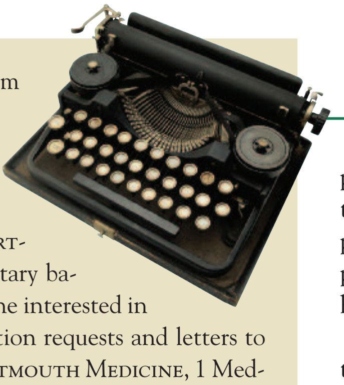
We're always glad to hear from readers—whether it's someone weighing in about an article in a past issue or someone asking to be on our mailing list for future issues. We are happy to send Dartmouth Medicine—on a complimentary basis, to addresses in the U.S.—to anyone interested in the subjects we cover. 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.



*All three of the features in our Spring issue came in for comment, as did another article in Spring plus several in previous issues, and from readers of all stripes—alumni, faculty, patients, and residents of the region.*

### Good stories from small places

I enjoyed the article in your Spring issue by Dr. Conner Moore, about his practice on the Maine coast beginning back in the 1960s (see **dartmed.dartmouth.edu/sp11/f01**).

A number of other Dartmouth alumni worked in the New Hampshire-Maine seacoast region during that era. One was Dr. Allan Handy, DMS '49, who around the same time pioneered the development of pathology and clinical laboratory services in several small community hospitals in the area (Dover and Rochester, N.H., and York and Sanford, Maine). I joined Dr. Handy's group in '66 and covered the hospitals in York and Sanford from '66 to '67.

Back then, Red Cross blood services had not been extended into Maine, so every day the lab would have to call donors and draw blood for any surgery scheduled for the next day.

I was somewhat surprised at this practice. I recall asking the chief tech in the lab at the Goodall Hospital in Sanford, "How do you handle an emergency like a leaking aneurysm or a major auto accident?" She assured me that was no problem—they just blew the fire whistle and picked out the blood type they wanted when the donors come through the door—because she knew everyone in town by their blood type!

Another day, I was looking through the refrigerator and saw an unlabeled bottle with a brown liquid in it. Standard lab policy was that any unlabeled bottle was to be thrown out. When I asked, "What is this?" she exclaimed, "Don't throw it out! It's the booze!"

"Booze!" I exclaimed. "What is booze doing in the lab refrigerator?" She quickly explained that it was for blood donors who came from up north. Loggers from the north country would willingly drive 40 miles to donate blood in return for a free shot of booze!

RhoGAM [a treatment for a baby with Rh-positive blood who is born to an Rh-negative mother] was introduced about that time. One of the old-timers didn't believe in it (he didn't understand the rationale) and refused to use it. So I set up a protocol that if an Rh-positive baby was delivered to an Rh-negative mother, the mother would be automatically sent for RhoGAM. If the attending physician or the mother objected, they would be required to sign a release that the use of RhoGAM had been explained and declined. Needless to say, the old-timer was not pleased with the "young whippersnapper pathologist" telling him how to practice.

I also recall once when a patient needed a spinal tap but her (old-timer) physician didn't feel qualified to do it. Since I had served a rotating internship in a university hospital, I ended up doing the tap.

It was all part of a day's practice for a GP (that is, a general pathologist)!

Dennis J. Carlson. M.D.
Housestaff '60-64
*Swanzey, N.H.*

Just Kidding

A DMS graduate who spent 40 years practicing pediatrics in a small town on the Maine coast reflects on the high points, the humor, and the occasional heartbreak of caring for kids.

By Conner M. Moore, M.D.

Portland Head Lighthouse, one of Maine's most picturesque spots, is just 15 miles from Saco.

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In 1956, a week after graduating from high school, I knocked nervously on the door of a modest suburban house. A middle-aged couple opened the door and, although we had never met, embraced me. They had awarded me a scholarship in memory of their only child, John, a classmate of mine who had succumbed to polio early in our senior year. The scholarship money had been earmarked for John's college tuition.

Two years later, I sat in the gymnasium at Dartmouth College taking my final exam for Organic Chemistry—a mandatory premed course that's the dreaded 500-pound gorilla guarding the door to medical school. Failure to wrestle this beast to the ground did and still does redirect thousands of aspiring doctors to other pastures every year.

