

Maybe the wet spring (at least in the Upper Valley) kept everyone indoors—but for whatever reason, readers responded in droves to our Spring issue. We were deluged with letters on the cover feature, about ICUs; on a feature titled “House Calls with John”; and on two essays—one by a Dartmouth undergraduate and one by a DMS faculty member.

Cold comfort for ICU patients

I thoroughly enjoyed the article in your Spring issue on the origins of intensive-care units.

I was a neurosurgery resident at Hitchcock in the 1950s and have many memories of Dr. Mosenthal’s revolutionary concept of placing all acutely ill hospital patients in one location. Hypothermia was thought back then to be beneficial in treating brain problems, such as from trauma or a ruptured aneurysm. So during the winters of 1956 to 1958, we placed such patients in a separate room on the ICU and left the window open; the nurses became very adept at keeping patients’ body temperatures close to 90 degrees by raising, lowering, or closing the window. I doubt this accomplished much, but it made for chilly rounds.

I also enjoyed John Sibley’s sketches, which I had not seen before. John and I were residents at the same time, and he was also at Dartmouth in 1982, the year I returned as a visiting professor of neurosurgery. We both found no comparison to the ICU we had known 25 years earlier.

DAVID M. BARRY, M.D.
HOUSESTAFF ’56-58
Stuart, Fla.



This painting of Dartmouth’s first ICU—featured on the cover of our Spring issue—came in for comment. See below for the identities of most of those pictured.

Where’s Wendell?

I wonder if you have any information about the individuals pictured in the painting on the cover and on page 40 of the Spring DARTMOUTH MEDICINE. The article mentioned Dr. Mosenthal but not the other people in the picture.

I currently take care of the gentleman to the left of the bed. His name is Wendell Cherrier and he is from Windsor, Vt. He is a retired nurse who worked at Dick’s House [the Dartmouth College infirmary] for 35 years, and before that for 10 years at Mary Hitchcock Hospital.

JOHN D. MACDONALD
Windsor, Vt.

We have, in fact, learned the names of everyone except the patient in the photo from which the cover painting (reproduced above) was made—thanks to a newspaper clipping featuring the photo. They are, from the left, Mary Thomas, an aide; Wendell Cherrier, then an orderly; Dr. William Mosenthal, then a surgeon; Janet Wenzell, R.N.; and Dr. George Cole, an intern. We

still don’t know the exact date the photo was taken, however. It was sometime between 1955, when the unit was created, and 1957, when the photo was used in an exhibit.

Medicine cum heart (and harmonica)

The article by John Radebaugh, “House Calls with John” [Spring 2005], is awesome, courageous, inspiring, visionary, and told with wonderful humor and wit! My medical education and training coincided with several points in his career; the article brought back memories of Rochester, Brawley, the Imperial Valley in the summer of 1970, and a month I spent with him in Fresno in 1975. I loved the story about the woman with the pseudopregnancy. But I never knew he’d started his career in Maine, and I’d forgotten about the harmonica he always carried.

Throughout the piece, he put into words exactly the ideals that inspired me and others to enter the profession of medicine—the compassion, the curiosity, the advocacy for patients, the outreach and partnering with them

on their “home” turf, and, ultimately, the quest for peace and social justice that is at the heart of the medical profession. Or at least should be.

RICHARD A. ARONSON,
M.D., M.P.H.
Augusta, Maine

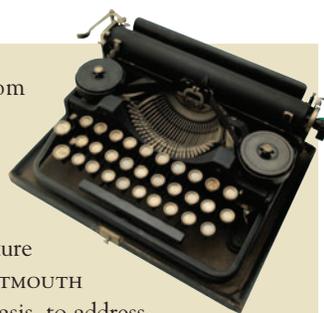
Aronson is medical director of the Maine Bureau of Health’s Division of Maternal and Child Health.

At patients’ beck and call

What a delight to read the entire Spring issue of DARTMOUTH MEDICINE—especially “House Calls with John.” Just as there are books celebrating *The Joy of Cooking* and *The Joy of Gardening*, Dr. Radebaugh should be encouraged to write *The Joy of House Calls*.

I was fledged in 1949 as an M.D. from Harvard Medical School—poor training for someone who wanted to be a family physician and make house calls. My mentor wanted me to do a fellowship and be a gastroenterologist, but I resisted and never regretted being the only LMD (local M.D.—a disparaging term in the ’40s) allowed to practice for 37 happy years at the lofty Massachusetts General Hospital. I even sewed up lacerations on occasion (unheard of for internists) and rode in ambulances to the emergency ward.

