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10TH ANNIVERSARY

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PRESIDENT'S message

Dan Albright, M.D.

Medical Liability Reform and the Election

The citizens of North Carolina have spoken loudly at the voting booths and strongly backed the agenda of George W. Bush. North Carolinians voted for President Bush by an impressive 56% to 43% margin in the November 2004 election. Our voters support Bush *more* than the entire United States on average. (Bush 51%; Kerry 48% for the entire nation). President Bush's ideas have clearly resonated with the North Carolina electorate. Another point is clear: Bush did not win this election based on his style or debating skills!

What does the Bush victory have to do with the medical physicians in North Carolina?....A lot.

Medical liability reform is high on the President's list of domestic priorities. An impressive portion of North Carolinians voted with the President's agenda and priorities. Surveys in North Carolina also confirm that the public is concerned about lawsuit abuse and its effect on healthcare.

Within the North Carolina General Assembly, the medical liability crisis has less strength and a lower priority. A number of our re-elected legislators were opposed to or are ambivalent about the need for powerful medical liability reform. This needs to change. The physicians and the voters of North Carolina need to impress upon our state legislators that President Bush's emphasis on the medical liability crisis is important and that a dramatic reform of our medical liability system is desperately needed.

Democratic legislators did well in the November election, gaining two seats in both the N.C. Senate and House. In the 50 district N.C. Senate, Democrats will control 29 seats versus 21 Republican seats. In the 120 district N.C. House of Representatives, Democrats will control 63 seats versus 57 Republican seats. The push towards medical liability reform must be a bipartisan process. Now more than ever, physicians need to communicate with legislators from both parties, communicating especially with the Democrats who dominate the General Assembly.

Consider the blossoming number of attorneys in the General Assembly. There are now 18 lawyers in the state senate and 14 lawyers in the state house. One of North Carolina's most successful and aggressive medical malpractice plaintiff's lawyers has just joined the House of Representatives. How's that fact for scary? (scary ultimately for our patients if plaintiff lawyers continue to plunder the system).

The point here is clear: doctors need to be involved in the political process or we and our patients will be overrun even further by lawyers and lawsuit abuse. Ultimately, lawsuit abuse is about protecting a patient's ability to find the right doctor in a timely manner and within a reasonable distance. *The liability crisis is a patient access and patient care issue.* Patients suffer if doctors cannot afford their malpractice insurance and cannot make themselves available to higher risk patients. Legislators need to be reminded of these realities on a regular basis by many physicians from different specialties. Electronic mail makes this communication easier and instantaneous. Ongoing communication by physicians with legislators makes a difference.

The theme of this President's Message is: **Communicate with our Wake County legislative delegation and with the leaders of the General Assembly.** This is the age of electronic mail and efficient messages. The legislators need to hear more from physicians about how patients are suffering from declining access to doctors due to the medical liability crisis. From my conversations with several state politicians, it is clear that they wish to be educated further on the liability issue and they wish to learn more about physicians' viewpoints. Remember this reality: the medical liability crisis centers around worsening access for patients to doctors.

Even non-digital doctors who get nervous around computers can do the following: when you have a relevant anecdote concerning the liability crisis, dictate a brief note to your secretary who can then

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EDITORIAL

By Assad Meymandi, MD, Ph.D. DLFAPA
Founding Editor

Dr. Assad Meymandi

Assad Meymandi, MD, PhD, DLFAPA (Distinguished Life Fellow, American Psychiatric Association), was honored at a luncheon on Friday Dec 3, '04 for endowing the Dr. Assad Meymandi Distinguished Professor and Chair of Psychiatry at University of North Carolina School of Medicine at Chapel Hill.

Introduction by Dr. Robert Golden, Chair, Department of Psychiatry, UNC School of Medicine.

Dr. Meymandi is a noted psychiatrist, humanist, and philanthropist, who frequently speaks and writes on diverse topics that relate to his interests in medicine, art, religion, and philanthropy. Dr. Meymandi earned his MD degree from George Washington University School of Medicine. In addition, he holds PhDs in both biochemistry and philosophy, and he was awarded an honorary doctorate in humanities. A longtime resident of Raleigh, he is in private practice as a psychiatrist and neurologist.
The News and Observer described Dr. Meymandi as "aristocratic in breeding, intellectual in temperament, and philanthropic in lifestyle. His hunger for knowledge is surpassed only by his generosity. His philanthropic activities in medicine, the arts and humanities have made his name synonymous with enlightenment." The city of Raleigh recognized this by honoring him with the Raleigh Medal of Art in 2000, and in the fall of 2002, Governor Easley appointed him to the Board of the North Carolina Arts Council. In January 2003, he was elected to the Vestry of Christ Episcopal Church, and he serves as President of the NCSU Friends of the Library. He has endowed a fellowship dedicated to the task of bridging the gap between the basic sciences and humanities at the National Humanities Center where he serves on the Board of Trustees. He has endowed professorship chairs, and gives scholarships to bright and promising medical and conservatory students.

The 1800 seat state-of-the-art Meymandi Concert Hall in Raleigh, which opened on 21 February 2001, was named by Dr. Meymandi to honor his mother. He is building 200 housing units for the survivors of the Bam disaster in Iran, where 35,000 people were killed in Jan '04. Upon completion, he will add a school and a community center.

Speech by By Assad Meymandi, MD, PhD, DLFAPA

In the annals of Neolithic man, roughly ten thousand years, there are many brilliant intellectual stars forming the constellation of the milkyway. But there are three who outshine all others. The first is Saint Augustine of Hippo, 354-430 AD. He was a Manichian converted to Catholicism in his early 20's. Augustine was a scholar extraordinaire. Throughout his career he wrote over five million words. His book, "The City of God", has been translated into some 200 languages. St. Augustine's writings are fascinating in that he has focused on the phenomenology and epistemology of grace and salvation. Specifically, his writings and sermons focus on how to achieve the nirvana of living a life full of grace (not necessarily a graceful life). There are more than 75 published biographies of St Augustine, the latest of which will come out on April 1, 2005. It is by James O'Donnell, Provost, Georgetown University, Washington, DC, and a fellow Trustee of the National Humanities Center, RTP. I do not confess to have read all of Augustine's 5.3 million words, but I have read a good many of them

The second star in this brilliant constellation is Moses Maimonides of Cordoba, 1135-1204 AD, a Jewish colleague of ours, especially an excellent semiologist. He was an expert in diagnosing and treating infectious diseases, closely following the teachings of Abu Ali Sina (Avicenna), 980-1037 AD, the Persian Physician who lived in 978 AD. He lived from 1137 to 1205. But Maimonides was more than a physician. He was a theologian, a philosopher, and an expert in Aristotelian rhetoric and forensics. He, too, wrote more than five million words in his life time. His book, "Confessions", is the definitive archetype of that literary genre emulated by many. Among them, for example, is Jean Jacques Rousseau, 1712-1778 AD, the French philosopher and opera critic. Rousseau's "Les Confessions" is a courageous, if not polemic, account of his life and his intellectual and perceptual architecture of "Natural Philosophy." Parenthetically, he was the prototype of an eighteen century beatnik!

Maimonedes, too, has a lot to say about salvation and living a life of grace.

The third equally brilliant star is Ibn Khaldoun of Tunisia (born in1335 and assassinated in Egypt in1406). Surprisingly, Khaldoun also wrote about 5.3 million words, among them the codifying of all the Islamic Laws and Fatwa. It is not surprising to see in his writings the emphasis on salvation and living a life of grace. Ibn Khaldoun was an economist, the father of "trickle down economics", a policy the late President Reagan adapted in 1981.

Incidentally, for music lovers and history buffs, allow me to share with you a fact as an ornament to the gift I am preparing to give you that Ibn Khaldoun brought music and painting back to the Islamic word. Specifically, in 1360, when he was 25 years old, he started a singing competition in all Islamic nations. It was and continues to be very much like the modern day Oscars and the Grammy Awards. Singers of all walks of life are auditioned and screened to enter Talavat (singing of Quran verses), an annual competition held in various Islamic countries of the world. It brings enormous spin off prestige and prizes. Talavat has been continuously performed, without interruption, since 1360. The 2004 competition took place in Nigeria. The only other composition in the world with a record of continuous performance is Handel's Messiah, to which has been played every year since 1742. Handel's years were 1685 to l759. Bach's years were 1685 to 1750.

The distillation of nearly 16 million words of these three very brilliant stars is this: the road to living a life of grace is to know and to be aware of what is good inside of us. These are God like attributes of love, compassion, integrity, intelligence, altruism, self confidence, self- respect and spirituality, and to know what is good outside of us, and these are life itself, the miracle of family, connectedness, friends, nature, trees, flowers, knowledge, music, the arts, dance and poetry…And to be thankful for them, by giving something back and making a difference in the lives of people around us.

So the first movement of my talk, which is a gift to you all, is,

I repeat, to know what is good about you inside and what is good about you outside, and be thankful by giving something back. This is the beginning of altruism.

The second movement, my dance, my minuet, is America. One of the best things outside of me, after my family, is America. I celebrate America and am thankful for being an American. America is the most decent and generous nation in the world.

The NC Medical Society has a program, "Doctor of the Day", when physicians spend a day in the legislature taking care of the legislators and staff. When my turn comes up, I am often asked by the Speaker, and now Speakers of the House, to say a few words at the start of the afternoon deliberations. I remind the audience that America is the best thing ever happened to this world. Since the dawn of creation, I believe God has set out to send man on the road of decency and self-improvement.

He sent Zaratustra (Zoroaster) to bring us the concept of good and evil, epistemological dualism. The Sumerians brought us literacy and language. Egyptians taught us social order, the Persians participatory democracy;and the Greeks the city-state. The Babylonians gave us the Code of Hammurabi and Abraham of Ur came to teach us faith. Mohammed, an illiterate Arab orphan, gave us the miracle of Quran and taught us possibilities and potential. Moses brought us devotion and discipline; and Jesus taught us love. 1215 years later, the Anglo-Saxons brought us the Magna Carta.

But it was not until 1776 that God commissioned, in a divine and mysterious manner, a group of faithful thinkers and intellectuals to lay the cornerstone of a new experiment that in short span of time has become the envy of the world. The experiment began in 1732 with the birth of George Washington and Patrick Henry, and in 1743, the birth of Thomas Jefferson. The Founding Fathers gave us America where the rule of law, and not the whims of a dictator, a Shah, an Ayatollah or a self appointed president-for-life, is supreme. The Framers gave us the US Constitution, which as a literary piece magically combines Augustinian grace, Franciscan tenacity, Christian hope and love, Talmudic order and Zoroastrian aspiration for good deed. We have seen dictators come and go, but American government, the rule of law, the unique legacy of the American Constitution and the Bill of Rights are here to stay. Yes, America is my dance, my minuet and my cause celebre.

And now the third movement of my symphony: Have you noticed that I have not said anything about psychiatry, the chair it is my privilege to endow and Bob Golden, its first occupant? Yes, the third movement is psychiatry and why this chair?

Medicine is a noble profession. Medicine is a priesthood. Last year, I was asked to give the commencement address to the graduating MDs of my alma mater, the George Washington University School of Medicine. I shared with them that to become a doctor of medicine is also an ordination to the priesthood of medicine. As they enter the holy temple of medicine and drink from the sanctified chalice of our noble profession, they must wear the cloak of service, humility and altruism. We must never forget that as doctors, we are there to serve others.

I submit that of all the specialties and subspecialties of medicine, psychiatry is the noblest. Here is the reason. Please forgive a self reference. During my senior year at George Washington Medical School, one morning I was tapped on the shoulder by Dr. Brian Blades, the Demi-God who chaired the Department of surgery. He picked me to be an acting intern. It entitled me to a slightly longer white coat, extended the privilege of counter-signing orders written by my fellow classmates, eating in the faculty/staff dining room, participating in making up the call roster and yes, not just doing Lee-White clotting and bleeding time in a corner of the operating room, but holding retractors and applying a few stitches here and there and closing up! It was a heady experience! But in about three months I was bored out of my skull. How many hemorrhoids? How many gall bladders? How many hysterectomies?

