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Winter 2014

“Be Worthy to Serve the Suffering”

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THE PHAROS
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## DEPARTMENTS

### Editorial

**Teaching and learning in medicine**

Alan G. Robinson, MD  
Richard L. Byyny, MD

### 2013 Robert J. Glaser Distinguished Teacher Awards

### The physician at the movies

Peter E. Dans, MD  
*Blue Jasmine*  
*Enough Said*  
*Call Northside 777 (1948)*

### Reviews and reflections

**I Wasn’t Strong Like This When I Started Out: True Stories of Becoming a Nurse**
Reviewed by Judy Schaefer, RN, MA

**Forgive and Remember: Managing Medical Failure**
Reviewed by Jack Coulehan, MD

**Guidebook for Clerkship Directors, 4th edition**
Reviewed by Deepti Rao, MD

**What Doctors Feel: How Emotions Affect the Practice of Medicine**
Reviewed by Johanna Shapiro, PhD

### National and chapter news

### ARTICLES

#### 8

**Fall from grace**
J. Joseph Marr, MD

#### 14

**Plagiarism of ideas**
Benjamin Rush and Charles Caldwell—a student–mentor dispute  
Charles T. Ambrose, MD

#### 25

**Last days**
Richard C. Reynolds, MD

#### New program

**AΩA Fellow in Leadership Award**

### POETRY

**So Long**
Thomas J. Balkany, MD, FACS, FAAP

**Negatives**
Alexander Fortenko

**O.E.D.**
Henry N. Claman, MD
**Editorial**

**Teaching and learning in medicine**

Alan G. Robinson, MD

Dr. Robinson (ΩA, University of Pittsburgh, 1988) is the Distinguished Professor, Associate Vice Chancellor, and Senior Associate Dean at the David Geffen School of Medicine at UCLA. He is a member of the board of directors of Alpha Omega Alpha.

**Introduction**

Richard L. Byyny, MD

Executive Director, Alpha Omega Alpha

I recently had a discussion with close friend Dr. Alan Robinson about the importance of teaching and learning in medicine. We shared our ideas and worries, including the problems of not having adequate funding for teaching in medicine and the dearth of medical teachers with a full understanding of educational research in pedagogy and learning. I subsequently asked Al to write an editorial for *The Pharos* on the topic.

Like many teachers in medicine I learned to teach by observing my teachers and adopting or rejecting their teaching methods and style. I also used the “see one, do one, teach one” pedagogy described by Al and others. I spent one summer with Dr. Kelley Skeff at the Stanford Faculty Development Center for Medical Teachers to learn how to become a better bedside teacher and worked hard to become an excellent physician, teacher, and scholar. I was surprised and flattered to receive some teaching awards and excellent evaluations from medical students, residents, and patients.

However, it wasn’t until I served as the Chancellor of the University of Colorado at Boulder that I really learned about the science of teaching and learning. There, distinguished research faculty applied what has been called “scientific teaching” in their courses for undergraduate students, using the principles set forth in the National Research Council’s report, *How People Learn: Brain, Mind, Experience, and School.* The report’s major points were:

- Individual learning is built on one’s own prior knowledge from instruction and experience.
- Learners differ in styles of learning, prior instruction, previous experience, and other factors.
- Learning is facilitated by formative evaluation with feedback for understanding of concepts.
- Learning requires reflection, awareness, and self-questioning of one’s understanding and learning process.
- Learning is enhanced for those who value the knowledge learned.
- Active learning results in better understanding and retention of knowledge and information.
- Learning is a continuum from novice to expert, where knowledge and information can be effectively retrieved, understood, and applied.

The most effective medical teaching requires not only medical and scientific knowledge, but also the knowledge of education science and the ability to apply these educational principles. Most basic science courses in medical school could utilize the principles of education science to organize their courses, or could apply the principles of education science to course organization. This involves changing the perspective from what is often instructor-centered teaching to student-centered learning. Incorporating instruction around student engagement with a case or problem early in medical education and then pursuing this during the clinical education experiences enhances learning and motivation. This shifts learning from the model of teaching of facts followed by application to one of inductive teaching that begins with a case or clinical problem and students learning the relevant concepts and facts in the process of understanding and solving the problem. The
shift takes advantage of the ability of technology to facilitate just-in-time learning.

Reflection is another important learning strategy. I was always surprised when I asked a group of students or residents to tell me one thing they had learned during rounds or the session and found that most couldn’t do it. Repetition of the request taught them to reflect on lessons learned. The challenge for us in medical education is not so much in what we teach medical students, but more in how we teach them to develop as expert physicians.

Medical schools are placing increasing emphasis on professionalism, one aspect of which is the willingness and ability to work within a team—including those in medical education, where a member of the team might be an education specialist skilled in the science of education. Faculty members who devote themselves to medical education are by the nature of the work dedicated to what is termed servant leadership. Their commitment is to serving the medical students in an effort to make them better servants of the people they care for.

Among AΩA’s core values is “to improve care for all by encouraging the development of leaders in academia and the community.” At its annual meeting this year, AΩA’s Board of Directors approved an AΩA Leadership Award and Development Program. I hope that some of the applicants will seek to develop their leadership skills in the science and programs described in Dr. Robinson’s editorial.

Teaching and learning in medicine

Alan G. Robinson, MD

It was my first meeting with the Senior Associate Dean for Medical Education in my new position as Executive Associate Dean at the UCLA School of Medicine. Sitting across my desk was a petite woman who is a big player on the national stage of medical education, LuAnn Wilkerson. I immediately exposed my unconscious ignorance about medical education by indicating that I thought the major
educational problem facing academic medical centers was to educate the public about the benefits of our wonderful research and clinical care... and, "oh yes, training future physicians." Over the next few weeks I rapidly became consciously ignorant of my understanding of medical education.

My direct reports were the deans responsible for research and for education, while finance, department chairs, and the clinical system reported directly to the dean. My unconscious to conscious ignorance of medical education was further brought to my attention in a discussion with the Senior Associate Dean for Faculty Affairs. He noted that I had an outstanding record in medical research, continuous NIH funding, and administrative experience by running a large division and serving as Vice Chair of Medicine at the University of Pittsburgh. However, he observed that I hadn't done much specifically related to medical education and wondered aloud how I would handle the oversight of that area. In the few minutes that I absorbed his comments I made a life-changing decision when I responded, "I'll do what I've always done; I'll start a journal club."

I went back to LuAnn Wilkerson to ask her help in setting up a medical education journal club. She embraced the idea as a wonderful venue in which people interested in medical education could exchange information about recent publications and discuss research opportunities in our school. What I wanted was for the journal club to educate me.

I came from the "see one, do one, teach one" generation that believed that any competent and good physician was a good teacher. Academic medicine has built a marvelous system of training physicians to become experts in a broad range of specialty disciplines. Rigorous standards define the experience necessary to be considered an expert. But for the most part less or little attention has been given to the method of the pedagogy.

Especially in the last decade medicine has begun to accept the concept that there is a "science" of education, just as there is a science that underlies each of our specialty disciplines. In 2001, experts from the Institute of Medicine joined members of the National Academy of Sciences and the National Academy of Engineering to publish a book by the National Research Council titled How People Learn.1 Physicians readily embrace the science of education when it is considered within the neurosciences and how the brain functions. Now, however, there is also a growing broader acceptance of the science behind the psychological approach to learning. The book How Learning Works2 is directed to college teachers, but is equally useful to medical school educators and stresses the science behind the authors’ Seven Research-based Principles for Smart Teaching.

There are two areas in which the science of education could make an enduring contribution to medical education:

1. Making every graduating physician a better teacher
2. Growing a cadre of medical faculty whose expertise, research, and faculty commitment is based on applying the science of education to medical education.

When we think about community practitioners as teachers, we usually think of the important contribution they make as volunteer faculty teaching our medical students. However, an
even more important role of teaching is the interaction with patients. Virtually every patient contact with a physician requires communication between the physician and the patient that "teaches" the importance and timing of an appropriate medical therapy. The science of education, the science of how people learn, can inform the teaching of patients as well as the teaching of students. Many of the principles of smart teaching are immediately recognized as principles of good medical care:

- What is the patient’s prior understanding of their disorder (correct or incorrect)?
- How might their ethnic and intellectual status affect their adherence to therapy?
- Etcetera.

These are all things that we know as physicians and hopefully gain as practice skills as we learn to take care of patients. But the science of patient care and education is not generally considered equally important to, for example, the science of clinical pharmacology. We all accept that there is not one dosage of one drug that fits every patient, so we think of pharmacology science in administering a drug, but do we think of education science in our conversations with patients?

A new technique used in teaching patients is the "teach back" at the end of the clinic visit. After the physician explains the recommendations to the patient, the patient is asked to tell the physician what the patient was asked to do. I was impressed with the value of teach back in a recent experience taking my ten-year-old grandson fly fishing with a guide in Utah. The young adult guide asked my grandson if he would like to learn how to tie the hook on the end of the line. When my grandson eagerly answered in the affirmative, the guide said, "Here's what I'm going to do. I'll describe every move of my fingers while you watch me tie the hook onto the line; then I will do it again with you telling me every move my fingers should make while I tie the hook onto the line; finally you will repeat the directions to yourself as you tie the hook on the line." I thought, "Wow, this guy is a good teacher! No wonder he's the person that was suggested by the marina when we requested a guide who was good with children!" I don't have any data that my grandson knows how to tie the hook on the end of a fishing line better than if he had been asked to try it after showing him once. I don't have a controlled trial. I do know by his response that he understood the directions and I believe he learned it better because of the teach back. Interestingly, the guide learned this technique when he was in training for his Mormon mission. It is encouraging that in a scientifically controlled study reported from UCSF titled, "Closing the Loop; teach back improved insulin therapy in diabetics."

One day I was talking with a medical student about his plans for a career. The conversation was rather laborious until I asked him about his experience as a volunteer mentor helping students in lower classes who were having difficulty. He brightened immediately and told me how he first evaluated the student's type of learning: visual, aural, or written; then he evaluated how the student organized his or her course material for study. I was so impressed with this scientific approach to teaching that I asked if he had had a course in education in medical school (not UCLA). He responded, "Oh, no. I learned that in training to become a skiing instructor."

So some of these approaches to education may find as ready application in the business and religious communities as in schools of medicine.

A new technique for classroom teaching that is receiving attention is the flipped classroom, in which students listen to the lecture material and/or read the material before the scheduled classroom time. Time in the classroom is then spent with question/answer or a more interactive workshop approach. This was reported in an article in Science to increase retention in an introductory physics course. I tried this for a lecture I give in the endocrinology block for second-year students. The week before the lecture I gave the students information that I was going to use this approach and provided a video lecture and written material before the scheduled classroom time. The students seemed engaged during the class, but the evaluations were not good, with most students preferring a straight lecture. I now think such a novel approach can't be introduced as a single event. I ignored one of the Seven Research-based Principles for Smart Teaching. I did something that was not consistent with the overall intellectual climate of the endocrinology block.

These examples indicate that science is being used to evaluate outcomes of some new pedagogic techniques. We propose that scientifically evaluating teaching of medicine should continue and increase. In the September 2, 2013, issue of the New York Times, science writer Gina Kolata described work being done in the Institute of Education Sciences to support randomized controlled trials in education similar to randomized clinical trials for new drugs. A new cadre of scientifically trained medical education specialists might regularly perform randomized trials to determine what works in medical education.

It is readily understood and accepted in academic medicine that to gain expertise in a specialty requires an immersion educational experience devoted entirely to the science of the specialty. Yet, those few medical faculty members who
choose to become experts in the science of education often have to fit this additional training into their multiple commitments for clinical care and research. Fortunately, there is some evidence that this is changing. In the September 2013 issue of *Academic Medicine* the AM Last Page describes the increase in master's degree programs in health professions education, noting that fifteen years ago there were fewer than ten programs and today there are 121. In a 2006 article in *Academic Medicine*, Larry Gruppen and coworkers reviewed nine fellowship programs in medical education and described some of the common elements among the programs. They noted that the Accreditation Council for Graduate Medical Education (ACGME) was then changing the requirement that something be taught, to requiring that a specific competency actually be accomplished. They further noted that the skill set required to develop tools to reliably measure competencies is one firmly based on the science of education. The master’s degree programs in health professions education are described in the AM Last Page as being “very prescriptive with many required courses and very few electives,” while the fellowship programs described by Gruppen and coauthors usually involve a scholarly research component leading to publications or presentations.

How do we better train clinicians as teachers and develop medical faculty devoted to the science of education? If we produced more education specialists and populated medical schools with a cadre of these specialists, that would increase the quality of teaching and learning in our medical schools. This increase in quality of education would help make all medical school graduates and ACGME trainees better teachers of patients as well as students. Training medical disciplinary specialists to also become education specialists requires a significant commitment of time: the school must first have a division or center with faculty who are specialists in the science of education, then the medical trainees must commit the time for specialty training in education. Academic medical centers will have to support the education expert faculty in the division or center and additionally support the physicians who want to obtain degrees or fellowship training in the science of medical education. Here at UCLA during my sixteen years as Executive Associate Dean in the School of Medicine we hired six PhD professors with expertise in the science of education (a couple of whom have gone on to other schools). Dr. Wilkerson has trained more than 140 faculty members who were supported by their departments to take her fellowship in medical education (many of whom have taken leadership positions in medical student and/or resident education). Five members of the Center for Educational Development and Research or the division of Student Affairs have obtained a doctorate in education. UCLA now has a cadre of faculty who are consciously competent in the science of medical education. They have, as described in *How People*
Learn, “pedagogical content knowledge.” This was not cheap. It required intellectual and financial commitment from the departments and from the Dean’s office, but considered as a return on investment the expense is often less than supporting new research or recruiting new faculty, while the payback to the medical school in the education of its students is real and lasting, equivalent to or exceeding other investments.

