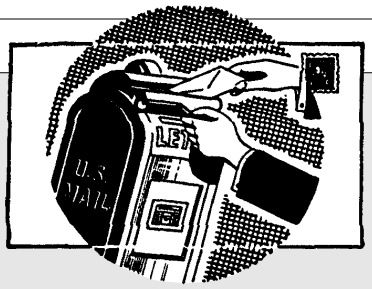
LETTERS



We're 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.

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 I applaud you for the articles on palliative care. I have been a hospice volunteer for 18-plus years, including with Home Health Hospice of Nashua for the past 12 years. The articles were informative and supportive. I would like to share the issue with a fellow hospice volunteer in La Crosse, Wis.; would you be able to send her a copy?

The issue also had an interesting article entitled "So, you want to be a doctor?" I am sending a copy of it to our granddaughter in Michigan. She is graduating from high school this year and plans to enter a premed program in the fall.

And I have more articles in this great issue yet to read!

Margaret L. Zoerb
Nashua, N.H.

We're happy to send a copy of the magazine to anyone who might be interested in a particular article.

Rx for caregivers

The biographical sketches titled "Facing Death" in the Winter issue are classics that should become part of the "bible" carried by medical students, house officers, and even seasoned practitioners gnarled by the managed-care wars. Not only do these direct, candid, personal reminiscences hit home emotionally, but they also point to a prescription for every prospective and current physician: 1) embrace opportunities to conquer your own natural fear of death through the desensitization that occurs when you allow your human concern, interest, and presence to be exposed to individuals who can teach you how to die in dignity without abandonment; and 2) learn how to use your doctoring skills to communicate, both verbally and nonverbally, your confidence that the relief of suffering is still the most important mission of the physician.

Robert P. Liberman, M.D.
DC '59, DMS '60
Los Angeles, Calif.

Liberman is a professor of psychiatry at UCLA School of Medicine.

Champion of chaplaincy

I was happy to see the articles "Facing Death" and "At 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. Three cheers 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, Ill.

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 DHMC, I swipe a copy of Dartmouth 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

shops, it's wonderful to see and be cared for in a place where the patient is number one!

Mary N. Western
West Townshend, Vt.

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. Overtreatment 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! Again, as always, it was a great issue.

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

Heights untold

The cover of your Winter issue took my breath away—no pun intended. With great excitement, I thumbed through the stories to reach the feature article about Dr. Dudley Weider's experience on Denali.

As I turned the pages, I reflected back to the early 1990s, when Dr. Weider operated on our beautiful little handicapped daughter, Brittany, to remove her tonsils and adenoids in an attempt to help her to swallow with greater ease. His kindness and gentleness with Brittany, who is not able to speak, were more than impressive.

I held this image in my heart and mind as I read about Dr. Weider's dramatic experience on Denali. I could see him leaving his tent to help those in need—that strong sense of dedication to his medical profession coming to the fore, even though he had envisioned his time on Denali as one of self-accomplishment.

Although I may not understand the desire to subject oneself to such harsh challenges, I realize that many people in many areas perform such feats every day of the week—alpine skiers coming down a mountain at 80 miles an hour, race car drivers going 150 miles an hour around a track, and marathoners running to the point of total exhaustion. Whatever the experience, it is wonderful to know that people like Dr. Weider are there to help when someone's dream turns dangerous.

Although Denali may be the highest physical peak in North America, I believe that one of the highest personal peaks is the ability to help another who is in need. Like Brittany, those other climbers were fortunate to have had Dr. Weider care for them.

Patti Pusey
Halifax, Vt.

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 Witters'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. As 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. And, 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.

Derrik Woodbury '77, who is indeed an orthopedic surgeon, was the author of the two articles Rider recalls—titled "An Untimely Frost" (Spring 1996) and "Life Without Mommy" (Spring 1997). We're happy to send copies to readers who recall them or missed them. Woodbury says his two boys, now aged 8 and nearly 6, are thriving and he is very proud of them. He himself is a member of the Dartmouth Medicine *Editorial Board.*

Professing pleasure

We enjoyed your Fall issue very much and would be happy to receive regular copies, which we will share with a cousin who is a doctor in Ohio. As retired professors, we see quite a number of college magazines and were very much impressed with both the contents and the presentation in yours! Thank you.

Stephen and Frances Fuller
Melvin Village, N.H.

Class action

I recently read a copy of Dartmouth Medicine and liked the information and format. I am a health educator at New Milford, Conn., High School and would find the articles helpful as background information for my health classes and for my own professional interest.

Kris Kaczka
New Milford, Conn.

Keepsake

I have just read the Winter issue of Dartmouth Medicine, and I would like very much to become a subscriber. Could I start with that issue? I'd love to have my own copy—there's so much in it of the greatest and most keepable interest. Many thanks.

Priscilla L. Howe
Hanover, N.H.

As noted in the box on page 16, we're happy to send the magazine to anyone interested in it. ■