomy; favorable results can count as beneficence. One can argue, however, that such procedures violate the principle of nonmalfeasance, since healthy patients with normal anatomy thus experience the risks and complications associated with cosmetic procedures. Cosmetic surgeons and dermatologists point out that complication rates are low and risks versus potential benefits must be weighed by each patient. At first it seems difficult to see how cosmetic procedures serve a spiritual good, but if we consider one's spirituality to include self-esteem and outlook, it can surely be positively affected by cosmetic procedures.

Franklin Miller and Howard Brody take the position that the goals and the morality of medicine "are not timeless and unchanging; of necessity they evolve along with human history and culture. The goals of medicine developed by the Hastings Center that Miller and Brody cite are examples of this evolution, as they allow that physicians may pursue a "peaceful death" for patients, something that would have been unthinkable before the concepts and principles of patient autonomy, withdrawal of life-sustaining measures, and, to a lesser extent, physician-assisted suicide, became more accepted by mainstream medicine. According to Miller and Brody, the problems treated by cosmetic procedures simply do not qualify as maladies. While they may cause suffering, physicians are not obligated to "relieve any and all pain and suffering." Only certain physicians, such as psychiatrists, might find themselves compelled to relieve the suffering associated with the failures and disappointments of everyday life, and even they must establish boundaries. Patients with borderline personality disorder, for example, may be told that they can call as late as 6 PM to speak with their psychiatrists; after that time, they must leave a message.

Related to the goals of medicine is the morality of medicine. Depending on whether we value autonomy or a broadly-defined patient spirituality more than the principle of nonmalfeasance, cosmetic surgery may or may not be acceptable according to the essentialist position of Pellegrino. Robert Veatch takes an entirely externalist position, arguing that medicine has no common internal core values and that all medical values come from external, culturally-specific sources. According to this view, the practice of a nonmedically indicated procedure such as castration by physicians would be acceptable because a particular society values the outcome, in this case the preservation of a high-pitched, beautiful singing voice. Cosmetic surgery would be entirely permissible according to this view because our society values the results.

Miller and Brody take a position in between the internalist/essentialist and the externalist positions. They hold that both the goals and morality of medicine are influenced by internal professional virtues related to the commonality of healing, as well as by external cultural factors. This position may be the closest to reality. Miller and Brody have stringent criteria for what defines a "malady" and for the types of communications that physicians can have with patients. They argue that the "defects" cosmetic patients choose to change must be clearly visible. A defect that, to others, may appear perfectly normal may cause the person with the defect intense dissatisfaction or unhappiness. Like other types of pain, pain associated with one's physical appearance may be at once undeniable to the sufferer but unverifiable to others.

Though Miller and Brody would not consider healthy patients with normal (if undesired) features as having maladies, perhaps the increasing prevalence and acceptability of cosmetic procedures is changing the commonly understood definition of "malady," along with the definition of "normal" itself. This appears to be more prevalent in certain affluent communities. According to Alex Kucynski, a New York City style reporter, people in certain parts of the country expect women's breasts to be augmented. Most breast implants are round instead of the more naturally shaped teardrop. The unnatural upper fullness that round implants create is valued, as is the way that augmented breasts remain erect when women are lying down. Surgical "vaginal rejuvenation"—removing excess skin to tighten sagging labia—while still uncommon, is one of the fastest-growing areas of cosmetic surgery. Equally worrisome are the hymenoplasties performed on women who have had premarital sex but who for cultural reasons need to appear to be virgins. In all these cases, different norms are imposed on women and perpetuated through cosmetic procedures—painful, expensive, and not without risk.

We may have to accept the evolving concept of "normal" using Miller and Brody's evolutionary position on medicine,
at least in specific groups of society. Nevertheless, they point out other ethical issues in the field of enhancement: cosmetic procedure advertisements often misrepresent benefits in proportion to risks to play on the public's insecurities, violations of the morality of medicine, as well as the ASPS's own code of ethics in the case of misrepresentative advertising. Cosmetic surgeons claim to enhance self-confidence, although they generally do not work with a team of mental health professionals, as would those serving sex reassignment surgery patients.

Few would argue that cosmetic procedures should not be permitted. The relative shortage of medical dermatology and reconstructive plastic surgery services is a related ethical problem that our profession will have to address. Perhaps the creation of dedicated medical and reconstructive tracks within residency programs should emphasize improved noncosmetic patient care, thus retaining more physicians in such practices.

The public also bears responsibility for creating the current environment. In trying to become prettier, thinner, younger-looking, or more virginal, the public recasts the collective definition of "normal" in ways that discriminate against women, the elderly, minorities who don't conform to mainstream ideals of beauty, and the poor who, despite being able to splurge on a procedure or two using credit cards, can never attain the look of the rich achieved through regular cosmetic services, and adhering to a morality of medicine that values restoration to normal more than manipulation of the normal.

As physicians we have the ability to choose what services to provide our patients. Discouraging sexism and other forms of discrimination, providing timely access to noncosmetic services, and adhering to a morality of medicine that values restoration to normal more than manipulation of the normal are to me the most compelling reasons for physicians to limit their cosmetic practices.

References

The author's e-mail address is araphael@medalum.pitt.edu.
My experiment started on Friday, January 30, at exactly 12:00 AM according to the friend I was talking to over instant message as he counted down from the official time.gov website. Back when I was five, I first discovered the wonders of the natural world. I wish I could say that it was an ant that I stared at in awe that led me to science, but I really can’t remember. Still, I love science. So this is a science experiment, and I must follow the rules of an experiment: change a single independent variable and observe its effects on any number of dependent variables. What did I change that fateful midnight? We’ll get to that. First, I need to bring you up to speed.

Med school. Two-thirds of the way done with my first...
I’m still in that tender phase where the term “ischio-anal fossa” can put a smile on my face. I’m still caught between the professional sterility of a hospital and the precious freedom of a student. But recently my grades have been declining. And Friday, January 30, is the two-week mark before our fourth and most difficult test. Friday, January 30, is that dreaded time when everyone starts studying and, unfortunately, some people stop showering.

But I find that the farther I get in my medical training, the more I try to escape it. I’m drawn to projects that couldn’t possibly be farther from my future. I’ve taken on a time-consuming role as producer for our yearly sketch comedy show. I’ve spent countless hours designing our class hoodie and t-shirt. But creative outlets aren’t the only reasons for my academic nadir. I’ve grown lazy. I’ve started watching TV and lost the will to turn it off. I’ve maintained only enough energy to change the channel to something less repulsive than silence and study. I do my assignments while chatting on-line, occasionally peeking behind my laptop lid just in time to see a building explode on my HDTV.

I take pride in being on-line nearly 24/7. I read RSS feeds about the latest phones and hottest gadgets instead of reviewing lectures. I use my BlackBerry religiously, whether showing visitors around the top of the Hancock Tower or sitting on the toilet bowl by my lonesome self. I’ve fallen victim to the ease with which I can read and respond to e-mails, texts, instant messages, and even Facebook notifications.

I’m shackled to my computer, to my phone, and to the Internet. And so my experiment was designed to change that. No, I’m not giving up my computer, my phone, or the Internet. That would just be too cruel. One independent variable at a time, remember? All I’m doing is giving up Gmail’s built-in chat for the two weeks before the exam. Yes, it’s an experiment designed to see how much instant messaging affects my academic performance, but more importantly it’s a test of my own determination and willpower.

And so at 12:00 AM on Friday, January 30, I turned off chat in Gmail.

The protocol? Perhaps I should have thought it through before starting. Well, I did know that I didn’t want anybody to know about it while it was still underway. That would have spoiled the fun. So I didn’t reveal the parameters of this experiment to anyone except the friend who counted down the time for me.

I started this experiment with the intent to quit Gchat and only Gchat, so I could still text, e-mail, and call people. But I faced a few troubling ethical dilemmas with that basic experimental premise. I found myself e-mailing back and
The effect of Gchat deprivation on medical student productivity

forth with friends every five seconds. It was instant e-mailing instead of instant messaging; could I proceed or would that be missing the point? I found myself trying to plan a study session with my roommate and a friend that my roommate was talking to on-line; could I ask him to tell her what/when/where and just use him as a proxy for my technological Lent or would I not be giving up enough?

I managed to survive the moral quandaries by choosing to go conservative. I stayed as far away from anything that might be construed as a breach of conduct by all the naysayers out there. I never used anybody else’s Gchat and I never used anybody as a Gchat liaison. I didn’t want the baby (read: results) to be thrown out with the bathwater (read: technicalities).

And what resulted from turning off Gchat? Besides infuriating the two girls I was holding active conversations with (hey, I’m a stickler for anal-retentive, obsessive-compulsive precision), I’ve found time to read over lecture material, complete assignments early, and go to sleep before midnight.

I will admit that the first few days were tough. I found myself loading up Gmail and keeping it in the background like I used to—available and waiting for anybody to start up a conversation. Whenever I sat down to work, I took out my laptop to get online, only to find a distinct lack of things to do since Gchat was turned off. The addiction was slowly fading. I no longer left my browser open once I was done reading my e-mail and feeds; I closed the window. I no longer reached for my laptop when I started to study; I took out my syllabus.

But it is not enough. While I’m ten to twenty lectures ahead of where I would normally be at this time, I’m still ten to twenty lectures behind the best in our class. While I sleep an hour more each night, it’s still an hour less than the amount needed to wake up refreshed. Giving up Gchat can only get me so far, because the problem lies deeper than that. There’s something preventing me from diving head-first into my future. It’s not a question of being in the right field, because I adore medicine. But despite my interest, this malaise persists. I must identify and deal with whatever is holding me back before I can reach maximal productivity.

I avoid doing work despite the fact that I love everything I do. Gchat isn’t the problem, it’s just a distraction. And since giving it up, I’ve found other distractions. I peruse Facebook like it’s CNN during election season, madly posting on people’s walls and commenting on their photos. I start (and finish) more crosswords. I even sit and stare at nothing at all.

And while it certainly has some obvious benefits, getting rid of an entire avenue of communication also has its downsides. I found myself one day in the following situation:

By and about Steven Quinn

I love living in Chicago despite its cold winters and hot summers. When not busy rocking anatomy practicals, I am creatively involved with both the school’s literary magazine and yearly comedy show. I plan to continue working on graphic design—through writing, photography, and filmmaking—in my free time until I graduate in 2012.
Noon. My friends are in the library and I am in my apartment. Earlier we mentioned eating lunch, but no specifics. We need to organize a get-together, but their phones don't get service in the library, so they can't call or text me. On the other hand, my BlackBerry isn't sending or receiving any e-mails due to a server outage, so they can't e-mail me and I can't e-mail them. And all this time I'm staring at the little Gchat icon on my phone, scrolling back and forth over it hoping I might accidentally click on it, void the integrity of the experiment, and be freed from the misery that is technological abstinence. Instead I just send them an e-mail from my laptop convincing them to leave their comfortable seats in the library and give me a call. We finally meet up and eat out somewhere an hour later. An hour. Wasted. Fie, lack of Gchat, fie!

