Rush vs Cobbett

Alpha Omega Alpha Honor Medical Society

Autumn 2014
THE PHAROS
OF ALPHA OMEGA ALPHA HONOR MEDICAL SOCIETY
AUTUMN 2014

“Be Worthy to Serve the Suffering”

Alpha Omega Alpha Honor Medical Society
Founded by William W. Root in 1902

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Telephone: (650) 329-0291
Fax: (650) 329-1618
E-mail: info@alphaomegaa.org
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INSIDE BACK COVER

The Robert H. Moser Pharos Editor’s Prize
Dr. Henry Kempe, author of the seminal “The Battered-Child Syndrome,” was a professor of Pediatrics and Microbiology and chairman of the Department of Pediatrics at the University of Colorado from 1956 to 1980. In 1978, he finished a hectic and busy day of work, grabbed a full suitcase and a heavy briefcase, and caught a flight to New York to receive the Aldrich Award of the American Academy of Pediatrics for contributions in the field of child development. He arrived at his hotel that evening, exhausted by the long day and travel. Shortly thereafter, he developed shortness of breath and hemoptysis. He called a colleague at NYU, who advised him to go to the ER at Bellevue Hospital; he took a cab to the emergency room and was admitted to the coronary care unit, where they fortunately had an open bed, in cardiogenic shock from an acute myocardial infarction with pulmonary edema. He was intubated and on a respirator, and had a balloon pump inserted in his aorta to assist in maintenance of his blood pressure.

With no recollection of his first two weeks in the coronary care unit, Dr. Kempe gradually awakened to pain and confusion. He continued to be very confused and sleep deprived by all that was going on in the unit, and was, in addition, fearful about his memory and reasoning losses and the delusions and frightening hallucinations he experienced. The only good thing about the unit was the nursing staff. They held his hands, bathed him, oriented him by looking him in the eye to tell him his name, his situation, and where he was and what day and time it was. The personal contact was comforting and caring. The nurses assured him that he would regain his sanity and that the “scary dreams” would resolve.

Two or more times a day his doctor and other physicians would make rounds. Dr. Kempe saw them as being like a school of sharks who would swim in, look at his chart, and watch the multiple monitors without talking to him, looking him in the face, or touching or comforting him. He watched them attentively to try to gain clues about whether he was getting better or worse: did they frown, grimace, shake their heads up or down, or yes or no? They would then swim out with his chart in hand.

One day, a few days after his balloon pump had been removed, he awoke frightened and crying. He could hear a loud pulsating sound. He was still intubated, so could not ask questions, but deduced that the balloon pump must have been reinserted indicating that he was worse. His nurse could see his disturbance. She asked, “Is the sound you’re hearing disturbing you?” She looked at him, held his hand, and said, “That is the wrecking ball knocking down the rest of the old Bellevue Hospital. You didn’t hear the noise on Saturday and Sunday, but you did hear it on Friday when your aortic balloon came out. That was a bad time. You remember not only how painful that was, but you also remember how the balloon sounded inside you during those rough days. I bet you are remembering that pain.” With her care and thoughtful reasoning about why he was suffering, and with her explanation, his distress disappeared. He gradually had fewer flashbacks—when he did the nurses would comfort and care for him. The nurses continued to support him with the intuition to understand his responses and distress to almost any change and to provide the needed care.

Editorial
The care of the patient
Richard L. Byyny, MD
care and support. In due time he was discharged and returned to work as a doctor, scholar, and teacher.

Dr. Kempe told this story to our General Internal Medicine Residency fellows while I was residency director, but found it too difficult and disturbing to relate it more than once. The Pharos published his article about the experience in the Winter 1979 issue (“Nursing in a coronary care unit: A doctor-patient’s view, pp. 18-19”), in which he included a footnote about the thirty-six physicians and surgeons involved in his care and his gratitude to them. No doubt many of the decisions made by the physicians were important in his successful outcome for which he was appropriately thankful and appreciative, but I am pretty certain that none of them were aware of his perception of their inability to understand his suffering and care for him. What he described was his need—as the patient—for caring by physicians.

Dr. Francis W. Peabody wrote in 1927 that “one of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is caring for the patient.” For me, the doctor-patient relationship and the care of the patient in the office or hospital represent the best in medicine. Serving as a physician has continued to be rewarding professionally and personally gratifying. It has remained true that successfully and effectively caring for patients is more than the application of science and technology. Caring for the patient is much more than treating a disease, illness, or injury. It includes—as AΩA’s motto proclaims—that we “Be worthy to serve the suffering.” Caring for patients may be primarily related to a disease in some patients and using specific and effective treatment may relieve most of the suffering, but many times there isn’t an effective, certain, or rapid intervention for the patient. Even when we are uncertain about the diagnosis or effectiveness of our treatment, caring for the patient and the relief of suffering is paramount.

Many changes in society and medicine have made it more difficult to care for and serve the suffering. Dr. Joe Marr described many of them in his article, “Fall from Grace,” in the Winter 2014 issue of The Pharos. These include: the rising cost of care; fee for service care; reliance on technology as a substitute for clinical judgment; organizational interference in the physician-patient relationship; the focus on patient visits per unit time rather than the care of patients and outcomes; the concept of profit and loss centers in medicine; billing and collection terminology; overuse and underuse of technology; development of cumbersome bureaucracies; for-profit hospitals; for-profit insurance companies with a focus on quarterly earnings; the use of non-physician employees to determine patient eligibility for care; the use of claims adjusters; the businesses and companies that set the rules of care; the use of euphemisms in medicine, in which a doctor becomes a “health care provider” providing “services” to a “customer,” “stakeholder”—anything but a patient; coding of conditions so that GERD is code 530.81; and others. George Carlin in one of his routines said, “When I was a little kid, if I got sick they wanted me to go to the hospital and see the doctor. Now they want me to go to a health maintenance organization or a wellness center to consult a healthcare delivery professional.”

Medicine is now often perceived as a business rather than as a profession. Profit, business practices, business principles, and business strategies, rather than the care of patients, too often determine the care or lack of care for people. Sir William Osler’s maxim, “The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head,” is being lost.

I gave a lecture a few years ago to community physicians who were mostly in their 50s and 60s. Over dinner most of the conversations and discussions were about how practicing medicine and caring for patients had become more difficult and less satisfying professionally. Across from me was a younger woman who was not participating in the discussion. I leaned forward to engage her in the conversation and asked, “What do think about our conversation and the practice of medicine”? Her response was, “I don’t remember the good old days. I cherish my time caring for my patients and they seem to appreciate and benefit from my care and my team’s thoughtful caring. I have learned to fill out the required forms, make the necessary calls, and deal with the nonmedical management required.” Shortly thereafter, I spoke with a retiring physician executive from the Mayo Clinic, who acknowledged that managing a large hospital and clinic was no longer fun nor particularly professionally rewarding, but he noted that there were exceptional younger physicians capable of enthusiastically and competently leading and managing the care of the patients. One’s past experiences and context are important to our perception of medicine and our professional satisfaction with medicine.

Despite the developing elements in the care of patients, how we care for patients continues to be our most important professional responsibility. The care of the patient continues to be based on what the patient needs and what is most important for the patient and his or her illness and suffering. The qualities that a physician needs to do this job are many, but foremost is being present and engaged with the patient. Think about it. The doctor-patient relationship is at the foundation of our medical profession.

E-mail Dr. Byyny at r.byyny@alphaomegaalpha.org
David Seegal

Ic ne wat and other maxims of a master teacher
1921 graduate of Harvard College, David Seegal began his professional career as a physical anthropologist at Columbia before matriculating in Harvard Medical School’s class of 1928 (ΑΩΑ, Harvard Medical School, 1927). Returning to the new Columbia-Presbyterian Medical Center as a medical intern, he rose to be a professor of Medicine in 1951. In 1964 he became emeritus.

Seegal believed that first-rate clinical research began at the bedside and he helped elucidate the role of beta-streptococcal infection in the genesis of glomerulonephritis. In 1935, he was named director of the first service devoted to research and treatment of chronic diseases at Goldwater Memorial Hospital on Welfare Island, a joint project of Columbia Presbyterian Hospital, the Rockefeller Foundation, and the City of New York. Some have called it a precursor of today’s clinical research units and even, in part, of the NIH itself.

Seegal and his wife Beatrice were major contributors to Alpha Omega Alpha through their endowment of the Leaders in American Medicine series, a priceless trove of interviews with respected men and women physicians (a list of the interviews follows the article). The interviews can be accessed through the AΩΑ website (http://alphaomegaalpha.org/leaders.html). To encourage AΩΑ members to sample them, the late Dr. Oliver Owen (ΑΩΑ, University of Colorado, 1961) summarized six interviews in previous issues of The Pharos.3–8

Seegal was a prolific writer whose hundreds of contributions to the medical literature included the classic Pharos article “Never a Dull Day for the Compleat Physician”9 and haiku, an art form he came to late in life.10

Yet, the accomplishment for which he is best remembered by more than one thousand students at the Columbia University College of Physicians and Surgeons (P&S) is the mark he left on us during a two-month subinternship at Goldwater. He personified Henry Adams’s famous epigram, “A teacher affects eternity; he can never tell where his influence stops.”11 Why does David Seegal still live on in so many of us? Probably because, along with conveying a sense of the great privilege and responsibility we would assume on becoming doctors, he dispensed a philosophy of life as well. I still remember our first encounter as we began our Goldwater rotation. We milled around in the solarium until he called us to order, asking us to take our seats and face forward. Did we notice anything that seemed out of place in a medical school classroom, he asked? When no one spoke up, he pointed out the statue of a baseball player and other things that were seemingly out of place. In so doing, he was highlighting the importance of observation that he would reinforce on rounds, noting what was on the patient’s bedside table like a family picture that could help us connect with the patient or provide some clue to who the patient was.

Seegal’s first teaching session would invariably involve his writing Ic ne wat on the blackboard and asking us what it meant.12 When no one responded, he would say it meant “I don’t know” in Old English, a springboard to his most famous admonition: know your limitations. He worried that when we put on the long white coat signaling the achievement of doctor status we would be reluctant to utter that phrase. He’d say that if we didn’t say “I don’t know” at least ten to twenty times a day, even as experienced doctors, we would not be true to our patients or ourselves.12 He then said that we couldn’t just stop there. It was just as important that we then “want to know,” followed by “look it up,” triggering the CML cerebro-mano-libro reflex or brain-to-hand-to-notebook-to-textbook.13 Today, one might substitute a trusted computer site for the textbook.

Another Seegal maxim was “Do it now.”2 Despite good intentions, important things might be put off with unfortunate consequences. He labeled procrastination the enemy of the conscientious clinician. Or take another maxim that hit home with me: “Be on time.”2 He said being late showed a disrespect for the patient and colleagues, implying that their time was not as important as our own. Still, he used to tell us that we should always, when correcting someone, allow them a way to escape to safety. In my case, he pointed out that I was an optimist, always thinking I could do more than I thought in the time allotted. When I slipped into my “late Dr. Dans” habit, his words came back to me. Other admonitions in his Decalogue included “Know your patients,” “Maintain an open mind,” and “Check and recheck” when presented with conflicting data.
Noting that the term doctor comes from the Latin root docere, “to teach,” Seegal impressed on us that being effective clinicians depended on our being effective teachers. He told us that if we looked patients in the eyes while instructing them, we could discern whether they would follow the plan, and could respond accordingly. Being a good teacher also extended to our peers and colleagues in whom, he said, we should strive to “Bring out the best.” Finally, he urged us to “Practice the Golden Rule” in helping our patients make difficult decisions, what he termed, “close calls.”

Okay, you say, isn’t this just plain old common sense? Of course it is, but, sadly, as Voltaire said, “Common sense is not so common.” Seegal anticipated and risked that reaction from students who were not all that different from those of today. One of his former students, Quentin Deming, said, “There aren’t many people who can drill students in truisms and get away with it. Seegal could.” I have found that most of today’s students hunger for evidence that their teachers not only preach the values Seegal espoused, but, more importantly, live them.

Take the necessity to say “I don’t know.” The students in my junior/senior seminars agree with this admonition; after all, they are in school to learn, and one learns best after admitting ignorance or error. In my study of anonymous self-reporting of cheating and lying, thirteen to twenty-four percent of four classes reported cheating in the clinical years. This probably was an underestimate—as one student said, admitting you cheated is the hardest thing to do. This included recording tasks not performed, making up values when they were “sure that the data were normal” and saying they saw the fundi and heard a murmur when others did but they didn’t. One woman admitted making up exact values after being reprimanded by her resident for saying “I don’t know” on professor’s rounds because he said that it reflected on him. Another reported being told by a resident that she would come off better if she “lied a little.” Others feared that saying “I don’t know” would put them at risk of being graded down and losing the opportunity for that hoped-for residency.

Students also commented on behaviors such as “gunning” (referring to hard-charging students who try to show up their peers), clearly contrary to Seegal’s admonition to create a milieu that “brings out the best in our colleagues.” They called attention to one clinical service that had a number of “toxic residents” who were insensitive to patients, laughed at them, or repeatedly used pejorative terms in referring to them. I have been interested in this phenomenon since writing “Dirtball” in 1982 (using a pseudonym so as not to call attention to Hopkins for what was probably a universal practice). Indeed, it struck such a responsive chord that six months later JAMA reprinted a sample of the many letters they received, including one—ironically—from an ex-Hopkins Osler house officer. Having canvassed four Hopkins graduating classes on the subject as recently as 1996, the good news is that the practice appears to have declined, but the bad news is that it is still prevalent. But the idea isn’t to get self-righteous about it, as one faculty member did in telling me...
that “they wouldn’t dare do that in my presence.” Rather, the trick is to try to understand why it happens and to conduct much of the discussion of the patient, as Seegal advised, not in the conference room, but at the bedside or in the clinic, to model the handling of even the most difficult patients and sensitive data with prudence and tact. It is admittedly harder to do in our fast-paced, bottom-line-oriented environment, where interactions between doctors and patients are often fleeting—but that’s the challenge. As Seegal would say, we “are the ones with the high IQs,” and if we fail to meet that challenge (paraphrasing Shakespeare in Julius Caesar), the fault lies in ourselves and not in our stars.

The timeliness of Seegal’s message is underscored by the fact that most diseases today are chronic, something that Seegal anticipated when he joined forces with Joseph Earle Moore, Hopkins’s renowned syphilitologist, to begin the Journal of Chronic Diseases in 1955, a publication that flourished before the era of specialties and subspecialties. Just as in an earlier time, many patients are desperately seeking compassionate care and relief of suffering. Seegal was fond of quoting Longcope that the patient should be better off for the physician’s visit irrespective of the seriousness of the illness, else why do it (his emphasis). He warned against projecting a dour mien, calling “cheerfulness” the “intangible elixir in the doctor’s bag.” Seegal endured a twelve-year bout with polymyositis that ultimately claimed his life, so he knew whereof he spoke.

Seegal also had excellent advice for treating our increasingly elderly population using what he called the “principle of minimal interference.” He cautioned us to be wary of causing iatrogenic disease through a well-meaning activism and polypharmacy, a problem that if anything is greater today with more medicines being given to patients by more doctors whose care is not coordinated. Still, he was no therapeutic nihilist. He just as forcefully warned against “pigeonholing” the elderly and chronically ill by ignoring the cues and clues that could possibly indicate something different and treatable.

Finally, we hear a lot about the importance of lifestyle as students seek a sense of balance between their professional and personal lives. Seegal had much to say on this. Happily married to Beatrice Carrier Seegal, a distinguished professor of microbiology at P&S, he cared about his students’ personal lives. He enjoyed meeting our parents and significant others. He once wrote me to say he had given me “the highest marks” before he died. He clearly was a shadow of his former self, but unlike what he wrote in the haiku, he wanted to teach until the very end. One might say that he died with his boots on.

Patient care and medical education have changed so much since David Seegal’s time, I would be interested in hearing from those on today’s front lines as to whether his maxims still apply—PED.

References

Alvin Barach captured him best in the title of his obituary: “David Seegal, the magnanimous.” Seegal indeed had a great soul. It is a pleasure to introduce David Seegal to a new generation of readers. To learn more about him, I recommend the David Seegal tape made in 1975, in which his colleagues and former students Walsh McDermott, Arthur Wertheim, Quentin Deming, and John Loeb give their recollections, intercut with clips from The Making of a Clinician tape of Seegal teaching a group of students at his apartment shortly before he died (http://alphaomegaalpha.org/pdfs/Leaders/SeegalDE.mp4 and http://alphaomegaalpha.org/pdfs/Leaders/MakingClinician.mp4). He clearly was a shadow of his former self, but unlike what he wrote in the haiku, he wanted to teach until the very end. One might say that he died with his boots on.

Skidoo
Emeritus
Quit making a fuss
You’ve had your day
To shape man’s way
Hand others clay
Banish dismay
Go ‘way and play.

The Pharos/Autumn 2014

The author’s address is:
11 Hickory Hill Road
Cockeysville, Maryland 21030
E-mail: pdans@verizon.net

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Interview with comments of four
of Dr. Seegal's former students,
and material taped shortly before
his death
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The emergence of statistics within the field of medicine is commonly traced to the French physician Pierre Charles Alexandre Louis, who, beginning in the 1820s, applied a “numerical method” to determine whether bloodletting effectively treated infections and fevers. A surprising predecessor to Louis was William Cobbett, a rabble-rousing British journalist in post-Revolutionary America. Cobbett’s literary foil and adversary was none other than the famous Philadelphia physician and patriot, Benjamin Rush, who inadvertently became the focus of one of the earliest applications of biostatistics in the history of medicine.

During the 1793 Philadelphia yellow fever epidemic, Rush made liberal and publicly-touted use of bloodletting, which Cobbett argued was both dangerous and did not reduce the death rate. After losing a libel suit to Rush, Cobbett defended himself with a novel weapon—data—and unwittingly opened the door to the modern concept of public health epidemiology. Despite having the numbers and facts on his side, Cobbett’s legacy is largely relegated to a historical footnote, whereas Rush’s continued support of bloodletting likely contributed to many preventable deaths well into the nineteenth century. The story is further enriched by its historical setting and political climate, challenging freedom of the press while the ink on the Bill of Rights was still moist.
The protagonists

Dr. Benjamin Rush remains one of the best known American physicians of his time. The son of a local gunsmith, Rush signed the Declaration of Independence and later served as Chief Physician of the Revolutionary Army, and enjoyed international acclaim and esteem as a physician and educator. After graduating from the College of New Jersey (now Princeton University), Rush apprenticed with a local physician before graduating from medical school in 1768 with the financial assistance of Benjamin Franklin. According to one student, Rush had a “voice, sweeter than a flute, [that] fell on [one’s] ears like droppings from a sanctuary . . . with his earnest, most sincere, most persuasive accents, sunk so deep into my heart that neither time nor change could eradicate.” Rush was reform-minded, petitioning for the abolition of slavery, education of women, and improvement of prisons. He was also a prolific writer who authored the first essay in American history advocating for an entirely public school system, and boasted about writing the first article promoting George Washington for president. He gained further notoriety when disease invaded Philadelphia.

