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On Choosing One's Patients



A resident sat in with me while I was seeing a patient I've known a few months. The patient has an intractable headache and a constant need for narcotics. The resident commented to me later that I had looked "annoyed" during our session. I use the term "session" ambiguously, knowing that the term is used typically for seeing a therapist. One has a "doctor's appointment" with a neurologist. But, of course, patients with chronic pain require a sympathetic ear, more than clinical acumen and science. Yes the patient upset me. She bothers me because I know her problem is not physiologic but she won't believe there's an emotional etiology.

My problem, though, is me, not her. Looking "aggravated," "annoyed," "pained" or however else I may have been described, was not fair to the patient, punishing her for complaining about the very problem for which she was seeking my help. It was bad doctoring. Unfortunately, while I can take forever with my slow-moving Parkinson patients, I have, in truth, limited patience for people with the more common intractable disorders that generally make up the bulk of a neurologist's practice: headache, dizziness, back and neck pain. Clearly, I cannot do a very good job then. On the other hand, although I do specialize in one narrow area of neurology, I continue to think of myself also as a general neurologist and welcome "challenging" cases, patients who have escaped diagnosis for any number of reasons. In addition, these problems may include pain syndromes, although not usually. Chronic pain and chronic dizziness syndromes are different from the acute disorders and always involve emotional issues. Interestingly, conversion disorders are a psychological challenge I find interesting. I called the

patient and apologized if I seemed annoyed. One problem solved. I'm less angry with myself, but here is the question. Should I refuse to see headache, back-pain and dizzy patients? Should I be like the orthopedist who sees only "shoulders" or "hips" or "spine," turning everyone else away? "Dr. Friedman doesn't see headache patients because he's not skilled in that area." "But I want to see him. He's listed in *Rhode Island Magazine*. I've seen five other doctors. I'm sure he'll help me." Of course, I won't, so, perhaps my secretary should say, "no, he won't. He told me to tell you."

Miss Lonelyhearts is a short, depressing novel, written in the 1930s about a newspaper columnist who, on a lark, takes over a daily advice column, of the Ann Landers genre. Except these letters are not about what to do if your daughter's father-in-law belches at the dinner table. These letters deal with the depths of human pain and suffering. The columnist becomes overwhelmed with the tide of human misery. How should we deal with the patient with constant headache who cannot pay her bills, whose children are doing drugs, getting into trouble, who is raising the teenage daughter's two children, etc etc? Antidepressants won't touch this; she needs a new life. Am I, the skilled neurologist, too busy to sympathize? Annoyed that a primary care physician would "waste" my time, thinking I could help, or relieve his responsibility to the patient knowing that he's going all out, even referring to the specialists?

When I can, I try to teach the medical residents how best to use their neurology consultants, how to avoid useless consults, but I owe it to the patient whom I actually see to be as sympathetic as possible, to try just as hard to help as I would a case of some

rare disorder, whose diagnosis or treatment will burnish my reputation and make me famous. I do not know whether it's the uselessness and inadequacy, the fact that both the patient and I could have put the time to better use, or the challenge I will have explaining to the patient that although there is pain, there is no threatening medical problem. No aneurysm, tumor, stroke or inflammations, just pain, physical and emotional; and you can't treat the former without grappling with the latter. "You mean it's all in my head?"

The better doctors among us are priests, but, alas, few of us are saints. I haven't solved the question in 20 years. As I know less and less about more and more, it may be taking care of itself. Perhaps it is the coward's way out.

— Joseph H. Friedman,
MD



The Seeds of Intellectual Success

The English have a knack for making genius hereditary. Great Britain's scholarly panorama is strewn with families containing three or more generations of illustrious mandarins contributing materially to the general body of information. Medicine, either as a committed profession or as a platform from which to enter experimental biology, appears prominently in the life histories of these intellectually endowed families.

Preeminent amongst the British intellectual dynasties were the Darwins, beginning with Dr. Erasmus Darwin [1731-1802], medical practitioner in Nottingham, England, polymath, poet, taxonomist, and when pressed, philosopher. His third son, Robert W. Darwin, was a gifted practitioner of medicine in Shrewsbury, but is largely ignored because of the preeminence of both his father and his son, Charles. Not to be neglected, too, was his brilliant daughter, Violetta, mother to the great Sir Francis Galton [1822-1911], England's preeminent anthropologist, meteorologist, originator of the fingerprinting system of identification and the ill-advised pseudo-science of eugenics, with its persistent aroma of racism.

Charles Darwin [1809-1882], the grandson of Erasmus Darwin, began his medical studies at Edinburgh, but found that anatomy and surgery were too upsetting to his overwrought stomach. His family regarded him as a wastrel and despaired of his future. He eventually embarked upon an extended ocean voyage as an unsalaried companion to the captain of HMS Beagle. His voluminous observations, accumulated during this extended voyage, immensely enriched the zoologic, geologic and botanical sciences, culminating by 1859 in what is arguably the most influential scholarly text of the 19th Century, *The Origin of the Species*, the basis for the theory of evolution.

Seven children survived Darwin and four became prominent in their chosen fields: Sir Francis Darwin was a great experimental botanist; Sir Horace Darwin was an internationally acclaimed civil engineer; Leonard Darwin was a prominent economist; and Sir George Darwin was England's leading astronomer. Charles Darwin's older brother, Erasmus Alvey Darwin, was one of Britain's leading art and literature critics.

In summarizing the contributions of the Darwins, mention should also be made of yet another outstanding family, eminent in its own accomplishments, a family that had twice intermarried with the Darwins. Josiah Wedgwood [1730-1795] was a skilled potter in Staffordshire, England, whose earthenware ceramic products became world-famous. Wedgwood had also been deeply involved in canal-building, welfare programs and the advocacy of universal public education. His daughter, Susannah, married Robert W. Darwin and was the mother of Charles. Charles Darwin, in turn, married his cousin, Emma Wedgwood.

Not all of the scientific savants of England were scions of upper middle class families. There was, for example, Thomas Henry Huxley [1825-1895], a self-educated son of a poor schoolteacher from Ealing, England. Lacking the formal credentials to enter any of the university medical schools, he managed to matriculate at the Charing Cross Hospital Medical School, receiving his medical degree in 1845. Huxley passed the rigorous examinations of the Royal College of Surgeons and was promptly assigned as ship's surgeon to the exploratory vessel, HMS Rattlesnake. For the next five years the ship traversed the South Seas, taking climatologic, astronomic and geologic measurements. Huxley assembled immense amounts of data on ocean life, sending manuscript after manuscript back to London's scientific societies. His meticulous studies on the jelly-fish in the tropical oceans formed the basis for modern invertebrate embryology. Huxley resigned his naval surgeonship and began a land-based research career documenting the structural changes underlying the maturation of organisms. In 1859 he confronted Darwin's great text and became, in time, the great defender and exegetist of evolutionary theory. Biologists regard Huxley as one of the world's greatest theoretic zoologists.

Much of Huxley's writings also reflected his deep religious conviction. In later years he condensed his theological beliefs to the prophet Micah's aphorism: "What doth the Lord require of thee, but to do justly and to love mercy, and to walk humbly with thy God?"

The HMS Rattlesnake interrupted its scientific expedition in 1849 to seek repairs and provisions in Sydney, New South Wales [now Australia]. While attending a dance, Huxley met and fell in love with Henrietta [Nettie] Heathorn, a brewer's daughter. Some years later, in 1855, Nettie voyaged to England to marry Thomas. The Huxleys settled in rural England, generating a large family of unusually accomplished scientists, writers and philosophers. Two of their grandsons, however, merit special attention. There was Sir Julian Sorel Huxley [1887-1975], who became England's leading evolutionary biologist of the 20th Century. He had a gift for transforming scientific thought to comprehensive language without compromising or oversimplifying the integrity of the core data. And then there was his brother, Aldous Huxley [1894-1963], also trained as a biologist, but who exploited his singular skill in the writing of science-fiction. His most famous work, *Brave New World*, became one of the most influential fictional, and prophetic, texts of the 20th Century.

While commenting on the eugenic theories of his cousin, Francis Galton, Darwin declared: "I am inclined to agree... in believing that education and environment produce only a small effect on the mind of anyone, and that most of our qualities are innate." On another occasion, however, Darwin ascribed much of his success to his sense of

industry, his mind open to new ideas and his disciplined capacity to collect facts. Skeptics, however, have concluded that all of this wealth of intellectuality in the Darwin, Wedgwood and Huxley families was little more than a coincidental happenstance of children given unrivalled educations while allowing their minds to mature unburdened by the need to seek gainful employment.

Whether it was an inherited or nurtured endowment, what indeed is being claimed for these gifted individuals?

What distinguishes them from the masses of other, equally well-educated souls? Perhaps, to paraphrase Milne, they are distinguishable from the third-rate minds who are happy when thinking with the majority; or the second-rate minds who are happy when thinking with the minority. They likely possess first-rate minds which are happy only when thinking.