P.S. The journal club at UCLA is ongoing and strong and has outgrown Dr. Robinson’s apartment as a meeting space. Anyone interested in Dr. Robinson’s ten rules for a successful journal club can request them by e-mailing Dr. Robinson.

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Was there a certain time when it happened? If so, probably the inflection point occurred in the nineties when business took over formally. That was a watershed series of events, surely, but the full process seems to have been more like death from a thousand cuts, some self-inflicted. Whenever it occurred, the transformation of the physician during the second half of the twentieth century from shaman to skilled labor was inexorable and, in my opinion, will prove to be irreversible.

All of us who were active in medicine and medical science during these years...
played a role in its transformation. We were troubled—and then horrified—observers, yet often more than a little complicit. Hubris had much to do with it, and all of us were culpable to varying degrees. Is medicine today better, worse, or just different? Does it matter? Perhaps not so much to people born in the late twentieth century, but it matters much to those of us who practiced medicine and loved it during the last half of the last century.

To answer this question with any hope of perspective, it may be valuable to consider the issue as having two components: the evolution of medicine itself and the effects of that evolution on the physician practitioner. The changes in the institutions through which medicine is practiced, important as they are to our current situation, will be treated as a concomitant and parallel sideline. Permit me to be an observer and guide here and use some of my own history to illustrate. I do not think of myself as Virgil, but rather as a fellow traveler. The comments and illustrative experiences I use are, within broad limits, common to us all.

A brief case history

Those of us born in the late 1930s or very early 1940s entered medical school in the later 1950s or early 1960s. It was a time that I have heard described as “a Golden Age of Medicine.” A golden age, of course, is relative to the observer. We were at the top of a revered profession dedicated to the care of others and almost solely responsible for the management and delivery of that care; on the other hand, that care was very unevenly distributed and closely related to ability to pay. The physician was priest and see; his opinions were respected, given great credence, and sought in areas outside of medicine. He was a scholar in the broad, liberal-arts sense of the term. He was the alchemist who understood science, and he knew the workings of the human body and psyche as well. He was a shaman at the end of the age of shamans. It was like that.

Two things happened in 1961, when I was a sophomore in medical school, that were to some degree prophetic. I recognized both of them as being significant, but did not see that they were harbingers of the future. An article in the Journal of the American Medical Association chronicled a study of the interpretation of chest x-rays read both by radiologists and by a computer. The two methods were about equally accurate. The conclusion was that computers were no better than radiologists. My conclusion was that the radiologists were doing the best they could and the computer was learning and would do better as time went on. The other event was a conversation with some physicians about the management of hospitals. I wondered if physicians should not be managing hospitals themselves since they knew more about patient care. The response was that physicians could hire people to do this; the medical staff actually ran the hospitals anyway. Yes, I thought, but actually we work for the administrative organization. For years afterwards, physicians who recognized this disconnect and went into administrative medicine were considered, quite unfairly, as simply unfit for practice and their real importance not credited. Where did that lead? Look around.

Hubris

There was considerable hubris among physicians in this time. We had social status, financial rewards, and the gratification of playing an important role in our society. Did this play a role in the changes in medicine? I believe so. A “cottage industry,” as medicine of the time rightly has been called, had no incentive to look at the larger social picture, nor the mechanism to introduce change had it wished to do so. The revolution of biotechnology and biomedical engineering as applied to the physician practitioner could be compared to the industrial revolution and the cottage industries that it eliminated. No one saw it coming: a computer reading a chest film caused no alarm. Physicians devoted their time to patient care and paid little attention to the institutions in which the care was delivered unless there were obvious issues of neglect or mismanage-ment. They also paid little attention to patients themselves beyond the office or hospital visits. The problem of health care delivery to the medically indigent was left to municipal hospitals, charitable clinics, and the free care provided by many medical practitioners. The fact that these municipal hospitals served sometimes as superb training facilities abetted the situation. Management and planning of indigent care largely was left to those who tried to respond to medical-social issues from a background of social work, law, or politics. These are general statements—there were physicians and physician groups that recognized the problem of delivery of care—but the emphasis remained on fee-for-service with some charity care done.

The “threat” of Medicare and Medicaid in the 1960s caused much of organized medicine to react strongly against governmental intrusion into medical practice. In particular, the American Medical Association (presumably to be the spokesperson for physicians generally) lobbied against any changes in the fee-for-service practitioner model of medical care. The specter of socialized medicine was raised whenever any governmental changes were proposed, but no alternative solution to the problem of the uninsured and underserved was put forward. When Lyndon Johnson brought Medicare and Medicaid into law in 1965, two things happened among physicians: first, outrage—there was much talk of “socialized medicine” and the downfall of the private practice model. Practice nevertheless went on as usual, although with the realization that a major event had occurred, the consequences of which were yet to develop. Second, the slow realization that the medical care physicians had been providing gratis now would be reimbursed by the government. Predictably, opposition softened. We gradually came
to tolerate, and then love, the beast. The words from Alexander Pope's Essay on Man, intended for other situations, were never truer:

Vice is a monster of so frightful mien,  
As, to be hated, needs but to be seen;  
Yet seen too oft, familiar with her face,  
We first endure, then pity, then embrace.1

Expansion of the medical care system

Those of us new to medicine in 1965 paid scant attention to these changes in the payment system, as there were internships and residencies to deal with. The familiar operational chain remained solidly in place: physician, nurse, and patient. Physician extenders had yet to make a significant appearance. There were technical personnel in hospitals and clinics to be sure, but they provided ancillary services in laboratories and radiology and not direct patient care. Surgical technicians were new, and, by and large, registered nurses filled these positions.

Then there was Viet Nam. For those of us who became part of the military, a world opened with a life-changing array of new experiences and considerations. Among these were physician extenders of many sorts (I use this term a bit loosely to make the point of the various forces that would come to bear on the delivery of medical care after that war): medical corpsmen who, though narrowly trained, were many times quite good at what they did and often took serious risks to do their jobs; technicians who performed a variety of tasks that simplified the work of physicians (some of these positions existed in civilian medicine, but not to the degree that they were employed in the military); helicopter medevac pilots greatly improved survival of the wounded and would apply their skills to air ambulances back home.

One thing about these workers was overlooked: not only did they do procedures generally reserved for physicians in the civilian world (start IV fluid or blood infusions; some surgery to prevent or mitigate larger surgery later), they also made the decisions to do so. Slowly it became clear that nonphysicians who had some training could make these decisions. This had started with the corpsmen in World War II, and expanded rapidly in the Korean War, but it came into full flower in Viet Nam. And unlike the situations after the former wars, these people came back home to a social milieu needing ways to lower costs while providing more care to the underserved or ignored. They began to fit into medicine and alter its practice. The expansion of the medical care delivery system and the dilution of the physician's role had begun in earnest. A very few years later, the paramedic appeared, as early studies of firefighters in several metropolitan areas showed that such a rapid response system could save lives. The delegation of immediate care outside of hospitals and physicians' offices had begun.

My time in the military gave me a grudging and then wholehearted appreciation of the skills and enthusiasm of corpsmen. Diagnosticians they were not, but they were doers and rather good at it. This was not new, but it was to me and started a line of thought about medical care extension and a re-examination of my reference frame that would become useful several years later.

Later, as a medical resident, I wrote a prescription for a new antihypertensive medication for a lady in the clinic at a city hospital. Because of military service and graduate school interludes, it had been a few years since I had been an intern, and new medications had appeared that I wanted to try. She thanked me and went away. About an hour later, she reappeared and dropped the prescription on my desk with the comment “I can't afford this.” This, of course, destroyed my plan of treatment and waved a large flag in my face. We reworked the plan using some older and quite generic medications that cost very little. I managed her for a long time using those generics; drugs had changed but physiology had not. I began my slow, yet steady, appreciation of changing medical economics and the disparity of medical care in our society.

Later, in the early 1980s, I was Chief of Medicine at the same metropolitan hospital and needed to conserve the time and energies of my medical residents. They could not manage seriously ill inpatients and a large outpatient clinic population without loss of quality of care and exhausting themselves in the process.

The solution was to staff the diabetic and hypertension clinics with nurse practitioners and a single supervising medical resident. This freed about five house staff from each clinic to manage in-patients. The nurse practitioners were knowledgeable, anxious to prove themselves, and very popular with the patients, since they spent more time with them than the house staff was able to do. It was surprisingly popular for all concerned, and bitterly opposed by the medical staff.

There was an additional, time-consuming issue: a medical resident was expected to read all the EKGs for the hospital. This was not a teaching exercise, it was a billing exercise for the hospital. The solution came in the form of a new EKG machine that read the results itself. It eliminated all normal readings; the abnormal tracings still were available for teaching purposes. This was the information technology equivalent of the computer-read chest films of fifteen years earlier. The time saved for the house staff was considerable. This time, the obvious was clear to me.

These small but important changes, instituted to provide good medical care in an overused and understaffed environment, were harbingers of changes in medical care to come.

Changes in diagnostic methods

At about the same time, the auto analyzer appeared in clinical laboratories and began to turn out reports with twelve and then twenty-five biochemical tests on small amounts of blood. It was
a wonderful advance and was the leading edge of the entry of technology into medical care. Many advances followed and were woven into the standard of care. The unanticipated concomitant was significant overuse and overreliance on these in lieu of clinical judgment. They also were used increasingly as defensive medicine and raised the cost of care not insignificantly. The device armamentarium, now much broader, more accurate, and more rapid, has improved medical diagnosis by making it more accurate and efficient. At the same time, it has raised the cost of care, probably has decreased clinical acumen, and has made medical care a bit more like that in Star Trek—impersonal, yet efficient and effective—and less like that provided by the beloved family doctor. Patients received more time, sympathy, and personal care from the latter but who would go there again? These improvements carried a price and that price was in cost, the strength of the physician-patient relationship, and the effect on our national economy. The physician’s arcane diagnostic knowledge gave way to technology based on science. We slowly became recipients of technical information and were on the road to becoming skilled labor.

The entry of business into medical practice

As the cost of care became an
increasingly visible issue, there was agitation to “do something about it.” The practice model was essentially the same as it had been for hundreds of years, even though group practices had begun to deliver care with more efficiency. Within medicine, there was unrest because the ability to pass a device of some type into the body garnered significantly more income. This led not only to specialization but also to increasing numbers of physicians migrating to more lucrative specialties and the proliferation of sub-specialties. This became a particular issue within academic medicine, where some divisions tended to operate at a loss while others had comfortable profits and often did not care to share them. The pressures to increase clinical revenue burgeoned for those specialties that did not have a financial gimmick (forgive the word, but is appropriate in this context).

Into this, in the early- to mid-1980s, came two major events that would change medicine forever: first, payment according to Diagnostic Related Groups (DRGs), the lynchpin of various payment changes to come from both the government and the insurance industry. The major tool for the savings that would come from this was to be the more efficient management of physicians and their methods of practice.² The second change was the business management people who appeared with the promise of instituting efficient “business practices” that would lower the cost of care. The increasingly incestuous relationship between the insurance industry and business conglomerates that managed ever larger and increasingly voracious “health care delivery” systems was the vehicle that ejected medicine from its delusional world where the doctor-patient relationship still was paramount and hurled it into the arena where quarterly earnings increases were the only thing that seemed to matter. These altered forever the nature of medical care and made it health care delivery. The physician now was definitely a mere employee of a system.

A little more case history
It was 1986 when DRGs appeared at our hospital and the sky began to darken. Raising fees for extra work was no longer permitted. In response, it was decided that if a patient was in an academic medical center, then, by definition, he or she had a complex problem and we were to bill accordingly. Hospital rounds were no longer just about patient care but also about spending time to be sure the chart reflected the hefty thinking that justified the top level of billing for the visit. I did this for a while and then realized that the flow of teaching rounds had been completely subverted by the documentation process. The chart had been well documented before, but now the quantity of words became as important as their quality. Consequently, I made two sets of rounds. The first was teaching and therapeutic rounds with students and house officers and fellows; then, a second set alone to do the additional notes and form checking that justified the billing. This, of course took more time—it probably cost me an additional hour or more each day when on service—but it led to better teaching. As a physician in academic medicine, the pressures of time were not those of physicians in private practice, but they still led to longer days and a definite feeling of being disingenuous regarding the billing situation. I felt I could not justify billing at the highest level all the time and backed down the charges as patients recovered—I heard about it more than once from those concerned with revenue flow.