I turned in my fourth test on Friday, February 13, at exactly 12:00 PM, two weeks and twelve hours after I started the experiment. But I didn't get back on-line until a few hours after that. (So much for that anal-retentive, obsessive-compulsive precision that got me yelled at.) I didn't get back on-line because I didn’t really want to. I no longer felt the urge to. It was a foreign, freeing feeling after so many years of being tethered to it. But of course technology is the future and I am right at the vanguard embracing it. I just don't want to embrace it so hard it sucks the life out of me.

Was it worth it? Absolutely. When the experiment started, I couldn't wait to feel the rush of being on-line again. The knowledge that I would get my drug back kept me alive during my self-imposed withdrawal. Before that, I didn't think I'd be able to give it up completely. Forever. But maybe that’s possible now. Would I do it again? If I did, I would allow myself one caveat. I would let myself go on Gchat on my phone. As inconvenient as it is to type out even short e-mails on a tiny keyboard with my knuckles knocking into each other, it would be nearly impossible for me to try to maintain multiple Gchat conversations all feigning interest in other people's days. Thus, Gchat on my phone would serve purely as a tool to set up real-life meetings—and an effective one at that.

What did I learn? By chatting with people less, I talk to people more. I listen to people more. Gchat is a prison of superficial connectivity that prevents us from true interactions. And those interactions are something I need to hold on to because they’re the only things keeping me afloat until I regain the wonder with which I once viewed the world, until I find medicine’s proverbial ant. I need to take advantage of the time I’m given in this tender phase of my life, because once it passes, the ischio-anal fossa will become just another body part instead of the butt of a clever joke.

The author’s address is:
333 E. Ontario Street, Apartment #2113B
Chicago, Illinois 60611
E-mail: s-quinn@northwestern.edu

Wynne Morrison, MD
Dr. Morrison is an assistant professor in Anesthesiology and Critical Care at the University of Pennsylvania School of Medicine and the Children’s Hospital of Philadelphia. Her address is: 34th Street & Civic Center Drive, Philadelphia, Pennsylvania 19104. E-mail: morrisonw@email.chop.edu.
January 3, after finishing her first day of class in the second semester of her second year of medical school, was the day a twenty-eight-year-old African American woman began a mother’s nightmare journey. After a morning of pathology and pharmacology lectures, she hurried over to her OB/GYN for her scheduled prenatal appointment. She thought it was just a routine prenatal visit until her clearly worried obstetrician concluded his examination. At twenty-six weeks gestation, she was eight centimeters dilated and, the physician said, about to deliver her third son prematurely. She visibly paled and likely would have shrieked if she hadn’t seen one of her fourth-year colleagues looking on. Her physician calmly noted all of this and kindly pulled the drape, blocking the student’s view. As if that drape were a solid wall, she allowed herself to burst into tears at the thought of another premature labor, of repeating a nightmare she thought she had left behind.

Thirty minutes after her diagnosis, she was in the OR being prepped for surgery. Her son was soon delivered, tiny but so beautiful, though only two pounds twelve ounces. Then began the NICU routine that was to consume their family once again.

Surprisingly, her first words after awakening from sedation were singularly focused on her son and his current status. She asked about her son’s vital signs, his oxygen saturation, and how he was being ventilated. The nurse looked perplexed, until her husband explained (almost apologetically), “She’s a medical student.” The nurse nodded in apparent understanding and told them to relax. She said she would check for the answers to those questions, left the room, and never returned.

The next few days were frantic for everyone. The patient seemed to disobey every physician order to stay in bed and rest. Instead, she went to the NICU as often and for as long as she could physically stand the pain. Fearing it would make her sleepy, she refused medication until the pain made it impossible to walk from her room to the NICU. She annoyed nurses, students, residents, and fellows with her incessant questions and hovering vigilance over their every move. She quickly came to define the term “terrible patient.”

On Sunday, the neonatologist told her that the team wanted to meet with her and her husband. Already feeling threatened and anxious, she had no illusions about what a
meeting on a Sunday morning with the entire team meant. To her nonphysician husband she simply said: “They don’t need you to meet with them for good news. Good news comes routinely.”

With that they rushed to the NICU and were escorted to a bare conference room filled by a large table surrounded by somber but familiar faces. The neonatologist started to talk. “We didn’t expect this, but there has been a turn for the worse.” There was a glimmer of sadness in his eyes and a hesitance in his voice, but his experience allowed him to continue. He kept talking, but the parents were no longer with him. She, especially, was watching the residents, who were looking down, away, anywhere but in the eyes of her and her husband. Their forced solemnity and discomfort told her all she needed to know.

While they had been gazing around, the NICU fellow had pulled up a CT scan on the screen. The neonatologist shook his head. “In twenty-six years, I’ve never seen a bleed this severe. An intraparenchymal hemorrhage this severe . . .” He kept talking, but her eyes were fixed on the screen. The whole left hemisphere seemed to glow like a light. The neonatologist kept talking, explaining the process of a bleed of this severity. He then explained how the blood would hemolyze, and how this type of bleeding carried an almost certainty of death.

Her husband grabbed her hand. “What is he saying?” The neonatologist tried to explain, but still he stared at her.

“He’s saying that our son is going to die.”

She could feel the relief from everyone in the room that someone had finally said it. The residents looked up as though it was now permissible to engage the parents, as though looking at them before that moment would have betrayed a truth for which no one wanted to be responsible.

The neonatologist walked them out of the room soon after, explaining that he would allow them time to think over what was said, and make any decisions with which they were comfortable.

The parents requested a DNR status for their son that afternoon, and Josiah, as they had christened him, died the next day. As they walked out of the pod where Josiah had drawn his last breath only minutes earlier, one of her classmates (a third-year) took her hand, silent, but comforting nonetheless. She and her husband walked out of the NICU, and tried to return to their life.

The next year, as a third-year student, she returned to the NICU on her first rotation of her pediatrics clerkship. She seemed the typical medical student. She asked questions, accepted patient assignments, and read about their conditions. When asked what she wanted to do in her medical career (or if she even knew yet), she always responded, “Pediatrics and then, hopefully, neonatology.”

There were moments when she lost her composure, became less than a medical student and perhaps more a future physician, but it is these moments that haunt her. She boiled with fury when hearing a resident say that the parents must not care for the child because they weren’t present every day in the unit. She choked back tears while witnessing other parents receive the terrible news their child wouldn’t survive.

Other moments were different. There were times when she would stand over her patients’ isolettes and talk to them, when she lingered over a Ballard exam just to watch a baby breathe. She found it easy to sit with the mothers of the sickest babies, to listen to their thoughts, concerns, worries, and fears. She would sit and listen, often without speaking, never uncomfortable with the tears, the long silent pauses, or the quiet desperation in the parent’s voice.

She still wants a career in pediatrics, and especially neonatology. Even serving in the same NICU where Josiah died, it was clear to her and others that she enjoyed those days more than any other of her clerkships. She was never bothered by the long hours, never tired of poring through records, examining infants, researching differentials. She stayed up late at night reading a neonatology primer for residents as if it were a bestselling novel.

It has been said that physicians are terrible patients, but what about the patient that becomes a physician? Is it better for the physician to have the separation that comes with never having been the patient that he or she now proposes to treat? And what should be a physician’s passion, her driving force? Should it be the general goal to do no harm and heal if possible? Might there be fear that this patient-student’s goal is no longer that noble aim, but a personal vendetta against death?

She does see a bit of her son in each of the babies she treats, and wants fervently to ensure their hospital course has the happy ending denied her own. But is that right? Is it a good reason to enter a field, to choose a life-long profession? In the end, this patient thought it was, and hopefully she was right.

The author’s address is:
600 Moye Boulevard
Greenville, North Carolina 27834
E-mail: ccorncason@gmail.com
Each year since 1988, Alpha Omega Alpha, in cooperation with the Association of American Medical Colleges, presents four faculty members in American medical schools with the AΩA Distinguished Teacher Award. In 1997, AΩA named the award to honor its retiring executive secretary Robert J. Glaser, MD. Nominations for the award are submitted to the AAMC each spring by the deans of medical schools.

Nominations were reviewed by a committee chosen by AΩA and the AAMC. This year’s committee members were: Peter G. Anderson, DMV, PhD; Paul Aravich, PhD; Carmine D. Clemente, MD, PhD, MS; Linda S. Costanzo, PhD; Arthur Dalley, PhD; Helen C. Davies, PhD; Daniel W. Foster, MD; Steven L. Galetta, MD; David E. Golan, MD, PhD; Charles H. Griffith, MD, MSPH, MS; Robert M. Klein, PhD; David W. Nierenberg, MD; John Nolte, PhD; Louis N. Pangaro, MD; Richard M. Schwarzenstein, MD; Robert T. Watson, MD; Jeffrey G. Wiese, MD.

Winners of the award receive $10,000, their schools receive $2,500, and active AΩA chapters at those schools receive $1,000. Schools nominating candidates for the award receive a plaque with the name of the nominee.

Brief summaries of the accomplishments in medical education of the 2009 award recipients follow.

Edward D. Harris, Jr., MD, Executive Secretary

Ronald A. Arky, MD
Charles S. Davidson Distinguished Professor of Medicine and Dean of Curriculum, Harvard Medical School

As the Charles S. Davidson Distinguished Professor of Medicine at Harvard Medical School, Ronald Arky (AΩA, Cornell Medical College, 1955) has discovered both his passion and his strengths. Arriving at Harvard in 1963 after receiving his MD from Cornell Medical College, Dr. Arky has focused not only on his expertise in endocrinology and internal medicine, but on the future of how medical students should and can learn their craft and be ready for the new imperatives of practice. Harvard students have honored him multiple times. One citation was for his “vital campus presence, unending advocacy of students and commitment to clinical education.” His platform for innovation has been Chair of the Department of Medicine at the Mount Auburn Hospital in Cambridge, serving from 1971 to 1993. He was instrumental in creating the HMS New Pathway that helped integrate for students the basic, behavioral, social, and clinical sciences, giving them a sense of a longitudinal understanding of a medical career. His concepts are being implemented at many academic medical centers in the United States and Canada. As Master of the F. W. Peabody Society, one of four at HMS, Dr. Arky has had the opportunity to advise and mentor hundreds of students, all of whom are grateful to him for his care and personal attention.

