

**W**ow! This issue, for the first time, we weren't able to publish all the letters we received—and even so, our “Letters” section runs longer than it ever has. We appreciate the fact that you, our readers, write in to praise, critique, and elaborate on what you read here; your letters further advance the discourse on important issues—not to mention the fact that they prove people really do read the magazine! The article that came in for far and away the most comment was “Evermore,” a Fall feature in which writer Nancy Price Graff described her struggle with chronic depression. Several other articles in the Fall issue, as well as a couple of pieces in previous issues, drew comment, too—fire as well as praise. Please keep the feedback, of whatever sort, coming.

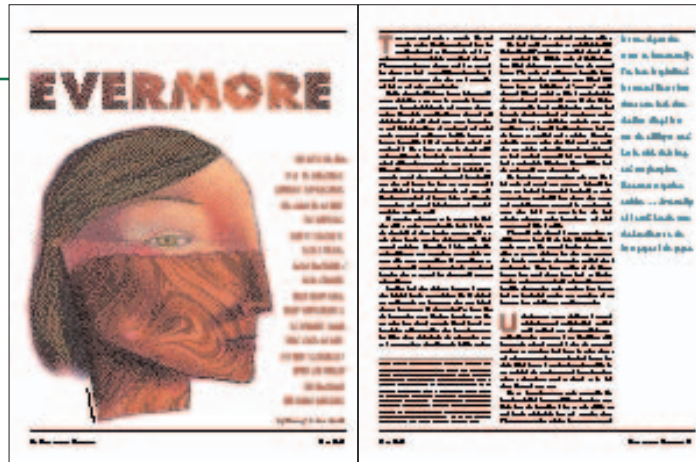
#### Eloquently told tale

The article in your Fall issue by Nancy Graff was incredibly powerful. It is essential to communicate openly about mental illness so that others will feel empowered to take these problems out of the closet. Bravo to her for her courage and her eloquence in telling her story.

I'd like to also read the feature she wrote for the Spring 1996 issue of DARTMOUTH MEDICINE. How can I obtain a copy?

ALAN A. ROZYCKI, M.D.,  
DC '61, DMS '63  
Norwich, Vt.

*Rozycki is a professor of pediatrics at DMS. Graff's 1996 article can be read online at [http://dartmed.dartmouth.edu/spring96/pdf/outer\\_banks.pdf](http://dartmed.dartmouth.edu/spring96/pdf/outer_banks.pdf). Readers without web access can obtain a photocopy*



**This Fall feature's eloquent insight into chronic depression moved many readers.**

by calling 603-653-0772 or e-mailing [DartMed@Dartmouth.edu](mailto:DartMed@Dartmouth.edu).

#### Taking steps

As a practicing psychiatrist and an alumnus of the Dartmouth psychiatry residency, I wanted to extend my thanks to Nancy Graff for her outstanding and courageous article, “Evermore,” published in the Fall issue of your prestigious magazine.

If I'm not mistaken, I had the privilege of being on the team that cared for her upon her initial admission to DHMC's psychiatric unit. I say this (knowing I'm not breaching confidentiality, as she has publically written of her hospitalization) to encourage her onward in her journey. And to echo the words in her article—just keep taking those steps, no matter how small, toward wellness and healing.

I would like to thank Nancy Graff for having the strength and fortitude to share her pain. May this be another avenue of learning for all of us, toward parity for and a better understanding of mental illness.

JACK A. MAHDASIAN, M.D.,  
HOUSESTAFF '91-95  
Grand Rapids, Mich.

#### Captivating, but not the norm

I have read Nancy Graff's remarkable account of her struggle with depression several times. It is captivating in much the same way that William Styron's lament of many years ago was.

There is, however, a danger that the medical community might use such cases as Graff's or Styron's as the gold standards against which all depressions are measured—and that lesser versions might be minimized as mere dysphoria, disappointment, and/or self-indulgent whining.

I've been treated for depression for the last five years (taking a Celexa equivalent). As I think back upon the previous 40 years, it seems quite plausible that untreated depression played a huge role in many of the darker times that cyclically populated my calendar but were passed off as “that's life.”

Fortunately, science and medicine have made it quite easy for those afflicted with depression to enjoy a vastly improved “that's life.” But we need to continue to encourage sufferers to step up, and front-line practitioners to better recognize the symptoms and to act more quick-

ly. This is best accomplished when all levels of depression, not just the extreme ones, are considered worthy of attention.

JAMES NOYES, DC '68  
Wheaton, Ill.