There came an afternoon in the clinic when I was talking with an older clinician. He looked upset and finally looked at me and said: “Dammit, Joe, I am not a Health Care Provider, I am a Doctor.” We talked about that and the directions of things for a while and then we both returned to providing health care.

Barbarians at the gates and everywhere else
It was during the 1990s that medicine fell increasingly under the sway of what are termed good business practices. Although a “cottage industry” could not change the system, a business organization with its hierarchical structure certainly could, and did. This led to our current situation, in which physicians who once tried to remain independent are rushing into the waiting arms of various health care provider organizations.

Each stage of the weakening of the physician-patient relationship came about gradually, as physicians were required to increase patient visits per unit time, accept lower reimbursement for these visits, vie with insurance claims adjustors for compensation or the right to carry out diagnostic testing, immerse themselves in relative value arcana to maximize the earned reimbursement, and, in general, devote more and more time and psychic energy to defending the citadel of traditional medical practice against an onslaught of accountants, middle managers, directors, and executives. Individual practitioners or small group practices now are less and less able to withstand the pressure to sell their practices to local or regional health care for-profit organizations. The entrepreneur increasingly becomes the employee. We have come to this: the selling of our patrimony to philistines because there is no other choice. The world does end with a whimper.

The remains of the day
If one looks at the cost in the United States to deliver health care relative to the rest of the world’s countries, we are in trouble. We know that. If one compares this cost with life expectancy, the picture is even worse. We know that as well. The United States spends about $4500 per capita for a life expectancy of about seventy-seven years; Cuba, to pick only one of many countries, spends about eleven percent of that for the same life expectancy.³ Our delivery structure is inordinately large, cumbersome, laden with a variety of profit centers, and burdened with regulations for both provider and patient alike.

The shift, in our lifetimes, from
individual and small group practice to institutional medicine was not necessarily bad. There are many instances of improved efficiency and better patient care. Kaiser Permanente, one of many not-for-profit health care delivery groups, has done well in caring for patients at a reasonable cost. Size is not necessarily a negative factor. Coupling medical care to the profit motives of health care companies and insurance organizations, however, has altered the focus of medical practice from patient care to patient care at the lowest possible cost to the caregiver organizations and payers. The intrusion of these companies into the practice of medicine to bring costs to an optimum level certainly is appropriate; demanding some discipline from physicians to be as efficient as possible and to conserve resources also is a reasonable request. Interfering with good medical care simply to cut costs is not.

I remain convinced that until the profit motive is purged from medicine—read quarterly earnings increases and insurance profits—all talk and action to improve our health care system will be of little or no benefit. One need only look at health care systems around the world, each with its own inefficiencies and abuses, and note that the general opinion of consumers is that their country’s system is good and benefits all. All of these health care systems are essentially not-for-profit models operated by governments with physicians as employees.4

But look at the system from another perspective. Set aside for the moment the ineptness of the creation of the Affordable Care Act (ACA), its fault-ridden introduction, and the new burden on our economy. These are not small issues, but they are temporary and, with some difficulty, will be overcome in the short term. The Supreme Court decision to uphold the ACA, the failure of the government shutdown in October 2013 to alter or rescind the ACA, and the general acceptance of the ACA by much of the public, all ensure that it is here to stay in one form or another. It will provide more health care, the care will be more affordable to people individually, there will be more preventive medicine, and, probably more emphasis on behavioral change to bring about healthier living. While it will not be the type of care that many of us recall, ultimately it will be a system that provides care to people who now cannot afford it.

Spend some time talking with younger people who know little or nothing about medicine of thirty or forty years ago. They are quite willing to accept governmental intrusion if it allows them to save for their children’s education. They understand that visits for care are brief and the physician is harried, but it is the system they know. The other thing they know is that they can afford it. The public is indifferent to how the physician feels; it just wants a system that provides affordable care.

Coda

Let us set aside the monster of the delivery and payment systems and look at the resultant of these fifty years with respect to medicine itself and physicians. Having reviewed some specific examples expanded into the general, we can see the changes that have occurred. The result is a complex body of knowledge that has given patients access to an ever-better level of scientific medicine: earlier diagnosis and treatment, fewer and less invasive procedures, telemedicine, the tailoring of therapy to genome structure, use of genomics to manage probabilities of diseases, better prenatal diagnosis and therapy, new applications of robotic surgery. Regenerative medicine will provide new tissues and, ultimately, new organs. Medicine is unquestionably better; another has taken its place. But he did not cure as many people as we did. Those who have come after us are just as intelligent and competent but have more knowledge and tools and are curing more people than we did. Good medicine persists. It is our model that is gone; another has taken its place.

The physician remains; he or she practices differently. We still play an important and essential role but it will be increasingly supervisory. Can you imagine a physician supervising a cadre of physician assistants or nurse practitioners in lieu of individual family physicians? How about a surgeon managing several operations performed by skilled technicians or robots? I can imagine all of these. In our own minds, we have been marginalized; in the minds of patients, we still are here. We remain very much in the game. Our problem is with the intangibles; we lost the spotlight.

References


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I spring from the pages into your arms—
decease calls me forth.
—Walt Whitman, "So Long!"

since you have come to me in the night
heated and empty, or in the afternoon
with need in your mouth for passion or
comfort,
a lifetime since you have wanted
the small flakes of my life that I could
spare
few enough though willingly.

You sense that I have withered or died
or ceased to be whatever it was
you wished me to be,
eroded, irradiated
cut sharply away with cold steel,
reduced anyway until
pulling myself up with great effort
from my dream of you in the late night
or in the afternoon, of wearing on you

a fashion no longer fit
removed for the last time
gently but finally obscene.

Do I alone remember our song
when you squeezed my thumb tightly
as we climbed hopeful
into the high stands of the glaring
afternoon
or met sweetly and often Sundays
on your breaking bed?

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Illustration by Laura Aitken
Richard C. Reynolds, MD

The author (ΑΩΑ, Johns Hopkins, 1953) is retired. He was founding chair of the Department of Community Health and Family Medicine at the University of Florida College of Medicine, dean of Robert Wood Johnson Medical School from 1978 through 1987, and the executive vice president of the Robert Wood Johnson Foundation. Dr. Reynolds also served on the editorial board of The Pharos for many years. Photographs are courtesy of the author.

I am an eighty-three-year-old physician living in a retirement community. I had been married to the patient described below for fifty-eight years. During the final two years I served as her full-time caregiver. I wrote what follows during and shortly after her last five-day hospitalization. She died on November 5, 2011. My wife's name was Mary Jane, but everyone knew her as MJ.

MJ and I first met in Baltimore when I was a fourth-year medical student and she was a second-year student nurse. I was doing an elective in obstetrics and MJ was earning extra money working overtime. I was preparing to deliver a baby when I noticed that the nurse assigned to assist me had a lock of the reddest hair I have ever seen peeking from beneath her hood.

Our first date was to a nightclub, our only visit to such an establishment.

We tried dating others after that first date, but it was soon
plain that we had become inseparable. Even though I had planned to leave Baltimore for residency training, I applied at the last minute to Johns Hopkins and was accepted as a medical intern at Johns Hopkins Hospital. We married after MJ’s graduation one year later, and stayed in Baltimore while she worked, supporting us during my payless residency.

What was MJ like? Many things come to mind—loyalty, love, humor, exciting, challenging—but, above all, MJ always remained her own person while giving me unlimited love and friendship. She could be feisty: In the 1970s while we were in Florida, there was a spate of divorces among medical school faculty. Arrangements were made to provide counsel to the faculty wives. At the meeting, the counselor asked MJ, “What is it like to be married to someone smarter than you?” MJ’s response: “And what makes you think my husband is smarter than I am?”

During her last few years I could see her failing; her death was not a surprise. It provided the family relief that we could not deny to a long tenure of pain and discomfort. But her death, its finality, has left me with a void that I doubt will ever ease completely. I am thankful for every day we were together, a message I conveyed to her many times.

November 2011

I sit on a sofa, eight feet from my seventy-nine-year-old wife in the Medical Intensive Care Unit (MICU). MJ was admitted to the MICU four days earlier in acute pulmonary insufficiency, following abrupt onset of aspiration pneumonia. She has the accoutrements of many patients in the MICU—an oxygen mask covers her face, there are IVs in both arms, a urinary catheter is in place, as well as a loosely fastened abdominal restraint applied during an earlier period of restlessness. She is attached to a monitor that graphically portrays her vital signs and beeps annoyingly when it records abnormal values.

I walk to the bedside and brush the hair from her brow. It is still naturally red and still beautiful, the hair that first attracted me to her some sixty years ago. With my mouth close to her ear, I try talking to her. There will be no response, but I try anyway. Events from the past life cascade through my memory. I walk about the room. I peer out the door, looking at nothing. A nurse walks by and asks if I need anything. Am I all right? How do you describe that you feel like someone has a hand in your gut, and is trying to pull something from you?

Twenty-five years ago, MJ began to have severe joint pains. Because we were living in New Jersey, Lyme disease was first considered as the cause. A consulting rheumatologist subsequently diagnosed rheumatoid arthritis. A quarter of a century later, the disease remains active, causing my wife to experience the full gamut of its manifestations and treatment complications. Progressive joint arthropathy required multiple surgeries on her hands and feet. There have been bouts of sepsis and pneumonias, exacerbated by the aggressive therapies to relieve discomfort and deter progression of her disease. Chronic anemia persists. Osteoporosis, osteoarthritis, and several decades of steroid therapy have contributed to spontaneous fractures in her pelvis and spine. She has lost six inches of stature. In spite of all this, MJ remained physically active until three years ago when her back pain became persistent and severely painful. Pain management specialists recommended low back surgery and para spinal injections. None of these treatments worked. She began using long-acting narcotics supplemented by additional opiates for breakthrough pain, but the therapy was only modestly successful. During episodes of severe pain, I would rub her back to soothe and comfort. To our surprise, this did help ease the pain. Before this hospitalization, pain was becoming refractory to increased doses of narcotics, and sometimes I would do back rubs twelve times a day to offer MJ some relief.

The day before the hospital admission, we were up as usual at 5 AM. I had made coffee and prepared breakfast. The morning newspaper was already at our doorstep and, as was our custom, we read it, kibitzing about items of interest. MJ went back to bed. Later on, after lunch, we drove to a big box store. I would usually push MJ in a wheelchair, though at times she was able to get behind the wheelchair and walk short distances. Her walking capability had declined the past six months. Even a few steps would often precipitate back pain. We replaced our afternoon walks with drives through the rural countryside. These were pleasant interludes. MJ was beginning to spend more of her daytime hours in bed. When awake, she was annoyed by her increasing memory problems. She could not remember what she had eaten at a previous meal, or recall a recent conversation. This evening, MJ was more tired than usual, ate little supper, and retired early. This change worried me as it mimicked episodes that were prelumesis to earlier hospitalizations. Her most recent stay had been two months ago.

I awoke about 4:00 AM, and reached over to touch her—she felt warm. I roused her with difficulty; though awake, she was obviously confused. She had trouble holding a thermometer in her mouth, but it registered 101 degrees. Transferring her from the toilet to the wheelchair took twenty minutes with encouragement and assistance. I knew she needed hospitalization. I called our daughter Karen, who lives in the same rural community that we do. Karen works as a nurse in the hospital where her mother had been admitted several times. I told her I had to take her mom to the hospital. Karen was already preparing to go to work and said she would meet us there. The trip from home to hospital required an ambulance. Our small community has excellent service, and within minutes after calling 911 an ambulance arrived.

I drove to the hospital, arriving a few minutes before the
ambulance. MJ was taken immediately into the ER. I could not join her until the ER personnel had placed her in a room and begun their assessment. My protestations to the staff that controlled visitors to the ER that my wife was obtunded and would not be able to answer questions were deflected. I was told that the professional staff was most capable, and I would be permitted to be with my wife as soon as they thought it was reasonable. The wait was not long, but it was frustrating. I knew the strange setting with unfamiliar people questioning and examining MJ would add to her confusion. When I was finally allowed to see her, she was in bed. An IV had been started and people were in and out of her room drawing blood, doing an EKG, and taking her for x-rays. They also asked questions and examined her, trying to assess her condition. Once the data were gathered, she was promptly seen by the ER physician, the hospital admitting physician, and pulmonary and infectious disease consults. I was able to help them review her complex and lengthy medical history and recount her present illness. During the early hours in the ER, MJ was awake, cooperative, and able to answer some simple questions. Overall, her mental acuity was sluggish and dull. The assessment was thorough and done quickly and efficiently.

The plan was to admit her to the pulmonary unit but no bed was available. Her condition worsened. She had become more obtunded and, at times, difficult to arouse. She required oxygen by face mask to maintain proper saturation. She remained in the ER until early evening when a bed became available in the MICU.

During her long stay in the ER, the staff was attentive, supportive, and comforting. Nurses were appropriately aggressive in contacting doctors responsible for her care, especially to obtain orders for analgesics to ease her back pain.

The first day, I stayed with MJ, taking only a brief lunch break. I was able to answer questions for the administrative and professional staff as they readied her for admission. But time hangs heavy waiting in the ER for a room to become available.