In 1793, a virulent yellow fever epidemic wreaked havoc on Philadelphia, killing up to one-tenth of the city’s population. A disease with a variable clinical course and no definitive treatment even today, physicians at the time were nearly helpless. The etiology, a mosquito-borne virus, along with effective prevention strategies, would not be discovered for over a century. In the absence of scientific evidence, public health debates became intertwined with politics—“contagionists” believed yellow fever was a communicable disease and generally sided with the Federalists such as John Adams and Alexander Hamilton, while “anti-contagionists,” on the other hand, favored environmental etiologies and tended to be Jeffersonian Republicans.

Rush combated the yellow fever epidemic with his characteristic fervor, converting his home into a hospital and seeing over a hundred patients daily. The idea for aggressive bloodletting, the crux of his treatment, was based on a medical publication from the 1740s given to him by none other than his patron, Benjamin Franklin. By trial and error, Rush settled on
a treatment regimen involving “depletion theory,” consisting of aggressive bleeding coupled with a mercury-based purgative.\textsuperscript{7} Convinced of its effectiveness, he publicized his treatment in newspapers and in impassioned pleas to medical colleagues, and intensely criticized physicians who spoke out against his ideas. The professional debate was relayed in communications between Henry Knox, Secretary of War, to President Washington: “The different opinions of treatment incite great inquietude... But Rush bears down all before him.”\textsuperscript{7}

As both mercury-based purgatives and bloodletting were very much a component of standard medical practice, it was these therapies’ applicability to yellow fever, the concordant use of aggressive emetics, and the sheer volume of blood removed that set Rush apart from his peers.\textsuperscript{8} A partial explanation for the aggressiveness of Rush’s regimen involves his gross miscalculation of the normal adult human blood volume, which he projected at twice the correct figure.\textsuperscript{6}

Empiric study would eventually bring into question the practice of routine bloodletting. To Rush’s credit, however, he did make substantive advances in the realm of public health with respect to yellow fever. His assertion that the disease was not transmitted among humans and his willingness to remain with the infirm served as a powerful example of medical professionalism; moreover, while the insect vector would not be identified until the twentieth century, his efforts to improve hygiene have been lauded.\textsuperscript{9} Rush urged the mayor of the city to establish hospitals for management of the indigent.\textsuperscript{7} His memoir of the epidemic provided a personal and riveting account of the illness and its effect upon the population.\textsuperscript{10} In addition, his sheer determination and work ethic throughout the epidemic of 1793 were highly praised.\textsuperscript{11}

Even though there were few satisfactory alternatives to Rush’s practice of bloodletting to treat yellow fever, some contend that Rush managed to “severely retard medical progress for almost fifty years after his death.”\textsuperscript{4} Elisha Barlett, a renowned physician himself, offered less than generous appraisals of Rush’s contributions to the field: “In the whole vast compass of medical literature, there cannot be found an equal number of pages containing a greater amount of utter nonsense and unqualified absurdities.”\textsuperscript{12} In fact, Rush applied his anecdotal experiences with bleeding as a panacea for yellow fever widely, espousing the theory that all significant illnesses resulted from increased vascular tension that could be resolved with aggressive bloodletting.\textsuperscript{10} This fallacy, popularized by his spirited rhetoric and prolific writings espousing the dangerous practice, spread significantly throughout the global medical community, and was applied by his trainees along the eastern seaboard as late as the 1840s.\textsuperscript{10}

William Cobbett, a British ex-marine and journalist residing in Philadelphia, was an unlikely opponent. Cobbett had received little formal education, but taught himself grammar and literature.\textsuperscript{13} After the American Revolution, Cobbett settled in Philadelphia and assumed the pseudonym Peter Porcupine, writing the popular Porcupine’s Gazette. A loyal Briton active in American politics, Cobbett bitterly opposed the Republicans, lending grudging support to Alexander Hamilton and the Federalists.\textsuperscript{14} Cobbett’s writings were popular as both entertainment and a source of news. Abigail Adams appreciated his
work, commenting that Cobbett’s “shafts are always tipt with wit, and his humor is such as frequently to excite more of good than ill.” Meanwhile, George Washington also offered guarded praise, despite his concern that the works contained “strong and coarse expressions” and “a want of official information on many facts.”

Cobbett ultimately chose Benjamin Rush as his main target. While not the first to criticize Rush (Knox, Hamilton, and others had already done so), Cobbett may have been the most acerbic. In Cobbett’s words, Rush “seized, with uncommon alacrity and address, the occasion presented by the Yellow Fever, the fearful ravages of which were peculiarly calculated to dispose the minds of the panic-struck people to the tolerance, and even to the admiration, of experiments, which, at any other time, they would have rejected with disdain.”

As Rush continued to espouse his techniques of bloodletting during further yellow fever outbreaks in the late 1790s, Cobbett mounted a systematic counterattack. Adding both credence and support to his arguments, Cobbett was joined by other physicians who were also troubled by Rush’s aggressive treatment regimen. The political climate of the time was dominated by vitriolic rhetoric, and Cobbett established a strong track record of ferociously attacking the Republicans and defending the Federalist political agenda.

In fact, the debate over the appropriate treatment of yellow fever was also tied to political affiliations, with the Republicans (including Rush and Thomas Jefferson) bitterly opposed by the Federalists (including Hamilton), despite a widely varying (and frequently minimal) degree of medical experience on both sides. Rush himself was not above mixing medical debate with political barbs, sardonically noting that “Hamilton’s remedies are now as unpopular in our city as his funding system is in Virginia or North Carolina.”

Branding Rush “The Bleeding Physician of Philadelphia,” Cobbett’s attacks were biting, popular, and downright entertaining, selling thousands of pamphlets to an eager public. Rush was known to refer to mercury as the “Samson” of medicine. In one of his many barbs, Cobbett continued the Biblical metaphor: “The Israelite slew his thousands, but the Rushites have slain their tens of thousands,” followed by “The times are ominous indeed./When quack to quack cries, Purge and bleed!”

In another broadside, Rush was given unholy company: “a mosquito, a horse-leech, a ferret, a pole cat, a weasel: for these are all bleeders and understand their business full as well as Doctor Rush does his.”

The pamphlets were influential. In a personal letter in which he disclosed his intent to file a legal suit, Rush admitted that “Their design proved successful. They lessened my business, and they abstracted so much of the confidence of my patients as to render my practice extremely difficult and disagreeable among them. To put a stop to their injurious effects upon my business and the lives of my patients, I commenced civil action.”

While the case awaited trial, Rush instructed local newspapers to refrain from publishing further inflammatory quotes by Cobbett, while he persisted in employing this medium in defense of his practice.

The stage was set for battle.

The libel suit

The case did not come to trial for over two years. Some contend that the delay was due to the plaintiff awaiting a more sympathetic jury. Ultimately, Cobbett was forced to defend his statements before Pennsylvania Chief Justice Thomas McKean—the very judge whom he had dubbed a “corrupt, hen-pecked alcoholic.” To add insult to injury, Cobbett asserted, in a pamphlet dedicated solely to McKean’s immorality, that “he beats his wife, and his wife beats him.”

In their opening statements, the lawyers for the two men traded blood-tinged metaphors. Mr. Hopkinson, counsel for the plaintiff, noted that “Dr. Rush is as well known for his peaceful habits and his amiable manners, as William Cobbett is for his disocial malignant disposition and inveterate hate.”

He characterized the libel against Rush as “of the most deadly and violent kind that malice could invent, or abandoned depravity execute—He is accused of murder, or destroying the lives
of his fellow citizens, in a time of dreadful calamity." Hopkinson went on to note the capriciousness of a physician's reputation, which he called "a fabric delicate as air, the slightest gust of popular prejudice or caprice dissipates it, even suspicion destroys it; if he is distrusted he is ruined." Mr. Harper, another attorney for Rush, argued that Cobbett's attack was malicious, and not simply based upon a disagreement with his medical theory. He even encouraged the jury to return a verdict for Cobbett if they believed that his writings were only intended to attack Rush's controversial medical practice, contending that Cobbett was also bent on destroying Rush as an individual.

Rush's attorneys based their case on Cobbett's writings, coupled with the testimony of three individuals who claimed that Cobbett had a personal vendetta against Rush. Meanwhile, Cobbett's representatives admitted that all of the submitted evidence attributed to their client was indeed written or endorsed by Cobbett himself, and did not dispute the facts of the case. They contested the charges mostly by arguing that there was no personal malice behind any of his writings, and that they simply reflected his low opinion of Rush's medical skills, as supported by other physicians. They argued that "A good, skilful, laborious, honest physician, is a very valuable member of society. But, on the contrary, an unskilful, avaricious, indolent physician deserves, not only public disapprobation, but, public contempt." Neither plaintiff nor defendant used medical, scientific, or epidemiologic facts in their legal strategy.

The case was ultimately heard by Judge Shippen, a close friend and colleague of Judge McKean. Judge Shippen essentially told the jury that the judgment should be in Rush's favor, given both the nature of the comments as well as the defendant's lack of evidence supporting the veracity of Cobbett's statements. The court went so far as to suggest that the monetary award against Cobbett should be substantial.

Pennsylvania's defamation law at the time was less favorable to Cobbett than it would be today, as the state's common law placed the burden of proof on the defendant. In addition, eighteenth-century medical debates and arguments among doctors frequently stayed into the lay press, particularly concerning the diagnosis and management of virulent, untreatable epidemics with massive social and economic implications.

After a two-hour deliberation, the case was decided in favor of Rush in the amount of $5000, one of the largest libel awards in American history at the time. In a classic example of historical irony, the verdict arrived on December 14, 1799, the same day President Washington lay on his deathbed, being bled dry by a colleague and pupil of Rush's, as was then the customary practice.

The aftermath

Despite the favorable outcome for Rush, the publicity ruined his medical practice. His connections proved useful, however—he was subsequently named treasurer of the United States Mint by President John Adams. Cobbett estimated that his total losses, including the settlement, legal fees, property loss, and loss of printed works, totaled $6,000. Cobbett's general opinion on the case was, naturally, contemptuous: "Of all the acts of which a man can be guilty, none is so mean, none is so base, none is so truly detestable, as that of seeking, through the law, vengeance for a literary defeat." Cobbett did not abate his criticism of Rush, retorting that "nothing provokes me but the thought of such a whining republican rascal putting 5,000 dollars in his pocket."

In the months after a ruling was rendered against him, Cobbett published a series of new pamphlets called the Rush-Light, in which he defended his actions and further denounced his adversary. He explained that "When I determined to discontinue the publication of Porcupine's Gazette, I intended to remain, for the future, if not an unconcerned, at least, a silent spectator of public transactions and political events; but, the unexpected and sweeping result of a lawsuit, since decided against me, has induced me to abandon my lounging intention." Cobbett's arguments were reasoned and structured, much more so than his attorneys' performance at trial. Among other tactics, he used one of the more obvious, questioning the impartiality of both the judge and jury.

Cobbett told the story of Dr. Glentworth, a friend and colleague of Rush, who contracted yellow fever and sought care under Rush in 1793.

Dr. Glentworth told me, besides (and he will tell the same to any one), that Rush attended him in the yellow fever of 1793; that he bled him till he was extremely weak, and ordered several other bleedings which Glentworth's knowledge made him omit, without, however, telling Rush of the omission; that he came one day, and finding his patient sitting up in the bed, ran to him, squeezed him by the hand, called his "dear Glentworth," and congratulated him on the salutary effects of his bleeding system; "but," said he, "my dear friend, you must lose a little. MORE BLOOD."—"Lose more blood," replied Glentworth, "when I am so faint I can hardly support myself."—Upon this, Rush started from the bed-side, caught up his hat, called his "dear friend" an assassin, told him he was leagued with [one of his critics] to ruin his reputation, and ran down the stairs bawling out: "you're a dead man! you're a dead man! you'll be buried. . . . before to-morrow night!"

Cobbett also criticized Rush for exclusively consulting his friends and other doctors supporting his treatments. "If the opinions of all physicians were settled, and were all the same, there could be no use in calling a consultation." Rush in fact denounced even the physicians who agreed with the tenets of his regimen, but whom he perceived overly conservative with the quantity of blood removed.

In an open letter to Elisha Dick, the Rush disciple who cared for George Washington on his deathbed, Cobbett implicated Rush as partially responsible for the former president's fate: "poor Fate had much less to do in the business than you and your colleagues. . . . P.S. Don't you think it would be a good thing, Doctor, if the names and places of abode of all Rush's pupils were published? If you don't, I do." Disillusioned with America, Cobbett set sail for England, where he noted that "neither the moths of Democracy nor
the rust of Federalism doth corrupt, and where thieves do not with impunity break through and steal five thousand dollars at a time.” In an autobiography written near the end of his life, he was even blunter: “That I was most unjustly and basely treated in the American States, and by two of the Governments of that country, is a fact pretty well known... I hate the United States and all their mean and hypocritical system of rule.” Despite the bitterness, Cobbett had the last laugh—the publicity surrounding the case and the popularity of the *Rush-Light* yielded a significant profit in pamphlet sales, and some estimate that Cobbett pocketed $10,000 in revenue prior to returning to London.

**Biostatistics: A fine legacy**

Lest we forget what is arguably the most important result of the Rush-Cobbett saga, let us turn to the numbers. In the February 28, 1800, edition of the *Rush-Light*, Cobbett used municipal records to prove that Rush's interventions did not decrease the death rate from yellow fever. He presented data on mortalities during the 1793 yellow fever epidemic; there was an average of sixty-seven deaths daily for the month following Rush's implementation and advertisement of his treatment, much higher than the prior month. Rush claimed that his treatments were successful by referencing surviving patients, to which Cobbett argued that proof that “everyone he touched did not die” was not a valid defense of medical practice. Rush published a list of twenty-two surviving patients who were bled greater than fifty ounces, which Cobbett cited as proof of his awful results, since Rush treated and bled many more—up to one hundred individuals daily during the epidemic. Moreover, Rush claimed a greater than ninety percent survival rate, whereas the data of a doctor with whom he worked suggested that Rush had a fifty-six percent mortality rate during the yellow fever epidemic in 1793. Unfortunately, the incomplete historical record precludes a retrospective attempt to apply modern comparative statistics to prove the lack of efficacy (and direct harm) that bloodletting afforded, but in a sense, the numbers that Cobbett himself assembled truly speak for themselves.

Although Cobbett's failure to use biostatistics in his defense at trial may seem to be an oversight from our modern perspective, his use of data in his later writings was ahead of his time. Francis Bacon had first developed the basis of the scientific method nearly two centuries earlier, but empiric study of science and medicine were slow to emerge thereafter. Pierre Charles Alexandre Louis's use of the "numerical method" to disprove the efficacy of bloodletting for pneumonia was published in the 1820s, and was groundbreaking at the time. Medical statistics as a discipline would not emerge until the 1830s, and only basic attempts at quantifying survivorship and death (mostly with regard to smallpox) had been made throughout the eighteenth century in Europe. A legal historian commented that "Cobbett's statistical research was an epidemiological tour de force that would have done a modern scholar proud.”

In the words of historian L. H. Butterfield, "Cobbett the layman must be credited with a suggestion of scientific importance that never seems to have occurred to Rush the physician. . . . It was easily demonstrable that the more the bleeders bled, the more the victims died.” Even President Adams, who named Rush treasurer of the U.S. Mint, retorted that Rush was “too much of a Talker to be a deep Thinker.” A historical review of Rush's career and reputation concluded that he had a “clever but not really a critical mind.” Jacqueylin Miller contends that Rush's impasioned treatment of yellow fever can be considered an anachronism of his unyielding political and social stances.

**Lessons for today**

Whether involving Federalists, Jeffersonian Republicans, or members of Congress in the twenty-first century, vitriolic attacks solely based upon political affiliations have the potential to distort issues, prevent healthy discourse, and deadlock progress. Such displays of unyielding devotion to dogma revealed the inherent arrogance of our protagonists, which, in hindsight, benefited neither them nor their contemporaries. Yet while clearly fallible, both Cobbett and Rush were consummate professionals. Cobbett wielded his pen to expose perceived injustices in the true spirit of journalistic freedom. Rush, for all of his flaws, never once abandoned his patients, and even his enemies recognized the zeal and passion with which he attempted, often in vain, to help and to heal.

Cobbett's nascent application of medical epidemiology heralded a revolution in which biostatistics framed the relative value of all medical interventions. It would certainly be a stretch to consider Cobbett the father of evidence-based medicine, but his precocious line of logic heralded a paradigm shift that would evolve in the coming century. The saga of Cobbett and Rush reminds doctors, journalists, and politicians alike of their legal, moral, and professional responsibilities, none of which are any less important today than they were at the birth of our nation.

**Acknowledgments**

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Bleeding by the numbers


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Address correspondence to:
Andrew G. Shuman, MD
University of Michigan Health System
1904 Taubman Center
1500 E. Medical Center Drive
Ann Arbor, Michigan 48109
E-mail: shumana@med.umich.edu
Perceptions of Ear Disorders

Tinnitus
Dying street lamps hiss endlessly. In shrill moonlight
the plum tree withers

Hearing Loss
bronze bell on new snow
its leash pulls only silence
isolation grows

Vertigo
autumn fallen leaf
whirls in rushing mountain stream
memories of wind

When Doctors Disagree
A plum blossom floats
lost in Osaka River
seeking one true voice

Hearing
lightning bugs flitter
winking paths evanescent
Be still and listen

Certainty
torn leaves of Basho
windy rags and skeletons
certainties of youth

Aging
winter's silent days
isolate the deaf old man
silent in his den

Thomas Balkany, MD, FACS, FAAP

Dr. Balkany (AΩA, University of Miami, 1972)
is the Hotchkiss Endowment Professor and
Chairman Emeritus, Professor of Otolaryngology,
Neurological Surgery and Pediatrics at the
University of Miami Miller School of Medicine.
His address: University of Miami Miller School of
Medicine, Department of Otolaryngology, 358
N. Ocean Boulevard, Delray Beach, Florida 33483.
E-mail: tbalkany@miami.edu.
Illustration by Jim McGuinness.
Drawing depicting Generals Robert E. Lee and Stonewall Jackson.
How postoperative respiratory distress conspired with friendly fire to kill “Stonewall” Jackson

Joseph J. DuBose, MD, James I. Robertson, Jr., PhD, and Philip A. Mackowiak, MD

Dr. DuBose is clinical assistant professor of Surgery at the R. Adams Cowley Shock Trauma Center and the University of Maryland School of Medicine. Dr. Robertson is the Alumni Distinguished Professor Emeritus at Virginia Polytechnic Institute and State University in Blacksburg, Virginia. Dr. Mackowiak (ÅΩÅ, University of Maryland, 1992) is the Carolyn Frenkil and Selvin Passen History of Medicine Scholar-in-Residence at the University of Maryland.

Before Stonewall Jackson was fatally wounded by his own men at Chancellorsville on May 2, 1863, he fought twenty battles for the Confederacy in which he earned a reputation as one of America’s preeminent military commanders. No less an authority than British General-in-Chief Lord Frederick Roberts stated, “In my opinion, Stonewall Jackson was one of the greatest natural military geniuses the world ever saw. I will go even further than that—as a campaigner in the field, he never had a superior. In some respects I doubt whether he ever had an equal.”

While Jackson lived, the Confederate States believed they might prevail in their desperate pursuit of a lost cause. Only after his light flickered and then went dark did they begin to suspect that God would let them be defeated. His death was all the more mysterious and demoralizing because Jackson at first seemed to recover from his wounds. Why he then faltered and died has been a source of controversy for a century and a half.