In the meantime that summer, Dr. Winfred Overholser, GW Chair, Department of Psychiatry who also was the Superintendent of Saint Elizabeth Hospital in Washington, DC, offered me a three month externship, and knowing my interest in biochemistry, he assigned me to the White Building. We know Egypt as the cradle of civilization. The White building and the Sandoz Laboratory in Switzerland are the acknowledged cradles of psychopharmacology and neurobiology. I felt like a kid in a candy store. Here were all kinds of laboratory facilities to work on the skills I had acquired in lipid and protein metabolism doing graduate work in biochemistry at Johns Hopkins. Here were the brilliant minds of so many scientists and thinkers that were truly exciting. That experience determined my destiny. I was going to train in psychiatry.

Psychiatry, like Shakespeare, is abundant. It is generous. It has so many highways, byways, avenues, and alley ways that are connected…As a psychiatrist, one can be a basic scientist, an endocrinologist, a physicist, a mathematician, a cultural anthropologist, a theologian, a historian, a humanist, an artist, and an art advocate…No other specialty in medicine offers so many possibilities and so many opportunities. Every day I give thanks for being a psychiatrist and not a proctologist or ob-gyn (no disrespect to those specialties!)

And now why this chair? Endowing this chair is an expression of my gratitude to the profession of psychiatry which has given me so much. And why Robert Golden? I have seen him around UNC for the past 19-20 years. He and his wife Shannon, a Kenan Professor of oncology at the Lineberger Center, are good friends. I have watched Bob doing an excellent job as Psychiatry Department Chair for the past ten years. I am sorry to see him leave the Department, but as Vice-Dean, he will continue to nurture the Department and help it grow in quantity and quality. I wanted very much for the chair to bear his name as its first occupant.

Finally, a word about UNC. A university ought to nurture ideas and promote curiosity. It ought to reward seekers and stay at the cutting edge of science and technology. Also, a university ought to nurture the soul, and provide for development of the arts and humanities…I believe UNC is doing this admirably well. I am thankful to Bill Friday, Chris Fordham and other past leaders of the University and those upon whose shoulders stand the current leadership, Molly Broad, Jim Moeser and Bill Roper. I want to assure them that my gift has no strings attached. I will not be dictating how they should teach psychiatry. Again, ladies and gentlemen, I thank you for your presence

Letters to the Editor

The Editor:

Thank you very much. As country chair of Democrats Abroad-Mexico, particularly enjoyed reading the references to today's political dilemma regarding universal health care and totally agree, not only for one system of health care for all but one system of social security for all (please note the benefits to members of Congress when they retire from Congress)! I would enjoy seeing future issues.

Sincerely,
Carol Mardell, Chair
Democrats Abroad, Mexico

President's Message Continued from page 1.

electronically send your note to the entire group of legislators listed below. The more our lawmakers hear from us, the better educated they will be about the specifics of our liability crisis.

Interest groups who communicate clearly and consistently with their elected leaders enhance their chance of success in the legislature. Yes, money matters in politics. However, sound ideas matter most in politics (according to this naive author's paradigm). Both our patients and our practice of medicine will benefit through our continued efforts to communicate with the General Assembly about liability reform.

The North Carolina General Assembly website (www.ncga.state.nc.us) provides the best listing for our legislators, even broken down by county. Generally, you can e mail any state legislator by typing his or her first name followed by the first letter of the last name followed by "@ncleg.net". For instance, Senator Vernon Malone's e mail address is: vernonm@ncleg.net. Check the General Assembly website to confirm the proper, updated e mail addresses for 2005.

If you can't remember exactly who your own state senator or representative is, go to http://yahoo.capwiz.com and type in your zip code and home address. Your specific district's elected officials are presented. This website is convenient and impressive in its political coverage.

The Wake County delegation to the General Assembly is as follows (though the official final results of the election have not been released at the time of this writing):

Senate:

Vernon Malone	Democrat	District 14
Neal Hunt	Republican	District 15
Janet Cowell	Democrat	District 16
Richard Stevens	Republican	District 17

House of Representatives:

Bernard Allen	Democrat	District 33
Grier Martin	Democrat	District 34
Jennifer Weiss	Democrat	District 35
Nelson Dollar	Republican	District 36
Paul Stam	Republican	District 37
Deborah Ross	Democrat	District 38
Linda Coleman	Democrat	District 39
Rick Eddins	Republican	District 40
Russell Capps	Republican	District 41

The Wake County delegation to the General Assembly has 7 Democrats and 6 Republicans. Democrats Marc Basnight and Jim Black will likely continue to lead the senate and house, respectively (as judged at the time of this writing). Include those two very important people in all of your e mails (marcb@ncleg.net; jimb@ncleg.net). Prior to the November 2004 election, both those key leaders personally expressed to many physician groups across the state their interest in the medical liability issue. It is known that legislative action in North Carolina is practically impossible without the leaders of the senate and house supporting the legislation.

In closing, please remember some key points:
- Physicians must communicate regularly with our state legislators about how the medical liability crisis is hurting patient care in North Carolina.

- Electronic mail is an extremely efficient way to deliver your message to the Wake County delegation and the leaders of the N.C. House and Senate. Face to face conversations with legislators are most effective.

- Medical liability reform will be an extended political struggle. There is no shortcut towards success with this issue. Persistence and good communication skills help in the lengthy American political process.

About the Cover . . .

Cover by Ippy Patterson, renown North carolina artist. She lives in Hillsborough, NC. She can be reached at ippyp@mindstram.com. Ippy's picture is by artist Roger Haile of Mebane, NC. Here is the artist explanation of the fascinating image on the cover.
Editor

I am fascinated by visual intricacy and detail. The surfaces of the world look simple but reveal themselves to be astonishingly complex up close. Nature builds from the bottom up.

When I'm drawing plants and flowers and insects with pen and ink, I clean my pen by scratching the nib on a scrap of watercolor paper; the resulting patterns, random and free of intention, are frequently more intriguing to me than the carefully rendered drawings I am laboring to produce. These scraps are the point of origin for the series of abstractions of which this image is one example.

Working on these pieces allows me to get lost in other worlds; there are times when the image seems to be forming itself without my conscious control, inducing in me, in my hands really, an exploratory invention that repeats, elaborates and ramifies on its own.

I try to do no planning --- a difficult, sometimes impossible constraint --- as I proceed with the development. Now and again I am able to achieve a welcome sense of surprise in spontaneously shifting forms; at this stage, I don't know what is to happen next, whether the lines will enter a vortex, devise a cave or a cliff or a hill of darkness or light.

A musician improvising may feel this way.

INTERSECTIONS

By Dr. Holden Thorp

Lots of recent editorials in major newspapers and news magazines have addressed the crisis America is facing in terms of the future of science and technology. It seems like everyone wants to chime in, and not just University presidents and business pundits.

Even Tom Friedman – the New York Times *foreign affairs* columnist – has piped up recently that the US is facing a train wreck in terms of its future innovations.

The first problem is that for the last several decades, US companies and universities have largely relied on immigrants – mainly from Asia – to provide the human capital and brainpower behind innovations. This "brain gain" is now slowing because of the tightening of our borders after 9/11 and the improvement in university systems in China and India.

The second problem is that the expansion of the national investment in science and technology is slowing. The National Institutes of Health experienced a doubling of its budget since 1998 that is now over, and the National Science Foundation took a cut this year, which inspired Friedman's cry for help.

Locally, Duke President Richard Brodhead recently described this problem to editors and reporters at the News and Observer, and UNC Professor Jim Johnson discussed these issues in his University Day address.

Business scholar Richard Florida has defined a new creative class of workers. This group includes "scientists, engineers, architects, designers, educators, artists, musicians, and entertainers, whose economic function is to create new ideas, new technology, or new content." Florida also includes business and finance, law, and health care and related fields that apply creative problem-solving. Florida estimates that 23.6% of US workers are in this creative class.

Unfortunately, the US is not even in the top ten countries in terms of the percentage of its workers in the creative class (it clocks in at #11). The champ in these rankings was Ireland with 33.5% of its workers.

I visited Ireland this summer to certify the Ph.D. thesis of a promising young scientist at Dublin City University whose research was closely related to my own. Two things stood out prominently on my visit. The first was the large investment being made by Ireland in science. The second was that the graduate students at Dublin City University were almost entirely from Ireland.

President Brodhead noted in his recent comments that the problem also results from a "lack of interest" among K-12 students in the US. As Director of the Morehead Planetarium and Science Center, I see this effect first-hand, but I don't think it stems from a lack of interest or ability on the part of students or teachers. Rather, there is a lack of both time and financial resources for providing science content to students.

The hunger of K-12 teachers for help with science is shown dramatically in the recent rankings of field trip destinations for NC students: the top four institutions in terms of field trip attendance (NC Museum of Natural Sciences, Discovery Place in Charlotte, NC Zoo, and Morehead Planetarium and Science Center) are all science centers.

This hunger is likely to intensify, since NC end-of-grade tests on science are now being phased in for Grades 5 and 8, and will be operational in 2008. These tests will, of course, only assess knowledge of content and not necessarily the application of science to creative problem-solving.

This Gordian knot gets tighter when looking at the present state of private investment in research. When I went to graduate school in the 1980s, the primary question facing Ph.D.s on graduation was whether to pursue an academic career or to do research for a large company.

Now, large US companies are cutting back on research, primarily because of the quarterly focus of Wall Street, which discourages long-term investment. And hiring of research faculty in academic institutions is relatively flat. So at present, even if interest could be stimulated among rising college and graduate students, their old-fashioned employment prospects are ever-dwindling.

The only answer, as articulated by Johnson and Florida, is a rethinking of the American research enterprise towards smaller, more entrepreneurial companies and entities, both inside and outside the university. This will require a number of steps.

First, we must teach our students to create their own opportunities rather than to rely on the research efforts of large entities. This will require us to blur the lines separating academics and industry, basic and applied research, and students and graduates.

Second, we must increase opportunity for economically disadvantaged students. If we can no longer import innovators, we must turn to our own citizens. Only then can the US take complete advantage of the potential untapped innovations in our workforce and convert more Americans to the creative class. This effort will require not just financial aid, but also innovations in the curriculum that will allow us to uphold our standards of rigor while ending the "weeding out" of potential innovators.

Finally, academic institutions must become more entrepreneurial. At University Day, Johnson challenged the UNC campus to do so "by developing, nurturing, and most importantly unleashing the full entrepreneurial potential of the university community". Chancellor Moeser responded by saying "we accept that challenge."

Universities large, small, public, and private must respond similarly. As Gene Kranz (played by Ed Harris in Apollo 13) said, "Failure is not an option."

Cited references

Florida, Richard. "America's Looming Creativity Crisis," *Harvard Business Review*, October 2004.

Friedman, Thomas. "Fly Me to the Moon," *New York Times*, December 5, 2004.

Johnson, James. "People and Jobs on the Move: Implications for Higher Education," University Day, http://www.unc.edu/news/archives/oct04/uday101204.html.

Stancill, Jane. "Research Woes Seen Ahead," *News and Observer*, December 17, 2004.

Zakaria, Fareed. "Rejecting the Next Bill Gates," *Newsweek*, November 29, 2004.

North Carolina Treasures

By Sue Jenkins

The ALICE AYCOCK POE CENTER for HEALTH EDUCATION

Writer's Note: From the very beginning meetings to the opening to students, the AAPCHE was 12 long, persevering, complex years in the making. Because of the word limitation necessary for the WCP, only the very "barest of bones" highlights can be touched upon, but anyone interested in more in-depth history may borrow my copy of the 600 page "History of the Formative Years."