During a conversation with one of the physicians treating my wife, I had the urge to urinate. There are no bathrooms in the patients’ rooms in the ER. Scattered along the corridors are unisex bathrooms to accommodate visitors one at a time. I spotted two bathrooms, both occupied and each with a person waiting outside the closed door. I kept looking. Being older, and with all the symptoms of prostatism, my sense of urgency was not to be denied. I finally found an unoccupied bathroom, but it was too late. My khaki pants had a noticeable wet stain down the inner side of my left trouser leg. All I could do to minimize my embarrassment was to walk with my head held high and hope that passersby would not notice. As I passed a nurses station, a nurse leaning against its surrounding counter fell in stride with me. She asked me what size pants I wore. Surprised, I muttered, “36.” She left at once.

When I entered my wife’s room, there were two pairs of clean, used trousers lying on a chair. Both were size 36. The reason for the earlier question was now clear—the nurse had provided two pairs of trousers of different lengths, hoping one would be satisfactory. I have spent a lifetime in hospitals as a clinician, teacher, administrator, and a visitor. Never before had I experienced such unique thoughtfulness. I did not discover the nurse’s name to say thank you.

On the second day, the hospitalist who served as MJ’s primary physician during this admission wanted to discuss what treatment strategy the family wished the professional staff to take. He said that the hospital record indicated we favored aggressive therapy including a full code for resuscitation.

I was surprised to hear this. MJ and I had prepared living wills with explicit directions that neither of us favored heroic measures that might prolong life but had little chance of improving the quality of life.

Later in the day, the pain management physician and the pulmonologist (both of whom had treated MJ during her previous hospitalization) and I met at her bedside. She was unresponsive but restless, and had obviously deteriorated since admission. Unspoken was the realization by all three of us that recovery was unlikely. A treatment plan emerged that we all supported; antibiotics for her pneumonia would be continued, she would receive IV fluids to maintain hydration and kidney output, she would be sedated enough to control agitation, she would be given analgesia if deemed necessary for back pain. The consensus was that this regimen would give her a chance to recover, though this was unlikely. The plan would be reassessed regularly. I thought this approach would meet MJ’s approval, a conclusion based on many conversations during the past several years. It also had the support of our three children.

Over the next forty-eight hours, MJ’s restlessness eased, she became afebrile, and the need for sedation and analgesia lessened. But she still remained insensate. I spent most of each day in her room. I paced and stood at her bedside. I brushed her hair from her forehead. This last gesture that I would be permitted to be with my wife as soon as they thought it was reasonable. The wait was not long, but it was frustrating. I knew the strange setting with unfamiliar people questioning and examining MJ would add to her confusion. When I was finally allowed to see her, she was in bed. An IV had been started and people were in and out of her room drawing blood, doing an EKG, and taking her for x-rays. They also asked questions and examined her, trying to assess her condition. Once the data were gathered, she was promptly seen by the ER physician, the hospital admitting physician, and pulmonary and infectious disease consults. I was able to help them review her complex and lengthy medical history and recount her present illness. During the early hours in the ER, MJ was awake, cooperative, and able to answer some simple questions. Overall, her mental acuity was sluggish and dull. The assessment was thorough and done quickly and efficiently.

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was also support for me. We sat silently on the sofa. When one of us said something, it was usually an anecdote, often humorous, from times past. We smiled and wept at the same time.

MJ and I had moved to Ohio two years earlier. Throughout my working life I had changed jobs several times, living ten or more years in Maryland, Florida, and New Jersey. We had retired to Florida, but I continued to teach and serve on committees at the medical school where I had been a faculty member twenty years before. Seven years later we moved to south Florida, where I tried unsuccessfully to help a community hospital transform into a major teaching hospital so that it could become part of an academic health center. After five years, MJ decided she wanted to be closer to family. Our children Wayne, Karen, and Stephanie lived in California, Ohio, and England, respectively. We decided to move to Ohio where Karen and her son were.

During MJ’s third day in the MICU, a member of the hospital’s palliative care team met with me. Her task was to prepare me for conclusions to the admission other than death. I was prepared for MJ to die, but suppose she didn’t? What were my thoughts and plans? Previous hospitalizations had been serious enough to raise similar questions. During those
episodes, I had been confident that she would recover. Each time I brought her home and together we would try to capture a semblance of a quality life. This time I did not feel that way. Now my fear was that any improvement that postponed death might leave her bedridden, obtunded, or even comatose, which would require a level of care that no one person could manage at home.

I remembered an earlier life-threatening illness at another hospital that required a week in the MICU. Our daughter Stephanie, an Anglican nun in a convent in Oxford, England, was visiting us at that time. “Dad,” she counseled me, “there comes a time when you must let Mom go.” Intellectually, clinically as a physician, I understood. But “letting go” is an emotional challenge. This time I thought I was ready.

The palliative care attendant had a nursing background. She put together a list of nearby facilities to care for MJ if she should live but remain unresponsive. I was at the stage where I wanted her to die and was afraid she would not. We had discussed this dilemma and had prepared living wills cautioning against heroic, aggressive treatment in a dire terminal state akin to MJ’s current condition. MJ had even threatened me that if I disavowed her wishes she would return to haunt me. But all that preparation is not enough to erase all doubt or reassure that you are making the right decision.

The palliative care professional nudged me toward my wife’s bedside as she left. She said I should give MJ a hug and a kiss. She added that I probably would like to comfort her by crawling alongside and entwining our legs. These are not her exact words but they relaxed my face into a faint smile. My God, I thought, is the love and lust of an eighty-two-year-old man for his wife in the throes of a terminal illness so obvious?

MJ died on the fifth hospital day. She had remained unconscious since the first day.

The last days were a continuation of the preamble. MJ never responded. She developed a cardiac arrhythmia with tachycardia that was not treated. Respirations become more labored, and it was now definite that death was the only conclusion. There were no abrupt changes. On the final day I went home to shower and change clothes—I needed a break in the vigil. As I entered our home, a forty-five-minute drive from the hospital, the phone was ringing. It was Karen, who had remained with her mother, telling me MJ had just died.

I returned at once to the hospital. Karen was still with her mother. The staff had closed the door to the room and pulled the curtains together that covered the window facing the inside corridor. Karen and I hugged and said little. We were alone in the room. After awhile, without words spoken, we left.

After MJ’s death I went to the funeral home for the required identification prior to cremation. Karen and Wayne were with me. MJ was laid out in a room by herself. She looked comfortable. Her hair, still naturally red, spoke to me of the beginning and end of our journey together. I imagined her saying: “Dick, it’s all right. I don’t hurt anymore. It was my time. I love you.” Our children and I hugged, wept. This was goodbye.

I want this essay to be a celebration of life, love, marriage, and MJ. It is our story. I grieve, I am sad, but I’m doing fine. I remember Lou Gehrig, famed Yankee player, who said as he addressed the fans at Yankee Stadium shortly before his death: “I consider myself the luckiest man on the face of this earth.” I think I can tell Lou Gehrig to move over.

Coda

I have shared this story with family and colleagues. Many have said they are deeply moved or touched by it. Some are uneasy about its frankness and its rawness. Why are you writing this, they ask, and for whom? I am not sure I have an answer. Throughout my professional life I have recorded observations, ruminations, and wonderments about daily events. I have filled notebooks with these musings. So the habit of writing about events may represent the hidden diarist that is part of me. But it was different this time.

As a clinician I have helped—or tried to—many patients and families through similar situations. During my first years of practice in a small western Maryland city, I recognized that despite my excellent clinical training, I came up short in providing them with comfort and wisdom. Later on as a department chair, I established a division of humanities. I never could set aside Thomas Mann’s phrase: “Medicine, that subdivision of humanities.” I would have liked to discuss with him his interpretation of this comment in The Magic Mountain.

I was not naive when caring for my wife during the early and late stages of her illness. I had witnessed similar situations in other patients and friends as they were dying. This was different. I began to doubt my clinical judgment. I was uncertain about previous decisions my wife and I had made to cope with death’s intimacy. I could see how even meager hope could push patients and families toward unwise therapies.

I was not depressed or troubled with guilt. I did not realize, however, the degree of sadness or emptiness I would experience. Even now, I weep as I reread these lines. If there is any take-away message from my story, it is that no matter how knowledgeable, how prepared an individual is for situations like this, it is still likely that the doctors, the health professionals in attendance will underestimate the hurt (I wish I could find a better word) that is occurring among the patients and their families.

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“There’s no such thing as death, really,” she said. “Just a lack of life.”
Her limbs hung loosely.
Body defined by what wasn’t there.
She dragged through the streets,
Accompanied by two lonely letters:
M.
S.
Which always seemed to buzz around her head.
A halo of desperation.
Leaving her few moments of peace.
To reminisce on better days.

Alexander Fortenko

Mr. Fortenko is a member of the Class of 2015 at George Washington University School of Medicine and Health Sciences.
This poem won Honorable Mention in the 2013 Pharos Poetry Competition. Mr. Fortenko’s e-mail address is: afortenko@gmail.com
Illustration by Erica Aitken
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 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. 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 prior award recipients J. John Cohen, MD, PhD; Ruth-Marie Fincher, MD; William H. Frishman, MD; Bruce E. Giffin, PhD; Richard B. Gunderman, MD, PhD; Brian Hodges, MD, PhD; John (Jack) Nolte, PhD; LuAnn Wilkerson, EdD; Amy Leigh Wilson-Delfosse, PhD.

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 2013 award recipients follow.

Richard L. Byyny, MD
Executive Director

Cynthia Lance-Jones, MA, PhD (Basic)
Assistant Dean for Medical Student Research, Associate Professor, Department of Neurobiology, University of Pittsburgh School of Medicine

Dr. Lance-Jones received her PhD at the University of Massachusetts at Amherst in 1977, and completed a fellowship
in neuroscience at Yale University in 1980. She joined the University of Pittsburgh School of Medicine in 1983 as an assistant professor in the Department of Neurology and is now Assistant Dean for Medical Student Research.

Dr. Lance-Jones has received many of the University of Pittsburgh’s awards for outstanding educator, including the Excellence in Education Award as a Preclinical Course Educator in 1997, the Dean’s Award for Master Educator, Kenneth E. Schuit Award in 2004, the Academy of Master Educators in 2005, the Excellence in Education Award as Small Group Facilitator in 2009, and the Sheldon Adler Award for Innovation in Medical Education in 2011.

Dr. Lance-Jones is coordinator for the first-year basic science block, and oversees implementation of the core anatomy, biochemistry, genetics, cell biology, and pathology courses. She was a major designer of the combined course in cell biology and pathology, has designed a computer module on vascular structure, atherosclerosis, and the potential use of noninvasive biomarkers, has created and implemented a team-based learning exercise on wound healing, and introduced the use of virtual microscopy material for histology workshops and laboratories.

As Assistant Dean for Medical Student Research, Dr. Lance-Jones is responsible for helping student design and implement Scholarly Projects, longitudinal research experiences required of all medical students. She has been asked to speak at other medical schools interested in establishing similar programs.

Dean Arthur S. Levine says of Dr. Lance-Jones, “She approaches . . . tasks with creativity and insight into student concerns and learning styles because she also serves as a lecturer, a small group facilitator, and/or a laboratory instructor in multiple courses. Her ability to clearly present and synthesize [information] . . . and to make topics relate organically to several different courses is recognized by the students not only with outstanding evaluations and attendance at her lectures but also by the fact that she is one of only three faculty members who are asked each year to provide review sessions for USMLE step 1 exams. Dr. Lance-Jones has served for several years as one of three faculty advisors to the Medical Student Honor Council. This working group of elected student representatives advises students on issues relating to our honor code and professionalism. This role, coupled with her teaching and Scholarly Project work, positions her as one of our most committed preclinical educators.”

Stuart Slavin, MD, MEd (Clinical)
(AΩA, Saint Louis University, 1984)
Associate Dean for Curriculum and Professor, Department of Pediatrics, Saint Louis University School of Medicine

Dr. Slavin received his MD at Saint Louis University in 1983 and completed his residency in Pediatrics at UCLA in 1986. He received his MEd at the University of Southern California 1992. He joined Saint Louis University as a professor of Pediatrics in 2004. He is currently the Associate Dean for Curriculum and chairs the Curriculum Management Committee.

Dr. Slavin received the Saint Louis University School of Medicine Distinguished Teaching Award for Humanism in 2009, 2011, and 2012, and the Father James Tobin award in 2008. He received numerous awards while a faculty member at UCLA, including the Golden Apple Award for Excellence in Teaching from the UCLA School of Medicine Class of 1999 and the Robert C. Neerhout Teaching Award from the UCLA Pediatric Residents in 2004.

During his tenure at UCLA, Dr. Slavin was cofounder of the Doctoring curriculum, which has since become a national model for curricula addressing underrepresented topics at medical schools in the United States. He was the primary architect for the Colleges system, which focused on enhancing the educational experience for fourth-year medical students, was pediatric clerkship director, and led the development of a core curriculum based on the COMSEP educational guideline.

At Saint Louis University, Dr. Slavin directed an effort to improve the mental health of medical students, and spearheaded a comprehensive restructuring plan for the four-year undergraduate medical curriculum.