Case summary

Thomas J. “Stonewall” Jackson was raised by a series of relatives after losing his alcoholic father to typhoid fever when he was two and his mother to pulmonary trouble (presumed tuberculosis) when he was seven. An older sister also died of typhoid fever at age six and an older brother of tuberculosis at age twenty. A younger sister survived him to age eighty-five, as well as a half brother, to age unknown.

Jackson suffered with chronic dyspepsia most of his life, which he treated with an ascetic diet heavy in fruit. On reaching manhood, he became convinced that all of his organs malfunctioned intermittently to the detriment of his vision, hearing, throat, digestion, liver, kidneys, blood, circulation, nervous system, muscles, and joints. To counteract these perceived disabilities, he dosed himself with a variety of medicines and compresses. He inhaled glycerin, silver nitrate, and the smoke of burning mullein. He also ingested a number of ammonia preparations. For a time, he imagined that one side was wasting away and sought to remedy the asymmetry by
exercising the withered arm and leg with pumping motions each morning. To some of his acquaintances these complaints amplified a wonderful eccentricity. To others they were symptomatic of an underlying insanity.

Not all of Jackson’s physical complaints were imagined. When he was seventeen, he had a brief episode of paralysis of unknown etiology. He had attacks of uveitis in his twenties, otitis media in his mid-thirties that left him deaf in his right ear, and an attack of “bilious fever” at age thirty-six, for which he took the water cure. War seemed to agree with his health. However, while campaigning the year before he died, he suffered briefly with fever and exhaustion, was battered and bruised as a result of a fall from his horse, and had a recurrence of his earache.

Jackson was thirty-nine when struck simultaneously by three .69 caliber bullets fired by his own men. One entered his left arm three inches below the shoulder, splintering the bone and tendons of the upper arm before exiting. Another entered the left forearm an inch below the elbow, ripped through the lower arm, and exited on the opposite side just above the wrist. The third passed through the right palm, fractured two fingers and lodged just under the skin of the back of the hand. He was hit in the head by a tree branch when his horse bolted, knocking off his cap, lacerating his face and nearly unseating him. Somehow he managed to catch the reins and bring the horse under control.

On initial examination, Jackson’s left arm was markedly swollen but not bleeding. A handkerchief was tied around the upper wound and the arm placed in a crude sling. Jackson’s legs were rubbery and his thinking foggy, so soldiers gingerly placed him on a canvas stretcher, raised it to their shoulders, and hurried to escape oncoming enemy fire. During the retreat, the man supporting the left front corner of the litter was shot and fell, pitching Jackson to the ground—in all probability on his left shoulder. When a replacement for the injured bearer was found, Jackson was again placed on the litter, only to be dropped a second time on his shattered arm when one of the bearers entangled his foot in a vine and fell. By this time there was heavy bleeding from the left arm, likely due to a torn brachial artery.

A rough tourniquet was applied to the left upper arm to control brisk hemorrhaging. A little whiskey mixed with water was given in an attempt to relieve Jackson’s excruciating pain. He was then placed in a wagon and bounced over a rutted road to the nearest aid station. When examined by his personal physician, Dr. Hunter Holmes McGuire, his clothes were saturated with blood still oozing from the wound in his left arm. His skin was clammy, his face pale. His thin lips were compressed so tightly his teeth could be seen through them. Whiskey and morphine were administered. Jackson was placed back in the wagon and pitched and bumped another four miles to a field hospital.

Five hours after the injury, the left arm was amputated just below the shoulder under chloroform anesthesia. A round ball from an old smoothbore musket was extracted easily from the subcutaneous of the right hand; isinglass plasters were applied to the facial lacerations. Thirty minutes later, Jackson was awake, alert, and able to drink a cup of coffee. Within six hours, his pain had subsided, and he felt strong enough to take a little food. Neither chills nor fever were present. He appeared to be regaining strength rapidly. However, in the mid-morning he complained of pain in his side (laterality not recorded) for which no evidence of injury could be detected. The lung was functioning well, and the pain soon abated. The general became his old self, issuing a rash of orders. McGuire was encouraged greatly by his appearance.

Jackson slept well that night and awoke refreshed and...
in admirable condition. He was then transported by wagon twenty-seven miles farther to the rear. During much of the fourteen-hour journey, he was bright and talkative. However, by its end, he was having renewed pain in his side and nausea. A wet towel placed over his abdomen gave him relief. When finally placed in a double rope-trellis bed in a little frame house at Guinea Station, he eagerly ate some bread, drank a little tea, and soon drifted into a sound sleep.

Jackson awoke the next day in good condition. He was cheerful and ate a good breakfast. The wound in the hand was draining and painful. A stabilizing splint and simple lint and water dressing were applied. The next day he continued to improve. However, at 1:00 AM on the fourth postoperative day, he was feverish and nauseated and complaining of intense pain in his left side. Towels soaked in spring water were placed on his painful side, this time to no effect. Paroxysms of pain in the side grew worse and every breath caused a piercing sensation. When finally examined by Dr. McGuire, Jackson was breathing heavily and gasping; his pulse was rapid. Although he was apparently not coughing (nor is a cough recorded at any time during his terminal illness), McGuire was convinced that “dreaded pneumonia” had developed, and applied mustard plasters, wrapped Jackson in blankets, and began administering regular doses of laudanum (a mixture of opium and whiskey). The laudanum alleviated Jackson’s pain but also put him into a stupor from which he never fully recovered.

An overview of General Stonewall Jackson’s boyhood home near Weston, West Virginia. © CORBIS.
How postoperative respiratory distress conspired with friendly fire to kill “Stonewall” Jackson

During the next three days, Jackson wandered in and out of consciousness. His breathing was heavy. For a brief period the pain in his side abated, he appeared more comfortable and rational, and evinced optimism that he would recover. His wounds were healing naturally with moderate suppuration. However, the fever, labored breathing, and delirium soon returned. He became progressively weaker, slipped into a deep coma and died on the seventh postoperative day.

Differential diagnosis

Jackson’s medical history has been a subject of ongoing analysis and debate since his death 150 years ago. Investigators have posthumously diagnosed various underlying disorders ranging from Asperger’s syndrome to chronic dyspepsia due to a lingering H. pylori infection or hiatal hernia. It is unlikely that any of these was responsible for his postoperative deterioration and death.

What we know of events that followed Jackson’s wounding on May 2, 1863, comes mostly from a report entitled “Last Wound of the Late Gen. Jackson (Stonewall)—The Amputation of the Arm—His Last Moments and Death,” published in 1916 by Dr. Hunter Holmes McGuire in the Richmond Medical Journal. McGuire was at the general’s side shortly after his wounding, performed the amputation of his left arm, and attended Jackson thereafter until he died. Although the manuscript remains the most comprehensive description of Jackson’s final days, it wasn’t published until three years after the events in question. Given the many other momentous events that transpired in the life of McGuire between 1863 and 1866, it would have been challenging, to say the least, for him to have recalled all of the critical details of his famous patient’s case history. Moreover, as he explained in a footnote in his manuscript: “A detailed account of [Jackson’s] treatment is prevented by the loss of notes kept of the case. These notes, with other papers, were captured by the Federals, March 1865.” Despite at least one concerted effort to locate them in 1963 by Dr. L. Whittington Gorman and experts at the National Archives in Washington, DC, these records have never been recovered.

In his report, McGuire gives “pleuro-pneumonia” as the cause of Jackson’s pleuritic pain, labored breathing, raised pulse and eventual death, without elaborating on the results of his examination of his patient’s lungs in arriving at the diagnosis. According to his thinking, “Contusion of the lung, with extravasation of blood in his chest, was probably produced by the fall referred to, and shock and loss of blood, prevented any ill effects until reaction had been well established, and then inflammation ensued.”

Modern investigators have proposed several alternative or expanded diagnoses to explain Jackson’s unexpected death. On examining the information included in McGuire’s report, L. Whittington Gorham in a 1963 article in the Archives of Internal Medicine considered pneumonia, fat embolism, and pulmonary emboli as possible causes of Jackson’s fatal postoperative complication. Given Jackson’s apparently modest fever and lack of cough or sputum production, Gorham felt that pneumonia was unlikely. Although fat emboli were worth considering given their association with long bone injuries and amputations, he concluded that this diagnosis was also unlikely in the absence of early pulmonary distress or mental status changes or a petechial rash. All things considered, Gorham settled on pulmonary emboli with pulmonary infarction followed by a massive pulmonary thrombosis as Jackson’s fatal postoperative complication. Gorham believes that ligation of the proximal vessels of the left arm during the amputation created a nidus upon which the fatal thrombus formed. His diagnosis was endorsed by Alan DeForest Smith in 1973 in an article published in the 1973 Bulletin of the New York Academy of Medicine.

Not everyone agrees with Gorham’s diagnosis. On reviewing the available evidence on Jackson’s death, Thomas Layton concluded that McGuire’s original diagnosis was probably correct, and that the chest trauma resulting from Jackson’s falls rendered him at considerable risk for subsequent pneumonia. Matthew Lively has hypothesized further that a lung contusion caused by the falls from the stretcher contributed to poor pulmonary clearance, which was responsible for a subsequent fatal pneumonia. In a radically different interpretation, Timothy Koch and Joseph B. Kisner concluded that the general did not die of a pulmonary complication at all, but of a perforated peptic ulcer or catastrophic gastrointestinal bleed related to H. pylori-induced chronic dyspepsia. To arrive at this diagnosis, they pointed to Jackson’s boyhood spent in a region known to be hyper-endemic for H. pylori (West Virginia), his gastric distress dating to his service in Mexico under General Winfield Scott, and the various treatments he had long used to control his dyspepsia. They hypothesized further that, unknown to McGuire, the stress reaction resulting from Jackson’s multiple wounds caused a long-standing peptic ulcer or chronic gastritis to perforate and/or bleed. Their hypothesis is weakened by the absence of hematemesis, hematochyesis, melena, and/or signs of peritoneal irritation in McGuire’s report.

Sepsis and contusion of the spleen with subsequent rupture are other remote possibilities worth considering as the cause of Jackson’s postoperative deterioration and death. Sepsis could have originated from an infected amputation site, a common complication of amputations performed during the Civil War. Moreover, when Jackson arrived at the Chandler house at Guiney Station, a case of erysipelas in the big house was one of the reasons he was placed in the tiny frame build next door. However, according to McGuire, Jackson’s wounds were healing properly. In addition, his deterioration was gradual and not precipitous, as would have been expected if he had been septic or the victim of streptococcal necrotizing fasciitis or toxic shock, and he only occasionally experienced...
fear. With regard to a ruptured spleen, Jackson had pain in the appropriate location—the left side. However, the pain was intermittent, which would have been atypical of an expanding splenic hematoma, and Jackson did not exhibit the usual signs of progressive exsanguinations (i.e., pallor, rising pulse rate, decreasing pulse pressure), all of which one would have expected McGuire to have detected and properly interpreted.

How then do we reconcile these seemingly divergent viewpoints in the face of the scant and potentially unreliable information provided in McGuire’s case summary? First, it is important to recognize that Dr. McGuire was a capable physician who was confident in his diagnosis of pneumonia. Although just twenty-seven years old at the time of Jackson’s injury, he was already one of the most gifted physicians of his era and would go on to have one of the most illustrious careers of any Civil War physician. It is true that his May 1866 report fails to list the specific physical findings upon which he based his diagnosis. Nevertheless, he would have been familiar enough with the signs and symptoms of pneumonia to have recognized it, even without the assistance of the chest radiograph that physicians rely on today in making the diagnosis.

Second, in his Richmond Medical Journal report, McGuire clearly states that when he examined Jackson at the time the patient first complained of pain in his side, “No evidence of injury could be discovered by examination; the skin was not broken or bruised, and the lung performed, as far as I could tell, its proper functions.” He might well have missed a pulmonary contusion at that time. However, he would have been much less likely to have missed fractured ribs or a painful spleen, both of which would have caused continuous, rather than intermittent, pain.

Third, Jackson had unmistakable signs and symptoms of massive hemorrhage and shock in the early hours after his wounding. His clothes were blood soaked, his lips pale, and his extremities cold. Blood loss of such magnitude would have placed him at great risk of a postoperative complication like pneumonia or pulmonary emboli.

Fourth, as noted above, evidence supporting alternative diagnoses such as sepsis and splenic rupture is inadequate. Fat emboli, likewise, are an unlikely cause of Jackson’s postoperative deterioration, even given the extent of massive destruction of the bones of his left arm, since he exhibited no pectechial rash and no mental status changes or pulmonary distress during the first few days after his injury.

On careful consideration of all of the possible causes of Jackson’s fatal disorder, we are left with McGuire’s diagnosis—postoperative pneumonia—and pulmonary emboli. Both are complications of battle injuries that continue to plague wounded soldiers even today. Despite state-of-the-art diagnostics, highly effective antibiotics, and modern anticoagulants, the incidence of infection and of pulmonary emboli among combat casualties in Iraq and Afghanistan exceeds five percent. Moreover, the risk of these two complications is especially high among soldiers with fractured long bones and amputations.

Pneumonia and recurrent pulmonary emboli are equally likely as the cause of Jackson’s postoperative deterioration and death. McGuire’s belief in the former diagnosis, one supported by numerous consultants who assisted him in caring for Jackson, must not be overlooked. He was a highly skilled physician with vast experience in diagnosing and treating pneumonia among Confederate casualties. Moreover, Jackson’s chest pain, dyspnea, and fever are all consistent with the diagnosis. However, the absence of cough, the waxing and waning of Jackson’s chest pain, respiratory distress, and fever are atypical of progressive, ultimately fatal, pneumonia. If Jackson did die of pneumonia, the absence of a productive cough could only be explained by its having been suppressed by the laudanum he received to control his pain. Otherwise, recurrent pulmonary emboli would be more consistent with Jackson’s clinical course, and since this disorder was unknown to physicians of McGuire’s era, it might easily have been confused with pneumonia. Unfortunately, in the final analysis, there is no way to determine in retrospect which of these two likely postoperative complications was responsible for Jackson’s death.

“The Christian Soldier”

Jackson was widely hailed in his day, and no less so today, as “Stonewall,” though “The Christian Soldier” would be more appropriate. His military experience prior to 1861 was in artillery, yet he excelled as a commander of infantry. His soldiers adored him, and told countless stories about “Old Jack,” even though he was a tight-lipped, sternly disciplined eccentric. Fellow generals were in awe of him. He was a man of few words whose silence concealed a fiery combative ness smoldering deep within. Indeed, it was the silence and the accompanying secrecy of his movements that led to mortal wounds inflicted by his own men.

Jackson’s Civil War service lasted but two years, despite the fact that he more than any other Confederate became the radiant hope of the Southern cause. More astounding are the number of people—from his time to ours—who assert that had he not died in 1863, his genius would have enabled the Confederate States to achieve their independence.

Such was the mystique of Thomas Jonathan Jackson.

An overwhelming faith is the key to understanding Jackson the general. He viewed the coming of civil war quite differently from other Americans. To Jackson, God for reasons that man could not know had placed a scourge over the land. North and South must fight to a conclusion. The side that displayed the greater faith would triumph in the end.

Jackson thus entered Confederate service intent on becoming not another Frederick the Great or Napoleon Bonaparte but another Joshua or Gideon. The enemies were not Yankees;
they were Philistines who must be destroyed in the name of God. And because Jackson was fighting with blind obedience to God's will, he expected the same blind obedience from the soldiers he was leading to glory. He ignored all acclaim and would accept no accolades. Credit for victory belonged to God. Jackson was merely a devoted servant waging a holy crusade. Jackson's death drew a clear line of demarcation in the history of the Army of Northern Virginia. Delegation of authority, under orders that not only permitted but encouraged a wide degree of latitude in their execution by subordinates, had been the basis of Lee's great victories during the ten months Jackson was with him. Yet at Gettysburg, with Jackson only seven weeks in the grave, the system failed Lee. He tried to do it all himself, and it didn't work. In Pennsylvania, Lee had no executive officer of first-class ability, no great tactician who could shout "Press on! Press on!" as Jackson had done on so many occasions. The price of victory at Chancellorsville was the cost of defeat at Gettysburg. But beyond Gettysburg was a decidedly deeper effect of Jackson's passing. There was no other Jackson. Hence, never again did Lee attempt the spectacular dividing of his army that he had risked not once but five times when Jackson was with him. Mobility—the prime ingredient of the Confederate army had to have for survival—disappeared with Jackson. Thereafter, Lee's ill-equipped, heavily outnumbered men had to engage in a toe-to-toe slugging match with the all-powerful Army of the Potomac. It was a fight the Southerners could not win. The Road to Appomattox may well have begun in the chaotic darkness of May 2, 1863, when a burst of friendly fire humiliated in defeat, nor did he have to struggle to regain his dignity in civilian life after the war's end.17

References

Address correspondence to:
Philip A. Mackowiak, MD
Medical Service-111
VA Medical Center
10 N. Greene Street
Baltimore, Maryland 21201
E-mail: philip.mackowiak@va.gov

How postoperative respiratory distress conspired with friendly fire to kill “Stonewall” Jackson

Conclusion
Some historians believe that until Farragut’s victory at Mobile, and then Sherman’s capture of Atlanta and Sheridan’s devastation of the Shenandoah Valley, the South had a chance of winning its independence—not through victories on the battlefield but by breaking the Union resolve to fight to the finish. They suggest that Jackson might have allowed the South to do so had he not died at Guinea Station. Other historians maintain that the defeat of the Confederacy was inevitable. The North had far greater numbers of soldiers, a limitless supply of war matériel, a common cause (preserving the union and ending slavery), and a dedicated leader in Lincoln, who had the will and the ability to prosecute the war to a successful conclusion. Although according to the Richmond Examiner, “Hannibal might have been proud of [Jackson’s] campaign in the Valley,"16/24 his performance during the Seven Days Campaign was near catastrophic. How he would have fared against Grant, Sheridan, and the other competent Union generals who emerged after 1863 is open to speculation. He was gone before they arrived in northern Virginia. Because he died before Gettysburg and long before the war’s end, he was never
Breast exam

And now we are going to drop the front of your gown.

Silently, she complies, but her eyes fix upon some light that shines behind us, over our heads. Her chin aligns with the tile floor, her neck becomes a stone column.

The doctor continues small talk—Sunday bread baking, slapstick antics of two young nephews, Labor Day lake swimming, the resilience of succulents—as her undulating fingers search our patient’s drooping breasts and soft, unshaven underarms for small stones hidden deep.

Our patient is now a lady of marble, harder than anything we can palpate. Closing her eyes, she takes the softer things to a place our prying fingers cannot reach.

Trang Diem Vu

Ms. Vu is a member of the Class of 2016 at Mayo Medical School. This poem won honorable mention in the 2014 Pharos Student Poetry Competition. Ms. Vu’s e-mail address is: vu.trang@mayo.edu. 
Photo by Robert Kato.
Haiti journal

Ken Barnes, MD
On Tuesday, January 12, 2010, Haiti experienced a catastrophic magnitude 7.0 earthquake, the epicenter sixteen miles west of Port-au-Prince, the capital. Affected by the quake were an estimated 3.5 million people, with at least 220,000 dead, another 300,000 injured, and over 1.5 million people made homeless.\(^1\)

The earthquake caused an estimated $13 billion in damage to Port-au-Prince,\(^2\) with sixty percent of government and administrative buildings, including the Presidential Palace, rendered uninhabitable. An estimated 290,000 residences and many hospitals were badly damaged or destroyed, as were eighty percent of schools (4,000) in Port-au-Prince.\(^1\)

Many countries responded with humanitarian aid, pledging funds and dispatching rescue and medical teams and other support personnel. As rescues diminished in number, medical care became a priority. It was in this context that, two months after the earthquake, we arrived in Haiti, drawn together with the common purpose of helping others in a time of tragedy.