One house call in particular delighted me. A friend of my in-laws had what sounded on the phone like nothing more than a heavy cold. Please would I drop by on my way home to see “Uncle Bobby”? I was greeted at the door of quite a fine home by Bob-



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, 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.

by's wife, who asked if I could first help her. She held a rattrap in her hand and asked me if I would bait it for her—which I dutifully did, seeing myself as “the compleat physician.”

Uncle Bobby was just fine, though I may have prescribed some medication to persuade him he really was sick.

The next day a second call came. Uncle Bobby was no better; would I stop by again? True to my calling, I did. His wife again said she had an unusual request: Please would I remove a dead rat from the trap? I did! Uncle Bobby was, again, just fine and pleased to see me. The socially registered of Chestnut Hill continued to think well of “the compleat physician.”

Like Dr. Radebaugh, I never wore a white coat either on house calls or within the great MGH, though my peers wore them—all the way down to their knees! I always felt it created a psychological gulf between doctor and patient, although my daughter, a resident at your magnificent hospital, disagrees. As a doctor, one should, as Rudyard Kipling put it, be able to “walk with kings—nor lose the common touch.” I am now 85 years old and loved every minute of my career, especially the house calls, and I love every issue of your excellent journal.

JOHN W. KELLER, M.D.
Nahant, Mass.

Laudable approach

I read the article “House Calls with John” with keen interest, for I remember when our family doctor made house calls. My

mother did not drive and my father used our car to commute to his work as a police officer. Public transportation in our farming community was poor. Our Dr. Lundberg made his hospital rounds first thing in the morning, then did house calls, and later held office hours in the afternoon—so I am somewhat familiar with the subject.

“House Calls with John” is well written and contains numerous true-life examples of real house-call experiences in a variety of venues across the country. Dr. Radebaugh has had several careers of medical practice and recounts them in a pleasant, easily read style to make the case for house calls in any general medical practice.

Dr. Radebaugh's recounting of the importance of house calls should resonate in the minds of many of your professional readers, including medical students. Not every medical doctor will subscribe to Dr. John's somewhat philanthropic approach to his various practices over the years, but it is laudable and should remind all physicians of the value of house calls. I mentioned the article to a family physician I

know, and he scoffed at the idea, claiming that making house calls is a highly inefficient approach to medical practice. He claimed that anyone who is so sick as to want a house call belongs in a hospital. Of course I didn't argue but I'm aware that he was looking at it strictly from the point of view of the physician's time and not from the viewpoint of the patient in need of qualified attention. Besides, he did not address the questions of where is the hospital, how does the patient get there, and at what cost to the medical care system.

Our Dr. Lundberg mentioned above, after a normal retirement, lived to a good old age in quite comfortable circumstances, so I don't think we can assume that making house calls equates with physician poverty.

HERBERT K. SEYMOUR
Falmouth, Maine

Grace note noted

I enjoyed the article “House Calls with John” by Dr. John Radebaugh. I played in a recorder group with him before he retired to Maine. He clearly made good use of his musical talents during his career. I can't

evaluate his approach to medicine, not having a medical background myself, but if I were a patient I'd be thrilled to find a doctor so attentive to my needs.

BURTON BICKFORD, DC '44
White River Junction, Vt.

Peripatetic passion

I am a faithful reader of DARTMOUTH MEDICINE and was delighted to find the article by John Radebaugh in your Spring issue. He (with his wife, Dottie) was a neighbor at Dartmouth's Sachem Village in the early 1950s, when we were both interns at Hitchcock. I have wondered where his career took him. Now I know. He's certainly had a peripatetic existence and a career driven by honesty and compassion, which comes as no surprise to anyone who has known him.

Though my almost-stay-put career looks dull by comparison, I had a great time, too, and hope I also made a difference. Like John, I learned early on the value of house calls. The norm when I began practice was that after hospital rounds, the morning was for house calls. Morning office hours were many years in the future. I bought a geodetic survey map to find the back roads. In those days, there was no charge for mileage and you could carry pretty much what you needed in your black bag.

I was glad to learn that John came full circle and ended his career back in Hanover. I might have wound up there, too. I stayed on at Hitchcock after internship for another year of general practice (GP) residency. There was no such official pro-

Board—and the author of an essay in this issue (see page 32).

