



Radebaugh made many a house call during his career.

I learned the value of making house calls early in my career and even in retirement continued to make home visits as a volunteer caregiver. The hustle and bustle of the usual medical practice allows the doctor to acquire only a superficial knowledge of the patient as a person. Sometimes the individual behind the clinical history—not to mention the patient's family and living situation—is central to the success of treatment. In addition, I have learned much from my patients, especially when I get a chance to see them in less structured settings. They have taught me the importance of taking time to listen, of digging for real answers, of regarding everyone with respect.

My interest in medicine arose during high school when I found part-time work as a hospital orderly. After service in the infantry during World War II, I entered Bates College on the GI Bill and—thanks to summer studies at Bowdoin and the University of New Hampshire—graduated in two

few resources. I also appreciated the dignity with which Dr. Blodgett approached patients, as well as their confidence in his caring manner.

By the time I finished my training I was married, and my wife, Dotty, and I had three small children—so I needed to open a practice quickly. We settled on Bangor, Maine, and bought a small house; as was the fashion then, I planned to open a home office. I even created a clinical laboratory in a former pantry next to the examining room. I was able to perform blood counts and throat cultures, which I incubated in a cardboard box heated with a 15-watt light bulb (I tested different-sized bulbs and determined that 15 watts was perfect to maintain a 98.6-degree temperature). I hung my shingle in August of 1955 and awaited patients. My first visitor was a woman who brought her ailing dog. This was not an auspicious start!

After a week of no (human) patients, no income, and mounting bills, we were getting desper-

House Calls with John

and a half years. Then it was on to Harvard Medical School, a rotating internship at Mary Hitchcock Memorial Hospital, and a pediatrics residency at Massachusetts General Hospital.

There, I came under the influence of Dr. Frederic Blodgett, who made regular house calls in the west end of Boston, an area filled with tenement housing. He knew the neighborhood well. As he walked the streets, former patients would call down from their apartments, "Hello, Dr. Blodgett," and he'd call back to them by name. I clearly remember one of the first times I accompanied him, to see a sick child in a fourth-floor flat. The building was in poor condition outside, but inside the apartment was immaculate. As he listened to the mother describe the illness and then examined the child, he placed them both at ease by explaining exactly what he was doing. He obtained a throat culture from the patient, who had tonsillitis, and left some medicine, assuring the mother that he would return in two days to check on her child's progress. I immediately realized the importance of such visits, especially for families without transportation or with

ate for some income. It was potato-picking season in Aroostook County, 100 miles to the north, so I rented a small room there and picked potatoes for four days. Finally a phone call to Dotty revealed that someone had made an appointment. I returned home eagerly and stepped into the waiting room to greet my first patient—only to find that our new puppy had left a calling card in the middle of the waiting room. Embarrassed, I cleaned the rug before inviting the mother and child in for an interview and examination.

Other patients followed, though slowly at first. Soon, however, the visiting nurses alerted me to a number of families living in poverty whose children needed care. I would often tell such parents, when I needed to follow up on a child with an ear infection, for example, that I would be making house calls in their neighborhood. "Why don't I stop at your home to check that ear without any extra cost to you," I'd say to them. They were always grateful.

One of my early house calls was to a family whose address appeared to be in the middle of a field. Puzzled, I asked for help from a neighbor at one end of the field. "Yes," was the response, "there is a family living in the field—in that little hill is a

A retired member of the Dartmouth faculty reflects on his varied career—and makes the case for the powerful healing effects of the house call.

By John F Radebaugh, M.D.

John Radebaugh, a retired pediatrician and family physician, is a clinical associate professor emeritus at Dartmouth Medical School. He also did a rotating internship at Mary Hitchcock Memorial Hospital. All the photos in the article are courtesy of the author.

potato house with a little door at the end.” The structure was partly below ground and had no windows. Needless to say, I did not charge for the house call and levied very modest fees for future office visits.

But the patients were not the only ones having financial difficulties. I did not send any bills for the first six months, in the belief that the schedule of charges posted in the office would be adequate notice. This did not prove profitable. When I began to send bills, our financial status improved, though not appreciably. At the end of my first year of practice, my annual income was minus \$50.