Our group of fifteen was comprised of nurses, surgeons, internists, a cardiologist, a pediatrician, anesthesiologists, and an ER physician, all part of Sutter Health in Northern California. Many of us knew each other from having worked together, some were new. We had good intentions, but did not fully understand what we were about to enter.

**Day 1, March 6, 2010**

I arrive in Miami from Boston, getting to my hotel at 1:00 AM, asleep by 1:30, and up at 4:15 to meet the group in the lobby of the hotel at 4:45. We fly to Port-au-Prince, Haiti, arriving at 10:30 AM. After waiting for suitcases and a short but eye-opening ride, we finally arrive at Fondation Aristide around 2:00 PM. This is where we will stay while working at Hôpital de l’Université d’Etat d’Haiti, the University Hospital of Haiti. Fondation Aristide is a community organization, named after former President Jean-Bertrand Aristide, who was toppled from power in 2001. We are there to give what help we can in the aftermath of the January 12 earthquake that leveled most of the capital and devastated the country.

We eat, put our things in our small one-person tents, and leave for the hospital. We arrive at 5:00 PM, and meet with the doctors and nurses from Boston whose shoes we will try to fill. They’ve been here for ten days and are leaving tomorrow. The other internist, Toni, and I spend the next twelve hours going over some fifty patients who are on the Internal Medicine wards of the hospital, which was significantly damaged but deemed habitable after the earthquake. Most of the rest of the hospital is neither safe nor usable, and tents have been put up for the emergency room, obstetrics, infectious disease/tuberculosis, ICU, and pediatrics. The operating rooms are in the administration offices.

The patients have a variety of problems. Several women have severe postpartum cardiomyopathy with shortness of breath, even at rest. We see possible pulmonary tuberculosis and tuberculous pericarditis; HIV/AIDS; malaria, including cerebral malaria; chronic renal failure on dialysis (amazingly there is a functioning dialysis center); pneumonia; strokes; seizures; malignant and rampant hypertension; breast cancer; lymphoma; failure to thrive; hyperthyroidism; inflammatory bowel disease; anemia; gastrointestinal bleeding; bone marrow abnormalities of unknown type; and a host of other common and not so common medical problems.

We come back to the Fondation in the morning, and after eating a breakfast of eggs and goat meat I go to my tent to try to get some sleep. We will work only the night shift, so will sleep during daylight hours. The heat is unbearable in my tent and I become terribly anxious: I am not going to be able to tolerate a week of this. I may need to leave the mission. If I stay in this tent, my thermoregulation will fail, I’ll get hyperthermic and die of heatstroke. My colleagues will find my body in the tent six hours later. I start to meditate, and after a few minutes I am able to gather myself, coming to a more dispassionate and balanced view of my situation. I leave the tent and put my mattress under the open awning. I again meditate, calming myself, my mind now quiet, and fall asleep. It is at least twenty degrees cooler outside the tent.

**Day 2, March 7, 2010, 4:00 PM**

We learn today that two women working with Doctors without Borders have been kidnapped by Haitians for ransom. Partners in Health, the organization with which we are working, says it doesn’t want us traveling at night, so our shift will now start at 4:30 PM instead of 6:00 PM.

**Day 3, March 8, 2010, 3:00 AM**

I am sitting in the medical ward, having worked ten straight hours. I am tired but feeling the deep satisfaction of knowing I am helping people in great need. I am struck by the kindness, gentleness, and inner strength of the Haitian people, even in the face of overwhelming adversity. They model for me an equanimity that is palpable. Such illnesses I have rarely, if ever, seen, including a catatonic young woman, mute since the earthquake (I later learn through a New York Times article that she died of an infection after we left).

Our cardiologist, Charlie, has brought a portable echo machine so that we can do cardiac and abdominal ultrasounds. I feel so blessed by this evening.
Day 4, March 9, 2010, 7:00 AM

I sleep for three hours. During that time, a woman died while seizing. Her daughter started to wail uncontrollably, common, as I will learn, when people in Haiti die. The nurses also cried.

Our drive home is through the rubble of Port-au-Prince, crumbled and pancaked concrete, slabs at odd angles, people everywhere milling in the streets.

Some, especially young men, have a look of desperation. No wonder there are kidnappings. The people are also subject to interminable lines: lines for the emergency room, lines for food, lines for water. Tent cities are everywhere in Port-au-Prince, some with 200 tents, some with 5000. They are not safe, as there is no security inside the camps. Crime, especially rape, is rampant. The level of destruction is unimaginable.

We are back at the Fondation, I eat, and go to sleep on my outdoor mattress. Before nodding off, I again face my fear and anxiety—fear that I am not going to make it here and will choose to leave. I again start to meditate, my mind quiets, the fear and doubt recede.

Day 4, March 9, 2010, 11:30 PM

Another patient died last night, and a current patient has moved her daughter into the empty bed, the daughter acting as if she were a patient. It is better than being outside in the tents, with all of their horrors.

The wards are open, twelve beds in each of the four wards. They are all full, and patients in beds line the halls. There are no bathrooms (people go outside to portable toilets), no running water, and no kitchen. Families bring food and water to the patients, and often sleep on the floor or under the bed. Suitcases of patients and family members are everywhere, their only remaining possessions.

One of the young women with postpartum cardiomyopathy is better. Her condition no longer requires one of the valued beds, but she doesn’t want to leave. Her home was destroyed, her family is in the countryside, and she is afraid to ride on buses, especially with her newborn child. To try to be allowed to stay, she complains of symptoms belied by her physical condition. I don’t have the heart to ask her to leave.

Suddenly there is screaming and wailing from outside the wards: a man is running through the street, his mother having just died in the ICU.

Day 5, March 10, 2010, 1:30 AM

So many patients cannot sleep. They are groaning, sitting upright fighting for their next breath. Many are racked with pain. I decide to make sleep rounds, giving sleeping pills to several of the patients, who promptly go to sleep after several sleepless nights. I also turn off the lights.
What misery these people suffer! Catatonic and depressed, homeless, little or no food. Many families living in the hospital, no place to go. Families separated since the earthquake, having no idea whether their loved ones are alive or dead.

Another young woman, Natalie, postpartum cardiomyopathy, very short of breath, cannot sleep and it is now 2:00 AM. She is very sweet, I give her a sleeping pill, she lies down on three pillows, and in the darkness I sit on her bed and rub her back as she slowly goes to sleep. Human touch: we all need it.

What will happen to these people after we leave? The health care system in Haiti, never good, is in shambles. Patients present late in their illnesses because, except for those few with money who can get private care, the public system cannot meet their needs, so they wait and wait.

It is the beginning of the fifth night. I realize that during the past two nights I have experienced an equanimity, an inner calmness, that has spawned deep compassion and love. I am suffused with a deep joy—joy at being able to serve, joy at seeing smiles on patient’s faces, joy from deep connection to the patients. I see the importance of just holding people’s pain with tenderness, bearing witness, not expecting a desired outcome, all of this keeping me open and receptive. I sense my inner strength, my “strong back, soft front,” as Roshi Joan Halifax so beautifully says about compassion. What a blessing and gift this has been.

I am so struck by the love of younger family members for their parents—sweet, concerned advocates, mostly men, although many women are here also. Perhaps the women are with the children. Many patients tonight are starting to feel better, possibly the effect of medications finally working. Alex, one of our translators, is so sweet and helpful.

Natalie, upon seeing me, gives me a big smile and says that she had her best night of sleep in a month. Once again I feel blessed and happy.

The city is so devastated it is hard to imagine rebuilding. There is talk of rebuilding in areas outside of Port-au-Prince—perhaps abandoning the city. Money is coming in, most going to non-governmental organizations (NGOs), but there is some question about how they are using the money. Loti, a doctor working with Partners in Health, says the central government is in great need
of money to provide essential health services.

Day 6, March 11, 2010, 5 AM
When the early morning hours arrive, there is a relative stillness on the wards, probably a result of massage, morphine, sleeping pills, and food. Food in the hospital is scarce, many patients ask for it. I have given away most of the food that I bought at REI before coming—power bars, bagged salmon, beef and turkey jerky. Love comes in such different forms.

Day 6, March 11, 2010, 9:40 AM
It's wonderful hanging out at the Fondation with such a good group of companions. We share stories and give strength and encouragement to each other. There is a camaraderie and deep respect among us.

We drive from the hospital through the rubble. The city is raw, people are milling, wandering aimlessly, sitting, standing in lines. I see the occasional well-dressed person, but mostly they are very poor. A few schools are open, but it appears that the majority are not. I don't see a lot of kids on the street. I wonder where they are. Some are in orphanages; many were killed.

Day 7, March 12, 2010, 1:00 AM
One woman patient of mine and her daughter, both Jehovah's Witnesses, become frightened in early morning. One of our sweet Haitian translators comes to me and says they want me to pray with them. It is dark, the wards now quiet. I go to the bedside where the daughter is sitting, her hand soothing her mother's abdomen. I put my right hand on top of hers and my left on her mother's heart, and I pray with them. I pray that they have relief from their suffering, that their bodies, hearts, and spirits can heal, that they are free from all danger, and that someday they will be well and at ease, and be happy.

I feel such compassion, a softness and gentleness in my heart, as if I have been broken open. Feelings of love and kindness flow from deep within. I feel I know more of myself, see myself as "bigger." There is a longing to help, and also a feeling of tremendous well being.
How lucky I am! And I realize I am in awe of the Haitian people who, despite tragedy after tragedy, show a strength of human spirit that is so inspiring.

I make morning “hello rounds,” where I shake hands, touch, and receive the most beautiful smiles. What a gift!

Day 8, March 13, 2010, 2 AM

It’s 2:00 AM, our last night, I have just finished with two paracenteses, one on a woman with infected ascites who could not breathe well because of the massive fluid accumulation. She looked tired and her eyes were bulging. After removal of more than three liters of infected fluid, her eyes seem to recede; she smiles and asks if she can go to sleep. I say yes, and she closes her eyes.

The other is an elderly cachectic man who hasn’t eaten in three weeks. The fluid in his abdomen was compressing his stomach, making his appetite disappear. Six liters of fluid are removed and he too goes to sleep. As his paracentesis is finishing, a mouse runs out from under his bed.

I am tired beyond tired, beyond exhaustion, having just worked nine straight hours in sweltering heat, sweating, drinking water, sweating, drinking water. As I walk around the ward after the procedures, a man asks me to see his wife, who is dizzy. I do so, gladly. Another person calls to me and says another patient needs water. I go to the nurse’s room, find water, and give it to her. We are down to three nurses tonight: one is sick, one is resting, one went to pediatrics for a good part of the evening. So I deliver medications to the patients, going back and forth between our small pharmacy and the patients.

Their requests come at me quickly, but I receive them with equanimity and a peaceful feeling—just accepting them as needs being expressed by people greatly suffering. I get to go home tomorrow—they must remain in this cauldron of misery.

A man with inflammatory bowel disease and his wife express their gratitude to me, telling me I have a big heart. I tell them that they too have big hearts, as I witnessed their concern for other patients. They smile. A profound human connection. They ask for my e-mail.

We stop at a drug store and buy diapers and paper towels for the patients. I buy about twenty bottles of scented body lotion and give them to the women. They all smile, many blush. Body lotion in the midst of urine, excrement, other bodily fluids—something to give them a moment of knowing their own beauty.

It’s time to read myself to sleep with The Pocket Pema Chödrön (a wonderful Buddhist teacher and writer).^ She has been the perfect companion on this journey.

Day 8, March 13, 2010, 9 AM

It is our last morning. I sleep for three and a half hours, then go back to the wards. The woman with possible tuberculous pericarditis has died, and the family tries to revive her for half an hour. They pinch her nipples, put scented cotton in her nose, and rub the bottom of her feet with a stiff comb. They finally accept her dying and start wailing, continuing for an hour. I feel particularly badly at her death, as I had tried to get her treated for possible TB, but couldn’t get it done in time.

The man with chronic renal failure and hypertension begins complaining of feeling weak. His blood pressure is 140/80 and his physical exam is unremarkable. I think he is very anxious, so I put my hand on his chest and rub him. I ask him to pray, and then pay attention to his breath as it goes in and out of his nose. Gradually he quiets down. He lost two houses in the earthquake and one of his children is ill. Finally he goes to sleep with 1 mg of lorazepam and me rubbing his heart.

The elderly man on whom we did the paracentesis earlier looks much better. We buy stuffed cakes, like empanadas, from a local woman and give them to every patient on the wards. I personally give one to this man, who has not eaten in a few weeks. He smiles and slowly eats the whole thing. His daughter smiles widely, hugs me, and tells me she loves me.

I go around the two wards, saying goodbye to all. There are many hugs and kisses, heart connections. A love and gratitude comes over me. This is why I had wanted to go on this mission so much.

I feel a rawness and a sadness as I contemplate what I have seen and experienced. Just giving them some small measure of comfort, of relief, soothes my spirit.

On this last morning, making my rounds, I ask if I can take pictures with them. All say yes. I now have poignant reminders of their stories. Taking pictures allows a space for saying goodbye, for heartfelt embraces—emotional for all of us.

Day 9, March 14, 2010, 3 PM

At the airport in Miami, leaving for San Francisco, entering security, an agent says my duffel is too big to carry on. I have carried it on four flights and no one has questioned it. I become a bit testy, the first time this has happened in a week. It is so noticeable, even though relatively mild. I have been so non-reactive during the trip even this small reactivity is a jolt. I have abruptly left that open and spacious place and am in me-versus-her mode, experiencing my solid self, my ego self. She graciously lets me carry it on.

Reflections

Port-au-Prince is a city so devastated that it is hard to comprehend. The concrete slabs, folded into each other, rebar showing, mountains of concrete, crumbled, bodies still inside. The nurses’ building at the hospital had collapsed, killing more than 100 nursing students and faculty, and a tower of concrete remained with bodies still not recovered from inside.

People wandered aimlessly on the streets, selling, cooking, sitting, talking,
but not many children. I wonder again how many children were killed. There were endless cities of tents bunched together with literally no space between.

I think again of the patients—such as the young women like Natalie with cardiomyopathies, clinging to hope and desperately wanting to go home to their children. One sweet young woman, who was getting better, asked me if she could breastfeed. She was on four cardiac medications. I went to Nadine, one of our pediatricians, and we looked them up in her pediatric book. Two of the medications were fine, one probably okay, and one a total question mark. Even though breastfeeding would be best for her baby—both for its health and economically—she quickly decided not to breastfeed. She didn’t want to put her baby in danger. I felt such respect for the love she had for her child and for her intelligence.

The young adult children who stayed twenty-four hours with their parents, come to mind again: they slept on chairs, the floor, under beds, in the hallways, or wandered the wards instead of sleeping. Such caring and devotion, love of the highest order.

Prayer was going on all the time. Sometimes the whole room of twelve patients and relatives and friends began praying together, hands often raised in the air, low chanting, eyes closed. It brought quiet and calm to the room.
Some patients had food, mostly those with family members. But a good number did not, and there was no functioning dining department or hospital kitchen. Quiet desperation was on the faces of many.

I felt like my compassion was more encompassing—opening into a space that was deeply connecting, both to myself and others. While in Haiti, I felt I had moved into a place that was very tender, one that allowed me to keep opening and at the same time be non-reactive, to be still, a definite shift in my consciousness—surrender, a feeling of peace, a groundlessness, an emptiness, no judgment, no them and me. There was a connection that was deeply real, one that allowed me to respond from a place of authenticity, free of my own personal biases and issues. Sharing the heart enlarges our view and helps us realize interconnection.

I felt the wretchedness of the lives of the Haitian people soften me, leaving me with a feeling of profound gratitude and great admiration for a people who have deeply tasted tragedy and yet maintain dignity and hope for a better tomorrow.

I returned to Haiti one year after the earthquake, again to work, but this time in the relatively large coastal town of St. Marc in western Haiti, population 180,000. I worked in the emergency room of the main hospital, as well as caring for people post-operatively. St. Marc had managed to escape much of the earthquake damage, but had become home to thousands of refugees, mainly from Port-au-Prince.

Reflections four years later

As I look back, I am struck by the slow pace of reconstruction. Housing still remains a need; according to the United Nations, approximately 170,000 people continue to live in tents, down from the 1.5 million in the immediate aftermath of the earthquake. Some 300 tent cities, teeming with violence, still exist, ravaged by the flooding of the rains. A cholera outbreak spread across the entire island, sickening over 700,000 people and killing some 8,500. Another hurricane lashed the country. When will it stop?

Figures show that less than one percent of emergency relief funding went directly to the Haitian government. Over ninety-four percent of the money went to United Nations agencies, international NGOs, and private contractors, most of which are not set up to rebuild cities. They have helped with medical care, sanitation, and education in the tent cities, which creates a perverse incentive to stay in a camp, even if you have a habitable home. But the encampments now are fewer in number, and buildings are slowly being renovated, including the international airport.

In post-earthquake Haiti it is clear that the violence and trauma suffered by the Haitian people affected the emotional, spiritual, and physical aspects of their being. Masters of Divinity student at Drew University Joshua Clough wrote of his observations after a 2010 summer internship in Haiti:

Fear structures the deepest levels of emotionality within the psyche of many Haitians; individuals and families continue to choose to sleep in tents due to the debilitating uncertainty that concrete walls and ceilings provide. . . . Ultimately, the whole physical and emotional body is impacted by the reality of the earthquake. Real flesh and blood human bodies were mangled in the trembling of earth; brothers, sisters, mothers, fathers, friends, and lovers killed with only those who remain to pick up the pieces.

In the end, I return to the endurance and strength of the Haitian people. They have managed to survive virtually everything that has come their way, demonstrating an almost superhuman solidarity, and continue to care for those who were shattered on January 12, 2010. And as writer Junot Díaz notes:

After all, apocalypses like the Haitian earthquake are not only catastrophes; they are also opportunities: chances for us to see ourselves, to take responsibility for what we see, to change. One day, somewhere in the world something terrible will happen and for once we will heed the ruins. We will begin collectively to take responsibility for the world we’re creating.

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The author’s address is:
53 Wilder Street, Apartment 302
San Francisco, California 94131
E-mail: baywestkb@aol.com
Match the photo to the name (and condition)!

1. George Huntington  
   (Huntington disease)

2. Etienne Louis Arthur Fallot  
   (Tetralogy of Fallot)

3. Carlos Chagas  
   (Chagas disease)

4. Thomas Hodgkin  
   (Hodgkin’s disease)

5. Herman Boerhaave  
   (Boerhaave Syndrome)

6. Paul Dudley White  
   (Wolff-Parkinson-White Syndrome)

Images courtesy of the National Library of Medicine.
Reflecting on a few well-remembered medical eponyms

Martin Duke, MD

The author is retired from private practice in cardiology. He was formerly director of Medical Education at Manchester Memorial Hospital in Manchester, Connecticut, and assistant clinical professor in the Department of Medicine at the University of Connecticut School of Medicine.