– Stanley M. Aronson, MD, MPH

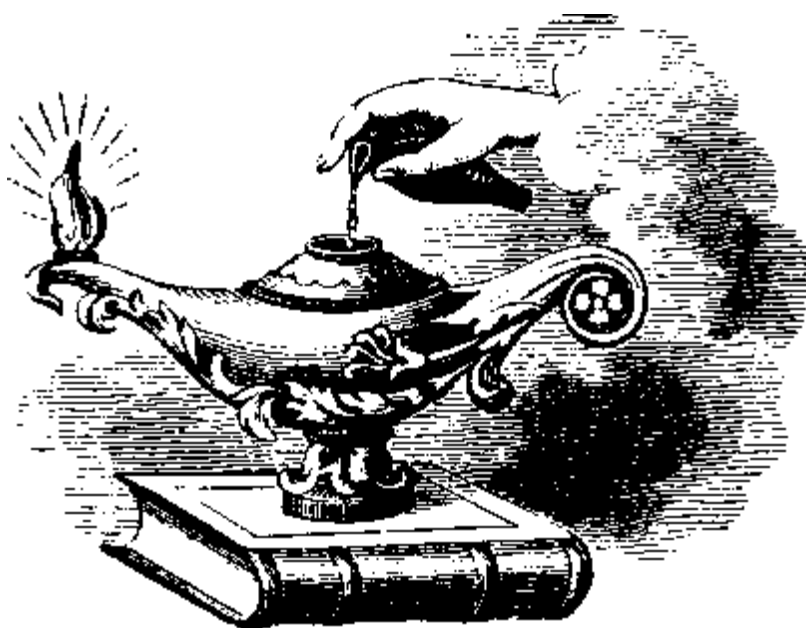
Lynn C. Epstein, MD

A century ago William Osler championed the marriage of literature and medicine when he declared to his medical students: “Books are the tools of the mind, and in a community of progressive scholars the literature of the world in the different departments of knowledge must be represented.” And further, “A love of books may be the one thing to maintain in him the sentiment of the ideal and it is particularly poetry that has such a value in helping a man to cherish thoughts that lift him above the petty details of life, that strew his path with flowers, that make him hopeful and helpful among his fellows.”

It is therefore quite appropriate that Lynn Epstein, a graduate of Johns Hopkins Medical School [founded by Osler] and a member of the prestigious Osler Society be

the organizer of this issue of *Medicine & Health/Rhode Island* dedicated to the belief that immersion in great literature quickens the mind and makes medicine’s practitioners more sensitive to the nuances of disease and the struggles of its victims.

Dr. Epstein has fulfilled many crucial roles in the evolution of the Brown Medical School: as a professor of psychiatry, as an associate dean of medicine, as founder and guardian of the affinity program, as teacher of campus-wide undergraduate courses on literature and medicine, and as fervent advocate of the notion that medicine is an art as well as a science. The editors of this Journal express their gratitude to Dr. Epstein for her labors in preparing this issue.



Why Doctors Write


Susan Mates, MD

Writing a novel is a terrible experience, during which the hair often falls out and the teeth decay. I'm always highly irritated by people who imply that writing fiction is an escape from reality. It is a plunge into reality and it's very shocking to the system. If the novelist is not sustained by a hope of money, then he must be sustained by a hope of salvation, or he simply won't survive the ordeal.

— Flannery O'Connor,
"Mystery and Manners"

Why *do* doctors write? Who knows? Why do we humans do anything not of immediate, efficient and tangible usefulness? Why do we paint, sing, act, climb mountains, pray, figure out how obscure compounds cross the membranes of obscure organisms? Why do we sit, when all else has failed, and hold the hand of those we cannot cure?

Surely there are many motives for the making of art — and many occupations which can be practised as art. Any endeavor, perhaps, that requires long and exacting study of technical, concrete skill, and then and only then, within those limitations, can pass into a kind of translucence through which *something*, not the practioner, sometimes flows, is an art. Of course this would include the standard "arts", music, literature, visual arts, theatre. But also the generation of new scientific understanding. Mathematics. Skilled athletics. And, yes, medicine. In fact, life itself, practised with grace, within the constraints of birth and death, the limitations of person and place — an art, too. In the languages of these activities, this, sometimes, can be said: beauty, clarity, truth, healing, that-which-illuminates, good. I would argue that this urge, this drive of ours to push through exacting here-ness (better know your facts, your physiology, your arpeggios, your three-dimensional perspective, your topology, your recombinant DNA, your ball-handling, your ethics) to other-ness, is particularly human. So nothing special

about doctors. And I still can't answer the question anyway; *why*?

"This is the eternal origin of art, that a human being confronts a form that wants to become a work through him...The form that confronts me I cannot experience nor describe; I can only actualize it." What is Martin Buber talking about, what is that "du" that "thou" that confronts us confronting it and wants to become a work, a thing, through us? Is this the *why*? We confront, are confronted by, stand in relationship to, that other, that you, who is without time or place or particularity, who wants to become—melody, story, picture, understanding, healing, truth, life itself, through us? That other world, timeless, formless, that world which encloses us and permeates us even as we live our time-overfilled, fact-structured, here-and-now I-lives. That world which we can reach only by giving it *form*.

"...in the beginning was the word...in the end, for doctors and writers, it is the stories."



So maybe that's the *why*? We want/need/must go/be there as well as here, and we can only go there in certain languages — the language of bow-on-string and diminished seventh, of metric spaces and closed set, of lyricism and narrative tension, of differential diagnosis and auscultate, palpate, percuss, of freely chosen growth or diminution, love or destruction, choice after choice, within the form we call a lifetime. Maybe we practise the art of music, of mathematics, of literature, of medicine, of life, because through those tongues we can become a vessel for the sacred.

Is there then, anything particular about doctors becoming writers and writers becoming doctors? Maybe it's this, that these are the alpha and omega

forms of the word; literature, the language of rhythm and allusion and sound that ends in story, medicine, the language of birth, suffering, illness and death that begins in story. Stories...*En archē ēn ho logos*, in the beginning was the word... in the end, for doctors and writers, it is the stories. We can write them, we can listen to them. We can let them become beauty through us, if we're lucky and work hard, or, we can let them become healing through us, if we're lucky and work hard. And if we are very very lucky, the "you" will seep through us, love maybe, or joy, or grace, and—Buber again—"As long as the firmament of the You is spread over me, the tempests of causality cower at my heel, and the whirl of doom congeals." And when *that* happens, we feel like Molly Bloom: yes I said yes I will Yes. So we work hard, plow the field, and hope this fertility, this life-making, comes through us again, some day. Even if it makes our teeth rot and our hair fall out, even if we get bad reviews, even if the HMO goes out of business and refuses to pay. Stories in, stories out. The doctor heals, the doctor writes. With work, and luck.

Susan Mates, MD, is a former violinist and Brown faculty member in Medicine (Infectious Diseases) and Biochemistry (research.) Her most recent story, "Mercy Shall Follow," appears in Recognitions: Doctors and Their Stories. Her work has won an Iowa Short Fiction Award (for the collection, "The Good Doctor"), a Pushcart Prize and Yaddo and McDowell Colony Fellowships.

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The Experience of Illness

Lowell Rubin, MD

Medicine is a meeting place for science and the humanities. That is its gift and wonder. For some physicians it is the fascination with the "illness" that is most compelling. For others, the fascination is also with the patient who is "going through" the illness, the one upon whose stage the illness is played with its drama and many characters.

Most of us are aware that, with the advances of scientific medicine, the person who has the illness gets farther and farther away. To at least some extent it was always so, in that doctors have always had to defend themselves against their patients: those to whom we gave the unpleasant medicine, or those we put "under the knife." Who knows when doctors began to talk about sick people as "cases" but, whenever it was, it provided a degree of safety and, perhaps, objectivity that made it easier for the doctor.

With the monumental advances of scientific medicine, the patient has shifted perilously far away. In fact, distance from the unique individual is one of the hallmarks of what we think of as science, whether it is part of medicine or, at an opposite extreme, the "science" of modern warfare.

The arts and humanities are more concerned with the inner life of the patient. In truth, the doctor's experience also needs to be described. And when the doctor really begins to describe what it is like to be a doctor, he or she begins to experience being connected to another person, the "patient." Literature about the patient's experience of illness makes us aware that almost any illness is far more than a minor event in that person's life. It is always a major life experience for the patient and often for family members as well.

It is the human part, a part which one cannot entirely escape, that is often the main contributor to the stress of doctoring. We must deal with a frightened person on the other side of the great divide, as well as the myriad family members. Rather than just being a tiresome part of doctoring, learning how to deal with patients and their families can be and should be a source of satisfaction. Unfortunately, most medical practices are not set up to do this properly.

Time and human resources are required for the best practice of medicine. Insurance companies and the proponents of the industrial/scientific medical model factor this out. As a result of what has been lost most medical practices could use a psychiatric or other consultation to improve the human side of what happens to their patients.

MECHANISMS OF DEFENSE

The human mind has many ways of decreasing stress. One way is to "split" or "dissociate," a basic human way of dealing with what threatens to overwhelm us. We doctors use a variety of defense mechanisms. This is basic to our survival. But keeping the whole person who is the patient in the picture is one of the most difficult and most elegant parts of the art of medicine.

Certain forms of distancing may cause us to miss much of what is important - perhaps diagnostically, certainly therapeutically. It also can cause us to miss whole dimensions of meaning in what we do. For the patient, illness is an experience that will unite many and unexpected strands of existence. It may be their first meeting with mortality. I always remember those patients, as you must too, who tell us when we find something wrong, "but doc, I have been healthy all my life".

I learned quickly as a psychiatric resident, interviewing patients on the general medicine and surgery wards, that often the patient's illness was related to some important life change or significant stress, when one took the time to investigate what was happening in the patient's life at the onset of illness.

There is another very practical side to giving more attention to the person who is the object of our ministrations. I believe that many malpractice suits could have been avoided if the doctor had been careful about his relationship to the patient and family.

THE USES OF THE HUMANISTIC LITERATURE

A good example of the different ways of looking at illness, and how the arts can help doctors find the patient, is the contemporary play *Wit*. Here the doctors are shown insulated from the experience of the patient because of their focus on tests, or research. The patient is alone. In modern medical practice, by default, the nurses may be the only people on the medical "team" who are really in touch with the patient. In *Wit* we learn much about the illness and the person who had the cancer from the dialogue between the patient and her nurse.

At one time psychiatrists as part of the medical "team" helped to keep in touch with the inner world of the patient. Sadly, this is rarely the case, because of the new emphasis on "Scientific psychiatry". I do not dismiss or regret the scientific advances in psychiatry, but the psychiatrist and other doctors must not lose track of the human side of medicine.

