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

Requests for reprints of individual articles should be forwarded directly to the authors.
The Pharos of Alpha Omega Alpha Honor Medical Society (ISSN 0203-7179) 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 © 2013, 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. Debbie Lancaster, 525 Middlefield Road, Suite 130, Menlo Park, California 94025. E-mail: info@alphaomegaalpha.org

POSTMASTER: Change service requested: Alpha Omega Alpha Honor Medical Society, 525 Middlefield Road, Suite 130, Menlo Park, CA 94025.
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Leadership for the future

Richard L. Byyny, MD, FACP

Leadership in medicine, medical education, and health care is more important now than ever before. I am convinced that the medical profession needs a new form of leadership, one based on the values that Alpha Omega Alpha was founded on: professionalism, leadership, service, research and scholarship, and teaching.

In 1935, as many as thirty-five percent of hospitals were led by physicians. By 2009, that number had fallen to four percent. Today’s leaders of health care organizations are mostly graduates of health administration programs or business schools, not doctors. What happened?

The twentieth century brought advances in science and medicine that transformed our understanding of medical science and patient care. These advances led to technological breakthroughs that resulted in better care for patients, but also brought an explosion in the cost of medical care. A growing perception that physicians were unable or unwilling to constrain the rising costs of health care led hospitals and insurance companies to develop the concept of “managed care,” in effect usurping the authority of physicians to directly manage care for their patients. This in turn led to the consolidation of economic power and political influence over the practice of medicine by corporations rather than with physicians. The traditional practice of medicine evolved into the corporate practice of medicine.

In theory, physicians, health care organizations, and patients should have a symbiotic and collaborative relationship, with the common goal the quality care of the patient. But in practice this is often not the case. All too often, medicine is a corporate business and the financial bottom line is the principal value and objective, even in nonprofit organizations. This means that leaders of health care organizations are chosen from among those who are educated and trained in health administration and business, rather than from among physicians.

Health care organizations are now the employers of many
Editorial: Leadership for the future

physicians, and this employer/employee relationship can disrupt the bond between doctor and patient by inserting the organization between them. The focus of health care organizations on the bottom line often means an imbalance between the need to manage costs and the vision to develop a future for medicine and health care that supports patients, caring, and health education, and enables the delivery of high quality compassionate care for patients and society. The profession of medicine needs physician leadership to restore that balance.

At the same time that medicine needs leadership, it needs a renewed focus on professionalism. Professionalism and leadership in medicine are inseparable because professionalism is the foundation for medicine’s contract with society, which is based on the following principles:

- The primacy of patient welfare, and the physician’s dedication to serving the interest of the patient.
- Respect of patient autonomy—being honest with patients, advocating for them, and empowering them to make informed decisions that are ethical and based on appropriate care.
- The pursuit of social justice, including the promotion of justice in the health care system and working to eliminate discrimination in health care.²

The future direction of health care will depend on physician leaders working together with health care organizations to use their knowledge, skills, experiences, and values to develop new models of health care delivery that fulfill the profession’s contract with society and meet the needs of patients. We believe that a good model for physician leaders is the concept of servant leadership.

A concept distilled by Robert Greenleaf in his 1970 essay, “The Servant as Leader” and expanded in his 1977 book, Servant Leadership: A Journey into the Nature of Legitimate Power and Greatness,³ servant leadership can be summarized this way: “Great leadership is about doing the right thing in service to others.” At its core, servant leadership asks leaders to identify their values, to share their vision, and to inspire others—to work with passion for their goals. In doing so, they will find joy and self-respect. Their rewards are the positive results they achieve and their personal satisfaction.

Effective leaders need to be competent as managers, but leadership is much more than good management—and more important. Leadership provides vision, purpose, and direction, while management makes it all happen.

Four contemporary thinkers provide further insight on leadership:

- Dr. Wylie Souba, Dean of Dartmouth Medical School, provides us with a concise definition of leadership: “Leadership defines what the future should look like, aligns people with that vision, and inspires them to make it happen despite obstacles.”⁴
- John Kotter, former professor at the Harvard Business School, defines leadership “by what leaders do: they cope with change, they set direction, they align people to participate in that new direction, and they motivate people.”⁵⁶
- Warren Bennis, pioneer in the contemporary field of leadership studies, emphasizes that leaders should be “catalysts for constituents who seek four ideals: meaning or direction, trust in and from their leaders, a sense of hope and optimism, and results.”⁷
- Jim Collins, who wrote Good to Great, argues that the leaders who will make the most difference are those who want to be great, and want their teams or organizations to be great. They want to make a positive, important, and distinctive difference over a long period of time. These leaders build enduring greatness through a blend of personal humility, professional will, commitment, and perseverance to the cause, movement, mission, or work—not to themselves.⁸

Whichever visionary we look to, all agree that modern leaders provide organizations with vision, purpose, and direction as they inspire the people they lead to serve the values all hold in common.

Medicine, health care, and education are not corporate businesses, although some health care organizations reflect the values of corporate cultures and missions. To be true to the profession, leadership in medicine must be based on medicine’s core professional value: the care of the patient. The medical profession desperately needs physicians—with their experience in clinical care and medical education, their commitment to service and patient care, and their special knowledge, skills, and education—to provide the leadership for the next steps in patient care, clinical medicine, medical education, and medical practice.

Much is changing in medicine, including the increasing complexity of the interconnected parts of basic and medical science; the systems of medical practice and education; the rapidly changing social structures surrounding medicine; and the accelerating pace of change and interconnectedness. In concert with these changes, leadership in medicine is also evolving.

The days of trusting that “doctor knows best” are fading, and the tasks of leaders and best practices in leadership are evolving. Great leaders can be developed with leadership education, training, mentoring, coaching, practice, experience, and reflection.

The traditionally accepted models of education and practice, however, are no longer effective to meet contemporary and future leadership needs. Flexible leadership—whether hierarchical or team-based, or both—is needed, but can be hard to develop without a plan and support. There is a disconnect in today’s health system organizations between
Leadership is about making a positive difference and everyone, especially AΩA members, has the skills and opportunities to make a difference and provide leadership.

This raises an important question for Alpha Omega Alpha and our profession: How can we best support and contribute to leadership promotion and development as part of our professional responsibility, mission and core values?

While AΩA will continue to support our society’s mission to advocate and support the work, development, and success of a new generation of leadership in medicine for this century, leadership that exemplifies the core values of our profession and the commitment to a spectrum of successful approaches to leadership that include servant leadership and leadership based on core professional values and caring, is there more we can do? You have my commitment to continue to carry forward our long-standing mission, vision, values, and traditions, and to advocate for and work to develop the next generation of physician leaders for medicine, health care, education, and society.

