

A publication by and for the members of the Wake County Medical Society, serving the citizens of Wake County since 1903.



# THE WAKE COUNTY PHYSICIAN

October 2005

Volume 10 No. 4



**George Mason**  
Portrait by Albert Rosenthal

**GEORGE MASON: Little Known Founding Father's Legacy 1725 – 1792**  
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## 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 1/2 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.

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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."**





Dan Albright, MD

## Take Time to...

"Take Time to..." is a theme introduced in a series of letters written by Carolyn Hart, M.D., a neurologist in Charlotte, addressed to a young medical student named "W." I have been so impressed by the wisdom in her published letters that I wanted to present some of her material to other physicians in Wake County.

The titles for Dr. Hart's letters are, in themselves, a guide for personal fulfillment:

- Take Time to Comfort
- Take Time to Use Your Manners
- Take Time to Volunteer
- Take Time to Live Healthily
- Take Time to Continue Learning
- Take Time to Advocate
- Take Time to Relax with Your Family
- Take Time to Notice Beauty
- Take Time to Run Your Business
- Take Time to Be Culturally Competent

If the physicians reading this article do nothing but simply reflect for a few moments on the topics of the letters above, they will benefit in a personal and almost spiritual way. *Take time* to notice the above titles.

### Take Time to...

The first concept in all of the above titles is "Take Time to...". Now there is a good idea...doctors need to take the time or make the time to focus on things that will enrich us as well-rounded, happy people. Through her titles alone, Dr. Hart suggests that busy medical physicians need to take action in order to be fulfilled. Without such action, many doctors are bombarded by medicine's daily urgencies or emergencies, and there is time for little else at the end of the day. We need to purposely carve out space in our cluttered schedules to accomplish some other things that matter.

**Take Time to Live Healthily.** What matters most? I would place a physician's physical (and mental) health near the top of the list. Without your health, what else matters? Despite my predilection for junk food, beer and keeping a few pounds overweight, I at least think about being healthy. It's the thought that counts, right? All joking aside, doctors need to practice what they preach: exercise regularly, keep your weight down, get enough sleep, and eat right. How hard is that? It's hard, I know. Dr. Hart broadens the focus on a physician's personal health: "In order to live healthily, a physician must look after his/her mind, body, and spirit."

**Take Time to Relax with Your Family.** What obvious good ideas...both relaxing and spending time with your family. Most of us want to do those rewarding things, all we have to do is make the time to do so. Add fun to your day. Laugh a little or laugh a lot. The cliché, "your kids grow up fast," hits home with me as I look at my 14 year old son. I only have four years

until he is off to college and then real adulthood. Where does the time go? My thought: I had better seize my time now with my kids because who knows when I'll get that time later in their lives.

**Take Time to Comfort** and encourage your patients, your family, and anyone else in need. Be polite and kind. As Dr. Hart says, "there must be time in your day as a physician to offer comfort [and encouragement] to people....You could be technically the best physician around, but if you don't take time to comfort your patients, your competence may help little." Of course, Dr. Hart is correct. Without a comforting approach to our patients, we practice the science of medicine but forget about our art. As our reimbursements decrease and our overhead increases, the pressure mounts to see more patients per day and spend less time with each individual patient. Resist the urge to be only a medical scientist who exclusively seeks objective data in your patient. Remember also to practice the art of medicine. Take time to comfort.

**Take Time to Continue Learning.** "The more you learn through reading, listening, and experience, the more confident, capable, and intuitive a physician you will become.", opines Dr. Hart. In this age of exploding medical information, it is essential that we all keep up with our medical subspecialty. A lifelong teacher in academic medicine, my dad likes to say that when you stop learning, you stop living. Invest in yourself and in your biggest asset, your brain. The ROI (Return on Investment) is worth it.

**Common sense pearls** offered from Dr. Hart include the following: Look your patient in the eye, shake his or her hand, sit down and communicate. "Remember, your words have a lot of power," Dr. Hart reminds us. Ask questions and listen closely. Touch. In the rush of a hectic day, these important things sometimes get forgotten. Dr. Hart notes, "treat everybody as if they were 'somebody who mattered'..."and remember the Golden Rule. Sir William Osler said, "We need to understand the person with the disease better than we understand the disease the person has."

**Commit to something outside of and bigger than your own personal self.** Dr. Hart touches on that idea in many of her letters. The world's great religions and spiritual thinkers have a similar theme. Have you ever noticed that the people who persistently think only of themselves often seem the most miserable? The converse also appears true: the people who are selfless and consistently think of and help others often seem more content. What a great concept.

As I write this article, I realize I am writing to myself at the same time! Dr. Hart's letters ring true and I recommend them highly to all physicians.

\*For the full text of Dr. Carolyn Hart's letters, visit online at [www.ncmedboard.org](http://www.ncmedboard.org) and click on "Fondly, Carolyn: Letters to a Young Physician."

# Letters to the Editor

To the Editor:

I'm so glad and so lucky to be a part of your mailing list. Thank you for the gift of Wake County Physician, and thank you for caring so passionately about education and art and music—and even trees...and everything from the most profound and ethereal to the most concrete!

I'm glad that you have your health back traveling. Many pray for your improved health. I do hope you have or are taking the time to write one or more books about your life and "LIFE" in general...to share with others your sense of joy, and serenity, and majesty, and awe, and giving. Oh, that all of us in this crazy world could have those qualities in abundance!

**Lois Nixon**

*Certified Environmental Educator  
Director, Wake County Keep America Beautiful  
Raleigh, NC 27602*

To the Editor:

Thanks so much for your wonderful magazine, Wake County Physician. I hope you and Mrs. Meymandi will come to visit us in Copenhagen. We would be delighted to entertain you. I greatly appreciate your friendship, and admire all that you are doing for our community and our world.

**Jim Cain**

*Raleigh  
Editor's Note: Mr. Cain is the US Ambassador to Denmark)*

To the Editor:

I am acknowledging that I have received this latest issue of WCP magazine, and although I am an educator, not a physician, I find the articles pertinent and interesting. Particularly resonating is Dr. Meymandi's editorial assertion that medicine is neither a business nor a commodity. I feel the same way about education--that it's about people, not product or profits, which makes it a complicated, sometimes messy, but always exhilarating enterprise.

**Theo W. Coonrod**

*Head of School, Saint Mary's School  
Raleigh, NC 27603*

To the Editor:

I have read with great pleasure your introduction to my father's profile in the current issue of the WCP magazine, and the terrific article by Christy Farrelly. Your words and your reference to Cicero were most generous, both with respect to my father's hard-earned accomplishments and wisdom, and indeed those of all octa- and nonagenarians who continue to engage life with his kind of hard-charging zeal-- and therefore enrich all our lives, especially when we truly take the time to observe and listen to them.

I know your introductory overture, with its harmonics to your admonition of a life of noble, priestly service in medicine (given in your recent commencement speech at the George Washington University School of Medicine), was especially meaningful to my father, given his deep sense of the importance of being attentive to the spiritual aspects of clinical practice.

When I read your speech to the medical graduates at GW, I

too was struck by your reference to the priesthood—and recalled my lunchtime discussions years ago at the Hastings Center with Robert Michels, MD (later dean of Cornell School of Medicine) whose body of scholarly work you may know. Your own advocacy for needed change has often reminded me of Dr. Michels' enthusiastic participation in the national discussions on the social context of psychiatric care. Also of note are his many references to the often overlooked moral covenants common to both medical and pastoral care.

In my father's case, I think his fascinating ancestral lineage contributes less to any sense of "nobility" than does the selfless and devoted care he gave to his patients in 50 years of medical practice. His Aesculapian authority as a healer, and the trust his patients placed in him, was earned by a life and practice filled with generosity, humor, humility, diligent use of collegial consultation, genuine affection for his patients, and total responsibility for clinical decisions.

My brother Chris joins me to sending thanks for featuring my father in your magazine. I have forwarded the other items you passed along to him as well. As I recall, Tosca is among his favorites, recalling an aria he sang with gusto as the evil Scarpia—so I'm sure he will enjoy knowing of your familial ties to Puccini!

Thanks too, for all you do as an exemplar of creative philanthropy in our community.

**Mark V. Bensen**

*Raleigh*

To the Editor:

Thanks for sending this fascinating magazine to me!

**Joe Newberry**

*Raleigh*

To the Editor:

Thank you so much for sharing the fascinating material in Wake County Physician with your readers. Besides having this glimpse into what for most of us is another world so rich in culture, I wish more young parents could read this and see how exposing their children to reading, music and the arts early on can impact future arts appreciation. am passing along the magazine to my friends and relatives for their enjoyment.

**Judy Wicker**

*Community Relations Manager  
News & Record, Greensboro, NC 27420*

To the Editor:

A friend of mine attended the Opera Company of NC performance of Tosca last weekend, and shared with me the program, which contained your essay recounting Puccini's visit with your family. I never cease to be amazed at the many fascinating chapters in your family's remarkable story!

**Robert N. Golden, M.D.**

*Assad Meymandi Distinguished Professor and Chair of Psychiatry  
Vice Dean, UNC School of Medicine  
Chapel Hill, NC*



Dr. Assad Meymandi

The Practice of medicine gets complicated by the day. We note that within the last month a new group of alphabets has enriched (or crowded) the medical soup de jour. It is the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). A good bit of time was devoted at the annual AMA meeting this past June to debating PFF, Pay-for

Performance Program, another government fiat whether physicians like it or not. PFF is the concept of reimbursing doctors based on how well they provide care. Even though we are not a participant in the Medicare program, and have not been for the past 15 years, the elaborate bureaucracy continues to include us in its massive mailing. We regularly and frequently receive thick packets of information, most of it in font eight, hardly readable with naked eyes and full of incomprehensible legalese.

Thanks to the internet and the National Medical Library, we set out to learn about MMA. Although MMA is nudging its head in the everyday practice of medicine, it was designed and created in the latter part of 2003 as Medicare Program's Part "D". It has to do with prescription drug benefit, and will go into full effect on January 1, 2006. MMA is mandated to be managed by Private Drug/Prescription Plans (PDPs). It applies to all Medicare beneficiaries, even those who do not wish to participate in the program. The PDPs are charged to negotiate contracts with pharmaceutical companies for a better deal. The packet of information further elaborates on the structure and conceptual architecture of the plan: the country has been divided into 34 PDP regions, and each region must have at least two PDPs. There is a third layer of administrative bureaucracy represented by the acronym DUM, Drug Utilization Management that makes the final decision of which patient(s) get(s) what drug(s). The practicing physician must know what drugs are available in the formulary, how can they be accessed, and what kind of documentation is necessary for off-the label use of drugs.

## Time Table

The Medicare and Medicare Services (DMS) has set November 15 (six weeks from now) to have all participating PDPs identified and certified. Formularies should be developed, with software in place for the plan to be implemented by January 1, 2006. Physicians and their staffs must learn to navigate the system and mind their ps and qs, if they have any hope for any kind of reimbursement for their services.

Practice of medicine is inundated by competition. Chiropractors competing with orthopedic surgeons, podiatrists ascending the leg, nurse anesthetists wanting their own board to bill third party payers directly, and optometrists constantly pushing the envelope for performing eye operations and writing prescription, are just a few illustrations of the deteriorating scope of medical practice.

In my own profession, psychiatry, we are faced with fierce competition from psychologists, behaviorists, nurses, social workers, PhD educators, and even acupuncturists, holistic masseurs, and airwave evangelists. At my latest count, with assistance from the National Medical Library, I counted 250 brand name varieties of brief treatments usually defined as "therapy", including primal scream therapy and "Z" therapy. No, it is

not sleep therapy. I could not find what "Z" therapy is, except for one obscure reference which cites "Z" stands for zoe which means life. Psychologists are now allowed to write prescriptions in the two states of Louisiana and New Mexico. If domino theory holds the 48 other states will follow. It is an abomination that politicians who are usually limited in education and training, through the instrument of political expedience, are allowed to legislate the scope of practice. It is not knowledge, training and experience that determines who can do what, but lobbying, public relations and political networking that make those decisions.

Our nation now has three times more social workers than psychiatrists.

As the system gets more complicated, it behooves us to become more and more aware that medicine is the only profession that allows us to offer a mixture of knowledge and skill with compassion and kindness. No other profession on earth enjoys that lofty perch. No matter how complicated the practice of medicine becomes, I remain humble and grateful for the opportunity to be of help to my patients.

## IN THIS ISSUE

September is the "Constitution Month" and December the anniversary of the death of George Washington. In observance of these two sacred occasions, we are featuring George Mason, a Founding Father who taught George Washington political theory and rhetorics (see pages 63 and 64), *His Excellency* by Joseph Ellis.

**Nancy Lilly**, a Raleigh historian and researcher, the writer of the article on George Mason, notes that "Mason died in 1792, less than a year after the ratification of the Bill of Rights. Washington was 7 years younger than Mason. Washington died 7 years after Mason, in 1799, at the same age that Mason died. These numbers are fascinating", she writes. Reading and learning history is very much like chamber music. You feel like you are sitting in the same room with the composer. The joy of history makes us feel contemporaries of the Founding Fathers, having conversation with them every day.

Emerita jurist and distinguished archivist, **Memory Mitchell**, the widow of the late Dr. Mitchell, NC State Archivist, has given us the "NC Treasures" column. It is about an old and venerable Raleigh institution, the Rex Hospital. Ms. Mitchell follows the roots of the institution to its origin on South Street. In addition, the usual fare, President's column, the Editorial, Thinking Things Through, Editor's Notebook, Book Reviews and our regular columnists and contributors, **Drs. Nicholas E. Stratas, Holden Thorp, Jeffrey Engel, Edward B. Yellig**, and Profile of the Month writer, **Christy Farrelly** are featured. The travel section covers Sicily and Africa.

We are receiving an average of over 100 letters to the editor per issue. It is regrettable that space allows us to print only a fraction of your very encouraging letters and input. But please do not be discouraged. Write to us, and let us know what you think.

Write to us. Essays, First Person column, commentaries, 750 to 1000 words long; letter to the Editor, 250-300 words; poetry, inspired prose and book reviews are welcome.



Paul Harrison

## Wake County Medical Society Inaugurates Its Fifth Community Service Program

Wake County Medical Society has inaugurated its fifth community service program in five years which tips the Society's annual budget over the \$2 million mark, including 28 full time employees. The Wake County Medical Society leadership made a decision in the late 1990s to redirect a portion of the Society's activity into community service with a focus on access to medical care for indigent residents of Wake County.

The latest program called the "Fragile Children's Program" allows seriously ill children, who would otherwise be institutionalized, to remain at home with their families with intensive nurse case management services. The nurses coordinate care which can involve numerous vendors and professional services. The Wake County Medical Society began the Fragile Service Program in April 2005 in association with the NC Department of Health and Human Services. Currently, 66 children are being managed and supported in their homes with the support of their families close at hand.

The four other services programs offered by the Wake County Medical Society, in chronological order are as follow:

**Project Access** provides free medical and surgical care to Wake

County's indigent population. In most cases, primary care physicians refer patients needing medical and surgical care to 450 volunteer physicians and surgeons. During the past five years 5,500 indigents patients have been served without charge. To date, \$9 million in donated medical and surgical care has been donated. The program began in September 2000.

**Children's Access Program** is an outreach program to enrolled eligible children in Wake County in the Medicaid program. Children with medical insurance are healthier than those without coverage and primary care physician continuity. Since the program's inception in January 2002, 11,500 additional children in Wake County have been enrolled in the Medicaid program

**Community Care Case Management** provides nurse case management services to more than 3,000 children enrolled in Medicaid who suffer from asthma, diabetes, and sickle cell anemia. The case managers coordinate their efforts with primary care physician practices and focus on those patients who are identified as frequently non-compliant with physician's orders. This program was started in November 2003.

**Early Childhood Development Program** offers training to local primary care physicians and mental health professionals to better identify and treat three and four year olds with developmental disabilities before their problems become entrenched and more difficult to treat. Five pediatric practices and 15 mental health professionals are affiliated with training program during its first year of operation. The program began in July 2004.

## FIRST *Person*

By Assad Meymandi, MD, PhD, DLFAPA

It was a hot day in Fayetteville, North Carolina. The August sun was beating down. You could fry an egg on the sidewalk by Cape Fear Valley Hospital. The thermometer at the Savings and Loan Bank registered 101. The street felt like something between a Turkish bath and a green house. I had just gotten back from lunch and was seeing my first patient at 1:00 o'clock. My personal secretary buzzed me. We had a strict rule that my sessions with patients would not be interrupted unless it was an emergency, like life or death. So her interrupting me must have been very important. It was. I answered the phone. My secretary was very upset. All she said was that I ought to step out and see a patient who urgently needed help.