David A. Asch, MD, MBA
Robert D. Eilers Professor of Medicine and Health Care Management and Economics, University of Pennsylvania School of Medicine and the Wharton School

Dr. Asch (AΩA, Cornell University, 1984), a member of the faculty of the University of Pennsylvania for nineteen years, has been a major contributor to innovative educational programs that connect the School of Medicine with...
Clinical skills education has been a major focus of his interests, leading to his current role as chair of the AAMC Task Force on the Clinical Skills Education of Medical Students, from which three monographs have already been published. In recognition, the Clerkship Directors in Internal Medicine awarded Dr. Corbett the Louis N. Pangaro Educational Program Development Award. He has definitely joined Ken Ludmerer in presenting the coming of the second revolution in American Education, emphasizing that careful examination of the patient is not passé.

**Erika A. Goldstein, MD, MPH**  
Professor of Internal Medicine, University of Washington School of Medicine

Dr. Goldstein (AΩA, University of Rochester, 1981) came to the University of Washington as a resident in Internal Medicine. Following her chief residency she was recruited to the faculty and now is a Professor of Medicine. Along the way she earned her Master of Public Health and a MA in Anthropology. Her strength and love in medicine is teaching, but her dean labels her a “triple threat” visionary, organizer, and role model in medical education, and a different kind of triple threat—teacher, mentor, and friend—for students, residents, and faculty.

Not surprisingly, she was recognized as the Distinguished Clinical Teacher Award recipient at UW in 2000, 2001, 2002, and 2003, and in 2003 received a designation as "Teacher Superior in Perpetuity," one of fourteen faculty ever to have received this honor. Her publications relevant to medical education include chapters and papers focusing on continuous professional improvement, and she has designed institutional approaches that can be implemented by all academic medical centers. She has promoted fundamental clinical skills using the competency-based approach. One student referred to this “uncommonly decent human being” by the comment, “There is a reason she is the only faculty member we call by her first name. She is more than a faculty. . .she is our friend.”

**Distinguished teacher nominees**

- **Thomas Andreoli, MD**, University of Arkansas for Medical Sciences College of Medicine
- **M. J. Burchman, MD**, The Brody School of Medicine at East Carolina University
- **Charles L. Barde, MD**, Weil Cornell Medical College of Cornell University
- **Craig W. Clarkson, PhD**, Tulane University School of Medicine
- **Larry Rex Cochard, PhD**, Northwestern University, The Feinberg School of Medicine
- **Tomer Davidov, MD**, University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School
- **Stephen E. DiCarlo, PhD**, Wayne State University School of Medicine
- **Renee Z. Dintzis, PhD**, Johns Hopkins University School of Medicine
- **Stephen W. Downing, PhD**, University of Minnesota Medical School
- **Stephen Evans, MD**, Georgetown University School of Medicine
- **Joseph C. Fantone III, MD**, University of Michigan Medical School
- **Paul Gillespie FitzGerald, PhD**, University of California, Davis, School of Medicine
- **Richard A. Hoppmann, MD**, University of South Carolina School of Medicine
- **Linda Y. Johnson, PhD**, University of Texas Health Science Center at San Antonio
- **James P. Keating, MD**, Washington University in St. Louis School of Medicine
- **Michael W. King, PhD**, Indiana University School of Medicine
- **Gary L. Kolesari, MD, PhD**, Medical College of Wisconsin
- **Salvatore Mangione, MD**, Jefferson Medical College of Thomas Jefferson University
- **Susan Masters, PhD**, University of California, San Francisco, School of Medicine
- **Gary C. McCord, MD**, Texas A&M Health Science Center College of Medicine
- **Dennis H. Novack, MD**, Drexel University College of Medicine
- **David A. Rogers, MD**, Southern Illinois University School of Medicine
- **Charles B. Rush, MD**, Vanderbilt University School of Medicine
- **Paul F. Shalney, MD**, State University of New York Upstate Medical University College of Medicine
- **Barbara Sheline, MD, MPH**, Duke University School of Medicine
- **Gerald H. Sterling, PhD**, Temple University School of Medicine
- **Linda C. Stone, MD**, Ohio State University College of Medicine
- **Marc Tischler, PhD**, University of Arizona College of Medicine
- **Nagaswami Vasan, PhD**, DVM, MS, UMDNJ—New Jersey Medical School
- **Bruce Wallace, PhD**, University of Colorado Denver School of Medicine
- **Michael I. Zucker, MD**, David Geffen School of Medicine at UCLA

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**The Pharos/Winter 2010**
The Woman with Everything

There she sat in another lobby
Checking into a fancy hotel
But from the downcast turn of her red lips
It may as well have been a cheap motel
Suites plucked straight from Hollywood films
Littered with thousand dollar wine
Private jets at her disposal
Everything was perfectly divine
Yet our privileged heroine
Felt a million miles from grand
Even with so much finery
At the drop of a hand
She couldn't help remember
All the times before
The empty lonely nights
As another marriage hit the floor
Her family torn to shreds
Children in stony, silent tears
No one left to ease the burden
Of the long stretched out years
The woman with everything
Sat alone with all her bags
Wishing why if she had everything
She felt like all she had were rags.

Ali Valdrighi

Ms. Valdrighi's e-mail address is: alivaldrighi@netscape.net.

A One Bag, One Leg Lady

Ready for a solitary journey
All longings and belongings compressed in a single bag
filled with dying sighs and tamed tears.
Stretched out handle held by invisible, resolute hands
ready to carry the cargo.

A discovering head covered with a hat
uncovering a thousand loose threads
finally untangled, free of knots.

A window showing a blind future
and a past swarming with emotions
that came to a standstill
like a spinning top.

Guts, glia, gonads joining
in harmony with her heart.
Life—a tragedy to one who feels
and a comedy to one who thinks.

Her feet fatigued from dragging
will now take steady steps
on a leg that lags no more
to reach an unknown address.

May the winds blow on her back!

Bhagirath Majmudar, MD

Dr. Majmudar was elected to ΛΩΑ at Emory University in 1979. His address is: Pathology Department, Grady Health System, 80 Jesse Hill Jr. Drive S.E., Atlanta, Georgia 30303. E-mail: bmajmud@emory.edu.
Reflections on a Photograph

This woman in red
Appears very well fed
A stylish hat sits upon her head
I approached her with fear and dread
She turned to me and then she said
"I'm on my way to again be wed
My late husband is now officially dead
I am heading to my new love, Ned
I hope he will be as gentle in bed
This bag I carry appears weighted with lead
It contains the ashes of my deceased Fred
I'm looking for somewhere they can be spread"
We glanced, we parted, no tears were shed
I hope she is happy—this woman in red

Newton D. Scherl, MD

Undaunted

“Vamp,” they whispered,
Not softly enough, as she
Strode from the soiree.

“Kept woman,” others hissed,
Citing her wardrobe,
Jewels and seductive currency.

Look below the hat and
Above the décolletage
And see the truth.

Somber resolve.
Courage to embark on
The next journey.

Determination to leave
Luxurious, meaningless trappings,
For the wealth of today.

Christine D. Hudak, MD

Dr. Hudak was elected to AΩA in 1991 at the Ohio State University College of Medicine. Her address is: 444 North Main Street, Akron, OH 44309. E-mail: hudakch@summa-health.org.

Dr. Scherl was elected to AΩA in 1954 at the Marquette Medical School, now the Medical College of Wisconsin. His address is: 363 Castle Drive, Englewood Cliffs, New Jersey, 07632. E-mail: nscherl@njr.com.
On that first day of class
we were like the young child
at the county fair
holding a plump plastic sack
to her face peering in
at the goldfish
turning cramped circles
in awe of the responsibility before us.

We were timid
fearful we would stumble
drop this gift to the ground
and lose the chance
to learn your secrets.

But we proceeded
encouraged by lessons
held captive
beneath your skin.

We grew more comfortable
sometimes so engrossed
as to forget that these structures
were once alive
were once parts
of a whole that danced and spoke
and laughed and wept
and made choices
like the choice that brought you to us.

And by the time your outer sheets
had been entirely stripped away
and your secrets exposed
it was clear
that our responsibility was not
to preserve this gift
but to preserve your hope
that you would make physicians
from youthful students
and through us
with us
heal.

Elyne N. Kahn

Mr. Kahn is a member of the Class of 2011 at Vanderbilt University School of Medicine. This poem was an entry in the 2009 Pharos Poetry Competition. Mr. Kahn’s address is: 1606 18th Avenue South, #26, Nashville, Tennessee 37212. E-mail: elyne.kahn@gmail.com.
As part of his health care reform program, President Obama has pledged to reduce what health care costs. How realistic is this goal? Let’s look at two of the elements that directly affect how doctors practice medicine.

Preventive care

It is a convention that preventive care reduces medical costs. If such risk factors as hypertension, hypercholesterolemia, smoking, and obesity are better controlled by regular ambulatory visits, and patients are regularly screened for cancer, the use of expensive hospital admissions should be reduced. Universal coverage with medical insurance for every citizen should remove the monetary factor that prevents many patients from receiving the preventive care they need. But will preventive care for all really save money?

Let’s take just one example from my specialty of cardiology. Compare the cost of prescribing a statin for everyone with elevated LDL cholesterol with the savings produced by not having to hospitalize those who would have developed myocardial infarction were they not taking a statin. The problem here is that providing universal preventive care includes many more people than it directly helps. Someday, we may know better who really needs to have the LDL cholesterol reduced and treat only them. Not yet, however. Obviously, there is great benefit to those whose illnesses are prevented or postponed, but have we saved money by applying preventive care in these cases?

Salaried versus fee-for-service practice

In July 2009, the president visited the Cleveland Clinic and came away praising the way it delivers medical care while costing less than other large hospitals.

David Brown, the medical reporter at the Washington Post and a physician, wrote, “The average spending on a Medicare patient with severe chronic disease during the last two years of life was $35,455 at the Cleveland Clinic, which was the cheapest. Massachusetts General Hospital came in at $47,880, Johns Hopkins at $60,653, and UCLA Medical Center led the list at $72,793.”