References

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I am in the middle of a controversy with your mother, and her mother about why you have been pulling at your ear, while you just sit there with pampered potbelly saying nothing.

The crunch of the examining table’s crinkled paper in your double-fisted hands makes you smile responsively and tune out their cacophony over antibiotics.

They do not buy into my normal exam or the presence of sticky waxy or the idea that you just found your ears after six months; or my internal thought you are just being a baby.

So they pack you up in haste, unsatisfied with me because of your habit, acquired from watching too much baseball with dad and his ESPN babysitter who has infected you with signaling everyone to steal second.

Aaron M. McGuffin, MD

Otitis media

Dr. McGuffin (AOA, Marshall University, 2002) is Senior Associate Dean for Medical Education at the Marshall University Joan C. Edwards School of Medicine. His address is: 1600 Medical Center Drive, Suite 3413, Huntington, West Virginia 25701. E-mail: aaron.mcguffin@marshall.edu.

Illustration by Jim McGuinness
Here she lies,
My love at 75
And I near 80.
Her jeans-clad leg
Swung across the bed
Climbing my withered frame
Reaching for the pacemaker of my
Heart.
Caressing the taut blue-veined skin revealing
The battery that drives my pulse;
Seeking closeness to the scarred, imperfect heart
of me.
With hands distorted by use and aging;
And love transcending time,
Youth,
And old age.
Lisa Babin

The author is a member of the Class of 2015 at the University of Maryland School of Medicine. This essay won second prize in the 2012 Helen H. Glaser Student Essay Competition. Ms. Babin writes: “For two years after I graduated from college I worked at a group home for severely emotionally disturbed children. These children suffered from a range of conditions from attention deficit disorder to paranoid schizophrenia, and their behaviors reflected such disorders. On a number of occasions I observed the suffering of a child reliving his or her trauma and decompensating as a result. The following is a fictional narrative relating one such experience.”

Dancing.

It’s 7:32 in the morning and I’m locked in a cage. 6 ft x 8 ft room of control, of peace. but there is no peace or control here. there’s just Me, My thoughts, and Staff Number One who keeps looking at Me through the window. I holler at Her to stop, to leave Me alone, to let Me out, to get Me a gun; anything. She just stares back at Me through bored eyes and sighs, as if My being locked up is all just an inconvenience to Her.

this cancer eats away at My brain. a banquet hall full of diners feast on My memories, ideas and dreams until I no longer know what’s Real. I hear them talking, in whispers or amplified, telling Me stories I know not to be true. a life I once had, long before I was in this cell. the chatter becomes overwhelming as breakfast wraps up. everyone is talking about their plans for the day, failing to realize that no one is going anywhere while that door is locked.

some of them ask Me questions. I try to ignore them, to pretend they don’t exist. if I can just prove to the Staff—I just want to go home. they keep asking and giggling between My ears, and it’s all too much to handle. just go away I implore them, but the laughing only grows louder. taunting
and singing and laughing; they all over-ride My will to be Out. I desperately search for something to drown out the noise, but in this cell I’m not even allowed shoelaces.

i knock on my temple—the doorbell to my brain. hi, i say. can you guys keep it down please? i wring my hands and climb up walls. the room gets smaller, or my head is getting bigger, and i feel like i’m running out of air. someone starts singing in French. i didn’t even know i understood French, but it feels appropriate to put on my tutu and take the stage. i spin and spin and practice my Pointe; soon i’ll be ready for the show.

12:03 and time for Meds. i sit in the corner and giggle with my friends in French and relish in the jokes Staff Number One doesn’t understand. i am handed: 1 pink oval pill, 1 yellow round pill, 2 blue round pills, a capsule filled with itty bitty purple beads, and 2 flintsstones vitamins. they are my favorite. i eat the vitamins and throw the pills back at the Staff—i’m not feeling very colorful today.

i know i’m in trouble when the Doctor comes to check on me. i can hear the Doctor and the Staff talking outside the door. They say words i don’t understand, like Decompensation, Psychosis, Schizophrenia. He likes to say long words to make Himself feel smart. He hands me small pieces of a Rainbow and promises i’ll feel better. the Doctor asks how i’m doing. je suis bien, merci, i reply. my Friends laugh at His confusion—how could He not speak French after all this time? He reaches out His hand to touch my shoulder but touching stray dogs is dangerous and i bite at Him. His skin is brown and i think He must taste like chocolate but He pulls His hand away and only then am i reminded that chocolate is in fact bad for dogs. that was a near miss.

He mumbles in a language i don’t understand. Je ne comprends pas, i inform him. His lips are curled and His jaw is slack and i’m pretty sure His tongue doesn’t work anymore. it just flops around like my goldfish did when i took him out of his bowl. thinking about my goldfish makes me sad and i don’t want to listen to the Doctor anymore. s’il vous plait sortez-vous. je suis fatiguée et j’ai besoin de repos. i ask politely at first, but pleasantries never get you far with the Staff. i knock on my door again—can You Guys get him to leave? can’t You hear me? i must knock harder.

the Doctor stands up and knocks on His own door and They let Him out. He must know the secret knock because i’ve been banging on that door for hours and i’ve gotten nothing. i’m smarter than They all think i am and when i get out of here i will take my tutu and my wings and dance on the stage. my ears perk up at the sound of the Doctor giving Staff Number One the Secret Code: 5150. i know that Code although i don’t know why and my body tenses up even as i teach myself le subjonctif. our time is short and...
I must break free, so i ask Puis-je aller à la toilette, s’il vous plaît? glanced at and rejected but They don't speak French so I try again. may i please go to the bathroom? success! I'm told to sit quietly for five minutes to prove that I can sit quietly for five minutes, and I do but They don't know that I don't need to open my mouth to talk to my Friends. They floss their teeth with my nerves and tell me stories of Paris in the spring of 1952 while I focus all my attention on keeping Us perfectly still and They smoke cigarettes and drink espresso—any flinch, spasm, imbalance will make the Staff believe We're not ready.

Five minutes fly by like eons and We're Allowed Out. very slowly I get up, trying not to smile because They'll know something is wrong if I'm too happy. three of Them walk Us to the bathroom but I'm 15 and They're not allowed to come in with Us. Staff Number One goes in and makes sure there is nothing dangerous that We could get a hold of—the cabinet is locked under the sink and the mirror is just a piece of plastic with a mirrored coating. She takes the roll of toilet paper and starts unraveling it. One or two? She asks. I hold up my fingers without making eye contact (I just know We'll burst out laughing if They look Us in the eyes) and She doles out the correct amount. I never understood this but I heard that one girl tried to eat an entire roll of toilet paper so I guess the Staff are worried about that. people in here are Crazy.

