

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

April 2006

Volume 11 No. 2



**HAPPY BIRTHDAY THOMAS JEFFERSON**

Related article page 2

## 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.

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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."





Brian GO, MD

As Wake County Medical Society (WCMS) members, we are of varied backgrounds but share a proud legacy and look to a bright future. We will strive to be a shining example based on the ethics and calling of our profession and fondness and respect for our home. As originally said by John Winthrop and later quoted by JFK and fashioned by Reagan in an effort to convey an idea of holding one to a higher standard, "We must always consider that we shall be as a city upon a hill—the eyes of all people are upon us."

As physicians, we are learning that we no longer have the ability to solely focus on the day to day delivery of patient care. If we do, our ability to deliver optimal care will be compromised. We are just now delving into our potential as a professional group to influence external political forces that affect our daily lives. Through emails, calls, money, and our vote, we can take back control of our future. The WCMS hopes to be a tool at the local level to offer a focused path and unified voice.

Wake County's population continues to change, both in numbers and demographics. Our county is one of the top 100 most populous counties in the US and will continue to grow. The county is increasingly diverse with minorities representing 30% of the population. Between 1990 and 2002, the Hispanic population increased by 825% and the Asian population by 240%. Access to health care has notoriously been problematic in minority groups. Despite an increasing median and per capita income, more people are in poverty every year in our county. There are a little over 79,000 individuals or 11% with incomes below 100% of federal poverty level (\$19,350 for a family of four)\*. Access to primary care and dental care remains a problem. Areas of obesity, asthma, dental decay, immunizations, and tobacco abuse will continue to be major hurdles in healthcare delivery that we will address.

Like any "society", we will be most judged by how we care for those who are least able to care for themselves. Through the direction and impetus of our Executive Director, Paul Harrison, the WCMS will continue to initiate and support community service projects. Programs such as Project Access, Children's Access, Community Care Case Management, Early Childhood Development Program, and Medically Fragile Children's Program will continue to be at the core of whom we are and for which we stand. While it is our moral obligation to help fill a healthcare need, we will continue to remind our government of their responsibility and work with our local legislators in addressing access until we have adequate care for all.

Our medical society will help unify our efforts towards issues facing us including providing adequate inpatient mental health care and liability reform. We are fortunate enough to have three Psychiatrists on our Executive Council this year and will take an active role in developing a solution to the healthcare void that will occur with the closure of Dorothea Dix. We plan to dedicate our April dinner meeting to this topic. Lead by Drs. Benevides and Albright, we will continue our support of meaningful liability reform and education of our local legislators in regards to the very real crisis that exists.

Member enrollment is the foundation of any society as

with increased numbers comes increased influence. We will renew our efforts at recruitment and sustaining our existing members. Please continue to support our efforts as we all strive to make Wake County the "city upon the hill."

\* "Needs Assessment 2005 Report", by Ms. Deborah Grammer, Wake Health Services, Inc., Raleigh, NC

### Hippocratic Oath -- Modern Version

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of over treatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

Written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, and used in many medical schools today.



Assad Meymandi

## HAPPY BIRTHDAY, MR. THOMAS JEFFERSON

April 13, 2006 marks the two hundred and third anniversary of the third president of the United States of America, founder of the University of Virginia, America's plenipotentiary to France (he succeeded Benjamin Franklin), architect, writer, intellectual, chronicler, farmer, inventor, avid bibliophile, superb oenologist and a fighting politician. He was a man of controversy. He was a devoted family man. When

his wife Martha died in 1782, he wrapped a lock of her hair with a scrap of paper containing an excerpt from the couple's favorite novel, Laurence Sterne's comic masterpiece, *Tristram Shandy* (the book will be reviewed in this magazine in the series of what our founding fathers read). As a writer, many scholars think that his 55 magical words in the Declaration of Independence beginning with "We hold these truths to be self-evident, that all men are created equal..." are indeed talismanic if not inspired by God. As a romantic, while serving as Minister to France, in 1784, he fell in love with a married woman, Maria Cosway. When they broke up, he wrote her the longest letter of his life (Jefferson wrote a total of 22,000 letters in his lifetime), worthy of expert dramaturgy (it will be reviewed in a future issue in this magazine). He sought small government, yet with one stroke of the pen, he doubled the size of US by the 1804 purchase of Louisiana. These inconsistencies are not hypocrisy. He was a human, in flesh and blood subject to frailties and errors of action. However, he was a man of substance and iron will with a superb sense of timing devoted to creating a Republic that one day would become the envy of the world. He succeeded. America is a beacon for liberty lovers and freedom seekers throughout the world.

Thomas Jefferson's birth offers an opportunity to examine the lives of all who sacrificed to give us the freedom and liberty we enjoy in America.



As an American by choice and not by birth, even though I have lived here for nearly fifty years, the basic goodness and decency of American, and American democracy never ceases to amaze me. I was recently asked to give the commencement address to the graduating MD class of '03 at my alma mater, The George Washington University School of Medicine. The impetus of my talk was about individual right and the supremacy of the rule of law in this country. I told the graduates that forty one years ago, when I was sitting in their seat, the commencement speaker faced an audience of capped and gowned white males only. That evening, in '03, I was looking at many handsome and attractive young men and women, white and nonwhite. "I am making a point of this because I do not know any nation on earth, except for America, that demonstrates such persistent reverential devotion to upholding the values of individual rights, equality and justice, not just for white males but people of all genders and colors. I am filled with pride to see the changes in our society over the

past 41 years brought about by the sweeping 1965 Civil Rights Act", I told the brand new MDs. Saint Augustin Of Hippo, born in 359, wrote in the preface to the book "city of God" that the path to salvation and grace is "our constant awareness of what is good inside of us, and what is good around us, and being thankful for them."

The sacrifices of the late Dr. Martin Luther King and his colleagues are indeed noteworthy. But for their efforts to have been fruitful, the basic infrastructure of our Republic was necessary. The ultimate credit for our fortune in having a government where the rule of law is supreme goes to the framers of the Constitution, the blood of George Washington's brave soldiers, and to the brilliance of the minds of Thomas Jefferson, John Adams and their colleagues. Yes, those dead white males who created the sacred US Constitution and its first ten amendments in the form of The Bill of Rights should not be forgotten.

Speaking of the sacrifices of the brave people whose unselfish acts guaranteed the freedom you and I enjoy today, I am using a correspondence contributed by colleague H. Raymond Madry, a retired Raleigh radiologist. In his letter Madry writes: Have you ever wondered what happened to the 56 men who signed the Declaration of Independence? Five signers were captured by the British as traitors and tortured before they died.

Twelve had their homes ransacked and burned. Two lost their sons serving in the Revolutionary Army; another had two sons captured. Nine of the 56 fought and died from wounds or hardships of the Revolutionary War. They signed and they pledged their lives, their fortunes and their sacred honor. What kind of men were they?

Twenty-four were lawyers and jurists. Eleven were merchants, nine were farmers and large plantation owners; men of means, well educated but they signed the Declaration of Independence knowing full well that the penalty would be death if they were captured.

Carter Braxton of Virginia, a wealthy planter and trader, saw his ships swept from the seas by the British Navy. He sold his home and properties to pay his debts and died in rags. Thomas McKean was so hounded by the British that he was forced to move his family almost constantly. He served in the Congress without pay and his family was kept in hiding. His possessions were taken from him and poverty was his reward. Vandals or soldiers looted the properties of Dillery, Hall, Clymer, Walton, Gwinnett, Heyward, Rutledge and Middleton. At the battle of Yorktown, Thomas Nelson, Jr., noted that the British General Cornwallis had taken over the Nelson home for his headquarters. He quietly urged General George Washington to open fire. The home was destroyed and Nelson died bankrupt. Francis Lewis had his home and properties destroyed. The enemy jailed his wife and she died within a few months.