But things improved. I got to know the three other pediatricians in Bangor; we asked each other for advice and shared night and weekend call. Soon I was quite busy and began seeing patients with more complicated problems that taxed my abilities. While I was covering for one of the other pediatricians, I made a house call on a child with a draining ear. He was already on an antibiotic and exhibited a fever and a stiff neck. Suspecting meningitis, I immediately admitted him to the hospital. A spinal tap, however, showed no organisms in the spinal fluid or the ear drainage. I had to guess, lacking any information to the contrary, that he was suffering from the most common cause of meningitis in his age group and treat him with the appropriate antibiotics. Cultures the next morning still showed no organisms, but because the child was worse I arranged to have him flown to Boston. Two days later, he died of tuberculous meningitis, which can only be diagnosed with special bacterial stains for tuberculosis. It was not a possibility I had even suspected.

This experience was devastating to me. Realizing that I needed more training in tuberculosis, I left my practice for two weeks to work with the country’s foremost expert in childhood tuberculosis, Dr. Edith Lincoln at Bellevue Hospital in New York City. I returned a better trained pediatrician and later encountered a number of young patients with tuberculosis.

I continued to make many house calls, including at night. These were very tiring, but I never refused such calls. Sometimes, however, after answering the phone, I’d fall right back asleep—only to be awakened again by a second call a little later when I didn’t show up. And occasionally in the middle of the next day, while I was taking a history in the office, a surprised parent would say, “Why, Doctor, I believe you’ve fallen asleep.”

I also began to carry a harmonica wherever I made house calls, finding that a few tunes were an ideal way to distract a frightened child. And I always remembered birthdays, whether in the office or on home visits, playing “Happy Birthday” for the unsuspecting child.

I had been in Maine for three years when I started receiving queries from practices elsewhere. I determined that one of my mentors at Mass General had been passing my name along. At first I turned down these approaches. I didn’t want to abandon the families in Bangor that had come to depend on me. But one call from a three-physician private practice in Rochester, N.Y., was appealing. Not only would I have a clinical appointment at the University of Rochester Medical School, enhancing my opportunities for continuing medical education, but I would have associates to share call with and could give up responsibility for managing an office.

So in 1958, Dotty and I moved the family to Rochester. One reason I even considered the move was the practice’s emphasis on making house calls. Parents were told they could expect a house call the



Radebaugh was director of the University of Rochester’s Migrant Health Program in the late 1960s. Above is a 1968 photo of the program’s clinic.

morning after a child with a high fever was seen in the office; they were asked to call by 7:00 a.m. and cancel the visit if the child was progressing well. Often we made eight to ten house calls a morning, in addition to our hospital visits.

Occasionally house calls could be life-saving. One morning, my list included a child with croup. Upon arrival at the home, I realized that the child was in extreme distress—struggling to breathe and in much more difficulty than the usual child with croup. I suspected epiglottitis, an infection of the small flap of tissue that separates the esophagus from the trachea, or windpipe. A swollen epiglottis can completely block the airway. There was no time to wait for an ambulance, so I phoned the emergency room, bundled the mother and child into my car, and drove—horn blaring all the way—to the University Hospital. An ear, nose, and throat specialist and an anesthesiologist met us at the door and took the child right up to the operating room. The anesthesiologist inserted an endotracheal tube to provide a temporary airway, and the child immediately went into a deep sleep, relieved of his tortured efforts at breathing. The ENT doctor performed a tracheotomy, cutting a small opening in the child’s neck, which allowed the insertion of a special airway tube. The tube was removed in four days, after the swelling of the epiglottis had subsided.

In the early 1960s, I started volunteering on evenings and weekends at an inner-city clinic run by a faculty member at the University of Rochester Medical School. It served impoverished, mostly minority families that had little access to the kind of care I was able to provide the families that were patients of my daytime practice. So I was receptive to making another change when, in 1964, I received an offer to join the Rochester faculty. I announced my decision to my colleagues with regret, for they had taught me many of the finer points of pediatrics.

As a junior faculty member, I was fully involved with hospital responsibilities but soon had my eyes opened to a totally neglected population. Unbeknownst to me, Rochester was surrounded by many migrant farmworker camps. Naomi Chamberlain, a perceptive African-American member of the medical school’s faculty, introduced a few of us to conditions in the camps. At one, I saw workers housed in a chick-



Radebaugh spent seven weeks as a volunteer in a Biafran refugee camp in 1969. At left is a Biafran nurse with a young charge. Above is a pair of siblings, probably orphaned, whom he saw constantly together.

en coop with whitewashed walls covered with chicken excreta. In addition to primitive living conditions, contaminated water supplies, and inadequate toilet facilities, they had no medical care at all. I was shocked that such conditions existed in the Rochester environs.