#### Articulate elocution

Nancy Graff's article on depression in the Fall issue was wonderful. She is an amazing, talented writer and is so articulate about her struggle. It is incredibly important to have work such as hers shared publically.

I also enjoyed the article on the history of nursing at Hitchcock and have sent it to my best friend, who is starting nursing school soon.

KATRINA MITCHELL, DMS '06  
Hanover, N.H.

#### Permissible purpose

I just read the wonderful article “Evermore,” about clinical depression, by Nancy Graff. It was wonderful and poignant. I teach a class in abnormal psychology at Dartmouth College, and I think my students would really benefit from reading this article. Is there a way I may secure permission from you and the author to reproduce this?

Thanks to Nancy Graff for an exquisite account of what it's like to suffer with intractable depression, and to DARTMOUTH MEDICINE for publishing it.

JANINE L. SCHEINER, PH.D.  
Norwich, Vt.

*Scheiner is a visiting assistant professor at Dartmouth College and an adjunct assistant professor at DMS. We are happy—upon request and unless copyright provisions prohibit*

it—to give permission for articles in DARTMOUTH MEDICINE to be used in academic contexts.

#### Educational aim

The article by Nancy Graff impels me to write. My personal medical history parallels hers in some respects. I was diagnosed with major depression 30 or so years ago and have been plagued with recurring episodes of deep depression in the years since, medications notwithstanding. All this culminated in a week-long hospitalization at DHMC this past July, including the beginnings of a full course of electroconvulsive therapy (ECT). It was my third hospitalization, first course of ECT. Nancy Graff's powerful description of ECT as "a gift wrapped in thorns" will stay with me for the rest of my life. It is so apt, with so many associations tied to "gifts" and "thorns"! She still has great power to evoke a strong reaction with her images.

I know her aim in writing this article was to educate. I have had an obsession with that going back to the '70s. My obsession took the form of describing depression, as well as medications and their effects, from the lay viewpoint, to anyone who would sit down with me and talk. This practice was not without its hazards back in the '70s, especially in a small, upstate-New York, somewhat conservative, rural community. It has been a happy discovery to learn in our four years in the Upper Valley that such subjects can be and are discussed here openly and without shame or embarrassment. Men-

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.



tal illness will probably never be regarded with the same aura of objectivity by the public as cholesterol levels, say, but we have come a long way since the '70s.

I find the conclusion of the article—that serious depression and its treatments to some degree diminish us—both realistic and at the same time heartrending, the more so in the case of a person of Graff's gifts. However, I want her to know that her influence may be more powerful than she realized when she wrote the article. I can't count how many kind people have recommended the article to me since the issue came out, nor how many people I have recommended it to. I sent it to my children in the hope that it would help validate their experience growing up in the care of a seriously depressed parent. And I've sent it to my extended family and my friends in the knowledge that the information would clear away a lot of the mystery and some of the fear of ECT.

I am resigned at this point to the idea that my future in all probability holds more ECT. But if knowledge is power, this article has empowered more of us than

Graff knows, and I personally am deeply grateful. Her influence may be dispersed, but the reality she describes gives the rest of us the information we need to keep on plugging, even if one of the gifts that struggle requires for relief is "wrapped in thorns."

SALLY STONE  
West Lebanon, N.H.

#### Toll taken

The feature article in your Fall 2005 issue by writer Nancy Graff, on the ravages of severe depression, reveals the toll taken by this mental illness.

I, too, through the years have experienced long periods of deep depression and sadness. I, too, have known all too well the ups and downs of depression that run not only through my family but through my own life as well.

I would like to add, however, a measure of hope to our situation, in reference to the last line of Nancy's article: "I am simply what's left." The devastating illness, so aptly described, does not, I feel, alter who we are inside. Our hopes, our dreams, our desires, and even our sadness and struggles make up our uniqueness—a picture of our true selves.

"What's left," therefore, is not the absence of things we've done before, but a changed look at who we are now underneath and have always been. It is our being, spirit, and soul that are sustained, with an inner knowing we must share. This is "what's left"—not erased, just subdued at times from the illnesses in our realm. This is called life.

LINDA STEELE  
Claremont, N.H.

Steele is on the staff of DHMC's inpatient psychiatry unit.

#### Riveted reader

Thank you very, very much for sharing Nancy Price Graff's experiences with depression with the readers of DARTMOUTH MEDICINE. Her article held my attention riveted all the way through.