Dr. Slavin is a popular teacher, as evidenced by the comments of students: “Dr. Slavin just gets it. I think it’s pretty rare for professors to be able to remember what it was like to be a student and the fact that he remembers and is able to relate to us is greatly appreciated. Fantastic.” “Dr. Slavin is an excellent teacher because he takes complex subjects and makes them simple to understand. I appreciate that instead of focusing on excessive detail, Dr. Slavin taught overarching principles that can then be used to remember why certain diseases present in a particular fashion.”

Dean Philip Alderson writes of Dr. Slavin, “He is being nominated because of the long track record of leadership and innovation that he has accrued during his career in medical education, his significant creative work in the field, and his outstanding record in teaching of medical students.”
Mikel Snow, PhD (Basic)
(ΔΩΑ, University of Southern California, 1988)
Director of Medical Education and Professor and Chair, Department of Cell and Neurobiology, Keck School of Medicine of the University of Southern California

Dr. Snow received his PhD in Anatomy at the University of Michigan in 1971 and his doctorate in Molecular Biology at the University of Washington in 1989. He joined USC in 1975 as assistant professor in the Department of Anatomy and Cell Biology. He is currently Professor and Chairman of the Department of Cell and Neurobiology and Director of Medical Education at the Keck School of Medicine at the University of Southern California.

Dr. Snow is the director of Anatomy at the medical school, known for his dynamic and comprehensive lectures as well as his original student materials. Dr. Snow played a pivotal role in the revision of the basic science curriculum, one of the greatest curriculum advances at USC in the past ten years. He serves as an advisor on the Student Ethics Committee.

Dr. Snow’s awards at USC are many: he received the Master Teacher of Distinction Award at the Keck School of Medicine in 2009, the Outstanding Teaching Award and Outstanding Mentor Award in numerous years, as well as the Excellence in Teaching and Lecturing Awards in several years. He was also given the Gender Equity Award for “Promoting a fair environment for the education and training of women physicians,” by the American Women’s Association in 1996 and the Dean’s Teaching Award in 2002 at the University of Wisconsin School of Medicine.

Dean Carmen Puliafito writes of Dr. Snow, “As an educator, administrator, and mentor, Dr. Mikel Snow is nothing short of exemplary. Through his directorship of the gross anatomy course, his chairmanship of the musculoskeletal system section, and his involvement in ethics and curricular committees, Dr. Snow is a pillar of the medical school and integral to students’ success. This truth may be most evidenced by the students who ‘vote with their feet’ and fill his lectures to 100% capacity, despite their opportunity to webcast lectures comfortably from home. . . . With his gifts Dr. Snow has helped thousands of students learn the difficult concepts inherent to physiology and anatomy. Simply put by one student, ‘Every time Dr. Snow speaks, I learn something useful.’ . . . We believe Dr. Snow is exactly the type of medical educator worthy of ΔΩΑ recognition.”

Roy Ziegelstein, MD, MACP (Clinical)
(ΔΩΑ, Boston University, 1986)
Vice Dean for Education, Sarah Miller Coulson and Frank L. Coulson, Jr., Professor of Medicine, and Executive Vice Chairman, Department of Medicine, the Johns Hopkins University School of Medicine

Dr. Ziegelstein received his MD from Boston University in 1986 and completed his residency in Internal Medicine at Johns Hopkins in 1989. He subsequently completed a Cardiology Fellowship at Johns Hopkins in 1993. Dr. Ziegelstein joined the faculty of Johns Hopkins University School of Medicine in 1993 as an assistant professor. He is currently Vice Dean for Education and professor and Executive Vice Chairman of the Department of Medicine.

Dr. Ziegelstein directed the Internal Medicine residency program at Johns Hopkins Bayview Medical Center from 1997 to 2006, and also coordinated the Internal Medicine rotation for third-year medical students. He redesigned that program to emphasize not just the didactic and technical aspects of medical education and clinical medicine, but also humanism and professionalism. Dr. Ziegelstein developed the fourth-year course “Transitions to Residency and Internship and Preparation for Life (TRIPLE),” which has become one of the highlights of the required medical school curriculum.

At Hopkins, Dr. Ziegelstein has won the George J. Stewart Award for outstanding clinical teacher five times and was awarded the Professor’s Award for Distinction and Teaching in the Clinical Sciences in 2003. The Maryland chapter of the American College of Physicians awarded him the C. Lockard Conley Award for contributions to resident education and research in 2004 and the Theodore W. Woodward Award for medical education in 2007. His clinical skills were recognized by the Miller Coulson Academy for Clinical Excellence in 2009.

Dean Landon S. King says that “Dr. Ziegelstein has been an outstanding teacher of medical students (and all levels of learners) since he came to Johns Hopkins as a member of the Osler House Staff program in 1987. . . . As a reflection of the commitment and excellence that define Dr. Ziegelstein’s approach to teaching, he was recently named as the Vice Dean for Education in the Johns Hopkins School of Medicine. In this critical role, he will oversee the medical school’s undergraduate, graduate, residency, postdoctoral, and continuing medical education programs.”
The physician at the movies

Peter E. Dans, MD

Blue Jasmine

Starring Cate Blanchett, Alec Baldwin, Andrew Dice Clay, and Sally Hawkins.

Woody Allen, who doesn’t attend the Oscars, has created roles that have garnered eleven Best Actress and Best Supporting Actress nominations with five Academy Award winners. The most memorable is Diane Keaton’s quirky but lovable Annie Hall. Other nominees portray decidedly less lovable women bordering on the despicable. The other winners were actresses who played against type: Dianne Wiest (Hannah and Her Sisters, Bullets Over Broadway), Mia Sorvino (Mighty Aphrodite), and Penelope Cruz (Vicki Cristina Barcelona). By contrast, male roles have received four nominations with only Michael Caine winning for best actor in Hannah and Her Sisters.

The latest shoo-in is Cate Blanchett for her extraordinary performance as a really mixed up and downright nasty woman in Allen’s forty-eighth and latest film. Jasmine (née Jeannette) is married to slick businessman Hal (Alec Baldwin). They live in an elegant Upper East Side Manhattan apartment, summer in the Hamptons, attend charity galas, and otherwise enjoy the lifestyle of the New York rich and famous who don’t produce anything but make money off deal-making.

Jasmine appears to be the only one who doesn’t know that Hal is a world-class womanizer; she is apparently blinded by the diamond necklaces and bracelets he showers upon her. When Hal’s business crashes down and he is indicted and put in jail for creating a Ponzi scheme, Jasmine is devastated. Unable to bear the ignominy and having lost millions, Hal commits suicide, leaving Jasmine untethered and bereft of her apartment and possessions, which are garnished. Popping Xanax, which she washes down with martinis (one of her more memorable lines is, “Who do I have to sleep with to get a Stoli martini?”), she moves in with her sister Ginger (Sally
Hawkins) in a really downscale apartment in San Francisco. Emotionally fragile but still haughty and superior, she disapproves of Ginger’s boyfriend Chili (Bobby Cannavale), who has to move out of the apartment to accommodate Jasmine. He turns out to be a very violent guy who rips up the store where Ginger works as a checkout clerk. Jasmine tells Ginger that Chili is another loser like Ginger’s ex-husband Augie, played by Andrew Dice Clay. (I had never seen any performances by Clay who according to Don Steinberg “calls himself ‘the most vile comic ever to walk on a stage.’ He became a rock star of stand-up comedy in the late 1980s as a filthy-mouthed braggart, selling out Madison Square Garden telling vulgar versions of nursery rhymes. He was vilified by women’s groups and gay groups for his material.”) Playing against type, he is the most sympathetic of the film’s characters. It turns out that Ginger and Augie won the lottery. Jasmine suggested they invest the money with Hal, and they lost everything, which led to their breakup.

Accepting Jasmine’s advice, Ginger takes up with Al (Louis C.K.), a sound engineer who seems to be a step up from Chili. He turns out to be another loser, married and unwilling to divorce his wife. Jasmine, who has never worked a day in her life, starts taking a course in interior design while working as a receptionist in a dentist’s office and doing a pretty bad job of it. The dentist hits on her and she quits. Then the seemingly perfect match appears, Dwight (Peter Sargaardt), a wealthy diplomat who is enamored with her. He has money, standing, and connections; she has the beauty and sophistication to be a good consort. She will design his new house and they will marry. Then he finds out that her background story is completely false and dumps her. Reeling, she learns that her son is working in San Francisco and seeks him out only to find that he hates her and wants nothing to do with her because of something that she did that is not revealed until the end. You get the picture: this is one mixed up lady and ninety minutes in her company is almost enough to make one reach for that antidepressant bottle that she carries around with her. I’m ready to give her the Academy Award and be rid of her. I wish Allen would use his great talent to create warm-hearted and inspiring characters. Annie Hall 2, anyone?

References

Enough Said
Starring James Gandolfini, Julia Louis-Dreyfus, Toni Collette, and Catherine Keener.

I was glad to get the notice of this screening. It had been a trying period and I needed some laughs. The film didn’t disappoint, especially in the first half. The very witty dialogue in the mode of When Harry Met Sally is enhanced by a talented pair of actors, Julia Louis-Dreyfus and James Gandolfini, who honed their skills on television. Gandolfini (Albert) the star of The Sopranos is so natural, it’s hard to believe he’s acting. His performance is so good that it magnifies the regret about his recent death of a heart attack at fifty-one. Louis-Dreyfus (Eva) who played the role of Elaine on Seinfeld has perfected the art of using facial expressions that are just as funny as the lines themselves. Unfortunately, some of the lines were drowned out by a person guffawing in the almost packed audience.

Dreyfus plays a divorced masseuse or massage therapist who is invited to a party that seems like another dead end for meeting Mr. Right. She tells the couple who brought her that no one appeals to her. Albert, a divorced curator of a Los Angeles television history museum, makes the same comment. But their words are belied by their well-matched senses of humor and easy repartee. Days later, Albert invites Eva out on a date. Despite her misgivings about this self-confessed portly slob, she agrees, and begins to take a liking to him. After their first date, they shake hands. On the second date, they begin a series of awkward, and to my mind too many filmed
sleepovers. In short, the story focuses on two divorced people coming together and the difficulty in navigating a relationship the second time around. Those who have been divorced might be able to relate better to the film than I, who was fortunate to have been married to a wonderful woman for over thirty-eight years before she died of breast cancer in 2004.1

Another audience connector involves both of them having daughters who are going off to college, and being parents who are facing the empty nest like the friend who joined me at the screening. The parting scene at the airport is well done. Albert's daughter Tess (Eve Hewson), who is off to Parsons School of Design, seems to have inherited the disposition of her mother, self-absorbed published poet Marianne (exquisitely played by Catherine Keener). She puts down Eva's daughter Ellen (Tracey Fairaway), who is going to Sarah Lawrence, which Tess proclaims isn't what it used to be. I'm not sure what Sarah Lawrence alums think about this, but I guess any mention is useful, especially since Eva sports a Sarah Lawrence sweatshirt which might otherwise be considered a product placement like the Taittinger champagne she pours out at their brunch.

The second half of the film introduces a major plot twist in which Marianne becomes a client of Eva and rags on her ex, with neither knowing the connection. When Eva sees Albert's daughter, she gets the picture. The second part seems like it was written by another screenwriter, with Eva exclaiming in potty-mouth language to her friend Sarah (Tavi Gevenson), something that was absent before and is dropped just as quickly. She becomes less appealing when her daughter's friend Chloe (Tavi Gevenson), who likes their house better than her own, asks whether she should let her boyfriend go all the way. Eva confirms that Tess is a virgin and tells her to do what feels good to do. When she tells her they did it, Eva praises her. At the end of the film the girl's mother tells Eva that she is the girl's mother, not her, and angrily berates her for the advice she has given her.

During the second half Eva becomes creepy, using what she heard about Albert's bad points to alienate and embarrass him. Later when we meet her ex, one senses that she was the principal party causing the divorce. Played by Toby Huss who was in the Wiz episode on Seinfeld, he seems to be very level-headed and caring. He has re-married to a widow, which Eva doesn't learn until she unleashes a wisecrack about them. As for Albert and the loopy poet, if one wants to pin the tail on the donkey, she seems to be the reason their marriage failed. Her judgmental and self-referential manner contrasts with his sweeter, more humble, and lighthearted disposition. The second half drags as Albert realizes what Eva has been doing and they separate. Still it ends on an up note with a few more laughs. Despite my reservations, I would recommend the film.

**Reference**


**Call Northside 777 (1948)**


_I_ will be reviewing some old films that I think you might not have heard of and which you might enjoy. This one is based on a true story adapted from Chicago Times articles by James P. Maguire. It is set in a grittier Chicago of the late 1930s and 1940s picturing the Merchandise Mart, the Holy Trinity Polish Mission, the Wrigley Building, and the neighborhood around the stockyards with a bar on every corner. The characters are...
believable. The cast is stellar.