With more than 600,000 participants since the Poe Center opened its doors in 1991, the Wake County Medical Society and Alliance members are often asked how they created such a successful new institution that cost over 3 million dollars and took a dozen years to establish. Where did the idea come from and how did it evolve?

This is the briefest of summaries of these 12 formative years of a very highly specialized state-of-the-art technology center, one of a handful nationally, dedicated to teaching good health and healthy lifestyles to the people of North Carolina—-and especially to its children.

It is the story of "miracle workers"—-physicians' wives and physicians joining hands with dentists and wives, educators, business leaders, and local government and community leaders—-the story of the most intensive and long-term community endeavor ever to be initiated by volunteers from the medical community, held together and laboriously developed by volunteers, and seen through to completion and viability by volunteers. This is the story of a multi-million dollar dream turned into reality.

Active efforts to start a health education center began in January, 1980, when 2 school health educators contacted the President of the WC Medical Auxiliary (Sue Jenkins) asking for help, and alluding to our (doctors' wives) responsibility. A number of emergency meetings were held, and acting on Cy Farley's suggestion, with approval from the general membership, the Auxiliary chartered a bus to take approximately 30 community leaders to visit health education facilities in Charlotte and Greensboro. From this all day field trip on May 7th, 1980, came the first organized, albeit loosely, Health Education Center Committee.

The next 4 years were lean and austere, meetings were held with sometimes few members, seemingly held together at one point by relentless efforts from Faye Miller holding meetings in her home—-but momentum was gathered by help from a few more doctors' wives and a few more health educators. Within a few short years, the agreement that had been made between the HEC Committee and the North Carolina Museum of Natural History (Sciences now) had been voided, but the Museum agreed to give the HEC Committee space for an interim exhibit. Plans were made for this "seed exhibit" (from which more could grow)—-and on September 27th, 1984, this exhibit on the heart and circulatory system opened—-to much public acclaim!

During this early 4 year+ stage, the first of three, funding came from the Wake Medical Staff Foundation, the WC Medical Auxiliary, and from the WC Delegation of the North Carolina Legislature.

In the spring of '85, the unanimous decision was made by the Committee to NOT go with State support. Pre-requisites for incorporation were readied, and incorporation took place on November 22nd, 1985. The HEC Committee now became The Center for Health Education, Inc.! The 6 names on this new document were Faye Miller, Dianna Burroughs, Claire Poole (all doctors' wives), and Charles Wood, Dr. Eloise Cofer, and Beth Page (all health educators).

From the successful seed exhibit to the finding of land (on which to build) in December, 1987, defines the second stage of this 12-year "dream to reality."

During this period, Board expansion into the community took place, 7 Board members did research at other health education centers in the country, and the HEC was endorsed by the WC School System, the WC Delegation of the North Carolina Legislature, all 3 major hospitals, the Medical Society and its Auxiliary, and the Dental Society and its Auxiliary. And the always pervasive, relentless search for land/a place to be, continued.

By the summer of '87, the decision was made that a completely separate, free-standing, independent facility was necessary.

Almost providentially, the HEC Board and the family of Jean Poe Smith and her husband Gordon came together. The land the Poe-Smith Family offered was 1.7 acres near Wake Medical Center—-and was contingent on naming the center for Alice Aycock Poe, Jean Poe Smith's mother—-and contingent on the Board's approval.

The Board unanimously accepted this gift of land and in the December '87 Board meeting, President Shirley Lucey made her historic statement—"We have the land now and we can do it!"

The acceptance of land was considered by the Finance Committee to be the beginning of the Capital Campaign—-and the Treasury now stood at 1/2 million dollars.

So begins the next 4-year period, the last of the defined stages. These would be the most intense, complex, demanding and challenging of all—-for now everything would depend on the Board and its leadership to raise the staggering sum of 3 million dollars more!

Now, re-organization (to maximize each one's individual skills), developing a plan of action, and determining the size and scope of the Center were in order. A report assembled by

Continued on next page.

Thinking Things Through

By George M. Stephens

FROM THE DECLARATION TO THE CONSTITUTION: 1776 TO 1787

The Declaration of Independence established the United States of America with a government to secure "life, liberty, and the pursuit of happiness" for its citizens. Its system wasn't working, however. The states tended to act as though they were independent of each other as well as Great Britain, and citizens referred to their state as "my country." This complicated the war against their common British enemy. General Washington had a very difficult time maintaining an army. Congress sent requisitions for funds to the states, which often did not pay, and those who paid were angry with the ones who did not.

They governed under the Articles of Confederation, adopted by the Continental Congress, which stipulated: "The said states hereby severally enter into a firm league of friendship with each other," but the Confederation could not collect taxes, pay the public debt or encourage and regulate commerce. (A now little-remembered provision was that Canada was entitled to join the confederacy).

Alexander Hamilton, Washington's *aide-de-camp*, pressed the General for strong measures and said that the only remedy was a convention of the states. He publicized the need over the next seven years, and in 1782 he persuaded the New York legislature to pass a resolution urging that one be convened. With the end of the war the states were even less cooperative, but a dispute between Maryland and Virginia over navigation of the Potomac River led to a meeting in Annapolis in 1786, opening a door to resolution.

The Annapolis Convention recommended to Congress that all thirteen states appoint delegates to convene in Philadelphia the next May, "to take into consideration the trade and commerce of the United States." The states were imposing duties on each other as though they were indeed separate countries, and their currencies were different.

In 1787, as in 1776, they convened in the Pennsylvania State House. Seventy-four delegates were named to the Convention, of whom 55 attended. Not included were John Adams, who was in London as the American envoy, or Thomas Jefferson, who was its representative in Paris. Adams' recent book on constitutions was being circulated among members, while Jefferson sent to his friend Madison hundreds of books on the subject.

There was no thought of writing a new constitution, because there was little support for a strong national government., so Congress resolved that the Convention was to meet "for the sole and express purpose of revising the Articles of Confederation. James Wilson said that he thought the Convention was authorized to "conclude nothing, but to propose anything," and that became the attitude of the members, who worked in secrecy, which allowed uninhibited discussion of controversial and complex issues. Decisions were made non-binding, so delegates could change their minds, accommodate to new understandings and work toward a complete concept of government.

That was the "forgotten" part of our history. What followed, the writing of the Constitution, is remembered, but we forget how limited a government the Framers created. The 1787 Convention was mainly concerned with creating just enough government to preserve property, per John Locke's doctrines.

Continued on page 13.

Doctors Leah Devlin and Helen Cannon helped document the health needs/statistics of WC and its far-reaching implications—-instrumental in identifying what was necessary and strengthening the case for support. A massive Awareness Campaign had to be launched in preparation for a feasibility study—-for it was on these findings that the fund-raising counsel would structure plans for raising the necessary 3 million dollars.

Shirley Lucey's Presidency (ending in May '88) was followed by Virginia Scanlan's Presidency (ending in May '89), and when the late Pat Hackney (the only non-doctor's wife to serve as president) became President in May '89, Lucey and Scanlan were designated the Capital Campaign leaders. This was, in effect, the building and operation of a very intense and complex business.

The Capital Campaign was launched in the spring of '89, beginning with the medical and dental campaigns. By the fall of '89, Nancy Rhyne and her Education Committee had spread into 32 counties, consisting of 49 public schools and 106 private schools. By the end of '89, Dr. Tom Dameron was named Chairman of the Campaign Steering Committee—-a bridge to community leaders.

OUR HEALTH—OUR FUTURE, the theme and logo for the Community Campaign, was launched by the Public Relations Committee in the spring of '90. Major contributions were being secured, architectural and exhibit planning continued, an Executive Director was hired the beginning of '91, ground-breaking took place on April 10th, 1991, and building was underway. And by ground-breaking, the 3 million dollar goal had been topped!!!

On September 25th, 1991, the Center was moved into—-and the doors opened to students on November 21st, 1991!

The list of contributors is much too long to print here (this is in the full history), but a general break-down of the $3 million is as follows: medical community—1.1 million; general public (corporate, individuals, clubs, Board, etc.)—1.4 million; grants (foundations and trusts)—.5 million.

There are so many "miracle workers" who should be recognized here, but again, for the sake of brevity for the WCP, it shall be limited to doctors' wives. In addition to Past Presidents Faye Miller, Dianna Burroughs, Helen Majors, Shirley Lucey, Virginia Scanlan, and Anna Hattaway, these are more doctors' wives who gave many years of their time and talents; Nancy Board, Nancy Dameron, Dianne Davidian (later President), Arlene Pike (later President), Claire Poole, Mary Rendleman, and Nancy Rhyne. Please please forgive unwitting omissions.

The Poe Center is now in its 25th year from the January, 1980 inception. Look for a follow-up au-courant article on the Poe Center—-coming soon in the WCP.

A History of Obstetrics and Gynecology in Raleigh and Wake County

By Thomas R. Greer MD in collaboration with Dr. Annie Louise Wilkinson, MD

The practice of OB & GYN as it is today is a respected and highly technical practice of medicine.

Prior to 1919, obstetrics was practiced by midwives. When medical attention was needed, the general practitioner and surgeons were called. At that time it was an accepted fact that women frequently died in childbirth. Gynecology was just lumped in with the general practice of medicine and surgery.

In 1919, Dr. Ivan Procter came to Raleigh. He had trained at the maternity Hospital in New York; the London Hospital in London, England; and the Chicago Lying In Hospital. He also did post graduate work at the Radium Chemical Company in Pittsburgh, Pennsylvania.

Dr. Procter became the first practitioner of OB & GYN in Raleigh and in the state of North Carolina. He helped established the first modern obstetrical unit in Mary Elizabeth Hospital where students from Wake Forest Medical School got some of their training. Dr. Procter was the first diplomat of the American Board of OB & GYN in the state. He then organized and was the first President of the North Carolina OB & GYN Society.

Subsequently Dr. Adlai Oliver Sr. and Dr. Robert Ruark helped develop a department of OB & GYN at Rex Hospital. Dr. Robert Ruark was soon called to service, as were many other practitioners in Raleigh. At that time Dr. Annie Louise Wilkerson had finished her internship at Rex Hospital and was accepted for residency at New York Lying In Hospital. However since so many physicians had to go into service, community pressure prevailed and she stayed in Raleigh to practice OB & GYN.

After the war, Dr Ruark returned to Raleigh along with Guy Branneman and Percy McElarth. Later, three sons of Dr. Adlai Oliver Sr. joined him: Dr. Adlai Jr., Dr. Richard Oliver and Dr. James Oliver. Two generalists Dr. Clyde and Titus Ward had encouraged their nephew Dr. Clifford Byrum to join the staff at the Rex Hospital. These doctors also maintained clinics at Rex and because of segregation, St. Agnes Hospital.

In 1962, St. Agnes was closed when Wake County Medical Center was opened. These same physicians developed a strong department at Wake Medical Center. Now residents from North Carolina University rotate through as part of their training.

As the department at Rex and Wake Med became stronger and more respected the general practitioners began to phase out their OB & GYN so as to devote more time to their general medical practice.

Thus we see what an important part Raleigh and Wake county has played in the development of OB & GYN in the state of North Carolina.

A History of Radiology

By: Albert M. Jenkins, MD, FACR

When the WCMS was formed, Radiology was in its infancy. X-ray and radium had just been discovered in 1895, less than ten years earlier. However the potential of use of radiant energy in diagnosis and treatment had rapidly been appreciated and by this time, many hospitals had "X-ray rooms" with designated physicians or technicians in charge. For example, in 1908, the Department of Roentgenology at Massachusetts General Hospital was officially dedicated, and Walter Dodd, M.D, appointed Roentgenologist. "Radiologists" in North Carolina in the early 1900's were probably closely associated with the existing Hospitals.

When I first visited Raleigh in 1952, Dr. Robert Noble was introduced to me as the pioneer Radiologist who had both a private office in Raleigh and a hospital based practice at Mary Elizabeth Hospital. His associate was Dr Robert Williams. At Rex Hospital, Dr. Thomas Worth had been the Radiologist since 1948.