John Hart was driven from his wife's bedside as she was dying. their 13 children fled for their lives. His fields and his gristmill were laid to waste. For more than a year he lived in forests and caves, returning home to find his wife dead and his children vanished.

Surely, we are forever grateful to be Americans and belong to the profession and priesthood of medicine. Freedom is never Free! The ministry of medicine is pre-ordained with altruism and giving. Wake County Medical Society's Access Program on which Pam Carpenter will report regularly in a new column is but a small token that as physicians we are dutiful.



### In This Issue

Guest writers for this issue are the eminent historian Bill Leuchtenberg. Dr. Leuchtenberg is Emeritus Professor of History, UNC Chapel Hill, author of dozens of book on history and a specialist in American presidency. He has penned for our readers the second part of the two part series on "The North Carolina Signers of the US Constitution." Dr. Robert Bilbro continues the discussion on "The State of Medicine" which we started, two issues ago,

with an article by Dr. Duncan S. Owen, Emeritus Professor of medicine and Rheumatology at Medical College of Virginia, Richmond, Virginia. Last issue saw Dr. Franch C. Church's debate on the topic. Dr. Bilbro adds his considerable intellectual heft and wisdom to the topic. We have started profiling physician couples who have made major contribution to the medical profession and the community at large. In this issue we are honoring Drs. Cynthia and Joseph Hardison. Book Reviews, memorials, and the intellectual fruits of your able columnists embellish the rest of the magazine.

WHAT DO YOU THINK? SHARE YOUR THOUGHTS IN WCP FORUM. LETTERS TO THE EDITOR AND CONTRIBUTION TO THE FIRST PERSON COLUMN ARE WELCOME AND WILL BE CONSIDERED FOR PUBLICATION

# Letters *Excerpts from letters to the Editor*

The Editor:

Thank you very much. This issue of WCP was a doubleheader for me, with articles about you and science at Carolina so well expressed by our own Holden Thorp.

Bernadette Gray-Little, PhD  
Dean, School of the Arts and Science  
UNC At Chapel Hill, NC

The Editor:

Please accept my sincere gratitude for including me on your mailing list. I find this publication particularly interesting: well written, pertinent, stimulating, and aesthetically pleasing. My congratulations. If you remember our first meeting at dinner on the campus of Peace College, you will recall that my academic discipline is English, while that certainly makes me no expert, the background gives me some insight into well done pieces, and this is one. I hope that we shall have the opportunity to meet and chat again, as your conversation was stimulating and provocative for both Joan and I. Our best to Mrs. Meymandi. We wish for you both happy holidays.

Jim and Joan Hemby  
ED' s Note: Dr. Hemby is Emeritus President  
Barton College, Wilson, NC

The Editor:

Thank you very much for sending the January issue of WCP. I really enjoyed reading several of the papers in it. I was particularly interested in the article by Holden Thorp. I have been meeting with Holden and other key people at UNC trying to establish programs that will improve the level of science teaching in North Carolina schools with the goal of making the University of North Carolina at Chapel Hill known nationally as a top science university. We have to start with the secondary schools since 83% of students admitted are required to be from North Carolina.

If possible, I would be pleased to receive a hard copy of this issue.

Joan Huntley, Chapel Hill, NC

The Editor:

Thank you for the January issue of WCP, and thank you for attending and speaking so eloquently at our community forum on the need for a Wake Psychiatric Hospital. I'm sorry I did not have an opportunity to personally welcome you and speak to you. Your participation and public support will help gain attention of our public officials and hospital administrators who can make this hospital a reality.

On behalf of family members and people with mental illness, please know that we appreciate your support. I welcome your advice and further participation as we plan and execute our strategy for making this hospital a reality.

Ann Akland, President  
Wake County Mental Health Association, Raleigh, NC

The Editor:

Thank you for the Excellent content of the January issue of WCP. On another matter, thank you for the talk you gave on music and its power to heal. It was thought provoking and appreciated.

I plan to read some passages about nephesh from Moses Maimondes of Cordoba.

William Thomason, Raleigh, NC

The Editor

Thank you for the wonderful article on Bill. He truly had a love affair with medicine and research. Thank you for the online copy of WCP. I have greatly enjoyed reading it. The memorial on my husband, Dr. William Koller made us very proud. Thanks, Vicki R. Koller. I have given the article to each of his children, and they are proud of their father. Again, Thank you,

Vicki Koller

Dear Dr. Meymandi:  
Congratulations on your continued distinctions! How fortunate NC is to have you in its midst!

Best,  
Doren L. Madey (Pinnell), PhD, Durham, NC

PS I am copying Jerry Lazarus (past Chair, Duke University and University of Pennsylvania Dermatology Departments.Ed) right now. I know he and Audrey will enjoy reading it!

The Editor:

I was fortunate to receive the January 2005 and January 2006 issues of The Wake County Physician.

To sit down and read these magazine issues at the beginning of the New Year, which sprinkled my mind and heart with your positive and uplifting thoughts, is indeed a wonderful beginning to the New Year. I was particularly moved by the speech found on pp. 2-3 of the January 2005 issue in which you focused on the goodness within us and outside of us, the attributes of love, compassion, integrity, intelligence, altruism, self-confidence, self-respect, and spirituality. What a gift for me to carry into the New Year.

I thank you deeply.

Doris B. Powers, Ph.D.  
Musician, teacher, scholar, and writer, Chapel Hill, NC

The Editor:

Thank you for sending me the online copy of the January issue of WCP. The speech given at the dedication ceremonies of the Assad Meymandi Distinguished Professor and Chair of Psychiatry, UNC School of Medicine is a must reading for my grandchildren. They must learn about our country especially from a non-native American. I am sending copies to all of them.

## WCMS December Dinner Meeting: A Summary of Dr. Victor J. Dzau's Comments



Paul Harrison

"Let us all work together to fulfill our mission, maintain the public trust and elevate the practice of medicine," urged Victor J. Dzau, MD, Chancellor for Health Affairs and President and CEO of Duke University Health System as he addressed the Wake County Medical Society at the December meeting. Dr. Dzau spoke candidly about the necessity of healthcare collaboration, the role of teaching institutions in our society, social responsibility and his personal commitment to developing strong working relationships with community physicians and healthcare leadership within Wake County.

Speaking in the spirit of collaboration, Dr. Dzau stressed the great, shared responsibility of physicians in our community saying, "regardless of how or why we entered the field of medicine, we all heed a higher calling that now holds us all to a higher standard. The trust our patients bestow upon us is enormous." He also highlighted the mounting challenges in medicine including rising costs, increased regulation and the need to reduce medical errors. He urged physicians to work together to "protect professional integrity and to secure a strong voice for physicians."

Dr. Dzau also discussed Duke's challenges and responsibilities as an academic institution. He said that Duke recognizes its obligation to help address the important challenges facing medicine today and is constantly working to strike a delicate balance to "shape a delivery system that allows us to care for patients, grow our research, meet our financial obligations and fulfill our social and humanitarian mission."

Acknowledging the very core of healthcare, the patient, Dr. Dzau additionally emphasized the importance of a patient's trust in their providers and the assumption that they will receive the safest, most effective and compassionate care. "Without question, our mandate is to deliver on those assumptions," he said.