In 1965, under Naomi Chamberlain's leadership, we began to hold a weekly evening clinic at one of the farms. Soon, we had enough volunteers—nurses, medical students, and several other faculty members—that we could open the clinic twice a week and also make some house calls.

One evening, I received a call that a woman in one of the camps was in labor. Another physician, two nursing students, and I soon arrived at her home. She looked pregnant, complained of crampy pain, and seemed to be in active labor. Since the University Hospital was 25 miles away, we didn't take the time to examine her but just bundled her into my car and drove hurriedly to the emergency room. While I was assisting her into a wheelchair, her membranes ruptured and I was completely soaked. We left her in the hands of the obstetric personnel and headed home.

The next morning I called to check on her progress. "Oh, she isn't here," I was told. "She was discharged last night."

"How could you do that?" I asked.

"She wasn't in labor. She just had a full bladder and pseudocyesis."

Never having heard of this diagnosis—but not wanting to appear ignorant—I hung up the phone and pulled out my medical dictionary. I learned that pseudocyesis is a "false pregnancy." It usually occurs in women under emotional stress or with a very strong desire to become pregnant and can mimic the symptoms of pregnancy over many months.

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What I had supposed to be ruptured membranes was instead an accidental emptying of an overfull bladder—it having been an evening too cold for our patient to comfortably use the outhouse at the camp. For about a week, the other doctor and I were the laughingstock of the hospital.

Another visit proved more productive. I examined a man who had broken his arm two weeks before but had received no treatment. Lacking transportation, the workers were at the mercy of the growers. I was able to arrange for his admission to the University Hospital.

Soon I was named director of the university's Migrant Health Program. I grew more and more incensed at the conditions in the camps and the exploitation of the workers. On one house call, a farmworker showed me the 10-cent check he had received for two weeks of work; the crew bosses would peddle liquor to the workers at inflated prices and deduct fines for minor infractions.

In 1968, I testified before a committee of the U.S. Senate and led Senators Robert Kennedy and Jacob Javits on an inspection tour of the camps. Local growers were, not surprisingly, unhappy with this activism. But so, too, were doctors in private practice in the Rochester area. They complained that the Migrant Health Program was "socialized medicine." The dean and my department chair asked me to meet with these critics but ultimately stood behind the outreach effort.

I was impelled to look beyond injustices in the Rochester area by the 1969 Biafran refugee crisis. The Biafrans of eastern Nigeria had suffered the

largest genocide since the Nazi Holocaust. I volunteered my services as a pediatrician in the Biafran refugee camps, hoping I could help save the lives of a few of these victims of a tragic civil war. I was granted a leave of absence from my faculty position and traveled to Africa under the auspices of Operation Medicorps.

The conditions in the camps were haunting. The children all had the potbellies, skeletal arms and legs, skin sores, and swollen feet characteristic of kwashiorkor, or protein deficiency disease. Malnutrition complicates infectious diseases, and many children also suffered from tuberculosis or intestinal parasites. Some had enlarged livers due to malaria; others had congestive heart failure, also from inadequate dietary protein; and most had scabies, a skin parasite that caused them to scratch incessantly. Sanitation was a major problem due to rampant diarrhea. Flies were so prevalent that the children could not keep them off their food and had a hard time sleeping.

Yet the children also had a strong will to survive. With proper food and good care, their health slowly improved. They began to respond to adults by hugging our legs or crawling onto our laps. Once, when I sat to watch a movie with the children, I found myself cradling half a dozen in my arms and several others on my lap, with a few more draped over my legs. Clearly, caring was as important as medicine. As I saw older children carrying younger ones to the dining hall, or feeding them in their rooms, I felt a strong sense of community and purpose.

When I returned after seven weeks to my safe and loving home, I couldn't forget the Biafran children—and the uncertainties and losses they would return to. In that frame of mind, I received a telegram a few months later. It read: "IT'S OFFICIAL. WE ARE FUNDED FOR JULY FIRST. A DAY TO CELEBRATE. WE ARE ALL WAITING FOR YOU. VIVA LA CAUSA. LA CLINICA GILBERT LOPEZ."