I hope she will stay with us!  
ROGER E. CONDIT, DC '59  
Farmington, Maine

#### Symphony of sharing

Recently, as I was sitting in the Norwich Car Store, waiting like a parent waits in a hospital lounge, worrying that the surgeon will come out with bad news about a procedure gone awry on one's precious child (well, okay, so I'm being melodramatic), I picked up the Fall 2005 issue of DARTMOUTH MEDICINE. I had read the cover story about Hilary Ryder but not the rest of the issue, which, due to the length of the automotive "surgery," I had the good fortune to finish in its entirety.

Though tears have been shed before in the Car Store, I am sure, it was never for such deep

reasons. Starting with the editor's note, through the personal accounts by Nancy Speck and Nancy Graff, I was profoundly moved. And not only by those stories, but by the heartfelt piece by the dean, by the persistent pushing against the edges of knowledge evident on so many pages, by the citations of accomplishments and accolades, even by the letters section—all these elements of the magazine reflect the way DM has touched and continues to touch so many.

I want to say how much I appreciate what the magazine's staff does again and again to reflect the best of medicine at Dartmouth—this whole crazy quilt of human beings working, living, suffering, sharing, growing, and giving. Like an orchestra, you create a moving symphony.

And when the news came, I felt no pain despite the size of the bill. After all, it was only a car.

JONATHAN M. ROSS, M.D.  
Norwich, Vt.

*Ross is an associate professor of medicine at Dartmouth and, as it happens, a contributor to one of the features as well as to the "Letters" section in this issue. See page 46 for an example of his way with words in verse rather than prose.*

#### Sensitive stories

I really enjoy your magazine and always learn something new when I read it!

For example, it was so interesting to read about the life of a resident; the article had good layout, interesting photos, and enough information.

Thank you also for publishing



**A day on call for the resident pictured on our Fall cover drew several letters.**

the personal stories of cancer researcher Nancy Speck's experience as a cancer patient and of writer Nancy Graff's struggle with chronic depression. We can all learn from articles like these and become more aware and sensitive. I am grateful these two individuals were willing to share their thoughts with all of us.

PAULA REYNOLDS  
Morrisville, Vt.

#### Dazzling photographs

I very much enjoyed the Fall issue of DARTMOUTH MEDICINE. Hilary Ryder is my daughter, so it was thrilling to see her on the cover [reproduced above]. What a wonderful story on her 24-hour day—I saw her in a new light and was dazzled by your photographer's success at capturing her concentration. I now have a new appreciation for the work Hilary and all physicians do!

SUSAN FURSTE  
Wellesley, Mass.

#### Longitudinal learning

We enjoyed reading the Fall 2005 article titled "24 Hours on Call," about second-year resident Hilary Ryder.

Although we will be accused

of being "old school" in our approach to medical education, both of us are impressed that most of the didactic teaching that the resident received occurred before 3:45 p.m. and seemed less instructional in its clinical aspects than the one-on-one contact that happened urgently in the later hours with students, attendings, and patients.

We are aware of the current concern regarding the number of hours a resident is permitted in a week and the fear of clinical errors. If we may be so bold, we would like to quote from a book written about Dr. Eugene Stead, who trained a previous DMS dean, Dr. Andrew Wallace. The excerpt refers specifically to the issue of becoming overtired in medical training.

From Bloomfield's *And the Pursuit of Healthcare*: "All of us had, or developed, this incredible fealty toward Dr. Stead. . . . Dr. Stead's pronouncement that there was no way to learn about disease other than by seeing patients is now falling on deaf ears. We were overworked but never overtired. I believe that patients are going to suffer in the long run because internists are simply not going to be knowledgeable enough to care for them the way we learned to.

Did we ever make mistakes? I honestly don't think so. . . . The system just didn't allow that to happen because every move of every student was watched over by [the residents], [the chief resident], and Dr. Stead. . . . There was just no room for errors. . . . Dr. Stead simply willed it so. . . ."

Arthur Finn, M.D., [Former] Professor of Medicine and Physiology, UNC-Chapel Hill, North Carolina."

We believe—even though this is unpopular with current residents—that there is an advantage in caring for patients and learning clinical medicine after hours—even beyond 24 hours!

ROBERT BLOOMFIELD, M.D.,  
DC '73, AND ELIZABETH  
GENTILE, P.A.-C.  
Winston-Salem, N.C.

#### Questioning the regime

Please enlighten me as to how sleep deprivation, caffeine hype, work overload, and spotty food intake by residents ("24 Hours On Call," Fall 2005) enhance the quality of health care.

