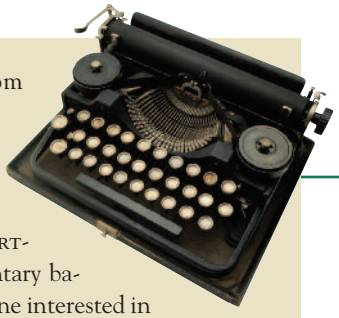


We're always glad to hear from readers—whether it's someone weighing in about an article in a past issue or someone asking to be on our mailing list for future issues. We are happy to send Dartmouth Medicine—on a complimentary basis, to addresses in the U.S.—to anyone interested in the subjects we cover. Both subscription requests and letters to the editor may be sent to: Editor, Dartmouth Medicine, 1 Medical Center Drive (HB 7070), Lebanon, NH 03756 or DartMed@Dartmouth.edu. Letters for publication may be edited for clarity, length, or the appropriateness of the subject matter.

The cover feature in our Fall issue inspired a reader to send us a letter and a photo of her adorable one-year-old son, while a 50-year-old photo of medical students inspired a quizzical letter from another reader. Dismay prompted a couple of other letters—in one case, an unintended implication about that 50-years-ago class, and, in another, a recent case of modern medicine not quite at its best.

Pleased to be part of history

I was delighted to read "Cause for celebration: A 50th and a 50/50 ratio" in the Fall 2010 issue of Dartmouth Medicine (see **dartmed.dartmouth.edu/f10/v01**). I was pleased to be part of DMS's record-breaking event, as enrollment of women in the 1987 entering class passed 50% for the first time at a U.S. medical school that was not historically all-women.

The Admissions Committee worked diligently to select a class of superb quality from a very large applicant pool, which had been growing each year in number of women applicants. It is a testament to the committee and its gender-blind selection process that this event took place at DMS in 1987, well in advance of other U.S. medical schools.

Frances "Frankie" Hall
Williamsburg, Va.

Hall was DMS's director of admissions, and later assistant dean for admissions and financial aid, from 1975 to 1991. She went onto become associate vice president for student programs at the Association of American Medical Colleges, from which she retired in 2000.

Who is that fellow?

I eagerly devour Dartmouth Medicine when it hits my mailbox; your writers, editors, and photographers do an amazing job of taking the subject of medicine and making it as compelling to read as any mystery or classic novel penned by one's favorite author.

I especially enjoyed the article about Valerie Leval, DMS's first woman student, but laughed out loud when I got to the photograph [which is reproduced below]. Who is the bigger-headed fellow in the front row, second from the right? It looks like a yearbook or student ID picture that got jammed in there. Is this maybe a "Where's Waldo" or "What does not belong in this picture" activity? Have I won a prize for spotting it? What gives?

Keep up the great work.

Lorraine Brady Kulik
Nashua, N.H.

Unqualified assertion

The Fall issue of Dartmouth Medicine states that in 1960, "when classes began, she [Valerie Leval, the first woman student at DMS] was at first met with open resentment from her 23 male classmates."

Unless you were there, how could you make such an unqualified assertion? I was one of those 23 male classmates, and at no time that I recall was I ever resentful of Val. She was just one of the members of the class. Did some of the others resent her? Probably. But for you to assert that all of us resented her is just inaccurate, poor journalism, and sloppy reporting. Try to qualify assertions like this—e.g., some, a few, several—in the future.

Theodore Tapper, M.D.
DC '61, DMS '62
Merion Station, Pa.

We are most apologetic about the implication of that statement—although it was a case of inattentive editing rather than careless reporting. The original draft of the article said merely that Leval "found open resentment among her classmates." But that seemed like a good place to work in a mention of the size of the class. Unfortunately, we failed to notice the resulting implication that the whole class, not just some members of it, were resentful.

When we expressed our regret for the oversight to Tapper, we also asked him about "the bigger-headed fellow" in the photo. Tapper (who is in the back row, on the far left) said that's a classmate who couldn't be there for the official portrait, so some pre-Photoshop sleight of hand was employed in the darkroom to include him in the ranks of his class.

Investigational incentive

I'm the mother of a one-year-old boy who has cystic fibrosis. I just read the article in your Fall issue on Dr. George O'Toole's findings on biofilms (see **dartmed.dartmouth.edu/f10/f01**). I encourage him to continue his diligent work.