They close the door and though I know They're all sitting there waiting for Us to come out I relish in Our isolation. I look around this smallest of sanctuaries and breathe the sweet smell of clorox and hand soap. We start humming “tiptoe through the tulips” and I do a couple Pirouettes before my eye notices the Plunger. how could Staff Number One forget to take the Plunger? I twirl it in my hands like a baton and decide to lead the parade down a new victory lane. I march among elephants and clowns and bands and brass and when I get home I will take the stage and dance.

My Friends start reciting Shakespeare in French in my head even though I know Shakespeare was English but it gives me an idea. hark! what light through yonder window breaks and while the window to the Outside is made out of unbreakable plastic the window to the Other Side isn't. like a javelin thrower in the olympics, I take my stance and hurl the Plunger into the Silver Window. a scuffmark is all I have to show for my first attempt, and I hear the Staff hearing my noise. They start to worry and I know I have to make haste! swinging like a baseball player I strike the Silver Window once, twice, thrice, and on the fourth time it shatters. like music with a thumping baseline the Staff are trying to break down the door but I'm 15 and They're not allowed in the bathroom with me so it's the only door in the whole house with a lock on the inside.

My Friends are all talking at the same time giving advice of what to do with the broken fake mirror. the talking becomes raucous and I'd like it to end but I know They won't listen to me if I ask so I just start singing louder. I want to paint a picture; I know body paint only comes in one color even though there are two colors before it comes out of your body and I decide to paint a red balloon. I will carry it through the parade and wear it on my wrist as I dance for the life I used to have.

Suddenly the door breaks in and They're on me like lions on a wilde-beest. I remember this from years before; the group of men, being pinned down, the Pain. I won't go through it again. I won't! there are six of me and only five of Them and the odds are in my favor, but the Staff are older than I am and stronger. my arms are slippery from the paint and I hold my shard of mirror like a sword of valor—I will slay the dragon and save the princesses and dance and sing and carry my red balloon all the way home. I dodge and weave their fiery breath, and slash with my broadsword (ho!?) but my Friends are cowering behind my ears and aren't helping at all.

It only feels like days that we've been struggling in the wet bathroom when more Men show up. my red arms are wound in Staff Number One's thick curly hair; They'll have to cut me out if She wants her head back. the Men and the Staff are trying to untangle me from Staff Number One and I bang Her

Illustrations by Laura and Erica Aitken

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About Lisa Babin

After graduating from Boston University in 2006 with a degree in psychology and visual art, I had the pleasure of diving headfirst into “life experience” at a group home for severely emotionally disturbed children. It is from this that I derive my strength as I pursue a career in medicine. I am currently an MS2 at the University of Maryland School of Medicine, and hope to enjoy a long career as a doctor of emergency medicine.
head on the ground as i bang my head on the ground; everyone needs a beat to dance to.

i know i’ll win because there are Rules to this game and the Rules say I’m 15 and They aren’t allowed to tie me down and They have to get me medical attention if i need it. i’ll go off-campus to the clinic and then my Therapist will come and buy me ice cream because its been Such A Rough Day. but i don’t recognize these new Men as other Staff and i start to struggle harder. five of Them lift me up and we walk like a retarded royal Egyptian procession; They are carrying me like their queen, i am dragging Staff Number One along like my dog, one of the Men is trying to get me to let go of Her hair. i laugh at the thought of my newfound royalty and at the trail of biological breadcrumbs we’re leaving as They walk me out the front.

in that moment of laughter, of lightness, i don’t think to look at the chariot that is parked out front, nor how it’s different, nor the way the bed is specially made. the Man gets my hand out of Staff Number One’s hair which isn’t fair because i’m distracted by the lights and noises and horses drawing the chariot. was it my bad timing or theirs? They lower me onto the bed as gently as a missile to the ground and before i can spit on more than one of Them my wrists and ankles are bound. They’ve paralyzed me! i hear other unfamiliar words; Safety, St. Vincent’s, Haldol, Stabilization, and i know i won’t be dancing anymore.

The author’s e-mail address is: lisa.babin@gmail.com.
What difference can a student make?

Richard B. Gunderman, MD, PhD

Dr. Gunderman (AΩA, University of Chicago, 1992) is AΩA councilor, Vice Chairman of the Department of Radiology and Imaging Sciences and Professor of Radiology, Pediatrics, Medical Education, Philosophy, Philanthropy, and Liberal Arts at Indiana University School of Medicine. He is a Councilor Director on the AΩA Board of Directors and a previous contributor to The Pharos.

What can a medical student do for a patient? With no degree, no postgraduate education, and virtually no experience, it’s no surprise that other members of a health care team rarely turn to a medical student for help. So what difference can a student make in the care of a patient?

Mr. Scott had been admitted to the medical ICU with an acute stroke. An elderly man, he suffered from several neurological problems, especially with speaking and swallowing. Mr. Scott was receiving state-of-the-art care, being attended by a team of physicians from various medical disciplines.

The lowest-ranking person on Mr. Scott’s health care team was newly minted third-year medical student Anup. Anup accompanied the team on daily rounds, listening and learning from what everyone else said, but adding nothing unless directly questioned. But because he was responsible for a relatively small number of patients, one thing he knew could offer each one of them was his time.

Anup got to know Mr. Scott. And over the course of the first few days of their acquaintance, while the team was subjecting the patient to an extensive battery of diagnostic tests and therapies, Anup realized that Mr. Scott was deeply troubled about something. He was withdrawn and downcast. Other members of the team attributed this to his recent medical catastrophe—what rational person wouldn’t feel afraid and blue after such an experience? Anup, however, felt something more going on, and he resolved to find out what it was.

Anup noticed that Mr. Scott hadn’t received any get-well cards—or any visitors. Working through Mr. Scott’s speech difficulties, Anup learned that he had outlived his wife; his children, to whom he was not close, lived in other parts of the country. Mr. Scott’s distress, Anup eventually found, was not for his own condition, but for that of his companion Angelina. As Mr. Scott expressed it, the only thing he looked forward to each day was the time he spent with her.

