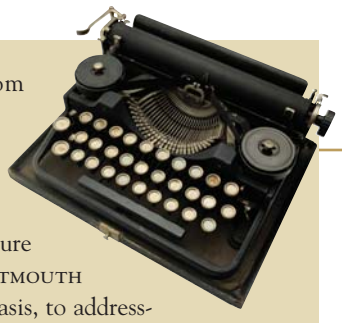
# letters from readers



We're always glad to hear from readers—whether it's someone weighing in with an opinion about an article in a past issue or someone wanting to be added to our mailing list to get future issues. We are happy to send Dartmouth Medicine—on a complimentary basis, to addresses within the United States—to anyone who is interested in the subjects that we cover. 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 DartMed@Dartmouth.edu. Letters for publication may be edited for clarity, length, or appropriateness of the subject matter.

*There are many kinds of impact. The first pair of letters demonstrates the impact that a much-loved recently deceased member of the DMS faculty had on the lives of alumni over a span of more than 40 years. Then there's the power to have an impact on people's health—as, according to the next two letters, a feature in our Summer 2003 issue by former Olympian John Morton appears to be doing. And finally there's the impact of ideas: two recent essays—one about new residency work rules and one about the nation's declining rate of autopsies—have sparked thoughtful responses from readers.*

### Affable and available

I was saddened to learn of the recent death of Dr. William Mosenthal. Both formally, as one of our gross anatomy professors, and informally, as an always affable and available adviser, he was a wonderful mentor for many generations of Dartmouth medical students. His insight and knowledge were our human bridge from the world of basic science to the world of clinical care, which often seemed frustratingly distant during our first year in medical school.

I'd like to share two anecdotes about him from my own class's first year. The first illuminates his wit and humorous encouragement of our studies. The second reinforces the incredible breadth of his career.

I recall being frustrated by the amount of memorization that was required during our first year. One day, Dr. Mosenthal came over to my group's dissection table to check on our progress, and he overheard us debating the clinical relevance of the facts that we were being forced to memorize. I asked him if we really needed to know the structure of every enzyme in the Krebs cycle in order to practice medicine. His succinct reply was, "All I remember about the Krebs cycle is that it is a circle with arrows spinning off energy."

On another occasion, Dr. Mosenthal used his own old anatomy atlas to illustrate some points for our table. Every page had dark stains. He asked us what we thought had so heavily stained his prized atlas. We made several wrong guesses along the lines of blood or bile from having the book open too close to the operating table. He then revealed that the stains were from the atlas getting soaked in his tent during a typhoon while he was serving in the Pacific during World War II. I have a vision of him, fresh out of training, calmly referring to that atlas to plan and successfully carry out difficult operations under the horrendous conditions of a combat field hospital.

We were fortunate to have Dr. Mosenthal as a teacher, adviser, and role model. Even though he had many hobbies and sports that could have fully occupied him in his retirement from surgery, he joyfully extended his career to teach us. He personified the consummate surgeon—extraordinary skill and knowledge shared with quiet confidence and compassion. I extend my condolences to his family, from his extended family in the DMS alumni body.

David Levine, M.D., M.P.H.
DMS '86
*Waban, Mass.*

### Much missed

I was very sorry to hear about the death of Dr. William Mosenthal. He was one of the very nicest people I have ever met, and I think he was about the best surgeon with whom I have ever worked.

He will be sorely missed by me and, I believe, the whole surgical world.

Rowland French, M.D.
DC '41, DMS '42
*Eastport, Maine*

*Both Levine and French are graduates of DMS; Levine knew Mosenthal as an anatomy professor and French as a surgeon. French, a retired surgeon himself, returned to Dartmouth after several years' service in the Navy to do a surgical residency in 1948—the same year that Mosenthal joined the faculty.* *See page 7 in this issue for more about Mosenthal.*

### Fitting commentary

I read with great interest the article by John Morton about his experience with heart surgery—and then passed it along to a friend who recently had a heart attack.

My friend, like John Morton, was fit and healthy by all empiric measures. Luckily, he is doing very well now. In fact, his cardiologist has told him he can return to work and begin vigorous exercise. So I continue to have hope about progress in science.

Jon Stableford
*Andover, Mass.*

### Willing to write

I read with special interest John Morton's description of his recent open-heart surgery. I did so with a certain amount of empathy, because of my own lengthy struggle with cyclical depression (hypomania plus episodes, in my case twice a year, of disabling depression). As my former Dartmouth roommate Dr. "Kip" Minaert puts it, his body is falling apart, but my mind is falling apart. Apparently the former is true for "Morty" as well.