I hope he will keep looking for the right combination of drugs that will help my son live a long and healthy life. I want to assure him that his work will help thousands of people. I hope

This photo of the Medical School's 1960 entering class, and the story that accompanied it, generated three letters—one positive, one quizzical, and one critical.

Be sure to tell us when you move! To keep getting the magazine if your address changes, tear off the back cover, write your new address next to the old one, and mail it to: Dartmouth Medicine, 1 Medical Center Drive (HB 7070), Lebanon, NH 03756. Our mailing list is drawn from seven separate databases, so it's helpful if you send the actual cover or a copy of it. If that's not possible, please include both your old and new address. And if you receive more than one copy of the magazine, it's because of those seven databases (which are in different formats, so they can't be automatically "de-duped"). But we are happy to eliminate duplications—just send us the address panels from *all* the copies you receive.

that is incentive enough for him to continue to solve the "mysteries of biofilms."

Lisa Dwyer
Hopkinton, N.H.

An absent essential

A surprise opportunity to experience modern medicine firsthand still has me shaking my head in wonder. There were many things that inspired awe and gratitude, from the quick response of the Westminster, Vt., rescue squad, to the remarkable skill of the Dartmouth-Hitchcock orthopaedic surgeons in putting the many pieces of my shattered femur back together.

The one noticeably absent essential was that of touch. I recall being thoroughly examined by the trauma team on my arrival in the emergency room; from then on, the only touching that happened was for taking vital signs, giving injections, or changing a bandage. No one shook my hand as they introduced themselves. No one laid a hand on my arm or shoulder as they asked how I was doing. I would have appreciated that extra indication that they were really interested in my answer to the question.

My doctors' choice whenever a potential problem arose was to ask a machine what was wrong rather than to examine me for clues. When I had a sharp pain in my upper chest, instead of checking my skin color and listening to my lungs, my doctors ordered an x-ray. When I had some frightening eye symptoms, the next thing I knew I was on a stretcher on my way to radiology again—this time for a CT scan of my face.

When did technological assessment replace physical examination of the patient? When I was a medical student eons ago, we practiced on each other as decorum allowed and then were let loose on patients. We learned the art of observation, palpation, and percussion. Technology was a tool for confirming the diagnosis after a careful history and physical had been completed.

One of the pearls of wisdom I recall from that time came from an old GP who had practiced in the era of house calls. He told us that if we listened carefully, patients would almost always tell us what was wrong with them. The secret was in the listening. The other secret was the hands-on exam. My favorite book when I was a student was a treatise on how to examine the belly and come up with an unerring mental image of what was going on inside it. It was better than a CT scan. But it seems the physical exam has gone out of style.

The exceptions to the lack of touch I experienced were so few they stand out: An EMT stabilized my head with firm, gentle hands while I lay on the barn floor after falling from my hay loft. A busy nurse took the time to wash my hair after my surgery. And after the CT scan of my face I was visited by some plastic surgery residents who actually touched my cheek bone.

I don't know that the outcome of my surgery and hospitalization would have been different if anyone had placed a caring hand on me during my stay. But the most beloved of my surgery professors never talked to patients without also touching them: a handshake, a touch on a forearm, nothing threatening, just caring.

I have a nightmare in which physicians of the future are on one side of a Plexiglas wall and patients are on an assembly line on the other side. The physician reads a computer screen listing the patient's chief complaint, associated symptoms, and history. Below this are the results of lab studies and scans that have been done automatically by a software system based on the chief complaint and other variables. The doctor can ask further questions of the patient through a speaker but rarely finds this necessary. Below the test results, the software lists a series of treatments in the order of most likely to succeed. The doctor chooses the best one and passes the patient on to a pharmacist or a robotic surgeon. There is never any need to touch the patient.

I am grateful for all the skill of those who managed my trauma, but I remember most the absence of caring touch. I fear I have witnessed the beginning of the era of No-Touch Medicine.

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

Dartmouth Medicine *invited a member of our Editorial Board, Dr. James Bernat, a professor of neu-*

A human face, left, is put on the research on our Fall cover, above, by the letter titled "Investigational incentive."