Angelina had cancer. Just a day before Mr. Scott was hospitalized by his stroke, her doctor had shared with him the unwelcome news that her disease had reached its terminal stages. She had only a few weeks to live. Perhaps the stress of receiving this dreadful news had contributed to Mr. Scott’s stroke. He was afraid that no one knew Angelina or could take care of her as he did. Above all, he feared that Angelina might die before he could leave the hospital, and he would never see her again or be able to tell her how much she meant to him. His own illness had struck at the worst possible time, and now he would not be able to say goodbye.

Anup’s heart was touched. He wanted to do something. If Mr. Scott could not leave the ICU to see Angelina, why couldn’t Angelina, despite her illness, come to visit Mr. Scott? Anup resolved to make it happen.

But at this point, Anup made a startling discovery. Angelina was not Mr. Scott’s girlfriend. She was neither an elderly neighbor nor a regular visitor to the senior citizen center near his home. Angelina, Mr. Scott’s only regular companion for the past decade, was his pet cocker spaniel.

Anup shared his findings with the rest of the medical team. They were sympathetic about Mr. Scott’s predicament, but said that it would be impossible for a dog to visit him in the ICU. Anup took the story to the unit’s director, who concurred with the medical team. It was against hospital policy to allow an animal into the unit. Anup
appealed to hospital administration, but they merely repeated what he had already been told. Anup found himself at an impasse.

Then something occurred to him. Mr. Scott’s recovery was progressing nicely. Even though he would not be ready to leave the hospital for another week or two, he would soon be able to be transferred to a regular nursing unit where he could receive visitors. Anup called the veterinary hospital and asked if the staff would be willing to bring Angelina to the hospital. He then presented his plan to the members of the medical team, who reluctantly consented. The next day a kindly veterinary assistant brought Angelina to the hospital lobby. Once she arrived, the medical team transported Mr. Scott to meet her. He and Angelina spent thirty minutes together, the old man tenderly embracing his ailing companion as tears rolled down his face. A few days later Angelina died. A few months afterwards, Mr. Scott died as well.

The medical record says nothing about Anup’s contribution to Mr. Scott’s care. He did not perform Mr. Scott’s initial assessment, order diagnostic tests, formulate his diagnosis, or develop his care plan. Anup possessed neither the expertise nor the authority to direct or even implement most of his care. His work generated no revenue for the physicians or the hospital. Every time Anup even signed his name, it required a co-signature.

Judging strictly by the medical record, we might suppose that this third-year medical student made no important difference to the patient. But to Mr. Scott, Anup’s curiosity and compassion made all the difference.

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Each year since 1988, Alpha Omega Alpha, in cooperation with the Association of American Medical Colleges, presents four AΩA Distinguished Teacher Awards to faculty members in North American medical schools. Two awards are for accomplishments in teaching the basic sciences and two are for inspired teaching in the clinical sciences. In 1997, AΩA named the award to honor its retiring executive secretary Robert J. Glaser, MD, who died in June. Nominations for the award are submitted to the AAMC each spring by the deans of medical schools.

Amy Leigh Wilson-Delfosse, PhD (Basic)  
Associate Professor,  
Department of Pharmacology,  
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Professor Wilson-Delfosse received her PhD in Pharmacology from Vanderbilt University in 1991. She became an assistant professor in the Department of Pharmacology at Case Western Reserve University School of Medicine in 1998 and is currently the assistant dean for Basic Science Education and associate professor in the Department of Pharmacology there.

In recognition for her contributions to teaching and education, Professor Wilson-Delfosse received the Case Western Reserve University School of Medicine Department of Pharmacology Excellence in Teaching Award in 2000. She was a Harvard Macy Scholar in 2005. She received the Outstanding Presentation Award of the International Association of Medical Science Educators in 2006. In 2010, she received the Scholarship in Teaching Award from the Case Western Reserve School of Medicine, and this year was elected president of the International Association of Medical Science Educators.

In the words of Case Western Reserve’s Dean Pamela B. Davis, Professor Wilson-Delfosse has “a passion for curriculum development, refinement, and faculty coaching. Seeing students respond to new curriculum approaches inspires her. . . . She recognizes that the most important thing faculty can do in this era of evolving information is to promote lifelong learning and train students to ask questions. . . . She also keenly recognizes that, as a basic science instructor, she has an opportunity, in her eyes even an obligation, to impart teamwork skills while teaching basic science content. She sees classroom students as the clinical team members they soon will be, and prepares them with opportunities to absorb knowledge through applicable team approaches.”

Bruce F. Giffin, PhD (Basic)  
Field Service Professor,  
University of Cincinnati College of Medicine  
Professor Giffin received his MS in Biology at the University of Dayton in 1981 and his PhD in Anatomy and Cell Biology at the University of Cincinnati in 1985. He joined the University of Cincinnati College of Medicine in 1990 as a Biology Fellow and is now Field Service Professor there.

Professor Giffin won the University of Cincinnati College of Medicine Dean’s Award for Excellence in Teaching in 2003, as well as numerous Gold and Silver Apple Awards at the College of Medicine. In 2005, Professor Giffin received recognition as a Representative of Excellence in Teaching from the Greater Cincinnati Consortium of Colleges and Universities.

In his nomination of Professor Giffin, Dean of the University of Cincinnati College of Medicine Dr. Thomas F. Boat writes, “Bruce is one of the most compassionate and effective teachers in the history of the College of Medicine. He has, and continues to, teach in and lead a variety of courses reflecting the diversity of his knowledge and experience and his love and passion for medical student education. . . . He is an excellent teacher who challenges his students in a compassionate way. He holds them to high standards and is always there to support them—both in the classroom and outside the school. He is a tireless advocate for continually improving the educational program—ranging from better integration within and across years, to better test development, to more interactive and student centered learning, to the use of technology in the curriculum. There are many, many changes that have occurred at UC because of his leadership by action. He is not afraid to try new things. He is a wonderful role model and mentor for his junior colleagues and his senior colleagues as well as the medical students. If there were ever anyone who is indispensable to the medical education program at the University of Cincinnati College of Medicine, it is Bruce Giffin.”
Indiana University School of Medicine

Dr. Gunderman received his PhD at the University of Chicago in 1989, his MD with honors at the University of Chicago Pritzker School of Medicine in 1992, and his MPH at Indiana University School of Medicine in August 2002. He joined Indiana University School of Medicine in 1997 as a fellow in Pediatric Radiology and is now Vice Chair of the Department of Radiology and a Professor of Radiology and Pediatrics there.

Dr. Gunderman has been the councilor of the AΩA chapter at Indiana University since 2009 and is currently a councilor director on the AΩA board of directors.