The Cleveland Clinic controls costs in several ways. One relates to the way the doctors practice. All are members of an integrated multispecialty group practice and are salaried. Theoretically, salaried doctors are less likely to overuse tests or consultations since their incomes are not directly dependent on fee-for-service compensation. If this is true, then overall health care costs would decrease or not grow so fast if more doctors worked in such salaried group practices. Although some doctors work in the type of salaried practice praised by President Obama, we can reasonably assume that
most are paid by fee-for-service. According to the American Medical Association’s (AMA) Physician Masterfile,\(^3\) 141,188 of the 801,746 direct patient care physicians in the United States (18 percent) are in solo or two member practices and 311,713 (39 percent) are in group practices of three or more.\(^*\) Data on how they are paid, by salary or fee-for-service, are not included in the AMA survey.\(^3\)

How many doctors now practicing privately would voluntarily become salaried employees of not-for-profit groups and give up the higher incomes that can accompany efficient private practices? Specific incentives might help, but what form would they take, and how much would they cost? Forcing doctors into such groups, of course, is politically untenable—not the “American way.” Furthermore, forming such groups and developing the systems to assure their financial efficiency will take time and capital. The Cleveland Clinic’s group practice is as old as the Clinic itself, which was founded in 1921.\(^4\) Many of its efficiencies depend upon refinements made to the system over decades.

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The author’s address is:

University of Maryland Medical System
110 South Paca Street
Room 2N-139
Baltimore, Maryland 21201
E-mail: jkastor@medicine.umaryland.edu

* Many of the other physicians in the AMA Physician Masterfile are employees of city, state, or federal governments and medical schools, and many, if not most, are probably salaried. 190,549 (24 percent) are reportedly working in hospitals, some presumably as radiologists, pathologists, hospitalists, and emergency physicians.

Health reform requires confronting myths

Thomas H. Lee, MD

The author (ΩA, Cornell University Medical College 1979) is Network President of Partners Healthcare System and Professor of Medicine at Harvard Medical School

Progress in health reform just might be underway, because the pain of the status quo is beginning to exceed the fear of the unknown for virtually all major stakeholders. But real movement will require that these stakeholders—including providers—confront some of the myths that prop up the status quo. Here are five widely-held but flawed beliefs\(^1\) worth taking on:

1. **Choice equals quality**

   American patients treasure the freedom to go to any doctor they choose, but they cannot judge the quality of providers from available data, so they rely upon the recommendations of doctors, family, and friends. They suspect that government, health plans, or provider organizations might restrict their freedom of choice for financial reasons—and these suspicions have some merit.

   The irony is that patients’ freedom of choice inevitably leads to the fragmentation of care—and worsens efficiency, safety, and quality. Patients end up with physicians in multiple hospitals and practices, and no communication among them. Their care would be better if they valued coordination among their physicians more than their freedom to go anywhere. They do not realize that average physicians who work closely together might help them more than brilliant physicians who do not.

2. **Higher quality will reduce costs**

   There are some issues for which better quality really does reduce costs, like smoking cessation and heart failure disease management programs. But the harsh reality is that better quality usually means higher costs, not lower.

   Nevertheless, many politicians and provider leaders suggest that our cost challenges can be addressed through prevention of disease. But prevention requires medications and patient education, both of which are costly. And, sooner or later, everyone does become sick and expire—generating
considerable costs in the process.

An analysis from the American Diabetes Association, American Heart Association, and American Cancer Society examined this issue using data on a national sample. They concluded that the only preventive activity likely to be cost-saving over thirty years is smoking cessation. Other preventive interventions such as control of blood pressure, diabetes, and cholesterol would substantially increase overall health care costs.

Secondary prevention programs that are focused on patients with a high risk for hospital admissions, such as patients with known heart disease, might actually save enough through avoided hospitalizations to offset their expense. But when preventive programs are focused on lower-risk patients, they do not save money. Some preventive programs actually require more to “buy” a year of life than liver transplantation programs.

3. Market forces can control costs

For every health care provider pinning hopes on better quality, there is at least one health care purchaser who believes that market forces can drive out waste and raise quality. These market forces would be unleashed by exposing patients to the true costs of care and providing data on the costs of care from various providers.

Unfortunately, patients do not enjoy exposure to costs, especially when they are sick. Few people have signed up for health insurance products designed to turn them into consumers. Furthermore, the data intended to help patients make choices are just not that helpful and are used by only small numbers of patients.

An additional limitation for market forces is that about half of costs are expended for five percent of patients. These patients are too sick and have conditions too complex to behave like consumers. In fact, if they shopped around and got their care at multiple places, their overall treatment would likely deteriorate.

4. A single-payer system would address all our problems

For every political conservative who hopes that market forces can solve health care’s woes, someone on the ideological left believes in a single government-run health care system. They cite countries where single-payer systems provide universal access, and where health data are better than in the United States.

A single-payer system could address the issue of access to care, but it would not necessarily address the quality and safety problems generated by a fragmented delivery system. Real progress in these areas will require payment systems that reward providers who can organize themselves around performance goals.

5. Physicians’ autonomy is the most important guarantee of quality

The most uncomfortable myth represents a challenge to physicians who oppose any threat to their individual autonomy. These colleagues argue that medicine is a mix of art and science, and they look with scorn on “cookbook medicine.” They worry that guidelines and disease management programs might control costs at the expense of their patients’ outcomes. They want to be free to do what is best for their patients, and to make their own judgment about what that might be. They do not want to be forced to work in teams, and they do not want to be told what to do.

Many of the physicians who feel this way are, in fact, wonderful people and terrific doctors. But concern over rising costs has helped expose the tremendous unexplainable variation in care patterns among physicians—raising the question of whether they can all be practicing the very best medicine. Efforts to reduce variation inevitably erode individual physician autonomy.

Furthermore, medical progress has made the right thing to do in many situations much more clear—thereby making possible increased roles for non-physicians. Nurses, pharmacists, and even the patients themselves can be active participants in health care delivery, if physicians will let them be members of the team. Physicians can be the leaders of those teams, but they have to keep in mind that team leaders are also team members. That means following the same protocols, using the same terminology, updating “teammates” on what is happening. And being part of a team inevitably means giving up some autonomy—that is, if you want your team to win.

There are still countless opportunities when the right thing to do is unknown, and physician autonomy will always be an important value in medicine. But individual physician autonomy is not the highest value in medicine, and there are times when it should be placed subservient to other values—most notably what is best for patients.

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The author’s address is:

Partners HealthCare System
Prudential Tower, 11th Floor
800 Boylston Street
Boston, Massachusetts 02199
E-mail: thlee@partners.org
The Curious Case of Benjamin Button

Starring Brad Pitt, Cate Blanchett, Taraji P. Henson, and Julia Ormond.

When I say that this film’s main asset is that it is watchable, I don’t mean to damn it with faint praise. Being watchable is no small distinction given the current crop of Hollywood offerings. It’s less shallow than most and has an intriguing premise. Other assets are the acting of Brad Pitt, whose voice and image are in almost every scene; the supporting cast, especially Taraji P. Henson; and the art direction, makeup, and visual effects for which it won Oscars. It also is more literate than most films produced today, possibly because it’s very loosely based on a short story by F. Scott Fitzgerald (more about that later). The discontinuities between scenes and its limited action are compensated for by the voiceover narration. The story begins in an ICU on the day Hurricane Katrina is about to hit New Orleans. Benjamin’s aged wife Daisy (Cate Blanchett), whose pain is being regulated with a morphine drip, is dying of cancer. She tells her daughter Caroline (Julia Ormond) to read Benjamin’s diary, which recounts his life. In the process, Caroline will learn that Benjamin is her father.

It’s 1918 and a New Orleans clockmaker who lost his son in World War I completes construction of a clock for the train station where he last saw his son alive as he went off to war. Unveiled on the day World War I ends, the clock has been made to run backwards in the clockmaker’s hope that all those killed in the war would return home alive. That same day in a local hospital, a progeria-like baby boy is born to a woman who dies after the delivery. The embarrassed father scoops up the child and is carried along by the crowd to the train station where he witnesses the clock run back in time. He then runs out and deposits the child with $18 on the step of a home for the elderly run by a kind and energetic black woman named Queenie (Taraji P. Henson). She decides to rear the child as her own, saying that he may be ugly but he’s “still a child of God.” She names the “child,” actually an old man who can’t walk unassisted, Benjamin. He is, as Queenie says, like “some creatures who aren’t meant to survive.” The saving grace is that he’s like everyone else in this nursing home, where the residents are seen going through their daily routine. An ex-military man raises the flag daily. An ex-opera singer sings Wagner. A man repeats his story about having been struck by lightning seven times and each time the scene plays out in his mind and onscreen. Supper is at 5:30.

Queenie’s helpmate Tizzy (Mahershalaalhashbaz Ali) is an equally good man who had been a dresser for John Wilkes Booth and recites Shakespeare. This prompts Benjamin to articulate a catch phrase like the line in Forrest Gump about “Life being like a box of chocolates, you never know what you’ll get” (except of course if you buy a Whitman’s Sampler). In this case, it’s, “You never know what’s coming for you.” On a Saturday night they go to church, where a faith healer attempts...
to heal Benjamin by casting him down and telling him to walk unassisted with only his two canes, which he does for the first time. Then the preacher dies. The significance of this escaped me except that, as Benjamin notes, death is a common visitor as “people came and people left” the home.

There is a confusing set of scenes where a so-called bushman from Africa appears at the home. I found it hard to understand his words and switched on the English subtitles, which were quite useful. The bushman reflects on the fact that “when you’re different like us, you’re going to be alone a lot,” but then he goes on to say that many folks (tall, skinny, fat) who are not so different are alone, too. A pianist comes to the home and Benjamin becomes very attached to her as she teaches him how to play, saying, “It is not how you play but how you feel about playing.”

Meanwhile Benjamin is growing younger. He goes to a party where he sees a little girl of eight, presumably his own age, (although he looks like he’s in his 70s) and “loves her from the first.” He is given a job by a tugboat captain who wanted to be an artist, but his father refused to send him to art school, insisting that he continue in the family tugboat business. So his artistry is the tattoos on his body. He initiates Benjamin to the screenwriter’s perception of rites of passage into adulthood by taking him to a bar to get drunk, and to a brothel to consort with prostitutes, which he enjoys. There he encounters his real father, a rich man who drives up to the brothel in his limousine. Dad, who runs Button’s Buttons, a prosperous enterprise that his grandfather started during the Civil War, recognizes him but does not let on.

As Benjamin gets younger, Queenie feels sorry for him because he’ll get to see the people he loves die, and that he does, including his pianist friend. In 1936, Benjamin joins the tugboat captain to salvage and repair ships ferrying supplies on the Murmansk run in the North Atlantic. Before he leaves, he promises Queenie to say his prayers every night and to write to her and Daisy. By now Daisy is eighteen and a member of the American Ballet Company in New York. After months in Murmansk, he writes Daisy to say that he has found a woman to love and begins an affair with the wife of the British Consul, whose rules for the affair are: (1) Never look at me during the day, (2) We must part before sunrise, and (3) Never say “I love you.” At this point in the reading, Caroline asks Daisy if she wants her to continue the story and Daisy says yes because at least he found someone to keep him warm. (How civilized?) Much of the next few scenes are of the romance, until the affair ends abruptly on the evening of December 7, 1941, when his paramour doesn’t come down for their nightly rendezvous. The tug is commissioned by the U.S. Navy, and after entering the war zone, is sunk. The captain dies, but not before he laments how his body art (his only pride and joy) has been devastated and utters a line that will recur when Benjamin’s father dies: “You can be as mad as a mad dog at the way things went. You can swear and curse the fates, but when it comes to the end, you have to let go.”