In 1953 I began my practice of Radiology in a small private office in Cameron Village, utilizing both diagnostic and therapeutic Radiology. I also joined the staff of Rex Hospital. Hence when the NCMS celebrated its 50th anniversary, there were just four Radiologists in Raleigh. The nearby Radiology Departments of the Medical Schools of Duke (lead by Dr. Robert Reeves) and UNC (lead by Dr. Ernest Woods) provided a rich source of expertise which enhanced our practices.

With the opening of the Memorial Hospital of Wake County in 1961 (WAKEMED), a new era began resulting in the explosion which still continues to this day in both the number of Radiologists in Wake County, and in the many variety of both diagnostic and therapeutic procedures performed. One of the major factors in this was the stimulus of Dr William H. Sprunt who joined me in serving as Radiologist on the WAKEMED staff. He quickly changed the focus of WAKEMED from that of a "county hospital" to the bustling medical center which now provides many of the newest and most cutting edge techniques. This effect has rapidly caused the expansive growth of Radiology in all of the medical facilities in Wake County, making this county the envy of many regions both in the state and throughout the nation.

Broadcasting In North Carolina
It all started in a hen house!

By Ben Waters

The history of broadcasting in North Carolina is both colorful and interesting. It started in 1920 when three men who had an interest in radio broadcasting met in Charlotte. The three, Frank Bunker, Fred Laxton and Earl Gluck decided to pool their equipment and build a radio station.

Gluck received his wireless operator's license and amateur wireless station license in 1914. Bunker was an engineer with Westinghouse and Laxton was a contractor, once associated with General Electric. Through Laxton's connections with GE, the three men obtained some vacuum tubes and built a "ham" radio station through which they could talk to other hams instead of just telegraphing.

The transmitter of North Carolina's first station was built inside an abandoned chicken house across the street from Laxton's home in Charlotte. It took much time and effort to get the transmitter to work correctly. One of the three men was required to be inside Laxton's home and talk into a microphone while testing proceeded. That job initially fell to Gluck. But because he wanted to be involved with testing the transmitter, he came up with the idea of playing a phonograph record with the microphone in front of it. Thus, in a way, Gluck became the first radio disk jockey.

The three men applied for an experimental license in March of 1921. It was granted by the U. S. Department of Commerce, which at the time regulated radio communication. The call letters of the first station were "4XD."

Playing phonograph records over 4XD soon started generating phone calls from people who had built their own receivers. The owners decided to go into the business of selling radio equipment used to construct receivers. At the time there were no receivers being built commercially.

With 4XD now operating as a business, the owners applied for a license as a commercial radio station. The Department of Commerce granted the license on April 10, 1922 and assigned the call letters WBT, which continues to broadcast in Charlotte to this day.

By 1934, only eight radio stations were on the air in North Carolina. Between 1934 and 1941, fifteen additional stations signed on the air. By 1947, over 40 radio stations were broadcasting in the state.

During World War II, radio developed beyond dispensing entertainment and information. For example, President Franklin D. Roosevelt used radio for his fireside chats to American citizens. Band leader Kay Kyser used the medium to urge the purchase of war bonds. The stations used their airwaves to explain such things as rationing and to support local groups dedicated to war service. And the stations provided detailed coverage of the war.

After the war, the growth of broadcasting exploded in North Carolina. FM radio was introduced in the 40's. The national increase for FM radio from 1946 to 1948 was 1,176 percent, compared to North Carolina's FM increase of 4,600 percent. AM radio increased by 122 percent.

Television station WBTV became the first television station in the Carolinas, signing on the air on July 15, 1949. By the end of 1954, seven TV stations were on the air, including WRAL-TV in Raleigh.

Today, there are 57 television stations in North Carolina and 421 radio stations. They use their airwaves to keep us entertained and to keep us informed with news, sports, weather and special programming.

According to Ardie Gregory, President of the North Carolina Association of Broadcasters, "The radio and television broadcasters in this state are a group of dedicated men and women who embrace their communities. They have set the highest standards of broadcast service and strive each day to meet and exceed those standards". Gregory is vice president and general manager of WRAL-FM in Raleigh.

Information for this article was provided by the North Carolina Association of Broadcasters in its publication "A 50th Anniversary Look at the Past." . It contains much historical information from a 1962 publication *The Development of Broadcasting in North Carolina, 1922 – 1948,* by UNC professor Dr. Wesley H. Wallace.

The article was compiled by Ben Waters, a veteran of 49 years in broadcasting. He retired from Capitol Broadcasting Company in Raleigh at the end of 2003.

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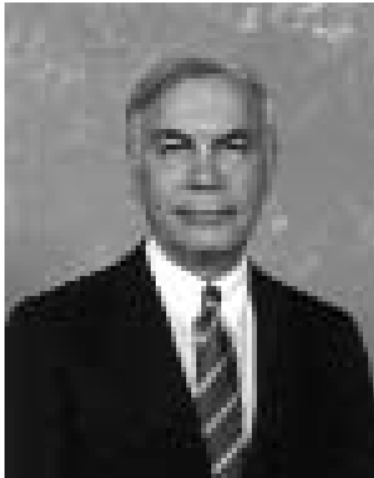
Physician Profile



Dr. Assad Meymandi

By Christy Farrelly

For ten years the Wake County Physicians Magazine has been profiling medical professionals who go beyond the simple practice of being a physician by making a difference in the way we view medicine, live life and contribute to our communities. On this special occasion, it is such a pleasure to honor a physician who is not only the architect of this magazine, but has been and continues to be a profound inspiration on so many levels for our community, Dr. Assad Meymandi.

The Meymandi lineage actually originates in a small city over 12,000 years old, aptly named Meymand. Commonly known as the "City of Roses," it is carved in the rocks of Iran, has lush gardens and conveys the balanced existence between man and his environment. The Meymandi ancestors eventually made their home in the historic city of Kerman in southeast Iran.

Dr. Assad Meymandi was born to a family rich in heritage and ancestry in the antiquity of Kerman, surrounded by ancient architecture and historic monuments. Here, enveloped in the richness of heritage and culture, his family instilled in him the importance of education, art, honesty and family. The youngest of nine children, it was clear to his family that he possessed special skills and talents and an elevated degree of integrity. As his brother, Javad, puts it so graciously, it is as if "all of the chromosomes of generations came together perfectly in him."

On one occasion, his father, an ardent poet, philanthropist and philosopher, returned home to find that a very precious and significant black box had been broken into pieces. Calling all of the children together, he asked what had happened to one of his most treasured possessions. The youngest of all stepped forward and revealed that he had broken the box. When his father asked him why he would do such a thing to something so dear, he simply responded, "I wanted to see how strong I am."

Dr. Meymandi always showed an exceptional talent for learning and comprehension. With no formal training, he would join in foreign language conversation as if he had studied in the native country. On any given subject of interest, he would be given books of study and completely immerse himself until he understood it to the core. Under the guidance of his mother, a devoted patron of the arts, his father and his siblings, Dr. Meymandi enjoyed a life rich in art, philosophy and scholarship and seemed to have an innate understanding of their interconnectivity.

His father passed away when he was seven and, with the strength, influence and mentorship of his mother and family, he persevered in his life path. His regimented education coupled with self-discipline allowed him to fully explore his uncommon talent for learning history, language and the arts. He went to a prestigious Jesuit school in Tehran. Graduating top of his class and with the highest marks in all of Iran, he continued a family tradition and attended the Sorbonne in France at the age of 16. Here, he again graduated top of his class and discovered his aptitude for the sciences, which turned him to the study of medicine. He opted to travel to the United States of America to fulfill his medical education.

Flying to New York City, not speaking a word of English and with no experienced knowledge of the culture, he chose to fully immerse himself traveling by bus from NYC to Logan Utah to meet his older brother, Javad. He memorized the English Dictionary and studied relentlessly to learn the language, history and culture. Upon expressing interest in medicine, he was met with some cautionary opposition. Some friends expressed their belief that medicine was an extremely challenging field and presented several reasons why it would be such an arduous task, especially for someone who just arrived in the USA. He met their arguments with one simple phrase, 'I will do it with determination.' And so began his journey in the medical profession.

Dr. Assad Meymandi attended undergraduate school at Arizona State University. Prior to his graduation, he was accepted into medical school. He chose to attend George Washington University and, as with all of his formal education, he graduated at the top of his class in 1962. He proved to be a talented surgeon, but found that specialty lacking in human connection. Instead, he discovered the field of psychiatry during a rotation at St. Elizabeth's Hospital in Washington DC. For him, this was the field that would combine all of his knowledge and talents. "Psychiatry is the only medical specialty that offers a person to be a doctor, scientist, humanist, theologian, artist and art lover."

His decision to continue his residency at Dorthea Dix

Hospital was the beginning of his great love affair with Raleigh and North Carolina. Staying for the full three-year program, he completed rotations in adult, pediatric and child psychiatry. At that time, there were some real visionaries in the field, particularly in North Carolina. Some key state and federal legislation developments made the next decade a honeymoon for mental health. Dr. Assad Meymandi saw a need in Cumberland County, Fayetteville in particular, and became very interested in the development of a comprehensive mental health program and soon became medical and area director for the Cumberland County Mental Health Center. Making great strides in the health of this community, he served as Chairman of the Cumberland County Mental Health Board, Chief of Staff at the Cape Fear Valley Medical Center and continued his private practice in Psychiatry and Neurology.

Returning to Raleigh in 1993, Dr. Meymandi continued his private practice. Because of his love and passion for psychiatry and patients, he will see patients as long as he is able. His book, Community Psychiatry, was published in 1997 and he continues to contribute editorials, articles and opinion pieces for lay and professional journals. He has served on the editorial board for the NC Medical Journal and is currently a member of the editorial board for The Disability Analyst and The American Journal of Forensic Medicine. Dr. Meymandi is a Life Fellow of the American Psychiatric Association, a Life Member of the AMA, Life Member of the Southern Medical Association and a Founding Fellow of the International Academy for Research in Learning & Disabilities.

His contributions to this community are far-reaching. Dr. Meymandi has laid a foundation of growth, not only to nurture the mental health of individuals, but our community as a whole. He has played an instrumental role in the development of artistic, scholastic and philanthropic organizations. Serving on the board for the NC Arts Council since 2001 and having recently been re-appointed for a second term, he has helped the organization with their work in Western European arts - from symphonic music and opera to ballet and modern dance. He has served on the Board of Trustees for the National Center for the Humanities for five years and been a long-time attendee of lectures and seminars. The recent endowment of the Meymandi Fellowship invites distinguished visitors for a short-term to further enhance the dialogue and connectivity of the humanities, science and arts. Equally supported by Dr. Meymandi and his family is the North Carolina Symphony and their most recent permanent home - Meymandi Hall, named in honor of his mother who passed away in 1994 at the age of 101. Currently, he serves as President of the NCSU Friends of the Library. In addition, he has established and supported scholarship and philanthropy programs, elementary and middle school music summer camps and taught post-graduate and Adult Education courses on Neuroendoctrinology of Salvation, Biochemistry of Behaviour and Happiness. His most recent and grand interest lies in the making of a Raleigh city-park from the Dorthea Dix campus.

He has been honored with numerous awards, including being named an Honorary Woman, and continues to explore and assist in building paths of productive living here and in his native country. He has built a library and an elementary school named for his mother, who was such a great and profound inspiration in his love of literature, arts and music, in Iran. When Bam, an Iranian city lying 200 miles southeast of Kerman, was devastated by a powerful earthquake in December 2000, he proudly assisted in the rebuilding process.

Dr. Meymandi's aptitude and thirst for knowledge has not waned since his youth and his uniqueness lies in the quality of his reception to the environment. As his ancestors lived in harmony with the rock 'city of roses,' so Dr. Meymandi has found that balance. He puts forward his personal experiences and knowledge and is uncommonly sensitive to the teachings of his surroundings. That is not to say that he does not play a role in defining his surroundings. He hears and feels every breath and seeks to fill the air with knowledge, reason and purpose.