This faculty profile reminded an alumna of the subject's warmth and empathy.

rology and the longtime chair of DHMC's Bioethics Committee, to respond to these observations:

"Dr. Petry's moving critique exposes shortcomings of contemporary technological medicine and has profound implications for medical education and practice. Because of her unique perspective as both a hospitalized patient and a clinician trained in the critical importance of physical diagnosis, she can see vividly how medical practice has evolved during the past several decades. I believe that her observations ring true, but, rather than reflecting practice behaviors specific to Dartmouth-Hitchcock, represent a national trend in the practice of young physicians.

"Her critique emphasizes two separate but related problems: the absence of caring touch offered by many of the professionals treating her and the tendency of some young physicians to substitute diagnostic technologies for a physical examination when assessing symptoms and reaching a diagnosis.

"Caring touch is such a fundamental and universal human need that it should require no explanation. The human contact resulting from the 'laying on of hands' helps to justify those elements of the routine physical examination shown by outcomes studies to lack preventive value. Yet today's widespread use of diagnostic technologies mirrors a reduced emphasis on physical diagnosis skills; this trend may be accounted for by the fact that medical schools nationwide require fewer hours of physical diagnosis teaching than prevailed 40 years ago when I was a medical student. Some schools, such as Stanford, have responded by establishing special physical diagnosis teaching rounds that showcase outstanding diagnosticians—such as the noted physician-author Dr. Abraham Verghese—and allow them to demonstrate to students the importance and excitement of the disappearing art of bedside physical diagnosis.

"Few physicians or patients would dispute the marvels that technology have brought to medicine, but high-tech care should be an adjunct to, not a substitute for, high-touch care."

Empathetic educator

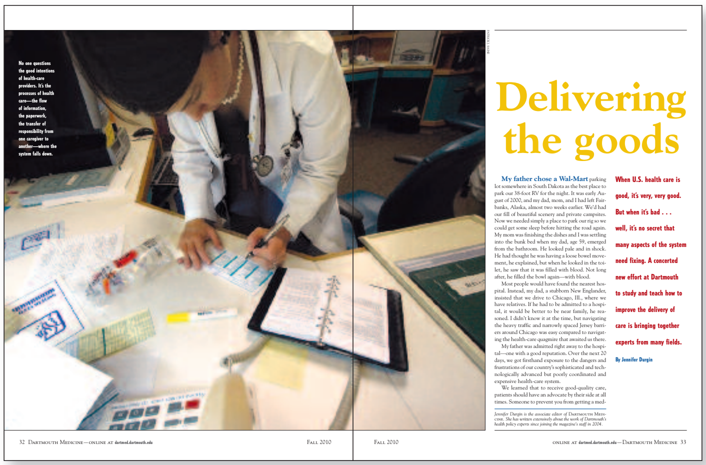
I loved the Fall "Faculty Focus" profile (see **dartmed.dartmouth.edu/f10/p01**). The writer did a nice job capturing Dr. Lyons's spirit and humility. He is the kind of person who has a powerful effect on everyone.

In fact, he made an impression on me the first day of anatomy lab. I remember how confused I felt after our first four-hour session of dissecting our cadavers. I had no idea what had just happened, if I had done what I was supposed to have done, if I had learned what I was supposed to have learned. The experience had been overwhelming, and I had no idea what to do to prepare for the next session. As my classmates started filing out of the room, I looked up at Dr. Lyons and stammered out some expression of confusion-cum-plea for help. I have no recollection of what he said in reply, but I do recall that he looked at me with complete warmth and empathy and somehow made me feel that everything was going to be okay.

And, in the end, it was.

But as much as I adored Dr. Lyons, I was unaware of his passion for gardening or of his involvement in Willing Hands. What a fun thing to learn about one of my favorite professors!

Julia Nordgren, M.D.
DMS '99, HS '02-03
Concord, N.H.



Dartmouth's new health-care delivery initiative prompted input from an alumnus.

Specialty delivery

I enjoyed Jennifer Durgin's article "Delivering the Goods" in the Fall Dartmouth Medicine (see **dartmed.dartmouth.edu/f10/f02**). She highlights very well some of the major issues in our too-expensive health-care delivery system. I'm very excited about the new Dartmouth Center for Health Care Delivery Science. This area was not addressed very well by the new health reform law, which did little to reduce the cost of health care.

I would recommend that the new Dartmouth center focus on the following issues in addition to those mentioned:

I believe physicians are being trained to answer specialty needs in major medical centers, not the needs of people in communities. There are far more community hospitals than major centers. We should train physicians who plan to practice in rural settings differently than those who plan to stay in major medical centers.