Dr. Dzau added that Duke Medicine has learned through recent experience the importance of patient-centered care and the many complexities of delivering it. "We have learned that the care we provide, the solutions we develop, the decisions we make and all of our interactions must focus first on our patients. Today we are a stronger institution," he said. Dr. Dzau said Duke Medicine has addressed clinical protocols, realigned the organization and its

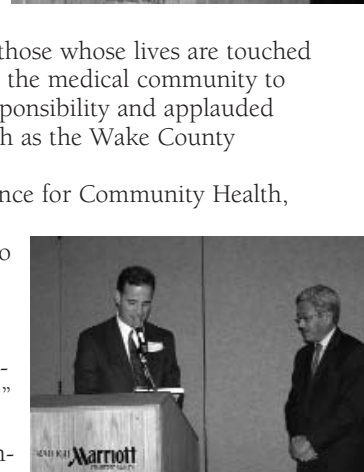
core capabilities and increased accountability – all centralized around patient care. With a high regard for community involvement, Dr. Dzau also described the overarching responsibility of social responsibility as a health system. "Put simply," he said, "it is about doing good and doing well."

Describing a corporation's responsibility to its shareholders, employees and others, he said that as a healthcare provider, "our shareholders are the people we serve and those whose lives are touched by our efforts." Dr. Dzau encouraged the medical community to work together to fulfill this social responsibility and applauded existing community partnerships such as the Wake County Medical Society and Project Access.

Dr. Dzau also addressed the Alliance for Community Health, established by Wake County's three hospitals saying, "perhaps it is time to reexamine the original intent of the Alliance and to measure its achievements. I would like to propose that we get together to review the collaboration – but with a broader mandate."

With this reevaluation, Dr. Dzau asked whether a Greater Triangle consortium of health professionals and organizations could have a more "powerful voice" while still maintaining the individual identities of local organizations like the Wake County Medical Society.

The Wake County Medical Society anticipates beginning a dialogue with Dr. Dzau and his staff to explore ways to improve access to healthcare for the indigent community, shoring up mental health services in Wake County and the Triangle, both inpatient and outpatient, and other initiatives to support local physicians. The Medical Society appreciates his understanding of the innate values of the medical profession and look forward to strengthening the partnership with Duke Medicine within our healthcare community.



## Project Access

By Pam Carpenter

Since Project Access started in 2001, more than 6,500 have received medical and surgical treatment or a diagnosis that ruled out disease from Wake County doctors donating their time and skills. The total value of these donations is more than \$23 million.

Project Access streamlined an informal, patchwork system where indigent care clinics could make only limited referrals to private physicians, hospitals and medication assistance programs. Such informal arrangements were often inefficient, ineffective and time-consuming. If patients needed services they could not afford, whether medications, lab work, x-rays, specialty services or hospital care - physicians and other healthcare workers would

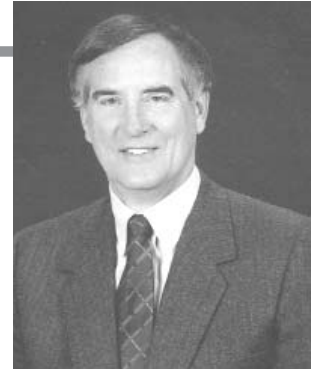
spend time and effort searching for resources, asking for favors, and dealing with paperwork. The coordinated care system Project Access provides is the reason physicians have continued to pledge support each year.

Project Access has also increased the collaboration with local healthcare systems, namely the Open Door Clinic, the Alliance Medical Ministry, and the Wake Health Service Clinics. This partnership has helped to achieve the goals of the program by 1) facilitating the development of a more integrated local healthcare system for Wake County residents; 2) decreasing the use of emergency room facilities by the target population; 3) increasing primary care capacity in Wake County; and 4) increasing volunteerism among physicians and other community partners.

"Thank you" doesn't really seem like enough. Hats off to all Wake County physicians who are actively demonstrating their commitment to promoting the health of all people in this community.

# REFLECTIONS REFLECTIONS

By Robert H. Bilbro, MD, FACP  
Raleigh, NC



Robert H. Bilbro

## The Debate Continues . . .

The articles of Reflections in the last two issues of Wake County Physician from Doctors Owen and Church have certainly provided stimulating food for thought. Interestingly they come from different perspectives on current healthcare issues, but seem to be in total agreement that our present system of medical care is not working. Repeatedly I hear that theme from both patients and healthcare professionals.

Their concerns are hugely important to our state and our nation. Not only do the burdensome inefficiencies of our healthcare system have a negative impact on patients and those of us who work in healthcare, but also the situation is hugely damaging to our national economy. At the Federal level, Medicare costs are competing for public funds that are sorely needed in other areas.

One response to this crunch in the federal budget is to decrease help to states to fund Medicaid. North Carolina is like every state in the union with Medicaid costs siphoning funds from education and other state sponsored programs. As healthcare costs continue to increase, more individuals are pushed to uninsured status, and this drives more people to qualify for Medicaid.

All of us are familiar with the theme of how industry in this country is being disadvantaged in its competition in the global economy because of the costs of employer-based healthcare costs that are continuing to escalate.

As Dr. Church wrote, while we spend far more per capita for healthcare than any other nation, by accepted measures of health quality we rank 37th in the world. Our expenditures for healthcare continue to rise more rapidly than for any other country, but our healthcare statistics remain unfavorable. We are world leaders in innovative technology, but collectively we do a poor job in delivering the nuts and bolts of healthcare which most people need.

Furthermore, from a moral perspective it is difficult to defend our system. We are the world's most wealthy nation and yet 45 million Americans, many of them children, lack health insurance. If serious injury or illness strikes a family without health insurance, it is a rare exception for that family not to be driven into poverty.

Our so-called system of healthcare is economically unsound, is morally difficult to defend, and does poorly by most medical models. Dr Owen in his closing paragraph invites anyone to offer a pragmatic solution to this now chronic problem.

Let me be so bold as to respond to that challenge. My proposal is that we define a basic benefits package and then strive to make that available to all citizens paid for by employer based insurance, by individuals, or by government-funded programs. Such a package should be determined by a commission that has the authority of governmental statute, but would be insulated insofar as possible from pressures by politicians and special interest groups. This commission should be comprised of healthcare professionals and healthcare economists, who would be given the challenging task of defining the healthcare benefits to which all persons are deemed to be entitled. Persons who wish healthcare beyond that basic package would pay for it either from personal funds or through supplemental insurance.

Critics may argue that this is rationing healthcare. In reality, we certainly ration healthcare now, but we do so in an irrational fashion. With such a commission we could make the rationing more logical and ethical. The approach would not be utopian, but would be more realistic. Under our current system many people are denied components of healthcare for economic reasons. My proposal would not eliminate such denials, but would establish a scientifically based threshold below which care is not denied for economic reasons.

This proposed approach would still include an active role for the health insurance industry. The insurance companies would be required to offer the basic benefits package which would give consumers an unusual opportunity for "apples to apples" comparison. The companies could then utilize their marketing ingenuity to sell supplementary insurance.

Healthcare providers and institutions would no longer have to absorb the costs of a huge number of patients who pay nothing for their care. Patients who have health insurance would not be as burdened with paying for the cost shifting that occurs when hospitals collect more from those who do pay, to offset the cost of those who do not pay.

The funding for this basic benefits package for all Americans could come in large measure from the savings that would accrue from persons not utilizing hospital emergency departments for their routine medical care. The average cost for patient visits to the emergency department is approximately 10 times the cost of a visit to one's primary physician. Furthermore, detection and management of chronic medical problems at earlier stages will not only enhance quality-of-life and decrease disability, but also will save dollars per year of life.