Dr. Meymandi is forever trying to see how strong he is, how much more he can learn, and how much more he can share. He continues to bring incredible foresight in his contributions to our community and is forever an inspiration to members of his family. The brother and sisters who were once his mentors now cherish his guidance and analysis. In all of his endeavors and relationships, he takes a great deal of personal interest and is outwardly supportive of organizations, staff and family.

Dr. Meymandi has three children Eric, Chris and Spencer with his wife, Pat, who has sadly passed away in 1990 and for whom the Patricia S. Meymandi Scholarship at Fayetteville Technical College is named. He has five grandchildren.

His involvement and strong commitment to family, ancestry and what it means in ones development and direction is shared with his current wife, Emily. She is his constant companion sharing in his love of living and learning and considers herself to be "the luckiest woman in the world." Her presence in his life propels his already optimistic view and improves his goodness. She has seen him conquer colon cancer with his optimism and unbeatable spirit and feels blessed to be able to share life with someone who truly enjoys living.

Dr. Assad Meymandi has left an indelible mark on this community. Giving us the tools and resources to achieve our own level of self-attainment through the arts, humanities and sciences, and in doing so realizing their interconnectivity in our lives and communities.

Issues on Care at the End of Life

By Edward B. Yellig, MD, FACP
Medical Director
Hospice of Wake County

Hospital Palliative Care

The care for hospital patients near the end of life is about to change…for the better. Many hospitals in America are exploring the development of palliative care services for their patients; 25% or more hospitals already have them in place. According to US News and World Report, one of the newest criteria for hospitals of excellence is to have palliative care services available to assist patients and families with terminal illnesses. Importantly, Wake area hospitals are also in different stages of developing hospital palliative care services. This is a brief and timely review of palliative care and what it means to patients, to physicians and to hospitals.

The World Health Organization defines Palliative Care as the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is the achievement of the best possible quality of life for patients and their families. To palliate means to relieve or lessen without curing.

Patients do not have to be imminently dying to receive palliative care. In fact, the principles of palliative care can and should be applied anytime following the diagnosis of a terminal illness, including those with a long chronic phase punctuated by exacerbations and reversible emergencies. Emphysema, congestive heart failure, and dementia are examples of such diseases. Palliative care emphasizes aggressive symptom management so that patients can function optimally, psychological support for the changes that they will experience, social support for the family as they adjust to the burdens of coping with the care of their loved one, and spiritual support for both patient and family. These elements of palliative care can be provided both in hospital and outpatient settings through appropriate referrals.

Why is palliative care such a big issue now? There is a rapidly growing population of aging Americans with the earliest baby boomers due to hit retirement age within the next four years. Chronic diseases now cause the majority of adult deaths: heart disease, stroke, COPD, cancer, and various neurodegenerative diseases including the dementias. The terminal phase of illness can be fairly clear as in cancer, or vague with a slow functional decline or even unrecognizable in some of the neurodegenerative diseases. Throughout the burgeoning hospice movement, there has been a groundswell of interest in high quality end of life care, both within the general population as well as among health professionals. Advance directives: the living will and the health care power of attorney, are receiving more attention in an effort to make them more practical and useful in the present circumstances of the dying process. Lastly, there has been a flood of information about the current inadequate or inappropriate care of patients whose lives hang by a thread in hospital emergency rooms and the intensive care units where high tech aggressive curative care is being employed when comfort care is more appropriate and a peaceful death preferable.

Why aren't we getting what we want? When asked about where they would like to spend their last days and die, most Americans would prefer to die at home, surrounded by a familiar environment, family and friends. However, the majority of North Carolinians will die in an institution and only ~20% with the presence and support of a hospice organization. In 2001, 54% died in a hospital and 22% in a nursing home. So, evidently there are some barriers that stand between what we want and what we are getting.

When faced with the prospect of dying, it is natural to begin the process of accommodating death with the question, "Isn't there something else that can be done?" Doctors, who are also reluctant to talk about and deal with death, will frequently respond with suggestions of new medical therapies so that "we can fight the good fight against illness and death," often at great cost measured not only in dollars, but also in physical suffering and emotional trauma. Death is considered "the enemy," and there may be a sense of failure if the patient is not saved. Doctors may have their own personal fears, worries, and a lack of confidence or competence in discussing end of life issues and thus avoid these important conversations with patients and families. There's always the discomfort of communicating "bad" news and a poor prognosis, but failure to communicate accurate information about the circumstances can lead to a misunderstanding about the status of the current illness and inadequate or poor planning for the issues surrounding the end of life. Lacking the skills for negotiating goals of care and treatment priorities can result in futile or non-beneficial therapy or lead to the rush to DNR requests. Medical schools and residency training programs as a rule provide minimal attention to the education of young physicians about terminal illness and their care. Lastly, until recently there has been a lack of acknowledgment of the importance of palliative care; consequently, it is introduced too late in the disease trajectory to be of maximum benefit. As Eric Cassell so eloquently stated in an article and book by the same title, The Nature of Suffering, "The relief of suffering and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick. Physicians' failure to understand the nature of suffering can result in medical intervention that (though technically adequate) not only fails to relieve suffering but becomes a source of suffering itself."

What can patients, physicians, and hospitals expect when a successful palliative care program is instituted in their local hospital? First of all, palliative care affirms life and regards dying as a natural process that is a profoundly personal experience for the individual and family. It neither intentionally hastens nor postpones death. Palliative care is patient and family centered, not disease focused, is death accepting, but also life enhancing. It is a holistic philosophy of care, tending to the physical, psychological, social, and spiritual aspects of the illness and of dying. In hospitals where palliative care services have been established, a kinder, gentler, more open culture of caring for all patients has followed, but particularly for those patients with life-threatening illnesses. Patients, families, physicians and other

hospital personnel have expressed greater satisfaction in the care of terminally ill patients. Patients and families have a greater sense of control over their circumstances and the decisions that affect them. Poignant, intimate conversations are encouraged to elicit patient and family values regarding personal goals and end of life decisions. Thus there are fewer intrusive diagnostic and therapeutic interventions as the focus of care is now on quality rather than quantity of life. With the increase of patient and family satisfaction, hospitals find their reputation for quality care increases, and that's not all they can expect. Because there are fewer expensive tests and treatments being offered and used and because there are fewer days spent in high cost areas of care such as intensive care units, the cost for those patients receiving palliative care will be lower, thus improving the hospital's bottom line. Palliative care also improves continuity between settings and increases hospice/homecare/nursing home referral by supporting appropriate transition management.

For hospital clinicians, palliative care is a key tool to:

Save time by helping to handle repeated, intensive patient-family communications, coordination of care across settings, and comprehensive discharge planning

Provide bedside management of pain and distress of highly complex and symptomatic cases, thus supporting the treatment plan of the primary physician

Promote patient and family satisfaction with the clinician's quality of care and with reduction in patient suffering.

What can be expected from a palliative care consultation? First of all, a palliative care consultation is a team effort. Team members might include a physician, nurse case manager, social worker, and chaplain. As a team, they will provide:
- Assessment and management of physical symptoms
- Assistance to patients in identifying personal goals
- Assessment and management of psychological and spiritual needs
- Assessment of the patient support system
- Assessment and communication of estimated survival time
- Assessment of discharge planning issues

Though dying patients are faced with many challenges, they also have the opportunity to grow in areas that they may never have thought possible. They can renew a sense of personhood and meaning through life review and reminiscence, bring closure to personal and community relationships, bring closure to fiscal, legal, and social affairs, and lastly, accept the finality of life, surrendering to the transcendent.

In the end, palliative care is about healing.
"The aim of healing is not to be cured.
The aim of healing is not to survive.
The aim of healing is to become whole." (Robert Twycross)

Thinking Things Through continued from page 7

They took the separation of powers: legislative, executive and judicial, from Montesquieu. John Locke had said only that they are often separated. They understood that it was imperative to create a sound legislature. To do so they were drawing on experience in their own states and in England, all of which reflected the Lockean model of the Natural Law as the basis for men's freedom. However, the question of unicameral or bicameral legislatures Locke left to others.

The large states favored the Virginia Plan of representation. Edmund Randolph, leader of Virginia's delegation, got to the heart of that Plan when he proposed a national government consisting of a supreme legislative, executive and judicial branches. It was to have a House of Representatives elected by the people, and it would elect a Senate. There was stunned silence. Did the convention propose to overthrow state governments?

Madison observed that a federal government operates on states, while a national one operates on individuals. James Wilson pointed out that if the operation was on states, then a state of 10,000 people would have the same power as one of 40,000. How could the states, which were creating the national government and the people of the nation at large both be represented fairly?

New Jersey presented a plan for equal representation of states in a unicameral legislature, and the convention deadlocked over it *versus* the Virginia Plan. Connecticut then advanced Oliver Ellsworth's "Great Compromise,: under which states would have an equal voice in the Senate, while proportionality was retained in the House of Representatives. The compromise was adopted and the crisis averted.

Many Americans think that the Convention established a "democracy," but the government being set up did not provide for direct decisions by the people *a la* town hall, but rather for election of representatives. They also established the Electoral College, awarding electoral votes to states, rather than choosing presidents by direct national election.

They were unable to deal with slavery, because they could not outlaw it and keep all of the states in the union. A terrible civil war two generations later resolved it, with president Lincoln enlisting Jefferson's Declaration in support of his position.

They provided for a national government of specifically enumerated powers. Congress could regulate commerce to keep states from setting up trade barriers between each other. It could tax and spend for the administration of the three branches of government and for about thirty specific functions enumerated in Article I, Section 8, such as navigation acts, collection of taxes and imposts, post offices, post roads and judicial tribunals. They carved out very limited functions for the national government and reserved all the rest of the rights and responsibilities for the people and the states. They specified that changes could be made only by constitutional amendment.

The final draft began "We the people of the United States . . . " which upset Patrick Henry and others who thought the union should be of states. There was no Bill of Rights in the final draft, because the Framers believed that liberty was firmly in place. Alexander Hamilton asked: "Why declare that things shall not be done which there is no power (in Congress) to do?" So, on September 17, 1787 they adopted the new Constitution without a bill of rights and sent it to Congress, which recommended ratification, and most of the states ratified without a bill of rights. When New Hampshire became the ninth state to ratify, the new government came into existence

Many people were still fearful of the powers of the new government and were against ratification, so when Edmund Randolph of Virginia came out in favor of a bill of rights one was drawn up by Congress and ratified by the states. North Carolina had refused to ratify until there was a bill of rights, and when there was one it joined the union in 1789, ratifying at its convention in Fayetteville, the twelfth state to do so. The legislative session held there at the same time chartered the University of North Carolina. It was an auspicious year for Tar Heels.

George Stephens is author of Locke, Jefferson and the Justices: Foundations and Failures of the US Government, Algora Publishing, New York, 2002.

By Jeffrey Engel, MD
NC State Epidemiologist

Influenza Vaccine Shortage and Enterohemorrhagic E. coli Outbreak

The fall of 2004 witnessed two major public health emergencies of very different origins. One was a crisis in a cornerstone of preventive medicine, vaccine supply; and the other was a zoonotic communicable disease outbreak.

Influenza has been grabbing the headlines recently with the events of widespread avian influenza in Southeast Asia and a moderately severe type A human influenza seasonal epidemic during the last winter of 2003-2004. The former has sparked concerns about the possibility of a new pandemic flu strain emerging from birds (type A H5N1). An avian type A H5 recombination (shift) with a human type A strain could result in a new virus capable of causing severe morbidity and mortality with efficient and sustained person-to-person transmission.

Last year's seasonal flu epidemic was notable for its early onset in late November 2003, the large number of infections, and reports of increased pediatric influenza deaths. Further, there was a discrepancy in last year's trivalent flu vaccine that contained type A/H3N2/ Panama when the drift variant A/H3N2/Fujian was the major circulating virus.