Medical eponyms—terms in medicine named after people and occasionally after places—thumbs up or thumbs down? Much has been written about their pros and cons; I can add little further to those observations.\(^1\)\(^2\) Like or dislike them, there are thousands of medical eponyms, some well-known and in daily use, others familiar only to those within a particular medical specialty or with highly specific interests, a few that have been vilified in recent times,\(^3\)\(^4\) a considerable number now barely remembered, and many recognized solely for their historical interest.

Having always had a passion for the study of history, medical eponyms gave me an opportunity to continue this interest while actively practicing my profession. After coming across references to medical eponyms in articles or books, I would satisfy my curiosity by looking into the lives and accomplishments of these medical ancestors of mine. My years in medical practice became more meaningful and richer knowing that I was part of this heritage. And for a variety of personal reasons, some of those eponyms continued to maintain a strong hold on my memory.

For many years, I cared for a young man who as a child during the 1940s had received one of the early “blue baby” operations for tetralogy of Fallot. Aside from attending to the unique medical problems he experienced during his adult years, I helped him find a job and took pleasure in seeing him married and raising his children. I grieved with him when his young wife died unexpectedly of cancer, and years later I was present at his graveside funeral service. As a result of that relationship, I have always had a special feeling for the following two medical eponyms—the tetralogy of Fallot named after the Frenchman Etienne-Louis Arthur Fallot who in 1888 described this condition,\(^5\) and the Blalock-Taussig procedure named for the cardiac surgeon Alfred Blalock and the pediatric cardiologist Helen Taussig whose description of the first “blue baby” operations in 1945 was a monumental moment in cardiac surgery.\(^6\)

Perhaps because it was one of my earliest contacts in medical school with a “real” patient, I have never forgotten an elderly man with Adams-Stokes attacks whom I saw in the early 1950s at the Bellevue Hospital Cardiac Clinic in New York. Named after two notable Irish physicians, Robert Adams (1791–1875) and William Stokes (1804–1878), their observations of this disorder, made many years ago in the first half of the nineteenth century without the advantages of modern-day technology, are still pertinent today and fascinating to read.\(^7\)\(^8\)

In 1963, I gave a presentation before the New England Cardiovascular Society at Boston’s Museum of Science. Seated in the front row of the auditorium only a few feet from the podium where I stood was Paul Dudley White (1886–1973), a leading figure in cardiology and the second “W” in the well-known Wolff-Parkinson-White or pre-excitation syndrome.\(^9\) I recall the occasion well—it is not a daily occurrence to find oneself face to face with a legend.

A few steps inside the entrance to St. James’s Church, Piccadilly, a seventeenth-century church in

Memorial plaque for William Bowman (1816–1973) at the St. James’s Church, London. Photo courtesy of the author.
London that survived the World War II bombing of the city, I came upon a marble tablet in memory of William Bowman (1816–1892), the anatomist, physiologist, and ophthalmic surgeon whose name is eponymously attached to both Bowman’s capsule within the glomeruli of the kidney and to Bowman’s membrane, one of the layers of the cornea of the eye. How I had struggled in medical school trying to locate these structures under the microscope and understand their functions! The same church also contains a plaque to Richard Bright (1789–1858), remembered for associating dropsy (edema) and albuminuria with pathologic changes in the kidney, although the once-much-used term Bright’s disease is now obsolete and referred to only within a historical context.

On a visit to the Gordon Medical Museum at Guy’s Hospital in London, it was a strange experience, almost like a voyage back in time, to find myself standing before the original pathologic specimens prepared more than a century earlier by Thomas Addison (1793–1860) and Thomas Hodgkin (1798–1866), specimens that showed the diseases they described and that today continue to bear their names—Addison’s disease and Hodgkin’s disease. In Westminster Abbey I walked with great care around the edge of the stone and inscription placed over John Hunter’s (1728–1793) grave in the floor of the north aisle of the nave, although when doing so it was not possible to avoid treading on the nearby memorial stones of Ben Jonson and others. Memories arose of being an overwhelmed first-year medical student trying to dissect and identify the structures within Hunter’s canal in the upper thigh of the cadaver to which my partners and I had been assigned. I later met up with John Hunter again at the Royal College of Surgeons, where the surviving specimens from the remarkable museum he acquired during his lifetime are now exhibited.

It is doubtful that Chagas disease would have entered my personal pantheon of medical eponyms were it not for an unusual memory I have of swimming mice. Until that time, this disease had been merely a name vaguely recalled from a parasitology course in medical school. However, during a cardiology fellowship in the early 1960s, some of my colleagues at the time were involved in a research project studying the effects of exercise on mice with experimentally induced Chagas myocarditis, the exercise consisting of running in activity wheels and/or forced swimming in aquaria. It was truly an unusual sight to see these rodent equivalents of Olympians-in-training being urged on by my cardiologic associates acting as swimming coaches. Chagas disease, named after the Brazilian physician and researcher Carlos Chagas (1879–1934), thus found a place on my special list of well-remembered medical eponyms, for which I owe thanks to Drs. Walter Abelmann and Ernest Federici and their aquatic mice for making me aware of a disease that I never saw or treated clinically but nevertheless came to appreciate as an important public health problem elsewhere in the world.

One cold winter evening in 1967, I was called to the emergency room at our local hospital to see a patient for a possible heart attack. He had been found by police on Main Street moaning in pain, vomiting, and with a strong smell of alcohol about him. On closer examination, however, it appeared that something other than a heart problem was the cause of his symptoms. Indeed, he had experienced a ruptured esophagus as a result of forceful vomiting during a recent drinking episode—an entity known as Boerhaave’s syndrome named after the Dutch physician, chemist, and botanist Hermann Boerhaave (1668–1738)—a surgical rather than a medical emergency. Once this was recognized, a chest surgeon was called and was there within a few minutes. Since his assistant was not immediately available, I was asked to temporarily substitute for him. And so I retracted and suctioned, observing at close hand the ugly-looking material within the chest as the surgeon proceeded to look for and repair the hole in the esophagus—my first active participation in an operating room since internship many years earlier. After about half an hour, a bona fide surgeon replaced me. Miraculously, the patient survived and returned to his usual haunts in Manchester. I would never see another case of Boerhaave’s syndrome during the remainder of my years in practice. However, my evening with that particular patient and my later reading of the fascinating story—it almost reads like a novella—that Boerhaave wrote in 1724 about his own patient with this syndrome, an admiral in the Dutch navy, probably accounts for my still vivid memory of this eponym.

Robert Massey, a former medical school dean, once wrote that a few eponyms “might become life-long friends.” And as with old friends, whenever we chance to meet them, either in our practices or in our readings, memories are awakened and reexamined. I have introduced a few of my old friends. Others, if they are fortunate, will meet up with and reminisce with such friends of their own.

References
I should have known something was wrong when she told me to call between five and seven p.m. on Friday, when she didn’t pick up on the second ring, when she didn’t ask about my exam.

“I went in for my MRI on Wednesday,” she says, and suddenly I know.

“It’s the right breast this time,” she says, and I’m clicking through the words in my head like flashcards—tamoxifen, letrozole, anastrozole, metastasis, metastasis, metastasis.

I think of the jelly bean-lymph nodes I plucked from a cadaver last year; I wonder if my mom’s are the same or if they’re already heavy as marbles with cells dividing uncontrollably.

Maybe if I had gotten that question right on the exam this morning, maybe if I had studied harder—was it raloxifene or exemestane for a fifty-eight-year-old post-menopausal woman with two sisters, one mother, one daughter and a tamoxifen-resistant tumor?

Maybe if I had listened when she asked me not to move away, I would have known.

Instead, I sat a thousand miles away, staring blindly into a microscope at slides of cancer cells, at their mitotic chromosomes splayed out like a skeleton’s fingers and I didn’t know that those same fingers were slowly growing, squeezing between fibrous tissue, and taking root again.

I think of the jelly bean-lymph nodes I plucked from a cadaver last year; I wonder if my mom’s are the same or if they’re already heavy as marbles with cells dividing uncontrollably.

Alyse Marie Carlson

Ms. Carlson is a member of the Class of 2016 at University of Iowa Roy J. and Lucille A. Carver College of Medicine. This poem won second place in the 2014 Pharos Student Poetry Competition. Ms. Carlson’s e-mail address is: alyse-carlson@uiowa.edu.

Illustration by Erica Aitken.

The weight of a marble

The author’s address is:
186 Jerry Browne Road #5416
Mystic, Connecticut 06355
E-mail: martinsetpoint@yahoo.com

The Pharos/Autumn 2014
The notes of a lullaby drifted through the labor and delivery ward, announcing the good news of a newborn baby. Muffled by the bustling sounds of the hospital wing, the song was missed by some. One young couple, however, heard the music clearly.

Steven Krager

The author is a member of the Class of 2014 at Creighton University School of Medicine. This essay won second prize in the 2014 Helen H. Glaser Student Essay Competition.
Their room was in the back of the ward, away from most of the traffic. A single solemn white rose was taped to the door. As the lullaby came to an end their eyes met for a moment.

“How are you feeling, Sarah?” John asked gently.

Sarah sighed. She did not know how she was feeling. How could she possibly express what was inside? How could she explain such a sense of loss? How could she put into words the sense that something was torn from the very center of her being? The only thing she could think of was having a beautiful dream, waking up and then feeling that dream slip away. Except this emptiness ached so much more.

“I’m okay.” She looked to the window.

Sarah thought back to a day ago. She had been content. She had spent the morning making preparations for the coming weeks. Family would be flying in and finishing touches needed to be put on the nursery. She had felt the baby kicking earlier in the day so she was not concerned when he calmed down in the afternoon. Later that day Sarah and John went to a prenatal appointment at the hospital.

The doctor frowned as she moved the device around Sarah’s belly. “I seem to be having a little trouble finding his heartbeat,” she said. “I’d like to check an ultrasound.”

The rest of the day was a blur. The ultrasound confirmed what everyone now feared and the nightmare became reality. Connor would never be born.

Sarah still had a hard time believing what had happened. While she had feared the idea of losing her child, nothing could have prepared her for what it was actually like. When they told her she would have to deliver the baby she was dumbfounded. The thought had not actually occurred to her. She had to actually deliver him? To go through the same discomfort and pain? To be greeted not with a forceful cry but a lifeless body?

“Love, what are you thinking about?” John asked.

Sarah looked at him. Throughout it all John had been a rock, but she could see the suffering in his eyes as well. She decided to be honest.

“I was thinking about yesterday. I . . . I cannot believe that we lost him. I’m trying to remember if I did something yesterday. Did I bump against the counter? Did I eat something wrong? I can’t think of anything. I just . . . I just don’t understand.”

“You remember what the doctors said. There was nothing that you did. Nothing that you could have done to prevent it.”

_Nothing that I could have done._ That phrase bothered Sarah. The idea of futurity was maddening. Her baby died inside of her body and she could not have prevented it. She was able to grow a child for over thirty weeks. Suddenly, something just happened to go wrong?

“I remember,” she replied softly.

They sat.

A quiet knock at the door broke the silence. A nurse entered. She seemed a little uncertain, her face a mixture of pity and hesitation. “Hello, Sarah, how are you feeling? Are you in any pain?”

_Am I in any pain?_ The question echoed through Sarah’s mind. With a flash of anger, she almost blurted out, “Am I in pain? What do you think?” but she stopped herself. She understood. One way the nurse could help would be to relieve her physical pain, and the nurse obviously wanted to help.

“No, I’m fine. Thank you.”

“All right. Let us know if you need anything.” The nurse left.

It was another common phrase that the nurse probably said all the time, but it stung Sarah. _I need my baby_, she thought. _I need to forget yesterday ever happened. I need to somehow replace this hole in my heart. I need . . . too many things that you can never get me._

“Everyone has been so nice here,” John remarked.

“Yeah.”

“I was thinking. We need to tell our families what happened. The last I told them was that you were getting checked over.”

The thought of talking about what happened with her family overwhelmed Sarah. For reasons she could not understand, she felt ashamed. The thought of talking about it with her mother, her sister, was almost unbearable. Sarah started to cry.

“Oh, I’m so sorry, Sarah.” He lay next to her on the bed, and she curled up against him. “Don’t worry about that right now. I can talk with them later.”

“It’s just so much. How do people get through something like this?”

“I don’t know how. I know people do, people do get through it. I know that we have each other. I do know that.”

Sarah continued to cry. She cried for her lost child. She cried for his father. She cried for all the birthdays he would never experience, all the places he would never visit, and all the friends he would never make. She cried because she would never give him a bath or hear his first word or watch him graduate. She cried because all of this had seemed certain to happen yesterday and now it was all taken away.

Down the ward there was a rush of activity. A newborn baby cried out. And then, the sounds of the lullaby drifted through the hallways.

Sarah looked towards the door. With a faint smile, she recalled the words to the lullaby she had learned long ago.

_Lullaby and goodnight,_
_With roses bedight,_
_Is baby’s wee bed._

_Lay thee down now and rest,_
_With lilies o’er spread,_
_May thy slumber be blessed._

—Brahms’ Lullaby

The author’s address is:

2111 W. 17th Street, Apartment K07
Santa Ana, California 92706
E-mail: krager21@gmail.com
Here comes a thorough review of all systems,
It's a rather long list of the usual questions,
To which you should answer: yes, no, or maybe.
And please, sir, don’t think that I’m utterly crazy
For asking you whether you tingle or twitch
When what you are here for is simply an itch.

We’ll start from the top, from your head to your toes,
And, oh, not to worry, we’ll get to your nose.
But first tell me this: do you smoke cigarettes?
Have you had any fever, chills or night sweats?
Very good, that all sounds more than okay,
Now, sir, have you had any chest pain today?

Any problem with feeling you can’t catch your breath?
Family history of sudden or unexplained death?
Yes, I know that these queries seem somewhat erratic,
But I promise I’m not being melodramatic.
Now let me inquire about pain in your tummy,
Does it ever feel even a little bit crummy?

Continuing downward, this is awkward, I know,
But it’s crucial to ask how it is when you go,
To the bathroom, that is, when you poop and you pee,
Have you noticed—well—is there blood you can see?
No? Great. We are almost done with the list,
Any surgeries? Even for a sebaceous cyst?

So now we’ve completed the record of those,
(And I promise I will take a look at your nose)
But first I’m afraid you may tell me to scram,
Because I must do a full physical exam.
Yes, I know it may seem a little bit much,
But I’m a student, remember, so I have a soft touch.

Let me get from my pocket my optical light,
To shine in your eyes—yes, it’s a little bit bright.
Next open your mouth and say “ah” if you’re able,
Great. Now please, if you could lie down on the table.
We’re really almost done, please don’t think I’m a nut,
As I listen to your heart and your lungs and your gut.

Everything sounds clear, and you don’t have a murmur,
No call to do tests or anything further.
Thank you so much, sir, let me say you were great,
I’m sure you’re relieved that we won’t keep you late.
I’ll just check very quickly with Dr. Butray,
To see if I can give you some—well—just nasal spray.
The physician at the movies

Peter E. Dans, MD

Jersey Boys

Starring John Lloyd Young, Erich Bergen, Vincent Piazza, and Michael Lamenda.

This film is not just for fans of Frankie Valli and the Four Seasons but also for those who came of age in the 1960s and 1970s listening to “Sherry,” “Walk Like a Man,” “Can't Take My Eyes Off You,” “Dawn,” “Big Girls Don't Cry,” “December 1963 (Oh What a Night),” and many of their other hits, most of which featured Valli’s falsetto, the group’s trademark. I came away amazed by the group’s sheer productivity, attested to by their worldwide sales of 175 million records.

The film is directed by Clint Eastwood whose fascination with jazz led him to direct Bird about the ill-fated Charlie Parker. Although not a fan of rock and roll, he did like this group and championed the film’s production. Jersey Boys is based on a story that originally appeared in a stage show that won four Tony awards in 2005 and is still running on Broadway and in national touring productions, as well as in London. While the stage show was sixty percent music, the film is about forty percent. Filming it allowed Eastwood to focus on the interplay between the members of the group. It also is more candid than the stage production, which didn’t reveal much of the group members’ early lives.

The film opens in Newark, picturing the group as what used to be called “juvenile delinquents” who collect stolen goods that supposedly “fell off the delivery truck.” Two of them, Tommy DeVito (Vincent Piazza) and Nick Massi (Michael Lamenda), are shown going in and out of jail. One feature of these early scenes that I didn’t particularly like was DeVito, the group’s bad boy, letting loose with F-bombs which mercifully abated when the film’s focus shifted more to principal songwriter Bob Gaudio (Erich Bergen) and to Valli himself (John Lloyd Young).

That these young men became renowned singers rather than small-time mobsters is in some respects a version of the Horatio Alger story in which hard work, determination, and a

John Lloyd Young (as Frankie Valli), Erich Bergen (as Bob Gaudio), Vincent Piazza (as Tommy DeVito), and Michael Lomenda (as Nick Massi) in Jersey Boys. © Warner Bros.
few good breaks led to success. That success had a dark side and came at a price, including addiction to drugs and alcohol, wild parties, cheating on spouses, absence from home, and Valli’s neglect of his two daughters as they were growing up. The toll it takes on his family is particularly poignant as his daughter, a talented singer, runs away from home, gets into drugs, and dies of an overdose. In his grief, all he can say is “your children shouldn’t die before you.” What is left out is that Valli was married and divorced three times and that a step-daughter died the same year as his first daughter.

The link between the Mafia and entertainment industry has been well documented in the life of that other Jersey Boy whom Valli idolized and hoped to surpass, Frank Sinatra, whose connections with the mob included the Copacabana in New York City as well as the Las Vegas and Cuban gambling/entertainment empires. The Four Seasons’ connections were considerably smaller, in the persona of “Gyp” DeCarlo, a local gambler and numbers runner, played by the only recognizable Hollywood actor, Christopher Walken, who adds a nice touch of lightness and steadiness to the film. DeCarlo promises Valli’s mother to keep Valli out of trouble. He also brokers a deal for the group to survive after DeVito gambles away their profits and Valli feels obliged to go solo to pay off the loan shark.

Eastwood chose almost his entire cast from the various stage companies. That probably was a good idea because they had internalized the story by playing their roles hundreds if not a thousand times. The scenes divulging how the group got its name and Frankie became Valli, rather than Valley, are particularly amusing. If you look carefully you can see Eastwood in an episode of the television series Rawhide which launched his career. He called it “a sneaky way of making a Hitchcock appearance.” One very effective technique Eastwood used was allowing the story to be told from the vantage point of the different singers. At the end of the movie, each group member talks directly to the audience giving his own point of view. The tagline is “Everybody remembers it how they need to.” This is an interesting way to conclude the story. Left unsaid is whether all those record sales, the election to the Rock and Roll Hall of Fame in 1990, the pleasure the group brought to many fans over the years, and the fame were worth the personal tragedies that came along with them.

References

Addendum
Growing up in New York City In the 1950s, I had a few degrees of separation from those reputed to be in the Mafia. In addition to many graduates of my high school, La Salle Military Academy, who served in the military or succeeded in business and the professions, it had graduates who became well-known, such as John Sununu, Chief of Staff of George H. W. Bush; John Zuccotti, deputy mayor of New York; Marcos McGrath, Archbishop of Panama; Peter O’Malley, son of Walter O’Malley, owner of the Brooklyn Dodgers and later owner of the LA Dodgers; the Somozas, presidents of Nicaragua; and director John Frankenheimer (see my review of his movie The Train below). There were also many young men from the families reputed to be Mafia. They were no different from a lot of other kids and I had no contact with their world; they were just in the same school.