The patient was a young man, in his early twenties. He was gaunt, emaciated, a shell of a man, and a mere shadow of a person. He was tall, unshaved, with matted hair and sunken eyes. His clothes were torn and his bare feet were caked with dirt. There was a stench of body odor, old dried sweat and neglect surrounding his handsome frame. His parents said that he had not eaten any food in four days. They reported that he had refused all forms of liquids, even Mountain Dew, his favorite drink. He had not slept for four days. That morning they had found him in the barn behind the house with a large butcher

knife trying to cut his throat. The family was a kind and gentle sort. They were farmers in a rural community near Fayetteville. They grew tobacco, peanuts, and soy beans. The family was well established and the farm went back several generations dating to the civil war.

I approached the young man and extended my hand to shake his. He ignored me. He was looking away, mumbling something to himself, something that his parents called "gibberish." They said that he had been saying the same thing, like some kind of mantra, day and night for four days. We quickly ruled out the possibility of alcohol and substance induced psychosis, because his parents had been with him day and night during his illness, and he had no intake of food or water, much less drugs or alcohol. He was locked up in his own closed world.

I noticed that he was agitated with a fine tremor in his hands, yet there was a sense of peace and calm about him. There was no question that he was psychotic, hallucinating and delusional. He was completely disconnected from his environment and those who were in the room with him, including his sweet and distraught mother. I took the patient to one of the examining rooms in my office. I listened carefully to what he was mumbling, what his parents and the family were calling "gibberish".

# GEORGE MASON: Little Known Founding Father's Legacy 1725 – 1792

By Nancy Cobb Lilly

Former member Board of Regents, Gunston Hall Plantation

*“Our All is at Stake and the little Conveniences & Comforts of Life, when set in Competition with our Liberty, ought to be rejected not with Reluctance but with Pleasure.”*  
– George Mason to George Washington, 1767

The above words, written by George Mason to his friend and neighbor, George Washington, are strikingly relevant for us today as we join forces with other peace-loving nations to protect our freedom and to fight terrorism around the world.

The past few years have seen a plethora of writings about the “founding fathers” - Washington, Franklin, Adams, Jefferson, Madison, and Hamilton. Yet little is known or has been written about George Mason, who made an enormous contribution to American independence and to the constitutional government of this country. George Will, in his Fourth of July column, said that David McCullough’s two themes in his book “1776” are: “Things could have turned out differently; and individuals of character can change the destinies of nations”. In this context, the name of George Mason readily comes to mind.

So, who was George Mason and why is he so little known? A Virginian of great intellectual ability, he was knowledgeable in English constitutional law and the writings of classical and contemporary political philosophers. Even though Mason preferred to stay in the background, his advice and his writing skills were often sought by George Washington and other leading politicians. He served only one term in the Virginia House of Burgesses, disliking a politician’s life. He was a planter and a widower whose wife died in 1773 leaving him with nine young children. He suffered from ill health much of his life. His biographer, Helen Hill Miller, said that Mason, more than many of his contemporaries, was untouched by political ambition.

George Mason’s enduring legacy lies in his authorship of the Virginia Declaration of Rights. Upon adoption in June 1776, the document quickly became a model for succeeding bills of rights in other states. Historians acknowledge that Mason’s human rights statements in his Virginia Declaration of Rights formed the foundation for the U.S. Bill of Rights and also for the French Declaration of the Rights of Man and Citizen. The Marquis de Condorcet, in Paris, about 1788, said: “The first declaration of rights which truly deserves the name is that of Virginia...and its author, is entitled to the eternal gratitude of mankind.”

Mason and Washington frequently were in contact. Both were members of the Ohio Company, justices of the peace, vestrymen of Truro Parish, members of the Committee of Safety, and trustees for Alexandria. In the face of British aggression, they often collaborated to defend the rights of the colonists. Though very different in personality and talent, they were nevertheless friends who respected one another.

The Constitutional Convention, beginning May 1787 in Philadelphia, had a notable delegation from Virginia, including George Washington, James Madison, Edmund Randolph, George Wythe, and George Mason. William Pearson, a delegate from Georgia, noted that Mason was “convincing in debate, steady and firm in his principles, and undoubtedly one of the best politicians in America.”

Through the long, hot summer deliberations, the idea of a

bill of rights was not even mentioned until five days before the end of the Convention when George Mason argued in vain for the inclusion of such a provision. A majority felt it was unnecessary to list specific individual rights since most states already had bills of rights and most delegates were eager to return home. Mason’s proposal was defeated.

The Constitution was signed on September 17, 1787 without a bill of rights and without a signature from George Mason who stated “he would sooner chop off his right hand than put it to the Constitution as it now stands.”

Prior to the Ratification Convention in Virginia, two men with two very different philosophies were highly visible - George Washington and George Mason. The viewpoint of each had justification. Washington believed the right course was to grasp what was at hand and accept the Constitution as written. Amendments could be added at a later date. Washington was certain to be elected president of the new nation if the constitution went into effect. Now, his friend and neighbor, George Mason, whose ability he respected, opposed him on this matter of utmost importance to the new nation and to Washington personally.

Mason, by contrast, whole-heartedly desired a national constitution but was convinced that the document was incomplete without a bill of rights. He believed that the time to assure a sound foundation for the new government was at its inception. His list of *Objections to the Constitution*, beginning “There is no Declaration of Rights,” became the ranking opposition document in Virginia and elsewhere. He was roundly criticized and his motives misunderstood. George Washington, who referred to George Mason as “my quondam friend”, never spoke to him again.

As debates in the states’ ratifying conventions raged on, an emerging consensus among those in favor of changes centered on the absence of a bill of rights. North Carolina, with its longstanding distrust of central authority, refused to ratify the Constitution at its first convention because it failed to guarantee specific individual liberties.

James Madison, twenty-three years younger than George Mason, voted for the Constitution at the Convention in Philadelphia and was a proponent during the ratification process. By May of 1789, however, Madison became convinced of the importance of the inclusion of a bill of rights and announced to Congress that he would submit amendments for approval. He justified his decision, in part, as an “accommodation” to encourage North Carolina, and other undecided states, to change their minds. These ten amendments, the United States Bill of Rights, closely resembled Mason’s ideas in his 1776 Virginia Declaration of Rights and were ratified by the necessary number of states by December 15, 1791.

At its second Ratification Convention in Fayetteville on November 12, 1789, North Carolina became the next-to-last original state to ratify the Constitution. The following month, on December 22, 1789, North Carolina became the third state to ratify the Bill of Rights.

Upon learning of the acceptance of the Bill of Rights, Mason wrote to a friend saying, “I have received much Satisfaction from the Amendments...With two or three further Amendments...I

# North Carolina Treasures

## Raleigh's Venerable Rex Hospital

By Memory F. Mitchell\*



Memory Mitchell

On January 21, 1924, a snowy morning (so I was told) I first saw the light of day. Thus my first experience at Rex Hospital, then located on South Street in Raleigh. When I was just over 2 1/2, my mother went into labor prematurely and my father drove her to Rex, taking me along. I was told to wait in the car while they went inside. My parents' word was law, and I know that they were confident that I would stay patiently in the car and that nobody would bother me. How times have changed since those days in Raleigh.

All of Mother's babies were premature, and it is a miracle that my brother James and I survived. Twins born in 1922 and another son born after James all lived only a few hours. But

Rex was our family's hospital.

On the South Street location, just west of the present Meymandi Concert Hall, a hospital was opened in 1894. John Rex, a Pennsylvanian who had moved to Raleigh and established a tannery, had died in 1839, leaving money to free his slaves and send them to Africa and providing money for a hospital to care for "the sick & afflicted poor" of Raleigh. Trustees for a hospital had been named in 1841; but for many reasons, including complicated legal controversies involving the settlement of the estate, poor investments, and the intervening Civil War, the hospital did not become a reality until 1894.

The first Rex Hospital was in a house that had belonged to former Governor Charles Manly. Several years later a decision was made to demolish the Manly house and erect a modern building on the site. In September, 1909, the "new" Rex Hospital was opened at the South Street location. (Patients had been moved to a 12-room house "out in Glenwood" during the time of construction.)

Appeals by the trustees for contributions toward furnishings brought favorable responses. On "Gift Day," September 28, donations included two brass cuspidors, a hundred-piece dinner set, soap, hot water bottles, two dozen glasses of jelly, a carving set, and "Book cases and the works of standard authors." There were also cash donations of \$500 downward. The News and Observer made suggestions as to suitable gifts, noting that a piano was "especially desired." Evidently no one responded favorably to that idea, because the trustees bought an instrument. The public had been told that a private-ward bed could be furnished for \$35.00 and a bed in a public ward for \$20.00. The operating room was equipped by the widow of Dr. E. Burke Haywood, in memory of her husband.

The hospital had two 14-bed wards, two 2-bed wards, 11 single-bed rooms, a children's ward, and a maternity ward. There were operating and sterilizing rooms as well as "etherizing" and emergency areas. Rooms were provided for the superintendent and 14 nurses, a reception room, a laboratory, and a records room.

When I was seven years old, my tonsils were removed at Rex Hospital, and I can well remember the white-painted iron cribs in the children's ward. I also remember ether being administered. I was in the hospital at least one night, maybe two.

Among my early childhood memories is the antiseptic smell of the hospital. One knew upon entering that he or she was in a hospital. I also remember the statue of Christ standing near the entry. The statue, a gift from a Raleighite who had moved from Raleigh to Baltimore, was a replica of a statue at Johns Hopkins Hospital. He was so touched by the care a family member had received at Rex that he had had the statue duplicated in Italy and shipped to the United States--this during World War I. Amazingly, the statue arrived in good condition. It was moved from South Street to the Wade Avenue location in 1937 and again when the hospital moved to its present site on Lake Boone Trail in 1980. Fingers that were broken were restored at the time of the last move.

John Rex, in his wildest dreams, could never have envisioned the huge hospital that grew from his small seed.

*\*The writer is a licensed attorney with a master's degree in history. She is the widow of Dr. Thornton W. Mitchell, the late state Archivist of North Carolina.*

(The story of John Rex and the history of Rex Hospital are detailed in several articles by Memory F. and Thornton W. Mitchell and by Memory F. Mitchell in issues of The North Carolina Historical Review, July and October, 1972; April, 1987)



Rex Hospital on South Street CA. 1910

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Dr. Thorp

## The Magdalene Reading (ca. 1445), by Rogier van der Weyden (1400-1464).

In my lifetime, numerous watershed moments have been proclaimed by pundits as signaling the end of all good things that came before: Shoeless Joe Jackson and Van Doren. Real People. The Grateful Dead's disastrous 1978 performance on Saturday Night Live. Pokemon.

So far, I've resisted joining in the proclamations that culture has ended, and I hate to think that I'm

now just one more cultural Chicken Little. But after reading this weekend's *New York Times*, I'm afraid that the sky may indeed be falling. Yes, it seems that with more than 36 million copies in print, *The Da Vinci Code* is the most successful book of all time except the Bible.

At least it isn't *Captain Underpants*.

Now my objections to Dan Brown's novel are not the typical ones. It is, after all, a work of fiction, and – the last time I checked, anyway – we had decided not to protect our citizens from fiction. I was raised Catholic, but my theology is now New England Episcopalian, and the notions in *DVC* are fair game as far as I'm concerned – especially if only used as chum in a mediocre whodunit.

No, I do not object to Brown on theological grounds. And although I would prefer it if the most successful novel of all time were – let's just say – a *real book*, like something by Marquez or Singer, it's not about prosaic or narrative quality, either. We have a free market, and if that market wants monosyllabic, mono-paginated chapters, then so be it.

In fact, having visited Milan, Paris, and London, I enjoyed reading *The Da Vinci Code*, and it once carried me admirably across the country and through an O'Hare layover on United.

No, the reason I don't like *The Da Vinci Code* is that now I've lost Mary Magdalene as I once knew her. To explain my dismay, I have to take you back to just before my arrival here on the campus in Chapel Hill.

My aunt Daisy was a famous art history professor at North Carolina Wesleyan College in Rocky Mount. Throughout my high school years, she tutored me on the finer points of modern art and the great masters. Her enthusiasm for her subject is the reason that I eventually became a college professor myself.

One of the things that Aunt Daisy told me was that even though I'd been treated to her skilled, one-on-one instruction, I'd be missing a once-in-a-lifetime chance if I didn't take art history when I came to the great university in Chapel Hill.

She was right. When I arrived at freshman orientation in 1982, I signed up for Art 31: History of Western Art I. I mainly signed

up for it because it was the only art history course I could take (I would have had to wait for the spring semester for History of Western Art II), but it worked out well, because Daisy and I had mainly concentrated on art from the Renaissance and later. So I was a blank slate on the Egyptians and Medieval Architecture.

The course was taught in the enormous Carroll 108 – a 400-seat lecture hall

evocative of many of the curriculum's cavernous spaces, such as Hagia Sophia and the Pantheon. Our professor, Dr. Jaroslav Folda, also had a Daisy-like enthusiasm for his subject, and his old-fashioned, silver halide slides filled the huge screen magnificently.

Folda was particular fond of the Byzantine mosaics, illuminated medieval manuscripts, and the great masters of the Northern Renaissance. These were topics that Daisy and I hadn't covered, so I was in new and exciting territory. It was my first real taste of higher education.

Because of what I learned in Art 31, I eventually made solemn pilgrimages to Ravenna to see the mosaics of San Vitale, to Dublin to see the *Book of Kells*, and to the National Gallery in Trafalgar Square to see the *Arnolfini Wedding* and other masterpieces by Van Eyck.

In my first year as a college professor, I went to a conference in England, and took my wife, Patti, to Trafalgar Square to see the masterpieces of the National Gallery. We were enchanted by *The Magdalene Reading* by Rogier van der Weyden, a younger contemporary of Van Eyck's but with a softer, much more appealing style. I had been so keen on seeing the Van Eycks that I had missed it on earlier trips, but I remembered Dr. Folda's lectures about the beauty of van der Weyden's painting and the scarcity of the examples of his work.

I bought a print of *The Magdalene Reading*, and Patti got it framed for me and put it in my very first faculty office. I've carried it – or should I say "her" – with me from the chemistry building at NCSU in Raleigh to my present research office in the Kenan Laboratories in Chapel Hill.

She's been with me from my first swivel chair to my first endowed chair — and all points in between. I've drafted, re-written, and revised 126 papers in her presence. She's read quietly on the wall while I mentored 16 graduate students for their PhD's. She's watched lovingly while thousands of undergraduates confronted the hard fact that they couldn't go to medical school because they didn't want to learn how to do a limiting reagent problem.

This month, I started my new job as chair of the chemistry department at Carolina. When I moved into the chair's office, I left the *Magdalene* in my research office at first. I hadn't taken her to the Morehead Planetarium with me, and in a sense, my full



Continued on page 22



## Issues on Care at the End of Life

By Christopher W. Yellig\*

### Physician-Assisted Suicide

Gary Scheffield, a prominent 57 year-old malpractice attorney was diagnosed with ALS (Amyotrophic Lateral Sclerosis or Lou Gehrig's Disease) two and a half years ago (Fictitious name and circumstances, E. B. Yellig, MD). Throughout these past two years, he has continued to work while watching his body dramatically change. His first symptom had been a stumble and then a fall while running the bases during a softball game of the Lawyers Softball League. His teammates who helped him off the field thought Gary had just sprained his ankle, but when he tried to walk to the car, he required the assistance of one of the fellow players. The following morning he found that his right leg was just as weak as it was the night before. He and his wife quickly called their doctor who assumed that he had had a stroke and immediately referred him to a specialist. Dr. Anderson, the neurologist, thoroughly examined him, moving all his limbs, testing for reflexes with a concerned look on his face. After the examination he met with Gary and his wife Linda with the bad news: he thought Gary had ALS.