The crucial job of being in touch with the patient is often left to nurses. And more and more their role is threatened, as insurance companies make nurses "more efficient." Reducing the nursing staff to the most "efficient" level is a disaster. Industry teams up with science and tries to eliminate what is human but "inefficient" about us.

One lesson in all this for doctors, certainly, is that they need to pay as much attention as possible to whatever the nursing staff does know about the patient. Of course it is ideal if doctors themselves can encompass all the tasks of good doctoring part of the old ideal of "bedside" medicine. Without this capability or other staff who take this responsibility and feed the information back, doctors may remain out of touch not only with minor details but with the main things going on with their patient.

POETRY AND MEDICINE

I have been asked to contribute this brief essay as a doctor who writes poetry. In fact, I rarely write poems about my doctoring, but I have written several in relation to my own experience of illness, or that of friends. As a doctor/poet I thought I could illustrate what I am trying to say in this essay with one of my own poems written several years ago when I went through a life-threatening medical emergency. Although what happened was harrowing, the prognosis, fortunately, was good. I just had to get through a rather difficult ordeal. This then is one of the poems I wrote on the occasion of that illness:

KINGDOM COME

“So who are you”, I asked.
“Death”, he replied.
“You have stumbled into my valley.”
“Show me the way
to the exit”, I said.
“Which one”, he replied.

I was on a line in Auschwitz.
I was tired.
Which way to the shower.
We had traveled so far, it had been
so long since I felt water on my skin.

The bells are ringing.
Am I out of my mind.
I am reassured.
You are here with me, between sleep
and waking, between night and day.
in the hour of life and death.

Time is suspended.
Then his voice said, “I take it back, you will have
five more years. No ten. Perhaps twenty”.
From that moment I can't remember what he said.

Why has the music stopped.
Why has it come to a halt, with a screech.
Was I hit by a car.
Am I lying on a battlefield
outside of Troy.
Is anything leaking.
Do I seem alive to you.
Hurry, call the surgeon, Shahinian.
He will know how to repair this wound
After all he stitches death back to life.

So we lay on the battlefield.
There were hundreds of us
with gashes in our bellies.
All the while the bells
were ringing.

Our eyes were fogged over.
Then they came
one after another,
the women in white.
They held our wrists,
looked straight ahead,
saw the markings of time,
told us not to worry,
not to give up,
to hold on,
to come back,
follow their eyes
into the darkness.
They would lead us,
they have been in this valley before.

All the while the bells
rang in my head.
“What time is it? Please, answer the telephone!
Can't you hear it ringing?”

Tell me where you are.
I know this is night.
Of that I am certain.
“How do I get out of here”,
I kept saying.
Does this end, the music
the bells, ringing in my ears.
No let it ring on.
“Which way is out?”.
The lights, keep the lights on.
“The bells, who do they toll for.
I am not an English poet, or a
Greek one.
Just a wandering Jew
who stumbled into
the valley of death and
stumbled out,
with surgeon and nurses,
with loving wife and children,
without a tombstone,
with bells, and yes,
a jagged wound.

The bells still ring
in my ears.

The poem captures some of the dislocation you feel as an ill person coming out of anesthesia, with pain and all the unknowns. It also speaks to the importance of the caretakers who surround the patient. Finally, it captures the flood of associations, personal and literary, that may go through your mind during the ordeal.

It is often said that the best way for a doctor to learn some important truths about medicine is to go through an illness. That may be the best way, but there are others as well. Literature provides a window. Great literature can help

doctors learn more about different aspects of what a patient is going through. Think of *The Magic Mountain*, by Thomas Mann, for instance, as a supreme evocation of the world of illness. Richard Reynolds, MD, and John Stone, MD, (one of my favorite doctor poets) compiled an anthology, *On Doctoring: Stories, Poems and Essays* (Simon & Schuster, 1995) which includes a variety of interesting and useful pieces by well-known authors as well as doctor/writers, known and less well known. Poet Jon Mukand, MD, edited an anthology of poetry on the body in illness, *Articulations* (Iowa University Press, 1994). Another anthology dealing with poetry and medicine is *Blood and Bone*, poems by physicians, edited by Angela Belli and Jack Coulehan (University of Iowa Press, 1998).

The ranks of doctor/poets include, of course, William Carlos Williams, as well as Dannie Abse, Marc Strauss and John

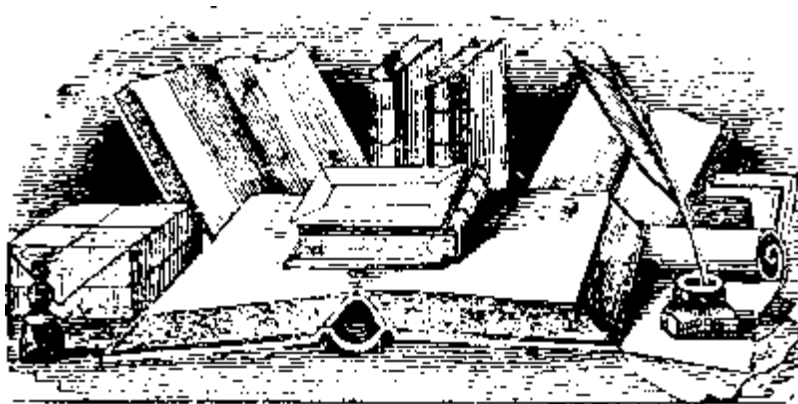
Stone. Rafael Campo, a wonderful poet-physician who works at the Massachusetts General Hospital, adds the gay perspective.

For those of you who want to try to write some poetry or fiction I encourage you to do so. It will help you process what you are going through as a doctor.

Lowell Rubin, MD, is on the Brown Medical School faculty and in the private practice of Psychiatry and Psychoanalysis.

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UPCOMING...

April 2003 *Medicine & Health/Rhode Island*

Diabetes

Guest Editor: Robert Smith, MD

May 2003 *Medicine & Health/Rhode Island*

PET Imaging

Guest Editor: John Cronan, MD

June 2003 *Medicine & Health/Rhode Island*

Blood-borne Pathogens Guest Editor: Marguerite Neill, MD
(a CME issue)

Revisions of a Medical Record

*Jon Mukand, MD, PhD
For Ivy Vimla and Sushil Eric Mukand, MD*

THE CARDIOLOGIST: DYE REACTION

What to write in the record?
He made rounds, then chest pain. Classic
sense of impending doom, crushing. Not a word
as the EKG pen scrawled out sick

electrical lines. We both saw a flood
of enzymes from a dying heart.
A lightning storm sparked
through our minds; he tried to start

forcing out a confession:
high lipid levels in his blood for years, a father
dead before fifty—the same conclusion.
He felt as if on a ladder

with miles until the top.
I injected the heart's arteries with a dye,
focused on the X-ray, then his vitals dropped,
his voice a choked cry.

We stared for a stunned moment
while he struggled, his lungs hungry
as unoxygenated minutes sent
his brain to a rarefied world. No battery

of tests could have saved him, already spun
down to a sediment
in a centrifuge tube. A lag in our reactions?
All our defibrillating current

useless. The neurologist said what
we already knew: In a coma, alone
with his coagulated thoughts,
his prognosis already etched into stone.

And now, breathing on a plastic lung,
convulsive twitching, no response to pain or light,
vital signs stabilized by tubing hung
from every hole. And still, still, what should I write?

THE CARDIAC MONITOR: DYSRHYTHMIAS

How still you lie, hunched up, asleep beyond
the reach of words that beat useless wings
against your flickering brain. When I found
a strained pump, sluggish blood, frayed wiring,
I knew a chamber might weaken, might burst.
You survived, though your future days swirled down
to dry leaf piles. The dye in your veins raced
to squeeze off the air to your lungs, your brain.
Now your life flows in and out of plastic tubes
with your ambivalent drugs: oxygen
far too late, balm of fatal roots.
You rest in a hospital gown, a gauze coffin,
as your friends the doctors approach your bed;
your old patients will read that you are dead.

THE WIFE: CORRIDOR TO INDIA

It would
be simple, they said.
The cardiologist would call.

We waited, counting
the large, cotton snowflakes.
Then the call.
Some problem, they said.

It was simple.
Simple as the sumac's red leaves
melting the snow. Or the pattern
of deer tracks
in our yard
leading to nowhere.

Death is easy
to understand. But this half-
death denies
the coldest hope.
What remains to flutter down
to the ground's embrace?
What can these machines tell me?

Stand and watch, that is all
I can do. Stare into his
metallic eyes.
Yes, I can watch
until my children say
I should leave. Feeling
his limp hands again, I walk

out through the same corridor.
It is always
clean, well-lit.
The plush carpet
muffles my footsteps.

If only this corridor could lead us
back, return us to the summer nights
under the tamarind tree, the mornings drenched in jasmine,
cool dew on the clay goblet of water:
all stamped in my memory like a heart-
shaped leaf of the peepal tree
trampled by worshippers on the marble floor of a temple.

Winters in India have
no claws like these, standing
guard beyond the glass doors.
But now I must leave
the hospital, and return
in the morning, to stand
by the steel bedrails,
waiting for his words
to spring up
like seeds of
dormant
winter
wheat.

THE SON: RETURNING HOME

Moist air crystallizes into morning, shimmers
in the sunrise, cutting my face as I leave the house,
as I leave you.

You are the medical texts,
the pipes scattered about in empty ashtrays, the sunlight's
dull reflection from the antique brass lamp.
You are gone, resolved
in an electric moment to urned ash, leaving behind
a stray sitar note that resonates
in me with its saffron music.

The respirator's measured, regular breaths
replaced your own cigarette-scarred lungs.
You tried to quit, but kept on borrowing
cigarettes from patients, as if a smile
were enough payment.

I tried imagining the incinerator,
but during the funeral
my memory could only filter
the burned fragrance of cumin and cardamom.

Why do we need oxygen
to live and to die,
for metabolism and for combustion?