Dr. Gunderman has received numerous awards for teaching excellence, including an honorary Doctor of Humane Letters from Northwestern University’s Garret Theological Seminary in 2012 for his “distinguished career of educational and scholarly excellence,” the 2012 Distinguished Educator of the American Roentgen Ray Society, and the 2008 Radiological Society of North America Outstanding Educator. He has been the Alpha Omega Alpha Visiting Professor at the University of Virginia School of Medicine, the University of Texas Medical School at Houston, and Boston University School of Medicine in 2012. At Indiana University, he has received the Trustees Teaching Award nine times, as well as the Robert Shellhamer Outstanding Educator Award, the Chancellor’s Award for Excellence in Teaching, and the Lieber All-University Award for Distinguished Teaching.

Concerning Dr. Gunderman’s teaching, one fourth-year student writes, “Dr. Gunderman is the best teacher with whom I have interacted. As many of my classmates have stated, he is the most thought-provoking educator at our school. He exemplifies the Socratic Method by enabling students to find answers with seemingly minor direction on his part. He inspires us to think.” Another writes, “One day I mentioned to Dr. Gunderman how dissatisfied a lot of physicians seem. ‘Why do you think that is?’ he asked. That sparked an amazing conversation and research project on professional fulfillment. I left feeling like my brain was on fire. We later published a paper in Academic Medicine. Dr. Gunderman challenges students to look inside themselves, encouraging them to bring up questions and then working fervently alongside them until they find answers. He is passionate, dedicated, kind, and brilliant. He is the most dynamic and engaging teacher I have ever known.”

Brian Hodges, MD, PhD, FRCPC (Clinical)
Professor, Department of Psychiatry, University of Toronto Faculty of Medicine

Dr. Hodges received his MD from Queen’s University at Kingston, Ontario, in 1989; his MEd in Higher Education at the University of Toronto in 1995; his Diplôme Interuniversitaire de Sciences Economiques et Sociales de la Santé at the Université de Paris VII in 2003; and his PhD in Higher Education at the Ontario Institute for Studies in Education at the University of Toronto in 2007.

Dr. Hodges has received many teaching awards in his career, most recently the Ian Hart Award for Distinguished Contribution to Medical Education of the Canadian Association for Medical Education and the National Board of Medical Examiners John P. Hubbard Award for outstanding contribution to the pursuit of excellence in the field of evaluation of medicine.

Dr. Catharine Whiteside, dean of the University of Toronto Faculty of Medicine writes about Dr. Hodges: “Brian Hodges is first and foremost an educator. His research, scholarship, and leadership roles are all undertaken in service to advancing medical education and holding it accountable to the highest possible standards for the benefit of learners, patients, and communities. . . . He is a local champion and capacity-builder and role model, a Canadian leader and trend-setter, and a respected international expert in medical and health professions education research and scholarship.” Others have said of Dr. Hodges that he has “a magical way of recruiting colleagues to the cause of education and . . . a remarkable ability to engage everyone in the importance of teaching” and that his “scholarly work is exemplary, his professional activities have been highly innovative and, most importantly, he is generous in offering his knowledge, advice, encouragement and oversight to individuals.”

Photos courtesy of the AAMC.
I nudged
the gear shift into neutral,
drifted into the gaping yawn
and found myself
cruising through a stomach,
foamy acid dribbling,
mucous curtain muscles rubbing,
roiling sudsy churning contents
of digestion sloshing, blurred in battle.
Suddenly hot gas erupted,
blasted heartburn hard
until it burped to jolt
my shiny car into the sunlight
to excuse me as I drove away.

Dianne L. Silvestri, MD

Dr. Silvestri (AΩΑ, Indiana University, 1974) is
associate professor of Medicine at the University
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Illustration by Jim M’Guinness.
The annual meeting of the board of directors of Alpha Omega Alpha was held in San Francisco, California, on October 6, 2012. Present were:

Officers: President Ruth-Marie Fincher, MD, MACP; President Elect C. Bruce Alexander, MD; Immediate Past President Rae-Ellen Kavey, MD, MPH; Secretary-Treasurer Joseph W. Stubbs, MD, FACP.

Members at large: N. Joseph Espat, MD; Eve J. Higginbotham, MD; Douglas S. Paaauw, MD; Don W. Powell, MD; Alan G. Robinson, MD.

Councilor directors: Lynn M. Cleary, MD, State University of New York Upstate Medical University; Richard B. Gunderman, MD, PhD, Indiana University School of Medicine.

Student directors: Alicia Alcamo, MD, the Ohio State University College of Medicine; William E. Bynum IV, MD, University of South Carolina School of Medicine; Christopher Clark, MSIV, University of Mississippi School of Medicine; Tonya Cramer, MD, Chicago Medical School at Rosalind Franklin University of Medicine and Science.

Medical Organization Director: Carol Aschenbrener, MD, Association of American Medical Colleges.

Coordinator, Residency Initiatives: Suzann Pershing, MD.

National office staff: Executive Director Richard L. Bynum, MD; Assistant Treasurer William F. Nichols; Managing Editor Debbie Lancaster; Programs
National and chapter news

Administrant Candice Cutler; Membership Administrator Jane Kimball; Controller Barbara Prince.

Attending by teleconference were: Councilor director Sheryl Pfeil, MD, the Ohio State University College of Medicine; Councilor director Alan G. Wasserman, MD, George Washington University School of Medicine.

Absent: Member at large Robert At nip, MD.

New to the board are: Alan G. Robinson, MD, elected to a three-year term as member at large; Lynn M. Cleary, MD, elected to a three-year term as councilor director; Christopher Clark, MSIV, elected to a three-year term as student director. Councilor director Sheryl Pfeil, MD, was elected to a three-year term as member at large.

Retiring from the board are: William Bynum IV, MD; Rae-Ellen Kavey, MD, MPH; Don W. Powell, MD.

Renewed for a three-year term is: Suzann Pershing, MD.

Constitutional changes

The board voted to approve the following constitutional changes:

Article IV. Membership and General Considerations

Section 3: Resident and Fellow Memberships

Residents and fellows who were elected as medical students to the Society are automatically members of the chapter of the medical school sponsoring the educational programs in which they are enrolled. In addition, each chapter may nominate for membership in the Society each year residents or fellows who have completed a first year of residency or fellowship. Their election shall be based on continued academic achievement, leadership, professionalism, service, teaching, research and promise referred to in Article II and Article IV, with special emphasis on commitment to scholarly excellence and medical education.