My mother was an Italian and Spanish interpreter in the courts (Special Sessions, General Sessions, the State Supreme court). Through her I met and dated the daughter of one of the prominent defense lawyers and was introduced to a world where if she wanted impossible-to-get tickets for My Fair Lady starring Julie Andrews or Gypsy with Ethel Merman, orchestra seats suddenly appeared. Despite living in a tenement and a housing project almost the whole decade, I have to say that the 1950s in New York City was a magical time. Cue “Manhattan.”

The Monuments Men

Starring George Clooney, Matt Damon, Bill Murray, John Goodman, Cate Blanchett, and Bob Balaban.

This film was almost uniformly panned. With a $70 million budget, personable and talented actors, a cast of thousands, as well as lavish costumes and cinematography, what could possibly go wrong? Have the same person be the producer, director, screenwriter, and leading star—and not just any person but a paparazzi and fan favorite. The result is a Gorge Clooney vanity piece even to the extent that his father, Nick Clooney, a host of a PBS nostalgia music series, closes the picture walking hand in hand with his grandson down a church aisle into the sunshine after a visit to the Madonna of Bruges. The screenplay is based “loosely” on the book The Monuments Men: Allied Heroes, Nazi Thieves, and the Greatest Treasure Hunt in History by Robert Edsel. In one of the DVD’s special features, Matt Damon says that they didn’t want the movie to be a history lesson but rather more like a buddy movie or a heist picture. They succeeded. By the movie’s end, I had learned almost nothing about this group of art aficionados tasked by President Roosevelt to save the precious art works being stolen or destroyed by the Nazis. We are told that the best of the lot were destined to be in a museum to be built after the war in Linz, Austria, the birthplace of the Führer.

The picture opens with Frank Stokes (George Clooney) getting FDR’s permission to form the unit. The film then flashes briefly to Paris in March 1943, where Gestapo Major Stahl (Justus von Dohnányi) escorts Hermann Göring (Udo
Kroschwald) in one of his twenty or so visits to the Musée Jeu de Paume. Stahl asks his assistant Claire Simone (Cate Blanchett) to get another champagne glass—she and her fellow worker spit in it before pouring the champagne for the Germans.

Stokes recruits old buddies in the art world: James Granger (Matt Damon), Richard Campbell (Bill Murray), Walter Garfield (John Goodman), and Preston Savitz (Bob Balaban). All must undergo basic training, which is played for laughs as buddies might do, not those who intend to go to the front. Goodman wouldn’t have lasted a day of training.

They land at Normandy months after the D-Day invasion and join their French and British counterparts Jean Claude Clermont (Jean Dujardin) and Donald Jeffries (Hugh Bonneville). The film becomes very disjointed as Stokes splits the group into pairs and sends them to Bruges, Ghent, and other sites to locate an altarpiece and a statue of the Madonna and Child. The retrieval of these two treasures closes the movie. Unfortunately, the Frenchman and the Brit aren’t there to see the fruits of their labors—they take foolish chances and are killed.

Somehow Campbell and Savitz land at Bastogne in December 1944, where Campbell receives a copy of his wife singing “Have Yourself a Merry Little Christmas,” sung by Judy Garland in the 1944 musical Meet Me in St. Louis. It is played on the camp’s sound system while he showers. That in itself is hard to believe, but insult was added to injury when they used the version containing lyrics that were changed in 1957 by Frank Sinatra from “We’ll muddle through somehow” to “Hang a shining star up on the highest bough.” Oops!

Granger meets Simone, whose brother was in the Maquis (the French Resistance). She gives him the book in which she recorded the location of every painting. She offers to spend the night with him even though he is married. “This is Paris after all,” she says. He politely declines. Chalk one up for Granger/Matt Damon. The book reveals that many paintings have been stored in the salt and copper mines and in a castle. There, they find not just art, but gold bullion, and lots of gold teeth. Later Stokes finds a Gestapo officer destroying paintings and interrogates him. The war being just concluded, the German knows he doesn’t have to talk. Stokes tells him that he knows that he ran a concentration camp. The German asks if he’s Jewish. When Stokes says no, the German says, “Then you should thank me.” Stokes tells him that every morning back in New York he goes for a bagel and that, in one of his morning rituals, he hopes to find on page 18 of the Times that the German has been executed for war crimes. This is my vote for the most inauthentic scene out of a myriad of candidates.

To give the film some props they do raise the question if saving art is worth anyone’s life. They conclude that the two dead group members would have said yes. The question is even more forcibly posed in John Frankenheimer’s The Train.

The Train (1964)
Starring Burt Lancaster, Paul Scofield, Jeanne Moreau, and Suzanne Flon.
Directed by John Frankenheimer. B&W. Not rated. Running time 133 minutes.

This is a much better picture about the efforts to save the precious works of art. That this film was billed as John Frankenheimer’s The Train with his name above the title shows
how long a way he came from his high school days at La Salle Military Academy. He had already directed such films as *The Birdman of Alcatraz*, *The Manchurian Candidate*, and *Seven Days in May*. It was another example of his having taken over a troubled movie after the original director was fired, and making it a success. The film opens with a tribute to the French railway men “whose magnificent spirit and courage inspired the story.”

It is August 2, 1944, day 1511 of Germany’s occupation of Paris, and the allies are on the outskirts of Paris. Colonel Von Waldheim (Paul Scofield), in charge of protecting the artwork at the Musée Jeu de Paume, arrives at the museum, which is guarded by Nazi soldiers. As he visits his favorite pictures, his reverie is interrupted by the curator Mlle. Villard (Suzanne Flon), who thanks him for saving the pictures. She assumes that because Paris has been declared an Open City, the Allies will not bomb it and that the art will soon be safely turned over to them. He tells her that he has no thought of doing that; in fact he orders the paintings to be crated and taken aboard a train bound for Germany. As the credits roll, we see separate crates for Gauguin, Renoir, Van Gogh, Manet, Dégas, Miró, Picasso, Braque, Seurat, Cézanne, Matisse, Utrillo, Dufy, and Lautrec.

The colonel is angered when his train is commandeered to take armaments and troops back to Germany. He argues to the general in charge that the artwork is more precious than the troops, being worth millions of reichsmarks. Meanwhile, the curator asks the trainmaster Labiche (Burt Lancaster) to hold up the trains until the allies come, notwithstanding that any evidence of sabotage on the part of the railway men results in swift execution. He tells her that he has no thought of doing that; in fact he orders the paintings to be crated and taken aboard a train bound for Germany. As the credits roll, we see separate crates for Gauguin, Renoir, Van Gogh, Manet, Dégas, Miró, Picasso, Braque, Seurat, Cézanne, Matisse, Utrillo, Dufy, and Lautrec.

The colonel is angered when his train is commandeered to take armaments and troops back to Germany. He argues to the general in charge that the artwork is more precious than the troops, being worth millions of reichsmarks. Meanwhile, the curator asks the trainmaster Labiche (Burt Lancaster) to hold up the trains until the allies come, notwithstanding that any evidence of sabotage on the part of the railway men results in swift execution. In fact, the number of engineers is already low. Labiche says, “We are talking about the potential sacrifice of men for what? ‘La gloire de la France?’” Meanwhile, they are warned that Spitfires will strafe the railyards at 11 AM. The old engineer Papa Boule (Michel Simon) pulls out “his” train containing the art against orders to avoid its being hit. Having saved the paintings, he returns to the yard and sticks a franc in the oil line to keep the train from going any further. Von Waldheim detects the old trick and has him shot on the spot. Labiche takes over and he and his two assistants orchestrate an ingenious plan to save the paintings.

It’s fun to watch Lancaster do all his stunts in the railyards and on the moving train. Before he became a movie star, he was a circus acrobat. If you get a chance check out *The Flame and the Arrow* (1950) and *The Crimson Pirate* (1952) to see him go full bore in his prime in two lighthearted actioners. Though *The Train* was made in 1964, Frankenheimer chose to film it in black and white—between the smoke, the oil, and the grime, it’s hard sometimes to make out what’s going on; apparently, the weather was terribly rainy during the shooting as well.

The film becomes a contest between Von Waldheim and Labiche. The colonel thinks they are going through Metz, an important switching nexus to Germany, whereas Labiche has orchestrated an elaborate ruse to bring the train back to Paris in hopes it has been liberated. Jeanne Moreau plays a small but excellent part as Christine, a widowed innkeeper who helps Labiche to pull off his scheme. Unfortunately, the liberation of Paris is delayed as a gesture to allow the French to lead the re-occupation in their march to the Arc de Triomphe. This “gesture” embitters Labiche because many Frenchmen trying to save France’s patrimony and held hostage by Von Waldheim could die as a result. If so, most of them will never have been apprised of the reasons for their being put in jeopardy.

I don’t want to give away any spoilers. Trust me, the film is worth seeing.

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
Propped up in his bed
I could see the sandglass in his eyes
He barely had the strength to live
I had forgotten the doctor’s advice
As I leaned forward
He kissed me
And I didn’t hear the cars braking in the background
I didn’t recall my neighbor yelling at the hungry strays
Nor did I notice how the sunlight made the burnt orange walls look beige
I wasn’t present
I didn’t hear the news anchor welcome in the spring season
Or the blueberry waffles pop out of the toaster
I didn’t notice anything in that moment
Nothing that defined my world
Nothing that would remain
He kissed me
Took my hand in reluctance
Said there was something else
Or was it nothing?
He said something
But I couldn’t hear him
I was barely listening
As white noise consumed me
Unprepared
I may have been standing
Or sitting
But I know a part of me was there
Long enough to discover
We were no longer hopeful
Because he kissed me with pieces of goodbye

Said he was tired
Time had taken its toll
So he closed his eyes
And allowed the sandglass to disappear

Aisha Harris

Ms. Harris is a member of the Class of 2017 at Georgetown University School of Medicine. This poem won third place in the 2014 Pharos Student Poetry Competition. Ms. Harris’s e-mail address is: harris.aisham@gmail.com.
Illustration by Jim McGuinness.
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.

Reviews and reflections

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

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.

**Doctors Without Borders: Humanitarian Quests, Impossible Dreams of Médecins Sans Frontières**

Renée Fox (AΩA, Honorary Member, 2004)
Baltimore, Maryland, Johns Hopkins University Press, 2014

Reviewed Andrew Flescher, PhD

In her latest examination of a historically significant medical movement, health care sociologist and medical ethicist Renée Fox chronicles the history, mission, and political complexities of Médecins Sans Frontières (MSF), Doctors Without Borders, first founded in 1971. In the volume Fox manages to capture, mostly through her access to the revealing blogs of several of MSF’s clinicians, the first-person, often emotional and intimate accounts of those charged with the often draining tasks of healing and nurturing underprivileged inhabitants in war-beleaguered and disease-stricken regions of the world. Besides her ample access to these journals, what makes Fox’s work distinctive is her treatment of arguably irreconcilable tensions inherent in a movement that since its inception has struggled with a dual identity.

Indeed, much of Fox’s analysis hinges on the internal power struggles within MSF. MSF is first and foremost a humanitarian organization devoted to addressing the medical needs, and in some instances ameliorating the living conditions, of suffering populations. This said, as Fox explains, it began as a French leftist grassroots campaign committed to preserving the ideal of témoignage, “bearing witness,” a notion its founders interpreted right from the beginning to entail a resistance to becoming media darlings or to exoticizing the imperiled others they were seeking to help. MSF, in other words, historically has had pretensions to be a movement that was contradictorily practical and pure, accompanying its clientele into whatever murky and dangerous environments it may be ushered, while striving to remain uncontaminated by the political realities attendant to such noteworthy journeys. Like any movement with profound ambitions, MSF has had its share of compromisers and purists. Doctors Without Borders, then, tells the story of what happens when such an organization, as a condition of efficiently addressing world health crises, must form partnerships with the governments of other countries, the media, and other non-governmental organizations (NGOs) that are predictably less innocent and more tendentious than MSF in their own modes of operation. Naturally, rifts and schisms will ensure the more the organization becomes recognized (and funded) for its heroic endeavors.

Particularly throughout the first part of the book, Fox alludes to poignant examples that call attention to this tension. In one instance she describes a mission MSF undertook in 1979, eight years after its creation. Led by the flamboyant founding member and president, Bernard Kouchner, MSF sought to retrieve by ship Vietnamese refugees, “the boat people,” from their formerly besieged country. Kouchner and his supporters were later vilified for manufacturing a crisis for the sake of publicity. In the years after, MSF coped with whether its founding presuppositions allowed for expansion beyond its French Marxist setting. Could there be, for example, a Belgian or Greek wing of MSF? Would MSF’s ideological identification be diluted by working in non-European settings? In bringing modern medicine to the third world, would MSF become a subtle, if well-intended, prong of colonialism?

Internal pressure came to a head in the fall of 1999 when MSF received the Nobel Prize for Peace for its groundbreaking humanitarian efforts worldwide. Following the “collective astonishment” of receiving such a recognition, however, the award triggered the most serious internal crisis to date: such international commendation, critics from within MSF feared, irrevocably “institutionalized” a movement that was better served rebelling (and being known for rebelling). The conventional and too easily sanctioned policies of corrupt governments in cahoots with Western ones were, after all, the ones originally responsible for the problems of the populations they were committed to helping.

In the context of winning the Nobel
Prize, Fox psychoanalyzes MSF as a group struggling to neither let the good compromise the perfect, nor to let itself get “too big a head” and become an organization that arrogantly rested on its laurels. Fox subsequently devotes nearly eight pages to the question of how MSF worked out who was to give the recipient speech and what to do with the prize money. In the next two chapters, she dwells on comparable schisms played out in the case of MSF Greece. Throughout, Doctors Without Borders is replete with Fox’s reporting of MSF leadership’s intermittent self-condemnations for aiding and abetting war criminals in this or that case, or for failing to stay independent of compromising and scandal-plagued governments. At times the reader is left wondering why these sorts of questions of self-identity trump the magnificent achievements of the clinicians themselves, whose indefatigable labor brought the movement to fame in the first place.

Where Fox shines is, correspondingly, in her less convoluted heralding of the almost 30,000 personnel at every organizational level of MSF. Their individual stories are inspiring in both their largesse and in their specificity. Fox tells of several examples of clinicians fearlessly rushing into perilous environments and describes in meticulous detail the many obstacles with which they had to contend: disease outbreaks, such as the multi drug-resistant tuberculosis epidemic in Siberian prisons; genocidal conditions such as those in Darfur; and hostile governmental reception, such as they encountered with “AIDS denialism” in South Africa. Fox notes additional examples in which MSF became an instrument of social justice, serving as the megaphone through which the public would learn that widespread abuses were taking place on a systematic level within a stricken country’s borders. And in her prose she humanely captures the idiosyncratic motivations that historically led to such a diverse body of doctors and nurses deciding to undertake the “humanitarian quests” and to live the “impossible dreams” for which MSF would become known. These portions of the book are enough to recommend the volume, even if they are sometimes overshadowed by the extended attention Fox devotes to infighting within the movement, which at times misleadingly gives the reader an impression that recognition is the curse of accomplishment, or that collaboration represents the falling away of singularity of purpose.

Dr. Flescher is an associate professor of Preventive Medicine and English and core faculty in the Program in Public Health at Stony Brook University. His address is: Department of English Stony Brook University Stony Brook, New York 11794-5350 E-mail: andrew.flescher@stonybrook.edu

**Genesis of the Salk Institute: The Epic of Its Founders**

Suzanne Bourgeois
Berkeley, California, University of California Press, 2013

Reviewed by Thoru Pederson, PhD

This story about the Salk Institute for Biological Sciences is a riveting account of an MD who turned to virology immediately upon completion of his internship, and who then dedicated himself to research for the remainder of his career, attaining national and worldwide fame and going on to create a research center of excellence, despite many setbacks. Free-standing clinical research centers founded by physicians include the Mayo Clinic in 1889 (as St. Mary’s Hospital) by Will and Charlie Mayo, and the Cleveland Clinic in 1921 by the local physicians Frank E. Bunts, George Washington Crile, William E. Lower, and John Phillips. Basic biomedical research institutes founded by physicians are even rarer. This book offers an engaging read to anyone interested in the history of American medicine and biomedical science.

Suzanne Bourgeois launches her book with a brief account of the work that led to one of the two polio vaccines, but immediately gets to the gist of the story—Jonas Salk’s zeal once he had become a household name in America to create a research institute. Bourgeois traces the efforts Salk made to create his institute at his own institution, the University of Pittsburgh, as well as his explorations of other sites, such as Palo Alto in California. Local and other complexities doomed these two sites. The author then recounts how Salk looked to the Institute for Advanced Studies (IAS) in Princeton, New Jersey as perhaps a better model for his idea, which was still being progressively refined. This institute’s design was based on bringing in physicists who would just think—no labs, no actual experiments. As the author vividly relates, this notion appealed to Salk—not that he didn’t want actual labs in his planned institute but that he thought having some free-floating thinkers also walking around would be ideal. A second seed was also planted in Salk’s mind when he visited the IAS: such a research center could be placed near the campus of a fine university but yet be administratively and financially separate from it.

And so it came to pass that, in part influenced by advice from the Princeton Institute’s Robert Oppenheimer, Salk went out to San Diego, where he encountered the oceanographer and dynamic scientific impresario Roger
Revelle, a towering Norwegian who had by this time convinced the San Diego city leaders that biology was one of the sciences of the future and had also convinced the trustees of the University of California that there should be a new campus in San Diego. Salk hit it off with both Revelle and the San Diego civic leaders and the rest is history.

What about Salk’s dream that his new institute should have both lab scientists and “thinkers”? He invited an elite cast of intellectuals to come as “Fellows,” envisioning that they would walk along the campus—a magnificent site overlooking the Pacific Ocean—and both among themselves and with the research scientists they would somehow divine trans-disciplinary ideas to advance biomedical science. The author emphasizes how strongly Salk, a physician, believed that this broader view was essential and how this outlook was embodied in his choice of the “founding Fellows,” including the humanist-philosopher of science Jacob Bronowski who was keen about Charles Percy Snow’s then-famous idea of “two cultures” (science and the humanities, each out of touch with the other). This part of Salk’s scheme began well enough but eventually ran down. The idea, however, was very much a part of Salk’s persona and was a surprising dimension that would not have been predicted from anything in his earlier career. Perhaps he believed in the notion of shem tov—to leave a name crowned not by fame, but by something good done.

What one can take away from this book is how a physician-virologist—possessed both by a physician’s drive to prevent a disease and later a zeal for leaving a greater legacy—got it done. Salk was never elected to the U.S. National Academy of Sciences nor did he or Albert Sabin win the Nobel Prize. One of Salk’s legacies was the National Foundation for Infantile Paralysis/March of Dimes. His other was the Salk Institute.

Due to the current NIH funding nadir, the lowest in forty-five years, many freestanding biomedical research institutes are now exploring university affiliations. What Suzanne Bourgeois’ book teaches us is that Jonas Salk had a restless ambition beyond pediatric infectious disease and that when he achieved unimaginable fame, he chose not to rest on his laurels but to push on for Act II. The author powerfully presents this fascinating man and his journey as the powerful drama that it was.