How does it add to the acuity of mind necessary for the very serious decision-making residents must handle from minute to minute and patient to patient, even including a code blue? Is anyone, having gone through 30 hours of such a regime, in any condition to take to the road and drive home?

GINGER LAMONTAGNE  
Stratham, N.H.

*We asked Dr. Worth Parker—who in his role as director of graduate medical education for DHMC oversees all the residency programs, to respond to the points raised in these last two letters. He replied as follows:*

"I appreciate the comments by Ms. Lamontagne, as well as those of Dr. Bloomfield and Ms. Gentile. DHMC takes very seriously its responsibility to ensure that our resi-



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dents are following the ACGME duty hours requirements put in force in July 2003.

"The article in DARTMOUTH MEDICINE's Fall 2005 issue presents a realistic picture of the present training situation for residents in internal medicine. The pace of inpatient medicine is undeniably hectic. We are currently looking at several alternative models of delivering education, through the process of patient care, that would limit the hours worked to less than what was depicted in this article. So the picture will look different in the near future.

"The real, ongoing challenge for medical educators is to produce physicians with the skills to manage acutely ill patients over a three-year course of training that includes fewer hours than residents historically have spent at the bedside."

### Tortious situation

The DARTMOUTH MEDICINE article "Study Debunks Medical Malpractice Myth" neglects to mention that the American Bar Association is delighted with the type of "research" Chandra is publishing.

First, there is no consideration of defense costs, which can reach \$25,000, even in a case that does not go to trial. Administration, defense, and reserves for future cases are a large part of an insurer's cost. The fact that large, reputable insurers such as Prudential and St. Paul's Marine and Fire no longer provide medical liability insurance supports the idea that this area is not lucrative.

Second, basing results on the National Practitioners Data

Bank often excludes self-insured institutions. This is important because these are the teaching and research hospitals that take care of the sickest patients. Their share of liability suits is probably higher.

Finally, a Rand Corporation survey has found that states with medical liability caps have lower medical liability premiums. In Florida, ob-gyns paid up to \$203,000 per year for insurance in 2000. That same year, California ob-gyns paid up to \$72,000. The difference was that tort reform in California led to the stabilization of medical liability costs.

In summary, Chandra's study and conclusions do not fit any of the above-noted facts. Rapidly rising malpractice rates in states without malpractice reform and the lack of profitability of malpractice insurance speak much more loudly than interpreting confusing claims data.

It is a disservice to the graduates of Dartmouth Medical School to publish these conjectures under the heading "Discoveries," while many graduates

are undoubtedly suffering from the excesses of the tort system. We hope that any new research into this area will attempt to examine the reality of the situation and not manipulate statistics without further study.

DAVID GOLDMEIER, M.D.,  
DC '78, AND LAURA  
HULBERT GOLDMEIER, M.D.  
Saint Louis, Mo.

### Following suit

I read with interest the article about Amitabh Chandra in your Fall 2005 issue. His studies imply that insurance companies are garnering enormous profits from the medical tort system and that the amount of money spent on medical malpractice activities is a small portion of the health-care dollar and only increasing in proportion to the overall cost of medical care.

However, in the real world, increasing insurance premiums are creating havoc for many physicians. To wit, a well-respected neurosurgical colleague of mine practicing in Philadelphia pays \$660,000 per year in premiums for medical malprac-

tice coverage! Who does Amitabh Chandra think pays to offset this astronomical cost of practice? Obviously the consumer—the patient.

While I'm not a fan of med-mal insurers, I will say that the insurers in my area are not reaping windfall profits and many are run by physicians as not-for-profits. In fact, many commercial insurers opted out of our area because they could not make a go of it.

Where then is the problem? In Amitabh Chandra's ivory-tower world, through his "research" we are led to believe that there is no problem. Well, from his vantage maybe not. I question if he has ever attended a malpractice court case or talked to lawyers and doctors who have experience in the field. I have, and I submit that the current system is escalating out of control. It is inefficient and horribly expensive, with lawyers, expert witnesses, and their fellow travelers (illustrators, jury consultants, and other facilitators of the theater) making \$500 per hour and up.

Even without going to jury trial, considering time lost from practice, the current system is incredibly expensive. Into this mix add jurors who cannot comprehend the details of medical practice but are swayed by the showmanship of attorneys and expert witnesses (in spite of new rules requiring lawyers and doctors to serve as jurors, most escape). The whole system ends up as an abomination, and the patient ends up with relatively little.