As we were handed a one-page exam, a collective groan echoed through the vast space. The sheet bore two questions. The more challenging ran as follows: *This is the chemical formula for chloramphenicol, a new antibiotic. Please make it from scratch.*

Hadn't it taken Parke Davis millions of dollars to engineer these chemical reactions? Several students rose and silently left the room. Although my humanities grades were rarely better than the proverbial gentleman's C, chemical compounding was my forte. A brew of carbon, hydrogen, and chlorine appeared effortlessly on the pages of my blue book. "Damn, I'm good," I whispered. An A in Organic Chemistry offset a disaster in Advanced Spanish and paved my way to medical school.

After medical school (preclinical studies at Dartmouth's then-two-year medical school and clinical studies at Cornell), internship at Boston City Hospital, two years in the Air Force, and a pediatrics residency at Cincinnati Children's Hospital, it was time to settle down. In the summer of 1968, my wife, Wendy; the first of our three sons, Christopher; and I moved to Saco, Maine, where I joined the practice of Dr. Maurice Ross. I was the first new physician in 11 years in Saco and neighboring Biddeford.

My fellow residents in Cincinnati had been politely aghast at my career choice—general pediatrics was bad enough, but rural Maine was compounding the error. Many of them pursued academic careers in pediatric subspecialties, changing institutions every few years. But, 41 years later, I wrote this account at my kitchen table in Saco.

Dr. Ross had been practicing pediatrics in his hometown since 1947. The vast majority of Maine pediatricians back then toiled in solo practice while frantically searching for partners. Dr. Ross and I were the only pediatricians in all of York County. Our office was in his house—a not uncommon situation then.

York County's geography dictated the predominant livelihoods: fishing, farming, and logging. Seaweed, cow manure, and sawdust regularly decorated the office carpet. (The region is somewhat less rural now but still more country than city.)

Within days, I was mixing a vial of chloramphenicol antibiotic that saved the life of an infant with meningitis and was administering the polio vaccine that had been unavailable to my high school classmate.

But there's a lot we didn't have in small-town Maine in 1968: emergency room doctors, intensive care units, ventilators for newborns, pediatric surgeons, pediatric specialists, or transport services. I administered chemotherapy, gave allergy shots, put in stitches, stabilized basic fractures, and occasionally assisted with surgery. Insurance didn't cover office visits, but we never refused to see a sick child, regardless of the family's ability to pay.

I learned a number of lessons quickly: That I would need a keen sense of humor and wonderment. That I must know the parent's occupation and the child's hobbies and sports interests, preferably without glancing at the chart. That I needed to be suitably appreciative of any gift from a child—be it a drawing, a popsicle-stick house, or a rock. That days off were rarely truly off; there always seemed to be emergency C-sections or transfusions. Vacations were restorative, but when I returned from mine, my partner would immediately take off for his 10 days of rest and relaxation.

I learned that the reality of small-town pediatrics ranges from house calls to phone calls, footballs to snowballs. The best part? The beautiful, courageous families and children.

The average annual snowfall in southern Maine is 70 inches. But, knock on wood, my only winter fender-bender occurred shortly after my arrival. I was headed down a marginally plowed hill in Biddeford. I drove a VW Beetle then, and its brakes failed to grip the gently sloping ice rink that passed for a road. At the same time, two blocks away, a delivery truck emblazoned with the Humpty Dumpty potato-chip logo was having a similar

*Moore grew up in the suburbs of Westchester County, N.Y., and graduated from Dartmouth College in 1960 and from Dartmouth Medical School in 1961. This article is excerpted and adapted from a memoir he wrote following his retirement from full-time practice in 2008. His book,* Black Bag to Blackberry: A Maine Pediatrician's 40-Year Journey, *was published by Bryson-Taylor Publishing; the proceeds from its sale are going to a nonprofit foundation that supports nursing scholarships. All the patients and families about whom Moore has written gave permission for their stories to be shared. Moore still lives in Saco, Maine, and now works part-time as the staff pediatrician for a family services organization and children's residential home in Saco and volunteers in the Maine Medical Center pediatric residency program.*

BLACK BAG to BLACKBERRY

This article is excerpted from this memoir by Moore, a DMS '61.