These events in addition to the new vaccine recommendation (the national Advisory Committee of Immunization Practices added children between the ages of 6 months and 2 years), the United States ordered over 100 million doses of the flu vaccine for the 2004-2005 influenza season. As it has in previous years, the federal government contracted with two companies, Aventis-Pasteur and Chiron to supply the US market with 50 million doses each.

The vulnerability of the US vaccine supply chain was starkly revealed when it was announced on October 5, 2004 that the entire vaccine supply from Chiron would not be shipped to the US because of bacterial contamination.

Supply and distribution of the annual influenza vaccine is a complex process. The components of the trivalent vaccine vary year-to-year depending upon the prevalent influenza strains detected by international laboratory surveillance. A decision is made in January on which viral strains (two type A and one type B) will make up the vaccine. Seed viral stocks are then created and disseminated to pharmaceutical manufacturers for production. The flu vaccine is scaled up by growing stocks on chicken egg embryos followed by inactivation and purification of the major antigenic components: the H and N proteins. The process from identification of the viral strains to delivery of the final product takes 10 months with people receiving vaccine by mid to late October.

Distribution of the vaccine supply occurs through both public and private channels. A private provider orders directly from the manufacturer or a regional distributor, whereas the public supply is handled via government agencies to local health departments. A local health department can order a supplemental vaccine supply privately if local funding allows and if there is a desire to provide vaccination to a more widespread constituency. Public and private providers (health departments, hospital, clinic, retail pharmacy, etc.) who ordered from the Chiron supply chain were simply told that they would not receive vaccine.

In response, the federal government intervened. The Centers for Disease Control and Prevention (CDC) led the effort by issuing strict rationing guidelines on who should receive the 2004-2005 flu shot. They also negotiated with Aventis-Pasteur to redistribute their unshipped supply (around 20 million doses) to the public distribution chain. State and local health departments became responsible for rationing and administering the remaining vaccine to the high risk groups as the private sector was largely forced to abdicate this role.

CDC 2004-2005 Flu Vaccine Indications

- **Persons >65 years of age**
- **Residents of extended care facilities of any age**
- **Adults and children with chronic cardio-respiratory illnesses**
- **Adults and children with chronic metabolic disorders, immune deficiencies, or immunosuppression**
- **Children (6 mo-18 yr) receiving aspirin (risk for Reye syndrome)**
- **Out-of-home caregivers and household contacts of children <6 mo**
- **Women who will be pregnant during influenza season**
- **Children aged 6-23 months**
- **Healthcare providers who provide direct patient care**

Clearly changes are needed. Biomedically, research is needed to find a way to shorten the production pipeline of influenza vaccine. The technology needs to shift from the egg embryo (which lengthens the process and is prone to contamination) to modern tissue culture techniques. Finally, pharmaceutical companies need more incentive to enter the vaccine marketplace. Having only two suppliers of the inactivated flu vaccine is a vulnerability that society cannot afford.

On the heels of the flu vaccine crisis, in late October, the Division of Public Health began receiving increased lab reports of *E. coli* O157:H7. On October 30, three children were admitted to Wake Med with either severe bloody diarrhea or the hemolytic uremic syndrome (HUS). Initial interviews with the cases or their families suggested that animal contact at the State Fair was the common link.

Continued on page 17.

By Nicholas E Stratas, MD, DLFAPA and
Clarence L Boyd, Jr., MSW, LCSW

A VOLUNTEER COMMUNITY MENTAL HEALTH EXPERIENCE: LINKING MORAL RESPONSIBILITY WITH CLINICAL SERVICE

Rationale: Psychotherapy for the low or no income population is largely unavailable. Clinicians have a moral and fiduciary responsibility, not only to the individual and/or family but also to the general population, to give back, having received a unique and specialized education largely provided by the community at large. The Community Mental Health Clinic in Raleigh, North Carolina, has been in operation over five years, and is based on clinical and moral principles. Our hypothesis was that a quality clinic of volunteer staff offering uncompromised psychotherapy to motivated people who cannot afford existing resources could be implemented in an environment free of monetary considerations and constraints.

Program development: We accepted an invitation to use classroom space at the Edenton Street United Methodist Church, which is conveniently and centrally located and is a sponsor of many community service projects. The clinic is open every Thursday afternoon and evening. We contacted clinicians and started with word-of-mouth publicity. All staff at the clinic are volunteers. One of the authors (CB) who was the Clinic's first Coordinator provided telephone screening contact now provided by our current coordinator Doctor Margaret Barham, informing the caller of clinic functions and ground rules. Services are free and only for those who are unable to pay and lack Medicare, Medicaid, or insurance. Treatment is provided by a therapist-psychiatrist team and is based upon an initial evaluation. Patients are expected to keep appointments, and be active and committed. Treatment is goal oriented and time limited. Medications are only prescribed with active psychotherapy. The clinic cannot respond to crises, and does not accept persons who are actively abusing substances, psychotic, suicidal, or homicidal, although a number have such a past history. A volunteer board evolved from an initial steering committee, meeting quarterly and including a member of the National Association for the Mentally Ill, two clergy, an attorney, a representative from the church board, one from the free medical clinic, a community advocate, the clinic coordinator and the medical director.

Results: During the first 9 years close to 1000 patients have been seen. For many others we serve a triage function, referring people elsewhere because of such problems as active psychosis, desire for medication or evaluation only, lack of motivation, availability of insurance coverage, or active substance abuse. Referrals come from throughout the community, including the local private psychiatric hospital, vocational rehabilitation programs, employee assistance programs, private and public psychiatrists, school counselors, and patient word of mouth. Presenting problems include losses, relationship conflicts, disruptive behavior, anger, anxiety, depression, joblessness and/or inability to work, poor energy, sleep disturbances, and traumatic memories. Diagnostic categories included mood, anxiety, adjustment, post-traumatic stress, and personality disorders, frequently comorbid with one another. Some patients had a prior history of psychosis, substance abuse and/or suicide attempts. At any one time 30 to 35 active patients are in therapy. Patients receive quality, timely services, approximately 90% with medication, primarily antidepressants and mood stabilizers.

Volunteers currently include 4 administrative staff, 7 psychiatrists and 14 therapists contributing 20 to 30 hours for 16 to 22 individuals, couples and/or families each Thursday. In most cases we can achieve the goal of helping patients become more self-sufficient through the attainment of employment, benefits, or insurance. We are then able to link them to other community resources in the private or public system.

Obstacles: Supports and links at first included the "Urban Ministries of Raleigh," which runs a free medical clinic. Initially, we had access to its pharmacy while preserving our self-determination. When this pharmacy service was withdrawn, our first crisis, we contracted with a downtown pharmacy to dispense samples or provide medications at Medicaid prices by drawing on unsolicited donations. This worked for two years until the State Pharmacy Board forbade dispensing of samples by retail pharmacies. This was our second crisis and the only time that money became a barrier to some of our services. By obtaining samples for the clinic, using pharmaceutical company patient assistance programs, and undertaking limited fundraising, we were able to obtain the needed medications. In January, 2001, Urban Ministries announced they were discontinuing the organizational connection after our rejection of their plan to integrate our clinic into the medical clinic and assume administrative and hiring responsibility, which, we believed, would jeopardize the primary psychotherapeutic purpose. Our Board expanded and restructured as an autonomous, not-for-profit clinic still operating at the church with sanction and approval of its board which has been most supportive and a true partner.

We are reevaluating and planning for the future.The original conceptualization is sound and will be continued. Issues being explored include staff recruitment, future leadership, expansion, development as a training site for psychiatry and social work, and any necessary fundraising.

Dr. Stratas was co-founder and is the Medical Director and staff psychiatrist.
Mr. Boyd was co-founder and Clinic Coordinator and continues as clinic staff member.
Both have a private practice at Raleigh Psychiatric Associates, 3900 Browning Place, Raleigh, NC, 27609. (stratas1@mindspring.com)

Mary Cassatt, An American Treasure

By Emily Barrineau Meymandi, MA

This year the U.S. Post Office issued first class stamps depicting four paintings of Mary Cassatt.

Mary Cassatt is an artist of subtle and profound surprises. Known as a painter of mothers and children she addressed her subjects with unsentimental but sympathetic clarity. Born in 1844, she was raised in a well-to-do family of French and Scottish ancestry. While her family was fairly conventional, Mary became a genteel rebel, traveling and living alone, partaking of the Bohemian life in Paris while developing a magnificent eye. She was the only American to exhibit with the Impressionists in Paris.

She was an independent artist at a time when no "respectable" woman considered that a possibility; a strong-willed, tough-cored businesswoman and influential tastemaker and an expatriate who always remained identified as an American.

As a little girl Mary was independent and demanding. Her temper was quick and she screamed, cried and kicked until she got her way, to the annoyance of her three brothers and sister.

Her mother was an educated, intelligent and outgoing woman with opinions on politics and current events. She had traveled abroad and spoke and read French. Mary was in awe of her father, a business investor who could take control of any situation.

Before she was ten, Mary had seen many of the capitals of Europe, including London, Paris and Berlin. In 1851 the Cassatts moved to France where they were to live for nearly two years. The children attended French schools and were taken to the Louvre and other museums and galleries.

In 1853 the family moved to Germany. Mary's brother, Robbie, was suffering from a mysterious bone disease, and they hoped to consult several renowned German doctors. However, the doctors were unable to help and he died. Mary was eleven years old and Robbie -just two years older- had been her closest companion. A few months later the Cassatts went back to America.

At 16, Mary was accepted at the Pennsylvania Academy of Fine Arts in Philadelphia. At the end of the Civil War in 1865, she went to Paris, accompanied by her mother, to travel and study in Europe. Despite the concerns of her parents and protestations of her father, who had hoped she would marry a wealthy young man and have a family, Mary chose to become a professional artist.

Serious painting was largely the domain of men in the 19th century. The Ecole des Beaux Arts, France's most important art academy, did not accept women. However, she was accepted by a popular painting master in Paris. Two years later she and a friend from the Pennsylvania Academy stayed and painted in the artist's colonies in the villages of France. They painted peasants and everyday village life.

In 1868 Mary's first real encouragement was having a painting accepted in the Paris Salon, an annual art competition sponsored by the French government, which all of Paris toured and discussed.

After 5 years abroad Mary's family begged her to come home and she reluctantly returned to Philadelphia. She continued painting and took her work to dealers in Philadelphia, Boston and New York, but it did not sell.

An opportunity to return to Europe was offered by a Catholic Bishop in Pittsburgh. He wanted copies of two paintings by Correggio in a church in Parma, Italy for his cathedral and offered to pay Mary to travel to Italy to make copies. Without hesitation the twenty seven year old aspiring artist packed her trunk and said goodbyes. In Parma she studied Correggio's dramatic techniques to make his viewers feel sadness or religious exaltation.

From Italy Mary traveled in Spain where she studied great Spanish painters before settling permanently in Paris in 1874. The paintings she produced in this period combined the skill of the old masters with the adventuresome subject matter of the moderns.

While walking past a Paris gallery window one day, she saw a bold pastel of ballet dancers by Edgar Degas. She later described this exposure to the revolution of Impressionism: "I saw art as I wanted to see it. I began to live."

That same year Degas saw her entry in the French Academy Salon. He was quite taken with it and after talking with her he invited her to join the Impressionists. The timing was perfect

since Mary was more than ready to cast off the academic conventions of the Salon. She accepted eagerly and became close friends with Degas, as well as Monet, Pissaro, and Morisot. She was the only American whose work would appear in the Impressionist Exhibitions of 1879, 1880, 1881 and 1886.

Mary and Degas' friendship was based on respect for each other's work and critical abilities. Degas was an established master 10 years older than she. They challenged each other's creativity. When Dr. Meymandi was a student at the Sorbonne in Paris, his art history professor, Andre Malreau, who became France's Minister of Culture, told his students that Mary had a child by Degas. I have not seen a reference to this in the literature.