In a recent case in which I was involved, the trial took four

months and the plaintiff's attorney spent over \$400,000 and received a judgment in his favor of \$2 million.

The answer is not to slough off the problem, as Chandra has done, but to develop a better system. While I would be the first to admit that a patient who has suffered from medical negligence should be compensated, there is a better way. Rather than more of the same, as Chandra suggests, the system should be revamped. Namely, professional review or arbitration panels should be set up, consisting of experts from the medical and legal systems who understand the nuances of medical practice in the context of the law. This would replace the expensive theatrics to sway the jury that we now experience, and the deceit of many expert witnesses, who present their views in depositions to opposing lawyers rather than to a non-biased panel of experts.

Unfortunately, this does not seem to be on the horizon and will be even less so if armchair experts in economics keep saying that there is not a problem. Additionally, I know for a fact that many neurosurgeons are avoiding lengthy high-risk operative procedures that lead to cures in favor of noninvasive palliative procedures that fail to cure but only temporize, pushing the problem down the road.

Good luck to Amitabh Chandra in his move to Harvard to evaluate "defensive medicine"; in that he has found a true myth.

BENNETT M. STEIN, M.D.,  
DC '52, DMS '53  
Bernardsville, N.J.



**This article about a study by a health economist sparked two critiques.**

We offered Professor Chandra an opportunity to respond to these letters. He replied as follows:

"These two letters highlight the acrimonious nature of the medical malpractice debate and illustrate the degree to which questionable evidence, casual anecdotes, and 'kill the messenger' attacks are favored over careful, empirical analysis. This is a common response among individuals whose self-interested convictions have been challenged. Fortunately, there is no room for such tactics in science.

"1. Contrary to the Goldmeiers' assertion, our research does not contradict the role of damage caps in lowering medical malpractice pressures. In fact, our paper did not study the role of damage caps at all—it only documents trends in malpractice payments made on behalf of physicians. By refuting the presence of explosive growth in these payments, our paper challenges the role of payment increases in raising malpractice premiums.

"2. The Goldmeiers' letter correctly notes that rising administrative costs may raise malpractice premiums. We also noted this point explicitly in our paper. However, the growth of defense costs represents a different mechanism for the increase

in malpractice premiums than the payment-premium nexus that is commonly asserted.

"3. Contrary to the Goldmeiers' assertion, it is not known whether self-insured hospitals (by virtue of disproportionately being teaching and research hospitals) face a disproportionate share of malpractice suits—there is no academic paper that establishes this fact. Even if this statement were true, the exclusion of self-insured institutions from both payment and premium data means that this is not a source of bias.

"4. Our research was carried out under Rand Corporation auspices, so we are extremely familiar with Rand research on this topic. In fact, Seth A. Seabury, Ph.D., a distinguished Rand researcher, is a coauthor on the paper. Contrary to the Goldmeiers' assertion, Rand does not conduct a survey of malpractice premiums. Nor has any Rand study ever noted the numbers they state above. Furthermore, contrary to another statement made by them, the Rand study of California's MICRA legislation limited its analysis to the study of awards and attorney fees. It did not study, or even speculate upon, the effect of MICRA on premiums.

"5. Dr. Stein's letter attributes conclusions to our paper that we never stated. At no point did we claim that insurers are making windfall profits. Indeed, we explicitly state that insurers' investment losses have contributed to the pressure to raise malpractice premiums. Nor do we believe that the right policy approach is 'more of the same.' It is naive to infer that because we do not share his doomsday view of the malpractice crisis, we are en-

dorsing the present system. Unfortunately, Dr. Stein's anecdotes, and statements that begin with 'I know for a fact . . .,' do not constitute evidence in a scientific debate.

"While no peer-reviewed study should be viewed as establishing 'truth,' ad hominem attacks on the authors of opposing viewpoints, anecdotes about the experiences of colleagues, and mischaracterization of other work do not further the cause of more informed public policy. The language of science, comprising dispassionate evidence-based research, is taught to everyone at Dartmouth, but until physicians and trade associations replace speculation with statistics, they will continue to be marginalized in the debate over medical malpractice reform."

We might add to Chandra's comments that the stories in our "Discoveries" section cover research that nearly always has been explained in depth in a peer-reviewed journal. We are much more limited in the space we can devote to each study. We strive to represent the work accurately but are unable to include all the caveats and procedures described in the original paper. That said, the use of the phrase "frivolous lawsuits" in our story about Chandra's study may have been misleading, since the study looked at the relationship between malpractice premiums and trial judgments, but not at the costs of defending against "frivolous" suits that may or may not go to trial. Chandra's paper can be read in full at [www.healthaffairs.org](http://www.healthaffairs.org); put his last name in the "Author" field of the search panel. Readers who don't have access to the web can obtain a copy of the paper by e-mailing us at

DartMed@Dartmouth.edu or by calling 603-653-0772.