I had been offering advice from afar to a group that was trying to organize a farmworker clinic in Brawley, Calif. They had received funding for the venture and wanted me to join them. I decided that full-time service to a migrant population was where my heart lay. It would be a big change from my part-time academic practice, part-time migrant activism. And it would be an even bigger change for the whole family, from the cool Rochester climate to the dry heat of the Imperial Valley and from Rochester's mixed culture to a predominantly Mexican-American, Spanish-speaking environment.

After a one-month immersion course in Spanish, we moved to Brawley in the summer of 1970. The Clinica de Salubridad de Campesinos approached many of my ideals of community-based medicine. Its board, consisting mostly of farmworkers, quickly won the loyalty of patients and staff alike. House calls were not the habit of most local physicians but soon were very popular with our patients. Many of the calls, usually made in the evenings, were for upper respiratory infections, skin infections, vomiting and diarrhea, ear infections, or high fevers of unknown origin.

During one house call, I dropped my stethoscope next to the sick child's bed. As I stooped to pick it up, I glanced at the bedsprings and was surprised to see a dozen black widow spiders and their nests. I suggested that when the child was ambulatory, the parents should sweep out the spiders.

On another house call, I noticed a large bottle of Pepsi-Cola in the refrigerator. It was a favorite beverage for many families in that hot climate. I explained that soft drinks are not a wise way to satisfy thirst,



Radebaugh testified in 1973 against the use of the short hoe on California farms. Above, he demonstrates its use in his own garden.

that ordinary water is much healthier and not nearly as expensive. Such teaching was an important element of house calls.

Our house calls also made us aware of environmental problems. Frequently I saw patients who had developed sudden asthmatic attacks when planes spraying pesticides flew too close to their homes.

In addition, I became aware of the efforts of César Chavez and the United Farm Workers union to improve the lives of migrant workers. We'd been in the Imperial Valley for three years when César sent a recruiter to our home in Brawley. He invited me to help establish a union-funded clinic near Fresno, in the San Joaquin Valley. I admired César's non-violent approach and decided that working with him would be a privilege.

While the search for a clinic site was in progress, the *Fresno Bee* reported that "the first case of polio in a decade took the life of an Avenal farmworker." César's office called and asked us to investigate the death, suspecting it might have another cause—possibly even pesticide exposure. A colleague and I drove to Hanford, about 40 miles west, and met with the doctor who had made the diagnosis. He was a retired pathologist who maintained a microscope in his office. He showed us his slides, which demonstrated marked nerve-cell damage in the pons, deep within the brain. He commented, "I have never seen such a rapid onset in a previously healthy man or such marked nerve-cell destruction with polio, but I am open to suggestions."

We told him that we intended to visit the home of the man who had died, a plan that he encouraged.

The deceased, according to fellow workers, had been planting melon seeds treated with Thiordan fungicide and Dieldrin insecticide. The men handled these seeds with bare hands, and the "polio" patient had padded his metal tractor seat with the empty burlap bags the seeds had been stored in. We visited his home and took samples of rice, tortillas, beans, cooking oil, and pastries in case they were needed for analysis. En route home, we stopped to talk again with the doctor, who had prepared more slides for analysis and was willing to assist us in any way possible. I asked him to forward a few slides to a pathologist at UCLA Medical Center—someone I had known in Rochester. "He is especially interested in neurologic prob-



During the early 1970s, Radebaugh worked at the *Clinica de Salubridad* in Brawley, Calif., then at a clinic run by César Chavez's farmworker union. At left is Chavez, above is Radebaugh at the Brawley clinic.

lems," I explained. The doctor said he'd be happy to send along the requested specimens.

Later, I studied the pathology of Thiodan and Dieldrin, both of which can be readily absorbed through the skin. I learned that the brain findings were more consistent with a toxin exposure than with an infectious disease such as polio. Ultimately, a definitive diagnosis from the Los Angeles pathologist corroborated that suspicion.

In May 1973, I testified before the California Workmen's Compensation Board regarding the use of the short hoe—known as "El Diablo" by the workers. Less than 17 inches long, it required farmworkers to stoop all day as they were thinning or weeding lettuce. Crew bosses could easily spot workers who stood to ease the strain on their backs. Those who stood too many times were dismissed from their jobs.