After further testing confirmed the diagnosis, the doctor explained that this disease was incurable and that Gary had an expected life span of two to three years. Two and a half years later, after suffering humiliating losses of neurological function, Gary was bed bound, paralyzed from the neck down, and fed through a feeding tube in his side. Although one might feel sorry that Gary had lost so much of his physical function, Gary's biggest loss and his greatest source of suffering was his inability to stand before a jury and defend clients in his famously aggressive and eloquent speeches. He did not see life as worth living at this point and began conversations with his wife and physician about how he would die. He wanted his doctor to give him the means to take his life in a way that he thought would best suit his need for control, dignity, and respect. Although the doctor felt great compassion for Gary, he stated clearly that he did not believe in physician-assisted suicide (PAS) but that he would stick close by Gary in his last days. Gary knew that Oregon was the only state in which PAS was legal, but he did not wish to leave his community. Frustrated, sad, and hopeless, he pleaded with his doctor to provide him with medications to help him end his life.

Gary is not alone in his wish to seek help from a physician to end his life. His story is one of many. Though physi-

cian assisted suicide is a complicated and controversial issue, Americans also need to establish clear guidelines for a humane system to care for terminally ill patients who experience intractable, intolerable suffering.

In dealing with people at the end of life, physicians hope to provide comfort, dignity, and relief of pain and other troubling symptoms. However, this is not always possible because some diseases do not respond to usual and customary interventions. At this point, people begin to explore other ways to die. Options of last resort have included withdrawal of life supportive therapies, voluntary refusal of food and fluids, terminal sedation, and PAS. Withdrawal of life support has decades of legal, ethical, and moral support because it is widely held that a patient can express his autonomous desire to remove a barrier that is prolonging a life of poor or unacceptable quality (Yellig, MD). Examples of life support include artificial ventilation, administration of food and fluids and renal dialysis. The voluntary refusal of food and fluids is also an expression of autonomous decision making and differs from PAS in that nothing is taken to intentionally commit suicide. Rather, a patient simply ceases to consume nutrients that would prolong a life of poor quality. Lastly, terminal sedation is the procedure in which sufficient sedating medications are administered to a patient whose symptoms are no longer amenable to customary interventions, i.e. these symptoms are intractable. While under deep sedation, the patient goes without artificial food and fluids. Thus the disease is allowed to progress to its natural end, and the patient dies without suffering. (Yellig, MD)

The goal of palliative care is to relieve suffering. The quality of life, not necessarily the quantity, is most important (Foley, p. 54). "Patients often say that they are not afraid of death but are afraid of the process of dying (Bascom, p. 91)." In the US, there are approximately 6,000 deaths per day that have been planned or indirectly assisted in some way, such as using high doses of pain medications or by discontinuing or withholding potentially life-sustaining treatments (Quill, p. 1380). Unrelieved pain, late stages of AIDS, and complex neurodegenerative disorders are among the most common conditions leading patients in asking for assistance in dying (Foley, p. 54). Even more importantly, three to thirty-seven percent of physicians responding to anonymous surveys reported secretly taking

# REFLECTIONS REFLECTIONS

## THE GOLDEN AGE OF MEDICINE THE BEGINNING AND THE END

By Duncan S. Owen, Jr., MD, FACP, FACR\*



It is estimated the golden age began in the mid-1940s and ended some 25 years later. Physicians returning from World War II were welcomed enthusiastically by patients, both previous ones and new ones. The patients looked upon physicians as friends. These physicians had received good training from teachers that were beloved by the students. Most teaching hospitals had few full-time faculty in the clinical years in medical school and in the postgraduate years. Most of the attending

physicians on the “staff wards” were outstanding adjunct faculty who donated their time because they loved what they were doing in training students and house staff. Most had practiced medicine for years. Private patients, i.e., those that had some way of paying their bills, may or may not have had students or house staff to help with their care. Most teaching hospitals were non-profit. The students, whether in their basic science or clinical years, were most appreciative of the ways they were being taught and for the personal interest being shown in them. The students and house staff were neat, on time for their duties, attentive, and attended their required classes. The students usually shape up during their third and fourth years and this continues during their postgraduate training. The changes in medical education began to change during the era of the Vietnam War.

During the Vietnam era, President Lyndon Johnson decided we needed a national health plan. He surreptitiously met with several advisors who were handpicked. They met many times and came up with a fine-tuned plan they called Medicare and Medicaid. With Mr. Johnson’s way of getting things done, both plans were passed by Congress. Then medicine changed in many ways. Greed among physicians and hospitals developed. For-profit hospitals expanded and research facilities such as the National Institutes of Health expanded greatly. Physician laboratory investigators proliferated. Most clinical investigators were left wanting. Adjunct faculty were put more and more in the background. The reason was money. Because of increasing cost of medical care, Medicare and insurance company silent investigators demanded and got permissions to review charts of hospitalized patients. These gnomes continue to proliferate. If an adjunct faculty put a note on a patient’s chart, any charges made were paid to the adjunct faculty and not to the respective department or school. Health Maintenance Organizations insti-

tuted the same plans. Geographic full-time faculty greatly proliferated. Most were laboratory investigators and many disliked having to leave their laboratories to do their required attending duties. We still see some of these “old timers” volunteering their times in indigent clinics, and medical students and house staff are being assigned to adjunct faculty “uptown” offices where they are seeing a lot of good patients and learning a great deal. Parenthetically, I miss the old days when, e.g., a patient was referred to the hospital as an inpatient because of recurrent ureteral calculi and a serum calcium of 14.0 mg/DL. I like to clinically teach by the Socratic method. It was fun for me to go to the blackboard and we would list the causes of hypercalcemia, and then discuss how we would handle the patient’s problems. Unfortunately, the gnomes will not allow this type of patient to be admitted. We have plenty of AIDS patients and their associated complications, and we have plenty of geriatric patients with their problems. Unfortunately, these latter type patients are “turning off” our medical students, and these students are leaving the primary care arena for something more exciting to them. This is a big problem.

The advances in technology have been enormous. Unfortunately, I see many younger physicians depending too much on this. We seem to be getting away from a good history and physical exam. One must keep in mind, however, that some of the “unnecessary” studies are done to prevent trial lawyers from their vicious snooping. Some of this may not be due to greed with some of the reimbursements from third parties for office practice barely covering the overhead costs. Primary care physicians are receiving fewer dollars and are trying to make up the difference by seeing more and more outpatients.

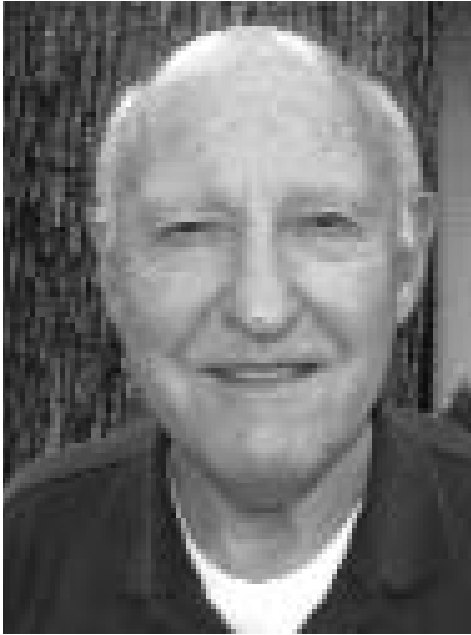
What has happened to our “Giants in Medicine?” A true giant, when he was in Boston, Emory, and later at Duke, was Dr. Eugene Stead. He is living, but inactive. He was an outstanding teacher, administrator, clinician, and researcher. A mentor of mine, when I was a medical student at UNC-CH, had gone to Emory University School of Medicine when Dr. Stead was Chairman of the Department of Medicine. The Emory student was serving a clinical rotation at Grady Hospital. He was sitting outside the blood bank at 2:00 a.m. waiting for blood being cross-matched for administration to a patient with a bleeding gastric ulcer. The hallway door flew open and there came Dr. Stead with his lab. coat trailing, and he said, “Son, why are you just sitting there? You should be reading a book or journal while you are waiting for your blood.” Dr. Stead expected perfection from students and house staff. I have a book written by a number of Dr. Stead’s former residents, and it is a delight to read and shows what love and admiration they have

*Continued on page 29*



# Physician Profile

By Christy Farrelly



*Dr. Frank Winslow*

## Dr. Frank Winslow

Dr. Frank E Winslow II was born November 2, 1924 in Rocky Mount, North Carolina. He was the youngest and only son born to Mr. & Mrs. Francis E Winslow. His mother enjoyed teaching and his father was a prominent lawyer who founded one of the oldest law firms in North Carolina – Battle, Winslow, Scott & Wiley. Together with his two older sisters and his twin sister, Frank benefited from his parents' com-

mitment to professional and social responsibility.

After graduating high school, Frank was drafted into the Navy and began his training in Bainbridge, Maryland. Upon transfer to Newport, Rhode Island for Port Master School, Frank successfully applied to the Navy's V-12 Unit and was sent to study at Bates College in Lewiston, Massachusetts. Eight months into his education, the Navy transferred all of its V-12 members to the Navy ROTC. With this change came the opportunity to attend Harvard.

Frank Winslow graduated from Harvard in 1946 and was subsequently commissioned as a Naval Reserve. He spent some time on a Minesweeper in Charleston, South Carolina before ending up on the USS North Carolina. Leaving the Navy, he returned home to Rocky Mount having every intention of following in his father's footsteps.

In 1947, he was admitted to the University of North Carolina Law School. While Frank enjoyed law, he wasn't excited about going into a field where he would be dependent on his father. "My father was a very prominent attorney and I had a great deal of respect for him. I didn't feel like I would be able to make any decisions without going to him first." So, Frank E Winslow II

declined his seat at UNC School of Law and began to take pre-med courses. He graduated Phi Beta Kappa and was accepted to several medical schools.

Frank chose to attend Duke University Medical School because they offered a four-year program. He graduated a member of AOA Medical Honor Society and went to the University of Maryland Hospital in Baltimore for a rotating internship. Upon completion of the internship, he became Assistant Resident in Medicine. With one year of Medicine behind him, Frank discovered his love of Pediatrics and had to start over with two years of pediatric training, which he completed at University of Maryland Hospital.

Dr. Winslow joined a friend in private practice in Columbia, South Carolina and within one year moved to practice in Virginia Beach. For two years he made the daily commute to Norfolk General Hospital.

In 1960, Dr. Frank Winslow moved to Raleigh and went into partnership with Dr. Frank Poole. Poole & Winslow was a partnership that he enjoyed for twenty years. Dr. Poole left the practice to join his son, also a pediatrician. Poole & Winslow changed to Winslow Brown & Allen and would eventually become Blue Ridge Pediatrics.

Jean Freeland was Dr. Winslow's Office Manager for nearly twenty years and believes he is "really one of a kind." "Dr. W", as she affectionately calls him, "is amazing with children." He is able to completely focus on the child and not be distracted by other family members. Dr. W. wanted to get the information straight from the child." In listening to children he was able to diagnose exceptionally well which often led to longer, healthier years, quicker treatments and cures. His main concern has always been that every child be healthy and well.

Dr. Winslow cared for all of his patients and if they needed anything, he was there for them - whether it was a small contribution towards their school supplies and books or continuing their medical care through their college education. He did little things in quiet ways and always was giving to patients and the community.

When St. Michael's Episcopal Church sponsored child refugees from Vietnam, Dr. Winslow volunteered to provide their care. His days off were spent visiting with children at the Tammy Lynn Center. After his retirement, he continued to work with MEPS (the Military Entrance Processing Station), examining inductees into the armed services.

One of his proudest professional achievements is his involvement in the creation of the Tammy Lynn Center. Serving as a founding board member, he discovered many people were pointing out all of the challenges in making this service and facility available to Wake County residents. Dr. Winslow stood up and simply stated, "We are not here to stop this thing. We are here to get it started. So, let's make it work." In sharing this belief and commitment, he helped to make the Tammy Lynn Center a reality. "Dr. Winslow is much revered and loved by the children and their families," says Mary Freeman, President & CEO. "As a pediatrician, he made frequent visits to make sure children were seen in a comfortable, familiar and family-friendly environment. As a long-time board member, he was a consistent and dependable leader, dedicated to the spirit of the Tammy Lynn Center." In honor of his commitment and to continue his legacy, the Tammy Lynn Center named a room for him – the Winslow Conference Room.

Dr. Frank Winslow is a member of the Raleigh Academy of Medicine, Wake County Medical Society, North Carolina Medical Society, American Medical Association and the American Academy of Pediatrics. He served as Chief of Pediatrics at both Wake Medical Center and Rex Hospital.

Dr. Winslow considers Pediatrics to be a rewarding specialty. "You are working with an ever-changing patient. They are growing intellectually and physically." So much so, that Dr.

Winslow would actually have to stand on a chair at times to check his patients' throats. He is amazed how a patient 4, 5, 6 years old can remember him 20 years on. "Still I see patients in the grocery store who say 'Hey, Dr. Winslow.'" It all seems to come back to his love of medicine and healing and his desire to see every child lead a healthy and happy life.

While he is obviously dedicated to his professional and civic life, Dr. Frank E Winslow II would hardly be the person he is if it weren't for the love and support of his family. He met his wife, Cecilia, in 1950 and they married six years later. Together they shared a relationship of mutual admiration and support. They have two children: Frank, who is married with two children, and Cecilia. Both Frank and Cecilia own a restaurant called The Point at Five Points in Raleigh. They have a high regard for their father and strive to live by the standards he has set. "He is a man of few words with a dry sense of humor who is dedicated to his family, his patients and his community. He lives by his word and believes in total honesty."

The strength of his family helped Dr. Frank Winslow beat colon cancer in 1994, which he correctly self-diagnosed. Sadly, he lost his wife to pancreatic cancer last year.

As for the personal achievements he holds dear, he is quick to answer: the day he married his wife, the birth of his son and daughter and his gorgeous grandchildren.

Dr. Winslow continues to enjoy his retirement with visits to the beach house his father built in 1931, surf fishing at Nags Head, walks on the beach and sharing it all with his family and his constant companion of eight and half years, an Irish Setter named Joshua.

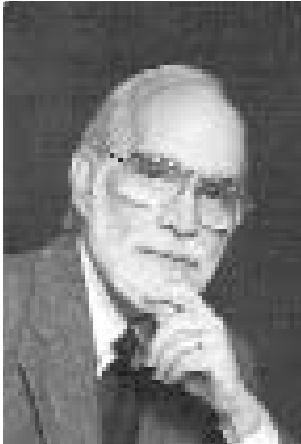
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## First Person continued

After careful listening and paying attention to the faint movements of his lips, I heard scattered words in a staccato and dysrhythmic manner. I heard "lamb of God...sacrifice...lamb of God...Jesus the Lord..." I asked Bryan (not his real name) to tell me more about the Lord, Lamb of God. He ignored me. We just sat there patiently with my request repeated. Without pushing him, I made it known that I would listen if he wanted to tell me more about the Lord, Lamb of God.

He began to throw skulking glances in my direction. His hand furtively approached my hand resting on the arm chair and extended in his direction. He finally said that he was Jesus, Lamb of God and wanted to be sacrificed for the Lord. A thought occurred to me like a stroke of lightning. I said, "The Lord does not want such a skinny and nervous lamb to be sacrificed for Him. Why don't you eat, fatten up, and take some medication to calm you down, so that you will be worthy of the sacrifice?" Somehow he connected with the promise of turning him into a more sacrifice-worthy lamb. He took a sip of water, and gradually ate some food. Then he accepted some intramuscular medication Thioridazine (Mellaril) and Benzodiazopine (Valium), state of the art medications in the 1960s. He took more food and drank some Mountain Dew before he was admitted to the hospital. When I made rounds that evening, he greeted me with some degree of warmth. His fulminating acute psychosis subsided. He gradually calmed down, rested and ate. In the following days, through psychotherapy, we explored the genesis of his psychotic breakdown. He continued to recover with full restoration to health. We never brought up the subject of wanting to be a sacrificial lamb, because through therapy he learned how to become an "I" and stop being a "me", a lamb-like subject who can be manipulated by people.

Several months ago, a fat packet came in the mail from Bryan. It was an invitation to the bicentennial anniversary of his farming village. My former patient, now in his early sixties, was listed in the program as the leading citizen of that community and the convener (master of ceremonies) of the festivities.