In addition more effective medical management of chronic problems decreases the frequency of inpatient care which typically costs multiple thousands of dollars for each admission. One example is with critically ill newborn infants whose care commonly costs more than a quarter of a million dollars. Evidence is compelling that the risk of such an expensive situation is diminished, although certainly not eliminated, by effective prenatal care that costs a few hundred dollars.

In recent months on several occasions I have raised the question with thoughtful, socially concerned persons who are not healthcare professionals as to whether they consider healthcare a right or a privilege. Repeatedly I hear hesitations in the answer, with thoughtful responders wanting to know how much healthcare is involved with this question. With finite resources, we must make some choices. We need some "tough love" with our healthcare system. We cannot pay for ever-expanding technology for all persons without limitations. We must recognize that in certain circumstances, death is inevitable no matter how many dollars we spend. My proposal is that we face reality and strive to deliver basic care to all persons leaving options open for those who can afford it, to seek more if they so choose.

# North Carolina Treasures

## Martha Maxine Swalin

by Sue Jenkins



Maxine Swalin

How does one describe a cultural icon, one of the most important musical arts and education figures in the history of North Carolina, a bright beacon on the North Carolina Road of the Arts and beyond, the Mother/First Lady of our Symphony, a living legend, and a veritable North Carolina Treasure?

This is the very condensed story of Martha Maxine McMahon Swalin, the third child of a physician father and arts-oriented teacher/mother, born in Waukee, Iowa, on May 7, 1903 - the year the Wright Brothers got their flying machine air-borne in Kitty Hawk, and the Wake County Medical Society was founded.

What was it in her turn-of-the-19th-century midwestern upbringing that prepared her for the life of a musician, educator, orchestra manager, popular arts figure loved and revered by thousands of children - touring 33 years with the North Carolina Symphony, from the mountains to the sea?

Her arts education started early - learning to play piano and read music before words, taking the train into

Des Moines for drawing and music lessons (by herself, by age 9), spending her first two years of high school in Denver with a great piano teacher and her last two years of high school at a private girls' school near the University of Chicago.

She spent a year in Junior college and then took more courses at Drake University, earning a teacher's certificate before teaching for two years in the Waukee schools. Then with her savings she was off to the Institute of Musical Arts (now Juilliard) in New York, where she met a tall, handsome, and extraordinarily talented young violinist named Ben Swalin. Upon graduation from Juilliard, Maxine taught music theory at the Hartford Conservatory of Music while Ben stayed at Juilliard, studying and teaching - and earning undergraduate and graduate degrees in English literature from Columbia University. When her betrothed went off to Vienna to study for his Ph.D., she returned to Iowa to finish her undergraduate degree and teach.

The newly titled Dr. Benjamin Swalin returned from Vienna and then went to Moscow, to study the art of children's concerts. With Ben's second return,

he joined the faculty of DePauw University - and soon-thereafter, on January 1, 1935, they were married!

The summer of 1935 brought them to North Carolina for Dr. Swalin to teach a summer session in the Music Department of UNC - while Maxine returned east to Radcliffe, to finish her Master's degree in music.

It is significant to note that the Swalins brought to North Carolina extensive experiences and formal training and education that both had spent young lifetimes accruing. How fortunate for North Carolina they decided to make their stay permanent!

This dynamic duo can best be described as a "synergistic team" - their lives and their very "raison d'être" were so enhanced by each other that it is hardly possible to speak of one alone. This marriage was most surely providential!

Because of the absence of government subsidy to the arts (in North Carolina, specifically musicians' pay), the North Carolina Symphony's "first beginning" met its demise the same year the Swalins came to Chapel Hill, but in just a few short years there was interest and encouragement for Dr. Swalin to try to restart the orchestra - the so-called "second beginning."

By the late '30s, the Swalins were able to put enough pieces of "Humpty-Dumpty" back together again to present a few performances, and on March 16th, 1940, the new North Carolina Symphony gave its first formal concert at Meredith College. More concerts followed, and in the spring of 1941, the first children's concert was given.

1943 proved to be a big milestone, for on March 8, 1943, the North Carolina Legislature passed the so-called "Horn-Tootin' Bill," which gave the struggling Symphony badly needed funds and credibility. This was the first time an American state recognized a symphony orchestra and placed it under official patronage, thus making the North Carolina Symphony the first state-supported symphony orchestra in the nation. This brought widespread attention and invitations for national broadcasts.

With the Swalins' persistence, the orchestra was held together during the war years. They knew if it were ever disbanded again, it would never be revived.

Maxine is credited with pioneering music in the public schools in 1942 and choral music in high schools in 1944. Her performance now seems legendary. She wore many hats - conductor's assistant, performing musician, librarian, assistant programmer of children's concerts, educator (instructing both teachers and children), commentator/narrator of chil-

# INTERSECTIONS

By Dr. Holden Thorp  
Kenan Professor and Chair, Department of Chemistry, UNC, Chapel Hill



Dr. Holden Thorp

Young people aspiring to be physicians usually wonder why they have to learn so much chemistry. “Why do I need to know the ins-and-outs of buffers and limiting reagents to practice medicine?” they ask. My response is usually that it’s not so much chemistry itself as it is the process of learning it. Learning chemistry is an experience that allows students to master difficult

material and to build problem-solving skills.

One of the great things about leading a unit at a university is meeting all of the smart people that have gone on to do fantastic things with their education. Many of the readers of WCP got degrees from UNC chemistry and went on to be excellent physicians – a point we hold with great pride!

I find it particularly exciting when I meet people who have found new ways to take what they have learned in our department and use it to do something totally new that was never explicitly contemplated by their training in chemistry, but for which the process of learning chemistry was a springboard.

I had such an experience recently on meeting one of our chemistry alumni, David Fortenbery, who is the founder of a company called Mantissa Corporation in Charlotte. Mantissa makes equipment for material handling and sorting. Their system is a giant network of conveyors and moving trays that make a huge circuit around a warehouse. The system allows companies like Land’s End to make sure that if you order a shirt, a pair of pants, and some hiking boots, that they all end up in the same box for shipping to your house. Such a system replaces up to 150 people that would be needed to do such sorting by hand.

The innovative genius of Mantissa’s system is something called a “tilt-tray sorter,” which captures your item and then tilts it into a correct chute on the giant circuit that goes through the warehouse at Land’s End or other Mantissa accounts. Their sorter is called the Scorpion because the wider part of the tray goes first, like a scorpion pulling its tail. Barcodes and computer control tell the Scorpion to tilt at the right time to make sure that your shirt goes in your box and that you don’t get someone else’s fleece pullover instead.

Mantissa’s operation is located in a campus of buildings near the Charlotte airport. When I went to visit Dave, he told me that he needed that location because he couldn’t make a sale of his system unless the customer came to his plant to see the Scorpion in person. I can see why: the system itself is impressive, and Mantissa offers great support, spare parts and maintenance to keep these systems running all of the time.

Mantissa’s technology is protected by 18 patents invented by Dave and his colleagues (for instructions on how to find them, see my last column). One of the great moments in my career came when Dave told me that when he was inventing the Scorpion, he relied on the kind of problem-solving skills that he learned in our department. In particular, he said, problems in acid-base equilibrium – which he learned from my colleague Don Jicha in Chem 21 – provided him with the kind of experience in reasoning that he used to develop the Scorpion. Right on!