There's a lot we didn't have in small-town Maine in 1968: emergency room doctors, intensive care units, ventilators for newborns, pediatric specialists, or transport services. I administered chemotherapy, gave allergy shots, put in stitches, stabilized basic fractures, and occasionally assisted with surgery.

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**A number of readers enjoyed DMS alumnus Conner Moore's evocation of practicing pediatrics in a small town on the coast of Maine beginning in the 1960s.**

### Moore like it

I enjoy reading your magazine very much. I especially liked the article by Dr. Conner Moore, the small-town doctor in Maine.

I am old enough to remember when doctors in the local area (Lebanon and Hanover, N.H., and White River Junction, Vt.) used to make house calls on a regular basis. The doctor my parents had was Dr. Charlie Cuson of White River. Many times he made house calls rather than asking people to sit in his small waiting room. He knew all his patients and wasn't the least bit afraid of sitting down and chatting after the house call.

I know things are different now, but I have been going to the same GP for 30 years, and I'll bet he knows nothing about me except what he reads on my chart before he walks in, spends 15 minutes, and leaves.

It really is a shame that things have changed so much. I would assume that medicine is about

the most important thing in today's world, but how can doctors know their patients with the "15 minutes and out the door" that seems to be the way of the world now?

I do realize that there are time constraints as well as money concerns, but when patients go to a doctor's office, perhaps they should find more Dr. Moores and fewer businessmen.

Richard Dupuis
*Wilder, Vt.*

### More on Moore

I just finished reading "Just Kidding" in the spring issue of Dartmouth Medicine. I don't want to flatter Conner Moore too much (he's an undergraduate classmate of mine), but I found it one of the nicest magazine articles I can remember reading in a long, long time.

The first paragraph had me almost in tears, and what followed was fascinating and entertaining both. What a great career he has to look back on. I wonder how it compares with the experiences of some of his colleagues who opted for the big city and big hospitals.

It was a beautiful tale, beautifully told—he has a great way with words. Thanks for providing such a wonderful, if too short, reading experience.

Dennis Goodman
Dartmouth College '60
*Etna, N.H.*

### And even Moore

The Spring issue of Dartmouth Medicine was superb—especially the article by my classmate Conner Moore (I loved the title "Just Kidding") and the stories about the DMS students' experiences volunteering in Israel (see **dartmed.dartmouth.edu/sp11/f02**).

Sol Rockenmacher, M.D,
DC '60, DMS '61
*Bedford, N.H.*

At the Heart of the Matter

Medicine's healing powers sometimes go beyond the physical. Two Dartmouth medical students found that was the case when, in successive summers, they volunteered for a nonprofit organization in Israel. There, they saw Israelis and Palestinians overcoming decades of conflict to work side by side caring for children with serious heart defects.

Lior Sasson (right), SACH's chief of pediatric cardiothoracic surgery, is intent, with assistance from a resident, on repairing a congenital heart defect.

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A Wonderful World

By Jonathan Zipursky

Every morning, in operating room eight at Wolfson Medical Center in Holon, Israel, Dr. Lior Sasson wielded his scalpel while soul singer Sam Cooke crooned in the background:

*Don't know much about history*
*Don't know much biology*
*Don't know much about a science book*
*Don't much about the French I took*
*But I do know that I love you*
*And I know that if you love me too*
*What a wonderful world this would be.*

The song "Wonderful World" was sandwiched in the middle of an hour-long operating room playlist that was otherwise composed of Israeli folk songs and French opera music. It seemed out of place given the other selections, but quite appropriate given the setting. The words resonated with me every day as I watched Sasson, a surgeon with Save a Child's Heart (SACH), give yet another sick child a chance at a new life.