The Independents worked toward a new way of painting that gave their subjects an unposed look, trying to capture a fleeting moment, like a snapshot. Conservative critics disliked their new ideas claiming the paintings looked sloppy and unfinished. One writer said they were "nothing but impressions", giving them a new name: the "Impressionists". They changed people's conception of how to paint and look at paintings.

In 1877, the Cassatts returned to Paris. Mary was very close to her loving sister, Lydia, and used her as a model. Five years later Lydia died of Bright's disease, a kidney ailment. Mary was filled with grief and unable to paint for months. A well known art dealer sold her paintings easily in France. Critics who had once scorned her work now praised it. Once a rebellious outsider, she had become fashionable.

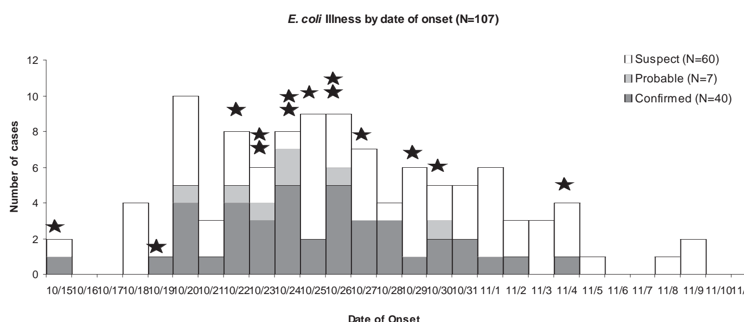
By the 1880's Mary painted women engaged in sewing, reading or drinking tea. They exude a sense of dignity and purpose that challenges conventional notions of decorative femininity. Her tender mothers and children reflected a surprisingly modern sensibility. She recognized a moral strength that women and children derived from their essential bond, a unity she would never tire of representing. The children were always themselves. Nieces, nephews, and friends' children were frequent models.

An innovative and original printmaker, Mary focused on making her own color prints loosely based on aspects of Japanese prints she had seen with Degas in an 1890 exhibition of woodblock prints from Japan. One of her largest and most ambitious works, The Boating Party, was included in a New York gallery opening by her Paris art dealer. The painting looks flat and is made up of simple shapes and colors showing the influence of Japanese prints. American critics did not care for it or any of her other paintings saying they were "somewhat crude" and "unfinished". Few paintings were sold and Mary felt herself a failure. Today The Boating Party is one of the most reproduced paintings in the world.

This was the beginning of a very hard time for her. She grieved over the deaths of her parents and her brothers. She became terribly depressed and suffered a nervous and physical break down. In 1912 she had diabetes and cataracts and lost most of her vision. She became a bitter, disappointed woman. After Degas' death in 1917, Mary felt isolated and alone. However, she continued to work on her biography and a study of her work and traveled extensively. By 1921 she was nearly blind. She died five years later at the chateau outside of Paris which she had bought in 1893. She was eighty two.

In 1993 a major art show featuring her most important paintings and prints attracted huge crowds across Europe. In 1999 The Art Institute of Chicago in collaboration with the Boston Museum of Fine Arts and the Washington National Gallery of Art presented a retrospective, Mary Cassatt: Modern Woman and called it the work of one of the greatest artists this country has produced. This year the U.S. Post Office issued first class stamps depicting four paintings of Mary Cassatt.

Public Health Issues continued from page 14.



By mid-November, over 100 cases from 23 counties (most were from Wake) were under investigation, half of whom were under the age of 5 and two-thirds under age 18. An investigation conducted by the Division of Public Health, the NC Department of Agriculture and Consumer Services, the CDC and the US Department of Agriculture led to the conclusion that contact with animals at a single petting zoo was the cause of the outbreak.

E. coli O157:H7 is a zoonotic infection causing severe gastroenteritis in people. Animals, most often sheep and goats carry the organism but remain asymptomatic. People acquire infection by eating contaminated food or beverages or by direct contact with animals. *E. coli* O157:H7 elicits toxins that cause enteric invasion and hemolysis. Severely infected people may develop HUS or the more severe thrombotic thrombocytopenic purpura (TTP). Children under 5 are at much higher risk for developing HUS.

The epidemiologic investigation compared cases with controls (age-matched people who attended the fair and did not get ill). The most striking finding was the highly statistically significant association of attending one petting zoo with opportunities for direct contact with animals and animal feces. Interestingly, the use of hand hygiene products provided at the fair was not protective. Food, beverage or water consumption at the fair was not associated with illness. Over 90% of culture-positive cases had the same DNA pattern in the *E. coli* isolated. Environmental cultures recovered the same DNA-type *E. coli* at the petting zoo grounds.

New unpublished information on the clinical management of children with suspected *E. coli* O157:H7 infection needed to be rapidly disseminated. This research revealed that children presenting with hemorrhagic colitis and who were treated aggressively with intravenous isotonic crystalloid were much less likely to develop HUS. The NC Pediatric Society was a critical partner in getting this message of "nephro-protection" out to its members.

Using the data from this outbreak and others in the literature, public health and agriculture officials are exploring policies that might prevent outbreaks in the future. If readers of this article have any thoughts, please email them to jeffrey.engel@ncmail.net.

MUSIC THERAPY—WHO CAN BENEFIT?

By Dr. Michelle J. Hairston, MT-BC

Professor and Chair, Music
Education and Music Therapy
East Carolina University

When many people hear the term music therapy, they ask, "What is it?" By definition of the American Music Therapy Association, music therapy is an established health profession in which music is used within a therapeutic relationship to address physical, emotional, cognitive, and social needs of individuals. It should be noted that this definition does not include music in medicine programs. They are separate and distinct from the music therapy profession as they tend to simply add pleasure to the patients' stay in the hospital. Music therapy is a research-based form of treatment provided by qualified, board certified music therapists.

Music Therapy has become more established in medical facilities as a result of research and awareness of the power of music. Music therapists can be found in the neonatal intensive care units (NICU), physical rehabilitation, hospice, labor and delivery, oncology, pediatrics, psychiatric units, as well as a host of other areas. Jayne Standley, PhD, MT-BC, at Florida State University recently had her book published entitled *Music Therapy with Premature Infants-Research and Developmental Interventions.* This book is the synthesis of over 20 years of her research with premature infants and infant learning. Through Dr. Standley's medical meta-analysis research, she found that the average therapeutic effect of music in medical treatment was more than one standard deviation greater than that same treatment without music. Live music provided by a music therapist has been shown to be much more powerful than recorded music because the music therapist is interactive with the patient and immediately adapts to the ongoing, changing needs of the patient. This is what sets the music therapist apart from music volunteers, certified music practitioners, music thanatologists, sound healers, or harp therapists. Benefits of music therapy in the hospital or medical setting include many things. Some of those might be: reducing fear of the unknown, anxiety release during cardiac catheterization, intravenous starts and venipunctures, and relaxation. Frank (1985) did a study on the effects of music therapy and guided visual imagery on chemotherapy. This study showed that music listening reduces the nausea of cancer patients receiving chemotherapy. An innovative technique of music paired with vibrotactile stimulation was shown to increase the awareness of comatose patients, to enhance physical therapy objectives (Skille, Wigram, and Weeks, 1989), or to reduce headaches (McElwain, 1993). Chesky (1992) found that music enhanced with vibrotactile stimulation reduced pain of patients with chronic arthritis.

Neurologist Oliver Sacks and author of "Awakenings" has long been a supporter of music therapy. In the early 90's, Dr. Sacks testified on behalf of music therapy in the U. S. Senate's Special Committee on Aging and the subsequent passage of the Older Americans Act of 1992. Dr Sacks stated, "Music can be a crucially important aspect of therapy. Often people who can no longer use or understand language and cannot achieve conceptual thought can respond to music. I've seen patients who couldn't take a single step but could dance, and patients who could not utter a single syllable but could sing" (Weiss, 1994).

Music is the energizing force that makes music therapy successful. It is non-threatening and allows for success when many other therapies are not able to reach a patient. An elderly patient recovering from a broken hip does not necessarily want to walk immediately after surgery-even though rehabilitation may require it for the success of walking again. Add a music therapist to work with this same patient and it may become more of a positive interaction involving music and gait rehabilitation. Imagine a small child who must undergo tests in preparation for a bone marrow transplant. A music therapist can be present to relieve anxiety and therapeutically use the music to act as an audioanalgesic for pain management. Music therapists can guide and direct patients to successful conclusions because of the intense training they have had which includes assessment and writing goals and objectives based on those assessments.

The Board-Certified Music Therapist has undergone rigorous training in music therapy, music, psychology, biology, social and behavioral sciences, disabilities and general studies. In addition to educational study, trained music therapists have completed an intense, supervised 1040 hour internship to put in to practice the skills and techniques they have learned. Once the education and the internship are completed, music therapists are eligible to sit for a board examination that, if passed, results in certification from an exterior certifying agency. Approved university curriculums are accredited and evaluated on a continuous basis by the American Music Therapy Association and the National Association of Schools of Music. Presently there are 72 universities with music therapy curriculums, many with graduate degree offerings. The main journals for music therapy research are *The Journal of Music Therapy* and *Music Therapy Perspectives.*

So, to answer the initial question, "Who can benefit from music therapy?" The answer is simple. Anyone with a physical or emotional need, whether it is to restore, improve, or maintain his or her health can benefit from music therapy. Specifically, music therapy in the medical setting is even more beneficial to a patient's overall well-being when it is a part of the treatment process.

For more information on Music Therapy or the American Music Therapy Association, you may look on the website at: www.musictherapy.org

Also, you may contact me at hairstonm@mail.ecu.edu or 252-328-4871.

References:

Chesky, K. (1992). The effects of music and music vibration using the MVT on the relief of rheumatoid arthritis pain. *Dissertation Abstracts International,* 9300593.

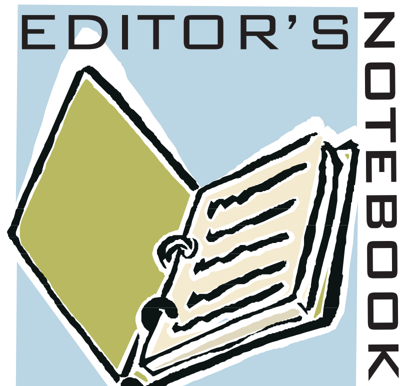
Frank, J. (1985). The effects of music therapy and guided visual imagery on chemotherapy induced nausea and vomiting. *Oncology Nursing Forum,* 12 (5), 47-52.

McElwain, J. (1993). The effect of Somatron and music on headache. In F. J. Bejjani (Ed.), *Current research in arts medicine* (pp. 437-439). Chicago: A Cappella Books.

Skille, O., Wigram, T., & Weeks, L. (1989). Vibroacoustic therapy: The therapeutic effect of low frequency sound on specific physical disorders and disabilities. *Journal of British Music Therapy,* 3(2), 6-10.

Standley, J (2003). *Music therapy with premature infants-Research and developmental interventions.* American Music Therapy Association, Inc.

Weiss, R. (1994). Music therapy. Doctors explore the healing potential of rhythm and song. *The Washington Post*-American Music Therapy Association.



By Assad Meymandi, MD, Ph.D. DLFAPA

We are quietly celebrating our tenth year of publication. No Clairons Sonnants. No Tambours battants! The magazine was born out of realization by the medical leadership that a more effective means of communication and conversation between the members of Wake County Medical Society and the world outside was needed. I believe we have asymptotically approached that goal. Wake County Physician is seen on the racks of several branches of the Wake County Public Library System. We know that the lay public reads it because we get letters from them.