I get really excited when I hear people like Dave talk about the connection between something fundamental – like acid-base equilibria – and innovation. Dave figured out that education in the liberal arts and sciences provides a direct route to new ideas. In my opinion, this kind of reasoning is the primary way to understand the importance of higher education and why American higher education continues to be the best.

At universities, we sometimes teach people skills that they use directly, like accounting or engineering, and it’s great to see these folks succeed. From visiting with lots of our alumni, however, I’m convinced that the exciting innovations come from the intersections and connections with seemingly unrelated subjects that folks discover. The connection between chemical reasoning and material handling recognized by Dave Fortenbery is one, but similar connections in the humanities and social sciences also lead to new ideas. No doubt, contemplating literature, art, and philosophy has also offered similar connections for other innovators in science and society.

In addition to Land’s End, Mantissa’s clients include Nike, Borders, and Columbia Sportswear (for the complete list, see [www.mantissa.com](http://www.mantissa.com)). Now, every time I see the UPS truck pull up with a package from one of those vendors, I can’t help but smile when I think about the innovative genius of Dave Fortenbery and how getting all the right things in that box was just like getting all of the right protons onto phosphate buffer.

## Doggett Intensive Care Nursery

by Ross Vaughan, MD

*The following comments were made on October 20 on the occasion of the Neonatal Intensive Care Unit at WakeMed being dedicated as the Jeanette and Ron Doggett Intensive Care Nursery.*



This is truly an amazing event for me. On behalf of the 150 or more staff in the NICU, I would like to thank the Doggett’s for their trust and faith in us. Not only were we allowed to take care of their twin grandchildren but our nursery has now been chosen to be dedicated in their behalf. The honor of our being the first area in WakeMed for this to happen is not lost on any of us. We are extremely grateful for what you and your family have done for WakeMed in the past and we are excited about what is happening in the future.

But I have been told I can ramble a bit about my favorite topic, the Doggett ICN. The unit you see today has had a gestation of over 30 years. Neonatal intensive got its jump-start in the 60’s when president Kennedy’s son died of hyaline membrane disease. Intensive care technology diffused from academic centers to community hospitals in the 70s. When I arrived in 77 we worked in a converted storage room that could hold around 8 isolates on a good day. The 4 bed intermediate nursery was down the hall and around the corner; the NBN down the hall around another corner. We used ventilators designed for adults, had iv pumps that could deliver only 5cc/hr accurately, took mls of blood to do lab tests, and we did not expect babies less than 2 pounds to survive. Incredible changes have occurred in 30 years. We now have IV pumps that deliver accurately to the ten and hundredth ml, ventilators designed expressly for prematures that are so sensitive that they can detect and assist the breath of a pound and a quarter baby. We do lab test on tenths of mls of blood. For over 10 years we have been able to replace the lining material of the lung that is lacking in premature respiratory distress. We were a part of the Burroughs Wellcome research that produced this 1<sup>st</sup> surfactant. We can nourish babies totally with intravenous nutrition or we can supplement them with donor breast milk from our own milk bank, one of only nine in the country. We use a respirator that vibrates the lung air column at over 600 times a minute. We have ultrasound machines

# The Tar Heel Framers

North Carolina sent three representatives to the convention that framed the United States Constitution. Two of them are remarkable not for what they contributed at Philadelphia in 1787, which was negligible, but for their careers afterward; the third for an extraordinary life well lived.

Born in New Bern, Richard Dobbs Spaight was orphaned at an early age but had the good fortune to be sent by his guardian, the royal governor, to study in Ireland and at the University of Glasgow.

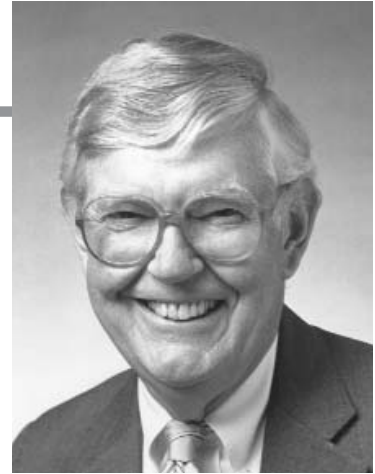
On his return to America, he served as aide to the commander of the North Carolina militia in the Revolutionary War and won promotion to commandant of artillery. At a time when the outcome of the conflict remained in doubt, Spaight, on his farm in New Bern, pledged his financial resources to the cause, a commitment that strengthened the resolve of General Nathanael Greene to fight on. In 1791, President George Washington paid a visit of homage to the cypress along the Neuse where Spaight had made his vow.

While not yet twenty-four, Spaight was elected to the General Assembly, and two years later to the Continental Congress. As delegate to the constitutional convention in Philadelphia, he advocated election of U.S. senators by state legislatures, a provision that would endure for more than a century. His renown as a delegate led to his election as governor of North Carolina in the young republic. Twice re-elected, he was the first governor to reside in Raleigh when the state's capital was moved from New Bern. His administration, it was said, was one of "dignity, fidelity and moderation." From 1798 to 1801, he served in the U.S. House of Representatives before deciding to return to North Carolina to win a seat in the state senate.

In choosing to leave Congress, Spaight gave way to twenty-eight-year-old John Stanly of New Bern, with whom he feuded venomously. In the midst of an acrimonious campaign in 1802, Spaight denounced Stanly as "both a liar and a scoundrel," adding meaningfully, "I shall always hold myself in readiness to give him satisfaction." Stanly, who in that age could hardly ignore such a provocation, challenged him to a duel. On September 5, 1802, each fired his weapon-without consequence. At that point, honor having been demonstrated, duels sometimes ended. But the combatants went three more rounds. On the fourth round, Stanly killed his adversary. Spaight at the time of his death was forty-four.

William Blount, nine years older than Spaight, came from a patrician family that had migrated to the New World following the restoration of Charles II. After a stint as paymaster of Continental soldiers during the War for Independence, he served four terms in North Carolina's lower house, where he rose to be Speaker, and two terms in the senate. North Carolina chose Blount to represent it both in the Continental Congress and at the convention to draft the U.S. Constitution. A fellow delegate said of the North Carolinian: "Mr. Blount is a character strongly marked for integrity and honor.. He is no Speaker, nor does he possess any of those talents that make Men shine; -he is plain, honest, and sincere." He took no part in debates in Philadelphia and had no influence on the document

By William E. Leuchtenburg, PhD  
Emeritus Professor of History, UNC  
at Chapel Hill



*William E. Leuchtenburg*

that emerged, but he did have a hand in overcoming objections in North Carolina to its ratification.

The most interesting phase of Blount's career evolved after the adoption of the U.S. Constitution when North Carolina's western lands were ceded to the United States. In 1790, President Washington appointed Blount governor of the vast trans-Allegheny territory and Superintendent of Indian Affairs for the Southern Department. Blount wielded autocratic powers until a territorial assembly was created. This legislature chartered three institutions of higher learning, one of them Blount College, which later became the University of Tennessee. Subsequently, Blount presided over Tennessee's constitutional convention and was elected to be one of the state's first two U.S. senators.

Blount's career crashed abruptly when federal authorities got hold of a letter he had written to a Cherokee interpreter revealing that he was conspiring to lead a band of frontiersmen and Indians to oust Spain from Louisiana and Florida and place them under the British crown. After President John Adams handed over the incriminating missive, the U.S. Senate expelled him by the resounding vote of 25-1.

