LETTERS

The Winter issue’s pair of features about palliative care, the article about Dartmouth premeds, and the cover story about Denali all came in for comment from readers.

Homage to hospice
Your Winter issue arrived yesterday, and, as usual, I was interested in a particular article. It’s always glad to hear from readers—whether it’s a letter from a longtime subscriber who’s weighing in with an opinion, or a note from someone who would like to become a longtime subscriber. In fact, we are happy to send Dartmouth Medicine—on a complimentary basis—to anyone who is interested in the subjects that are covered in the magazine. We regret, however, that the complimentary subscription offer can be extended only to addresses in North America. Both subscription requests and letters to the editor may be sent to: Editor, Dartmouth Medicine, One Medical Center Drive (HB 7070), Lebanon, NH 03756, or via e-mail to: dartmed@dartmouth.edu. Letters for publication may be edited for clarity or length.

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Robert P. Liberman, M.D.
DC ’59, DM S ’60
Los Angeles, Calif.

Liberman is a professor of psychiatry at U C L A School of Medicine.

Champion of chaplaincy
I was happy to see the articles “Facing Death” and “A last . . .” in the most recent issue. They were wonderful! It is great to see medical schools finally dealing with acknowledging feelings of loss and exploring palliative care. It looks like Dartmouth is on the leading edge of this movement—that’s great.

These are issues that are close to my heart. Because of deaths in my family, I’ve had to deal with them personally, but I didn’t begin to get help for myself till the late ’60s and early ’70s, when Kubler-Ross sparked the study of death and dying. I have also dealt with these issues in my work. A retired Lutheran pastor, I spent part of my career as a chaplain in health-care settings. Sadly, I saw more bad examples than good ones of how doctors deal with families and patients. Few chirps that we are finally doing something about our ignorance and denial.

I did miss, however, seeing any mention of the role of chaplains. It would be interesting to know about the interrelationships between the chaplaincy discipline and the various medical disciplines in end-of-life issues as well as in issues of pain, suffering, etc. I bet they work together at Dartmouth, or at least that the chaplains are engaged in developing the process.

Katharine Zimmerman
Tinley Park, III.

Zimmerman is right—the chaplaincy is indeed involved in the initiatives described in the Winter issue. Unfortunately, there was space for just a mention of the fact that the palliative-care teams include a pastoral caregiver. In addition, chaplains attend the palliative-care planning meetings, and palliative-care coordinators refer patients to chaplains for end-of-life counseling.

New and improved
Whenever I visit D H M C, I swipe a copy of D a r t m o u t h Medicine to bring home. It’s always interesting and fun to read. As a head nurse from 1952 to 1954 in the old Mary Hitchcock Hospital on Faulkner 2 (when Faulkner 3 was the top floor), I enjoy staying in touch.

I recently brought home the Winter 1999 issue. The article “Facing Death” is stimulating and moving. The medical profession in the past few decades has made much improvement in the care of the dying. The availability of medical information, the honesty of prognoses, the choices for the patient, and the sources of support for the dying person and his or her family have changed and improved the dying process for many people. In the midst of the grand new building, with its nice eating places and
Poignant and timely
I was about to conclude that the Winter DM didn't quite match its usual high quality— it's hard to always hit a "home run"— until I read the "Facing Death" vignettes. That short feature was especially poignant and timely, for we've all had some brush with end-of-life issues in our personal lives. I've already sent a photocopy to a neurosurgeon-colleague who became interested in the topic after dealing with brain tumors in children for 20 years and with his own heart transplant more recently.

I found Megan Cooper's piece most poignant and especially meaningful in the context of the perversity of end-of-life events—at least in teaching hospitals. Over treatment and futility have become the rule, even when a patient has a living will. The abandonment that she so eloquently describes is the flip side of the caregiver's sense of inadequacy in not being able to effect a cure, or at least a better result. Thank you for sharing her experience and her feelings about it.

Fredrick Orkin, M.D.
Hershey, Pa.

Wowed reader
I just finished reading "Drama on Denali" in your Winter issue. Wow! A gain, as always, it was a great issue.

John L. Gillespie, DC '54
Hanover, N. H.

Meaningful mentorship
I am one of the students who was interviewed for the story on Dartmouth premeds in the Winter issue. I'd like to reiterate my appreciation for the time that Dr. Michael Mayor, an orthopedic surgeon at DHMC, spent with me when I shadowed him last year. I can't say enough about what his mentorship meant to me. In addition, I had the experience, not mentioned in the article, of working in Dr. Lee Witter's lab; he truly deserves much credit for revitalizing the shadowing program and the Nathan Smith Society.