Making a difference

The eloquent appeal in your Spring issue by Dr. Jonathan Ross, for the retention of the generalist, may fall on deaf ears. There is an old expression that “it’s different at Dartmouth.” I wish this were so. Most longtime DHMC patients have noticed the problems that result from the lack of continuity in patient care. This is most obvious when one physician is your primary-care physician, another the “hospitalist” who sees you as an inpatient, and another a specialist or surgeon. One can wait hours or even days for them to communicate with each other. They never see the whole picture.

Dartmouth-Hitchcock can still make a difference, both in practice and training, but it takes courage on the part of hospital and clinic administrators to do so. Patients need to make themselves heard, but unfortunately even at the friendly Dartmouth-Hitchcock Clinic they do not know how.

JON H. APPLETON
White River Junction, Vt.

Appleton is the Arthur R. Virgin Professor of Music at Dartmouth.

We offered Jonathan Ross an opportunity to respond to the points made by both these letter-writers, and he replied as follows: “I appreciate both written responses to my essay in DARTMOUTH MEDICINE; they complement many oral comments I’ve heard from students, housestaff, faculty, and patients. There is no doubt that a chord was

struck—everyone has felt, directly or indirectly, the loss of continuity and accessibility in health care.

“Whether alternative medicine practitioners can adequately fill that gap is doubtful, despite their provision of many desirable practices. And as frustrating as it is in our own backyard, I continue to be proud of my DHMC colleagues, who strive to practice a quality of medicine that most other regions in the country would be grateful to approach. My sense is that Dartmouth-Hitchcock once again has a chance to lead in the renaissance of the best in medical care, by answering the plaintive cry of so many: ‘Where is my doctor?’ I continue to be hopeful that the expectations of our patients, which have at times strongly influenced the course of medical care, will, in this instance, force the profession to rescue care from the increasingly fragmented model so dominant today.”

A rich resource

I enjoy every issue of your fine magazine and was especially delighted to see the article in your Spring issue on Dr. Rich Rothstein’s latest work [on perfecting robotic-assisted incisionless surgery]. He was my primary doctor when I lived in Hanover, so I know how fortunate Dartmouth is to have him on the faculty and performing such great work.

Keep up the excellent work.
JOHN L. GILLESPIE, DC ‘54
Boothbay Harbor, Maine

Name-dropping

I enjoy receiving DARTMOUTH MEDICINE and always look to see if there is anyone I know mentioned in it. In the Winter 2004



A DMS alumna shares here some ruminations sparked by this article.

issue, I noticed an interview with Joan Crane Barthold, M.D. I wonder if she grew up in Plymouth, N.H., and if her parents were doctors. If I’m correct, she is from a wonderful family and is following in her parents’ footsteps in serving others—and the surgical suite at Spear Memorial Hospital in Plymouth is named in her father’s memory.

It’s nice to come across acquaintances as well as read all the articles. In the same issue was a story about Ethan Bennett Gagné, who died only a few days after his birth. It reminded me of our son, Raymond, who was diagnosed in 1981 with a brain tumor. Dr. Peters at Plymouth made the diagnosis and sent Raymond to Dartmouth for testing, where we had Dr. Saunders and his team, who all were very nice. I was a patient at Dartmouth myself as a child; I had nephritis and was sent to the old hospital for tests. I remember looking out at a lovely sunrise.

DHMC is a wonderful place, expanding and reaching out to the community. I’m so very glad there’s a place like it nearby.

FAY GRAY
Rumney, N.H.

A consequential matter

I was interested in your Winter 2004 article about the DMS faculty member who was involved in the withdrawal of the anti-inflammatory drug Vioxx. I believe the Vioxx story is a perfect example of the law of unintended consequences.

Treating inflammation has been one of the major tasks of medicine since ancient times. The problem has persisted, so makers of medications continue to come up with all manner of new drugs. Studies in the 1880s showed that aspirin was beneficial against inflammation, and later research showed benefits from antipyretics (anti-fever drugs), analgesics (anti-discomfort drugs), and anti-inflammatory drugs. These all became known as “aspirin-like,” and the term non-steroidal anti-inflammatory drug (NSAID) was first used (for phenylbutazone) in 1949. The mechanisms of these drugs were all found to involve activity of the enzyme cyclooxygenase (COX), which mediates the synthesis of endogenous prostaglandins. Yet we still don’t completely understand how NSAIDs curb inflammation.