Once, under the heat
of the Indian sun, you lifted me up
to the branches
of a mango tree, caught me when I jumped down.
Now I am left with the fruit of long days,
nights away delivering babies: your heart on
crutches, arteries rusted away.
And you knew, you knew.

Hints of self-diagnosis in journal articles
you underlined: *coronary bypass, cardiac
catheters, myocardial infarctions*. Reading
your medical records, I also knew.

We can walk only so far away from home,
from our fathers, who have left us
their lives in each dying cell, each spiral
DNA staircase that ascends
or descends to the next day.

The house holds me
like a kite, reeling me in, taut
against the gusts blowing on this bamboo frame.

You will be waiting:
wire-rimmed glasses, trim moustache, smiling
with my mother, a photograph on the night-stand
before I turn off the brass lamp.

So I turn
homeward, promising to write
a *ghazal* for which you
have left behind a melody.

Someday, I will hear the *tabla*, whose rhythm
no EKG can capture and no cardiologist
can interpret. The music will
take me back to the lotus pond
at our old home in the village of Sultanpur:
then, I will drift away on the fallen petals.

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Medical Narrative

Randal Rockney, MD

*“The painful aspects of medical training make personal change both inevitable and necessary. What hangs in the balance is the direction of that change.”*¹

This issue of *Medicine & Health/Rhode Island* is devoted to the question, “Why do doctors write?” There are likely as many answers to this question as there are doctors, or at least as many as there are doctors who write. Being a physician thrusts one into the center of many of life’s most dramatic moments, birth and death for example. Physicians, therefore, constantly face a wealth of material from which to fashion rich narrative or poetic works. It is no surprise that many famous writers were physicians and that many physicians aspire to be famous writers. What is perhaps not so obvious is the unproven but likely value of encouraging doctors to write as a means of reflecting on the dramatic and often distressing circumstances encountered in the course of medical practice. As expressed by Dr. Steven Miller at Columbia University:

“Reflection is thinking critically about thoughts or actions that seem to be occurring spontaneously and without conscious deliberation. It turns experience into deep learning—that is, reflection allows new experiences to either modify one’s existing knowledge structures or schemas or be integrated into one’s existing knowledge structures. True behavior change, in contrast to mimicked behaviors, can occur when one reflects on new experiences and changes their own knowledge structures.”²

The long and arduous preparation for becoming a doctor - medical school and residency— is rife with challenge and uncertainty for the trainee. It is of

ten a watershed experience for the individual. There is tremendous potential for growth and development, but there is also the potential for the erosion of moral values and ethical behavior. This is expressed well by Dr. William T. Branch at Emory University:

“The young physician-in-training faces arduous tasks. Knowledge must be absorbed, and skills must be mastered. But, becoming a physician is a moral as well as an intellectual task. The attitudes and values that a young physician adopts will determine the way he or she practices, and be equally as important as intellectual and technical proficiency. Physicians-in-training are young adults. They have emerged from adolescence into adulthood, hopefully with a firm image of themselves and a self-awareness of their values and inner feelings. Erik Erikson thought that the principal task of adolescence was to establish identity. As young adults, these individuals now move to the task of developing intimate relationships, the capacity for commitment to partnerships and affiliations. This includes marriage and family, but may also include close associations with friends and teachers, and relationships to patients and colleagues. Erikson conceived of the opposite of intimacy as the withdrawal into isolation and self-absorption. One can visualize the challenges and dangers in the professional development faced by young physicians from this perspective, establishing functional, healthy relationships with pa-

tients and colleagues, versus dysfunctional distancing or withdrawal. The ability to establish functional relationships may hinge upon having developed personal values and identity sufficiently strong to withstand the stresses, both physical and psychological, of medical training.”³

The process of becoming a physician challenges the physical, personal, and moral wellbeing of the young men and women engaged in that process. One of the Nine Abilities of the Brown Medical School Competency-based Curriculum is “Self-Awareness, Self-Care, and Personal Growth,” (Ability VI).⁴ How can this ability be promoted, taught and assessed in medical school? An approach I have been using, an approach that has been used and is being used at other medical schools, is to encourage medical students to reflect on their clinical experiences and write a narrative account of one of those experiences. Such an exercise has been a part of the core pediatric clerkship, Bio-Med 450, at Brown for the past seven years.

Here are excerpts from one narrative, chosen because it includes many commonly-cited themes.

In reflecting on a clinical experience during the course of the pediatric clerkship, a medical student wrote:

“I felt sickly. The queasiness you feel when you know you’ve done something really wrong and Mom has found out. The sensation that a snake is coiling in on itself in your stomach. The feeling that the bottom of your heart has fallen off and your life has drained away.”

What could have possibly happened in the course of this student’s

clerkship experience to prompt this depth of feeling?

The student had been following a patient, an adolescent girl, admitted with a symptom for which no explanation had yet been found. The patient had been readied for a diagnostic procedure and the student waited with the patient for the specialist scheduled to perform the procedure. While waiting, the patient, who was very anxious, turned to the student for support:

“She undid the fist she had made and grabbed my hand which was in this reassuring pat. This was no simple grab. This was a needing grab. This was the grab that I had put on my Dad’s arm during my first viewing of *The Exorcist*. This was the grab my fiancé had given my hand when she first heard her grandfather had passed away. In short, this was a grab that said in no uncertain terms, “Please stay here and let me hold you, I need strength to get through this and I feel you can provide me with some.” Shortly, the student says to the patient, “Don’t worry, I’m here.”

The students’ narratives almost invariably demonstrate strong empathic identification with the patients.^{5,6} Third year students’ roles as clinicians are in an embryonic stage. While they seek to become self-sufficient, competent clinicians, most of their lives have not been spent in the hospitals and other sites where health care is delivered in our society. Their world, their experiences to this point probably have more in common with the patients and families than with their faculty-mentors. Most narratives written by the medical students emphasize the intense emotion experienced by students when caring for sick, dying, and stressed patients and families. Students often are reminded of friends, siblings, parents, or grandparents in the course of their clinical training, making the clinical circumstances that much more poi-

gnant for them. More than once a student has included the aphorism, “there but for the grace of God go I,” in the body of the narrative.

Later in this student’s narrative, the specialist arrives at the site where the diagnostic procedure is to be performed and proceeds to give the patient a 1 minute synopsis of what was to happen. As the procedure is occurring, the patient continues to grip the student’s hand and the student continues to offer support and reassurance. The student is at one end of the table, by the patient’s head, while the specialist is at the other end of the table. And then the student is presented with a dilemma. The specialist has found some pathology and calls the student over, saying, “It will be quite difficult for you to see...from over there.”

“The students’ narratives almost invariably demonstrate strong empathic identification with the patients.”



The students’ narratives often focus on the struggle to maintain empathy while assuming the role of doctor. Students come to medicine with praiseworthy idealistic impulses they often find difficult to preserve in the course of their medical training. Specifically, conflicts with persons in authority are often written about because of the highly charged nature of the relationship between student and any more senior clinician. The senior clinician has the knowledge and experience to which the student feels he or she must defer. Also, the senior clinician is the evaluator of the student making it difficult for the student to adhere to every aspect of his or her own personal code of ethics. In a survey of 1,853 medical students, Feudtner and Christakis reported that 40% had done something unethical to “fit in with the team or for fear of a poor evaluation.”⁶ Such a practice, especially if it becomes habitual or routine, cannot help but have

a lasting negative impact on a student’s developing personal and professional psyche.

In this student’s narrative the dilemma is resolved in the following manner:

“It was a choice I had to make quickly. I knew if I left her side [and] discarded her need, that the trust we had so immediately created could just as quickly be destroyed. And I knew what I wanted my primary role to be... There was really a pregnant pause. If I had even a smidge [sic] of backbone I would have said “that’s OK” and stayed by her side. But fear is a great motivator, and attendings are factories of medical student fear, often spewing forth torrents of terror to minds whose sole objective it is to learn. ‘I pried my hand away from hers and walked around the stretcher.’”

The passage above is a literal illustration of what students often perceive as their initiation into the world of being a physician: a severing of their natural empathic feelings for their patients in order to assume the role of physician. What follows in this student’s narrative is the description, given above, of the feeling of having done something terribly wrong. The student concludes, “I had left compassion behind when I went to the other side of the bed and there was no going back.”

The medical narrative exercise in the pediatric clerkship includes one other feature: the students are asked to share their narratives by reading them aloud in the presence of the other clerkship students and the clerkship director, me. This sharing of reflections often serves as a catharsis for the student who reads as well as the students who listen and then participate in a discussion of that student’s writing. Students are given the opportunity to recognize their own circumstances and difficulties in the narratives written by

others. The discussions which follow the presentation of each narrative often uncover similar situations or emotions experienced by the other students. In my role as clerkship director I often find myself validating the feelings of the students; at times I cite events from my own experience of medical education.

Catharsis in a safe setting is useful. Exploration of personal values and efforts to enhance self-awareness does lead to better patient centered interviewing. It should be kept in mind, however, that one such experience by itself is unlikely to be sufficient to immunize medical students against the almost certain erosion of empathy that will continue to occur as they proceed through the rest of medical training and eventual practice. Attention to that phenomenon, however, and more and different means of eliciting reflection

upon and discussion of the personal and ethical stresses of medical training can be a first step toward helping students with the all important lifelong goal of Self-Awareness, Self-Care, and Personal Growth. In the language describing the competent medical graduate, it is stated: "The graduate assesses personal values and priorities in order to balance personal and professional commitments."

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Information for Contributors

Medicine & Health/Rhode Island is a peer-reviewed publication, listed in the *Index Medicus*. We welcome submissions in the following categories.

CONTRIBUTIONS

Contributions report on an issue of interest to clinicians in Rhode Island: new research, treatment options, collaborative interventions, review of controversies. Maximum length: 2500 words. Maximum number of references: 15. Tables, charts and figures should be camera-ready. Photographs should be black and white. Slides are not accepted.