Reference


Dr. Pederson is the Vitold Arnett Professor of Cell Biology and professor of Biochemistry and Molecular Pharmacology at the University of Massachusetts Medical School. His address is:
364 Plantation Street
Worcester, Massachusetts 01605-2300
E-mail: thoru.pederson@umassmed.edu

The Teaching Hospital: Brigham and Women’s Hospital and the Evolution of Academic Medicine

Peter V. Tischler, Christine Wenk, Joseph Loscalzo (AQ&A, Boston University, 1997), editors
Reviewed by William P. Reed, MD

This year is the one-hundred-year anniversary of the founding of the Peter Bent Brigham Hospital. It combined with four other hospitals and other entities at various times to form the present Brigham and Women’s Hospital. The intervening century has seen enormous changes in the practice and effectiveness of medicine, and changes in its teaching. This book was written to document many of those changes and to show the leading role of Brigham and Women’s Hospital in bringing them about. For instance, the most common diagnosis for patients admitted to the Medical Service during the first year of the Peter Bent Brigham’s existence was typhoid fever. This diagnosis is now rare in the United States and many other countries. In fact, I know many young physicians who have never seen a case of it. Portions of this book were written by dozens of authors and tied together into a cohesive whole by the editors who themselves also authored large parts of the book. I graduated from Harvard Medical School in 1959, and a large share of my clinical work was done at the Brigham. The hospital structure today is entirely new and vastly superior to the original that I experienced during my training.

For writing this review I read the entire book, but I presume that many people who refer to it will read only portions. The index is quite complete and should allow most readers to do that with ease. During my second year in medical school I lived at the Free Hospital for Women, where I knew and worked for Dr. John Rock, helping with some of his research in infertility. Therefore I found portions of the book about him to be of particular interest. The book points out that he was a world leader in evaluating and treating infertility. He strongly felt that women should be in charge of their own fertility and the timing of their pregnancies. He is perhaps best known for his work in developing and clinically testing the first birth control pill. He was excommunicated by the Catholic Church for this work, and felt deeply wounded by this action.

Another of the many interesting
The treatment of renal failure was of great interest to many people at the Brigham during the Nazi occupation of Holland in World War II, a Dutchman named Willem Kolff invented an artificial kidney and used it to dialyze patients who were dying of renal failure. Kolff ended up working with John Merrill, an internist and sub-specialist in renal disease, and with Carl Walter, a surgeon and engineer. The result was a much more compact machine than Kolff’s original and they called it the Brigham-Kolff Dialysis Machine. It now resides at the Smithsonian, and is the forerunner of a wide variety of newer machines. This new machine was successful in prolonging life, but the cost was high, especially in time spent on dialysis by the patient.

This situation rather naturally led to a high level of interest in kidney transplantation, and the Brigham also became a leader in this. The world’s first successful kidney transplant was at the Brigham in 1954 and involved identical twins as donor and recipient. The surgeon was Joseph Murray.

However, subsequent attempts at transplantation usually failed, and it soon became apparent that the major problem preventing transplantation was host rejection of the transplant. There were several potential approaches to reducing the immune response that led to rejection. For instance, I did a renal rotation at the Brigham at a time when total body radiation was being tried as a mode of immunosuppression, but the result was that most subjects died of the radiation. It was quite discouraging. In 1959 investigators from Tufts reported that treatment of experimental animals with the anticancer drug 6-mercaptopurine (6-MP) lowered antibody titers. Investigators from Murray’s laboratory at the Brigham tested a number of derivatives of 6-MP and found that azathioprine prolonged graft survival. Azathioprine plus corticosteroids became the standard immunosuppressive drug for tissue transplantation for nearly two decades, but has subsequently been replaced by cyclosporin A.

By the 1970s it became recognized that most medical research had been performed using adult white male subjects and the results might not be applicable to other groups. One of the early responses to this observation was from Frank Speizer, a Harvard physician at the Channing Laboratory, which at that time was located at Boston City Hospital and soon became a part of the Brigham Hospital. The original question from this national questionnaire-based study was: does use of the birth control pill by women lead to breast cancer? Later it was expanded to look at many aspects of women’s health, and clinical trials were included. One of these added studies showed that daily low dose aspirin may have a role in preventing ischemic stroke in women. However, it lacked the role of preventing the thrombotic consequences of coronary artery disease which a PHS study had shown in men. Although it did not reduce the frequencies of heart attacks in most women, it did reduce heart attacks in women over the age of sixty-five.

I have focused this review on a few of the remarkable research aspects of Brigham and Women’s Hospital during its first century. However, it also showed excellence in patient care and teaching. The Flexner Report had recently come out when the Peter Bent Brigham Hospital was first formed, and the Brigham Hospital and the Johns Hopkins University Hospital were the first two to take this report seriously and thoroughly reorganize medical education along the lines the report suggested.

The book is well organized, well written, and a pleasure to read. I would recommend this book to anyone presently or formerly associated with Brigham and Women’s Hospital, and would recommend reading of selected parts by those interested in the huge changes that have taken place in the past 100 years of medicine including medical education, medical care, and research.

Dr. Reed is retired from a professorship in Internal Medicine and Infectious Diseases at the University of New Mexico School of Medicine. His address is:
317 Hermosa SE
Albuquerque, New Mexico 87108
E-mail: wreed1@centurylink.net
Letter to the editor

Wonder Bread

It was the summer of 1935 at 195 West Central Avenue, Pearl River, New York, and one of those hot, sultry days made hotter by the pushing of our old lawn mower over grass that I had let grow for too long. I was happy to be called by my Mom from the porch of our $35-per-month rented four-room bungalow. Anything to interrupt mowing was fine with me.

“I’m looking for a penny and I’ll bet I can find one before you can. I have a dime and need eleven cents for you to take downtown to buy a loaf of Wonder Bread.”

“What do I get if I win?”

“You get to have a piece of bread with dinner tonight,” she replied.

I ran to my room, opened the lower drawer of my dresser and, as I suspected, there among bubble gum cards, bottlecaps, unusual colored stones, and pieces of colored ribbon was a penny.

I had never, at age seven, thought of our family as poor. But at this point my Dad had not worked for three years except for brief stints as a playground supervisor at $18 dollars per week. After three years of college he commuted to a good job in New York City with an up-and-coming advertising firm. He was the last person to be let go before the firm folded in 1932. He and my Mom had planned to save enough to build their own home but my mother died in 1958 and my Dad three years later, both in the little bungalow.

I had never known the magnitude of the debt incurred over the span of the three and a half years my father was without a job. However, when he died in 1961 his total estate consisted of a single term-life insurance policy with a benefit of $6000. As his sole heir, I used all of it to pay the remaining balance on the loan he had taken from the Pearl River State Bank in 1936 to pay off his creditors. He had added six percent interest to each account in appreciation for their kindness and patience.

I was thirty-three years old in 1961, married, with a three-year-old daughter, and completing my research fellowship at UCLA prior to starting my academic career as a full-time assistant professor of Medicine at Columbia College of Physicians and Surgeons in New York City. My starting salary was $15,000 per year. From my perspective this was a huge income, given that I made it through Colgate University as a premed with a $1,000 per year scholarship, through Columbia medical school with a $4,000 per year scholarship, and then internship, residency and fellowship with $9,000 per year. All in all close to $74,000 in supplemental scholarships over sixteen years of post-high school education. This made it possible for this Great Depression kid to start his career unburdened by debt and that made a huge difference in my life. I retired in 1997 as Castera Professor of Medicine and Physiology and Director of the UCLA Cardiovascular Research Laboratory.

A year prior to retirement I began to volunteer at the 2,400-student Lennox Middle School as an advisor for their Science Fair and speaker for their Career Day. The Lennox Community occupies just 1.3 square miles immediately east of Los Angeles International Airport. It is extremely impoverished, with ninety-six percent of its students qualifying for free lunch. Sixteen gangs operate in the district. Progression of a student through high school to graduation was problematic; entry to a four-year college, a rarity. Many of the students had never travelled outside the district in their lives! This Depression kid immediately identified with these twelve- to thirteen-year-olds.

My wife, Marianne, and I launched what we called “The Partnership Scholars Program” at Lennox in 1996 with the following goal: That motivated but economically and culturally disadvantaged students are limited not by their environment but are assured of progressing to a level determined only by their own considerable talents to the end that they will be competitive for entry into four-year colleges with scholarship aid.

A volunteer college-educated mentor is assigned to a seventh grader and mentors him/her extracurricularly for the next six years through high school graduation until college entry. An annual stipend of $2,100 per year covers scholar and mentor expenses for extra books, calculators/computers, museum trips, concerts/plays/meals with mentors and other scholars, campus visitations, educational travel, summer enrichment programs on college campuses, SAT prep—all the things that a middle-class family would provide for their college-bound child.

As of June 2013 we have graduated a total of 286 high school seniors from nine school districts, both urban and rural, in California. Of this group 265 (ninety-three percent) have been accepted to, are attending, or have graduated from sixty-one colleges across the country. The 265 have received more than $25 million in scholarship/financial aid, averaging over $94,000 per scholar for their four years of college or more than seven times the monetary investment of the Partnership Program over six years.

One of our current scholars recently wrote in thanking his sponsor: “You have given me the opportunity to prove I can be someone, that I can be more than a high school graduate working at Wal-Mart. You see, I have dreams; dreams that are one step closer to becoming true. At first I had no dreams, but now, knowing that there are people out there that see the potential in me, everything is changed.”

Glenn Langer MD
(A2A, Columbia University College of Physicians & Surgeons, 1953)
Founder, Partnership Scholars (www. partnershipscholars.org)
P. O. Box 361
Little River, California 95456
E-mail: glang@mcn.org
Leadership has long been a core value of Alpha Omega Alpha Honor Medical Society and is one of its criteria for membership. Because of their unique knowledge in medicine and their understanding of medicine’s core professional values, physicians are ideally suited to serve as leaders in these areas. Their professional experiences in serving and caring for people and working with teams in the health professions provide a solid foundation for leadership. AΩA believes that the best and most sustainable leadership for medicine must be grounded in the professional values of integrity and honesty, loyalty and duty, respect and care, service, and communication.

The AΩA Fellow in Leadership Award recognizes and supports 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 AΩA Fellow in Leadership Award 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.

We are pleased to announce the 2014 AΩA Fellows in Leadership, each of whom received a $25,000 award to be used for further development as future leaders:

- **Nathan E. Goldstein, MD**—Interim Director, Palliative Care Program, Mount Sinai-Beth Israel Hospital
- **Lieutenant Colonel Joshua D. Hartzell, MD**—Associate Program Director, Internal Medicine Residency, Assistant Chief of Graduate Medical Education, Army Intern Director, Walter Reed National Military Medical Center
- **Monica Vela, MD**—Associate Professor of Medicine and Associate Dean for Multicultural Affairs, University of Chicago Pritzker School of Medicine

Fellows and members of the AΩA Board of Directors Committee on Leadership met in Hanover, New Hampshire for a two-day orientation meeting on July 8-9, 2014, in which fellows were helped to think more deeply about their projects and their leadership opportunities. Following the orientation meeting, fellows and some committee members attended the Geisel School of Medicine leadership course, The Science and Practice of Leading Yourself.
Nathan E. Goldstein, MD
Associate Professor of Medicine, Icahn School of Medicine at Mount Sinai

Dr. Goldstein (AΩA, Mount Sinai School of Medicine, 1998) is an Associate Professor in the Brookdale Department of Geriatrics and Palliative Medicine at the Icahn School of Medicine at Mount Sinai. His areas of expertise include pain in older adults, palliative care, and the use of advanced technologies for patients near the end of life. Dr. Goldstein is a clinician investigator whose work examines ways to improve patient-physician communication in patients with advanced heart failure. He has published both on his research as well as on a broad range of communication issues in palliative medicine in both general medicine and specialty journals. He lectures extensively across the country on palliative care.

Dr. Goldstein is an attending physician on Mount Sinai’s inpatient palliative care consult service, and is a clinician researcher at the James J. Peters Veterans Affairs Medical Center in Bronx New York. He was recently promoted to the position of Interim Director of the Palliative Care Program at Mount Sinai-Beth Israel Hospital. He graduated magna cum laude with a BA in Biology from Carleton College in Northfield, Minnesota, where he was elected to Phi Beta Kappa, and attended the Mount Sinai School of Medicine, where he was elected to Alpha Omega Alpha. He completed his training in internal medicine at the Mount Sinai Medical Center, followed by health services research training in the Robert Wood Johnson Clinical Scholars Program at the Yale University School of Medicine. He then returned to Mount Sinai to complete a clinical geriatrics fellowship, and subsequently joined the faculty in 2004.

**Leading and Redesigning an Academic Palliative Medicine Program**—Palliative care is interdisciplinary care that aims to relieve suffering and improve the quality of life for patients and their families; it is provided at the same time as life-sustaining or curative treatments. As a palliative care physician and geriatrician in the Brookdale Department of Geriatrics and Palliative Medicine at the Icahn School of Medicine at Mount Sinai, I am deeply dedicated to providing high-quality palliative care for patients and their families. I have recently been appointed the Director of the Palliative Care Program at Mount Sinai-Beth Israel, an 856-bed teaching hospital founded in 1889 on Manhattan’s Lower East Side. My new appointment is a result of a recent merger of hospital systems and the staffing changes associated with the addition of Beth Israel to the Mount Sinai Health System. In this position, I am charged with redesigning the organizational structure of the division, creating a strategic plan and business case for the new service, and developing metrics to track the quality of care delivered by the palliative care team. I will use the AΩA award to develop skills to help me lead this new division through this period of change and transition. I will be reporting directly to the president of the hospital as well as to the director of the palliative care institute for the Mount Sinai Health System. In addition to being mentored by both of these individuals, I will undertake a program of formal coursework and work with an executive health care coach.

Joshua Hartzell, MD
Associate Program Director, Internal Medicine Residency
Assistant Chief of Graduate Medical Education
Army Intern Director, Walter Reed National Military Medical Center

Lieutenant Colonel Hartzell (AΩA, Uniformed Services University of the Health Sciences, 2001) was born and raised in Pennsylvania and then went to Duquesne University where he was one of the Distinguished Military Graduates of the Army ROTC program. Dr. Hartzell then attended the Uniformed Services University of the Health Sciences School of Medicine (USUHS). Following medical school, Dr. Hartzell went to Walter Reed Army Medical Center for his residency in Internal Medicine. He was selected as Chief Resident and served in that position until starting his Infectious Diseases Fellowship in 2006. He is currently board certified in Internal Medicine and Infectious Diseases and holds the Certificate of Knowledge in Clinical Tropical Medicine and Travelers’ Health from the American Society of Tropical Medicine and Hygiene. He is a graduate of the Stanford Faculty Development Facilitator Course. Dr. Hartzell currently serves as the Associate Program Director for the Internal Medicine Residency, Assistant Chief of Graduate Medical Education (GME), and Army Intern Director at Walter Reed National Military Medical Center (WRNMMC). Dr. Hartzell’s current interests include mentorship, teaching, and leader development.

Dr. Hartzell has thirty-six peer reviewed publications, four letters to the editor, one book chapter, and eighteen abstracts. Dr. Hartzell has been an invited speaker or guest lecturer twenty times at different regional, national, and international venues. Dr. Hartzell has served as a reviewer for nineteen
different scientific journals including Clinical Infectious Diseases and Lancet Infectious Diseases. He currently holds the rank of associate professor at USUHS.

Moving Beyond Accidental Leadership: A Leadership Curriculum Proposal—Few medical schools and GME programs including the military provide explicit training on the knowledge, skills, and attitudes necessary to be an effective physician leader. Rather, most leaders develop through what has been called “accidental leadership.” I propose to create a leadership curriculum for the Graduate Medical Education Programs at WRNMMC and beyond. Instilling these concepts and skills into physicians during residency or earlier will create better leaders and develop a cadre of physicians who are more likely to pursue careers in leadership or, at a minimum, to be more adept at handling the day-to-day leadership moments faced by physicians. I am fortunate to have a team of leaders who are supportive of this proposal and will be providing personal mentoring throughout the year. The leadership and vision of Colonel Michael Nelson (Director of Education, Training, and Research at WRNMMC), Colonel Cliff Yu (Chief of GME at WRNMMC), Arthur Kellermann (Dean of USUHS), Lieutenant General (Retired) Eric Schoomaker (former Army Surgeon General, current Scholar-in-Residence and Distinguished Professor of Military and Emergency Medicine at USUHS), and Colonel Pat O’Malley (AΩA councilor at USUHS) have been instrumental in creating momentum for this project. Just as important has been the response of the trainees, who are eager to solidify their skills as leaders. As medical educators and leaders, we must continually evolve and make it a priority to develop the next generation of leaders. The goal of our team is to create a curriculum that enhances the leadership skills of a generation of military physicians.

Monica Vela, MD
Associate Professor of Medicine and Associate Dean for Multicultural Affairs, University of Chicago Pritzker School of Medicine

Dr. Vela (AΩA, University of Chicago, 2003) received her MD degree in 1993 at the University of Chicago Pritzker School of Medicine, completed internship in a dual Internal Medicine and Pediatrics program there, and completed residency in Internal Medicine at the University of Chicago in 1996. She provides primary care for patients at the Primary Care Group of University of Chicago Medicine (UCM). She has taught the nationally recognized course, Health Disparities: Advocacy and Equity since 2006. She directs a summer enrichment program for under-represented minority students and also directs the Minority Visiting Clerkship program for visiting senior students. She has served as the Associate Vice Chair for Diversity within the Department of Medicine at the University of Chicago since 2006 and as the Associate Dean for Multicultural Affairs at the Pritzker School of Medicine since 2011. In 2011, she was awarded the American College of Physicians’ National Award for Diversity and Access to Care, and in 2014 she was awarded the Society of General Internal Medicine’s Nickens Award for Diversity and Minority Health.

Promoting Diversity in the U.S. Physician Population—Promoting the diversity of the U.S. physician population is an important step in addressing health and health care disparities for minority and underserved populations. Multiple studies have shown that under-represented minority (URM) physicians are more likely to provide care for minority, underserved, and indigent populations. Under-representation of minority medical students is problematic because medical students value diversity in their classmates, and diversity improves all students’ academic experiences and their abilities to work with patients from differing backgrounds. Medical schools vie for the same limited number of qualified minority premedical students. Medical schools have responded to this challenge by developing a pipeline of students supported by a variety of summer enrichment experiences.

The lack of published studies on existing programs significantly limits the ability for others to reproduce successful pipeline elements and to share process measures. No studies exist that review the practices of these unpublished programs for curricular content, teaching modalities, or assessment practices. My project has two specific aims:

• To develop and deliver a survey of the minority medical students across the United States to understand a) how many of them participated in pipeline programs, and b) explore which intervention practices have impacted either their admission to medical school or their success in navigating medical school.

• To develop and deliver in-depth interviews of pipeline program directors at U.S. medical schools in an effort to explore the types and scope of pipeline program interventions within academic centers and the perceived barriers to and facilitators of the interventions’ success. We will explore: a) those interventions that address the assets believed to promote minority student success in the process of applying to and succeeding in medical school, and b) the tools and instruments being used to assess pipeline intervention strategies.
The Board of Directors of Alpha Omega Alpha is pleased to announce the winner of the 2014 Edward D. Harris Professionalism Award. This award emphasizes AΩA's commitment to its belief that professionalism is a crucial facet of being a physician, a quality that can be both taught and learned. Originally named the AΩA Professionalism Fellowship, the award was renamed in 2010 to honor the late Edward D. Harris, the longtime executive director of the society. Applications were open to medical schools with active AΩA chapters or associations. Faculty who have demonstrated personal dedication to teaching and research in specific aspects of professionalism that could be transferred directly to medical students or resident physicians were encouraged to apply for these funds.