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Letters

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I was a community general, vascular, and hand surgeon in Plymouth, Mass., for 32 years. I was one of the last general surgeons who had training in hand trauma and common upper extremity pain syndromes. When I arrived in Plymouth in 1972, there was no one interested in caring for hand trauma, a fairly common problem. So I attended hand symposiums and set up a microvascular rat lab in my office building so I could become proficient in the developing field of microsurgery. This helped me in managing soft tissue problems in hand as well as distal bypass vascular procedures.

After taking care of hand trauma for 20 years, I realized that HMOs would not list me as a hand surgeon because I didn't have a hand surgery certificate (which wasn't available when I finished my residency in 1972). As a result, patients in Plymouth were going to Boston for care that I could treat as well if not better. So I called the American Board of Surgery (ABS) and asked if I could sit for the hand surgery exam. I'd taken the hand surgery self-exams and done well. I explained that my community needed someone capable of treating hand trauma and common upper extremity pain syndromes. But the ABS refused to let me sit for the exam because I didn't do rheumatoid, congenital, complex reconstructive, etc., hand surgery. I explained that these were indeed hand specialties and were rarely emergencies, and that Boston was only 40 miles away. Even many hand surgeons didn't try to handle all those specialties. But the ABS appeared to care more about the "turf" of hand surgeons than about the people of my community.

This example points out a real problem in the delivery of health care. Not only does overspecialization lead to more expensive care, but it also decreases access to care. We need more properly trained generalists in our communities. And patients need to understand that good care can be provided by generalists as well as by specialists. When I hear the public relations campaigns that encourage everyone to come to centers of excellence, where the cost of care is higher than in community settings, I cringe!

Consequently, I recommend that the medical profession, now fragmented by specialties, come together and have a dialog re-

garding what procedures and treatments can competently be provided in the communities by generalists and what should be referred to the major centers. Physicians should be able to select which modules of training they want in order to practice in communities or major centers. And the ABS should rethink how they certify the various areas of surgery. If we truly care about the cost of and access to health care, we need to work together. Dartmouth's new Center for Health Care Delivery Science is an excellent place to start this dialog.

William Babson, Jr., M.D.
DC '61, DMS '63
Sinclair, Maine

Fodder for the dinner table

When I read the article "Rumored effect is still a puzzle" (see **dartmed.dartmouth.edu/su10/d01**), I felt the researchers missed one very important immeasurable ingredient in the "July effect"—the will to live. I'm not sure how a study can measure the innate will to live, but it is a factor. Most of us want to get through an anniversary, or visit with family, or simply enjoy a summer before we give in to our body's declining ability to cope with increasing debilitation. New, inexperienced residents, who might be more apt to make a mistake, may be helped by this factor.

I enjoy reading Dartmouth Medicine—this article would have sparked a good dinner-time conversation with my physician dad and brother in earlier days.

Anne R. McCune
Keene, N.H.

Another kind of new resident

My wife, Jill, and I recently moved to Hanover and have begun using DHMC for our health needs. During a recent visit, I picked up a copy of your excellent magazine. I have relied on *Science News* for about 28 years to keep me abreast of contemporary medical issues, but I found your magazine to be amazing in its breadth of coverage. I am especially interested in DH's use of biostatistics; I first learned of Dartmouth's role in this field in the book *Overtreated*.

I would like to receive Dartmouth Medicine regularly, please. In addition, I shared the Fall issue with a close friend who is on the board of a large Maryland hospital system. He asked if I could obtain a subscription for him as well. Many thanks.

Richard Potter
Hanover, N.H.

Maine-lining DM

Would you please send your fine magazine to Jessa Barnard, J.D., at the Maine Medical Association (MMA)? She's a Dartmouth graduate who more recently graduated from Stanford Law School and is now on the MMA's administrative and legislative staff.

I already get Dartmouth Medicine. My wife and I were on the housestaff at Dartmouth-Hitchcock in the 1970s. We especially enjoyed the article about head trauma (with the picture of Dr. Saunders) and the article about Dr. Jack Lyons. Back in the day, we knew him better in the OR and as a tennis player rather than as a gardner.

Edward Walworth, M.D.
Housestaff '70-75
Lewiston, Maine

We're happy to add to our mailing list anyone who is interested in the subjects that we cover. See the box on page 22 for details. ■