In the summer of 2009, after finishing my first year as a medical student at DMS, I spent five weeks as a medical volunteer with SACH. This nonprofit humanitarian organization provides life-saving cardiothoracic surgery to children born with congenital heart defects who do not have access to sufficiently advanced medical care in their home countries. More than half of the patients served by SACH are from the Palestinian Territories of the West Bank and the Gaza Strip or from the nearby countries of Syria, Lebanon, Jordan, and Iran. The remaining patients come from Africa, Asia, and Eastern Europe.

The children helped by SACH travel hundreds or even thousands of miles to receive free, state-of-the-art care at Wolfson Medical Center. Their treatment is part of SACH's mission, which is to provide excellent care to children with congenital heart disease, regardless of their nationality, race, religion, or gender; to train pediatric cardiologists and cardiothoracic surgeons from underserved countries to improve such care around the world; and to bridge the gap between Israel and other countries in the Middle East.

While they are in Israel, the children being treated by SACH physicians live near the hospital in a house in a suburb of Tel Aviv. During my time working at SACH, there were children and families from Angola, China, Tanzania, Uganda, and Zanzibar living there. Many Palestinian children were also treated by SACH during my time there, but because of the proximity of their homes to Israel, the Palestinian families would stay at the hospital and usually traveled back and forth from the Palestinian Territories several times during the course of their child's care.

Lunchtime was always a spectacle. Depending on what time between noon and 2:00 p.m. I happened to walk into the kitchen, I'd be eating anything from pilau—a traditional rice dish from Zanzibar and my personal favorite—to noodles and corn soup, staples for the Chinese families at the house. Fatima, a young Arab-Israeli translator for SACH, told me, "Sometimes, I feel as though the world meets here, under one roof."

The time I spent at SACH brought pediatric cardiology to life. With very little teaching time devoted to this specialty in the first two years of medical school, we medical students begin to consider congenital heart diseases—such as tetralogy of Fallot or transposition of the great arteries—to be medical fascinomas: rare diseases seen in the pages of our textbooks but never firsthand. Little did I know that the worldwide incidence of congenital heart disease is as common as one in 100 live births. It has become a much smaller problem in the Western world, as the identification and treatment of birth defects have improved. But in the developing world, congenital heart disease remains a major cause of illness and death.

Houzanoul, a three-year-old boy from Tanzania, helped change my perception of pediatric cardiology. Houzanoul suffered from tetralogy of Fallot, a condition characterized by four simultaneous problems: a hole between the heart's left and right ventricles; a narrowed opening from the right ventricle to the pulmonary artery, which brings blood to the lungs; an aorta that accepts both oxygenated blood from the left ventricle and deoxygenated blood from the right ventricle; and an abnormally large right ventricle. This combination of factors leads to very low blood-oxygen levels.

I vividly recall watching Houzanoul run around the yard behind the SACH house, stopping every few minutes in tears to catch his breath while squatting low to the ground. Prior to this, I had only heard about these so-called "tet spells," in which toddlers with tetralogy of Fallot become lightheaded and short of breath. They reflexively squat, which increases the flow of blood to their lungs. I had the privilege of following Houzanoul for nearly four weeks, through his preoperative care, his surgery, and his postoperative care in the pediatric

*Zipursky is a third-year medical student at DMS. He grew up in Toronto, Ontario, and majored in biochemistry at Queen's University in Canada. He is a member of the DMS Admissions Committee and for the past two years has also taken part in electrophysiology research in the Section of Cardiology at DHMC.*

Zipursky volunteered with Save a Child's Heart in Israel in 2009.

The time I spent at SACH brought pediatric cardiology to life. Little did I know that the worldwide incidence of congenital heart disease is as common as one in 100 live births. In the developing world, it remains a major cause of illness and death.

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**In another Spring feature, two DMS students shared their experiences as volunteers in Israel with a program serving children with serious cardiac problems.**

### Present perfect

A colleague at Exeter Hospital happened to loan me a copy of the Spring 2011 issue of Dartmouth Medicine. I was especially interested in the article titled "Simply Present" (see **dartmed.dartmouth.edu/sp11/f03**), about palliative care at Dartmouth-Hitchcock. I did an observership with the DHMC palliative-care program, and it was wonderful to see everyone's faces and to recall the work they are doing.