Told in the documentary style of *Naked City*, it opens with a *Times* ad offering $5000 for information in connection with the murder of a policeman, for which Frank Wieck (Richard Conte), who claims innocence, is serving a ninety-nine-year sentence. It's the heyday of newspapers, signified by the newspapers coming hot off the presses and being bundled to go into the delivery truck. The *Times* managing editor Brian Kelly (Lee J. Cobb) calls in reporter P.J. McNeal (James Stewart) to follow up. He begins his investigation in a municipal building where the ad-placer, a Polish cleaning woman, is scrubbing floors and steps. That struck a responsive chord with me because when I was a boy I lived in a cold-water flat with my extended family, I used to join my Italian grandmother when she worked the 4:00 to 12:00 shift as a cleaning woman in Brooklyn's Borough Hall.

McNeal learns that Mrs. Ciecek (Kasia Orzazewski) worked eleven years to get $5000, a lot of money in those days, that might tempt someone to step forward with new evidence to clear her son, who was apparently framed. In 1932, the year of the murder during Prohibition, there was a close relationship between corrupt policemen, organized crime members, and speakeasy owners. All sides are anxious to get a quick conviction. The film is filled with nice little touches such as when McNeal goes home and after dinner, sits down with his wife to do a jigsaw puzzle as he tells her about the case he is working on. This also resonated with me in that it was our family's favorite after-dinner pastime as attested to by the many completed puzzles around ours and my daughter's house where our prized 2000-piece Casablanca puzzle resides.

McNeal visits Ciecek in the penitentiary. There are interesting posted rules governing where inmates may meet and kiss relatives. McNeal, the typical cynical journalist who has seen and heard it all—including the fact that all prisoners are innocent—questions the warden, who says that Ciecek is a model prisoner who works in the hospital and may be that one who is really innocent. McNeal begins a series of interviews and learns that everyone except the prosecutor and the jury thought he was innocent, including the judge, who has since died. The interviews lead to a series of front page articles. Ciecek submits to a polygraph or lie detector test even though he is told if that if he fails he is "cooking" but if he passes, it would be inadmissible in court. Leonarde Keeler, the inventor of the polygraph, administers the test in the movie. In one of the articles, McNeal reveals the story of Ciecek's wife, who was faithful to him but divorced him at his insistence so that she could marry a man who promised to care for her and their son. The story is accompanied by a photo that infuriates Ciecek by compromising their anonymity and he tells McNeal to call off the search. McNeal, who is becoming unsure of Ciecek's innocence, makes one more effort to find someone in the bars who knows something. There is an interesting twist at the end. It's an enjoyable travel back in time.

Reference

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@verizon.net
O.E.D.

Don't you just love it when suddenly one of your off-track words occurs by luck in conversation or better, when you can float the word itself into the stream saying why that's so apotropaic!

Henry N. Claman, MD

Dr. Claman (AΩA, University of Colorado, 1979) is Distinguished Professor of Medicine and Associate Director of the Medical Humanities Program at the University of Colorado, Denver. He is a member of the editorial board of The Pharos. His address: Mail Stop B164, Research 2, 12700 E. 19th Avenue, Room 10100, Aurora, Colorado 80045. E-mail: henry.claman@ucdenver.edu.
The book review editors request that books for potential review be approved by the editors before the reviews are written. Reader interest and space are always considerations in this section and unsolicited reviews may be rejected. Contact Dr. Bennahum at dbennahum@salud.unm.edu and Dr. Coulehan at john.coulehan@stonybrookmedicine.edu.

**I Wasn’t Strong Like This When I Started Out: True Stories of Becoming a Nurse**
Lee Gutkind, editor
Pittsburgh, In Fact Books, 2013
Reviewed by Judy Schaefer, RN, MA

Let me say this before I say anything else: I love these stories. Yet, had I not been asked to write this review, I would have unwittingly left this book to gather dust on the shelf. Why? The cover has four lovely blurbs written by doctors. The early praise for this book of creative nonfiction by nurses came from a total of nine doctors. All nice and knowledgeable people, surely, but what do nursing leaders think of this book? I can’t help but chuckle as the cover blurbs reflect the trite and out-of-fashion tradition of physician approval. The cover of the book suggests that nurses, the nursing profession, still seeks primarily—primarily—the praise of physicians.

Ironically this collection illustrates nursing autonomy. We can remain seated when doctors walk into the room and we “implement prescriptions”; we don’t take orders. Some of us with advanced degrees write prescriptions. We nurses “consult” with each other and with our multidisciplined colleagues. We provide peer review and peer support. A nurse is not a handmaiden to the physician but works with the doctor as colleague in the best interest of the patient.

Perhaps the book is intended for doctors? Every doctor should indeed read this book. The narratives are such a good source of information for doctors, the public, and nurses, and especially nursing and medical students. What would Flo* say?

The narratives in this book are bold, funny, scary, and true to the bone. Twenty-one nurses tell compelling stories of their training and subsequent growth in the nursing profession. Their stories can be the basis for learning as well as for entertainment. I wish I could have read and discussed these stories when I was a nursing student. They are powerful.

As the nurses in this collection describe, nurses make decisions on the spot and on the run, without recourse to contemplation at a desk. A family member once brought this to my attention when she asked, “Where is the nurse’s desk?” I had never thought of it before. These ward warriors make life-and-death decisions on the go, in soft shoes, with grace and good humor—as these stories attest. There may be a break room or cubicle where coffee is dosed out in between patients and family, attendings, interns, and residents, medical and nursing students, but nope—nope—no desk for retreat. Nurses learn to turn on a dime in the fishbowls of their wards, trailing a computer; or in the patient’s home trailing a phone. Graceful and elegant. Swift and bold.

All of these stories have both strong “telling” voices and strong interior, self-deprecating, voices loaded with good humor. In fact, humor is one of the strongest tools for these nurses. I laughed reading Eddie Lueken’s “Hitting the Bone.” Demonstrating the good student’s desire to learn and experience hands-on skills, she writes, “I was paying the college to teach me how to keep people alive; I already possessed the skills to let someone die.” The interior dialogue of this essay is priceless. Oh, I wish I would have read this one as a student.

I wanted to cry when I read Kimberly A. Condon’s “Approaching Death.” In the first paragraph she writes, “There is a terrifying, soul-piercing scream that a mother makes when she loses a child. This scream is so universal that everyone, in every corner of the emergency department, knows what has just happened when they hear it.”

I sympathized and felt a chill when I read Thomas Schwartz’s “The Haunting.” While a story of the loss of innocence, it is also a soul-searching story of scarring and redemption. He writes, about himself and his patients, that not all injuries can be seen and judged with the human eye or reasoned with the human mind. “Nor do all illnesses have scientific, rational roots. Some surround the heart like barbed wire, never admitting peace or happiness, never allowing the release of residual, unspoken, or misplaced guilt.” This is a superb story for both new and experienced nurses.

I wanted to jump and shout when I read Tilda Shalof’s “I See You.” Her superb writing inspires the title of the collection. She writes, “Most of all, you need moral courage because nursing is about the pursuit of justice. It requires you stand up to bullies, to do things that are right but difficult, and to speak...
your mind even when you are afraid. I wasn’t strong like this when I started out. Nursing made me strong.”

Does Shalof remind us that nurses are like hired-guns and are certainly paid observers? I laughed and I cheered as I read her description of the nurse as angel, “In addition to holding the patient’s hand, that nurse had analyzed her twelve-lead electrocardiogram and monitored her for arrhythmias. She had drawn serum troponin levels and ensured that electrolyte levels were normalized. She had given information, oxygenation, anticoagulation, and pain relief.” Not just another angel! These angels have strong wings.

The implications and challenges of diverse cultures are inherently addressed in all of these narratives and specifically addressed in “Healing Wang Jie’s Bottom” by L. Darby-Zhao, “Docking in Togo” by Jennifer Binger, as told to Ann Swindell, “Listening and Other Lifesaving Measures” by Karla Theilen, and “Messiah, Not Otherwise Specified” by Janet Gool. These are superb essays for discussion by students of nursing and medicine who are interested in global as well as domestic health care pursuits.

Pamela Baker’s “Individually Identifiable” touches on the need for stories in spite of the HIPAA climate. She addresses issues of policy and procedure that could be the ground work for policy research. And importantly she touches on the reasons nurses do not write. What an essay to facilitate discussion for nurses in their English requirement courses!

The narratives could be read one at a time or in one setting from front to back. Each one stands alone. Read them as you will. Now having said this, I thought the book ended poignantly with “The Nurses Whispered” by Patricia A. Nugent and “Becoming” by Lori Mulvihill. “The Nurses Whispered” is subtle truth telling and “Becoming” is a loving summary. They bring the book to a satisfying closure with a respectful and knowing salute to the nursing profession. Well done!

And—one more thing—and write this on your cover: Flo would like this book! No, that’s wrong. Flo would LOVE this book!

Judy Schaefer, RN, MA, edited the first biographical autobiographical work of English speaking nurse-poets, *The Poetry of Nursing: Poems and Commentaries of Leading Nurse-Poets* (The Kent State University Press, 2006), and co-edited the first international anthology of creative writing by nurses, *Between the Heartbeats* (University of Iowa Press, 1995). Her address is:

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**Forgive and Remember: Managing Medical Failure**

Charles L. Bosk
Chicago, University of Chicago Press, 2003

Reviewed by Jack Coulehan, MD

In the late 1970s, sociologist Charles Bosk spent eighteen months as a participant-observer in the surgical residency program at a major West Coast teaching hospital. His report, *Forgive and Remember: Managing Medical Failure*, which became a classic of medical sociology, investigated power relationships and decision-making in academic surgery. Bosk described four types of error and the consequences of each for surgical residents. In technical errors the surgeon performs “his task conscientiously, but his skills fall short of what the task requires.”

Errors of judgment occur “when an incorrect strategy of treatment is chosen.” When a resident makes a technical or judgmental mistake in patient care, his superiors’ response is generally supportive, despite scrutiny at the Morbidity and Mortality Conference, and the resident is forgiven, as long as his mistakes are infrequent, and he learns from them. Hence, the book’s title, *Forgive and Remember*.

The third type, normative error, occurs when a surgeon fails “to discharge his role obligations conscientiously.” In other words, the surgeon neglects his duty to a patient or to his colleagues on the surgical team because of laziness, inattention, lack of respect, or irresponsibility. Quasi-normative errors represent a failure to discharge an obligation specific to a given hospital or surgical service, i.e., a regimen the Chief insists upon, although other approaches might be equally valid. Normative and quasi-normative errors are considered moral failings, rather than evidence of insufficient skill. Accordingly, they evoke a more negative response from attending surgeons. A resident guilty of normative error can expect dire consequences, e.g., failure to advance, or even immediate dismissal.

This second edition of *Forgive and Remember* deserves our attention because it sheds new light on Professor Bosk’s study. He now confesses to having made his own errors of judgment in writing the original book. In a remarkable Appendix entitled, “An ethnographer’s apology, a bioethicist’s lament—The surgeon and the sociologist revisited,” Bosk describes two omissions that he once considered trivial, but he now realizes were important.

The first omission relates to his discussion of the process by which residents were chosen for advancement to the next level, or dropped from the
program. At the promotion meeting, only one resident failed to make the grade. Every one of the senior surgeons considered that person guilty of normative errors, i.e., unprofessional behavior. In fact, attendings applied words like "sick" and "crazy" to the resident. Following standard practice, Bosk preserved the confidentiality of his subjects by altering names and other distinguishing features—including gender. Thus, the failed resident, always referred to as “he” in the book, was actually a woman; in fact, she was the only female resident.

There were no precedents for a female surgical resident in that program. While the male sociologist blended in with the surgical “gang,” the female resident never did. She remained an outsider. How much did this alienation affect her performance? How much did her attendings’ bias affect their evaluations? Was she considered “sick” or “crazy” simply because she aspired to become a surgeon? Whatever the answers, there can be no question that her gender was an important datum omitted in the original edition.

The second omission Bosk reveals is “the hectoring, often abusive behavior of senior surgeons.” He originally chose not to tell his readers that “verbal harassment was a rather routine event for all residents,” at least in part because he wanted his work “to read differently than other sociological accounts of this time which seemed to engage routinely and somewhat unreflectively in doctor-bashing.” The author believed that if he gave a full account of this harassment, it would distract the reader from his major theme, an analysis of decision making in the strict, authoritarian social system of a surgical residency. He didn’t want to be just another doctor-basher. In the new Appendix, he describes a typical example of harassment. In the operating room, a senior surgeon verbally “trashes” both Bosk and a resident, makes derogatory comments about “slopes, gooks, and dinks” to an Asian anesthesiologist, and asks an African-American scrub nurse, “Do you know how many times I had to practice this operation on blacks before they let me do it on whites?” Tellingly, the author has to reconstruct this scene from memory because he failed to include it as important in his field notes.

Why did the author choose after all these years to reveal his omissions? He considers several reasons, ranging from personal catharsis to demonstrating the difficulty of using supposedly detached and objective ethnographic data to draw inferences about professional morality. It is obvious to today’s reader that the female resident’s failure cannot possibly be understood in isolation from gender discrimination and sexual harassment. It is also obvious that any resident’s response to intimidation and humiliation by superiors must have influenced how normative and quasi-normative errors were perceived and evaluated.