Growers insisted that the short hoe was the only way to properly care for lettuce. Those of us who testified on behalf of the workers showed x-ray data and described workers incapacitated by permanent changes in their vertebrae after only a few years of the constant bending. But the workers themselves were the best testimony. One older worker demonstrated the position required to use the short hoe compared to a long-handled hoe. He also demonstrated the post-work position of the back at the end of a long day in the fields. Shortly after the hearings, California prohibited the use of the short hoe, a wonderful victory for the workers.

Yet despite my pride at being part of such efforts, by the end of 1975 I had reached a burn-out state. The fatigue was physical, psychological, and economic (since I was essentially a volunteer for the union; Dotty and I got an allowance for an apartment, gas for business use of our car, and \$25 a

Our house calls made us aware of environmental problems. Frequently I saw patients who had developed sudden asthmatic attacks when planes spraying pesticides flew too close to their homes. One patient died of toxin exposure.

week). Although I admired César Chavez, it was time to move on. Over the next seven years, I worked at a clinic serving farmworkers in Woodburn, Ore. (which closed due to loss of its funding); at a network of three neighborhood health centers in Pueblo, Colo. (where administrative problems drove many staff—including me—to leave); at a clinic in Greeley, Colo. (where administration was again a problem); and at an urban community health center in San Jose, Calif. (from which both the medical director and I were fired when a new director decided to start with a clean slate). Such were the vicissitudes of working in this underfunded arena. But by this time, I had added board certification in family medicine to my credentials in pediatrics, opening up additional opportunities.

In 1982, I was offered an associate clinical professorship in Stanford Medical School's Department of Community and Family Medicine. I would teach part time in the family practice residency at San Jose Hospital and oversee the preceptor program for first-year medical students. The students were pleased to have an opportunity to work with live patients and soaked up information like sponges. Among many other lessons—such as the importance of caring, of learning to listen to patients, and of not being hasty with advice—I tried to teach them (including by example) the value of home visits.

Occasionally, a house call would uncover a problem that could only be solved outside the parameters of medicine. The visiting nurses once asked me to see a family that lived in a rural area south of

San Jose. In a small house, surrounded by high raspberry bushes, I met a middle-aged woman who had just received a notice saying that her welfare benefits were being canceled and that she had to find full-time work immediately. She was distraught, for she was the only support for three retarded children, all in their twenties, who were ambulatory but could not support or care for themselves. They would have to be moved into an institution! She said she'd take her life before she would allow that to happen.

I said I would try to persuade the welfare department not to drop her from its rolls. Hoping this was not an idle promise, I met with the visiting nurses to plan our action. We calculated that putting three retarded children in an institution would cost the county far more than the present welfare benefits, which allowed the mother to care for her children. After a few more house calls, we got a date for a court appearance. The mother, her three children, a visiting nurse, a social worker, several welfare department representatives, and I were present for the hearing. Our arguments persuaded the judge to order continuation of support for the mother. I was pleased with the outcome of this unusual situation. To my mind, it is important not to overlook social problems that can often complicate medical care.

A new challenge soon arose for our family practice clinic. It became a refuge for AIDS patients from San Francisco who felt unwelcome elsewhere. Word spread that ours was a caring program. I recall one such patient, a Mexican-American, who was referred to me by the visiting nurses. Though he was in the final stages of his illness, he wanted to continue home care. He was in no pain but was emaciated and depressed.

On my second visit, he voiced a desire to visit his brother in Hawaii; would we allow him to do so? I discussed the idea with his family and the home-care nurse, and we agreed that he should go. He made the trip and returned two weeks later, obviously much happier after a very satisfying visit with his brother.

Soon he was on a hospice regimen, and within two weeks of his return he was in a terminal state—semicomatose and unable to eat. I was called to his bedside late one night, found him close to death, and stayed there for the next few hours. When he died, the family called the undertaker, who upon arrival realized this was an AIDS patient and refused to accept the body. "If you refuse, your name will be publicized all over the San Jose papers," I threatened. "There are no risks to you as long as you wear gloves and are careful with needles." It did not take long for the undertaker to decide to cooperate. I visited the family twice in the succeeding weeks to support their grieving.