The growth of our circulation has been impressive. The online copy of the magazine is sent to triangle business leaders, legislators in both House and Senate, and to many non-MD leaders of the community. The incoming volume of mail several months ago exceeded 100 letters of which we printed about 20. The magazine enjoys the hard work of a group of bibliophiles, if not bibliomaniacs, who helps with the direction and vision of the magazine. The Editorial Board members were chosen carefully from the darkened, sun thirsty stacks of various libraries in the triangle area. They spend much of their lives in the ambiance of books, reading and intellectual pursuit of absorbing knowledge!... With this issue, we are adding Christy Farrelly and George M. Stephens to the roster of the contributing editors. Christy has been in charge of Physician Profile. George's pieces appear frequently in WCP. He is the author of a volume on John Locke, Thomas Jefferson and the historiography of our nation. The book was reviewed in WCP two years ago.

The magazine enjoys the steadfast commitment and devotion of a group of columnists. They are Ned Yellig, Nick Stratas, Holden Thorp and Jeffrey Engel. In addition, we have the President's Message, Wake County Medical Society CEO Paul Harrison's column, topped by contributions from the Alliance, Access Program's Pam Carpenter and regular reports by the chair of the WCMS Legislative Committee, a job held by the new President Dan Albright.

Future Plans:

The editorial Board has been carefully considering joining forces with the Orange-Durham Medical Society to produce a publication for the entire catchment area of the triangle with three thousand MDs and over five thousand doctoral level subscribers. UNC and Duke are a potential intellectual resource, and financial/advertising and income producing venues.

We are grateful to WakeMed. This special tenth anniversary issue is supported by a grant from WakeMed. We will continue the trend to find other sources of revenue to expand and improve both the quantity (frequency of publication and number of pages) and the quality of WCP.

Several issues ago, I mentioned that we need to revisit the mission statement of the magazine and the language by which the mission is expressed. We have grown beyond the vision of the initial board. However, the focus of the magazine, elevating the intellectual, artistic, and spiritual level of our readers, will remain unchanged.

We would like to hear from you. Write to us, preferably by e-mail, at emeymandi@nc.rr.com

Lunch At UNC

On Friday December 3, '04, UNC Department of Psychiatry at Chapel Hill celebrated endowment of the Dr. Assad Meymandi Distinguished Chair of Psychiatry, UNC Medical School. A huge throng of university leaders, friends and professors, along with Meymandi's family and friends gathered to mark the occasion (see this issue's editorial). It was not only celebration of an academic triumph, but an exercise in transcendence of human spirit.

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(L to R) James Moeser, Chancellor University of North Carolina at Chapel Hill; Dr. William Friday, President Emeritus, UNC System; Dr. Jeffrey Houpt, Emeritus Dean, School of Medicine; Mrs. Friday (Ida); Emily Meymandi (face hidden); Dr. Assad Meymandi

The Night of Yalda

December 21, the Winter Solstice, when the sun is over the tropic of Capricorn, the night is the longest and the day is the shortest. some 3000 years ago, the Persian dubbed the longest night of the year the night of YALDA. In early days when the people's mind was full of superstition, and ignorance was the order of the day, folks were afraid that the sun would never return. To quell their anxieties, the Romans, for example, celebrated Saturnalia, a period between Dec 17 and Jan 1 when sacrifices of goats, sheep and oxen to the gods were made in the hopes for the sun to return. During those 14 days, barbecues, banquets, feasts and gift giving were common place.

Persians were most aware of the celebratory nature of the season. Here is the translation of a poem by Sheik Mosleh-Din Saadi Shirazi (1200-1292, yes, he lived to be 92) about the sacred night of Yalda.

Yalda is the longest night of the year.
It gives more time to contemplate,
It gives more time to worship
It gives more time to be aware of our gifts
the gift of life, the gift of Zekr,
the gift of transcendence to a God like state
the gift of learning
the gift of abandoning selfishness and acquiring selfhood
The night of Yalda gives us more time to love...
and more time to fuse with eternity...

Although Yalda is passed. We still have some long nights left in this winter...

Continued on back cover.

IN MEMORY

Tom Dameron, *the quintessential man of medicine and humanity died on December 11, 2004. He was 80 years old. In his honor and memory, we are reprinting the following Profile of the Month for WCP Vol.1, No.3, May/June issue, 1997. The Editor*

Some years ago, when Tom Dameron had a full head of hair and was president of everything including the North Carolina Medical Society, some upstart reporter from AM NEWS interviewed him about the future of medicine and what strategies the doctors should assume to protect their turf. This was 1985, the year most HMOs , PPOs, IPAs, MSOs and HPOs began to burst forth littering the landscape of medical practice. Tom's interview grabbed national attention because of pervasive angst amongst physicians. Everybody hung on every word of the guru from North Carolina. With his calm , deliberate and thoughtful manner, Tom put a couple of extra vowels in his southern drawl and replied: "Doctors ought to pursue the same strategy-if you insist on using this unpleasant owed-handed down to them by Hippocrates, Galen, Osler and William Harvey: Be advocates of patients at all costs. Treat them with respect and compassion and keep up with advancements of science and technology". Tom also recommended that physicians tithe ten percent of their time to treat the uninsured, under insured and the poor free of charge.

Tom started his practice of Orthopedic Surgery in Raleigh in 1954. He has looked after patients, given his time, his leadership and himself to his profession, his community, state and country. At 73, he continued to give. For all his giving, he has received many honors and awards. Among them, to name a few, The NC Orthopedic Association's Outstanding Service Award (1995); Southern Medical Association's Doctor of The year Award (1996); Clinical Orthopedic Distinguished Service Award, Duke University Medical Alumni Association. This is only a small selection of literally dozens of honors and awards bestowed upon him since the late 1950's. It seems that Tom has been president of everything but the United States of American and has won every prize except the Nobel and Pulitzer Prizes; even though he served on a the award winning Editorial Board of the Southern Medical Journal for many years and was on the founding Editorial Board of American Journal of Shoulder and Elbow Surgery. To some of us, his devotees, it is not too late! Tom has given innumerable hours to charities such as Wake County Muscular Dystrophy, Crippled Children and Cerebral Palsy. His contributions to civic affairs and legislative matters, including the 1994 for reform, are quite, steady and brilliant.

We wondered if the weight of leadership and the "guru" image that gets Tom's face onto the pages of nationwide medical and civic publications are too burdensome. With typical self effacement and a charming smile, he says, "Pay no attention to the hype and keep on doing the best you can . . ." "Besides, you are making too much of all this!", he continues.

With the Book of Genome and vast attribution to genetic causes, one is tempted to wonder where our hero obtained his abundant energy, sense of fair play, altruism and outstanding leadership. Once at Harvard Colloquium, they asked Ralph Waldo Emerson, what is the most important decision he made in his life. "Choosing the right parents," he immediately replied. Like Emerson, Tom chose the right set of parents. His father, Thomas Barker Cameron of Warren County was born to a Methodist minister and raised in a religious home. The senior Dameron attended UNC at Chapel Hill where he played football. He became the Eastern Regional manager for Jefferson Standard Insurance Company. Prevalence of religion and primacy of education are evident in Dameron's clan. His father had four sisters all of whom were educated. Two of his sisters were missionaries in China and Korea. Tom's mother, the beautiful former, Miss. Is a Sills, educated at Women's College of Greensboro, was a no nonsense "perfect" mother. She took care of the family and was active in garden clubs and social activities of Goldsboro where Tom grew up. When Tom was serving in the US Army during the Korean conflict, he has a fantasy of finding the place where his aunt was a Methodist Missionary!

After attending the Citadel, like his father, Dr. Dameron attended UNC and received his MD from Duke University School of Medicine in 1947, with internships at Baylor of Texas and general surgery residency at Grady Memorial Hospital in Atlanta and Orthopedic residency training at Johns Hopkins. In 1946, he met Nancy, a beautiful Duke coed. After several years of courtship, Nancy began teaching and they were married in 1949. This is an example of deferring immediate gratification which Tom urgently recommends to young people. Tom and and Nancy have five children and nine grand children. Speaking of his wife, Nancy, his face bursts into a gentle and wide smile, his eyes aglow with glitter, he pays her the greatest homage; "Nancy has good direction . . like my mother . . " Nancy's contributions to Raleigh as President of the Junior League, President of the Medical Society Auxiliary (now Alliance) and chair of innumerable charity galas are well known.

What else would he advise young people? "Whatever you choose to do in life, you must enjoy doing it. When you enjoy doing something, you will do it well. Also, you must be helpful to others in whatever they do. Giving of yourself is full and enjoyable . . "

Our Profile of the Month is a role model. He lives his convictions through his personal, family and professional conduct. Few people have set such high standards in giving, altruism, and service to their county and fellowman. We celebrate both of you, Nancy and Tom Dameron.

THE WAKE COUNTY PHYSICIAN

The Wake County Physician is a publication for and by the members of the Wake County Medical Society. The Physician publishes four times a year: in February, May, August and late October. We will consider for publication articles relating to medical science, editorials, opinion pieces, letters, personal accounts, photographs and drawings. Prospective authors should feel free to discuss potential articles with the editorial board.

Manuscript Preparation

Submit a cover letter and a 3 ½ inch computer disk that contains the text written in MS-DOS compatible format. Also enclose one hard copy of the text for review purposes. Double space text with one-inch margins and no smaller than point 12 fonts. Articles should be no longer than 500 words.

Submit photographic illustrations as high quality 5 x 7 or 8 x 10 glossy prints, or as black and white glossy prints. Label all illustrations with author's name and number them sequentially according to their position in the text and indicate the orientation of the images.

Authors Bio and Photos

Submit a recent black and white or color photo along with your submission for publication. The photo may be a 3x5 or 5x7 photo. Snapshots are suitable. All photos will be returned to the author. Include a brief bio including your practice name, specialty, special honors and positions on boards, etc. Please limit the length of your bio to 3 or 4 lines.

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The Wake County Physician's motto:
"To nurture the bonds between us."

Mission Statement:
"The Mission of this publication is to educate our community, publicize physician activities, inform and educate our readership and nurture the bonds between Wake County Physicians, allied health care professionals and patients."

Ten Minutes With The President

contributed by George M. Stephens

Mr. President,
You are now free from reelection politics and can think about how you want to be remembered. Summon America and the world to a "New Age of Liberty" encompassing "democracy" abroad and the "ownership society" at home. Liberty is a right of mankind under the Natural Law given by our Creator, proclaimed in our Declaration of Independence and Constitution. The Age of Liberty overspreads both foreign and domestic interests.

However, we must be aware that democracy by itself is not enough, because the majority can oppress minorities, whereas Liberty is secured by enforcement of rights in property, which the Declaration defined as life, liberty and the pursuit of happiness. Many peoples have little Liberty, and even in America guaranteed liberties have been weakened by unconstitutional laws and court misinterpretations. Judged by constitutional standards there is considerable illegal governmental interference in our lives.

The foreign policy tools are cooperation, information, education, technical and financial assistance and free trade. Where terrorists and rogue states threaten Liberty sanctions or force may be necessary.

At home, cut back and try to eliminate federal functions not authorized in the Constitution. Individuals or their associations can provide for social needs at a cost far less than if done by government.

Tax rates should be low, ideally paying for only enough government for defense and to protect property and other civil rights. Low taxes will provide powerful incentives to work and save, which will produce the strongest possible economy.

Enforcement of individual rights in property is important for Liberty and indeed to an American ownership society. Enforce the Bill of Rights, especially the Takings Clause of Article V, which prohibits government from expropriating individuals' rights in their properties. Some think this a rich man's right, but the poor suffer most from regulatory barriers and need unrestricted opportunity to pursue happiness, to make a career, without restriction. Encourage all nations to adopt similar rights.

The justices who will enforce the Constitution are crucial to this restored Liberty, because the Constitution is designed to limit government. Fight for confirmation to the last ditch.

Challenge the world to enter this New Age of Liberty with America as it renews its commitment to its founding principles.

THE WAKE COUNTY MEDICAL SOCIETY
2500 BLUE RIDGE ROAD
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