Dr. Stratas

## Maturity: A Beacon

Decades ago in the midst of what I thought was a serious personal medical crisis and wanting to briefly express my thoughts about a fulfilling experience of life, I wrote the following:

- *“To be open to the experience of the world, personally, directly, unambiguously.*
- *To be excited about and grateful for our life.*
- *To be curious about what “is” and be drawn to it, both with regard to our own feelings and with regard to what we see in ourselves and in the people and the objects in our world.*
- *To struggle to come close to ourselves by being in touch with our feelings whatever they may be, and free with our thoughts for there is no limit to what they can be.*
- *To let that which “is” show itself in itself - it is not necessary to lie about what exists in the world. In the long run the facts are friendly.*
- *To choose for ourselves what we will do, how we will live, how we will spend ourselves in our limited time and space.*
- *To be less possessive and more fully appreciate the existentiality of others.*
- *To desire for our fellows the joys of experiencing and choosing for themselves. Our fate is common.”*

The word maturity is now applied widely, beyond human growth to many diverse areas such as computer software, food, organizations and many others. The Internet produces an endless number of matching sites having to do with the maturity of all sorts. Books and treatises have been written. In a general sense human maturity means complete physical and psychic growth. The physical aspect is clearer, visible, and measurable and in most people, attained at some level.

The use of the word maturity which interests me has to do with the development of an advanced level of existence. Maturity is not a state one reaches but rather as in the poem, *Ithaca*, by the Greek poet Cavafy, it is a journey where the road is long, full of adventure, full of knowledge. Moreover each person's journey is unique and varies in degree from time to time. Maturity according to Webster's is “full development”. The Oxford Dictionary provides the definition, “deliberateness of action, mature consideration, due deliberation, fullness or perfection of natural development, ripeness, due promptness, the state of being complete, perfect, ready,” and so on. Interestingly, as recently as 1960, Hinsie and Campbell's Psychiatric Dictionary only defined maturity in the context of genetics as the process of meiosis which

leads to the formation of gametes in the gonads. In the modern era the magazine of the American Association of Retired Persons which positions itself as the magazine of mature people, identifies its target population age as over 50.

Psychologists, Stone and Church in 1968 provided a nicely sculpted definition. Helpful towards maturity is a secure development allowing for growth out of childhood experiences without the loss of childhood's best traits - the basic emotional strengths of infancy, the stubborn autonomy of toddlerhood, the capacity for wonder and pleasure and playfulness, the capacity for affiliation and intellectual curiosity, the idealism and passion of adolescence. Maturity consists not of deflecting energies into refiguring childhood battles or nursing old hurts but rather it is living with the past without being bogged down by it. It is being adaptable, capable of continuing change, with the development of wisdom, aware of one's aliveness with vigorous interests and a sense of humor, at home with reality, at home with the self, loving comfortably with one's soul, mind and body, with a high priority for human relationships, with powerful concern for social problems and ways of alleviating them. Maturity is being self-reliant, not dependent on always having company, responsible to one's self and to others. It is being in touch with feelings, thoughts and actions and their interconnectedness. It is clarifying one's beliefs and values - not accepting values ready-made, knowing when to conform and when not to conform, when to speak out and when to remain silent. It is to have peak experiences and yet maintain one's balance. Moreover it is living in consciousness of one's own mortality, that living is a matter of choosing alternatives and each alternative costs something, that there are things we will never be able to do and experience and there are things we will never be able to do again. Integrity, continually threatened by practical demands, seductive temptations, concessions, compromises and conflicting values, is preserved at the cost of some considerable psychic strain. Maturity is having the knowledge that the only real rewards in life come with continued growth with no room for major regrets. Maturity is having loved, having worked, having made one's mark on people and, while wishing there were more time, having made most of what there was and being grateful for it.

Suggestions, comments, questions are welcome at 3900 Browning Place, Raleigh, NC 27609; 9197877125 or <stratas1@mindspring.com>

# Thinking

By Assad Meymandi, MD, PhD, DLFAPA

## Things Through

Each year there are gazillions of meetings, assemblies, conventions, congresses and seminars held across the globe. Some of these meetings are celebratory in nature, some are to advance science, some are to anoint politicians and some are to promote a common cause. In the past couple of years, Wake County Medical Society has had some of its own. The December 10, 1993 gala celebration of its centennial anniversary at the executive mansion in Raleigh was one. The April 7, '05 meeting of WCMS was designed to both celebrate the arrival of a prominent scientist, the first "Meymandi Fellow" at the National Humanities Center, and to learn from his scientific knowledge and benefit from his vast reservoir of wisdom. Dr. Wilson is a Harvard Professor of entomology, father of sociobiology and twice Pulitzer Prize winner for his many books, among them, the famed volume, *Consilience*, and he did not disappoint us.

But as a good editor should, I have sifted through the proceedings of hundreds of conferences held in the last couple of years, and here is a summary of the most consequential and impressive ones.

The first meeting of stellar proportion was the Golden Anniversary of the day James Watson and Francis Crick walked into the Eagle Pub in Cambridge, England, and announced that they had discovered "the secret of life". The discovery has been dubbed "the most important scientific breakthrough in the annals of Neolithic man." This meeting was held in Berkeley, California. Among the participants was, of course, Nobel Laureate James Watson. Other luminaries were from the world of biochemistry, physiology, and biology. For three days they talked, they bantered, they gave brilliant papers on what the marriage of genomics, proteomics and textonics will bring to the 21st century and how knowledge will be democratized through textonics. Children of backwoods nations as far away as Timbuktu will have access to information stored in the Library of Congress, the Louvre, the Met, and libraries of the pre-eminent universities of the world.

Other papers examined the marvelous achievements of advanced technology and science triggered by Sputnik. The late 50's, all of the 60's and 70's accelerated studies of mathematics, science and physics, paving the way to the July 20, 1969 US landing on the moon.

All the while the humanities were placed on the backburner. Many thoughtful analysts believe the cause of widespread terrorism and horrendous losses such as nine eleven are the direct cause of that neglect. However, in the course of those three days, what was lacking, sadly, and to the chagrin of many, was an almost total absence of a discourse or discussion on how to

transform the enormous amount of available information and technology into wisdom. If we ever catch up with this part of the missing link, perhaps we will have fewer nine eleven phenomena and threats of global terrorism.

At the conclusion of the meeting, it was agreed that input from humanities, such as philosophy, history, psychology, epistemology and linguistics, dance and poetry is needed to achieve the elevated goal of nirvana of wisdom, peace and love.

Another remarkable meeting in the past two years was a "Meeting of the Minds." It was indeed a gathering of some of the world's best thinkers. It was held at the Massachusetts Institute of Technology (MIT) to discuss how scientists, people of religion, Christians, Moslems, Jews, Buddhists, Sufis and transcendentalists, can collaborate to understand the nature of reality. The meeting focused on neuroscience and psychology.

The participants were The Dalai Lama, Arthur Zajonc, professor of physics at Amherst, George Dreyfus, Chair, Department of Religion at Williams College; Ajahn Amaro, co-abbot, Abjayagiri Monastery, Ca.; Ann Harrington, Professor, History of Science, Harvard University; Stephen Kosslynn, Professor of Psychology, Harvard University; Eric Lander, Director, Whitehead Institute, Center for Genome Research, MIT; Jonathan Cohen, Professor of Psychology, Princeton University and Jerome Kagon, Professor of Psychology, Harvard University, just to name a few.

The meetings were most stimulating and informative. The participants were indeed thinking through how to transform knowledge and information into wisdom leading humankind to peace. I was impressed by all the presenters. The common pathway to reaching peace, happiness and the ultimate form of unconditional acceptance, labeled by the Sufi as "love", may be achieved through introspection, self analysis and altruism.

The Dalai Lama said, "Buddhism is a 2500-year-old tradition of analyzing and investigating the inner-world, the reality of the mind, in order to transform one's emotions and reach happiness. It seeks to understand the causal dynamics of emotions. It uses intelligence to the maximum for the purpose of developing compassion."

Looking back at the history of human conflicts as seen in ancient Punic, Peloponnesian, Thermopile and Trojan wars, the crusades, and the more recent wars, including the conflict in Iraq, we should learn that victory does not come with guns and swords but with understanding, compassion, self denial and love. For example, it would be helpful to send ambassadors and representatives who know the language and the culture of the host countries. This would be a good start on the glorious highway of humility, love and respect for others.



Dr. Jeffrey Engel

## Water, Water, Everywhere! Legionnaires' Disease in North Carolina

In 1976, an outbreak of pneumonia occurred at a hotel hosting the American Legion Convention in Philadelphia. Epidemiologic investigation led to the discovery of a new bacterium that was aptly named *Legionella pneumophila*. Since its discovery, *L. pneumophila* has been implicated in numerous outbreaks, both in the community and within health-

care institutions (nosocomial), and is also responsible for sporadic cases of pneumonia in the community. A milder form of the disease known as Pontiac fever was subsequently described as a week-long self-limited flu-like illness without pneumonia.

The ecology of the legionnaires' bacillus is fascinating and pertinent to infections of humans. The natural habitats for the germ are aquatic bodies including rivers, lakes, and streams. *L. pneumophila* can survive in a wide range of environmental conditions including temperatures from 0° to 63° C and a pH from 5.0 to 8.5. It can survive for years in water samples stored in refrigerators. In nature it survives by feeding on other microbial life forms including amoebas and ciliated protozoa. Unfortunately, it is relatively chlorine tolerant and can contaminate drinking water distribution systems.

Colonization of water distribution systems by *L. pneumophila* depends on water temperature, sediments, and the presence of other microflora. The germ particularly favors warm or hot water reservoirs with relatively low or absent chlorine levels. Humans become infected when they aspirate or inhale aerosolized contaminated water. Nosocomial outbreaks have been linked to contaminated shower heads and tap water used in nebulizers, humidifiers, and ventilators. Community outbreaks have been associated with a mist machine in a grocery store, cooling towers, and hot tubs and spas. The 1976 American Legion outbreak may have been caused by water consumption at the implicated hotel. Interestingly, outbreaks have not been associated with swimming in rivers, lakes, or pools.

People at risk for developing legionnaires' pneumonia are those with compromised immune systems, chronic lung disease, the elderly, and cigarette smokers. In hospitals, post-operative patients and organ transplant recipients are at highest risk.

In North Carolina, legionnaires' disease has been rare. From 1993-2002, anywhere from 11 to 34 cases were reported per year. In that decade, all cases were sporadic and healthcare-associated infections had never been described in the state.

### Three investigations of legionnaires' disease in NC, 2003-2005

During the spring and summer of 2003, my office investi-

gated an unusually high number of legionnaires' pneumonia cases reported to the state by clinical laboratories. Investigations revealed that the 29 patients reported from April through August all had the expected clinical risk factors, no recent travel or hospitalization, and were from different locales across the state. Other than the seasonal cluster, it appeared to be simply more sporadic cases than usual. We notified the Respiratory Disease Branch at the Centers for Disease Control and Prevention (CDC), and to our surprise, they were receiving similar reports from other mid-Atlantic states including Maryland, Delaware, Pennsylvania, and Virginia.

A series of conference calls ensued and state and federal epidemiologists wondered if the increased rainfall the region was experiencing at that time might be responsible. Using the observed and historic legionnaires' disease rates from the involved states and weather data from the National Oceanic and Atmospheric Administration, investigators from the CDC showed a striking association between legionnaires' rates and temperature and rain variables. Compared to the baseline years from 1990-2002, the model suggested that the average increase in rainfall of 2 inches (experienced in the spring and summer 2003 in the mid-Atlantic region) led to a 20% increase in legionnaires' rates.

In the fall of 2004, we were asked to assist the Cherokee County Health Department with 2 cases of legionnaires' disease associated with a long term care facility. Since NC had never experienced healthcare-associated legionnaires', I in turn asked for assistance from the CDC. Active case finding revealed seven cases associated with this outbreak with symptom onset from September 10 to October 16. A detailed investigation into suspected contaminated water sources at the medical center including sampling of sinks, washers, tubs, showers, and water heaters turned up completely negative.

Environmental investigation subsequently led to a cooling tower located at a factory across the street from the medical facility. Cultures from this tower revealed heavy growth of *L. pneumophila* of a similar type previously linked to healthcare-associated outbreaks in other states. Although bacteria could not be cultured, swabs taken from filters of the air handlers located on the roof of the long term care facility were positive for *L. pneumophila* DNA.

In August and September 2004, the remnants of 3 hurricanes (Frances, Ivan, and Jeanne) swept across the western part of the state, including Cherokee County, and caused significant flooding. Additionally, wind directions were opposite of their normal flow during these storms. Investigators concluded that the most likely cause of the outbreak was hurricane-induced intensive wind and water aerosolization of *L. pneumophila* from the cooling tower to the air intakes of the medical facility. The ensuing environmental contamination then infected a number of vulnerable elderly bed-ridden people.

In April 2005, the Virginia Department of Health called

# Aging into the Last Years of Life

By Robert Seymour

Aging is a sensitive topic for most Americans. No matter what our age, we tend to think that the word “old” applies to those who are at least ten years older than we are. If you are sixty, those who are really old are seventy. If you are seventy the old are eighty.

At my 57<sup>th</sup> reunion of my Navy unit, it was somewhat jarring to see how old everyone looked. I was pleased when several friends from more than a half-century ago said, “You haven’t changed.” Of course I knew it was a lie, but that is the kind of lie we like to believe.

We generally think of senior citizens as the aging segment of our population, but no one escapes the aging process. It begins the moment we are born. I like that bumper sticker which reads, “Aging is the only way to life.”

Recently at the Carol Woods Retirement Community where I live, we welcomed new residents at a social event, and I was asked to say a few words about what to expect when we move from the “go-go” stage of life to the “slow-go” stage. Here is what I said.

You know you are approaching old age when you begin to realize that you are no longer “a promising young man” (or woman), or when you suspect that you may not be indispensable to whatever it is that you are doing. As you move out of the mainstream to the sidelines, you will discover that the world can adapt to your retirement remarkably well.

If your ship has not already come in, you begin to suspect that it may never arrive. You will have more nostalgic memories of the past and fewer ambitious plans for the future. You may observe traits in yourself that you remember seeing in your mother or dad. (And I hope you are glad about that!)

The “slow-go” stage of life should not be dreaded, for it offers many entitlements. From now on you can accept senior discounts gracefully, for there is no way of concealing your age. You can set your own agenda and do only those things you really want to do. You can spoil your grandchildren and get away with it. You no longer need to be cautious about what you say or the opinions you express. You are free “to let it all hang out,” to tell it like it is. You can complain, “We never did it this way before,” And you can exclaim repeatedly, “What’s the world coming to!” Because many people will assume that your hearing has diminished, you can listen selectively, pretending not to hear things you would prefer to ignore.

There are several “don’ts” you should respect. Don’t cup your hand to your ear to hear better. This has gone out of style. Instead, just smile a lot and appear interested in the conversation. Don’t contradict your grandchildren. They may know better than you do, but even if they don’t, you will have trouble reversing their self-assurance. Never neglect to enter engagements and appointments in your calendar; otherwise, you may find yourself scheduled to be three different places at the same time. Although you may be a splendid storyteller, don’t ever tell a story without first searching your memory to make sure you have not told it to the same people before.

There are other things you should know as the “slow-go” stage of life edges toward the “no-go” stage. Never worry about being taken hostage as you travel to exotic places because you will be the first one released. There will be times when you will find yourself more interested in going back home than in getting to where you are going. Expect people to call you before nine o’clock at night and ask, “Did I wake you up?” You can still be the life of the party if it ends before eight. You will spend more time looking for things you have lost, but be assured that you have hidden them in a very secure place.

At last, your health insurance will begin to pay off. Your acquaintances will no longer consider you a hypochondriac. You will spend more time in waiting rooms reading PEOPLES MAGAZINE. Don’t be surprised when your children begin to parent you. They will call and ask, “Where have you been?”, similar to the way you used to ask them the same question.

Relax and enjoy your advanced age. You will be able to get away with a lot. After you are 80, people will forgive you for almost anything. “Senior moments” may cause your conversation to come to a sudden end because of an inability to recall a word. This can be embarrassing, but people will understand.

Aging is like climbing a mountain. The terrain may be steep, and your steps may slow down almost to a stop as you struggle to reach the top, but the view from there is wonderful and well worth the effort.

*Robert Seymour is the Minister Emeritus of the Binkley Memorial Baptist Church in Chapel Hill.*



## Sicily

Two miles off the toe of Italy, Sicily is about the size of Vermont. As the result of waves of invaders this island possesses one of the greatest concentrations of historical and archeological landmarks in the Mediterranean and a cultural legacy that has endured for 3,000 years.

By 800 B.C. Phoenicians had established colonies in Sicily. Foundations have been discovered under Roman ruins near Palermo. They brought written language, as seen in inscriptions and coinage.