Meanwhile, Stanford had decided that the Division of Community and Family Medicine would be placed under the Department of Medicine. I was concerned because the Department of Medicine valued research publications more than the service and educational aims that were a priority for me; I had published only five papers during my entire career.

While exploring other opportunities in medical journals, I saw an ad for a family physician at Dartmouth Medical School. My career had started in New England, and both Dotty and I had family back East. More important, I liked the sound of the program. I applied and was invited to come for a visit. We were well received by the faculty, which ran a primary-care clinic and a preceptor program for medical students. Once again, I did not relish the thought of leaving my pa-



Radebaugh spent the last few years of his career on the Dartmouth faculty. Above, he plays his ever-present harmonica to woo a wee patient.

tients in San Jose, but I was eager about the chance to promote teaching and service opportunities at Dartmouth.

It was a chilly 10-degree day in January 1986 when we moved to Hanover. My colleagues in the clinic included a seasoned family physician, a family physician who had a half-time research project, and a former dean of the Medical School who was an internist.

One of my first students was an African-American woman from New York City who was in cultural shock from the transition to the mostly white community of Hanover. She seemed uncertain of herself in the clinic, and I tried to take extra teaching time with her. She accompanied me on some house calls, one of which was to the home of a former nurse who had rheumatoid arthritis and was housebound in a second-floor apartment. The patient liked my student so much that she wanted her to accompany me on future house calls, which, of course, was easily arranged. Over several months, the student developed a close relationship with the patient, which proved beneficial to both of them.

In addition to seeing patients in the clinic (and making house calls), I maintained contact with the preceptors who opened their practices to first- and second-year students. The students' time in their preceptors' offices helped them to correlate classroom teaching with real, live patients.

In January 1989, I was asked to take over the practice of one of our preceptors whose National Health Service funding had been revoked. That left the Mt. Moosilauke Clinic in Warren, N.H., without a physician. Because of the poverty of many of the patients, the program was unable to hire another physician and approached Dartmouth Medical School for help. I stepped in to serve this rural population. I often had medical students with me as I saw patients in the clinic and in their homes. In many ways, my years there were among the most satisfying of my career.

It was while I was at Mt. Moosilauke that I proposed a student elective focused on home visits. It was clear to me that students learned much by venturing onto patients' turf. Other family members, pets, the state of repair of the home—all of these elements placed

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an important framework around the center of attention, the patient. In addition, eliminating the artificial barriers of the white coat and the office or clinic or hospital—which can be threatening to patients—strengthened the true teaching, much of which comes from patients.

I was thus delighted when one of our students, Patricia Ruze (now Chapman), a 1990 Dartmouth Medical School graduate, wrote the dean about her experience making house calls. Here is her letter, slightly condensed:

“Dear Dean McCollum: I am writing to share my enthusiasm for a one-day elective I recently attended. The informal elective is the work of Dr. John Radebaugh, whom you know as a faculty member in the Department of Community and Family Medicine. For some time now, Dr. Radebaugh has been exploring the idea of a single-day elective for medical students, which might be called ‘Plain Doctoring’ or ‘House Calls with John.’ The elective consists of a full day of visiting four or more families, several visits with health-care professionals in the community, and several readings in epidemiology and family medicine.

“Our day began in Bowler Auditorium for Pediatric Grand Rounds. Radiology was our next stop. The two of us reviewed films with the radiology staff for patients we would see later that day.

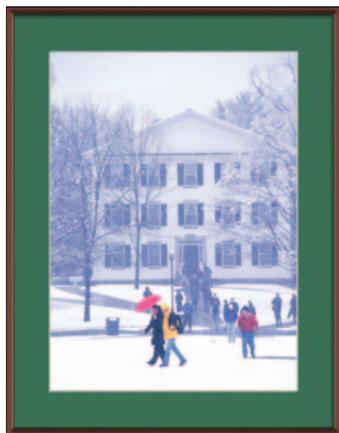
“We then proceeded to the depths of the Hospital to the autopsy suite, where a pathology resident presented his gross specimens and his findings for a recently deceased patient. Not unexpectedly, the partially fixed brain tissue revealed a peach-sized necrotic mass characteristic of glioblastoma multiforme. We were later to visit this patient’s family in their home in Warren, N.H.