In 1992, a new enzyme, cyclooxygenase-2 (COX-2), was cloned from human and animal sources. COX-2 levels rise in the presence of inflammation. Prostaglandins are also involved in inflammation and form a group of fatty-acid derivatives called prostanoids. Once the existence of two different cyclooxygenases was known, it was theorized that NSAIDs’ anti-inflammatory effects were due to inhibition of



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COX-2, and the unwanted side effects to inhibition of COX-1. This concept then led to the development of anti-COX-2 drugs—Vioxx, Celebrex, and others.

The use of these drugs skyrocketed. But as more and more people used them, and more years of patient-use experience accumulated, researchers began to pay attention to some precautionary notes in a 2001-02 article on COX-2 inhibitors in the *Therapeutics Letter*. The widespread use of these drugs demonstrated the law of unintended consequences (first discussed by Robert Merton in 1936).

When one bumps against a wall of evidence not perceived in advance, it is always sobering. In today’s responsibility-oriented climate, adverse outcomes can be devastating. Soon there were reports of an elevated risk of cardiac events in patients taking COX-2 inhibitors. The risk of these adverse events seems to be only about 1.9%, however, and only with long-term use. Nevertheless, there has been a huge decrease in the use of COX-2 inhibitors and a return to more basic treatments.

It was also known as early as 2002 that there was a family of bioactive products, resolvins, produced from omega-3 fatty acids by aspirin. These compounds, which are involved in anti-inflammation signaling, were thus of interest in the treatment of inflammation. New evidence about aspirin’s role in triggering potent anti-inflammatory actions was reported in 2004; this article also speculated that COX-2 inhibitors could block

the synthesis of resolvins. Once again, the law of unintended consequences is at work, for anti-COX-2 drugs appear to inhibit this natural anti-inflammatory mechanism.

Further work is being done on resolvins, and it’s likely to lead to well-controlled clinical trials and perhaps commercial production of synthetic human resolvins. However, until that time, patients suffering from inflammation can take advantage of the knowledge that if your diet is high in omega-3 fatty acids, you can add aspirin and produce resolvins to treat inflammation. How much aspirin must be taken to get the desired anti-inflammatory response? No one knows, yet. However, I myself take two tablespoons of flax oil morning, noon, and night at the time of major meals, plus one regular (325 mg.) aspirin tablet at these same times. This routine controls my joint discomfort due to arthritis just as effectively as Vioxx or Celebrex. This is only an uncontrolled, one-person result, but it may be worth others’ consideration. I would also cau-

tion that aspirin at these dosages can have adverse gastrointestinal effects, so preventive measures against that problem must be taken.

This small saga shows that the mechanisms of this machine we live in—the human body—are very complex, and the introduction of any chemical to treat a medical condition can have unintended consequences.

MICHAEL J. McKEOWN, M.D.
DC '58, DMS '59
Hillsboro, Ore.

Author! Author!

I very much enjoyed John Morton’s excellent article about his open-heart surgery [“Heart Of An Olympian,” Fall 2003].

In 1970, I had the good fortune to serve in Vietnam with then-Captain Morton, who was our team leader. I will always be grateful for the opportunity to meet, serve with, and learn from this gifted, dynamic, and inspirational man. He led by example, and one of the most valuable examples he set for me was the value of sustaining a positive attitude and sense of humor, even

under the austere and sometimes scary conditions under which we operated in Vietnam. Over the subsequent years, whenever I have faced the various challenging situations that life brings, I have instinctively thought back to Captain Morton and his incredible spirit, confidence, and optimism to bolster my own courage and will to succeed.

John Morton is a great human being. I was not surprised to read of his spectacular achievements since his army service.

CSM (RET.) GARY BOONE
Fayetteville, N.C.

Touched by Tanzer story

I read with melancholy the article in your Summer 2003 issue about Dr. Radford Tanzer, a member of the DMS faculty who was for the last year of his life the holder of the *Boston Post* cane. [The article explains a tradition dating back to 1909, when Edwin Grozier, the publisher of the *Boston Post*, distributed gold-topped ebony canes to 700 towns in New England, to be presented to each town’s oldest citizen.]

I was especially touched by the story because I am Edwin Grozier’s great-grandson.

THEODORE G. GROZIER
Hanover, N.H.

Grozier is, as it happens, a student at Dartmouth’s Tuck School of Business and Thayer School of Engineering. And there’s a further “rest of the story”: Tanzer’s widow, Sheila Harvey Tanzer, wrote a feature for the Winter 2004 issue of DARTMOUTH MEDICINE, eloquently detailing her husband’s choices at the end of his life. ■