CREATIVE CLINICIAN

Clinicians are invited to describe cases that defy textbook analysis. Maximum length: 1200 words. Maximum number of references: 6. Photographs, charts and figures may accompany the case.

POINT OF VIEW

Readers share their perspective on any issue facing clinicians (e.g., ethics, health care policy, relationships with patients). Maximum length: 1200 words.

ADVANCES IN PHARMACOLOGY

Authors discuss new treatments. Maximum length: 1200 words.

ADVANCES IN LABORATORY MEDICINE

Authors discuss a new laboratory technique. Maximum length: 1200 words.

MEDICAL MYTHS

Authors present an iconoclastic, research-based analysis of long-held tenets. Maximum length: 1200 words.

For the above articles: Please submit 4 hard copies and an electronic version (Microsoft Word or Text) with the author's name, mailing address, phone, fax, e-mail address, and clinical and/or academic positions to the managing editor, Joan Retsinas, PhD, 344 Taber Avenue, Providence, RI 02906. phone: 272-0422; fax: 272-4946; e-mail: JRetsinas@aol.com

IMAGES IN MEDICINE

We encourage submissions from all medical disciplines. Image(s) should capture the essence of how a diagnosis is established, and include a brief discussion of the disease process. Maximum length: 250 words. The submission should include one reference. Please submit the manuscript and one or two cropped 5 by 7 inch prints with the author's name, degree, institution and e-mail address to: John Pezzullo, MD, Department of Radiology, Rhode Island Hospital, 593 Eddy St., Providence, RI 02903. Please send an electronic version of the text to: JPezullo@lifespan.org.

On Being a Writer

Peter D. Kramer, MD

Though common enough, the doctor-writer is a *monstrum horrendum*—a chimera that insults category.

Which came first for you? readers and patients ask. Which is to say, What are you really? A doctor who happens to write? Or a writer who makes a living in medicine?

The concern is not, I think, a matter of the two cultures, scientist versus humanist, as it might be for, say, chemist writers. Everyone understands that medicine calls on “soft” skills, empathy and intuition. The sense of impossibility concerns devotion. Both medicine and writing demand full commitment.

Chekhov alluded to this issue when he called medicine his wife and writing his mistress. The formulation is satisfying; it balances the long-term effort doctoring demands and the passion that informs artistic creation. But then Chekhov revealed himself by calling fiction his wife and theatre his mistress - which is what we believe anyway. For Chekhov the serious romance, the inevitability is in the writing. Doctoring represents some other, contingent drive - an incarnation, say, of the religious vocation certain critics understand him to have repressed.

As regards chronological priority, my own memory seems clear. Long before I had heard of psychiatry, I was a writer. From the earliest ages, I imagined life situations as stories. *I will have him say just what he is saying now.* I was constantly conscious of a wish to make note of one or another delicious confrontation between family relations.

In second grade, a teacher asked our class to go home and write as many stories as we could on a set topic. On Monday, to my confusion, the other children each came in with only a contribution or two. I had written sixteen pieces.

The quantity was not the sign that I was a writer. The sign was this: I felt guilty.

One of my stories turned on a nugget of fact that I had been unable to ascertain. I was worried that the teacher would catch me out—not as a liar only, but as someone who had taken desperate measures to make the plot work. Disbelieve the shaky detail, and the story was laughable.

Five decades (almost) later, I am hazy as to the topic assigned, nor can I recall a single element of any of those early stories—except for that unresearched nugget. And I can still feel a seven-year old’s guilt and confusion, as I hand in the sheaf of papers.

It is ordinary for a writer to have such a memory, an indication from early childhood of a calling. To adopt another profession would be to remain incomplete, unfulfilled—as if fiction were less a path to be chosen than an aspect of identity.

All the same, I was frightened of writing. By adolescence, I doubted I had what Hemingway calls the true gen. I took advanced courses in mathematics and physics. I edited my high school newspaper. I went on to serve as an editor on my college paper and to write (while in college) for the Ralph Nader organization and for *Newsweek*. Journalism felt to me a betrayal of self. So did literary history and criticism, which were at the core of my undergraduate major.

I accepted an honorific scholarship to University College, London—in English literature again. Simultaneously, I entered psychoanalysis as a patient, at the Hampstead Clinic, the Freudian epicenter. I wanted to know why my academic success did not make me happy.

I remember a bleak winter break spent in a friend’s flat. I struggled to work on an early novel-in-progress, only to find myself distracted by real-life romance. That failure—the manuscript was soon discarded—was grist for the therapeutic mill.

But psychoanalysis cannot be steered to a fixed end. One unexpected

discovery in therapy was a repressed desire to become a doctor. My father was a pharmacist; my mother, a school psychologist who had longed to study medicine. (Both parents had their education interrupted by the Holocaust, and emigration to America.) I had focused on anything but. And yet here we were, in the midst of the Vietnam War, with an imperative toward relevance, service, practical good. And so I signed up for summer school biology and chemistry courses. Presently, I found myself in medical school.

Psychoanalysis can create these paradoxes of identity. Who is to say that the vocation of physician, or even psychiatrist, does not hark back to earliest childhood, or before, in parental dreams? (For the son of a pharmacist and a psychologist to come to public attention as I did, via *Listening to Prozac*... it is hard to write off that result as coincidence.) Besides, psychiatry employs the skills of fiction - attention to dialogue and to character, care in phrasing and timing, interpretation of meaning, devising of tension, worry over denouement. The very instances I recall of preparation for writing might equally be understood as grounding for a career in psychiatry as it was when I entered the field, a profession centered on the talking cure. And for me, medicine had another advantage, in terms of self-expression, allowing a role for the sciences, where my natural aptitude was most evident.

Mostly, I do not accept this revisionist view of identity. I became a doctor as many do, through acculturation in training, adoption of professional standards and credos. And via a quite separate early propensity, to care about suffering. But writing cuts deeper, relates more naturally to the unvoiced workings of the mind. As a doctor, I am aware of maintaining an outsider’s perspective and stance. I am no natural; some of my moves are mechanical - in the manner of a skier who comes to the sport at midlife. But I just know

I am a writer. This claim has nothing to do with talent or accomplishment. I am driven onward (though, as years pass, with decreasing desperation) by terror over inexactness of phrasing, inauthenticity of voice, immaturity of viewpoint. Awareness of inadequacy can be an aspect of identity.

I never left writing—wrote through medical school and residency, when I could, if only the scribbled notes that we know, even as we compose them, will be lost before being put to use. I did write a novel just after residency—never published, a private achievement. The novel gave rise to an invitation to write book reviews and then a column in a trade paper, in psychiatry. For ten years, I contributed an essay per month, 120 in all. A book editor who read the column in its first year invited me to write a nonfiction volume for her. What heaven, to be approached by a publishing house, after the multiply rejected novel! That solicited book (*Moments of Engagement*, published in 1989) gave me the standing to write a proposal, and attract an agent, for what became *Listening*

(1993). Two books later, I had a novel to my name, *Spectacular Happiness* (2001), a title which, with the irony extracted, characterized my response to its appearance.

But all along it had been as if I were writing fiction. I attended a workshop (with W. P. Kinsella, in Iowa) on short story techniques and promptly applied them in my case vignettes. My book about the vicissitudes of intimacy (*Should You Leave?*, 1997) employs second person narrative almost exclusively—the main actor is “you”—and the most prominent character specified in the third person (the narrator’s mentor) is of unspecified gender. Few reviewers noticed the post-modern stylistic touches, but I am convinced that they contribute to the book’s effects, for instance, a silent undercutting of the Mars-and-Venus assumptions of the mass culture. Having published a novel now, I pay less mind to the contrast between fiction and the essay. They come from the same place and demand the same attention to craft. Technique, technique, technique—it is all writers talk about, when they gather. That and

money—like any professionals.

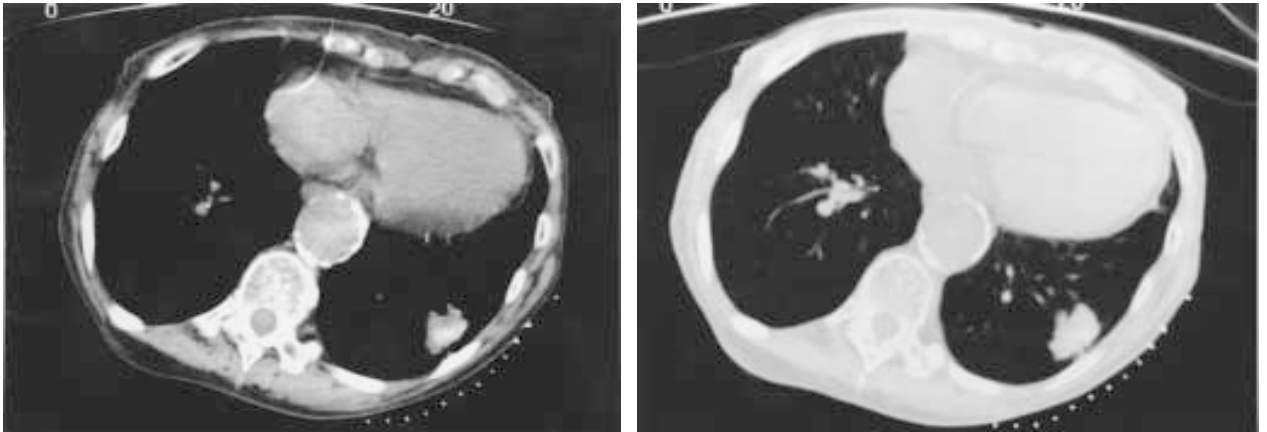
I toss and turn nights, now and again, from concern over a patient’s fate, or my own flawed intervention or omission. This unease can lead to the late bloomer’s worry: Have I any business being here—in medicine? More often, I waken to thoughts about a story I am working on. *That’s the next step*. Or, in a bad patch: *Best to scrap the whole thing*. But even that negative certainty comes free of any sense of displacement or alienation. Fretting over writing is what writers do. The worst nights come when I have avoided a chance to write, or have written out of false emotion—pique or self-pity. I always pay a price. The measure of a calling is the anxiety provoked by its betrayal.