The Greeks came about 756 B.C. and by 700 they controlled half of Sicily.

In a couple of centuries there were dozens of Greek cities. One hundred years after its founding Syracuse was one of the greatest cities in the civilized world. Sicily lay in the center of the trade routes to the west and markets in the Near East.

By 215 B.C. all of Sicily was under Roman occupation. It became the first Roman province outside the mainland.

Arabs arrived in 827 A.D. They were very constructive, imported new crop types, repaired aqueducts and raised the intellectual level of Sicily after it had been devastated by Franks in 278 and invaded by Byzantines in 535.

The Normans conquered in 1078 followed by Spanish and French invasions. And finally Sicily was invaded at Palermo by the Allies led by General Patton in WW2 as the key to the invasion of Europe.

Palermo, the largest city in Sicily sits on the Tyrrhenian Sea. Four days stay in Palermo was enhanced by a performance of Rossini's La Scala de Seti at the magnificent opera house which opened in 1897.

Segesta boasts a Greek Acropolis (acro means high, polis means city; thus high city) built in 5th century B.C. out in the country in the middle of nowhere in a majestic setting on a hill. It was never completed, but is in an excellent state of preservation. Nearby was a Greek theater built into the side of a mountain overlooking a scenic valley.

Sicily had the highest concentration of temples in the world at one time - more than in Athens. They were built by the Greeks between 350 and 406 B.C. Ten in various states of ruin are still standing in Agrigento and they are well preserved on a majestic setting on a hill. The most ancient, the Temple of Hercules, once ranked in size with the Temple of Zeus. Seeing the temples illuminated as we drove through the valley under a full moon while listening to Holtz's The Planets was a dramatic experience.

In the town of Piazza Amerina is "Villa del Casale" with 62 rooms of the largest mosaic floors in Sicily and the most outstanding from the ancient world. It is a wonderful example of Roman life during the 3rd to 5th century when Sicily was the bread basket of the world. It depicts Roman aristocrats banqueting, hunting, religious festivals and gladiators fighting exotic African animals. These mosaics are perfectly preserved and are the original bright colors. A huge earthquake created a landslide in 1601 which buried the villa in mud until it was excavated in 1950.

Taormina, Sicily's most famous resort dates from mid 4th century BC and is perched dramatically on a rocky promontory overlooking the Ionian Sea. It is the site of a Greco-Roman amphitheater with a view of Mt. Etna and the sea. The theater was carved out of rock on the slopes of a mountain. Superb acoustics allow audiences in the back row to hear a whisper on stage. The back of the stage is open to the sea so the sea breezes bring in the sound.

The hotel where we stayed for six nights was on the top of a mountain overlooking the Ionian Sea and the town of Letojanni on the beach.

Siracuse, a city founded by Greek Corinthian colonists in 734 BC became a major trading center on the south east coast of the island. Here is located a Greek 5th century theater where the first Greek tragedies were performed outside of Athens. It had wide entrances and exits for people called vomitoria so there are no lines.

In the 16th century the Spanish arrived and began to destroy the amphitheater to use the stone for fortifications. Eucalyptus trees were imported from Africa.

On the small island of Ortigia connected to Siracuse by a little bridge, are the remains of Greek temples. On the Piazza is an 18th century cathedral, which originally was a 5th century BC doric temple with changes made by Romans, Arabs, Normans, Spanish and other conquerors and the architectural alterations can still be detected.

Messina, founded in the 8th century BC, was "the largest and richest of cities" in Greek and Roman ages with a natural harbor on the Mediterranean, a strategic position for economics and war. It was almost depopulated when conquered by Arabs in 843, but Christianity recovered with the Normans in 1061. The Duomo, built by Normans in 150, was restored after an earthquake and the bell tower rebuilt. The clock, installed in 1933, is the only one of its kind in the world.

At midday there is a spectacular display. Beginning with sacred music, a golden lion comes out of the tower and roars. Then a rooster flaps his wings and crows followed by a procession of church figures.

Mt. Etna, the highest mountain in Sicily and the largest volcano in Europe, 10,000 feet high, is always covered in snow and is always active. We drove up 7,000 feet and walked around an extinct crater. The desolate landscape was covered with black lava. Last year when it erupted many tourist buildings were destroyed. Friends from Chapel Hill saw red lava flowing down the mountain. Tourist markets nearby sell jewelry made from lava and anthracite.

## Africa

Africa is the second largest continent. It has 51 different countries and more than 1000 different cultures or backgrounds and 800 different languages.

Unfortunately, despotic governments, draught, famine, lack of economic and political infrastructure has robbed this vast region from basic elements of civility and humanity. The blite of Sudan's Darfur is the latest. Tens of thousands of people are being killed, maimed, raped, displaced or otherwise starved to death. Traveling through these countries is most

instructive and most moving.



## Down, But Not Out



Marc Benevides MD

Unfortunately, cross-over day came and went. You may be asking yourself, "What exactly is cross-over day"? Procure's Carter Wrenn in a recent info-email called it a "mythical beast". The day represents a technical deadline that says if a non-spending bill has not passed either the House or the Senate by a set date, the bill cannot be considered for that session. It is not, however, an absolute deadline. Legislators can attach the bill as an amendment on a spending

bill. An independent committee can also reexamine the bill at a later date and bring it to the legislature.

House Bill 1359 and House Bill 1344 never made it out the Committee on Rules, Calendar, and Operations of the House chaired by Rep. Alice Border (DEM - [Aliceb@ncleg.net](mailto:Aliceb@ncleg.net), phone # 733-5820, occupation: attorney) and Rep. Jean Butterfield (DEM - [Jeanf@ncleg.net](mailto:Jeanf@ncleg.net), phone # 733-5898). It is interesting to note that Bob England, a physician, sits on the committee that failed to act. Senate Bill 44 never made it out of the Committee on Commerce headed by another attorney R. C. Sales (DEM - [Rcsoles@ncleg.net](mailto:Rcsoles@ncleg.net), phone # 733-5963). Most importantly, Senate Bill 989 never made it out of the Committee on Ways and Means headed by Charlie Donnelly (DEM - [Charlied@ncleg.net](mailto:Charlied@ncleg.net), phone # 733-5955). This bill is probably the most important legislation because it caps non-economic damages to \$350k, introduces sliding fees for attorney's fees (40 to 15%) and also lays out rules for paying settlements in installments rather than in lump sums.

Where do we stand on a national level? The House of Representatives recently passed H.R. 5, the HEALTH Act, by a vote of 230-194 on 7/28/5. The stated purpose of the bill is to

improve access to health care services and to improve medical care by reducing the excessive burden the liability system places on the health care delivery system.

Below is a brief summary of the HELP EFFICIENT, ACCESSIBLE, LOWCOST, TIMELY HEALTHCARE ACT OF 2005:

- Sets a statute of limitations of three years after the date of the injury or one year after the claimant discovers the injury.
- Limits non-economic damages to \$250k.
- Sliding scale for attorney's fees.
- Provides for periodic payment of awards.
- Allows for the introduction of collateral source benefits as evidence.

According to U.S. Representative Virginia Foxx from North Carolina, "Skyrocketing insurance premiums and out of control lawsuits have diminished our nation's health care systems for too long. Health care dollars should be spent on patients in the hospital – not on lawyers in the courtroom. This legislation is pro-patient in every way. It will increase quality of care and decrease patients' costs. Spending health care dollars on frivolous lawsuits instead of treating and curing the sick is a travesty."

N.C. Representatives Foxx, Jones, Hayes, McHenry, Myrick and Taylor voted for HR 5. While Representatives Coble, Butterfield, Etheridge, McIntyre, Miller, Price and Watts voted against the reform bill. The legislation is now referred to the Senate Committee after being received from the House. It is important to note that a similar bill was passed in the House in 2003, but was not taken up by the Senate. If we plan to see tort reform in the next year, our hopes lie at a national level.

**"Life is a gift from God.  
What you do with your life is your gift to God."**

**- Rahul Patel**

*Contributed by M. Javad Meimandi, PhD  
Malibu, Ca*

# Access-to-Care: A Crisis in Psychiatry

By Stanley Monroe\*

*But nothing is more estimable than a physician who, having studied nature from his youth, knows the properties of the human body, the diseases which assail it, the remedies which will benefit it, exercises his art with caution, and pays equal attention to the rich and poor. -- Voltaire.*

There is a crisis in the practice of psychiatry in the USA. Even as it becomes clear that extraordinary numbers of people suffer from mental illnesses, it is also clear from the research that most of these people are under-treated or not treated at all. Inadequate treatment of mental illness has many contributing factors - the stigma attached to seeking help, lack of health insurance for the working poor - and admittedly, many of these factors are outside the control of individual psychiatrists. But there is one overriding problem that is certainly within the ability of psychiatrists to ameliorate, if not eradicate. That problem? Even for insured people who seek treatment, there is a profound lack of access to psychiatrists because many psychiatrists have refused to open their doors to them.

Often a psychiatrist that discriminates against certain patients has good reason for being concerned. A patient's insurance plan may demand large discounts or make it difficult to get paid at all by placing managed care obstacles between the psychiatrist and reimbursement. Most reasonable doctors would acknowledge it can be vexing and even dangerous to share medical decision-making with insurance care managers. These reasons are valid, but to solve these dilemmas by refusing to treat some patients based solely on their insurance coverage is throwing the baby out with the bath water. The net effect is psychiatrists gaining a reputation for being elitists, while being marginalized in the health care field. It also forces patients to demand alternatives. Much is made of the debate about psychologists prescribing medications, but the real alternatives are the family physician and the emergency room. While both are valuable medical resources, to be effective they must be able to refer more complex cases to readily available psychiatric care. As it now stands, a family physician who is eager for a same-day referral of a patient displaying symptoms of mental illness in his or her [the physician's] waiting room, is lucky to find any psychiatrist who accepts the patient's insurance plan, much less one who is available within the month.

There is a better way. Mental illness cuts across all demographic and economic lines. In order to remain relevant medically, and to ensure that people get adequate care, psychiatrists must treat whole communities of people. The wealthy, the middle classes, and the poor. To do this, psychiatrists may need to adopt newer, more efficient models of practice that allow them to treat patients as they come while still making a comfortable income. They need to advocate for patients when insurance companies won't authorize or pay for necessary services. Can this be done? Absolutely. These goals are being accomplished every day by some practices that are able to accommodate almost any patient by establishing some depth clinically, administratively, and financially. And by adjusting their sense of mission to include contributing to the care of every strata of society.

In our private practice, Carolina Partners in Mental HealthCare, PLLC, we have been experimenting with this kind of practice model for about twelve years. Carolina Partners now has ten multi-disciplinary offices in six North Carolina cities.

Within reason, we accept and treat any patient that walks through our doors regardless of his or her illness or insurance coverage. We are focused on being a larger practice because theoretically it should provide us with more financial depth, and we emphasize administrative efficiency as a way to offset our acceptance of lower fees from some insurance companies. We have established a central intake system so patients can be routed to any practice within our group with one phone call. This makes it possible to offer patients quicker appointments and to do a certain amount of fitting the patient to a particular clinician who might have extra expertise in treating the patient's illness. We encourage family physicians to refer to us their complex cases and we try to accommodate these patients, especially those in crisis, very quickly. I should mention at this point, however, that we do not attempt to treat many indigent patients, although if we could figure out a reasonable funding source we would try that too. We acknowledge that it may become increasingly necessary for private providers to try to care for indigents as mental health reform proceeds.

Our efforts to convince other psychiatrists that our practice model can result in better access-to-care and a decent income have been met with skepticism at times. Some doctors have pointed out that individual providers might make more money if we cherry-picked healthy clients with good insurance from among the populace and only treated them - and they may be right in the short term. There are certainly psychiatrists who have adopted this strategy who seem to be doing all right. Other psychiatrists opt to work in the public sector or a hospital-based system of care for a variety of reasons.

There is room at the table for different practice philosophies, as long as we remember that patient-care remains the primary reason for psychiatry to exist. At Carolina Partners, we will continue to work on our proposition that it is possible to focus on patients, treat everyone from rich to poor, and still make a good living. And we certainly believe that the field of psychiatry is in peril if it fails to serve large numbers of people who need care. Psychiatrists may become marginalized while nurses, physician assistants, and psychologists take up the yoke of providing mental health treatment to communities of people. Once this becomes the norm, psychiatrists - all psychiatrists - may have trouble making the argument that they are medically relevant given less expensive, more accessible care from other professionals.

*Stanley Monroe, Esq. is an attorney in Chapel Hill, concentrating on mental health issues. For the past 12 years, Mr. Monroe has been Executive Director of Carolina Partners in Mental HealthCare, PLLC, a private mental health practice with ten offices in six North Carolina cities. Mr. Monroe is a consulting member of the North Carolina Psychiatric Association's Practice Management Committee. Mr. Monroe can be contacted at: Phone 919-967-9567; Fax 801-729-9867; Email misosoup@att-global.net; Address 1502 W. Hwy 54, Suite 103, Durham, NC 27707.*



## North Carolina Churches Portrait of Grace

By Assad Meymandi, MD, PhD, DLFAPA

Edited by Mary Best

Photography by Mark Wagoner

224 PAGES

214 Plates

Size: Coffee Table Size

Our State North Carolina Books

Printed in China by R. R. Donnelley & Sons

At the first glance, this stunning book of beautiful prose and spectacular photos reminded me of the seven celestial books. The first, of course, is Torah, the teachings of Abraham and Moses bringing mankind lessons of faith and discipline. The second, Avesta of Zoroaster (Zaratustra) with its 32 books starting with Gushtasb, the religion of Cyrus the Great, published 2500 years ago (550 BC) admonishing people of to espouse the holy trinity of "Good Thoughts, Good Words and Good Deeds). The third, the Book of David's Forghan, the melismatic "mona-



*Christ Episcopal Church in Raleigh,  
circa 1821*

jat", or dialog between man and God--The Psalms/Psalter--. The fourth, The Holy Bible of Christians with its first, the Vulgate Bible in Latin, at the time of Saint Augustine of Hippo and Saint Jerome (359 AD), and later the King James Bible (1611) to bring us the essence of love; the fifth, The Holy Quran of Prophet Mohammad bringing the promise of possibilities, redemption and salvation; the sixth, the Book of Mormon (some do not think of it as a celestial Book) and lastly, the Book of Abdollah Afandi or Bahaii, the Persian Prophet who came and claimed to be the latter Messiah. The compelling beauty of the book brought in a rush all these uplifting thoughts. Then I began to leaf through the book. It is indeed a celebration of man's appreciation of Christianity through architectural beauty, photographic perfection and artistic expression. The book has dozens of photos of "grand cathedrals, historic tabernacles, rivalvalist campgrounds, family chapels, and humble meeting houses..." "...And their stories told in absorbing essays and soul-stirring photography..." describes the Book's dust jacket.

The theme of the book is what is universally known about

Christianity, "LOVE". The book begins with a series of almost transcendental photos of stain glass window, a totally absorbed woman in the act of prayer, with progressive captions of LOVE...Bears all things, believes all things, hopes all things, endures all things...Love never ends...

The book contains 214 plates of exquisite photography and maps of early Christian churches.

Mary Best, the Editor of the book in her introduction recounts her childhood confusion about religion, church, big words...She then writes" During one cool Easter sunrise service when I was 12, the haziness of the minister's sermon began to clear..." She marks age 12 as the "clearing of confusion" and beginning of her faith... which has led her to compiling, editing and overseeing the writing of this enormous piece of work, truly an opus magnum. It depicts a combination of beautiful writing and impressive photography.

## History of England

by Paul de Rapin-Thoyras (1661-1725)  
Oxford Press, 1705

Etymology has always fascinated me. Etymology of the English words fascinates me the most. The English language is young, fresh, dynamic and growing. When I came to US in 1955 to study medicine, the entire Oxford Dictionary contained 285,000 words which I memorized in three months. The last edition of Oxford boasts 750,000 entries, tripling its size in fifty years. Will I memorize the new words now? I don't think so!

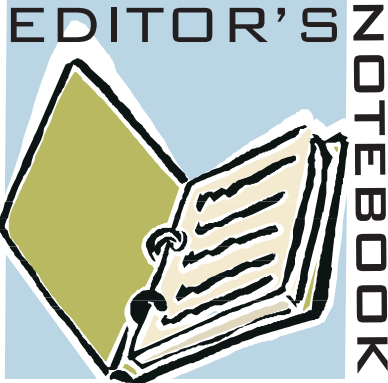
It is so exciting to find a language whose individual building blocks, its words' roots and ancestry are so readily accessible. This is a rather unique characteristic of the English language. Try that with any of the ancient languages such as Farsi, Arameic, Arabic, or even more modern languages like French and Italian. You get lost in a hurry!