This raises another question: Why recommend a decades old ethnographic study recently revealed as flawed from the outset? In my opinion this new edition of Forgive and Remember is doubly relevant. First, it remains a richly detailed investigation of surgical training that still applies in many ways to clinical education today. This is especially true with regard to the classification of error and the relative valuation of technical and moral competence. Second, the author’s revelations provide the reader with an altered lens through which to view his original ethnographic narrative. The temptation to delete messy details that don’t “fit” with a preferred diagnosis is always present in medicine. The new Forgive and Remember is a “retrospect-o-scope” that teaches how important such details can sometimes be. It also shows how much the mores of clinical education have changed in the last thirty years. Unfortunately, gender discrimination and trainee harassment still occur, although now considered aberrant, rather than routine.
Reviews and reflections

interrupted and I lost my way in that noble pursuit. Instead I began to read single chapters as questions came up for which I needed answers. And to my surprise, I found that in following my own academic pursuits, over the course of several months, I had the chance to read most of the chapters in this book. For instance, I am working on a clinical reasoning elective for fourth-year medical students, so I read the chapters on clinical reasoning and working with students who had experienced difficulties. I am in the process of revising a behavior-based PRIME grading form that I helped develop, so I read a very helpful chapter on evaluation of students (authored among others by Louis Pangaro). I am currently working on a simulation-based training for clinical procedures, so I read the chapter on simulation in medical student education. The book mirrored the information I needed to gain not just as a clerkship director but also as a medical student educator.

With respect to the book itself, I found the chapters very thorough, well organized, and easy to understand. I presented a few of the chapters above but there are several other topics including but not limited to chapters on the management of a clerkship, the clerkship orientation, longitudinal clerkships, and career development. I found the chapters presented new knowledge that often gave me some new insight or helped me structure the thoughts I had about the subject. For instance, the chapter on clinical reasoning had a very thorough and organized summary table outlining teaching strategies and tools. Also the chapters were organized so that if I wished to read a good review of a subject I could, or if I wanted to skip to a very specific topic I could do that as well.

As a busy clinician with a family it is definitely hard to find time to research and read on every topic. This book has a wealth of information in a very accessible format. As stated at the end of the first chapter, "This guidebook is intended to be a reasonably complete manual for clerkship directors as well as other members of the medical student teaching team." That makes it very valuable not only for clerkship directors, but also for any clinician who teaches students of medicine and the health sciences. I recommend the book as a truly unique and helpful guide.

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What Doctors Feel: How Emotions Affect the Practice of Medicine
Danielle Ofri, MD
Boston, Beacon Press, 2013
Reviewed by Johanna Shapiro, PhD

Emotions in medicine are both a neglected and problematic subject. As internist and author Danielle Ofri observes in her new book *What Doctors Feel*, the model of detached concern is still prevalent in clinical practice and in training. As she writes, "the often unspoken (and sometimes spoken) message in the real-life trenches of medical training is that doctors shouldn’t get too emotionally involved with their patients." But what does this really mean? Medical education rarely addresses the emotions of learners, although research has documented an intense panoply of positive and negative emotions. Even outstanding physician role models rarely discuss their feelings, leaving medical students to attempt to deduce appropriately professional emotional responses from indirect verbal, nonverbal, and behavioral cues. The medical literature as a whole is surprisingly silent on this topic.

Thankfully, Ofri has stepped forward to tackle this sensitive issue. Through a series of examples derived from her own clinical encounters and those of other physicians, as well as regular citation of relevant literature, she makes the argument (using a metaphor borrowed from the neuroscientist Antonio Damasio) that the physicians’ feelings are the “underlying bass line” exerting a profound effect on their actions regarding patients. In a bold and forward-looking move, Ofri calls for careful attention to, understanding of, and skill to work with personal emotions in the interests of patient well-being. Although she rarely uses this term, in effect she suggests that physicians need to develop emotional intelligence.

Following in the footsteps of Jodi Halpern, Jack Coulehan, William Branch, and countless other physician-scholars, Ofri reminds us of the key role of empathy as the gateway to managing one’s emotional reactions and achieving the goal of compassionate care. She recognizes that it is easiest to feel empathy when the patients’ suffering “makes sense,” and much harder when it does not. Yet empathy (which of course is not the same as enabling or indulging the patient’s every claim) is essential in all clinical encounters, not simply those involving likeable and grateful patients. Yet how to cultivate empathy under challenging, time-pressured circumstances is rarely included in the curriculum. Reflecting on her own training (mostly by older white male physicians)
she identifies the quality of respectful curiosity, “the . . . act of taking a patient and her story seriously,” as going a long way toward yielding positive doctor-patient relationships.

The chapter “Can We Build a Better Doctor” skillfully dissects the multiple pressures on medical students to de-identify with the patient and instead cathect to the residents and medical team. This often means prioritizing efficiency and productivity over compassion, laughing at or making fun of the patient, and not protesting the use of derogatory terms such as “gomer” (an elderly, demented nursing home patient) or a racially charged term such as “status Hispanicus” to refer to a vocal patient in labor. This and similar chapters on medical malpractice point to some of the systemic underpinnings of physician disillusionment and resultant “bad behavior,” and suggest that solutions focused only on the individual level are doomed to failure.

Ofri does the medical community a favor by naming some of the most difficult emotions that physicians experience, starting with fear. There are small fears (looking or actually being incompetent in a given situation) and large fears (is this really the right profession for me?) in medicine, all culminating in the oppressive fear of doing irreparable harm, or even killing a patient. Ofri points out that sadness, like fear, is unavoidable, and further, that neither emotion is without value (the alertness that results from a certain level of anxiety can keep the physician on her toes; grieving for a patient can bring some measure of peace to the physician), but the key is to learn how to navigate these emotions so that they do not destroy the physician, but rather serve the larger goals of patient (and physician) well-being.

Ofri also discusses shame, and its disabling properties. Whether her distinction between guilt (about a specific behavior) and shame (a more global experience) is accurate, her larger point is that the toxic blaming and shaming that still occurs in medical school and residency training has persistent negative effects that paradoxically make it more difficult to accept responsibility for mistakes and apologize to patients. The tendency to hide and cover-up incidents perceived to be shameful, and the resultant quest for perfectionism, is both unrealistic and detrimental to good patient care.

Burn-out, stress, and disillusionment with the profession of medicine are also considered in What Doctors Feel. Ofri pinpoints many causes, from paperwork, time pressures, financial demands, family strains. None of these insights is new—much research and anecdotal reports already exist supporting the deleterious consequences of these conflicts. But Ofri brings these experiences to life. She is particularly eloquent on the emotional toll malpractice suits extract, citing evidence that concludes that, whether the physician is liable or not, the emotional reverberation of anguish and self-doubt is lengthy and profound. In her words, they are “soul-corroding events,” often because the physician had a strong emotional connection with the patient.

What Doctors Feel is written in accessible, personal style, easily absorbed by lay persons, medical students, and physicians alike. One of the most touching aspects of the book is the narrative of Julia, a longtime patient and undocumented immigrant with two children about whom Ofri wrote in Lost in Translation. Charting the ups and downs of Julia’s progressively worsening struggle with genetically induced CHF while she is in her thirties and forties is a moving example of relationship-centered care. Ofri does not shy away from documenting the joys and heartbreak she experiences in caring for Julia. She does not expect that she—or other physicians—should feel such emotional connection with all patients. But she does fearlessly excavate all that it can mean to step within the orbit of a patient’s suffering, yet not be pulled so closely that she implodes. The result is a portrait of the doctor we would all long to have as we embark on our final journey.

What Doctors Feel takes a crucial step into the murky waters of emotion, long a taboo subject among both academicians and practitioners. It points the way toward systematic research, teaching, and clinical practice that acknowledges the humanity of the physician, as well as of the patient, in the service of better patient care.

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The annual meeting of the board of directors of Alpha Omega Alpha was held in Denver, Colorado, on October 5, 2013. Present were:

Officers: President C. Bruce Alexander, MD; President Elect John Tooker, MD, MBA; Immediate Past President Ruth-Marie Fincher, MD; Barbara Prince; Richard L. Byyny, MD; John Tooker, MD, MBA; Lynn M. Cleary, MD; Alicia Alcamo, MD; Robert G. Atnip, MD; Steven A. Wartman, MD, PhD; Laura Tisch, MSIV; Christopher Clark, MD; Wiley Souba, MD, DSc, MBA; William F. Nichols; Richard B. Gunderman, MD, PhD; Suzann Pershing, MD; and Alan G. Robinson, MD.

Members at large: Robert G. Atnip, MD; N. Joseph Espat, MD; Eve J. Higginbotham, SM, MD; Sheryl Pfeil, MD; Alan G. Robinson, MD; Wiley Souba, MD, DSc, MBA; Steven A. Wartman, MD, PhD.

Councilor directors: Lynn M. Cleary, MD, State University of New York Upstate Medical University; Richard B. Gunderman, MD, PhD, Indiana University School of Medicine; Mark J. Mendelsohn, MD, University of Virginia School of Medicine; Alan G. Wasserman, MD, George Washington University School of Medicine.

Student directors: Alicia Alcamo, MD, the Ohio State University College of Medicine; Christopher Clark, MD, University of Mississippi School of Medicine; Tonya Cramer, MD, Chicago Medical School at Rosalind Franklin University of Medicine and Science; Laura Tisch, MSIV, Medical College of Wisconsin.

Coordinator, Residency Initiatives: Suzann Pershing, MD.

National office staff: Executive Director Richard L. Byyny, MD; Assistant Treasurer William F. Nichols; Programs Administrator Candice Cutler; Membership Administrator Jane Kimball; Managing Editor Debbie Lancaster; Controller Barbara Prince.

Absent: Secretary-Treasurer Joseph W. Stubbs, MD; Member at Large Douglas S. Paauw, MD; Medical Organization Director Carol A. Aschenbrener, MD, Association of American Medical Colleges.

New to the board are: Mark J. Mendelsohn, MD, representing the University of Virginia School of Medicine, elected to a three-year term as Councilor Director; Wiley Souba, MD, DSc, MBA, elected to a three-year term as member at large; Laura Tisch, MSIV, representing the Medical College of Wisconsin, elected to a three-year term as student director; Steven A. Wartman, MD, PhD, elected to a three-year term as member at large. Councilor director Richard Gunderman, MD, PhD, was elected to a three-year term as member at large.

The board of directors recognized the retiring board members, and expressed thanks for their service to Alicia Alcamo, MD; N. Joseph Espat, MD; and Ruth-Marie Fincher, MD.

Thanks were also expressed for the exemplary service of retiring President C. Bruce Alexander, MD, who becomes immediate past president.

Elections
The following members of the board were elected as officers for a one-year term:
National and chapter news

1. John Tooker, MD, MBA—President
2. Douglas S. Paauw, MD—President Elect
3. C. Bruce Alexander, MD—Immediate Past President

Five honorary members were proposed this year and 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. Shotai Kobayashi, MD, PhD—President, Shimane University
2. Mats Lundström, MD, PhD—Professor Emeritus, Lund University, Sweden
3. Boris Malyugin, MD, PhD—Deputy Director General, S. Fyodorov Eye Microsurgery State Institution
4. John H. Pearn, MD, PhD, MPhil, AO, RFD—Professor Emeritus, University of Queensland, Brisbane, Australia
5. A. G. Prentice, MBChB—President, the Royal College of Pathologists, London

Reports

Dr. Alexander 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, and communications and public relations.

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

Mr. Nichols presented a proposal for regular small dues increases, subject to approval each year by the Executive Committee. The proposal was passed by unanimous consent.

Dr. Gunderman reported on the councilor meeting that immediately preceded the board meeting. A final report on the councilor meeting from the committee chairs (Dr. Gunderman, Dr. Gabriel Virella, and Dr. Elma LeDoux) follows.

Dr. Fincher reported on the status of new chapter chartering.

A report on the Professionalism Award and the Professionalism Meeting in July was presented by Dr. Paauw by teleconference.

A report on the work of the committee for the Leadership Award was presented by Dr. Higginbotham. A motion was made to approve the Leadership Award and Development Program to promote the development of leaders in academia, medical and health organizations, and the community. The motion was passed by unanimous consent.

A report on The Pharos was presented by Managing Editor Debbie Lancaster.

Dr. Pershing presented a report on the Residents Initiative project and the results of the Postgraduate Award.

Miscellaneous

The minutes of the 2012 board meeting were approved. A final budget was also approved.

Respectfully submitted
Executive Director Richard L. Byyny, MD

Alpha Omega Alpha elects new officers and directors

Alpha Omega Alpha Honor Medical Society is pleased to announce the election of its officers and directors for the 2013/2014 year.

Officers

President—John Tooker, MD, MBA, MACP (AΩA, University of Colorado, 1970), is Emeritus Executive Vice President and CEO of the American College of Physicians and Adjunct Professor of Medicine at the Perelman School of Medicine at the University of Pennsylvania. Dr. Tooker served as Executive Vice President and Chief Executive Officer of ACP from 2002 through 2010. He served as Medical Organization Member on the AΩA Board of Directors from 2009 through 2011, and was elected a member at large in 2011.

Immediate Past President—C. Bruce Alexander, MD (AΩA, University of Virginia, 1970), Professor and Vice Chair of the Department of Pathology at the University of Alabama at Birmingham. Dr. Alexander was elected to the board of directors of AΩA in 2002 as a councilor director, and subsequently elected as member at large in 2005. He became secretary-treasurer of the society in 2007 and president of the society in 2013.