Much the most admirable of the trio of Framers was Hugh Williamson. Born into a Scotch-Irish family in Pennsylvania, he was the son of a clothier from Dublin and a mother from Derry who had once been held captive by the pirate Blackbeard. After preparation at a school in Newark, Delaware, that won his lifelong devotion, Williamson studied at the College of Philadelphia (later the University of Pennsylvania) and graduated in its first class. At a precocious age, he was appointed professor of mathematics there. He went on to study theology in Connecticut, but, vexed by doctrinal disputes between Presbyterian factions, he turned to the study of medicine-at Edinburgh and London and then at Utrecht, where he earned an M.D.

A weak constitution hampered his medical practice but not his love of learning. Williamson was so frail that he ran the risk of falling seriously ill whenever he treated a fevered patient, and, as a result, he turned toward a career in business. But his fascination with science continued. In 1768, he won election to the American Philosophical Society, and the following year was named to a commission studying the transits of Venus and Mercury across the sun, an experience that led to the publication of his well-regarded paper, "An Essay on Comets."

In 1773, on his way to Europe to raise funds for his beloved Newark academy, Williamson witnessed the Boston Tea Party, and it was from him that England got the first news of that affray. Called before the Privy Council, he warned that if Britain persisted in its policies, it would provoke revolution. In an open letter to Lord Mansfield, *The Plea of the Colonies*, published anonymously, Williamson again called attention to the grievances of his countrymen. He also got revealing letters written by the Massachusetts royal governor into the hands of the

American envoy, Benjamin Franklin. He found time, too, to collaborate with Franklin on scientific experiments and to read a paper on the electric eel before the Royal Society. In Holland, word reached him of the Declaration of Independence, and he hastened home. A British man-of-war captured his ship off the Delaware capes, but he made his way to land in a small boat.

A subsequent adventure with His Majesty's fleet had more enduring consequences, indeed altered the course of Williamson's life. On a voyage from Charleston to Baltimore, he was compelled to disembark in Edenton because the south-bound movement of the royal navy made further progress north inadvisable. He liked the North Carolina port so much that he decided to settle there, combining a mercantile enterprise, catering to French West Indian markets, with a medical practice. Appointed surgeon-general of North Carolina troops in the American Revolution, he won distinction at the battle of Camden, where he crossed redcoat lines under a flag of truce to treat British as well as American wounded, and by his performance in the Dismal Swamp, where his insistence on sanitary methods resulted in remarkably low casualties.

Though Williamson was capable of "a Johnsonian rudeness" when provoked, and was something of a bigot, he had, for the most part, attractive qualities that served him well when he entered the political field. In 1782, he was elected to both the North Carolina House of Commons and the Continental Congress, where he served with such distinction that Thomas Jefferson called him "a very useful member, of an acute mind, attentive to business, and of an high degree of erudition." He quickly became so well connected that he appears in John Trumbull's famous painting of Washington resigning his commission as commander of the Continental army in a ceremony at Annapolis. The North Carolina historian J. G. deRoulhac Hamilton later characterized Williamson as "not an attractive

speaker, but . a good debater, with flashes of wit and much force of expression."

Appointed by the governor of North Carolina to the Federal Convention in 1787, he made a far larger contribution in Philadelphia than the other two delegates from the state. To be sure, he vacillated so often that the French chargé commented, "Il est difficile de bien connoître son caractère; il est même possible qu'il n'en ait pas." But Williamson played an important role in working out compromises that held the convention together. Though he never owned slaves, or condoned slavery, he helped work out the compromise on slavery that made possible southern acceptance of the new charter. Over the course of that sultry summer, he gave more than seventy speeches.

After his labors to create the new republic were completed, Williamson lived on for over two decades, a period he devoted both to public service and to private pursuits. A member of the original board of trustees of the University of North Carolina, he served for a long time as its secretary. He was elected to the First U.S. Congress, then re-elected, but, after finishing out his second term, moved to New York where he cultivated his interest in science by publishing papers such as "Observations on the Malignant Pleurisy of the Southern States." His most important work was on climate, which won him membership in the Holland Society of Sciences and the Society of Arts and Sciences of Utrecht. The University of Leyden awarded him an honorary degree. He did not forget the state he had represented so well. In 1812, he published, in two volumes, the first history of North Carolina to appear in print during the early republic. But he had long since made New York his permanent abode. He lies buried in historic Trinity Churchyard, adjacent to the canyons of Wall Street, far removed from the quiet harbor of Edenton, where he had once hazarded a fresh start.

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# Physician Profile

By Christy Farrelly

## Drs. Joseph & Cynthia Hardison



Joseph and Cynthia Hardison

**D**rs. Joe and Cynthia Hardison have been wedded to medicine and each other for over 45 years. They have shared a dedication and passion for patients, family and each other.

Born and raised in Raleigh, Dr. Joseph Hardison showed an interest in science and medicine from the earliest age. He attended Duke University and graduated medical school at the age of 23. After completing his residency at The New York

Hospital – Cornell Medical Center, he spent two years as a Warden Medical Officer at the US Naval Hospital in Japan. Fellowships in Internal Medicine, Cardiology and Gastroenterology at the Mayo Clinic followed.

Dr. Cynthia Hardison wanted to be a physician from the time she was a little girl growing up in Canada, nothing else ever entered her mind. She attended Wellesley College, graduated from Stanford University and continued her medical education at Northwestern University. Upon completion of her internship at Evanston Hospital in Illinois, Dr. Hardison went to the Mayo Clinic where she was the first female staff clinician. Here, her focus was hematology and she became authority on Sjogren's Syndrome. "The field of Hematology was really coming into its own. We were beginning to develop treatments for many diseases, Sickle Cell Anemia in particular. It was exciting and I entered on the cusp of Hematology as a specialty."

At the Mayo Clinic, Dr. Cynthia Hardison also became a mentor and supervisor to many newcomers, one of whom happened to be Dr. Joe Hardison. "The luckiest thing happened to me. Cynthia was my advisor, we would discuss my work and somehow we ended up getting married." They have been inseparable ever since.

In the 60's, the Hardisons made the move from New York to Raleigh, North Carolina. Dr. Joe Hardison was one of the first gastroenterologists in Raleigh. "I decided to practice gastroenterology because of the large numbers of cardiologists. As a practicing gastroenterologist, I saw more sore throats and colds for the first two years than

most pediatricians." The Hardisons worked for a brief time with Wake Internal Medicine before forming Hardison & Hardison, an internal medicine sub-specialty practice modeled on the Mayo Clinic and focused on referral medicine.

As luck would have it, IBM relocated to the area at this same time. Drs. Joe and Cynthia Hardison would work late hours to accommodate employees who worked during the day. These patients referred others and the practice grew to have a number of loyal and dedicated patients.

For four years, Dr. Joseph Hardison was on call and there was no family break or vacation. Then something most fortunate happened from a personal and practice point of view. The Hardisons recruited Dr. John Paar to the practice and formed Hardison & Paar. This relieved some of the time pressures and marks the official start of subspecialty recruitment efforts.

It was a new concept at the time. The Hardisons were leaders in the notion of expanding a subspecialty practice to include comprehensive outpatient evaluation and treatment. Hardison & Paar became Raleigh Internal Medicine and had positive recruitment of physicians throughout the country, simply through word-of-mouth. The Hardisons built a practice of diversity. They actively sought physicians with different backgrounds who showed a strong commitment to medicine.

Drs. Hardison seemed to have a talent for reading the pulse of this community. In the 80's, they added radiology expertise and used office-based computer software and systems to coordinate and provide patient care. In 1989, the Hardisons retired from their practice, leaving room in the growing practice for new talent.