Besides etymology of the words, I have been intrigued by the origin of the British system of government, the Whigs, the Toreys, representative form of ruling, parliament, etc. These studies, including an intense review of the books that Thomas Jefferson and John Adams read during their political formative years of mid eighteenth century, led me to the discovery of a scholarly book, History of England, by a French Huguenot, Paul de Rapin-Thoyras (1661-1725), out of print since early 1700s, first printed in 1705. It is most interesting that this in depth and scholarly work about British history was written and produced not by an Englishman, but by a French scholar.

An aside, this phenomenon reinforces the premise that it is often the immigrant and the foreign born who advances the cause of a nation. For example, it took Jean Baptiste Lulli (1632-1687), an Italian born orphan, immigrated to France, at the age 14, rising through the ranks in the very difficult and competitive musical scene in Paris to become the Sun King, Louis XIV's court composer. He gave us the majestic dotted rhythm of French overture, the Ballet and a wealth of operas.

Back to the main topic, Jefferson, in his daily journal, has several references to Rapin's book, calling its author "the greatest historian of England." So, did John Adams and many other framers of the US Constitution. Later, Jefferson became an intense student of the proceedings of 1748 British parliament.

Here is a brief review of this fascinating book. I wish members of the present administration would read the book carefully. I also wish the policy wonks in charge of giving advice to



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

## Ladies in Lavender

I was about to lose my faith in movies. In recent years I have walked out of movies that used offensive language, violence, and allusion to drug use and sex. I was beginning to think that the movie industry had lost its com-

pass, adrift in a sea of meaningless fast action, destruction and aimless pseudo sophisticated psychobabble. Whatever happened to those thoughtful, meaningful, redemptive movies, like *Lilies in the Field* with Sidney Poitier, produced with a budget of under 50 thousand dollars? I had told my wife to quit thinking about going to the movies altogether. Until we saw *Ladies in Lavender*...

This was a different kind of a movie. It had no sex. It had no violence. I did not get bored or fall asleep. Every frame of the nearly two hour long movie was brilliant, delicious, sensual and meaningful. There was little talk in the movie. The dialogue was conducted in several languages - German, Polish, some French, and, of course, English. But the encompassing language that every one understood was the universal and transcending language of love, gestures, tenderness and care. All that was made possible by the celebrated talents of two actresses, the heavy weights of today's theater, Maggie Smith and Dame Judy Dench, both accomplished Shakespearean actresses. In *Ladies in Lavender*, they spoke volumes with one small gesture, twist of the nose or the most subtle roll of an eye. I fought tears throughout the movie. It had laughter, tears, sadness, fear, jealousy, happiness and redemption. It had moments of supreme sacrifice, ministering and healing. But above all, it had love. It was not the kind of love expressed by the mid-section of the body, nor the kind of love that is perceived in the ether of spirituality. Not the kind of love that comes out of the warmth of family, like the touchy feely Walton TV Series, and not like the intellectual understanding of love. But pure love of one human being for another human being, expressed through the powerful and universal instrument of music, the kind of music that only a violin can produce. And the violin was that of Joshua Bell. I found this movie to be truly a celebration of human spirit, human tenderness and human connectedness. I do not wish to give away the plot or review it frame by frame, not even what the story was all about. That you should see for yourself. You are in for a treat.

Reprinted from N&O

## Neurosurgery crisis

I commend your recent articles on the North Carolina neurosurgeon who has abnormal vision and, more importantly, multiple malpractice payouts. Without question, North Carolinians must be treated by physicians who are highly skilled and who practice an acceptable standard of medical care.

However, another neurosurgery crisis exists that is harming far more people: the growing shortage of neurosurgeons. One hundred and forty-seven neurosurgeons practiced in North Carolina four years ago. One hundred and ten neurosurgeons now practice in our state. Fewer than 60 neurosurgeons take care of emergency brain injuries. There are fewer than 10 neurosurgeons east of Raleigh.

North Carolinians die or suffer irreversible brain damage on a regular basis because of the dramatic decline of neurosurgeons who are available to take emergency calls for brain injuries. Many specific and tragic patient stories exist.

The neurosurgeons are disappearing due to several reasons. One dominant reason: many neurosurgeons cannot afford the multiple frivolous lawsuits that are routinely filed in brain injury cases and cannot afford the associated malpractice insurance. The cost for brain surgeons to do brain surgery is becoming too high. Neurosurgeons are doing more spine surgery and less brain surgery.

The worsening shortage of neurosurgeons doing emergency brain surgery is seriously harming a substantial number of North Carolinians. The crisis in neurosurgery is real and must be imported or people will continue to suffer irreversible brain damage or die needlessly from their brain injuries.

### Dan Alright, M.D.

*President, Wake County Medical Society; President, Protect  
health Care Now  
Raleigh*

July 28, 2005

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## The Economics of Lottery

Your page one story, May 30, '05 re: "departure of the legislature's lottery expert" has many inaccuracies and misinformation. The suggestion that the poor and the rich tend not to play the lottery, and that the lottery does not adversely affect the poor is a gross misstatement. Scholarship and research on this subject backed by epidemiological studies sponsored by the National Institutes of Health (NIH) and Center for Disease Control and Prevention (CDC&P) strongly suggest that the poor with median wages of 12,000 to \$24,000 a year is the big spender on the lottery. Also, the rate of addiction, pathological and compulsive gambling requiring professional treatment is much higher than stated. The notion of setting aside a portion of the lottery revenues to treat the addicted is a violation of all the principles of prevention and practice of sound public health.

Again, I submit the legislature to have the courage to defeat the ill conceived and delusional lottery bill. The State should look to other sources such as raising taxes on tobacco and alcohol--sin taxes--to enhance its revenues.

A.M.

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## Poor Marks for the Legislature

I have been reviewing the report card of our legislature, and it does not look good. In a most generous mood, it has earned maybe a D minus or a D. With the dominance of inaction, squabbling and general inertia, the session continues at enormous per diem cost to the tax payers. The structure of the legislature is troublesome. We really do not have a representative form of government. Only a few rule. This form of oligarchy, where decisions are made by a few at the exclusion of general public input and the press, is barbaric and detrimental to our society. It is a throw back to the dark ages.

Some of the very few legislative actions taken place are downright abominable. I have reviewed and read most of the documents related to the inexcusable passage of the bill to increase alcohol content of beer to 15%. I have found not one redemptive reason for this incredibly unwise decision. As the result of this law, we will see more drunken drivers, more death on highways, more incidence of alcoholism and alcohol addiction. The legislators have not shown the courage to increase taxes on tobacco to two dollars a pack. This could fund education and mental health. They have not allowed the necessary funds to expand the NC Museum of Art which would make Raleigh a destination. And, I am concerned that our law makers will succumb to the developers' lobby and not allow the Dorothea Dix land to be turned into a City Park, another way to make Raleigh a destination. But miracles do happen. I remain hopeful.

A.M.

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## More on Lottery

The policy wonks and budget gurus in the legislature should prohibit the lottery in our state. For income, they ought to increase tobacco, beer and liquor (sin) tax to the maximum, like \$2:00 per pack of cigarettes. Bringing the lottery to North Carolina is an unkind, unloving and abusive act purported by a state whose origin is enshrined with the holy motto "Esse Quam Videri". The lottery is an addiction. It is all appearance, frill and foam, false hope with no redeeming features. We ought not to allow our government and legislators to become enablers and facilitators of an addiction which like alcoholism and drug use and abuse is a form of delinquent behavior. We ought not to let our state become addicted to the unwelcome and ugly income called lottery money. Increasing sin tax will bring the state income, limit access to cigarette and beer, eventually lowering the incidence of lung cancer and alcoholism. These afflictions are sky rocketing the cost of health care and bankrupting state's Medicaid program. Our politicians need courage to do the right thing, kill the lottery and increase the tax on cigarettes, beer and liquor.

A.M.

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## In Support of PBS

It is a travesty and dishonor to cut the funding for Public Broadcasting System. It is sad to see the institution of PBS to be mired in meaningless partisan politics. PBS provides the basic minimum daily requirement of human civility and thoughtfulness for its listeners. The information is balanced, responsible and accurate. I read France's Le Monde and Le Figaro and England's the Guardian. By comparison, PBS provides the most credible information in a non hysteric and sound manner. I am willing to pay additional taxes to keep the service alive.

A.M.

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## Flaws in Our Educational System

Lawyers speak in incomprehensible legalese, politicians in unintelligible double talk coming out of both sides of their mouths, boards of education speaking in language of victims, oh poor us, see what the county commissioners are doing to us....And you had a good representation of each on the pages of Q Section, Sunday June 19. What everybody left out was the question of why educating our children requires such elaborate edifices as the granite palace on Wilmington Street. In addition, every local board of education has to have its own fancy offices, staff and separate layers of bureaucracy. Why should education be involved in food, transportation and social services, all of which are tantamount to baby sitting? Should schools be in the business of providing and making up for what children do not get at home?

From the ancient days of Socrates, Plato and Aristotle to the modern day Jesuit system, education requires a student to learn, a teacher with knowledge to teach, and motivation. It does not require fancy buildings or centrally dictated procedures by a cadre of persons with six figure salaries, clad in buttoned down three piece suits, often overfed and obese, who administer a staff of clipboard carrying minions to ensure a politically correct curriculum. This is not education. This is a watered down excuse doomed to deterioration and devoid of intellectual stimulation. Throwing money at this corrupt and unfortunate system will not correct the outcome where a majority of our high school graduates can not read, write, balance a check book, or fill out an application. Budget fights will not help college graduates with an English major who never read Shakespeare, do not have a clue as to where Tunisia, Ireland and Jerusalem are on the map, or what of the US Constitution the Bill of Rights is, nor will they make so many PhDs with degrees in diversity studies and other novel curricula to speak better English. In the course of my daily clinical practice, I see many of these unfortunate people equipped with graduate and post graduate degrees who can not carry out a normal conversation without using "you know what I mean" ten times in the course of a simple conversation. I submit that we stop the tread mill, get off it, and go back to the fundamentals of education: learning and teaching. The neurotic pre-occupation of blaming, finger pointing, competing and empire building does not solve the problem of teaching our children.

A.M.

Continued on page 22

## Hear Me Out

Hear me out I may have a learning disability  
But I know where my heart-frame mind and soul is  
I know what road to take for God to lead me to my success  
People point, laugh, and make jokes because I have a learning  
disability  
They call me special trying to be funny  
But yes I am a special, sweet, young lady looking to fulfill my dreams and goals  
But I might have a learning disability  
But I'm not going to let that stop from believing in myself  
I keep my head up and keep trying and trying  
I know I don't have to be labeled as a girl who has "L.D."  
I can be anything I want to be  
A poet, singer, actress, or lawyer  
But I know one thing . . .  
I'm someone special, someone sweet and kind  
I do have a learning disability  
But I'm unique, bright, intelligent and I have style

**Bianca Stewart**

*Raleigh, NC*

*Age 16*

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### INTERSECTIONS continued

identity never really moved there, either. I was merely a non-astronomical interloper hoping to revive an old tradition and then pass the reins to someone else. I was still a chemist, and she stayed over in chemistry.

I realized that I must really want to do more than just *serve* as the chair of the chemistry department; I must actually want to *be* the chair of the chemistry department, because after a month or so, I brought *The Magdalene Reading* to the chair's office and put her up on the wall. Something tells me that we're going to need her quiet contemplation in some of our faculty meetings.

And maybe culture is safe, after all: when I contacted my

now colleague and friend Jaroslav Folda for some information about van der Weyden for this column, he was just as excited about the old master as he had been 23 years ago. That's probably enough to protect us from both Dan Brown and *Captain Underpants*.

But for those 36 million air travelers who suddenly decided upon deplaning that Mary Magdalene would now be their proprietary paragon, I just have one thing to say.

I loved her before you did.

## Issues on Care at the End of Life continued

active steps to hasten a patient's death, but these survey data were flawed by low response rates and poor design (Quill, p. 1380). Other physicians may withhold pain medication because of largely ungrounded fears that terminally ill patients will become tolerant of or addicted to the medication or will abuse medications (Snyder, p. 209). However, common sense dictates that death will come before addiction becomes a problem. One of the most important purposes of medicine is to allow terminally ill patients to die with comfort, control, and dignity. Thus any request for PAS should be interpreted as a call for help, perhaps just to relieve uncontrolled symptoms or suffering.

PAS is a very complicated issue and there are many different aspects to end of life decision making. These include patient rights, trust, limits of medicine, legal, ethical, and moral components, and both individual and societal view points. (Snyder, p. 209) The definition of PAS is "to enable a patient to perform an act that is specifically intended to take his or her own life," while euthanasia is where "the physician performs an act that is specifically intended to take the patient's life (Snyder, p. 210)." The role of a physician is to provide care, give information, and respond to suffering regardless of the physician's moral view. Attentive listening by the physician will lead to a greater understanding of a patient's fears and sense of suffering.

The compelling arguments in favor of PAS have been set forth in clear language by the proponents. Those arguments include:

1. Respect for Autonomy: Decisions about time and circumstances of death are very personal. Competent persons should have the right to choose death.
2. Justice: Justice requires that we "treat like cases alike." Competent terminally ill patients are allowed to hasten death by treatment refusal. For some patients, treatment refusal will not suffice to hasten death; the only option is suicide. Justice requires that we should allow assisted suicide for these patients.
3. Compassion: Suffering means more than pain; there are other physical and psychological burdens. It is not always possible to relieve suffering. Thus PAS may be a compassionate response to unbearable suffering.
4. Individual Liberty vs. State Interest: Though society has a strong interest in preserving life, that interest lessens when a person is terminally ill and has strong desires to end their life. A complete prohibition of assisted death excessively limits personal liberty. Therefore PAS should be allowed in certain cases (Braddock).

Physicians have the obligation to explore the request fully. In assisted suicide, the final act is solely the patient's. The physician is counselor and witness and makes the means available but does not perform the act (Quill, p. 1381). Supporters of PAS see it as a "compassionate response to a medical need, a symbol of non-abandonment, and a means to reestablish patients' trust in doctors who have used technology excessively (Foley, p. 55)." Another factor that tends to lead to requests for PAS is existential suffering, which is the feeling of hopelessness, indignity, or the belief that one's life has ended in a biographical sense but not yet ended biologically (Snyder, p. 212). PAS is viewed by many as a humane way to end a life that has run its course. As noted by Dr. Snyder, "the decision to seek physician-assisted

suicide was more often associated with concerns about loss of autonomy and control, not fear of pain or suffering" (Snyder, p. 211). People want a noble, dignified death. Physicians have the obligation to explore the request fully. In the words of Quill, "If we are to consider allowing incurably ill patients more control over their deaths, it must be as an expression of our compassion and concern about their ultimate fate after all other alternatives have been exhausted" (Quill, p. 1381).

Although many people are in favor of legalizing PAS, there are just as many people who strongly oppose it. Opponents argue that the notions behind eliminating death and human suffering are false goals (Snyder, p. 211). The case against both physician-assisted suicide and voluntary euthanasia is based mainly on the implications for public policy and the potential effect on the moral integrity of the medical profession. As Quill said, "Assisting in suicide carries with it the danger of compromising the patient/physician relationship and the trust necessary to sustain it. It also undermines the integrity of the profession and diverts attention from the real issues in the care of the dying, subverting the social role of the physician as healer, and altering the meaning of beneficence in medical practice" (Quill, p. 1383). Requests for PAS can sometimes conflict with the physician's moral beliefs. Also, physicians may be reluctant due to risk of censure, investigation, and prosecution. (Bascom, p. 94) One of the main arguments against PAS is the need to preserve the professionalism of medicine and the commitment to "do no harm." All physicians take the Oath of Hippocrates when they graduate from medical school. The oath clearly states "I will give no deadly medicine if asked, nor suggest any such council." No matter how good the intentions are of those in favor of PAS, there is always the potential for abuse. Certain groups of people, lacking access to care and support, may be pushed into PAS. (Braddock) Data suggests that physicians are not adequately trained to deal with the symptoms associated with requests for PAS. Only 5 out of 126 medical schools in the United States require a separate course in the care of the dying. Also, out of 7,048 residency programs, only 26% offer a course in the medical and legal aspects of care at the end of life. Studies show that poor communication between physicians and patients, and physicians' lack of knowledge about end of life care and lack of knowledge about the control of symptoms prevent good care at the end of life. Of 1,177 physicians who had treated a total or more than 70,000 patients with cancer in the previous six months, 76% of the responders cited lack of knowledge as a barrier to their ability to control pain. As said by Foley, "Legalization would endorse justified killing... guidelines would not be followed, even if they could be developed" (Foley, pp. 55, 56).