### Plain white caps . . .

I enjoyed the article “Beyond Nightingale” in the Fall 2005 DARTMOUTH MEDICINE. One of the photographs on page 54 [reproduced at right] is labeled “undated.” This is actually the MHMH School of Nursing Class of ’73. This photo, judging by the plain white caps, would have been taken during our first year—so in the fall of 1970 or the winter or spring of 1971.

This happened to be my class. I recognized those in the front row right away and then found myself in the back row (wearing dark-framed glasses, looking up).

SALLY PATTON, M.S.,  
MHMH SON ’73  
Lebanon, N.H.

Patton is nursing director of the inpatient surgical services at DHMC.

### . . . and cuffs that chafed

I read with gratitude and nostalgia your article on the Hitchcock School of Nursing. Much to my surprise, the undated photo on page 54 is of my class. We graduated in 1964, so the photo would have been taken in the winter of 1961-62. We are wearing caps, so it is after our probation period—but we are still wearing the collars and cuffs that chafed and choked us, so we have not completed our first year (after which we received a triangular and much kinder kerchief). And each one of those white buttons had to be carefully inserted in its buttonhole—usually the night before the uniform



DARTMOUTH COLLEGE ARCHIVES

**This photo, which was labeled “undated” in our Fall issue, clearly pictures a class act. But which nursing school class? See below for three (different) claims.**

was to be donned, because it took so long we would never have been on time for anything. And judging from the length of the skirts and aprons, we had not yet dared to introduce “fashion” by shortening them—then being subjected to the “bend-over test” to make sure the tops of our stockings were not visible should we lean over to select a treat from the ice cream bin in the dining hall (mustn’t present an unchaste appearance to all the males in the cafeteria!).

I recognize most of the students but do not see myself. The teacher looks familiar, but I don’t recall her name.

I was particularly interested in the comments about the nurse-physician relationship being more collaborative and collegial at DHMC than in many other institutions. It helps me to understand where my rather “uppity” assumption that that was the norm had its roots. That attitude/belief hasn’t always set well here in the south, where “nurse as handmaiden to the doctor” has until recently been the expectation.

My spouse (Peter Wright, DMS ’65) and I had a wonderful

time at his class’s 40th reunion this past September and are looking forward to moving back to the area in a few years’ time.

Again, thank you for such a comprehensive and caring article on a very formative aspect of my life.

PENELOPE FRIZZELL WRIGHT,  
M.S.N., MHMH SON ’64  
Nashville, Tenn.

*We checked with Peter Nolette, B.S.N., a 1977 graduate of the MHMH School of Nursing and the school’s de facto historian, to see if he could settle the “which class was it” question. But the plot thickened—he was sure he recognized a member of the Class of ’66, and he said another ’66 was certain the class was hers. But there appears to be no doubt that the faculty member pictured is Olive Cummings (later Paine; she married after she retired), who taught nursing arts.*

### Cultivating relationships

The essay by Jonathan Ross—“Is this what we want?” in the Spring 2005 DARTMOUTH MEDICINE—raises a number of issues overlooked in our compartmentalized approach to medical care. One of my close friends, depen-

dent for care on the internal medicine division at DHMC, has difficulty reaching her physician and often encounters an entirely new physician for follow-up care. This is quite in contrast to her previous physician, who almost always returned her calls and seemed to understand her needs prior to his untimely death a few years ago. She feels her care is now impersonal in contrast.

Her observations are echoed at Maine Medical Center in Portland, which is similar in size to Dartmouth-Hitchcock Medical Center. Both institutions are known for their superb achievements with hospitalized patients, due largely to competent specialists—many of whom are outstanding in their skills.

But I believe that DMS needs to continue and expand its efforts to create an environment that encourages young doctors to take an interest in the patient as a person, to understand the patient’s concerns and fears, and even to provide house calls for local patients. I agree with Dr. Ross that interpersonal relationships with patients and families are important to cultivate and should be encouraged throughout the training of students and residents, regardless of their fields of interest.

DMS has developed a fine program to foster these relationships, but such training is in danger of being eclipsed by clinical duties and long working hours.