“Dr. Radebaugh and I, with a long list of patients’ names and addresses, packed ourselves into his car. Our first stop was New England Industries in Lebanon, N.H., which produces machine parts. Dr. Radebaugh had met previously with the owner of the company, who this day welcomed us and presented us with ear plugs and safety glasses. We had come to see Mr. R.M., a patient of Dr. Radebaugh’s who has persistent problems

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with nasal polyps. Weaving through the maze of giant metal monsters, noisily pounding frail strips of steel into a precise geometry, we found R.M. rolling a drum of industrial chemicals into the plant's back door.

"R.M. told me that his nasal polyps had been treated surgically several times but continued to reappear and caused him difficulty breathing. The etiology of the recurrent polyps was unclear. R.M. felt that the chemicals he was working with at the plant contributed to the development of the polyps.

"He gave us a tour of the plant. We examined the labeling on many of the drums of chemicals that he was frequently exposed to. R.M. asked me to climb the stairs leading to the operator's station of a machine that chemically and mechanically washed some of the metals used in production. He turned on the machine so that I could experience the sharp odor and harsh racket of his daily working conditions. This was a new experience for this medical student from suburban Concord, Mass.

"We proceeded on to the home of Mr. and Mrs. D.C., a middle-aged, middle-class couple. They were expecting us, and we sat and chatted about his recent hospitalization for COPD [chronic obstructive pulmonary disease]. I examined his lungs and heart, and we gave him a report on the chest films we had reviewed earlier in the day in radiology.

"Our next stop was Mr. T.S., a frail but good-humored 92-year-old New Hampshire farmer whose wife died 10 years ago, leaving him to live alone with his horse team, advanced bilateral cataracts, osteomyelitis, and severe hearing loss. As we approached his tiny, run-down wooden shack nestled in the weeds just off a dirt road, I asked myself how it could be that I have had a full four years of medical school here at Dartmouth, yet have been so successfully sheltered from New Hampshire's poverty.

"My country doctor and I lunched for 50¢ at the Lebanon, N.H., Senior Citizens' Center. There, I met many septa-, octa-, and perhaps even nonagenarians—most of whom knew Dr. Radebaugh well and had many sores, aches, or pains to report, along with jokes and bits of gossip. It was valuable for me to get a sense of the services that are available in the community. I met a social worker and a community health worker and now feel I have a better sense of what can be available for the elderly in the Lebanon area.

"From there, we headed towards Warren, N.H., stopping to meet a nurse who directs the Visiting Nurse Association in Canaan. I had a chance to hear her opinions about community health care in the Upper Valley and to share my own views. Dr. Radebaugh caught up on the news about patients he was following.

"We visited, counseled, and examined seven more patients during the remainder of the afternoon, including an elegant woman painter in her scrupulously cared-for colonial and an overweight hypertensive who lives in a cat-infested trailer. One highlight of the afternoon was meeting and examining a delightful middle-aged woman with transposition of the great vessels.

"I could go on with tales of these individuals, their medical histories, their homes, and their jokes, but the day was long and I realize that your time for reading student letters is short. I write only to share my memories and to offer a vote of support for this opportunity. I feel grateful to have attended a medical school that encourages a broad perspective in medicine and supports enthusiastic faculty such as Dr. John Radebaugh."

I have to say that I regard that letter as a capstone of my career.

After my retirement in July 1991, I continued to serve as a volunteer physician with the Good Neighbor Health Clinic in White River Junction, Vt., which provides free care to un- and underinsured individuals in the region. I also served occasionally as a substitute physician for small practices. In those roles, I continued to make house calls.

Once I was covering for another doctor and was asked to visit a woman in her seventies who was originally from Finland. When I arrived at her home, she answered the door with surprise and suspicion. "I don't know you and will not allow you to examine me," she said firmly.

"I'm not replacing your doctor, only trying to help him," I replied.

Just as she was about to close the door in my face, I reached into my bag, pulled out my still-ever-present harmonica, and started playing *Finlandia*, the Finnish national anthem. There were tears in her eyes as she opened the door to welcome me in.

It was a most cordial visit, and it concluded with a request: "Please play *Finlandia* again the next time you come." I did. ■

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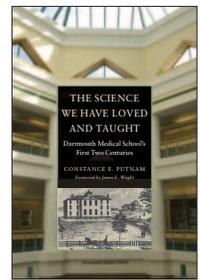
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