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Human Pulmonary Dirofilariasis

This 90-year-old female, who presented with chest discomfort, had a history of a right nephrectomy for renal cell carcinoma ten years ago, and a recent history of right ureterectomy for transitional cell carcinoma of the right ureter. A chest CT examination performed as part of the diagnostic work-up to rule out pulmonary metastases demonstrated a new 3 cm high-density, nodular lesion within the left lower lobe (Images A and B). CT guided biopsies of the left lung were performed. Pathology samples revealed foreign body giant cell reaction and chronic non-specific inflammation in peripheral lung portions. The lung parenchyma was extensively infarcted. Morphologic features were consistent with the diagnosis of dirofilariasis.

Most patients with pulmonary nodules caused by *Dirofilaria Immitis* are asymptomatic. The nematode resides in the right ventricle and pulmonary arteries of dogs. The microfilariae are released into the bloodstream and are transmitted to secondary hosts, like humans, by mosquitoes. *D. Immitis* is known to cause solitary, non-calcified pulmonary nodules in humans, mostly reported in the right lower lung. The case reports emphasize the need to consider this diagnosis in all cases of necrotizing granulomas of the lung. Studies report that if inflammation exists around the nodule, the nodule should be removed surgically. Otherwise, treatment of this self-limited condition is not required.

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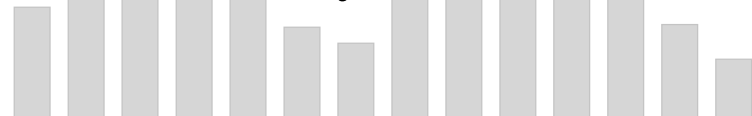
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Health by Numbers



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Gastric Bypass Surgery for Obesity

Jay S. Buechner, PhD

Obesity, a risk factor for chronic disease, is rapidly increasing in both Rhode Island and the United States.¹ As of 2001, 17.7% of Rhode Island adults and 20% of adults nationally are obese. Accordingly, targets for the reduction of overweight and obesity have been included in the Leading Health Indicators for Healthy People 2010 and Healthy Rhode Islanders 2010.^{2,3} Proposed population-based interventions to meet these targets include behavior changes to improve diet and increase exercise among the overweight.

For extremely obese persons, whose weight presents an immediate threat to their health and for whom behavior change has repeatedly failed, surgical procedures are available as a method of weight reduction and control. The most common of these procedures, gastric bypass surgery, has been performed increasingly often since 2000, and endoscopic methods have been developed that reduce the invasiveness of the procedure, the likelihood of complications, and the length of stay required in the hospital. This analysis presents findings on the performance of gastric bypass surgery in Rhode Island.

Methods

The Rhode Island Department of Health conducts the annual Behavioral Risk Factor Survey, a telephone survey of a sample of Rhode Island adults concerning health-related risks and behaviors, including specifically height and weight. In 2001, the survey obtained 3,866 responses. For respondents, overweight and obesity are based on the Body Mass Index (BMI), calculated as weight in kilograms divided by the square of height in meters. For this analysis, the BMI is used to determine obesity (BMI > 30 kg/m²) and morbid obesity (BMI > 40 kg/m²) among respondents, both male and female. (Table 1)

Information on inpatient surgical procedures was obtained from Rhode Island Hospital Discharge Data (HDD), patient-level records submitted to the Department of Health from the state's acute care hospitals on a quarterly basis. The HDD include patient demographics, multiple diagnosis and procedure codes, utilization details, and discharge status. For this analysis, gastric bypass surgery was defined as ICD-9-CM⁴ procedure codes 44.31 [High gastric bypass] and 44.39 [Other gastroenterostomy]. ICD-9-CM⁴ diagnosis codes for obesity are 278.00 [Obesity, unspecified] and 278.01

[Morbid obesity]. For trends, HDD from calendar years 1995 through 2001 and for January-September 2002 were analyzed. For description of current practice, HDD from January 2000 through September 2002 were grouped.

Results

In 2001, an estimated 17.7% of Rhode Island adults were obese, based on their reported height and weight. Included in that group are those who were morbidly obese based on the BMI definition, comprising 1.5% of the state's adults, or over 11,000 persons. These persons represent potential candidates for gastric bypass surgery.

During the first five years of the period for which hospital data were examined, the number of patients undergoing gastric bypass surgery as their first-listed procedure remained stable, averaging 28 per year. Beginning in 2000, the number of such patients approximately doubled in each successive year, resulting in an estimated eight-fold increase by 2002. (Figure 1) Over the same period, the average length of stay experienced by these patients fell from over 20 days to under 5 days, with most of the decrease occurring during the period of expanding volume. (Figure 2) Although the procedural ap-

Table 1.
Minimum Weight for Obesity (BMI = 30) and Morbid Obesity (BMI = 40), by Height.

Height (feet/inches)	Weight (pounds)	
	At BMI = 30	At BMI = 40
5'0"	154	205
5'2"	164	219
5'4"	175	233
5'6"	186	248
5'8"	198	263
5'10"	209	279
6'0"	221	295
6'2"	234	312
6'4"	247	329

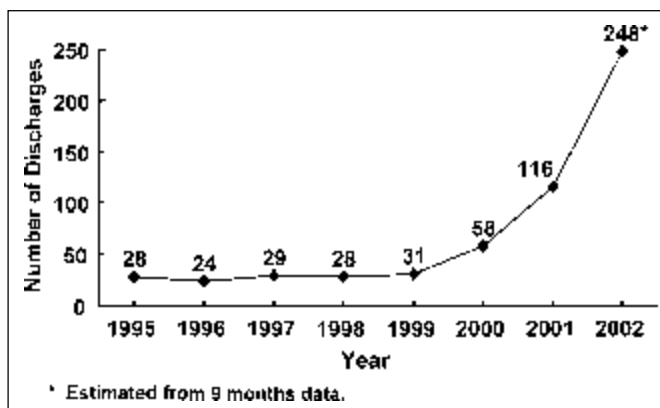


Figure 1. Inpatient Discharges with First-Listed Procedure of Gastric Bypass, Rhode Island, 1995-2002.

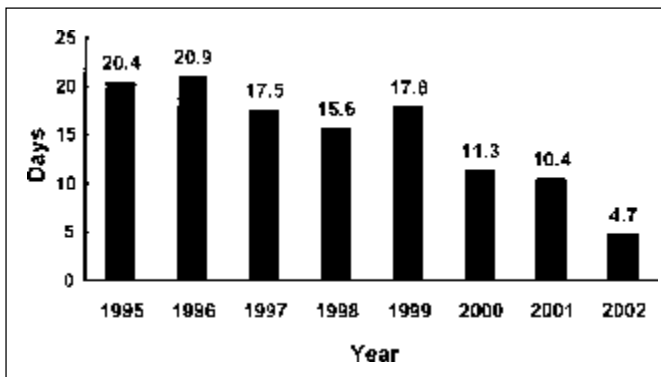


Figure 2. Average Length of Stay for Inpatient Discharges with First-Listed Procedure of Gastric Bypass, Rhode Island, 1995-2002.

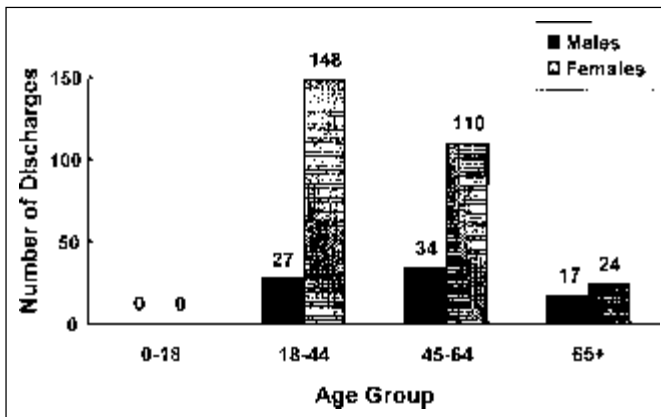


Figure 3. Inpatient Discharges with First-Listed Procedure of Gastric Bypass, by Age Group and Sex, Rhode Island, 2000-2002.

proach is not indicated by the procedure codes for this type of surgery, it is likely that the reduced length of stay is due in great part to the adoption of endoscopic techniques.

During the period January 2000 – September 2002, 360 patients underwent gastric bypass surgery as their first-listed procedure. Of these, 293 (81.4%) had obesity as their principal diagnosis. For January – September 2002, 175 (94.1%) of the 186 surgical patients had obesity as their principal diagnosis. The large majority of procedures during 2000–2002 were performed at Rhode Island Hospital (55.3%) or Roger Williams Medical Center (31.1%)

All gastric bypass surgeries during 2000–2002 were performed on adults, with the largest percentage of patients being ages 18-44 years (48.6%) or ages 45-64 (40.0%). (Figure 3) Female patients outnumbered male patients overall (78.3%) as well as within each age group. Most patients were discharged home from the hospital (93.3%), and a small proportion (2.2%) died in the hospital. The rest were transferred to a variety of other health care facilities, most notably nursing facilities (3.6%).

During 2000–2002, 60 patients underwent gastric bypass surgery secondary to some other first-listed procedure. This smaller group of patients experienced a longer average length of stay (27.0 days) than patients with gastric bypass surgery as their first-listed procedure (7.6 days) and a higher in-hospital mortality rate (11.7%). The number of patients in this group varied between 19 and 28 per year during 1995-2002, with no apparent trend.