The numbers eligible to be nominated and elected in these categories will be determined by the Executive Director periodically.

a. Alumni/Alumnae: Graduates of medical schools in which a chapter exists, who were not elected as students, residents, or fellows, but who, after ten years or more following graduation are judged on the basis of academic and professional achievement, leadership, professionalism, service, teaching, research and promise referred to in Article II and Article IV to be qualified, may be nominated for membership in the chapter of the medical school from which they graduated.

b. Faculty: Members of the sponsoring school’s Faculty of Medicine who hold an earned doctoral degree (M.D., Ph.D., or equivalent) and have demonstrated continued academic and professional achievement, leadership, professionalism, service, teaching, research and promise referred to in Article II and Article IV, and a commitment to scholarly excellence and medical education may be nominated for membership in the chapter of that school.

The numbers eligible to be nominated and elected in each category will be related to the size of the medical school class and the number of students eligible to be nominated to membership in AΩA in the school. The minimum in each category will be two faculty and two alumni. The numbers related to size and the increment in these categories will be determined by the Executive Director periodically.

Article V. Organization and Central Administration

Section 3: Executive Director and National Office

The national office shall be directed by an Executive Director, chosen by the Board, who shall be the chief executive officer of AΩA and shall be responsible for implementation of all activities of the society, for maintenance of all society records, and for reports to the Board each year on the state of the society. The Executive Director shall serve ex officio, without vote, on the Board of Directors.

Section 5: President

The President shall be the senior elected officer of the AΩA Board of Directors, shall preside at all meetings of the Board and shall have general supervision and direction of the activities of the Board. The President shall perform such other duties as are specified in these bylaws or as may be assigned by the Board. The term of
The President shall be one year, beginning and ending at the conclusion of the Annual Board meeting. At the end of the term the President shall become the Immediate Past President.

The relevant changes to the constitution may be seen on AΩA’s web site: www.alphaomegaalpha.org/constitution.html.

Elections
The following members of the board were elected as officers for a one-year term:
1. C. Bruce Alexander, MD, President
2. John Tooker, MD, MBA, President Elect
3. Ruth-Marie Fincher, MD, MACP, Immediate Past President

Two honorary members were proposed this year. Both were elected to honorary membership for their distinguished contributions to medicine. Profiles of these honorary members will appear in a future issue of The Pharos:
1. Giovanni Romeo, MD
2. Slavomir Majewski, MD

Reports
Dr. Fincher and Dr. Byyny presented their reports for the year, summarizing the year for AΩA programs, new medical school chapters, chapter visits, fundraising, the membership directory and database, communications and public relations, and staffing.

The financial review was presented by Mr. Nichols and Dr. Stubbs. A presentation on AΩA’s investment program was given by Jennifer Ellison and Diana Lieberman of Bingham Osborn & Scarborough.

Mr. Nichols and Dr. Stubbs presented a proposal for a dues increase in 2013, which was passed by unanimous consent. Dues were last raised in 2010.

Dr. Byyny and Dr. Fincher reported on the site visit to Florida International University, which has petitioned for an AΩA charter. They recommended that a charter be granted. The motion was passed contingent on the school receiving full LCME accreditation.

A report on the Professionalism Award was presented by Dr. Pauuw and Dr. Maxine Papadakis of the University of California, San Francisco, School of Medicine.

A report on the work of the committee for the proposed Leadership Award was presented by Dr. Tooker and Dr. Byyny.

A report on The Pharos was presented by Ms. Lancaster.

Initiative project and the first year results of the newly offered Postgraduate Award. She proposed a motion that the award be opened to all residents and fellows at institutions affiliated with an AΩA chapter. The motion was passed and will be implemented in the 2013/2014 academic year.

Miscellaneous
The minutes of the 2011 board meeting were approved. A final budget was also approved.

Instructions for Pharos authors
We welcome material that addresses scholarly and nontechnical topics in medicine and public health such as history, biography, health services research, ethics, education, and social issues, as well as philosophy, literature, the arts, professionalism, leadership, and humor. Poetry is welcome, as well as photographs/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. References should not exceed 20 unique items (see below).
3. Poems or photographs/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. Electronic submissions are preferred. Send them to info@alphaomegaalpha.org. Or send by mail to Richard L. Byyny, MD, Editor of The Pharos, 525 Middlefield Road, Suite 130, Menlo Park, California 94025.
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, 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 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. PubMed or MedLine citations are also acceptable. 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:


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.alphaomegaalpha.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. The collection has been digitized and excerpts will be featured on AΩA’s web site in the future. A listing of videos available for loan as DVD or VHS tape can be found on our web site: www.alphaomegaalpha.org, or by contacting Debbie Lancaster at d.lancaster@alphaomegaalpha.org or (650) 329-0291. 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.
Bones Books & Bell Jars: Photographs of the Mütter Museum Collection
Andrea Baldeck (AΩA, University of Pennsylvania, 1979)
Reviewed by Rhonda L. Soricelli, MD

In 1787, twenty-four prominent Philadelphia physicians, including Benjamin Rush, a signer of the Declaration of Independence, formed a private medical society whose goal was to “advance the science of medicine and lessen human misery.” Today, that society is The College of Physicians of Philadelphia, the oldest professional medical organization in the country. It is home to one of America’s most important Historical Medical Libraries as well as the world-renowned Mütter Museum. Begun with donations from its founding members, the library houses more than 400 incunables (editions printed before 1501) and over 12,000 other rare books that helped lay the foundation of modern biomedicine. Among them are two copies of the 1543 edition of De humani corporis fabrica (On the fabric of the human body) by Andreas Vesalius. The Mütter Museum began from a small “cabinet of pathological specimens” collected from College Fellows in 1849 and was named for Dr. Thomas Dent Mütter in 1858 following the donation from his extensive private collection of 1,344 items—wet and dry preparations, wax models, plaster casts, and illustrations. Of course, over the years, the collections of library and museum have grown so that only a fraction of their holdings is on public display. Stacks and storage spaces throughout The College’s magnificent 1908 Beaux Arts building are a treasure trove of materia medica.

Among those treasures are more than three thousand historical medical photographs, 200 of which appeared in the handsome volume Mütter Museum: Historical Medical Photographs published by Blast Books in 2007 and edited by Laura Lindgren. An earlier book, Mütter Museum of The College of Physicians of Philadelphia (Blast Books, 2002) by then-curator Gretchen Worden presented an equally fascinating array of old photographs interspersed with striking contemporary images of The College’s collections, many in vivid color, taken by fourteen prominent photographers including Rosamond Purcell, Joel-Peter Witkin, Max Aguilera-Hellweg, and Olivia Parker.