After the war, Benjamin meets Daisy in New Orleans but when he refuses to have sex with her during her brief stay, she is angry and returns to New York. Benjamin’s dying father reconnects with him and leaves him the Button factory and considerable wealth, which Benjamin uses to help Queenie and her home. He then goes to New York to see Daisy perform in the ballet scene in Carousel, hoping to sweep off her feet, but she snubs him. Later, on a world tour in Paris, Daisy sustains a devastating accident that Benjamin describes like the cascade of events leading to medical catastrophes, as he catalogues the timing of a series of seemingly unrelated circumstances involving a number of disparate people that led to Daisy being run down and having her leg crushed. As he notes, “Sometimes we are on a collision course and we just don’t know it, whether by accident or design, and there is nothing we can do about it.” He flies to Paris, but Daisy sends him away because she doesn’t want him to see her as she is. Finally, they get together and there are a number of scenes of them having sex. Daisy opens a dance studio and after they have a “normal” child, she worries that she is getting older while he is getting...
younger, and that he will tire of her. He denies this and tells her, “You can’t be perfect forever.” (I didn’t know anyone ever is perfect.) However, he decides after a few years that he can’t be a doting father because he’s growing younger and doesn’t want Daisy to have the burden of another child. He cashes in his possessions, leaves the money to Daisy and the child, and goes off to an ashram in India, which again makes no sense. He finally comes back to see the child. Although Daisy is happily married, she can’t resist one more bout of sex with Brad Pitt (oops, excuse me, Benjamin Button) who then completes his life journey and the story ends as Katrina hits.

The Fitzgerald story is much different. Set in Baltimore instead of New Orleans, it has a more medically interesting opening as the father runs to the Maryland Private Hospital for Ladies and Gentlemen where he is treated rudely by a Doctor Keene who is on his way home and is worried about how the baby he just delivered will affect his reputation. Button, who had dreams of a strapping boy whom he would send to Yale, runs into the hospital where the nurses are terrified when he tells them his name. Finally, he is led to the “crying room” where he sees “wrapped in a voluminous blanket, and partially crammed into one of the cribs (with his legs hanging over the side), an old man apparently seventy years of age. His sparse hair was almost white, and from his chin dripped a long smoke-colored beard, which waved absurdly back and forth, fanned by the breeze coming in at the window.” Although the mother survives, we don’t hear more of her. The father, who is devastated and wondering what Baltimore society will say about his son, goes off to get him a suit to take him home. They age together in different directions.

At eighteen, Benjamin passes the entrance exam to Yale but is thrown out when the registrar sees that he looks fifty years old. When the Yalies hound him to the station for his return home, he vows to take it out on Yale by going to Harvard. He works for his father and the company prospers. When he looks fifty (actual age about twenty) he sees an eighteen-year-old with whom he falls in love. She marries him against her par

The film follows the setting in pre-Katrina New Orleans, the clockmaker, Armistice Day, the size of the baby in the hospital, the mother dying, the father abandoning the baby, the black couple, the nursing home, the tugboat captain, the house of prostitution, the profanity, Murmansk and the affair, World War II scenes, Daisy being a ballet dancer and her world tour with the American Ballet, the daughter, his going to India and the Armistice Day, the size of the baby in the hospital, the mother dying, the father abandoning the baby, the black couple, the nursing home, the tugboat captain, the house of prostitution, the profanity, Murmansk and the affair, World War II scenes, Daisy being a ballet dancer and her world tour with the American Ballet, the daughter, his going to India and the return to the home, and finally their last sex scene together and all the sex scenes for that matter. This does not count the large number of goofs and anachronisms in the film, detailed on the Internet Movie Database (IMDB) website (imdb.com). One wonders if F. Scott Fitzgerald is turning over in his grave at the major surgery on his story or just happy that his estate is getting some residuals.

References

Taking Chance
Starring Kevin Bacon.
Directed by Ross Katz. Running time 77 minutes.

Based on the true story of a dead Marine’s voyage home from Iraq to Wyoming, this beautifully-rendered and remarkably apolitical film is both somber and important. It opens with a black screen as we hear the voices of Marines on patrol in Ramadi. A suspicious vehicle is spotted approaching the convoy at a high speed. All of a sudden there’s an explosion, followed by the firing of machine guns, mortars, and grenade-launchers. Chance Phelps, a Pfc. (promoted posthumously to Lance Corporal), is riding shotgun, his favorite position. He had insisted on going on the patrol, even though he was not scheduled to do so. Refusing to take cover, he draws the enemy fire to himself by rapidly firing his machine gun, thereby protecting the rest of the convoy. While being evacuated, he sustains a head wound and dies. The film follows the
transport of his body to Ramstein Air Force Base in Germany and on to Dover Air Force Base in Delaware, where the loving care taken by the workers in the mortuary and all the support services is quietly evinced.

What makes this journey different from those that have occurred over 3,500 times is the nature of the person who volunteers to transport the body. An officer is not usually assigned to escort an enlisted man, but Lieutenant Colonel Michael R. Strobl (Kevin Bacon), in reviewing the casualty reports, notes that Chance enlisted in Strobl’s hometown of Clifton, Colorado, and so volunteers to take Chance home. The trip is important to Strobl, who had fought in Operation Desert Storm and now is on his second office duty assignment tour, which he sought because he wanted to stay with his wife and children. He feels guilty for not being in Iraq fighting alongside his fellow Marines.

The screenplay was based on Strobl’s action report. Usually, such reports are fairly straightforward bare-bones accounts of the trip and issues that occurred. The reports are designed to help others do things better: making sure that maps of the destination and cell phone chargers are available, for example. However, probably because of what the trip meant for him, Strobl was alert to everything that transpired and was taken by how he and the casket containing Chance’s body were treated along the way. The result was a twenty-page report that was subsequently authorized to be circulated to the family as well as his comrades in arms and later appeared on the Internet, where it came to the filmmakers’ attention.

The film shows the amazing stylized ritual of the journey as the Marine and his escort are treated with dignity, honor, and respect at all points, starting at the mortuary where technicians clean Chance’s body, fit him for a new uniform, even though the casket will be closed because of the severe injuries, and clean his few effects: a Saint Christopher’s medal his Grandma gave him, which he was wearing that Good Friday in 2004 when he was killed; his dog tags; and his watch, still on Iraq time. As the casket is about to be loaded into the hearse for transport to the airport, a technician says, “It was my privilege to care for him.” Strobl is accorded respect by the airlines agents, including a flight attendant who gives him a small crucifix. Later, he gives it to Chance’s mother, for whom he feels it was intended. She places it on the casket before it is lowered into the ground. Also beautifully shown is the reverence of the baggage handlers in loading the casket in Philadelphia and unloading it in Minneapolis, where Strobl meets another Marine escorting a body and learns that the escort is the Marine’s brother, whose family is meeting them at the airport.

Strobl elects to stay with the body in an airport hangar during the layover rather than go to a hotel. The respect by airport personnel and passengers continues in Billings, Montana, and then by passing motorists on the long drive to Dubois, Wyoming, where the family had moved. There are some moving scenes as Strobl meets with Chance’s divorced parents,
The physician at the movies

Kevin Bacon as Lt. Col. Michael Strobl and Noah Fleiss as Army Sergent in Taking Chance. Photo credit James Bridges/HBO.

his stepfather, and sister, as well as the veterans at the VFW Hall. One very close friend blames himself for Chance's death and wonders what he could have done differently. The answer, which is difficult to accept, is nothing, but it mirrors the guilt felt by Strobl. In an exchange with a VFW member, Strobl castigates himself saying, "I was trained to fight. I'm not over there. I'm not a Marine." The man brings him up short saying; "You brought Chance home. You were his witness." The DVD has some excellent special features involving fellow Marines, some of whom give up their leaves to be with the Phelps family on Memorial Day. The mother feels like she gained sons and the feeling is mutual.

Chance is described as always getting into trouble; his mother said that being his mom was a challenge. Everyone agreed that he was the type of kid whose ever-present smile would defuse a situation or help him escape punishment after some wrongdoing. He reveled in doing things that nobody else wanted to do. Chance was a good athlete and was being scouted in high school by major league teams because of his ninety-four-mile-an-hour fastball. His father was disappointed when he passed up that opportunity and applied to the Marines after 9/11, but Chance said that was what he always wanted to be. Being underage at seventeen, his parents had to approve his enlistment. Despite his mother's being against it, she went along and said that she did not regret doing so. He thrived in boot camp, as he continued to be a fun-loving guy who touched many of his platoon members' lives. As his platoon leader said, "He died a hero. More importantly, he lived a hero. It may sound ironic but if the world had more people like Chance Phelps, there wouldn't be a need for a Marine Corps." A Marine training camp mess hall is dedicated to him, which his sister said was fitting because he loved food. As for the film, Chance's father, a Vietnam veteran who placed his medals on the casket, said it best; it's good for Americans to know Chance's story "no matter whether you're antiwar or pro-war."

Addendum: A posting on the film's IMDB website notes that two of the most dramatic scenes were not in Strobl's report: he slept in a hotel as is usual and not the hangar, and there was no mention of a Marine escorting his dead brother. These may have been Hollywood inventions; even had they been deleted, it would not have lessened the thrust and impact of the film.

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

The Pharos/Winter 2010
Beep!
A ten dollar clock whines
As ambient light shines
Exhausted eyes, weary brain
In the moment, break the chain

Whiz!
An aging projector chides
As one studies Netter’s guides
Sore bum, a cephalic vein
In the moment, break the chain

Pop!
A cadaver’s joint cries
As a classmate grows wise
Formaldehyde, lab coat stain
In the moment, break the chain

Sizzle!
An enticing TV-dinner sings
As eyes glaze over meaningless things
Calming bike rides, little strain
In the moment, break the chain

Sigh!
A worn medical student groans
As mind stretches on carpal bones
Wandering thoughts, barely sane
In the moment, break the chain

Creak!
A tempting bed selfishly protests
As sleep comes without care of success
Distracting dreams, efforts drain
In the moment, break the chain

David DeWitt

Mr. DeWitt is a member of the Class of 2012 at the Sanford School of Medicine at the University of South Dakota. This poem won honorable mention in the 2009 Alpha Omega Alpha Pharos Poetry Competition. Mr. DeWitt’s e-mail address is dave.dewitt@gmail.com.