Discussion

For the large proportion of the population that is overweight or even moderately obese, the appropriate strategy for reducing their long-term risks for chronic diseases is weight reduction through diet modification and increased exercise. However, there is a much smaller group whose obesity presents substantial short-term risks for disease and death. They are turning in increasing numbers to the surgical solution of a gastric bypass procedure.

The adoption of gastric bypass surgery as a treatment for morbid obesity in Rhode Island has occurred in just the past three years. It appears to have been spurred by the development of less-invasive surgical techniques that reduce the length of stay required, the costs involved, and, presumably, the risk to the patient. Given the number of persons in the state whose weight places them in the morbid obesity range, and the observed trends in the weight distribution of the state's population,¹ there is sufficient demand to fuel further rises in the rate of performance of gastric bypass surgery.

As in the case of any surgical procedure for which there is rapidly expanding demand, there is the potential for adverse outcomes and for inappropriate utilization. The data presented here document the overall pattern of utilization and outcomes, but they do not address issues of quality. Monitoring the quality of care involved in these procedures must be done by the surgeons who perform them and the facilities where they are performed, working with Quality Improvement Organizations, third-party payers, and accrediting organizations.

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Point of View:

The Rapid Spread of HIV Among Minority Communities In The United States: A Call To Action

Emma M. Simmons, MD, and Timothy P. Flanigan, MD

In 1981 in America, HIV/AIDS only occurred in white homosexual males. It is now an epidemic where the great majority of new infections are among African Americans and Hispanics¹ In 1996, for the first time, the number of newly diagnosed AIDS cases in African Americans exceeded that of Caucasians.² A 2001 **Centers for Disease Control and Prevention (CDC)** surveillance report showed that African Americans comprised 38% of all the AIDS cases in the United States, but only 12% of the population.³ Blacks and Hispanics accounted for more than half of the deaths reported from HIV through June 2001.^{3,4} (Figure 1) One in fifty African American men, compared to fewer than one in 250 Caucasian men, is HIV-infected. Over 65% of children in the United States under the age of 13 with AIDS are African American.⁴

These trends are getting worse. The Surgeon General estimated that almost 50% of all new HIV infections occurred in African Americans in 2000.⁴ Hispanics, comprising 11% of the United States population, accounted for 19% of new infections during that period. Black and Hispanic women accounted for 78% of all the newly reported HIV cases in women.³ AIDS is now the second leading cause of death for black males aged 25 to 44 years, and the third leading cause of death in Black women.²

In Rhode Island, HIV also disproportionately affects Blacks and Hispanics. During 1991-1996, AIDS was the fourth leading cause of death in the Hispanic community and the third leading cause of death in the African American community. The rate of HIV disease among African Americans is seven times the state's overall rate; among Hispanics it is four times the overall rate.⁵ (Figure 2)

There are many reasons for this disparity. The public health system has fallen short in its goal to decrease HIV infection. This occurs within the context of continued inequalities in minority health, independent of insurance status.⁶ The gaps in education, earnings, power and wealth between African Americans and their Caucasian counterpart are strongly correlated with and help to perpetuate poverty and poor health in the Black community.⁷ Poverty and residential segregation contribute to poor health care. This lack of care impedes the prevention and treatment of HIV.

ROLES OF PUBLIC HEALTH CARE SYSTEM IN PERPETUATING BARRIERS

Public health programs, in general, have not traditionally encouraged or compensated aggressive, preventative health care. State and federal governments have been reluctant to fund safer sex initiatives that would reduce sexu-

ally transmitted diseases, and have been more reluctant to fund needle exchange programs.⁸ Public health information often does not fully incorporate cultural and language differences.⁹ Twenty years into the HIV epidemic, a significant percentage of Blacks believe in HIV transmission myths, due to the historic distrust of the medical system/professionals caused by previous discrimination. Many people of color believe that AIDS is a form of genocide.¹¹ Some even think that the virus that causes AIDS was deliberately given to African Americans through donated blood or contaminated needles. (In the Tuskegee experiment, the government-sponsored physicians withheld information and medications from their African American patients diagnosed with syphilis in Tuskegee, Alabama from 1932-1972.¹²) This has contributed to an under-representation of African Americans in most clinical trials, including those related to HIV, in spite of governmental guidelines encouraging increased minority participation.⁸

PATIENT BELIEFS/MYTHS

The term HIV/AIDS has negative, stigma-laden connotations. Many still feel that it is a "gay" men's disease.¹³ Religious and political spokesmen who are usually outraged by societal and political inequalities within the Black community are virtually mute when it comes to the devastating impact of HIV and AIDS upon the Black community.¹⁴ In addition, Blacks don't tend to identify themselves as 'homosexuals' when they occasionally engage in sexual relations with same sex partners.^{13,14} Men having sex with men still account for the largest percentage of HIV transmissions among Blacks,¹⁵ but many of these men are bisexual and do not self-identify as gay/homosexual. Therefore they do not consider themselves to be at risk for HIV and may not seek or consent to HIV testing; which contributes to the insidious spread of HIV among their heterosexual partners.^{13, 14,15}

ROLE OF THE CHURCH

The church in the Black community is a key institution. It has led the war on social injustices and has spurred important community health programs. However, the Black church has played an unimpressive role in the HIV/AIDS epidemic, in spite of the fact that in a recent survey, African Americans viewed AIDS as the number one health problem facing the nation and the world.¹⁰

ROLE OF SUBSTANCE ABUSE

Substance abusers are at risk for HIV due to needle sharing and the exchange of sex for drugs. One third of African American men and 42% of women with AIDS are

injection drug users (IDUs).³ IDUs are less likely to seek out HIV testing, counseling and treatment.¹⁶ Blacks are also even less likely to have private insurance.⁸

POTENTIAL SOLUTIONS

HIV prevention must be culturally and age-appropriate and implemented earlier rather than later. Schools should teach children as early as the elementary years, the age-appropriate facts about HIV and its transmission, addressing myths and misconceptions similar to drug abuse prevention strategies. A 1998 AmFar poll showed that approximately 50% of young adults aged 18-24 years perceived their risk of contracting AIDS to be "zero" percent, although people under the age of 24 years accounted for half of new HIV infections.¹⁷ Knowledge alone of HIV transmission and progression is not sufficient to decrease its incidence. African American college students represent the educated future generation, yet a study by Bazarjan et al showed that a large majority of college students, knowledgeable about HIV and AIDS, still engaged in risky behaviors.¹⁸ This is frightening because the median time of infection with HIV to progression to AIDS is approximately 10 years.

Physicians must claim partial ownership of the spread of the HIV epidemic, because they, like patients, bring their beliefs, attitudes and expectations to each clinical encounter, consciously or unconsciously.⁸ Physicians often feel uncomfortable introducing the topic of HIV to their patients. Even once a physician has initiated a discussion on the risk factors for HIV disease, few physicians complete a comprehensive (i.e. three additional minutes) assessment to investigate the patient's true HIV risk.¹⁹ This is made even more difficult by the finding that approximately 80% of African Americans perceive that access to HIV care and treatment is a problem affected by income and race.¹⁰

Some doctors feel that HIV testing and counseling is financially restrictive as well as too time-consuming. Philips *et al* researched the cost of identifying HIV in the primary care arena. They found significant savings per identified infection when comparing routine HIV testing to HIV testing based on risk history assessment. The study also demonstrated that routine counseling and testing offered savings in harder to measure areas such as quality adjusted life years saved, years of life, and in averting additional HIV infections.²⁰

Primary Care Providers need to play a much more vocal role in preventing new infections with HIV and progression to AIDS for those already diagnosed. Although most people with HIV can receive more up-to-date care at a tertiary academic care center, primary care doctors are in a better position to deliver healthcare by their sheer numbers within the community, because they know the local culture, politics, and belief systems of their patients. Major teaching hospitals take care of only 30% of HIV-infected

patients.²¹ Unfortunately primary care doctors are frequently overworked, stressed and underpaid so that inadequately reimbursed and time-consuming services assume a lower priority. This low priority for counseling in the medical profession, coupled with poor information or misinformation within the minority community, precipitates failure. It also leads to missed opportunities for HIV counseling and testing that could be addressed at preventative visits, such as physicals and pap smears, and also at acute visits with upper respiratory infections, similar to the counseling now done for smoking cessation and weight reduction.

Doctors' offices and clinics should obtain drug and sexual histories as well as provide counseling and HIV testing. If this is not feasible, one simpler solution to the detailed history gathering would be to offer routine testing (no history required). The prevalence of HIV infection is high enough to warrant routine screening similar to screening protocols for pregnant women with serology for syphilis and for cancer with the Pap smear.²²

We should begin to make counseling and testing for HIV as much a part of our practice as recommending seat belts and exercise.



^{23,24} A recent study in an urban ambulatory care center showed that when providers routinely recommended HIV testing to all patients, more infections were detected and more patients were diagnosed earlier in their infection, compared to the practice of offering these tests only to patients with symptoms or risk factors.²⁵ Primary care providers can have a tremendous impact on prevention and early treatment as well as maintenance and follow up care.²¹

Primary care providers in conjunction with the African-American community can be employed to play a larger more aggressive role by examining attitudes, sponsoring low cost workshops, and using the church for education. More community organizations can support needle exchange programs and condom training workshops for those people who continue to engage in risky behavior. Even though changing behavior is not an easy task, it must begin immediately and with collaborative roots between minority communities and the primary care medical system if we are to stem the HIV/AIDS epidemic ravaging these communities.

Primary care providers have not only the opportunity but also the responsibility to recommend screening to all patients at risk for developing HIV. The record shows that the medical community is missing a significant percentage of those who are HIV infected. These unidentified patients are losing out on the opportunity to get early, appropriate and life saving care to improve both their quality of life and their longevity. The primary care community would not tolerate this loss for any other disease, acute or chronic, with consequences such as this. We should begin to make counseling and testing for HIV as much a part of our practice as recommending seat belts and exercise. Similarly we should make screening for HIV akin to screening for cholesterol and breast cancer until every last affected person is identified.