Obviously, an issue this divided would eventually make its way to the court system. The Supreme Court has been involved in a number of end of life issues, beginning in 1976 with the case of Karen Ann Quinlan. In this case, the Supreme Court affirmed the right to stop treatment based on the "right to be free of unwanted bodily invasion." (Angell, p. 51) This ruling was affirmed by the Court again in 1990 in the case of Nancy Cruzan and within the 1990 Patient Self Determination Act. The 1997 Supreme Court concluded that there is no constitutional right to assisted suicide (Snyder, p. 211). On the other hand, the Ninth US Circuit Court of Appeals decision in *Compassion in Dying v. Washington* determined that individuals have the right to choose how and when they die. "The competent terminally ill adult, having lived nearly the full measure of his life, has a

*Continued on page 25.*

## Letters To The Editor continued

To the Editor:

Greetings from UNCG. Thank you for sending your interesting and informative magazine. essay on Tosca. You are a man of so many interests. Your talents are admirable. I am sure the Raleigh audience was delighted with Wake County Physician.

We want to show off our fascinating world class music building which now attracts more than 650 students pursuing degrees from the bachelor's to the doctorate. It is an exciting time on campus as we grow to meet the needs of North Carolina.

Thank you for the interesting editorial on medical malpractice. I think your message of love would work well in many spheres of human endeavor including politics and economics.

**Patricia Sullivan**

*Chancellor, UNCG  
Greensboro, NC*

To the Editor:

What a pleasure to get your news, both the latest issue of WCP and your wonderful impressions from bella Sicilia. It sounds as though you are in good health and spirits and that you and Emily had a fabulous trip.

I enjoyed reading your editorial piece about tort reform and took special interest in E. O. Wilson being the first choice for the Meymandi Fellow at NHC. Great selection! I had the good fortune of meeting Dr. Wilson on a few occasions and he was helpful in guiding me with a sound ecology mapping project proposal in the Amazon about 13 years ago. His "Biophilia," among others, remains a special favorite of mine.

I will be presenting a lecture on my research in bioacoustics and acoustic ecology at the Polish Academy of Sciences in Warsaw in October.

**Douglas Quin, Ph.D.**

*CEO, NC Humanities Council  
Greensboro, NC*

To the Editor:

Your emphasis on cultural and intellectual topics makes Wake County Physician unique. My mother would have enjoyed reading it so much. I remember growing up with the Texaco Radio Opera every Saturday afternoon--afraid I wasn't appreciative then. I've forwarded it to my son John who spent two summers during his Swarthmore days with the stage crew of the Santa Fe Company and one summer as assistant manager of the Nebraska Opera Company. Thank you again for the magazine.

**Margaret H. Fisher**

*Raleigh*

To the Editor:

What a delightful experience to receive the online copy of Wake County Physician. And what a pleasure it is to read the variety of articles by such learned and erudite writers and columnists. I have taken the liberty of forwarding the magazine to a friend who is an active board member of the opera company in Honolulu.

**Barbara Mannen**

*Raleigh*

To the Editor:

Such an interesting and remarkable publication! Your mother must have had a great influence on you ... the extensive education you received and the great appreciation you have for the arts and your kindness, consideration and generosity to others. I am so proud I know you.

**Sarah Morrow, MD**

*Raleigh, NC 27606*

To the Editor:

I am always delighted to receive your magazine, Wake County Physician. I read your article "Giacomo Puccini, A Personal Glimpse" in the playbill of the Tosca produced by the Opera Company of North Carolina. It was exceptional. Thank you for sharing these inspiring childhood memories and reflections of your extraordinary and wonderful mother and her relationship to some of the world's creative "giants". Absolutely fascinating!

**Janet Parks**

*Fayetteville, NC*

To the Editor:

Saw your piece on Giacomo Puccini in Tosca's playbill.....your mother must have been quite a force. It certainly has rubbed-off on you! Thank you for including me on Wake County Physician's e-mail list.

**Gene Brown, Architect**

*Raleigh, NC*

To the Editor:

Thank you for sending me an e-mail copy of Wake County Physician. What a fascinating publication, combining the arts, humanities and medicine. Our conversation in Raleigh after my solo performance with the NC Symphony made me think so much of my father, who unfortunately is not among us anymore.

I was very touched by your kind message and invitation which my wife and I would be delighted to accept. The only problem is that unfortunately my schedule (concerts, teaching, travel, etc.) does not allow me to have one single free weekend for the next three months. I hope that, as soon as life becomes a bit less hectic, we will be able to have the pleasure in enjoying your company.

**Arnaldo Cohen**

*Professor of Music and piano soloist  
University of Indiana, Indianapolis, Indiana*

To the Editor:

What a wonderful personal essay this is on your family's friend and collaborator in art and culture, Giacomo Puccini in Tosca' playbill. My daughter, Jane, and I enjoy opera. Puccini is my personal favorite, has been since I was about 10 or 12 years of age, when my family supported the Met when it came to Cleveland for a week each May 15 – 22, approximately. It was a gala time for my brother and me to attend with our parents, our aunt and uncle.

Tosca is my favorite of Puccini's masterpieces, so I am very pleased that you—a true expert—find the Opera Company of N.C. a worthy company.

**Linda W. Hobson**

*Durham, NC*

*Continued on page 26.*

## Book Review continued

Iraq and Afghanistan, two nations in the throes of forming a new government and writing a constitution would study this book.

Before 400s, The British Isles had an egalitarian, democratic form of government which they had copied from the Medes and the Persians. There are quite a few references to Cyrus the great and Achaemenid Empire of 500 BC in Rapin-Thoyar's book. There are passages alluding to Cyrus' cabinet which consisted of 12 Vizirs (ministers) each one in charge of a section of the government. Of the twelve, five were women. Cyrus invented the post office, and appointed as the first post master, a woman (Post Mistress). The British Isles had that kind of monarchic democracy before 400s when the Romans took over and 1066 when the French invaded the Isles. Thomas Jefferson and John Adams were fascinated by these ideas. Reading and re-reading Rapin's History of England brings another message home. The British Isles between 400 and 1066 were ruled by many kings, very much like the Native Americans and their tribal Chiefs. There are three people who had more to do with shaping the US Constitution. They are Thomas Jefferson, Benjamin Franklin and James Madison. They each had intense and deep personal relations with the natives. The natives had a major influence on the Founders. By having read Rapin's history, all three came to the conclusion that there is striking commonality between early British form of government and the Native Americans. Much of the US Constitution, besides borrowing from the British philosopher and physician John Locke (1632), comes from the written documents of Iroquois Confederacy or the Saxons form of government outlined by Rapin.

As an aside, in the service of accuracy, it should be mentioned that John Locke never received his license to practice medicine. But as a brilliant clinician, he was often asked to cover for colleagues like Huntington of Huntington's chorea and made teaching rounds at the medical school in their absence.

Back to the main topic, the three Founders with their reverential obsession to craft a constitution for the nascent US that embodies all the positive aspects of the past governments focused on post 1066 British history and incorporated much of Rapin's thoughts. I have this fantasy that I wish I could ask Thomas Jefferson to write this review for our readers in my stead.

Rapin's book is a brilliant and detailed chronicle of the ancient history, as stated above reaching to Medes, Persians and Greeks, and incorporating the thoughts and writings of more modern philosophers especially, Montesquieu 1689-1755; Voltaire, 1694-1778; Hume, 1711-1766; Bolingbroke (Henry V), 1387-1422; and John Locke, 1632-1704.

There are a few other books published in recent years, principally one by J.H.M. Salmon, *Liberty By Degrees*: Raynal and Diderot on the British Constitution that further explore the work Rapin. I highly recommend reading Rapin's and Solomon's books to get a better understanding of whence our nation comes. It also helps to see the wrong direction our government is taking.

It is rather unfortunate that in today's intensely polarized political scene in America, both the liberals and conservatives quote Rapin to their own advantage, advancing their causes and views. I think the holy trinity of the US Constitution, Jefferson, Franklin and Madison are rolling in their grave uncomfortably.

*\*The writer is a Raleigh psychiatrist, philanthropist and art advocate. He is Adjunct Professor of Psychiatry at UNC School of Medicine, Chapel Hill, North Carolina.*

## Issues on Care at the End of Life continued

strong interest in choosing a dignified and humane death, rather than being reduced to a state of helplessness, diapered, sedated and incompetent." - Judge Stephen Reinhardt, Ninth Circuit Court (Foley, p. 54). Although US Attorney General John Ashcroft issued a new interpretation of the Controlled Substance Act, prohibiting the use of federally controlled substances to hasten death, counter-suits have prevented this ruling from taking effect. In its 1997 decision, the US Supreme Court did not formally ban PAS, and in not doing so, it allowed individual states to legalize it. So far Oregon has been the only state to do so.

In regard to the Oregon Death with Dignity Act, which was passed as a citizen initiative by Oregon voters in November of 1994, the prognosis of death within six months must be confirmed by a consultant, and the patient must make two oral requests and one written request over a period of 15 days. Referral to a mental health professional is required if either the attending physician or the consultant is concerned that the patient's judgment may be impaired by a mental disorder. Physicians must report to the Oregon Health Division that they completed all of the requirements (Ganzini, p. 557). In 2001, thirty-three physicians in Oregon wrote forty-four prescriptions for lethal doses of medication. This number increased from twenty-four in 1998 (Hedberg, p. 450). Several studies have revealed interesting findings in regard to Oregon's experience with PAS. Data revealed that 1% of dying patients will make a specific request for PAS, but of these patients, only one in ten will die by PAS (0.1% of all dying patients) (Bascom, p. 93).

In another study of the outcomes for 165 patients, twenty-nine received prescriptions for lethal medication and seventeen of these patients died after administering them. Requests for assisted suicide were more likely to be honored if the patient was enrolled in a hospice program or if the patient had cancer. (Ganzini, p. 561) In the same study, for 142 patients, physicians provided information about interventions that they either recommended or implemented. The most common interventions were those for pain control, control of other physical symptoms, obtaining a second opinion, referring to a hospice program, obtaining a mental health consultation, trials of anti-depression or anti-anxiety medications, withdrawal of food and water, and consultations for palliative care, social work or a chaplain. One or more interventions seemed to alter forty-two of 140 patients' desire for a prescription for lethal medication (Ganzini, p. 560). The results of these studies found little evidence to justify the fear that only vulnerable patients would be given prescriptions for lethal medications instead of good palliative care.

PAS remains a contentious issue because terminally ill people want to have the right to determine how and sometimes when they will die, yet there is a fear that it may be used either inappropriately by physicians or that it will lead to a morass of legal and ethical dilemmas with no possible resolution. In the meantime, patients should expect the medical profession to be assiduously responsible for relief of suffering and pain at any time during a patient's life, which will reduce the need to even contemplate ending life by physician assisted suicide.

*\*Christopher Yellig is an eighteen year old senior at Raleigh's Needham Broughton High School. His interests include cars, lacrosse, and fishing. Future career goals include the study of law with a minor in Spanish. Recently Chris's interest in that language led him to The University of Salamanca, Spain in June. Chris will be interning with attorney W. Stacy Miller this school year. Chris's father is Edward B. Yellig, M.D..*

## Letters To The Editor continued

To the editor:

Thank you for the online copy of the WCP magazine which opened beautifully on my computer here at work. How wonderful to read, especially, the Letters to the Editor, detailing his generosity to his community. Even a letter from the 102-yr-old Maxine Swalin who we all owe so much for her foundational work on the North Carolina Symphony! I, too, enjoyed Dr. Stratas' lovely article on "Forgiving." Received and enjoyed!

**J. Mark Scarce, PhD**

*Director, Department of Music  
Price Music Center, Box 7311  
North Carolina State University  
Raleigh, NC 27695-7311*

To the Editor:

Thank you for putting me on the e-mail list of Wake County Physician. Your love of this country is admirable. It is truly amazing what you have done to make the world a better place.

I was not aware that you had endowed the Bob Golden Chair at UNC. Thank you for your generosity and support for the arts and for the wonderful work of the UNC Dept. of Psychiatry. Dr. Golden has always been very helpful to me in my advocacy work. I would very much like to see UNC provide staffing for the new Wake County psychiatric hospital and eventually establish a community mental health research program like the Schizophrenia Treatment & Evaluation Program in Chapel Hill.

Right now, my biggest effort is targeted toward getting a quality hospital built in Wake County. I am very grateful to see that the Wake Medical Society is continuing to advocate with me. Dr. Nick Stratas has been by my side many times as we advocated to keep Dorothea Dix Hospital open, to stop the so-called mental health reform, and to establish services for people with severe mental illness.

Dr. Stratas is on our Advisory Board and Dr. Michael Zarzar serve on our Board of Directors of Derek's Renaissance House. Judge William Creech is also a member of our Board, and he has mentioned a number of times how wonderful it would be if you would consider serving also

**Ann Akland, President**

*Derek's Renaissance House, Inc.  
President, NAMI Wake County*

To the Editor:

I feel honored and privileged to receive Wake County Physician online. Also, I read your piece on Giacomo Puccini in Tosca's Playbill. I, for one, would be thrilled to hear of your early life and upbringing in Persia. I hope you have kept a journal. You have knowledge and experiences that would be difficult for most people to imagine. I have had the privilege of some personal exposure to the middle east (having traveled there extensively since the early 60's and am now planning a three week trip to Libya, the United Arab Emirates, Jordan and other nearby countries in Sept-Oct), so I can, to a degree, grasp and appreciate the grandness, the elegance, the customs, and special early life. I think we should have a "Salon" Sunday afternoon in my living room for the opportunity for you to share and enlighten a select group of friends of your special knowledge and perhaps memories. You are most generous.

**Jeanette Hyde**

*Former Ambassador to Barbados  
Raleigh, NC*

To the Editor:

I saw the feature on colon cancer, UNC Department of Oncology and you on PBS (telecast time: 2:00 PM, May 12, '05, UNCTV). It was more than worth the break time to see that the conclusion of the story in which you were featured was to note that it is your attitude that profoundly affects your wellness and your prospects for the future.

**Theresa J. Rosenberg**

*Raleigh, NC*

To the Editor:

Thank you for appearing on the colon cancer program yesterday (PBS, May 12 '05). I am a committed believer in the process and early detection. We remain in your debt and continue to admire your good works among us - and your eloquence in general and in this program in particular.

**Elizabeth Nordstrom**

*Maine*

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## George Mason continued

could cheerfully put my Hand & Heart to the new Government." Less than a year later George Mason died and was buried at his beloved home, Gunston Hall.

Madison, Jefferson, and James Monroe maintained respect, friendship and continuing regard for Mason's opinion. Madison noted that George Mason was a "powerful reasoner, a profound Statesman and a devoted Republican." Jefferson, one of Mason's last visitors at Gunston Hall, called him "a man of the first order of wisdom among those who acted on the theatre of the revolution, of expansive mind, profound judgment, cogent in argument. . . ." James Monroe and Mason continued an active correspondence during Mason's final years.

Recent scholarship has returned George Mason to a place of deserved prominence, and has confirmed that he was among those who played a crucial role in the founding of our nation. We might expect that David McCullough also would see George Mason as one of the individuals of character who changed the destiny of our nation.

There now is a Memorial to George Mason in the National Mall in Washington, D.C., the first to a non-president. Mason's

beautiful home, Gunston Hall Plantation, built in 1755 and situated seven miles south of Mount Vernon on the Potomac River in Mason Neck, Virginia, is open daily except for New Years Day, Thanksgiving, and Christmas. Guided tours are available. Consult: [www.gunstonhall.org](http://www.gunstonhall.org).