In fact, I truly enjoyed the whole magazine and found it inspiring and informative. I'd like to be added to your mailing list.

Wayne E. VanGundy, D.Min.
*Exeter, N.H.*

### One of 55 in '55

The "Then & Now" column on page 10 in the Spring 2011 issue (see **dartmed.dartmouth.edu/sp11/v03**) noted the number of DMS faculty in 1838 and in 2010.

It would be interesting to see a "Then & Now" box listing the number of M.D.'s at Hitchcock in 1955 (not counting interns and residents)—because there were exactly 55. And I wonder how many M.D.'s practice at Hitchcock now?

I was one of the 55 in '55. The staff at that time was as dedicated as they are today.

Robert C. Shoemaker, M.D.
*Claremont, N.H.*

*Many thanks to Shoemaker for taking the time to point out this delightful numerical coincidence. See page 12 for a "Then & Now" box constructed around this fact.*

### Senior counsel

The title of the article on page 17 in the Spring issue of Dartmouth Medicine, "DMS students find elders 'kind' and 'witty'" caught my attention, because I am an elder who fits that description. (See **dartmed.dartmouth.edu/sp11/v01**.) However, elders are much more than "kind" and "witty." Elders are active in their communities; attentive to the world around them; possessed of knowledge, skills, and abilities that the community can, and sometimes does, call upon; and much, much more.

It is unfortunate that DMS students are apparently unable to connect with their own grandparents and other elders. It is also unfortunate that DMS students aren't afforded the opportunity to spend some time with DHMC volunteers. Then they might not

Every weekday at 8:00 a.m., the members of the palliative-care team crowd into a conference room to discuss their patients. They begin with a poem or some other reading that helps them leave behind, at least for the moment, whatever had been on their minds as they made their way to work. "What we want to do is come together and focus on those we serve," says Donna Soltura, the team's social work coordinator (at the end of the table, in front of the bookcase). "Alone, none of us would be as good at this as I think we are together."

Communication is key to the team's work, so they all know how patients are doing—from problems with pain to disputes with family. Here, Dr. Diane Palac (far left), confers with Dr. Sharona Sachs, as Dr. Jennifer Savoca (far right), an intern, gets a briefing from Lisa Stephens, an advanced practice nurse.

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Simply Present

Palliative care is sometimes thought of as an alternative to receiving treatment—in effect, preparing to die. It's true that the doctors, nurses, and other staff members on DHMC's palliative-care team deal with death as part of their daily routine. But it's quickly apparent when observing them at work that their real gift is for helping patients and their families to live.

While some palliative-care patients are close to death, others have many years ahead of them. But all have serious illnesses that affect their health and complicate their ability to get through each day. The issues raised by the palliative-care team in their conversations with these patients and their families can be uncomfortable: physical disability, emotional well-being, family dynamics, finances, and, of course, death. But they do raise them, gently, time after time. Evidence from clinical trials shows that these efforts are effective—that palliative care can both improve patients' quality of life and, in some instances, even prolong their lives.

But the methodologies of palliative care do contrast with much of modern medicine. Unlike other specialties, what palliative care has to offer is not the promise of a cure but the ability, and willingness, to talk and to listen. As Dr. Ira Byock, the director of the program, wrote in his book *Dying Well*, "While I may bring clinical skills and years of experience to the task, ultimately I am simply present, offering to help."

All the patients pictured on these pages gave permission for their images and stories to be shared.

*Amos Esty is the managing editor of Dartmouth Medicine.*

Often confused with hospice care, palliative care is, at its core, about caring. About caring for the patient, not just the patient's disease. About simply being present for patients, as Ira Byock, the nationally prominent director of the DHMC palliative-care program, puts it. Here's a look at just what that means.

Text by Amos Esty
Photographs by Jon Gilbert Fox

For a WEB EXTRA with links to further information about the DHMC Palliative Care Program, including several videos, see dartmed.dartmouth.edu/sp11/we05.

Dr. Ira Byock (left), long a leader in palliative care, has been the director of the program at DHMC since 2003.