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NOTICE: Pain Assessment Regulations from Department of Health

On June 28, 2002, the Rhode Island General Assembly enacted Chapter 5-37.6 of the Rhode Island General Laws, the "Pain Assessment Act of 2002." This law requires that the Rhode Island Department of Health promulgate regulations containing requirements related to the assessment of pain by health care facilities and health care providers in Rhode Island. (To view a copy of the law, go to: www.rilin.state.ri.us/Statutes/TITLE5/5-37.6/INDEX.HTM).

The Department is circulating a draft of the pain assessment regulations for public comment. If you would like to receive a copy, you may access them online at either the Health Department's website: www.health.state.ri.us/news.htm, the Secretary of State's website: www.rules.state.ri.us/rules/, by writing to LizS@doh.state.ri.us, or by contacting the Office of Health Services Regulation at 401-222-1039

– A Physician's Lexicon –



The Sources of the Amazon

The Spanish conquest of South America did not always go smoothly. In 1541, for example, the conquistador Francisco Orellano encountered great difficulty in a battle with the Tapuyas tribe, who had their women fight side by side with their male warriors. Orellano then recalled an ancient Greek tale of a race of women warriors from Caucasian Scythia who had ruled over Cappadocia under Queen Hippolyta and had routinely cut off their right breasts so that they might use a bow with greater ease. The Greek root for breast, *mazo-*, had then been combined with the Greek privative prefix, *a-*, signifying the absence of, to create the word Amazon, the Greek name for this legendary Asiatic warrior tribe. Orellano, conversant in classical mythology, then applied the name, Amazon, to the central South American region as well as its mighty river.

The *mazo-* root [or its derivative Latin form, *masto-*] creeps into medical

terminology in words such as mastitis and mastectomy. The mastoid bone was so named because of its rounded contour and thus its resemblance to a breast; and the *-oid* suffix from a Greek word meaning similar to.

The word, breast, on the other hand, is derived from Germanic, non-Mediterranean sources. In Old German the word was *brust*, originally meaning any swelling of the chest or abdomen. The word, breast, is now employed widely to signify anything related to the ventral aspect of the thorax [in words such as breastbone, breastplate, breaststroke and, by inference, even words such as breastwork and breast plow]. The word, brisket, [meaning a cut of meat near the ribs] also comes from the old German word, *brust*.

Another Latin term for breast, *mamma*, survives in such English words as mammal and mammary gland.

A more discrete word for breast, *bosom*, was frequently used in the 19th Cen-

tury but has since retreated to the pages of the unabridged dictionaries. It too is a derivative of an archaic German term.

To browse, to look at something casually, had earlier meant to graze slowly, to nibble; and it, too, had originally stemmed from the word, *brust*, meaning, by extension, to provide a source of nutrition.

A synonym for breast, namely chest, is from an older Celtic word *kista*, meaning any cavity or container. And *kista* is probably derived from the Latin, *cista*, also meaning cavity. The English words, cistern and cyst, and the Latin, *cisterna magna*, both originate in the Latin *cista*.

Other imprecise synonyms for breast include thorax, derived from a Greek word; and pectoral, a Latin adjective pertaining to the breast [and thus to expectorate, to spit, means to expel from the chest].

– Stanley M. Aronson, MD, MPH



Vital Statistics

Rhode Island Department of Health

Patricia A. Nolan, MD, MPH, Director of Health

Edited by Roberta A. Chevoya

Rhode Island Monthly Vital Statistics Report

Provisional Occurrence Data
from the
Division of Vital Records

Underlying Cause of Death	Reporting Period			
	March 2002	12 Months Ending with March 2002		
	Number (a)	Number (a)	Rates (b)	YPLL (c)
Diseases of the Heart	280	3,088	294.6	4,043.0
Malignant Neoplasms	206	2,428	231.6	7,640.5
Cerebrovascular Diseases	51	544	51.9	807.5**
Injuries (Accident/Suicide/Homicide)	39	415	39.6	7,317.0***
COPD	67	533	50.8	507.5

Vital Events	Reporting Period		
	September 2002	12 Months Ending with September 2002	
	Number	Number	Rates
Live Births	1,015	13,345	12.7
Deaths	786	10,281	9.8
Infant Deaths	(9)	(99)	7.4
Neonatal deaths	(8)	(67)	5.0
Marriages	1,072	8,253	7.9*
Divorces	339	3,468	3.3
Induced Terminations	466	5,569	417.3#
Spontaneous Fetal Deaths	82	1,094	82.0
Under 20 weeks gestation	(74)	(1,022)	76.6
20+ weeks gestation	(8)	(72)	5.4

(a) Cause of death statistics were derived from the underlying cause of death reported by physicians on death certificates.

(b) Rates per 100,000 estimated population of 1,048,319

(c) Years of Potential Life Lost (YPLL)

Note: Totals represent vital events which occurred in Rhode Island for the reporting periods listed above. Monthly provisional totals should be analyzed with caution because the numbers may be small and subject to seasonal variation.

* Rates per 1,000 estimated population

Rates per 1,000 live births

** Excludes one death of unknown age.

*** Excludes two deaths of unknown age.

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NINETY YEARS AGO

[MARCH, 1913]

A Child Welfare Conference and Exhibit, held in Providence, spurred several papers, as well as editorial comments.

The Editor cautioned against over-emphasizing children at the expense of adults. Noting an American Association for the Advancement of Science release that the rate of deaths in people over 40 had increased in 30 years over 20%, while the infant mortality rate had dropped, the Editor remarked: "While the wealth of a nation must necessarily be in the young generation, it has a present value in its active population, and if we are going to kill off our active men and women in our endeavor to diminish the mortality of the child, it seems a question as to which is the more valuable asset to the country."

The Editor also complained about the recent restrictions to assure sanitary drinking cups and ice on Rhode Island trains. An investigative study had found filthy water, served in filthy cups, with filthy ice. The state legislature could not regulate the water, but did require that all receptacles be "thoroughly cleaned by the railroad and company and ...no ice...be placed in any of the water served for drinking." On a hot summer day, the Editor could not get a cup of cold water on the train. He asserted, "...many travelers would prefer to take a chance of catching some disease for the sake of a cool drink of water with which to wash away the dust of travel, but this State in its desire to protect us from disease is to do away with that."

Henry Bowditch, MD, [from Massachusetts Babies' Hospital] in "Hospital Milk and Its Substitutes, Proprietary Foods, in Relation to Infant Mortality," noted that 25% of infant deaths were caused by diarrheal disease, 25% by wasting disease. He urged hospitals to stock breast milk, communities to supply wet nurses.

W.P.Lucas, MD, in "The Common Cold: Its Contagiousness, Complications and Sequellae and Their Relation to Infant Mortality," cited "predisposing" causes of colds in young children (e.g., adenoids, large tonsils, deviated septums, spurs, auto-intoxication, chronic gastro-intestinal indigestion). Dust was not an etiologic factor, but a "mechanical irritant."

FIFTY YEARS AGO

[MARCH, 1953]

Malcolm Winkler, MD, contributed "Medico-Legal Aspects of Hand Dermatoses." For physicians, the problem was often to determine whether the dermatosis was occupational. Dr. Winkler briefly reviewed common dermatoses, including psoriasis, pompholyx, infections, foods, dermatophytids, postular bacterid.

Joseph C. O'Connell, MD, president, Rhode Island Medical Society Physicians Service, summarized "Three Years of Voluntary Prepaid Surgical Insurance in Rhode Island." At the end of 1952, Rhode Island's program enrolled 314,560 persons, or 42% of the state's eligible population - one of the four highest percentages in the nation. It combined service with an indemnity, fixed physician fees for families earning less than \$3600 annually (physicians could charge higher fees for families earning more), and offered both small group and individual memberships (71,298 enrollees were direct subscribers).

Banice Feinberg, MD, in "Sulfonamides and Penicillin in the Control of Rheumatic Fever in Children," reported on a study at the Rheumatic Fever Clinic at Rhode Island Hospital (one of several rheumatic fever clinics established by the state in 1941).

An Editorial, "Hospital Trustees," praised Westerly Hospital for appointing a physician to its board, a practice begun four years ago at the hospital, but a comparatively rare one in hospitals nationally.

TWENTY FIVE YEARS AGO

[MARCH, 1978]

Kathleen A. Caizzi, MD, Richard P. D'Amico, MD, and Robert E. Knisley, MD, contributed "Angioimmunoblastic Lymphadenopathy: A Prospectively Studied Case with Therapeutic Implications." This "unusual disorder" in a 70 year-old man responded to corticosteroids.

Charles B. Kahn, MD, in "Present Status of Diabetic Retinopathy in Rhode Island," urged careful screening for early detection of retinopathy, to select patients early for "photocoagulation therapy, possibly combined with cataract surgery, vitrectomy, or both."

Donald D. Edinger, Jr., MD, reported on "Screening of DES-Exposed Women in Rhode Island, 1974-77." He reviewed the case records of 74 patients, ages 14 to 27, from the Special Gynecologic (Colposcopy) Clinic at Women & Infants' Hospital, from June 1974 - March 1977. The reports showed no case of CCA, but 38% of women had a biopsy-proven adenosis.

In "David vs. Goliath: Eight Physicians from the Nation's Smallest State Challenge Four of the Country's Largest Malpractice Insurers," Anthony F. Merlino, MD, described the Rhode Islanders' \$100 million antitrust suit against the four insurers who wrote 95% of the malpractice claims for the state's 1250 physicians. The insurers had hiked rates, as well as changed the terms (e.g., going from a claims-occurrence to claims-paid basis). Although the court initially dismissed the suit, the federal trial court reinstated it; and the author expected the four insurers to appeal to the Supreme Court.