I'm now a first-year student at Harvard Medical School. Although I miss the New Hampshire scenery, I really enjoy what I am learning. In fact, largely due to my experience with Dr. Mayor, I have become interested in orthopedics. So not only did Dr. Mayor influence me to go to medical school, but I think I want to go into his specialty!

Let me also mention that I really enjoy reading Dartmouth Medicine.

Scott Warden, DC '99
Boston, Mass.

Waste not
We have come a long way at DHMC with waste management and environmental programs. We are pleased that these issues have gotten so much attention [see pages 14-16 in the Winter issue]. We would like to emphasize that this success at DHMC is grounded in employee participation and involvement. While these programs are supported by the administration and developed and implemented by our office of safety and environmental programs, staff involvement has been the real key to success.

And a point of clarification: The statement that "DHMC has two large autoclaves that sterilize medical waste before it's incinerated" is incorrect. The autoclaved waste is not incinerated but sent to the landfill with our other solid waste. One of our objectives is to minimize incineration due to its negative impact on the environment and human health; this is one of the reasons we closed our on-site incinerator in 1995. We do, however, send pathological and chemotherapy waste off-site for incineration, as required by law, but the majority of our general infectious waste is autoclaved on-site.

Laura Brannen and Victoria Jas
Lebanon, N. H.

Brannen and Jas run DHMC's safety and environmental programs. Our cheeks are "burning" with embarrassment about the error regarding incineration practices.

Healing tools
Modern western medicine has become a functionally autonomous exercise in tunnel vision: looking for tinier and tinier physical signs of the diseases that affect us. The answer to the
dilemma that Drs. Fisher and Welch ("The Making of a Medical Skeptic," Summer 1999) are busy researching may lie in the simplest of solutions. Change the focus of medicine from curing to healing, and the problem dissolves. To heal means to become whole. This may be too vague a term for scientifically obsessed M.D.'s, but it is what humans are searching for.

I suspect the estimate that three out of four humans are diseased is an understatement. We are all out of balance in one way or another. A modern medicine adopts other phrases and ideas (like "dis-ease") from alternative systems of healing, our definition of illness will expand. Hopefully, our consideration of "healing" will broaden as well.

If the physician can let go of the need to be the authoritative dictator of health care, and resume the intended role of facilitator, the natural partnership between patient and physician will obviate most of the issues surrounding the overuse of medical resources. Simply recognizing illness as a message from the consciousness spoken through the language of the body allows the technology of modern medicine to be used for the purpose it is best suited—a tool for healing—and in a more effective manner than its invasive, have-to-fix-it-now role allows.

Individual patients, injured or ill, are the only ones capable of healing themselves. In the new paradigm of healing, if my chest pain causes so much fear in me that I am unable to search for the deeper meaning of its message, I may opt, with my partner, the physician, to investigate, through the use of selected technological tools, how much damage has been sustained as a result of my years of ignoring the subtler messages of my body. At the same time, a team of facilitators who can assist in my exploration of the underlying imbalance in my consciousness or my world (including environment, relationships, work, etc.) will be gathered under my direction and guided by my belief system, ethnic background, prior experience, and other influences. The team may involve alternative healers, psychotherapists, nutritionists, surgeons, or clergy. Surgery or acupuncture or whatever other tools were chosen would be used as such. A surgical experience would not be a rape, an invasion of body and spirit without regard to its effect on anything other than anatomy and physiology. It would be an essential component of a sacred healing opportunity.

In order for healing in partnership to work, several basic changes must be made. First, medicine and physicians must redefine their role from director to participant. Second, illness and healing must be redefined in terms of where each individual patient is on the healing path. Lack of cure, or death, will no longer be considered failures but options for growth and ultimate healing. As most importantly, humans must be encouraged from childhood to listen to their bodies and to take responsibility for their balance, for their care, for their continued growth on all levels of being. This is the real challenge—not what to do with technology, but how to restore human beings to a loving relationship with their bodies, their minds, their emotions, their spirits...themselves. Everything else will follow.

Judith J. Petry, M.D.
Westminster, Vt.

Petry is the medical director of the Vermont Healing Tools Project.

Follow-up
I hope you might be able to locate an article that was published in Dartmouth Medicine sometime in the past few years.

It was a poignant story written by a physician (I think an orthopedic surgeon) about his young wife dying of cancer and leaving him with two young boys to raise. There may have also been a follow-up article, as well as some letters to the editor.

I am a pediatrician who recently had a young mother in my practice die of ovarian cancer, leaving two little girls and a husband. I'd like to send these article(s) to the husband, as I think he'd find them very helpful.

In addition, I wonder how the author and his sons are doing now. Thank you very much.

Beth Rider, M.S.W., M.D.
Chestnut Hill, Mass.