Retirement proved to be challenging. "You are ready to go somewhere at 6am and there's no where to go. The first year or two it is very difficult to just leave medicine behind. We had a complete lifestyle change." With retirement came more time for their hobbies and passions – reading, trips to the beach, family, music (Cynthia has been a long-time supporter of the North Carolina Symphony) and, of course, each other. They enjoy time and conversations with their three children, Jay, Sandy and Anna, and grandchildren. The only time they are apart is when Cynthia attends her weekly book club and Joe his medicine club.

It's hard to imagine that through all of their civic and professional involvement, the Hardisons found time to be dedicated parents. Jay, Sandy and Anna recall at least one of the parents being at every game or school event and appreciate the involvement in their lives. "My parents have a solid relationship based on their mutual respect for each other and their mutual interest in medicine and their practice, which was really like an extension of our family."

The Hardisons look back fondly at their careers in medicine. Both have been members of the Wake County Medical Society and the NC Medical Society. Dr. Cynthia Hardison contributed to JAMA in responding to Letters to the Editor. Dr. Joe Hardison has been President of the Raleigh Society of Internal Medicine, Chairman of the Department of Medicine at Raleigh Community Hospital and served on the board of the American College of Gastroenterology.

Both doctors can see vast changes in medicine. "It's hard to see medicine without Medicare now. But, back when we started, you would help patients whether you got paid or not. It

made medicine a much more real situation. Back then, we could spend 40 minutes on an office visit. Now, 10 minutes is the most you can do. So much is missed in that situation. Medicine has evolved into an almost scientific fact-finding mission, working solely on probabilities." Both agree that medicine has become too reliant on expensive equipment to make the diagnosis, when the process of diagnosis is what makes medicine fun and challenging.

Drs. Joe and Cynthia Hardison retired over a decade ago from medicine, but their legacy lives on through many of the significant practices in Wake County.

## FIRST *Person*

### ON BEING "GOOD FOR GOODNESS SAKE"

*He sees you when you are sleeping;  
He knows when you're awake;  
He knows when you've been bad or good,  
So be good for goodness sake!*

A phrase from this secular seasonal song lends itself to ethical reflection. It raises the fundamental question of morality. Why be good? During the year end holidays many of us feel motivated to multiple acts of generosity and kindness. What prompts us to do this? There may be many reasons.

Imagine yourself leaving a shopping mall weighted down with an arm full of presents. You pass a Santa Claus ringing a bell for the Salvation Army, asking for a contribution. You hesitate for a moment, but then you fumble for your money and drop a ten dollar bill in the kettle. Why did you do it?

Consider the possibilities. Your motive may have been prompted by a twinge of guilt. Having spent money all day on friends and the people you love, you may have made the gift to offset feeling a little selfish. Or you may have given out of a strong sense of duty, remembering that your parents taught you to share. Or perhaps you are impressed by the Salvation Army's reputation for assisting the needy, and you wanted to have part in it.

There are other possibilities, less altruistic. You could have given out of a sense of pride, to bolster your self-image as a caring person. Or maybe the person playing Santa Claus happened to be someone you know, so you felt the pressure to respond to his appeal with a sizable bill. You want him to think of you as a generous person.

But there are better reasons. Your act of charity could have arisen out of a sense of gratitude for all that has been given to you. You might have felt thankful when you compared your privileged circumstance to the plight of the poor.

And there are worse reasons. Such as acting on the advice of those television evangelists who say that if you give you will get much more in return. "Cast your bread on the waters, and it will come back to you ten fold," they promise.

The lyrics to the song suggest one further motive. It is fear. Somebody's watching to see who's "naughty or nice." Someone knows whether you've "been bad or good." So "you better watch out!"

Any of these multiple reasons could account for your having contributed ten dollars to the Salvation Army. Goodness is seldom "for goodness sake" only. Psychiatrists tell us that even our highest motives are generally mixed and seldom pure, yet all

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of the world's religions call us to purity of heart and singleness of purpose. Most of us can identify with the whole range of possible motives suggested by the above analysis.

Have you noticed that an increasingly common way to raise money for charity is to plan a "benefit" event? Special social functions offer pleasurable evenings to participants with a portion of the proceeds for admission being designated to some worthy cause. What a shrewd way of serving ourselves while serving others! The motivation is murky.

An appropriate resolution for each of us as we move into the New Year is to relinquish lesser motives for doing good to higher motives. "Being good for goodness sake" becomes a matter of prioritizing our reasons for the good we do, like ascending a ladder from its lower rungs to higher ones.

I would label the bottom rung on such a scale the giving that is prompted to expiate guilt, suggested by the phrase "conscience money." Substantial contributions to good causes are often made because the donor feels some discomfort about how the wealth was acquired. For example, did you know that the Nobel Peace Prize comes from a family fortune amassed from the sale of explosives? Obviously, they have not always been used to bless humanity.

We move up a rung on the ladder if we give from a sense of responsibility, when we understand that the wellbeing of our corporate life depends upon everyone supporting a broad spectrum of good causes. At this level, the gift is simply an acknowledgement of what we conclude as our share.

Near the top of the ascending ladder is the motive of thanksgiving. We give out of a sense of gratitude for all that has been given to us. Indeed, gratitude is recognized as a primary main-spring of ethical living.

The results are the same for the Salvation Army no matter what may have motivated our giving, but what a difference it makes to the giver if the reasons are right! Remember that couplet from T.S. Elliott's play, "Murder in the Cathedral?"

The last temptation is the greatest treason,  
To do the right thing for the wrong reason.  
The temptation is always there even though our ideal in life may be to act with consistency between our inner motivation and our outward action. Nobody wants to be called a hypocrite, for a hypocrite is: someone who acts from a false motive. Integrity exists where outward goodness reflects genuine goodness within, "good for goodness sake."

# Milestones for the Restless Legs Syndrome Foundation

by Pickett M. Guthrie, MLS and  
Georgianna Bell, MPH, MBA



Georgianna Bell



Pickett M. Guthrie

*Never doubt that a group of thoughtful committed citizens can change the world; indeed, it's the only thing that ever has.*

- Margaret Mead

Patients with restless legs syndrome (RLS) often have difficulty describing their symptoms. Most feel an irresistible urge to move the legs which occurs or worsens at night. Some experience a creeping, crawling sensation, and others report it feels like a bottle brush is twisting up and down inside their calves. Walking or pacing brings temporary relief, but many patients are unable to remain at rest long enough to read a book, watch a movie, enjoy a concert, travel, or fall asleep. Severe symptoms may cause long-term sleep deprivation.

In the 1940s, Swedish neurologist Dr. Karl Axel Ekbom published numerous scientific articles on this poorly understood condition, but for the next 50 years the syndrome got little attention from the medical world. People with RLS continued to suffer alone.

For years, the only way RLS patients could connect with each other was through a resource center called the National Organization of Rare

Disorders (NORD). By 1989, eight individuals with RLS had learned about each other through NORD and began exchanging letters. Medical knowledge on how to diagnose and treat the condition was still so limited that others who suspected they had RLS began to contact this fledgling support group with questions about coping methods and therapies.

One of these eight RLS pioneers designed a query sheet to record the medical history and family background of those who contacted the group. In return, respondents received NightWalkers newsletter, named after the relentless nighttime pacing the condition causes.

Eventually, members of the support group asked Pickett M. Guthrie (an RLS patient and law librarian from Raleigh) to create a framework that would transform this group into an official organization. Lawyers from the Raleigh office of Moore and Van Allen contributed pro bono advice to give the Foundation a sound legal footing. Three short years after those first eight patients contacted NORD, the Restless Legs Syndrome Foundation was incorporated in North Carolina. Pickett Guthrie became Executive Director and again enlisted help from her law firm to obtain 501(c)(3) status. Recognition as a nonprofit was critical to the Foundation's goal of building research funds.