Illustration by Jim M’Guinness
The major themes of this collection of essays by Richard Holm and photographs by Judith Peterson include the importance of humility in dealing with the world and the people in it, deep listening to understand the world and the people in it, and taking the time to really hear what is being communicated by the world and the people in it.

These precepts apply to doctors in their treatment of patients, to parents in their relationships with their children, and to people in any kind of relationships. They might also be said to apply to photographers who seek to produce pictures that convey their authentic responses to the visual world.

The three essays at the end of the book, which were written as editorials for the *Journal of the South Dakota Medical Association* during Dr. Holm's tenure as president of that organization (2001–2002), are the most complete statements of these themes and, unlike the essays that accompany individual photographs, were written primarily for a physician audience. They are intended as cautionary tales and give the reader a pretty clear picture of Dr. Holm's character and beliefs.

In “Hobbit Lesson” the message is that power corrupts: “and today, our profession in particular can bring out the worst in people.” Using the writings of Tolkien as his point of reference, Holm urges doctors not to wear the ring of power, but rather to understand that “it is a privilege to have a job that provides the opportunity to be of such service to people,” “Let us all, each and every one of us, never forget the dark and evil lure of the ‘ring’ of power . . . and may the humility of the Hobbit be always at our side to protect us.”

In “Who Makes the Best Doctor?” the author argues that the metrics commonly used to measure physician performance are seriously flawed. Outcomes measured in terms of adherence to protocols, cost of care, and patient satisfaction, are, he argues, both internally inconsistent and (intentionally or unintentionally) exclude the most important components of physician performance: “I submit that the most important characteristics of an ideal doctor are immeasurable! What about the mysterious internal thing that drives a doctor to continuously learn throughout a lifetime? How about the intuitive talent of an older doctor and the wisdom that comes from experience?”

In “The Elephant Stake” Dr. Holm asks, “Why is it that we have this overwhelming and paralyzing fear of suffering and death in this country?” His answer: “I believe one reason is that modern medicine has given all of us a false sense of security.” He argues as well that parental protection of children from any experience of death has contributed to the impossible belief that medicine can prolong life indefinitely and prevent any and all forms of suffering. He asks physicians to become experts on death and dying in order to “untether” from the fear of death. “Drop[ping] the fear of death [will allow us to] revel in the bright beautiful day we have before us.”

The brief essays that constitute the main section of the book were originally written as editorials to be read on a weekly program on South Dakota Public Television. The series, which was entitled *On Call*, featured one or more physician experts each week, who presented on a medical topic, followed by Dr. Holm’s commentary. It is important to understand this because, if the essays seem incomplete in themselves, that is because they are missing the material on which they were intended to provide commentary. It also helps to realize that the editorials were intended for oral presentation. These mini-essays are full...
of homey advice. For example:

“Check your own blood pressure regularly and do what is necessary to keep it under control.”

“Eat 40 percent less, live 40 percent longer.”

“We must end the cycle of domestic violence. It has to do with giving away control of another person and taking control of oneself.”

“With help and the right medicine you can say, ‘Out, out, damn obsession.’”

“Those in medicine have ancient and modern promises to keep, and you should expect no less.”

“All of us can help bring to an end this compulsion. We need to hold two hands out to those who abuse or may abuse, say ‘never more,’ and may the healing power of forgiveness (the most effective medicine) fill our veins, sweep through our bodies, and find its way to our hearts.”

The editorials cover a range of topics and some include interesting historical facts. For instance, when Stalin, Churchill, and FDR were dividing up postwar Europe at the Yalta conference, Churchill was weakened by alcohol, and FDR had a blood pressure of 240/130. Holm asks us to imagine “how the history of the world would be different had we understood then what we know now about how to control blood pressure.” Another editorial notes how Pasteur “almost by accident” first observed immunity induced by vaccination.

Each essay includes an accompanying color photograph by Judith Peterson. A striking aspect of this collection of photographs is the absence of people. The closest one comes to images of people are the feet clothed by striped socks that enter from the bottom of one picture, a brownish-red footprint, and a picture of a rusted chain that accompany the essay on “Coronary Heart Disease and the Rat.” Some are intended to convey mystery or meaning through out-of-focus or motion-blurred images accompanying the essays on psychosis, spirituality in medicine, dreaming, and sports medicine.

Most of the photographs did not seem particularly innovative, or explore unusual dimensions of the subject of the essay. There was at least one notable exception, however. The photograph of the American Flag blowing in the wind that accompanies the essay on post-traumatic stress disorder is a compelling image that greatly expands the meaning of the essay. The oversaturated colors of the almost posterized image are jarring, as is the sense of the flag in chaotic motion. The composition refuses to be quiet, as the eye is taken back and forth from the deep empty space on the right to the noisy flag on the left. This photograph seems to me to be a fully-realized authentic response to a troubling aspect of the world we live in.

Overall I found this to be a friendly and encouraging book, although not especially provocative or deep.

Dr. Trotter is Professor of Cell Biology and Physiology Emeritus and Deputy Executive Vice President for Health Sciences at the University of New Mexico Health Sciences Center. His address is:

Health Sciences and Services Building, Suite 302
1 University of New Mexico
MSC09 5300
Albuquerque, New Mexico 87131-0001

Despite the absence of people, most (if not all) of the photographs evoke or illustrate the subject of the essays that they accompany. For example, the picture of a rusted chain that accompanies the essay on abuse and domestic violence, the “KEEP RIGHT” sign painted on the street that accompanies the “Primer on Medical Ethics,” and the under-sink drain pipe that accompanies the essay on constipation and laxatives. Some of the photographs are cute, like the one of beaded toy rats that accompanies the essay on “Coronary Heart Disease and the Rat.” Some are intended to convey mystery or meaning through out-of-focus or motion-blurred images accompanying the essays on psychosis, spirituality in medicine, dreaming, and sports medicine.

Before medical school, maybe even before college, did you have a friend who you liked to go to the movies with? Was he (or she) funny, smart, opinionated, fair and insightful, with interests and tastes close enough to your own to pick movies you’d both enjoy, but different enough that the conversation after the movie became the most interesting part of all? Well, I’ve found your friend. His name is Peter E. Dans, and after reading his book, Christians in the Movies: A Century of Saints and Sinners, I feel like I’ve been to the movies with him a hundred times.

Dr. Dans, a board-certified internist, is associate professor of Medicine at Johns Hopkins School of Medicine. He has shared his love of the cinema arts on these pages, writing the column “The Physician at the Movies” for The Pharos for more than ten years, and authoring a similar volume of reviews entitled, Doctors at the Movies: Boil the Water and Just Say Aah. In that work, released in 2000, Dans explores the way that movies throughout history have perpetuated myths and clichés regarding doctors, and have reflected society’s perceptions of doctors and doctoring, its changing attitudes toward science, and the evolution of issues that still surround us, unite us, and divide us.
In *Christians in the Movies*, Dans examines with the same careful sensibility the changing attitudes toward Christians, in many cases Catholics, as reflected in the movies. A true movie buff, he compiles his impressions of over 200 films, arranged by decades, from the silent era to the present. He introduces each decade with historical context that sheds light on his reviews of the films that follow.

The reviews are peppered with interesting backstories, adding well-researched and often compelling details surrounding the people, production, and themes of these films. It is here that Dans showcases his depth of knowledge of the American filmmaking industry, his embrace of the social contexts that shape and drive it, and his inability (like most doctors I know) to resist a great story. Whether he is contrasting “The Real Scopes Trial vs. Inherit the Wind,” revealing the deep-seated roots of a traumatic Catholic education that led to director Luis Buñuel’s cinematic attacks on the Catholic Church, or tracing “The Transformation of Nuns from Beautiful and Serene to Weird and Nasty,” Dans’s backstories are filled with intelligent and informed commentary, language that proves generous and fair, and a genuine sense of curiosity that helps the reader understand why he wrote *Christians in the Movies*. The backstories are the highlight of this book.

In Chapter one, “Portraying Christians in Film,” Dans outlines the trajectory and purpose of his work, describing the social and political influence that organized religions and religious organizations have had on the American movie industry. He introduces the Motion Picture Production Code, adopted in 1930, and the National Legion of Decency, established originally by the American Catholic bishops and later including many Protestant and Jewish clergy. He explores the differing treatment of Christian groups in society as reflected in films over the years, culminating in *The Passion of the Christ*, produced by Mel Gibson in 2004, which Dans argues served as a Rorschach Test for American society. Dans ends chapter one with the question, “Why Should Christians Care About Their Portrayal in Film?” This is his first call to the reader, in whom he hopes by the end of this work to ignite a vision of personal and societal responsibility for the return of balance in the movies we watch, and in the things we do. “The restoration of a better movie culture,” he argues, “like the return of civility and good manners in everyday life, is our responsibility both individually and collectively.”

The arrangement of Dans’s reviews chronologically by decade proves a logical and palatable system for presenting this encyclopedic work, setting it up as readable, yet also easily referenced. His chapter introductions follow the arc of his thesis, that the portrayal of Christians in early films is favorable and reverential, but becomes much less favorable as the twentieth century winds to a close.

Dans’s collection of reviews provides extensive support for his theme. Each analysis is bite-sized, just a few paragraphs, including enough plot and detail to identify the film, and enough commentary to assist the reader in understanding at a glance how the film fits into the context that Dans has laid out. Before long, the reader becomes accustomed to Dans’s style of commentary and trusts him as a reliable reviewer. He is clear as to what he likes about movies, and proves a sharp critic of work that falls short of an informed audience’s expectations. Reading reviews of movies I had seen helped me understand my original reactions to the films as I compared them to his reactions and framed them within the questions he has carefully raised. Really—it was like that conversation at the diner after watching a movie with your friend.

Dans makes no claims of being a great authority on religion or film. He tries hard not to criticize any given film’s (in)consistencies with biblical texts or traditional religious teachings. His casual style of analysis is never threatening or pedantic. He discloses his Catholic upbringing and reminds us of this context in often lighthearted and humorous ways throughout the book. Make no mistake, however—neither his love of movies, nor his foundation of belief shield him from being offended as certain movies during the decades from the eighties through the present grow at first critical and then clearly anti-Catholic (*Agnes of God*, 1985; *Priest*, 1988); and finally adopt a more dangerous stance, sheer indifference, rendering lost faith as less a tragedy than an irrelevant annoyance (*Dogma*, 1999; *Chocolat*, 2000).