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**The collaborative and multidisciplinary nature of the palliative-care program at Dartmouth-Hitchcock was the focus of this photo-feature in the Spring issue.**

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.

have been surprised at what they found during their one-day experience at Kendal. Most likely, they also would have not had the perception that "geriatrics is stodgy."

You see, elders possess most of the same qualities and zest for life, interaction, and activity as "youngers." We've just had more time to practice.

Alan Tanenbaum
*Grantham, N.H.*

### No issue

I missed two issues of Dartmouth Medicine and have only recently seen the article about myself as the first woman student at DMS (see **dartmed.dartmouth.edu/f10/v01**) and the letters in response (**dartmed.dartmouth.edu/w10/m01** and **dartmed.dartmouth.edu/sp11/m01**). The otherwise mostly accurate article said that I "was met with open resentment." That was not the case. Some of my classmates thought that a wait-listed DC student should have been admitted instead of me. Even so, they were uniformly nice to me. I made good friends among my classmates—they looked out for me, showed me the ropes, made me welcome in the AKK house, and even taught me to ski.

My only challenges with my classmates—most of whom, as undergraduates, had seen women primarily on dates—were 1) to get them to stop holding the door open for me so I could go out first after class, and 2) to persuade them that it was okay to joke around me.

Being the first woman at DMS was a privilege and a delight. I thoroughly enjoyed my whole DMS experience, including, and especially, my wonderful classmates!

Valerie L. Graham, M.D.
DMS '62
*Charlotte, Vt.*

### That's another story

I was at Dartmouth too early to know Joe O'Donnell, but I enjoyed his essay on stories in the Winter issue (see **dartmed.dartmouth.edu/w10/f02**) and the two letters it spawned in the spring issue (see **dartmed.dartmouth.edu/sp11/m01**).

Listening to the stories patients have to tell brings a huge benefit in addition to what the auditor gains; that is the pleasure of the person speaking that someone is indeed listening. The complaint I hear most often these days is that doctors have their eyes glued to the computer, and patients can't tell if they're really listening.

When, as a former New Yorker, I began practicing in a small New England town many years ago, I should have had a tape recorder with a concealed button to activate it under my desk à la James Bond. But I didn't, and the rich accents and local terms escaped unrecorded. Most of the stories I heard have vanished with the years, but I still remember a few bits of the peculiar local terminology: "shock" (pronounced "shawk") for stroke, "spleeny" meaning timid, "fell out" for syncope or dropping dead, and many others. I never forgot the terms or the patients who uttered them.

Thirty years later, in a southern emergency room, a patient said, "Careful, Doc, I'm spleeny." I replied, "Where in New Hampshire are you from?"

My point is that no matter what technology one uses and no matter how scientific one's approach, what the patient takes away from the interaction is that someone was (or was not) listening.

Jerome Nolan, M.D.
Housestaff '52-54
*Wilmington, N.C.*

### Share-ware

I recently read the Winter 2010 issue of Dartmouth Medicine and would like to be added to your mailing list. I found it very interesting and informative and plan to share the magazine with family members, too.

We have had wonderful experiences with the doctors, surgeons, and other staff at Dartmouth-Hitchcock.

Catherine J. Greene
*Keene, N.H.*

### Heart-y thanks

Please add us to the mailing list for Dartmouth Medicine. Every time we have appointments at DHMC, we look for the latest issue and read every word in it. What a great educational magazine, not only for alumni, physicians, and students, but also for the patients who frequent your facility.

I was stricken with a myocardial infarction (a heart attack) at the age of 52, was transferred to DHMC, and had excellent care, including insertion of a stent. I am now 67 and going strong. I would not be writing you today without the great care I received.

I truly do love your magazine and have passed along several articles to friends and to my husband. He also visits DHMC often for appointments with Dr. John Yost, the greatest rheumatologist one could wish for. He volunteers in Nepal, he teaches at Dartmouth Medical School, and he treats his patients as friends. He is truly interested in making his patients comfortable in spite of the grueling pain of rheumatoid arthritis.

Thanks for all you do to produce this great magazine.

Irene Stewart
*Montpelier, Vt.*

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