I am hardly surprised that a straight-arrow Olympian like "Morty" had a paucity of risk factors. That risky quality known as a type-A personality is something I never perceived in him in my encounters with him over the years. But it is true that you

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Be sure to tell us when you move! If your address changes and you want to continue to receive Dartmouth Medicine, just tear off the address panel from the back cover of a recent issue, write your new address next to the old one, and mail it to: Dartmouth Medicine, One Medical Center Drive (HB 7070), Lebanon, NH 03756. It helps us greatly—since our mailing list is drawn from six separate databases—if you send the actual cover or a copy of it. If that's not possible, please include both your old and new addresses. Note, too, that if you receive more than one copy of the magazine, it's because of those six databases (which are in different formats, so they can't be automatically "de-duped"). We're happy to eliminate duplications, but it's a help to have the address panel from *all* the copies you receive, not just the one(s) you'd like deleted.

don't get to be an Olympic level athlete, or motivate others to achieve at that level, by being milquetoast.

In my book, *Dr. D's Handbook For Men Over 40: A Guide To Health, Fitness, Living, and Loving in The Prime of Life*, I sweated through my own insecurities about sudden death by trying to explain the odds, as well as some ways to avoid the pitfalls that appear to increase our risk.

John has more than a little of that cool-under-pressure gestalt of the elite athlete who never reveals as much inner angst as the rest of us do.

So bravo to him for his willingness to share his unscheduled journey from being in front of the pack to becoming just another scared mortal. No matter who you are—an elite athlete or even a doctor yourself—being on the business end of medicine is difficult.

Peter J. Dorsen, M.D.
DC '66
*St. Paul, Minn.*

### Deleterious effects

As a social scientist interested in medical anthropology, I could not agree more with Dr. Mary Margaret Andrews's assessment [in "Grand Rounds" in the Summer 2003 issue] of the deleterious effects of residency work schedules.

What she did not address was the tolls these workloads take on the residents' private lives and on their life satisfaction. Not only available studies but also casual anecdotal surveys (of friends and colleagues) show that residency programs favor "unencumbered" people: singles, or else those with a spouse who, if there are children, is a housewife/househusband who lends support and whose labor saves on child-care costs. Almost completely absent in residency programs are single mothers. Should a resident ever protest an additional ad hoc meeting scheduled "after work" or at 5:00 a.m. because of child care, he or she will likely be reprimanded.

Furthermore, residents with family duties or healthy outside interests are less likely to participate in peer-group bonding activities than are residents who can afford to extend their work hours until the middle of the night to "hang around" or to discuss interesting topics into the wee hours.

This state of affairs is not so by design, as Dr. Andrews points out; it is ingrained in the physician culture. But this culture is supported by the financial interests of the hospitals who as a result get resident workers at a fraction of the hourly remuneration of just about any other highly qualified medical worker.

And this is the crux: the physician culture alone could be changed, just like any other culture, and Dr. Andrews's article could be a beginning. But with the financial costs inherent in making this change, administrators and their physician-helpers—such as chairs of departments, directors of institutes, or directors of residency programs—are not likely to change their expectations of residents. Yes, there is arrogance, and yes, there is fear, but they are not part of medicine per se—they are part of the financial power structure of today's teaching hospitals.

Thus the old physician culture is kept alive, and one can fear and predict that ways and means will be found to subvert even the 80-hour week which now is being hailed as an improvement. Residents will keep quiet about these subversions because they will be afraid of being negatively evaluated and called "lazy," and administrators will keep quiet because the system is in their interest.

Erika Friedl
*Kalamazoo, Mich.*

*Friedl is a professor emeritus in the Department of Anthropology at Western Michigan University.*

### An excellent yardstick

The Winter 2003 issue of Dartmouth Medicine was, as usual, superb.

I was especially intrigued by the "Grand Rounds" essay on autopsies by Dr. Wendy Wells. She is right on target—the percentage of deaths for which an autopsy was performed used to be the sole yardstick for evaluating medical schools, internships, and residencies when my classmates and I were making those choices. McGill, Stanford, and Harvard were very high that year, and Johns Hopkins was very low!

I still believe that the autopsy rate is an excellent measure of quality. It cannot be fudged in any way and supercedes such claims as "world-class" or "state-of-the-art."

The national autopsy rankings used to be published once a year, in the August issue of the *Journal of the American Medical Association* (JAMA). But JAMA stopped doing that shortly after I left Dartmouth in 1939. I have always wondered why.