*Christians in the Movies: A Century of Saints and Sinners* was a pleasure to read. It should appeal to cinephiles of any faith, and may prove an important analysis of how the treatment of Christians in the movies reflects society’s challenge, as once-revered institutions may be vilified, undervalued, and discarded. With our leisure time and disposable funds so limited, and the shift of viewing habits from a night at the movies with friends to DVD family nights at home, the movie industry is facing a crisis of its own. This may be a critical time to pick up Dans’s clarion call to participate in restoring the balance. His backstories can show us why; the chapter introductions explain how. Should this be important to physicians? Only if we sense our own professional identity being vilified, undervalued, then discarded, like the church. Only if we believe there is balance to be restored to society’s perception of our roles, once revered, now increasingly ignored. Only if we still care.

Dr. Basile is Clinical Assistant Professor of Surgery and Preventive Medicine at the Center for Medical Humanities, Compassionate Care, and Bioethics of the Stony Brook University School of Medicine. Her address is:  
HSC Level 3, Room 080  
Stony Brook University School of Medicine  
Stony Brook, New York 11790  
E-mail: maria.basile@stonybrook.edu
Letters to the editor

Selling Teaching Hospitals

The recent informative review of John A. Kastor’s book, Selling Teaching Hospitals and Practice Plans: George Washington and Georgetown, by Pascal James Imperato, MD, MPH&TM (Summer 2009, pp. 47–48), states that Appendix A lists six universities whose hospitals are owned by for-profit companies. The University of Southern California no longer belongs on that list since in 2009 USC University Hospital and Norris Cancer Hospital were purchased by the University from Tenet.

L. Julian Haywood, MD (AΩA, Howard University, 1981) Los Angeles, California

Medical hand-me-downs

As I was dressing for the beach the other day my wife asked: “How can you wear those old bathing trunks? They’re full of tears, are shredding, and the elastic has worn out.” I responded shortly, “They’ve been my bathing trunks for many years. I like them and am comfortable in them. So I’m wearing them.”

As we bobbed up and down in the water, though, I started to think medically (as is sometimes my wont). Specifically I was thinking of a woman I had given an expert opinion on only that morning. It was the case of forty-five-year-old Letitia, who was applying for long-term disability on the basis of rheumatoid arthritis. The administrative law judge, faced with voluminous medical records, a tearful claimant, and an aggressive attorney (who stood to gain some twenty percent of any awards in favor of the claimant) called on me to help him interpret the records so that he could evaluate the claim.

I started with Day One, some seven years previously. Letitia had had a mild respiratory infection, low-grade fever and generalized aching, especially in the neck and shoulders. When it persisted for a week she saw her primary care physician who did the usual laboratory tests including a sed rate which was 30—the only abnormality. He made the quite proper diagnosis of probable common influenza and, remembering his medical school days, and in honor of the mild elevation of ESR, wrote “R.O. rheumatoid arthritis.”

Letitia recovered promptly from that episode but in the course of the next two years had brief episodes of body aching and each time that ominous “Rule out R.A.” was written. A year after that, having moved to a new community and acquiring a different physician, she was found on routine examination to be at risk for osteoporosis and was started on medication. Her general doctor referred her for evaluation to an orthopedist who reviewed her record and referred to her in his notes as “with a history suspicious for rheumatoid arthritis.” The next doctor down the line, the gynecologist who removed her uterine fibroids, referred to her as a “43-year old woman with rheumatoid arthritis.” During this entire time her sed rates, CRPs, latex fixations, ANAs, and x-rays of joints had been entirely within normal limits. However, every time Letitia had an ache or a pain she would tell all: “You know, it’s because I have rheumatoid arthritis.”

When she fell on hard times at age forty-five she felt even more achy and became convinced that she was forever a crippled victim of rheumatoid arthritis, a disease for which there was not, and never had been, any evidence. Letitia was the victim of a “hand-me-down” diagnosis—words which have been carried forth through a medical record without being specifically rendered invalid.

We have all seen countless examples of this sort of perpetuation of diagnosis when it has once been proposed. The establishment of “check-mark” sheets of medical history and findings make it even easier to perpetuate this mistake. It’s far easier to check the “yes” box when asked if there is a history of arthritis and to include the code for rheumatoid arthritis for patients like Letitia that will ensure that this quite improper diagnosis follows her and will be included to the end of her days. Perhaps worse, Letitia may “google” “rheumatoid arthritis” and discover a whole new set of symptoms which she may come to believe she has, and a “worst-case” scenario which she can come to believe is responsible for her not having a job.

How can this be prevented? Especially in the modern era of punchboard charts. There must be a column for “diagnosis established with a reasonable degree of medical certainty,” not just those which have been entertained. This will require the physician who makes the check-marks to actually think (remember that?) about whether the evidence really establishes reasonable medical certainty. Letitia should have been told years ago that she surely does not have rheumatoid arthritis; she would then probably not have developed “google symptoms.”

As with everything in medicine, however, we should not throw out the baby with the bath water. I remember coming as a visiting professor to a large municipal hospital and being presented with a middle-aged male patient who had been in the teaching hospital for over a year but remained a diagnostic puzzle. His voluminous records included lengthy notes from successive generations of medical students, interns, residents, attendings, and consultants (who included all classes of internists, neurologists, dermatologists,
vascular and other surgeons, and nurse-practitioners). I, too, was puzzled by this man who was obviously chronically ill, had a non-characteristic rash, non-specific cardiac findings, rather severe neuropathy which was non-diabetic, and depression. I looked over the lengthy record and found a great many diagnoses having been proposed and many carried forward as “hand-me-downs.” I then went back to the very first record, written by a fourth-year student and obviously given short shrift, who made the diagnosis of “Hansen’s Disease.” No one, unfortunately, had carried this down and thus this unfortunate man with leprosy had remained undiagnosed.

Charles M. Plotz, MD, MedScD
(AΩA, SUNY Downstate, 1968)
Emeritus Professor of Medicine
Brooklyn, New York

I get nervous when I receive a large Priority Mail envelope. That is, until I recall that a subpoena must be delivered in person. When I opened the big envelope yesterday and saw the cover of The Pharos, my immediate reaction was, “No, it’s not possible.”

Well, of course, it was not only possible, it was true. I have always admired the publication for its brilliant editing and for its outstanding artwork. For this longtime bar poet, whose oeuvre is usually submitted in blue ballpoint pen on a stack of cocktail napkins, to be the recipient of such elegance—well, it’s overwhelming. No, truly. The feeling is quite like that I experienced the day that I was told I had been elected to AΩA. These are honors quite considerable. And more than a little moving.

Robert L. Chesnaw, MD
(AΩA, Washington University in St. Louis, 1975)
Cheshire, Connecticut

Accelerating human evolution??

I will agree that human behavior has evolved—at times for the better and at times for the worse. However, I do not think that humans or human nature have evolved at all. To me evolution would refer to changes in the genetic code that would alter the human who had it. I do not believe that we humans have evolved to suit our current society and economy. I sometimes think that we have cancelled survival of the fittest and promoted survival of the less fit. Do I think the use of chemicals to enhance brain function is a good thing?

No, I do not. Show me the data.

Treatment of malfunction of brain chemicals is a different matter. Alteration of those chemicals in cases of bipolar disease, depression, obsessive-compulsive disorder, or maybe schizophrenia certainly are needed. By definition no more than fifty percent can be above average. Granted it would be desirable to have more people better educated and more able to use their abilities to the maximum. It is my view that we have too many relying on drugs rather than using common sense and good judgment.

Donald W. Bales, MD
(AΩA, University of Tennessee, 1946)
Kingsport, Tennessee

I read with interest the editorial by Dr. Harris in the recent issue of The Pharos (Summer 2009, p. 1) asserting that human evolution is being accelerated by both modern medical interventions and cognition-enhancing drugs. Perhaps my knowledge is incomplete, but I fail to see how either could produce the genetic change and/or selection required for real evolution. Longevity, as produced by dialysis (or any other late-life intervention), has no connection to the genetic variation that would lead to a naturally longer life. Likewise, unless drug therapy produces gamete-changing effects (rather than mere stimulation of neurotransmitters), it is also difficult to link these effects to evolutionary change.

Unfortunately, while any intervention after the reproductive age has passed is genetically ineffective, medicine has facilitated the survival of many unfortunate individuals with otherwise fatal defects to an age where reproduction is possible. Rather than dwell on the sad thoughts that further discussion of this would unavoidably produce, let us agree that the editorial topic is a difficult one.

Now, I would agree that recent medical advances give the appearance of evolution; however, the fundamental substance of humanity has languished, deprived of the pressures of selection. Unless (and it may be soon) we can pick and choose genetic material before birth, no real evolutionary change is possible (save perhaps slow regression). So, although the overall message of the editorial was thought-provoking, the attempt to link the grand themes of evolution, time, and medical training was less than successful.

James Berry MD
(AΩA, University of Texas at Houston, 1983)
Nashville, Tennessee

The right to sue

To Dr. Manganiello’s three prerequisites to health care reform (Summer 2009, p. 43), I would add a fourth: A reform of our country’s medical malpractice litigation system.

The current system promulgates the notion that someone must be to blame
for every adverse outcome, and encourages disproportionately huge plaintiff awards. The resulting enormous cost of professional liability insurance for hospitals and clinicians must get passed on, at least in part, to the consumer. Health care expenses are also driven up by the performance of countless unnecessary tests, so as to avoid the unlikely but not impossible chance of missing a significant diagnosis in a patient with an unremarkable presentation, followed by a medically unsophisticated jury being persuaded that the test “should” have been done. In still other instances, a sympathetic jury may simply wish to make it possible for the plaintiff to receive funds from the institution, practitioner, or insurance company with the deepest pockets.

It is discouraging, though perhaps not surprising, that with all the discussion of health care reform in the media, the subject of runaway malpractice litigation and its effect on health care costs gets glossed over or not mentioned at all. Measures such as placing caps on awards for damages and pain and suffering (which some states have already done), and the use of impartial expert physician panels to review cases on their true medical merit could bring down the cost of health care significantly, making it more affordable for government programs, insurance companies, and private individuals.

Before the government tries to figure out how to pay for coverage, let it be part of the solution by lowering the cost of that coverage—not by declining payment for services rendered, but by making it less financially burdensome for physicians and hospitals to practice medicine. Until this issue is widely discussed and ultimately addressed, I fear that attempts at reform will be unsuccessful, and our country’s reputation for inefficiency in its health care system will persist.