JOHN RADEBAUGH, M.D.  
Falmouth, Maine

*Radebaugh, a clinical associate professor emeritus of community and*

family medicine at Dartmouth, wrote a feature for our Spring 2005 issue about his career-long practice of making house calls—to which the next letter is a response.

### Bringing down the house

The article in DARTMOUTH MEDICINE's Spring issue about Dr. John Radebaugh's total dedication to the care of his patients via the almost-passé house call was inspiring. What a pity that, for all the miracles of modern medicine, the warmth and satisfaction for both patient and physician provided by the house call now hardly exists. It is also of interest to note that many of the letters in the Summer issue lauding his dedication appeared to be from physicians of essentially the same generation—those who experienced the now-defunct golden age of medicine.

One of them, Dr. John Keller, could not resist sharing with your readers a rather humorous twist on the house call. It involved a woman who deviously took advantage of his good nature by claiming that her uncle was ill in order to have his visit actually serve to trap and subsequently remove a rat. This incident reminded me of a somewhat similar event, though one based on an honest request, that occurred during my own career as a surgeon.

One evening at home, I received a telephone call from a close friend who hysterically asked if I could come to her home immediately. I, of course, was concerned that some form of medical emergency had occurred. But she related that, pri-

or to leaving her home several days earlier, she had set several mousetraps. Upon her return that night (sans her husband), she discovered a dead mouse in a trap in her kitchen. The sight of it was so repulsive that she could not face the problem and pleaded with me to come dispose of the carcass. To which I replied very nonchalantly, "Sally, don't you know that nowadays doctors don't make mouse calls . . ."

Needless to say, as did Dr. Keller, I followed through in my role as a humanitarian (and mortician?). It did not take long for my friend to appreciate the deed as both humorous and priceless.

EDWARD TOBER, M.D.  
Hanover, N.H.

### History of a compact desk

I was pleased to see the piece on the Wooton desk—er, sorry, cabinet secretary—given by the Class of 1877 to Dartmouth President Asa Dodge Smith and then passed down through the Smith family to the third generation, my father, Thayer Adams Smith, DC '10.

Not noted in the article was the fact that my father was also an M.D. He received his medical degree from Columbia in 1914. The reason he didn't continue his education at Dartmouth Medical School may have been because his father's tenure as the dean of DMS ended in 1909 with his death (and my father's mother had died several years previously).

At any rate, my father went on to serve as a medical officer during World War I and eventually met the right girl and mar-



Two readers share below more about the provenance (and Dartmouth ties) of this striking desk that was the subject of a story in our Fall issue.

ried her in 1923. They decided, for purposes of raising a family, to leave New York City for a suburban environment in New Jersey. With the deepening of the Great Depression, he took a medical administrative job with Mutual Benefit in Newark. He commuted to work on the Lackawanna Railroad, leaving in the morning and returning at day's end, and so we several boys were not aware that he was even a doctor.

Later, eager to put his medical education to use in actual patient care, my father took the bold step of going into private practice and built an office suite off our house. It was there the Wooton desk found its place in the consultation room. The article shows one view of the desk with its hinged sides closed, but we kids never saw it in that position; they were invariably open. My father decided that the *sine qua non* purpose of a desk—er, cabinet secretary—was as a writ-

ing surface, so that portion, shown latched and still in its vertical position in another photo, was always down in its horizontal position.

I might add that when the Smiths decided collectively to donate the desk to the College, its finish had over the years lost a good deal of its attractive glow. Dartmouth restored it to what was likely its original appearance, now on view in the DMS dean's office.

THAYER A. SMITH, JR., M.D.,  
DC '45, DMS '45  
Downey, Calif.

### Wooton you know

The Wooton Desk depicted on page 17 of the Fall 2005 issue of DARTMOUTH MEDICINE has yet another connection to Dartmouth, because it was made by William S. Wooton, my maternal great grandfather. (The spelling is Wooton, though it is pronounced "Wooten.")

William was one of 13 children in a family that had roots in North Carolina and that migrated west to Ohio (where William was born in 1835) and Indiana. He was a Quaker minister who began furniture manufacturing in 1859, probably to supplement his meager stipend. He married Theodocia Stratton, also a Quaker minister, in 1862, and she bore him eight children—three girls and five boys.

Wooton began manufacturing desks in Indianapolis in 1870 and patented his cabinet office secretary on October 6, 1874, according to the Kansas State Historical Society. Wooton desks—known as the "king of desks"

with “a place for everything and everything in its place”—were characterized by multiple pigeonholes and compartments. There were four grades—ordinary, standard, extra, and superior—with the better grades having more ornamentation and exotic woods. The standard grade could be purchased for as little as \$135, while the superior grade cost as much as \$750.