**Sources:** In writing this article, the following bibliography was relied upon:

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## Roy Jackson “Jack” Blackley, 83

Jack Blackley died at 83, on June 24, 2005. Jack was a good man, a good husband to his late wife Simmone, a good dad to his daughter Tina, and to his son Jake, Jr. He was a good father and role model to literally hundreds of psychiatrists and mental health professional in and out of North Carolina. He was a good grand dad to his grandsons, Andrew and Jonathan Blakeley. He was a good uncle to his nieces and nephews. And he was a good friend. To those of us who knew him personally, professionally and socially, the grief of his loss is enormous.

Jack was a Tarheel. And he was proud of it. He would regale you with tall tales of his birthplace, Hamlet, NC, the thriving industry of moonshine and the warmth of small rural communities of NC with the skill of professional raconteur. My own early education of farm life in NC in the early 60s was provided by Jack. But his humble and casual manners belied the vast scope of his knowledge of the classics and awareness of the world.

He graduated from Hamlet High School and served in the Army from 1943 to 1945. For his heroic service in the Army, he received two Bronze Star Medals and various other decorations.

After WWII, he completed his pre-medical education at UNC, Chapel Hill, followed by an MD from McGill University in Montreal, Canada. Those of us who knew him well used to tell him that all great physicians like Sir William Osler went to McGill or taught at McGill!

His returned to Hamlet and opened up a general practice (that is what is was called in those days), before getting employment in the NC Department of Mental Health Services. He rose through the ranks and became the first Director of the Division of Mental Health, Development Disabilities and Substance Abuse. He served as Adjunct Professor of Psychiatry, UNC School of Medicine at Chapel Hill.

His community service brought him many honors, among them The Order of the Long Leaf Pine, the highest civilian award, equivalent of the Nobel Peace Prize, given by the State of North Carolina. There are several drug rehabilitation facilities named for him, among them R. J. Blackley Drug Abuse Rehabilitation Center in Butner and the Elmore Blackley rehabilitation Home.

His surviving family, his colleagues, friend and former students will miss him.

## John L. McCain, 78

John McCain died after almost two years of meaningful and reflective dealing with a devastating cancer of pancreas. No, he did not fight with his cancer. No, he did not “courageously battle with the disease.” He dealt with his illness, as he dealt with any other event of his life, with patience, with curiosity and with tenderness of the soul. He was as a good a patient as he was a doctor. He let the physicians entrusted with his care do the doctoring, and he followed all the orders and recommendations. Yet, he continued to practice medicine until a few months prior to his death. Only a few days before his death, I visited with him at his home on Woodland Drive in Wilson, NC. We had a friendship of over 40 years. Saying goodbye was difficult. Yet he made it easy for me by recalling the fun experiences we had together over the years working on NC Medical Society

Projects. He told me that once his doctors started him on narcotics, he resigned from his job as medical director of a nursing home because, “My judgment is impaired.” As we visited he was signing the last charts brought to him by the nursing home. John McCain was truly the embodiment of a consummate child of God, as a knowledgeable physician, a compassionate healer, a servant to his community and profession, and an advocate for the underdog and the disenfranchised. He told me with some excitement of his current passion. He was co-chair and a founding member of the Wilson Internet Empowerment Project, which seeks to improve the quality of life of residents of local and regional long-term care facilities through access to computers and volunteers. He was hooking up and digitizing rural health care of older citizens to the world’s state of the art facilities. With this effort John McCain democratized health care access, a remarkable feat.

It would take a 500 page book to catalog all of John’s academic, social and professional achievements. This memorial is NOT about what he did. It is about who he was. He was a husband, father, grand father, friend, teacher, mentor, church deacon, elder, choir member, community builder, advocate for mental health, academician and above all an altruist whose primary goal was welfare of others. Encouraging his honored wife, Betty Ray McCain, to serve eight years as North Carolina Secretary of Cultural Resources is an example of his incredible spirit of altruism.

John comes from a long line of physician-servant-altruists. His father, also a physician, was the director of the sanatoria system for the state of NC. McCain Sanatorium, now McCain Prison, was named in his honor. His late mother, a Susan B. Anthony-esque assertive lady, was a Committee Woman for the NC Democratic Party. The McCains are imbued with public service, advocacy and excellence genes.

We extend our heart felt condolences to his beloved wife, Betty, children, grand children, and a multitude of friends, colleagues, former students and fellow workers.

## James Bernstein, 62

Jerry Bernstein was not a physician. Then why are we devoting space to a non-physician? Well, Jim was the leading authority on rural health. In his short life he contributed so much to this once neglected field that many dubbed him the “Nobel Warrior.” Jim was respected by public health officials of not only NC, but throughout the nation. He retired five years ago, but continued to work pro bono for the state as a consultant.

Jim was born in New York. He graduated from Johns Hopkins University and served for two years in the Peace Corps in Morocco. His love of the Moroccan people made him learn Arabic, which was most impressive. Being a serious Jew, he knew Hebrew. He and I often had lively conversations and love feasts about the epic language of Arabic and its relationship with Hebrew and Aramaic, the language Jesus spoke.

Jim went on to receive a Master’s Degree in Hospital Administration from the University of Michigan. In 1970, he started a three-year fellowship in US Public Service and moved to NC to study at UNC. He chose rural health, which became not only his profession but his passion.

His 30 year stellar career made him the academic darling of public health in the entire nation. He served as Assistant Secretary for Health overseeing the North Carolina Department

## In Memory continued

of Facility Services, Medical Assistance, Mental Health, Minor Health, Public Health, and Rural Health. Under his leadership, eighty one community-owned rural health clinics were opened in NC. Using his membership on the Board of the NC Medical Society Foundation, he recruited 1800 providers to NC, and implemented measures to retain them.

Jim was an enthusiastic golfer, sportsman and world traveler.

We extend our deepest condolences to Susan, who was married to Jim for 40 years, and to their children and grand children. In the annals of humanity and love, Jim was indispensable and now irreplaceable.

## Carol B. Kirschenbaum, 55

Dr. Kirschenbaum was born in Brooklyn, NY. She came to North Carolina 1979, at the age of 29, to study and train as a physician assistant at Duke. Her teachers and supervisors noted her intellectual abilities and compassion, and encouraged her to apply to medical school. She received her MD and residency training in internal medicine from UNC at Chapel Hill. Carol was well known for her activities in the political and cultural events in the Triangle. She was a dedicated role model of progressive Judaism in the community. She worked with various aspects of the UN, and Middle East issues and traveled extensively in South America promoting peace and understanding. She and her husband were well suited in that they traveled the common pathway of service to humanity and peace. She was an excellent physician, an exemplary diagnostician and a compassionate friend to her patients. She and her husband developed a national project to support and improve communication between all the organizations working for universal health care at state level in 21 states. The issue of patient access to health care was one of her many passions. Her family, nieces, nephews, innumerable devoted friends, patients who affectionately called her Dr. K, and the house of medicine will miss Carol.

## Robert Malcolm Bardin, 104

The sheer death defying act of living for 104 years distinguishes this sweet and compassionate gentleman who practiced medicine for over 60 years in Rutherford County, Roanoke Rapids and Wilson, NC, before he joined Watts Hospital of Durham, NC. He retired from the practice of family/internal medicine at age 85 in 1986. Throughout his distinguished career(s) he touched the lives of many. He was a legend in the sacred house of medicine.

## Albert Joseph Diab, 78

Dr. Albert Joseph Diab, a retired Raleigh internist and a member of Wake County Medical Society died at home on July 28, 2005. Dr. Diab received his MD from UNC in 1954, served in WWII from 1943 to 1946 and was in the "Battle of the Bulge." Prior to establishing his practice in Raleigh in 1964, he practiced in New Bern for six years. He retired in 1991. Highlights of his distinguished career were the presidency of the Wake County Heart Association and leadership on the board of Wake Medical Center.

His passion for music and arts was evident in his support of the NC Symphony and NC Museum of Art. He was also an avid sportsman and a skilled craftsman, working with wood and creating finely crafted furniture. He will be missed by his family and friends.

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Gerald Blake, MD, lost his brother, Lt.Col. James Blake from a sudden illness in late July. WCP extends condolences to Dr. Blake and his family.

### Correction

In the last issue of WCP, the name of Mary Duke Biddle Trent Semans was misspelled. We regret the error.

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## Public Health continued

us about an elderly man who had died of legionnaires' pneumonia. Three of his middle-aged family members were also diagnosed with the disease (and survived) and all were present at a family reunion at a beach house in Nags Head, NC in the previous 2 weeks. All had used a hot tub spa at the house including use of the jet circulators that aerosolized the water. Working with the Dare County Health Department and the regional surveillance team, the beach house was immediately quarantined and evacuated. Inspection revealed a hot tub in use on the second floor balcony. Inspection of the tub showed a chlorine level of zero (recommended level, 1-2 ppm), a water temperature of 37° C, and slime present on the filters and in the tub itself.

Active surveillance of other parties who had rented the house (and used the tub) showed no further cases of legionnaires' disease. Cultures of the hot tub were sent to the CDC and were positive for *L. pneumophila* and were the same type isolated from

lung tissue of the dead Virginia man. Cultures of water from inside the house (sinks and showers) were negative for *L. pneumophila*. The quarantine of the beach house was lifted after the owner removed the hot tub from the premises.

These three episodes (literally from "Murphy to Manteo") in the last 2 years emphasize the influence of environment on human health. Waterborne infections such as legionnaires' disease remain difficult to predict and prevent. Further, remediation and preventive maintenance of water sources may not prevent outbreaks, particularly if they are caused by weather conditions. The public should be reassured that despite these 3 outbreaks legionnaires' disease remains relatively rare. Only time will tell if these investigations represent a true increasing trend in North Carolina.

## Reflections continued

for Dr. Stead, notwithstanding Dr. Stead being tough as nails during their residency years. The book is titled, "What this Patient Needs is a Doctor."

Have the advances in medicine allowed patients to live too long? We have made great strides in treating diseases in most organs except for degenerative diseases in the central nervous system. Ironically, President Lyndon Johnson and his committee had no idea people were going to live so long. (Look at the trouble Social Security is in today.) Unfortunately, long-term life is not necessarily associated with quality of life. There has been the proliferation of retirement, assisted living, and nursing homes, most being very expensive. Very few get federal dollars to help with their care. Some of these places call themselves non-profit but they take a huge portion of the individuals' estates. Others admit they are for-profit. Unfortunately, personnel and care in most of these places tends to be fair at best, especially when one becomes incapacitated. Unfortunately, many families have to hire "sitters" to help care for their loved ones who are cared for in these nursing homes. That's a disgrace. Because of these problems the Department of Health and Human Services is pushing Long-Term Health Care Insurance. That amounts to more money to be spent out of one's savings.

Every adult should have a Living Will. They are available at most medical societies for free, and are easy to complete. Physicians should make copies and have them available in their respective offices, and insist they be completed with copies with the office chart and family members. We have not done a good job with this because it seems the subject itself induces fear into the patients. A short and simple explanation by empathetic physicians usually works. Another valuable item to have is Power-of-Attorney. This will certainly prevent a lot of anxiety and frustration later. A patient has a right to die without pain, in peace and with dignity. It seems we forget that on occasion.

Physicians must avoid getting "burnt-out." In these stressful times, it's easy to do. Watch yourself and do not start self-prescribing controlled substances. Being licensed in Virginia and North Carolina, I receive the publications from both Boards

of Medicine listing the sanctions placed upon physicians. It depresses me. If they had sought help, most of these problems could have been avoided. Don't try to solve the problem yourself. Counseling can help in many ways including your family life, relationships with fellow physicians, and even changing into a different work environment.

### Business vs. Practice of Medicine

There doesn't seem to be a practice of medicine any more. It is the BUSINESS OF MEDICINE. It is depressing to me what has happened. You really cannot fight the system. We mentioned how electronic gizmos had come into play. Venture capitalists have gotten into laboratory and radiographic facilities. A huge number of radiographs, plain, CT and MRI scans are outsourced mainly to India. This concerns me because I don't know the competency of the "radiologist" reading digitized films. What about dictating? Say you are discharging a patient and pick up the phone to dictate the discharge summary. Did you know your dictation may go over fiber optic cable to India, Australia, or Israel? Your digitized voice recognition has been fine-tuned by technologists running computers in those places, and your dictation is printed in milliseconds as you speak. The printouts are reviewed for correctness, especially if the computer did not voice recognize something you said. The printed summaries should be available for your signature the next day. This costs the hospital about 20 percent of what it would if done locally. With this outsourcing going on, what is next? Are robot physicians on the way?

### What is the Solution?

What's the answer to our medical problems? I am including teaching, greed, insurance companies, HMOs, Social Security, nursing homes and being over-worked just to name a few complications of today's medical practice. Unfortunately, our medical societies are almost impotent when it comes to dealing with the politicians. Fewer and fewer physicians are joining medical societies. When the AMA lobbyists go to

Congressmen, most are ignored because less than 50 percent of practicing physicians belong to the AMA.

During President William Clinton's first term in office, Mrs. Clinton had a plan to change everything when it came to medical care. She even acquired 900 consultants to help her institute her program. (Can 900 consultants agree on anything?) Her plan was shot down. It put medical care on the back burner in Washington. We need medicine to be on the front burner. We have the experts that could put a workable plan together, and we need only a few experts, not 900. In my opinion, if we don't get a workable plan, our present system will collapse. I can foresee the brouhaha from lobbyists representing anything having to do with our present health care system doing anything to throw monkey wrenches into the gears. You can really be sure those pesky trial lawyers will be there. Opinion polls show physicians at the bottom of the barrel. We used to be at the top. This has to change.

What do you think is the solutions? Write to us. Essays and opinion columns, 500-750 words, are welcome.

*\*The writer is Taliaferro/ Scott Professor Emeritus (Internal Medicine and Rheumatology) Virginia Commonwealth University School of Medicine, Medical College of Virginia Campus, Richmond, Virginia. The son of a physician, Duncan S. Owen, Sr., MD, he was born and raised in Fayetteville, NC and graduated from UNC School of Medicine. The School bestowed upon him the Distinguished Alumni Award in 1995.*

He may be reached at  
DOwen75089@aol.com

## What Is The Alliance?

Those of you who receive this magazine may have wondered over the years, "What is this Alliance mentioned in these pages every so often?" Not such an easy question to answer, for nationally the Medical Society Alliance can have as many identities as the Medical Societies with which it partners. John Nelson, the outgoing AMA President, said this past May that the Alliance was, "Love with its sleeves rolled up." He continued that he knows of, "no other association in the United States whose members' spouses are as unified, motivated, and effective for good in America as the Medical Society Alliance." When he thinks of the heroes of medicine, he "not only thinks of those with MD or DO following their names, but of those with Mrs., Mr., or Ms. in front of theirs, performing individual acts of heroism every day across this nation."

Our Alliance is that and more. Just in Wake County and surrounding areas, our members are a hugely diverse, talented, and interesting group of individuals. For the past eighty years, we have been united by only one common fact; we are spouses of physicians. These days, we may be physicians as well. We are committed to partner with physicians to promote the good health of our communities and America and to support the family of medicine.

We offer opportunities for personal development and community outreach.

We offer opportunities in leadership, networking, and legislative advocacy for health issues. We reach out to the community through our annual Health Extravaganza which brings health information and testing to the public at no charge. We have reached children through our "Funny Tummy Feelings" self-advocacy against sexual abuse program; "Healthy Minds," a literacy and language skills program; and the Poe Center for Health Education, a free standing health education facility for all the children of North Carolina, developed and established by the Wake County Medical Society Alliance.

We also have fun! We have bridge groups, a book club, day events, and evening events, sometimes with spouses. We have a "Yearbook" which includes all our members contact information and an almost monthly newsletter to keep us in touch with each other. But perhaps the most valuable thing we offer is the opportunity to work beside and interact with each other, the unique group of individuals who make up the Wake County Medical Society Alliance.

We invite you to join us! This coming year, 2006, is our eightieth anniversary! Join in the celebration! Get involved: a little, a lot, or just financially, as your time permits. Become a part of the Wake County Medical Society Alliance and be a "physician spouse making a difference."

2500 Blue Ridge Road, Suite 312, Raleigh, NC 27607  
Membership Dues —\$110.00 (County - \$30.00, State -\$40.00)

## WHO'S *news*



**Maxine Swalin**, widow of **Dr. Benjamin Swalin**, the first Conductor of the NC Symphony turned 102 years old.



Neurologist **Pamela Whitney** models her elegant South African outfit.

**THE WAKE COUNTY MEDICAL SOCIETY**  
**2500 BLUE RIDGE ROAD**  
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**RALEIGH, NC 27607**

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