Passionate about photography since childhood, Andrea Baldeck retired from anesthesiology practice at the University of Pennsylvania in 1991 to focus on her photographic art. Her many published collections reveal the range of her interests and work: Talismanic (Hawkhurst, 1998), Venice, a Personal View (Hawkhurst, 1999), and from the University of Pennsylvania Museum of Archaeology and Anthropology Touching the Mekong (2003), The Heart of Haiti (2006), Closely Observed (2006), Presence Passing (2007), and Himalaya: Land of Snow Lion (2009).

With Bones Books & Bell Jars, her first photographic essay related to medicine, Baldeck joins the remarkable tradition of medical photography at The College of Physicians. With the heart and training of a doctor and the eye of an artist, she creates photographs that speak as eloquently to students and practitioners of health care as they do to the general public.

In her book, Baldeck takes us on a personal journey of discovery through the stately College building that begins in the Historical Library. Here she iden-
Baldeck uses black and white photography on film (silver-gelatin print) as her medium. In her view, black-and-white creates an abstraction from reality and facilitates greater emotional connection between viewer and subject than color photography can ever do—color in itself can be a distraction. Exquisitely lit with natural light, revealing a richness of tonality in shades from velvety black to the purest white, these are three-dimensional images that draw us in. The script and illustrations in rare books are as crisp as if we were looking at the original pages. One can almost feel the texture of the paper and smell the worn leather of old book bindings and well-used Gladstone bags. We want to grasp those gleaming metallic instruments and brush away the flakes of precipitate that cling to the preserved baby face of the Short-Limbed-Dwarf.99

Bones Books & Bell Jars is a magnificent volume to be savored in several sittings, revisited time and again, and shared with others. An exhibit of many of the photographs in this collection is on view at The College of Physicians through the end of December 2012. While the quality of printing in this book is outstanding, nothing can compare with Dr. Baldeck’s original works of art!

Dr. Soricelli is an adjunct assistant professor at the Department of Family, Community, and Preventive Medicine at Drexel University College of Medicine. She is a member of the Board of Trustees at The College of Physicians of Philadelphia. Her address is:

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The Creative Destruction of Medicine: How the Digital Revolution Will Create Better Health Care

Eric J. Topol, MD (AΩA, University of Rochester, 1979)

Reviewed by Dean Gianakos, MD, FACP

Along with hundreds of other internists from across the United States, I recently attended the American College of Physicians’ Annual Leadership Day in Washington, DC. The purpose of the meeting was to update physicians on the significant health care problems facing our country and, more importantly, to mobilize physicians to advocate for reform. Although I have practiced medicine for more than twenty-five years, this was the first time I had ever lobbied a congressman for anything. I felt it was finally time to share my medical experience and two cents with those in political office.

What I learned from the experience is old news: America’s health care system needs a major overhaul. There are too many uninsured Americans. Quality of care is poor. Medical care is expensive, and inefficient. Payments to physicians are inequitable. Administrative waste is excessive. Defensive medicine is rampant and expensive. Electronic health records are expensive, underused, and not delivering on promises for improving quality and lowering costs.

In his book The Creative Destruction of Medicine, Eric Topol, MD, an eminent cardiologist and director of the Scripps Translational Science Institute in La Jolla, California, offers no explicit solutions to get us out of this mess, but his implied answer is this: more and faster adoption of new technology. Topol describes how information systems, increased computing power and data analysis, imaging technology, social networking, genomics, and wireless sensors will converge to form a new model of medicine:

Think of the cell phone . . . loaded for medicine, capable of displaying all of one’s vital signs in real time, conducting laboratory analyses, sequencing parts of one’s genome, or even acquiring ultrasound images of one’s heart, abdomen, or unborn baby. This embodies a technological convergence, a coalescence of distinct and far-ranging functional- ities, from elemental forms of communication to the complexities of medicine.\textsuperscript{pvi–viii}

Although Topol states “The intent of this book has not been to provide a techno-tour”\textsuperscript{p228} that is primarily what he has provided: an amazing tour of a highly technical, individualized, digitized model
of medicine. His knowledge of medicine, genetics, and technology is vast. I learned much about new advances in genomics, the problems with population medicine, and the power of wireless body sensors. Topol feels strongly that these changes, what he calls the creative destruction of medicine—basically a radical transformation, not true “destruction”—must be led by consumers, because most physicians are reluctant and resistant to change their practice ways.

Topol spends little time addressing the well known problems with using new tools in medicine: Should we use them? When? By whom? Who pays for them? It's hard to imagine inexpensive technology—at least when first introduced. He acknowledges other familiar problems: data overload, depersonalization, technology malfunction, data misinterpretation. Again, he offers no solutions.

To be fair, Topol is not interested in offering solutions to these problems and the ones I heard about in Washington. He is more interested in describing coming technological changes and innovations in medicine—and how the revolution must be sparked by empowered consumers.

I do not share Topol’s hyperenthusiasm for technology and innovation. Whether one talks about using simple blood tests or advanced technology such as MRI scans, wireless body sensors, and detailed genetic analyses, all of these are simply tools to help physicians better care for sick patients. Innovative technology will come and go, and certainly in many instances help patients. What will not disappear will be the need for vulnerable patients coming to trusted physicians to ask for help and compassionate care. I believe patients and physicians—more educated and informed, in part, because of technology—can figure out what's right and good for patients. Protecting and encouraging that fundamental relationship matches or exceeds the importance of discovering the next wonder machine, and gives us important reasons to keep traveling to Capitol Hill.

Dr. Gianakos is associate director of the Lynchburg Family Medicine Residency in Lynchburg, Virginia. He is a member of the editorial board of The Pharos. His address is:

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Incomplete Nature: How Mind Emerged from Matter
Terrence W. Deacon

The Righteous Mind: Why Good People Are Divided by Politics and Religion
Jonathan Haidt
New York, Pantheon Books, 2012, 419 pages

Reviewed by Kurt Fiedler, MD

Within the past several years, the pertinent faculty committees of medical schools as diverse as the University of New Mexico and Harvard University have specifically rejected reorganizing their curricula to begin with instruction in what neuroscience now understands about the process of learning. Aside from demonstrating understandable doubt that successful medical practice can be based on puzzling concepts like “emergent complexity,” they continue professional allegiance to the time-honored reductionist training in anatomy, physiology, biochemistry, etc. But merely adding some genetics and informatics to that list seems unlikely to expand basic science to sufficiently address the behavioral and social chasms that increasingly separate individually based traditional medical practice from the broader expectations of the worldwide socially networked public.