John D. Rockefeller, Ulysses S. Grant, and Joseph Pulitzer owned Wooton desks. One was commissioned by Queen Victoria for her personal use, and it may be this desk that John Fontaine sold for \$123,200 in January 2002, as reported in *Maine Antique Digest*. The company closed in 1893, and rights to the patent were sold the next year. The popularity of the fountain pen and the typewriter likely contributed to the demise of the cubbyhole filing system.

Though his factory was in Indianapolis, Wooton moved to Wichita, Kans., and subsequently to Denver to join his daughter, Mattie Wooton Spray, my grandmother. He died in Denver in 1907 and his wife died there the next year.

In addition to the sources listed above, I am indebted to my kid sister, Rev. Patricia Robbenolt, who listened to our mother and her stories better than I did.

WALTER S. ROTHWELL, M.D.,  
DC '45, DMS '45  
Trenton, Mich.

#### A motivated mega-mentor

I have just finished reading your profile on Dr. Mark Israel (“Mega-mentor,” Summer 2005)

and want to compliment you on capturing his essence and spirit. I have known him for about 12 years and not only is he a wonderful friend, but I consider him one of the brightest, most motivated people I know. He will serve DHMC's Norris Cotton Cancer Center well and be a credit to your university.

HENRY R. KWIECINSKI  
Philadelphia, Pa.

#### Reading list

I have to tell you that DARTMOUTH MEDICINE is on my reading list for sure. The articles are extremely interesting.

I was a general practitioner in Orlando, Fla., for 50 years—and loved it.

IAN MACDONALD, M.D., DC '44  
Vero Beach, Fla.

#### System gets gamed

There was a recent article in the news about research from DMS regarding physician responsibility for the variance in medical costs.

Absolutely true! However, much of this is because the system and its rules manipulate and dictate how physicians must code different diagnoses to get paid. There has been a squeeze on physician reimbursement to keep down the cost of care. One can argue how much a physician should make, and I don't intend to go there. However, it is true that in 1976 the amount of “adjustment or denial of payment for write-off” of physician billings was about 26%. By the mid-1980s, it had risen to about 54%. That means if a physician billed \$1.00, he or she received 46¢.



**A letter below about this plaque, buried deep in New Hampshire's Lincoln Woods, offers a coda to a feature in our Winter 2000 issue about an event that took place in 1959.**

Most hospitals and medical practices have professionals who know and apply the most appropriate codes to get the best reimbursement. It is a game played by both sides—those paying and those submitting the bills. This is the result of the transformation of health care into a business. If consumers aren't aware of this game, it can cost them. I have written an article with some advice on the subject—see <http://www.cancerlynx.com/healthrecord.html>.

It is unfair to blame only doctors. They are relatively unwilling participants in the sad business game that health care has become.

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

*The letter above is commenting on a report in the national press about a study by Dr. Brenda Sirovich that is covered on page 5 in this issue of DARTMOUTH MEDICINE.*

#### Plaque gets scrubbed off

I recently came across your article on the two Dartmouth Medical School faculty members who crashed their plane in Lincoln Woods in 1959—Drs. Quinn and Miller (“Unforgiving For-

ests,” Winter 2000 issue). Enclosed is a photo [reproduced at left] that I took in 1994 of a memorial plaque to them.

We came upon the bronze plaque while we were camping, deep in the woods. It was covered in growth and mounted on a concrete slab. I cleared it off and photographed it. None of the rangers at the trail office had even heard of the plane crash, much less laid eyes on the plaque.

The photo has been in a scrapbook that I recently came across. I decided to Google the names of the doctors and found the article about them on your website. I thought I'd share with you the fact that the two doctors are not yet forgotten.

HANK DAVIDSON  
Medford, Mass.

#### Holyoke communion

After reading in the Summer issue of your magazine, at a Mt. Holyoke classmate's home, the article about Susie Neidlinger (who was also in our class at Mt. Holyoke, for our freshman year), I continued to read other articles and found the whole issue so informative.

My friend said that I had only to request a subscription to get on your mailing list—so I hereby do request one. I hope she was not wrong, and if she was not, many thanks in advance.

MARY L. BENNETT  
Feeding Hills, Mass.

*We are happy to add to our subscription rolls anyone who is interested in the subjects we cover. See the box on page 29 for details. ■*