Perhaps Dr. Wells knows the answer.

Dwight Parkinson, M.D.
DC '38, DMS '39
*Winnipeg, Manitoba*

*Parkinson is a retired neurosurgeon and still a member of the University of Manitoba's Faculty of Medicine, in the Department of Human Anatomy and Cell Science. We posed his question to Wells, but she doesn't know why* JAMA *stopped*


**This Winter 2003 feature, about new quarters for Dartmouth's Norris Cotton Cancer Center, prompted a former director of the center to describe some of the meanderings that predated its latest move, into the building shown here.**

*publishing national autopsy rankings. She did, however, share some interesting further information on the topic: "Nationally, autopsy rates declined from 50% in the 1940s to a discouraging 14% in 1985. And in nonteaching hospitals, the rate was only 9% by 1995. But perhaps of most interest to Dr. Parkinson is the fact that in 1995, the National Center for Health Statistics decided to stop collecting autopsy data, so national statistics are no longer available. The autopsy rate is most likely lower now—some experts consider it to be as low as 5%—but since no national body collects the information, I don't know for sure. This is ironic, to say the least, since study after study and the College of American Pathologists continue to tout the value of the autopsy and to lament the drop in autopsy numbers. It seems that only medical institutions that use autopsy findings as an integral part of their mission to improve clinical care now keep autopsy statistics. Incidentally, the autopsy rate at DHMC last year was 35%."*

### Site lines

It was thrilling to see the photos of the new building housing the Norris Cotton Cancer Center in the Winter 2003 edition of Dartmouth Medicine. The description of the exciting multidisciplinary research programs housed within this wonderful new building is certainly heartwarming to this former Cancer Center director.

I wish to clarify a point about the history of the Cancer Center. When the new DHMC facility in Lebanon opened, the Cancer Center administrative staff and several of its research programs moved into this new complex. The radiation oncology component of the Cancer Center remained in Hanover until 1995, and certain other Cancer Center programs continued to be located on the Hanover campus after the demolition of the old Hospital and Clinic buildings.

Interdisciplinary research programs are seldom restricted to one building or site and often gain vitality by extending across campuses and institutions.

O. Ross McIntyre, M.D.
DC '53, DMS '55
*Lyme, N.H.*

*It was during McIntyre's 17-year tenure as director of Dartmouth's Norris Cotton Cancer Center that the institution was first certified by the National Cancer Institute as a comprehensive cancer center—an honor that, among other achievements, requires excellence in multidisciplinary research.*

### A heady thought

I enjoyed the piece on the prize-winning Bugatti in your Winter issue, being a bit of a sports car buff myself (though my 'collection' is a single 1958 Triumph TR3A, which, as far as I know, has never won anything). In fact, I remember seeing Peter Williamson's Bugatti collection at the Montshire Museum some years ago.

One thing I have always recalled from the show at the Montshire was a point made by one of the folks demo-ing the cars. He mentioned that Bugatti engines (at least some of them) are so finely machined that the head fits onto the block without the need for a head gasket. That is, it's a metal-to-metal seal, yet it does not leak—a fact I still find amazing (if true).

Anyway, I thought I'd mention this in light of the comment in your story about Williamson's Bugatti going "head gasket-to-head gasket" with one owned by Ralph Lauren.

Roger Sloboda
*Etna, N.H.*

*In addition to being an antique sports car buff, Sloboda is the Ira Allen Eastman Professor of Biology at Dartmouth College. And he's right about Bugattis having no head gasket. Scott Sargent, who recently restored Williamson's "Atlantic" Bugatti, says that, in fact, Bugatti engines have no gaskets at all. They are so finely made that they simply don't need them. Sargent adds that only three Atlantics were ever made and one was crushed by a train—and the show in California at which Williamson's car took the top prize was the first time the two remaining Atlantics have ever been together.*

### Compliments

I visited Dartmouth-Hitchcock for the first time last week, on a business trip, and was tremendously impressed with the people and the facility—an impression that was reinforced by the copy of Dartmouth Medicine that I picked up in the lobby.

I'd like to receive a complimentary subscription. Many thanks in advance.

Nan Doyle
*Cambridge, Mass.*

### Translational publication

Visits to DHMC are always an experience in superb medical practice and extraordinary caring. Dartmouth Medicine translates that experience into writing and brings forth both the personalities and the medical science of the Medical Center's great gifts to the learning and practice of medicine.

Please enter my complimentary subscription.

John R. Carty
*Meredith, N.H.*

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