The two books reviewed here present complementary detailed scholarly reviews of pertinent historical and current data, as well as cogent discussion of the evolution of knowledge and beliefs regarding two topics that could actually help reframe medical study and practice at either elementary or advanced levels. Terrence Deacon in Incomplete Nature describes how individual intentional behavior emerges from constraints inherent in the layered complexity of neuronal interactions in the human central nervous system. Jonathan Haidt in The Righteous Mind describes how socially based choices from one set of such constraints result in foundational divisions between groups of humans, for example, between political liberals and conservatives.
Incomplete Nature stems from Deacon’s belief that the multiple cumulative failures to adequately explain such nonphysical events as mind, consciousness, and intentional behavior are due to the previous persistent efforts to define their origins in physical events, such as neuronal or neurohumoral circuitry. He takes his novel approach from the sixth-century Chinese philosopher Lao Tse:

Thirty spokes converge at the wheel’s hub, to a hole that does not allow it to turn. Clay is shaped into a vessel, to enclose an emptiness that can be filled. Doors and windows are cut into walls, to provide access to their protection. Though we can only work with what is there, use comes from what is not there. p18

Deacon argues that valid explanations of such immaterial concepts are defined by their fundamental incompleteness; that they “exist only in relation to something that they are not,” p23. In contrast to an organ like a heart, or a molecule like hemoglobin, which inherit their functions from their ongoing involvement in the survival of an organism and—biologically speaking—have no teleological representation, these mentally conceived emergent intentional processes are explicit “teleodynamic” representations of the consequences they produce.

Deacon considers two emergent transitions at length: that from nonlife to life, and from insentient mechanism to mind. Unlike most previous commentators he does not consider such “emergence” to be something added that brings about organization; rather he regards organization as something that results from restrictions or constraints that are the actual immaterial emergent properties produced by the multileveled evolution of the nervous system. “The molecular interactions, propagating neuronal signals, and incessant energy metabolism . . . are necessary substrates; but it is because of what these do not actualize, because of how their interactions are constrained, that there is agency, sentience, and valuation implicit in their patterns of interaction. We are what we are not: . . . necessarily incomplete.” p335

The admitted inspiration for The Righteous Mind, by Jonathan Haidt, comes from the nineteenth-century founder of sociology Emile Durkheim, who first pointed out the differing political solidarities that result in collectivist versus individualistic societies. But Haidt’s virtually unacknowledged mentor is Daniel Kahneman, who won the 2002 Nobel Prize in Economics for a career that documented the essentially immediate intuitive, rather than well-reasoned, basis of most people’s decisions—whether confronted with economic or any other uncertainty. Kahneman showed that people construct explanations to rationalize their choices based on those intuitive socially derived moral foundational beliefs.

Haidt and his co-workers have empirically defined six discrete moral foundations, which they characterize by listing the positive and negative aspects of each trait: care/harm, fairness/cheating, loyalty/betrayal, authority/subversion, sanctity/degradation, and liberty/oppression. Socially defined choices as to which of these constraints are predominant among various groups explain “why good people are divided by politics and religion.” It turns out that “Liberals,” who of course are individualistic, emphasize care (for victims of oppression) and liberty, promote fairness moderately, and place relatively little value on loyalty, authority, or sanctity. In contrast, “Conservatives” value all six, but emphasize the foundations that “preserve a moral community,” i.e., choosing loyalty, authority, and sanctity in preference to care, liberty, and fairness. Notably, such differences in attitudes are suggested to have a genetic basis from a human genome-wide analysis by Paul Hatemi and coworkers.1

Haidt’s data, and the number and definitions of the moral foundations themselves, are compiled from ongoing questionnaires (on-line at YourMorals.org); readers are invited to participate. Haidt wishes for a peaceful resolution of these foundational differences, but does not offer anything beyond wishful commonplaces (e.g., hoping for more egalitarian financing of elections). Apparently unless people indulge in “groupish” intoxication (by marching or dance or substances he ironically calls “Durkheimogens”), the saddest consequence of the realization that socially defined beliefs take precedence over rational knowledge is admitting that reason is unlikely to ever prevail.

Stylistically these monographs are very different. Deacon is reserved, prolix, and unashamed to offer well-defined neologisms, and is often intentionally repetitive in an effort to help readers recall the embedded sources of the most recent postulate in his multilayered argument. Haidt is ostensibly more self-revealing and colloquial, although often unashamedly contrived—more than once he pats himself on the back for having chosen a long way around to more effectively persuade the reader. Both are convincingly erudite, and arguably professionally selective in their chosen domains and references. Both present new and challenging concepts whose implications extend well beyond neuroscience. And both books, while demanding, are well worth the time and attention of clinicians and teachers of medicine.

Reference


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The same energy that jump-started my heart when I was a five-week-old fetus in a yolk sac rescued me again today as I lay anesthetized in an emergency room, heart muscle quivering in chaotic rhythm.

My old friend, atrial fibrillation, had paid me another visit, not like that Christmas time when his present was the "holiday heart" after too much wine, but a greeting he now lavishes upon many of old age.

My doctor advised electrical cardioversion—a carefully placed shock to stop the heart and restore normal rhythm again.

I pondered: Consent to be electrocuted? Could I know for sure it would start again?

I have no memory of my dreamless sleep but it may have been like the calm of that fetus drifting in the warm sea of the womb's nest—who suddenly came alive when that energy ignited his heart—as today it reignited mine.

Henry Langhorne, MD
A proud reflection of AΩA

AΩA's new scarf highlights the society's insignia, based on the shape of the manubrium sterni. The center medallion feature the Pharos lighthouse of Alexandria, one of the seven wonders of the ancient world, for which AΩA's journal is named. The borders are stylized DNA strands.

Alpha Omega Alpha neckties or freestyle bowties are fashioned from fine silk by Vineyard Vines of Martha's Vineyard, Massachusetts.

Scarves are 35 x 35 inches, of 12 m/m silk twill with handrolled hems. Four colorways are available as shown: red/black, turquoise/purple, peach/mint, and navy/lavender. Scarf design by J&J Designs of San Francisco (jnjdesigns.biz).

To order, send a check for the appropriate amount to: Alpha Omega Alpha, 525 Middlefield Road, Suite 130, Menlo Park, CA 94025. Or order online at www.alphaomegalpha.org/store. Price includes shipping and handling.