The winner of the 2014 Edward D. Harris Professionalism Award is:

**Lisa Moreno-Walton, MD, MS, FACEP, FAAEM**
Professor of Clinical Emergency Medicine at Louisiana State University Health Sciences Center—New Orleans

Professionalism in clinical medicine entails providing every patient with the best service, and this requires that physicians are culturally competent and sensitive to the needs of unique patient populations. A recent review of the literature and an unpublished study conducted by Moreno, et al., indicate that medical school and residency didactic curricula provide an average of forty-five minutes a year of education regarding the unique health needs of the lesbian/gay/bisexual/transgender (LGBT) population. For this project, our team will create a video teaching tool designed to familiarize the learner with several health care situations unique to the LGBT population. It will address several errors and misconceptions common in the treatment of this population and will model culturally competent treatment interventions that can be rendered with dignity and mutual respect. The video project will make the learning of material, for which there are few content experts, widely available to medical students and residents, schools, and programs, both nationally and internationally.
In 2011, the board of directors of Alpha Omega Alpha established the Postgraduate Award to encourage and support AΩA residents or fellows from programs or institutions with an active AΩA chapter or association to pursue a project in the spirit of the AΩA mission statement. Project applications were accepted in the categories of:

1. Research: Support for clinical investigation, basic laboratory research, epidemiology, or social science/health services research.
2. Service: Local or international service work, focusing on underprivileged or immigrant populations or those in the developing world, as well as patient and population education projects.
3. Teaching and education: Research, development, or implementation of education academic curricula, with the focus on postgraduate education.
4. Leadership: Leadership development.
5. Humanism and professionalism: Projects designed to encourage understanding, development, and retention of traits of humanism and professionalism among physicians, directed to physicians in postgraduate training.

Ten applicants received $2000 awards to support their work. The recipients of the 2014 awards are:

Tyler Albert, MD
University of Washington School of Medicine
Project category: Teaching and education
*Mechanical ventilation training curriculum for critical care residents in Phnom Penh, Cambodia*
T. Eoin West, MD, mentor

Paige Armstrong, MD
George Washington University School of Medicine and Health Sciences
Project category: Research
*The effect of self-reported limited English proficiency on patient care and satisfaction in the emergency department*
Melissa McCarthy, ScD, mentor

Caitlin Demarest, MD
Columbia University College of Physicians and Surgeons
Project category: Research
*Development of a pulmonary assist device for chronic lung disease and pulmonary hypertension*
Keith E. Cook, PhD, mentor

Neha Gupta, MD
University at Buffalo State University of New York School of Medicine & Biomedical Sciences
Project category: Research
*Implementation of a palliative care screening tool in a genitourinary oncology clinic and assessment of its impact on volume of palliative care referrals, improvement in patients’ symptom burden and satisfaction: A quality improvement project*
Roberto Pili, MD, mentor

Cara Liebert, MD
Stanford University School of Medicine
Project category: Teaching and education
*Interdisciplinary simulation-based crisis resource management training curriculum for general surgery and anesthesia residents*
James N. Lau, MD, mentor

Robert McGarrah III, MD
Duke University School of Medicine
Project category: Research
*Identification of clinical characteristics and metabolic pathways linking insulin resistance and cardiovascular disease*
Swati Shah, MD, MS, mentor

Akshitkumar Mistry, MD
Vanderbilt University School of Medicine
Project category: Research
*Probing glioblastoma heterogeneity to expose cellular and molecular predictors of therapy response using novel flow- and mass-cytometry based assays*
Rebecca Ihrie, PhD, mentor

Joshua Palmer, MD
Sidney Kimmel Medical College of Thomas Jefferson University
Project category: Research
*Glioblastoma multiforme outcomes, toxicity and patterns of failure based on radiation therapy treatment volumes*
Maria Werner-Wasik, MD, and Jing Li, MD, PhD, mentors

Deepali Tukaye, MBBS, PhD
Ohio State University College of Medicine
Early remote ischemic conditioning provides cardioprotection in NSTEMI
Subha Raman, MD, mentor

Lisa VanWagner, MD
Northwestern University Feinberg School of Medicine
Project category: Research
*Derivation and validation of a cardiac risk index in liver transplantation*
Donald Lloyd-Jones, MD, ScM, mentor

Marjorie Sirridge, MD
1921–2014

Pharos Editorial Board member Dr. Marjorie Sirridge died on July 30, 2014. Dr. Sirridge was one of the founding faculty members of the University of Missouri-Kansas City School of Medicine. She is one of the women physicians profiled on the National Library of Medicine’s Changing the Face of Medicine: Celebrating America’s Women Physicians web site. Read more about Dr. Sirridge here: http://www.nlm.nih.gov/changingthefaceofmedicine/physicians/biography_296.html.

Dr. Sirridge (AΩA, University of Kansas, 1943) was appointed to the editorial board of The Pharos in 1997 and served until shortly before her death. We will miss her insightful reviews and her unfailing willingness to serve. The note from her son informing us of her death included this observation: “I am sure she would have liked to review one more article! That was her nature.”
Beginning in 2002, Alpha Omega Alpha’s board of directors offered every chapter and association the opportunity to host a visiting professor. Sixty-seven chapters took advantage of the opportunity during the 2013/2014 academic year to invite eminent persons in American medicine to share their varied perspectives on medicine and its practice.

Following are the participating chapters and their visitors.

ALABAMA
University of Alabama School of Medicine
Thomas Harbin, MD, MBA, University of Alabama School of Medicine

ARIZONA
University of Arizona College of Medicine
Jesse Hall, MD, University of Chicago Division of the Biological Sciences The Pritzker School of Medicine

ARKANSAS
University of Arkansas for Medical Sciences College of Medicine
Wesley Burks, MD, University of North Carolina at Chapel Hill School of Medicine

CALIFORNIA
University of California, Davis, School of Medicine
David Watts, MD, University of California, San Francisco, School of Medicine

DISTRICT OF COLUMBIA
George Washington University School of Medicine and Health Sciences
Dianna Grant, MD, Chicago Medical School at Rosalind Franklin University of Medicine & Public Health

FLORIDA
Florida State University College of Medicine
C. Bruce Alexander, MD, University of Alabama School of Medicine and the AΩA Board of Directors

INDIANA
Indiana University School of Medicine
Charles Moore, MD, Emory University School of Medicine

KANSAS
University of Kansas School of Medicine
Robert Simari, MD, University of Kansas School of Medicine

LOUISIANA
University of Louisiana School of Medicine
Robert Pynoos, MD, University of California, Los Angeles David Geffen School of Medicine

MARYLAND
Uniformed Services University of the Health Sciences F. Edward Hébert School of Medicine
Darrell Kirch, MD, Association of American Medical Colleges

MASSACHUSETTS
Boston University School of Medicine
Richard Gunderman, MD, PhD, Indiana University School of Medicine and the AΩA Board of Directors

MICHIGAN
University of Michigan Medical School
James Bagian, MD, University of Michigan Medical School

MISSISSIPPI
University of Mississippi School of Medicine
Ponjola Coney, MD, Virginia Commonwealth University School of Medicine

MISSOURI
Saint Louis University School of Medicine

NEW JERSEY
Rutgers University School of Medicine

NEW YORK
New York University School of Medicine

OHIO
Case Western Reserve University School of Medicine

OREGON
Oregon Health & Science University

PENNSYLVANIA
University of Pennsylvania School of Medicine

RHODE ISLAND
Brown University School of Medicine

SOUTH CAROLINA
Medical University of South Carolina

TENNESSEE
University of Tennessee Health Science Center

TEXAS
University of Texas Southwestern Medical Center

VERMONT
University of Vermont College of Medicine

WASHINGTON
University of Washington School of Medicine

WEST VIRGINIA
West Virginia University School of Medicine

WISCONSIN
University of Wisconsin School of Medicine and Public Health

WYOMING
University of Wyoming

The Pharos/Autumn 2014
The Alpha Omega Alpha Volunteer Clinical Faculty Award

The Alpha Omega Alpha Volunteer Clinical Faculty Award is presented annually by local chapters or associations to recognize community physicians who have contributed with distinction to the education and training of medical students. AΩA provides a permanent plaque for each chapter’s dean’s office; a plate with the name of each year’s honoree may be added each year that the award is given. Honorees receive a framed certificate and engraved key ring. The recipients of this award in the 2013/2014 academic year are listed below.

**CALIFORNIA**
University of California, San Francisco, School of Medicine
Abhay Dandekar, MD

**DISTRICT OF COLUMBIA**
George Washington University School of Medicine and Health Sciences
Helen Burstin, MD
Howard University College of Medicine
Marc E. Rankin, MD, FACS

**GEORGIA**
Morehouse School of Medicine
W. Steven Wilson, MD

**HAWAII**
University of Hawaii, John A. Burns School of Medicine
Greg K. Sakamoto, MD

**ILLINOIS**
Chicago Medical School at Rosalind Franklin University of Medicine & Science
Martin P. Lanoff, MD
University of Chicago Division of the Biological Sciences The Pritzker School of Medicine
Mark Talamonti, MD
University of Illinois College of Medicine
Fred Richardson, MD

**INDIANA**
Indiana University School of Medicine
Jerry M. Jesseph, MD

**IOWA**
University of Iowa Roy J. and Lucille A. Carver College of Medicine
Spencer Carlstone, MD

**KENTUCKY**
University of Louisville School of Medicine
Ronald Wright, MD

**LOUISIANA**
Louisiana State University School of Medicine in Shreveport
James Jackson, MD

**MARYLAND**
Johns Hopkins University School of Medicine
Willard Standiford, MD
University of Maryland School of Medicine
John Irwin, MD

**MASSACHUSETTS**
Boston University School of Medicine
Stephen Brooks, MD
University of Massachusetts Medical School
Audrey Tracey, MD

**MICHIGAN**
University of Michigan Medical School
Amanda Rabquer, MD

**MINNESOTA**
University of Minnesota Medical School
David Freeman, MD

**NEBRASKA**
University of Nebraska College of Medicine
Jerry Fischer, MD

**NEW JERSEY**
Rutgers New Jersey Medical School
Paul Ahn, DO
Rutgers Robert Wood Johnson Medical School
Gary Forester, MD

**NEW YORK**
Icahn School of Medicine at Mount Sinai
Mark C. Rabine, MD
New York University School of Medicine
Maria C. Shiao, MD
State University of New York Downstate Medical Center College of Medicine
Peter Gillette, MD
State University of New York Upstate Medical University
Daniel Harris, MD
University of Rochester School of Medicine and Dentistry
Stephen Ettinghausen, MD
Weill Cornell Medical College
Shari Midoneck, MD

**NORTH DAKOTA**
University of North Dakota School of Medicine and Health Sciences
Michael Luckenbill, MD

**OHIO**
Ohio State University College of Medicine
Roger Chaffee, MD
University of Cincinnati College of Medicine
Anthony Cionni, MD

**PENNSYLVANIA**
Drexel University College of Medicine
Daniel Taylor, DO, FAAP
Sidney Kimmel Medical College at Thomas Jefferson University
Rebecca C. Iaffe, MD
University of Pittsburgh School of Medicine
Andrew B. Lobl, MD

**SOUTH CAROLINA**
University of South Carolina School of Medicine
Matthew Marcus, MD

**TENNESSEE**
East Tennessee State University James H. Quillen College of Medicine
Sarah Edwards Bharti, MD
Meharry Medical College
Carolyn Lightford, MD
Vanderbilt University School of Medicine
James Henderson, MD

**TEXAS**
University of Texas Southwestern Medical Center at Dallas Southwestern Medical School
Reese A. Mathieu III, MD

**VERMONT**
University of Vermont College of Medicine
Jennie Lowell, MD

**WASHINGTON**
University of Washington School of Medicine
Thomas Biehl, MD

**WEST VIRGINIA**
Marshall University Joan C. Edwards School of Medicine
Mathew Weimer, MD
West Virginia University School of Medicine
Mary S. Boyd, MD

2014 Volunteer Clinical Faculty Awards
This award recognizes the ΑΩΑ chapter administrators who are so important to the functioning of the chapter or association. The nomination is made by the councilor or other officer of the chapter. A gift check is awarded to the individual, as well as a framed certificate of appreciation.

The following awards were made in 2013/2014, clockwise from top right:

DISTRICT OF COLUMBIA
Howard University College of Medicine
Ruth Yaasi Sackey

FLORIDA
University of Miami Leonard M. Miller School of Medicine
Gini Benen

ILLINOIS
University of Illinois College of Medicine
Rachel Maldonado

MISSOURI
University of Missouri—Columbia School of Medicine
Suzanne Neff

NEW YORK
Albert Einstein College of Medicine of Yeshiva University
Christina Chin

OHIO
The Ohio State University College of Medicine
Eileen Mehl

PUERTO RICO
University of Puerto Rico School of Medicine
Wanda Pizarro-Merced

SOUTH CAROLINA
University of South Carolina School of Medicine
Lynn Heard
On January 11, 1964, at a packed press conference in Washington, DC, Surgeon General Luther Terry released one of the most important documents in the history of medicine. The Surgeon General’s Report on Smoking and Health was the culmination of a year-long analysis of the world literature on smoking by a ten-member scientific advisory committee. The damning conclusion: “Cigarette smoking is causally related to lung cancer in men... and is a health hazard of sufficient importance to warrant appropriate remedial action.”

Yet for decades—right up until the 2000’s—cigarette manufacturers continued to publicly dispute the evidence about the harmfulness of smoking and sought to allay consumer anxiety by implying that new filtered, low-tar, and light brands were not harmful. The result: fifty years after the Surgeon General’s landmark report, even as other epidemics such as AIDS, obesity, and diabetes have taken center stage—and in spite of advances in the diagnosis and treatment of lung cancer and heart disease that have prolonged lives—the health and economic toll taken by smoking remains devastating.

“The Surgeon General vs. The Marlboro Man: Who Really Won?” is the provocative title of an original exhibition to commemorate the fiftieth anniversary of the report. It is curated by veteran anti-smoking strategist Alan Blum, MD, director of the University of Alabama Center for the Study of Tobacco and Society. Featuring more than 130 artifacts that include cigarette ads in the Journal of the American Medical Association, a cigarette filter made of asbestos, packages of candy cigarettes identical to real ones, hospital ashtrays, and a Mayo Clinic cigarette case, the exhibition traces both the promotion of smoking and the efforts to end it. A gallery tour of the exhibition may be seen here: http://youtu.be/O1-8DY9ojLo.

The exhibition debuted at the Gorgas Library of the University of Alabama before going to the Lyndon Baines Johnson Presidential Library in Austin and the Texas Medical Center Library in Houston. A traveling version of the exhibition is available to medical schools, libraries, and museums. Contact Dr. Blum at ablum@cchs.ua.edu.

In the companion film, “Blowing Smoke: The Lost Legacy of the Surgeon General’s Report,” Dr. Blum argues that efforts to eliminate smoking have become more symbol than substance. The twenty-five-minute film, available free online (https://docs.google.com/file/d/oBj5sVTNHmZZmcfFJWLW1wbDF3Mms/) and for screening to audiences, chronicles what he calls “the fear, foot-dragging, and squandering of funds on the part of public health agencies, universities, and organized medicine in ending the smoking pandemic.”

“Surgeon General Terry’s indictment of cigarettes in 1964 should have marked the beginning of the end of the Marlboro Man,” Blum says. “Yet far from riding off into the sunset, the tobacco industry is still riding high in the saddle.”

In the film, Blum points to the record profits of the nation’s leading cigarette manufacturer Altria, maker of Marlboro; the company’s recruitment of college students on more than thirty-five university campuses as the new Marlboro sales force; and the significant investment in Altria by TIAA-CREF and other major pension funds. Moreover, although the percentage of American adults who smoke has declined to twenty percent, the number of people who continue using cigarettes—nearly 45 million—is not much less than in 1964.

“The fiftieth anniversary of the first Surgeon General’s Report is hardly a time for celebration,” Blum says. “Rather, it should be a sobering reminder of the missed opportunities to reduce demand for cigarettes, which remain the nation’s number one avoidable cause of cancer, heart disease, emphysema, and high health costs. That nearly all government funding that is allocated to fight smoking is spent on research that adds very little to what we have known since 1964 is disgraceful. It suggests that the most addictive thing about tobacco is money.”

Contact Alan Blum, MD (AΩA, Emory University, 1985) at ablum@cchs.ua.edu
Robert H. Moser, MD, MACP, served for many years as an enthusiastic and skilled member of the editorial board of *The Pharos*. He was the book review editor of the journal from 2001 to 2004, and continued to contribute to *The Pharos* until his death last August.

Alpha Omega Alpha wishes to honor Dr. Moser by establishing an annual award in his name to recognize excellence in writing in *The Pharos*. We invite your help. We propose an annual award of up to $6000, to which Alpha Omega Alpha would contribute $2500 annually. To reach our goal of a prestigious and significant award, worthy to bear Dr. Moser's name, we have set a fundraising goal of $100,000 to fund the award annually. Dr. Moser’s wife Linda has pledged $10,000 toward this amount. If you would like to contribute to funding this award to honor one of the giants of American medicine of the last century, please send your contribution, noting that it is for the Moser Award to:

Debbie Lancaster
Managing Editor
Alpha Omega Alpha
525 Middlefield Road, Suite 130
Menlo Park, CA 94025

Dr. Moser’s illustrious career included an enormous variety of fascinating endeavors:

- He organized and serving as a surgeon in one of the first MASH units during the Korean War.
- He was a pioneering flight controller who monitored the physiological and psychological performance of astronauts for the Project Mercury through Project Apollo space programs.
- He served as Chief of Medicine at Walter Reed Army Medical Center in Washington, DC; William Beaumont Army Medical Center in El Paso; and Tripler Army Medical Center in Honolulu. During this period, he was instrumental in setting up programs that guided the education of generations of internal medicine house officers by integrating university-level training standards in Army teaching hospitals. He remained passionate about medical education throughout his life.
  - During his years of private practice in internal medicine in Maui, he served as one of the doctors treating patients at the Kalaupapa leper colony on Molokai.
  - Dr. Moser was the author of several medical reference books, some still in use today, and was one of the first physician/writers to deal with the problem of drug-induced disease.
  - As editor-in-chief of the *Journal of the American Medical Association* from 1973 to 1975, Dr. Moser instituted sweeping changes in the journal that are still evident today.
  - Dr. Moser served as Executive Vice President of the American College of Physicians in Philadelphia from 1977 to 1986. While there, he was invited to the People's Republic of China to observe medical practice there in one of the earliest signs of detente. More importantly, he met his wife Linda while working at the ACP.
  - In the 1980s, he served as Director of Medical Affairs for Monsanto's NutraSweet division.
  - After so-called retirement, he and his wife formed a medical consulting company to establish networks of medical experts in various specialties for large corporations.
  - Not least, Dr. Moser was a frequent contributor to *The Pharos* and a member of its editorial board, on which he served until his death.

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.alphaomegaa.org/store. Price includes shipping and handling.

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

Alpha Omega Alpha neckties or freestyle bowties are fashioned from fine silk.