President-Elect—Douglas S. Paauw, MD, MACP (AΩA, University of Michigan, 1983), Director, Medicine Student Programs, Professor of Medicine, Rathmann Family Foundation Endowed Chair in Patient-Centered Clinical Education at the University of Washington School of Medicine in Seattle, Washington. Dr. Paauw was elected to the board of directors of AΩA in 2005 as a councilor director and was elected as member at large in 2007. He was awarded the AΩA Robert J. Glaser Distinguished Teacher Award in 2001.
Alpha Omega Alpha elects new officers and directors

C. Bruce Alexander, MD

Richard B. Gunderman, MD

Mark J. Mendelsohn, MD

Douglas S. Paauw, MD, MACP

Wiley “Chip” W. Souba, MD, DSc, MBA

Laura Tisch, MSIV

John Tooker, MD MBA, MACP

Steven A. Wartman, MD, PhD, MACP
Directors

Member at Large—Richard B. Gunderman, MD, PhD, MPH (ΩΩΑ, University of Chicago, 1992), Professor of Radiology, Pediatrics, Medical Education, Philosophy, Liberal Arts, and Philanthropy, and Vice Chair of Radiology, Indiana University School of Medicine. Dr. Gunderman was elected to the board of directors of ΩΩΑ as a councilor director in 2010. He was awarded the ΩΩΑ Robert J. Glaser Distinguished Teacher Award in 2012. Dr. Gunderman was elected to a three-year term as member at large.

Councilor Director—Mark J. Mendelsohn, MD (ΩΩΑ, University of Virginia, 2007), Associate Professor of Clinical Pediatrics at the University of Virginia School of Medicine was elected to a three-year term as councilor director. Dr. Mendelsohn has been the ΩΩΑ councilor at the University of Virginia since 2008 and is regularly recognized as one of the university’s outstanding teachers. Dr. Mendelsohn serves on the medical school Admissions Committee, is the long-time chair of the Pediatric Intern Selection Committee, and co-directs the university’s International Adoption Clinic.

Member at Large—Wiley “Chip” W. Souba, MD, DSc, MBA (ΩΩΑ, University of Texas at Houston, 1978), Vice President for Health Affairs and Dean of the Geisel School at Medicine at Dartmouth College, was elected to a three-year term as member at large. Dr. Souba is widely recognized for his innovative approaches to developing leaders and leadership, having published more than forty articles on health care leadership challenges, personal and organizational transformation, leading oneself, barriers to effective leadership, and the language of leadership.

Student Director—Laura Tisch, MSIV, at the Medical College of Wisconsin, was elected to a three-year term as student director. Ms. Tisch is the ΩΩΑ chapter president at MCW and was elected to ΩΩΑ in 2013. Ms. Tisch has been active in her chapter's volunteer activities, including the MCW Saturday Clinic for the Uninsured, the USMLE Step 1 Board Review Tutoring program, and the MCW Department of Admissions Applicant Liaison and Student Interviewer program. She has participated in research in early breast feeding rates and Kaposi Sarcoma.

Member at Large—Steven A. Wartman, MD, PhD, MACP (ΩΩΑ, Johns Hopkins University, 1970), President and CEO of the Academic Health Centers and member of the editorial board of The Pharos since 1996, was elected to a three-year term as member at large. Dr. Wartman is recognized internationally for his work in the organization and management of academic health centers. He is currently a Distinguished Professor in the Department of Medicine at Georgetown University and an Adjunct Professor of Medicine at George Washington University and Johns Hopkins.

A complete list of the members of the ΩΩΑ Board of Directors is on the inside front cover.

2013 ΩΩΑ Councilor Meeting

The 2013 ΩΩΑ councilor meeting was held in Denver, Colorado, on October 3 and 4. Approximately one-third of chapter councilors attended, as well as several national officers and staff members from the national office. The program for the meeting was organized by a committee including Richard Gunderman, Elma LeDoux, and Gabriel Virella, and members of the ΩΩΑ staff. Experience of participating councilors varied widely: several had served as councilor for more than two decades, while others had been appointed to the post only a month or two before the meeting.

Executive Director Richard Byyny opened the meeting with a discussion of the importance of the leadership opportunity that every councilor enjoys, particularly with regard to promoting both ΩΩΑ and its mission to students, faculty, and alumni. There is ample evidence that many contemporary physicians are discouraged about the future of medicine, and ΩΩΑ can make a big difference in redressing this situation by fostering local discussions of medicine’s core aspirations and the practical steps all physicians can take to help promote them.

At each medical school, the ΩΩΑ councilor can serve as a node in the nexus of important networks in medicine, including different medical specialties, academic and nonacademic physicians, and different generations of physicians, from the most senior to the most junior. An effective councilor can act as a catalyst, helping the chapter and its members do a better job of serving physicians at all levels, as well as schools of medicine, hospitals and health systems, and the communities they serve. Councilors can provide critical leadership and help all parties regain a focus on medicine’s most defining and essential missions.

The meeting featured the debut of the first chapter handbook for councilors and chapter ΩΩΑ personnel developed by the staff in the national office. Dr. Byyny stressed that the handbook remains a work in progress, but it represents by far the most useful resource chapters have ever enjoyed. The handbook’s purpose is not to tell councilors how to do their jobs, but to provide an organizing framework and range of options for the activities of each chapter.

The handbook addresses a variety of core topics of concern to every councilor and chapter, including ΩΩΑ’s constitution, information about the roles of officers and the board of directors, and eligibility and nomination procedures for different categories of members, including
students, residents, faculty, alumni, and honorary members. It also covers AΩA's many award programs, which support a variety of chapter-based and national opportunities in service, creativity, and leadership. Other helpful sections address chapter organization, staffing, and finance.

It is worth stressing that, in many respects, there is no "correct" way to run a chapter. Every chapter must operate in accordance with AΩA's constitution, but doing so still provides considerable latitude to adapt to local challenges and capitalize on local strengths and opportunities. The councilors meeting provides an opportunity for participants to share new ideas and best practices. Many councilors commented on the many ideas they had encountered at the meeting, which they intended to share with members back home.

A perennial point of great interest among councilors are the different procedures chapters have adopted for nominating new members, which should include criteria beyond just grades and board examination scores. Chapters at schools with pass/fail grading policies often find it difficult to nominate students in their third year, which means that student members are elected as fourth years and then graduate in the same academic year. This makes it difficult to achieve the level of engagement and continuity in student leadership found in chapters that nominate third-year students, who stay on as fourth years. It is not difficult to identify the top three or four students to be nominated late in the third year, and earlier selection of a few student leaders can provide important continuity with student involvement in the chapter.

Another important point regarding new members is the fact that the organization's constitution was revised in 2012 to allow many AΩA chapters to nominate more candidates in non-student categories for membership, in proportion to the size of the size of each student class. This change was enacted without reducing the number of such candidates any chapter can nominate. Many councilors report that new members in the alumni and faculty categories often demonstrate a particularly high level of enthusiasm for AΩA, so chapters should consider taking full advantage of this opportunity.

Chapters should also take steps to ensure that their school's students, including incoming first-year students, are well-informed about AΩA's mission, history, and the nomination criteria for membership, so that students...
know how new members are selected. As previously indicated, different chapters assign different weights to such factors as scholarship, leadership, service, professionalism, and research. Though it happens infrequently, it is always a shame when a nominated student elects not to join, in part because it usually takes a spot away from another student who might be eager to do so.

Some chapters are inviting all students whose class standing makes them eligible for membership to submit brief reflective essays setting forth their understanding of AΩA’s mission and describing the ways in which they would help to advance this mission if they were to become members. This helps to prime newly elected members to hit the ground running and play an active role in the life of AΩA. It also provides additional useful information that chapters can use in determining which students to nominate for membership.

It is especially important that all chapters engage new members as active participants in the work of the organization. The probability that members will get involved seems to be highest near the time they first join. Many of AΩA’s most vibrant chapters have developed programs that give new members in all categories an opportunity to support the organization’s missions with their time, talent, and treasure. Going forward, the plan is to disseminate examples of such best practices through both the website and upcoming issues of The Pharos.

AΩA’s award programs are too numerous to detail here, but one that deserves more participation by many councilors is the Administrative Recognition Award, which provides a certificate of appreciation and a modest honorarium to the chapter staff person who assists the councilor in day-to-day operations. These administrators often contribute a great deal, and in many cases, doing so is not a part of their formal job description. The board and national office encourage councilors to nominate worthy administrators, many of whom find the recognition one of the most meaningful they have received.

Another program that merits more chapter participation is the Visiting Professorship program, which brings distinguished physicians and scientists to medical school campuses, where they address both AΩA members and broader medical school communities. One particularly appropriate occasion for such visits is each chapter’s annual induction banquet, at which visiting professors often serve as featured speakers. The national office supports each visiting professor’s travel and lodging expenses and provides an honorarium, making it a no-cost opportunity for chapters.

The induction dinner can play several important roles. Some chapters use the occasion as an opportunity to recognize faculty members who have been nominated by students as models of teaching excellence or professionalism. Many charge a sufficiently high price for paying attendees that inductees can be subsidized to attend at no charge. Others use the occasion as an opportunity for fundraising, sending out a request for donations with invitations. Some also hold silent auctions at which...
attendees can bid on items that have been produced by members or donated by local organizations.

Debbie Lancaster, managing editor of The Pharos and webmaster, reviewed the national organization’s website, which continues to improve. The website now features a Chapter Resources page with information specifically for chapter personnel.

A session at the councilors meeting led by residency initiatives coordinator Suzanne Pershing focused on keeping newly elected members engaged throughout their residency training, which often takes place at an institution different from the medical school where they were elected. An informal poll of participants revealed that at most institutions, resident members tend to have little role in chapter life. Residents can be involved in many ways, including participating in the new member nomination process, contributing to service projects, and helping to educate students about residency training in different fields.

One key in engaging resident members is determining which residents at an institution are ΑΩΑ members and then encouraging them to become involved in their local chapter’s activities. It is generally helpful to identify a resident or two who will serve as a local champion of resident engagement. The new Postgraduate Research Award program also provides another opportunity to engage residents. Of course, it is always important to query residents themselves about how they would like to become involved.

In conclusion, the 2013 councilor meeting was highly informative and energizing for those who attended, and provided participants with an opportunity to get to know one another and exchange helpful tips and perspectives. It is primarily at the level of each individual chapter that ΑΩΑ comes fully to life, and the extent to which each does so hinges in large part on the imagination and dedication of its councilor. Serving as a councilor is an effective and rewarding way to make a difference not only for ΑΩΑ but also for the profession and the suffering patients whom we strive to be worthy to serve.

Respectfully submitted,
Richard B. Gunderman, MD, PhD
Elma LeDoux, MD
Gabriel T. Virella, MD, PhD

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 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

Lesley Motheral, MD, councilor at the Texas Tech University Health Sciences Center School of Medicine, and John Brust, MD, councilor at Columbia University College of Physicians and Surgeons.

Lynn Cleary, MD, councilor at the State University of New York Upstate Medical University and councilor director on the ΑΩΑ Board of Directors, and Melvin Lopata, MD, councilor at the University of Illinois College of Medicine.
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 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. 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.
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. A listing of videos available for loan, as well as streaming videos of some of the collection, can be found here: www.alphaomegaalpha.org, or by contacting Debbie Lancaster at d.lancaster@alphaomegaalpha.org or (650) 329-0291. Those wishing to purchase copies from the National Library of Medicine 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.

Participants meet in small groups to discuss chapter participation by residents.
At its annual meeting in October 2013, the AΩA Board of Directors approved an AΩA leadership award and development program to be implemented in 2014.

Leadership has long been a core value of Alpha Omega Alpha Honor Medical Society, and is one of the criteria for membership. Unfortunately, many AΩA members with leadership potential or leadership experience at mid-level positions may find themselves without the resources to advance their careers. We believe this is a lost opportunity for medicine.

How can AΩA as an interdisciplinary honor medical society best support and contribute to leadership promotion and development as part of our mission and one of our core values—“to improve care for all by encouraging the development of leaders in academia and the community”?

The AΩA Fellow in Leadership Award will recognize and support further development of outstanding leaders exemplifying the qualities of leading from within, the society’s professional values, and the concepts of servant leadership. The five essential components of the program are: 1) Self-examination, the “inward journey,” leading from within; 2) a structured curriculum focused on topics related to leadership, including an understanding of the relationship between leadership and management; 3) mentors and mentoring; 4) experiential learning to broaden the perspective and understanding of leadership as it relates to medicine and health care; 5) team-based learning and developing communities of practice.

Mid-career physicians providing outstanding leadership in organizations in medicine and health care, including schools of medicine, academic health centers, community hospitals, clinics, agencies, or organizations, with a high promise for future success and contribution are eligible to apply. The proposed nominees must be members of AΩA.

For information about the AΩA Fellow in Leadership Award, please see our web site: http://alphaomegaalpha.org/leadership.html.
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 features 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.alphaomegaalpha.org/store. Price includes shipping and handling.