Jeffrey S. Menkes, MD
(AΩA, Yale University School of Medicine, 1972)
Manchester, Connecticut

Informal Education

She sat alone within her room
Bedside roses full in bloom
A listless look, a foreign stare
Lips reciting familiar prayer

The room was bare, clean and white
Anything but a healing sight
We were strangers in her world
Intimate secrets soon unfurled

In we marched, one by one
Her quiet sanctuary came undone
Students stood along the wall
Detailed health at prompt recall

We looked at her just like a text
A detailed case, she’s quite complex
Her heart was failing, slow but sure
Her trust in us to find a cure

Her quiet way, it drew me near
What I’d say was yet unclear
As I knelt beside her chair
I felt, I knew, her calm despair

I peeled away my stethoscope
Feeling ways to help her cope
I placed it softly in her ears
She knew not what she would hear

The drum I placed upon her chest
And in one breath I did confess
The sound she heard, it was her own
Her heart was sick, the beat postponed

She looked down into my eyes
Her lips apart, content surprise
A simple tear, a quiet smile
My little gesture well worthwhile

Melanie Buskirk

Ms. Buskirk is a member of the Class of 2011 at Mayo Medical School. This poem won honorable mention in the 2009 Pharos Poetry Competition. The author’s address is: 207 5th Avenue SW #408, Rochester, Minnesota 55902. E-mail: buskirk.melanie@mayo.edu.
The new Alpha Omega Alpha web site
We invite you to visit our freshly redesigned web site, featuring our new logo. The web site now includes the ability to search for members by last name, submit program applications on-line, and much more. We hope you’ll give it a test drive!

Winner of the 2009 Pharos Editor’s Prize

The 2009 *Pharos* Editor’s prize has been awarded to Terrell Nabseth Stevenson of the University of California, San Francisco, Class of 2011, for her essay, “The power of language in medicine—Case study: Mongolism” (Winter 2009, pp. 4–9).

Ms. Stevenson tells us: I received my BA from Stanford University in History, with an emphasis on modern European history. One of my final research projects, which inspired my article in *The Pharos*, was entitled “The Language of Down Syndrome: The Weight of Language on People with Trisomy 21 from 1866 to the Present.” During the first two years of medical school, the amount of science to be learned was overwhelming, so I continued to turn to reading and writing as my creative outlets. I am grateful to discover that my interests in history have a valued place in the field of medicine, and I look forward to future projects in the history of medicine.

Announcing the 2010 Pharos Editor’s Prize

For the thirteenth year, Alpha Omega Alpha is pleased to offer up to four prizes of $1000, $750, $500, and $250 to the author(s) of original nonfiction manuscripts published in *The Pharos*. Authors need not be members of ΑΩΑ, but must be forty-five years old or younger as of December of the calendar year in which the paper is submitted. To be competitive for a prize, the paper submitted must be in the standard format of *The Pharos* (see Instructions for *Pharos* Authors immediately following), and not published previously in any form. Content should be in the areas emphasized by *The Pharos*—medical history and biography, ethics, professional issues, and personal essays. Essays submitted to the AΩA Helen H. Glaser Student Essay competition are not eligible for this prize, nor are previous winners of the Editor’s Prize eligible to compete. All manuscripts are subject to review of *Pharos* editorial board members. Judging will be on the basis of style and composition, originality, scholarship, and interest and relevance to medicine.
To my official association with the Pharos editorial board, I look forward to being asked to serve on the editorial board; I am delighted now to anticipate its quarterly arrival, even when my copies were hand-me-downs from Harold Godwin. I have come to value the older age of disease. Over the course of years since, and in the steady company of patients, I have come to value the older wisdom—that the real task of medicine is to find ways to be helpful to people who are in trouble. Nowadays we are inundated by appeals to let “evidence-based medicine” enhance life in the practice of medicine. He is a past president of the American Osler Society, and for ten years he served as editor of the North Carolina Medical Journal. Dr. Neelon has this to say about his appointment to The Pharos:

I graduated from medical school having absorbed the pervasive (albeit unvocalized) advice that the goal of “real” medicine is to unravel the secrets of the body well enough to devise treatments that will forestall or undo the ravages of disease. Over the course of years since, and in the steady company of patients, I have come to value the older wisdom—that the real task of medicine is to find ways to be helpful to people who are in trouble. Nowadays we are inundated by appeals to let “evidence-based medicine” (largely evidence-based treatment) guide what is best to prescribe for patients with this or that kind of disease. I have no problem with guidance in what-to-do; my pitfall is how to get patients to do-what-they-should. Few of the papers in the medical journals I read help me sort out the dilemmas of doctoring. I suppose because those problems do not lend themselves to the abstraction that would permit their assembly into a scientific paper. That means I rely on the stories, the poems, the musings, the historical or personal essays that do, sometimes, clarify things. Because The Pharos is a bastion of this kind of writing, I have for years anticipated its quarterly arrival, even when my copies were hand-me-downs from Harold Godwin. I am delighted now to be asked to serve on the editorial board; I look forward to my official association with The Pharos.

Correction
The Autumn issue incorrectly identified the visiting professor at the University of Kansas in 2008/2009. The actual visiting professor of Dr. Allan R. Fleming of the University of Kansas Medical Center.

Instructions for Pharos authors
We welcome material that addresses scholarly and non-technical topics in medicine and public health such as history, biography, health services research, ethics, education, and social issues. Poetry is welcome, as well as photograph/poetry combinations. Photography and art may also be submitted. Scholarly fiction is accepted. All submissions are subject to editorial board review. Contributors need not be members of Alpha Omega Alpha. Papers by medical students and residents are particularly welcome.

Submissions must meet the following criteria:
1. Submissions may not have been published elsewhere or be under review by another journal.
2. Essays should have a maximum of 15 pages (approximately 5000 words), and be submitted in 12-point type, double-spaced, with one-inch margins. They should be accompanied by a covering letter and a title page with the word count (or page count), return address, and e-mail address. Papers exceeding the page count noted will be returned to the author. References should not exceed 20 unique items (see below).
3. Poems or photograph/poetry combinations should be in 12-point type, with one-inch margins, with the author's name, address, and e-mail address on the first page.
4. Send your submissions to Edward D. Harris, Jr. M.D., Editor of The Pharos, 525 Middlefield Road, Suite 130, Menlo Park, California 94025. You may also e-mail them to: postmaster@alphaomegaalpha.org.
5. After peer review, comments on the manuscript will be sent to the author along with an editorial decision. Every attempt is made to complete preliminary reviews within six weeks.
6. The editors of The Pharos will edit all manuscripts that are accepted for publication for style, usage, relevance, felicity, and grace of expression, and may provide appropriate illustrative material. Authors should not purchase illustrative material because the editors cannot guarantee that it will be used.
7. In accordance with revised copyright laws, each contributor will need to sign an Author’s Agreement, which will be sent with the edited galleys. Information on copyright ownership and re-publication of articles is detailed in the Author’s Agreement.

Reference information
Authors are responsible for the accuracy of citations and quotations in their papers. Once a manuscript has been accepted for publication, therefore, the author will be required to provide photocopies of all direct quotations from the primary source material, indicating page numbers. (Please mark the quoted material on the photocopies with a highlighter.) In addition, the editors will require photocopies of all references: the title page and copyright pages of all books cited, the first and last pages of book chapters cited, and the first and last pages of journal articles cited, as well as the Table of Contents of the particular issue of the journal in which the cited article appeared. The foregoing items...
will be used to verify the accuracy of the quotations in the text and the references cited, and to correct any errors or omissions. The photocopies will not be returned.

References should be double-spaced, numbered consecutively in the text, and cited at the end in the following standard form:

**Journal**


**Book**


**Book Chapter**


Each reference should be listed in the bibliography only once, with multiple uses of a single reference citing the same bibliography reference number. Examples are available at our web site: www.alphomegaalpha.org.

Citation of web sites as references is discouraged unless a site is the single source of the information in question or has official or academic credentials. Examples of such sites are official government web pages such as that of the National Institutes of Health. Encyclopedia sites such as britannica.com are not primary references.

**Leaders in American Medicine**

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

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

thought of you the first time I felt like a medical student—standing at the light board before an x-ray, discussing the bones in the hand, pointing to that picture and knowing I would be a doctor now. You smile at me as I attempt to identify every structure my hand drifts over, cradle my head just so on your chest to hear your heart, trace the muscles in your shoulders when water beads there, diamondlike, transient. They say we are not just the sum of the parts and I do not know if you mean more to me now that I have named each part for you, memorized each ponderous and gleaming organ, all the waxy tendons and tissues like gold leaf, the helix of veins weaving up each arm. Every structure has become yours, no matter whose name, no matter whose body on the table. Your pacemaker tattoos its message on the EKG, your oxygen decrescendoes on the green monitor beside me and your unknown pain twists in my flank alongside yours. Everyone’s agony is yours, and mine as well, and when you die, it will be me who kills you, who lets you die, your face a soft sapphire in my small hands, your wide eyes that flicker and fade out before me. I know what will happen and I still have that x-ray to bring you back each time, the ghostly outline that outlives us both, the white haze not bone but smoke, a scorch marked deep into the skin—a sign of damage, of something burning, but also of life remaining, of something living on to burn.

Ashley Mann

Ms. Mann is a member of the Class of 2011 at the University of Missouri—Kansas City School of Medicine. This poem won first prize in the 2009 Pharos Poetry Competition. Ms. Mann’s e-mail address is: aah9pd@umkc.edu.
Purpose
To encourage photography that illustrates АΩA’s motto: “Be Worthy to Serve the Suffering.”

Prizes
Twelve winning photographs will be selected to be displayed for one month each on АΩA’s website: alphaomegaalpha.org. A short description of the photograph and its context will be displayed with the photograph. No cash prizes will be awarded.

Eligibility
Only amateur photographers. Anyone may participate, except for professional photographers and those affiliated with the АΩA national office operations, including contractors, staff, and members of the Board of Directors and Pharos Editorial Board members.

Dates
Photographs must be submitted by e-mail no later than February 15, 2010.

Requirements for the photos
1. Photos must not have been published elsewhere, and must the work of one person.
2. All entries must be submitted by e-mail.
3. Only one entry per person is allowed.
4. Files must be submitted in JPEG format, and must be at least 500 KB in size, and no larger than 2 MB.
5. Files must be uncropped and generally unedited (except for brightness, contrast, and color balance). Conversion of color photos to black and white is allowed.
6. Photographs must be in landscape orientation and must be able to be cropped to fit the dimensions of the photograph on АΩA’s homepage.
7. Each photograph must be accompanied by the photographer’s name, address, telephone number, e-mail address, and a description of the photo of less than 100 words.
8. Photographs must adhere to HIPAA regulations.
9. The photographer of a winning photograph must sign a release allowing Alpha Omega Alpha the sole right to display the photograph for a period of one year. Copyright remains with the photographer.
10. Send entries to info@alphaomegaalpha.org. All e-mails must have the subject: AOA Web Site Photography Contest.

More information
Contact Managing Editor Debbie Lancaster at (650) 329-0291 or info@alphaomegaalpha.org.
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