One milestone in the Foundation's growth came through the interest of several neurologists from Robert Wood Johnson Medical School. These researchers had been studying a group of patients with strange leg discomfort that forced them to walk the floor sleeplessly at night. The new RLS Foundation aided the researchers by providing access to a large group of patients with similar symptoms. Eleven years later these same researchers would join the RLS International Study Group in collaborating with the National Institutes of Health (NIH) to publish four basic criteria for diagnosing RLS:

- Urge to move legs, usually accompanied by uncomfortable leg sensations
- Worsening of symptoms in the evening and at night
- Onset or worsening of symptoms at rest or inactivity, such as when lying down or sitting
- Relief with movement - partial or total relief from discomfort by walking or stretching

In 1994, Modern Maturity published an article on RLS entitled "The Most Common Disorder You May Never Have Heard Of". With advance notice that this article might generate a large response, the RLS Foundation moved to a one-room office on Glenwood Avenue in Raleigh. Volunteers and a single paid employee opened what proved to be a 40,000-letter avalanche of mail. This article captured public attention and encouraged RLS sufferers that their condition was real and treatable.

In 1996, the Foundation relocated to Rochester, MN. Under the leadership of current Executive Director Georgianna Bell, the Foundation has grown to a staff of 10. From its humble beginnings as a single informal support group in 1991, the Foundation now includes 100 active support groups in the United States and five in Canada. Members of the Medical and Scientific Advisory Boards represent such institutions as Johns Hopkins, Emory University, UCLA, Stanford, and the University of California at San Francisco.

In 1997, The Foundation's Scientific Advisory Board laid the groundwork for a program of competitive grants. Since 1997, a total of 21 grants totaling \$847,600 have been funded. Several Foundation-funded researchers have gone on to receive grants from the NIH.

Researchers now report that restless legs syndrome appears to be related to a dysfunction of the dopamine system and is frequently associated with iron insufficiency. In May 2005, Requip (ropinirole), produced by GlaxoSmithKline, PLC became the first drug approved by the FDA for treatment of RLS. Several other agents are being developed to treat the syndrome's symptoms and improve the quality of life for patients.

RLS is still far from a household name. Despite numerous studies that estimate as many as 10% of Americans have RLS (about one-third of these patients have severe symptoms), less than 10% of RLS sufferers receive appropriate treatment.

For that reason, the RLS Foundation provides several programs to educate patients and physicians. Useful patient resources include:



Edward B. Yellig

# Issues on Care at the End of Life

By Edward B. Yellig, MD, FACP

## Important Considerations for Heart Patients

Bob Taylor was known to his many friends for his big chested hearty laugh, his love for his Saturday afternoon cookouts replete with gourmet grilled steaks, fries, and beer, and of his disdain for main stream American health consciousness. At 45, he had been smoking more than two packs a day of unfiltered Camels for thirty years. His days of high school football and baseball were a distant memory. Perhaps, then, it was no surprise that he suffered his first heart attack when the 2001 profits of his company, Engineering Data Sets, failed to meet market and stock holders' expectations. The attack was a large inferior myocardial infarction, resulting in congestive heart failure (CHF) accompanied by low energy, reduced endurance, and shortness of breath. He retired on disability and experienced these dramatic changes that left him both frustrated and depressed.

Congestive heart failure has become the major cause of death in the United States, accounting for 300,000 deaths each year. It increases with age and, with the rising population of senior citizens, it will continue to increase for decades to come. In spite of progress with diagnosis and treatment, it remains a significant killer, a surprise to many who expect that cancer takes more lives than heart disease. Hospitalizations for heart failure have increased from 550,000 to 900,000 per year in the last 10 years (Davis et al., 2005). Half of patients with heart failure die within 5 years and more importantly, half of these deaths occur suddenly (Pantilat & Steimle, 2004). This trend is the outcome of the lifestyle exemplified by our patient and has been prevalent for the last 60 years in our culture. Fortunately, attention is now being drawn to the appearance of adult diseases, such as hypertension, diabetes, and hypercholesterolemia, in our children, and health officials and school systems are making changes in school programs to counter this unfortunate trend in adult heart disease. For patients like Bob, palliative care becomes an essential part of the management of the symptoms of heart failure to maximize his quality of life as well as the length of his life. Palliative care is the active total care of patients for the relief of symptoms to improve the quality of living often in the setting of a terminal illness. Palliative care can also accompany traditional curative care or general medical management of any chronic disease.

Bob saw his physician, Dr. Thomas, who adjusted his medications carefully so that his symptoms of shortness of breath, recurrent angina, weakness, and fatigue were minimized. An

older physician, Dr. Thomas had treated many patients like Bob and was aware of the multiple facets of the disease, including how acceptance of the required alterations in lifestyle was often the most difficult consequence of the disease. Depression is a common response to these changes and Dr. Thomas initiated the use of appropriate antidepressants as well as an occasional longer office visit for empathic listening and coaching, assisting Bob to accommodate and cope with his losses. Knowing that sudden death was an unpredictable outcome of heart disease, he counseled Bob to create advance directives (AD's) so that if at some time in the future, Bob were unable to make his own healthcare decisions, his thoughts and wishes would be recorded and subsequently followed.

Health professionals have long expected AD's to hold the promise of control over the treatments given to persons at the end of life so as to limit non-beneficial interventions. They are usually applied when patients have lost the capacity to make important decisions regarding their healthcare. Advance directives are usually of two types: the living will and the healthcare power of attorney. Both are statutory documents, i.e., regulated by state law, requiring two witnesses and the signature of a notary public. The living will, as well as other forms of medical directives, consists of directions to family members or healthcare providers, limiting treatments and procedures in the setting of terminal illness, including, and most importantly, cardiopulmonary resuscitation. AD's can also be used in the setting of brain injury, like persistent vegetative state, even when no terminal illness exists. The purpose of the AD is to give the patient control over the circumstances of his or her healthcare and/or dying. The Healthcare Power of Attorney (HCPOA) document designates someone, often but not necessarily a family member, to carry out the wishes or directives listed in the Living Will. Advance directives need not be written; verbal expressions of values, wishes, and desires are also acceptable for directing care of someone mentally incapacitated. Most people are familiar with the sad circumstances of Terri Schiavo's demise and many people subsequently created these documents just so that they would prevent having a similar experience. In spite of this tragic event and in spite of the Patient Self-Determination Act of 1990, it is estimated that more than 70% of Americans have yet to create an advance directive. The reasons are plentiful: AD's can be complicated; many persons may not understand all the options; the HCPOA's or the papers themselves may not be present when needed; and people may change their minds over time



Jeffrey Engel

## *Clostridium difficile* Associated Disease: An Emerging Epidemic

Healthcare providers who manage hospitalized patients in the acute care setting have long recognized hospital-acquired gastrointestinal disease. Patients at risk tend to be elderly with multiple medical problems and receiving antibiotics. A large proportion of antibiotic-associated diarrhea in this clinical setting is caused by the bacterium *Clostridium difficile*. The spectrum of illness ranges from mild diarrhea to pseudomembranous colitis, toxic megacolon, sepsis and death and is collectively termed *Clostridium difficile*-Associated Disease or CDAD.

The organism is a spore-forming bacillus spread by fecal-oral transmission through contaminated environments and hands of healthcare personnel. People with CDAD shed large quantities of spores in their stool. Spores are particularly hardy survivors in the environment resisting many hospital disinfectants (such as the ammonium and phenolic based cleaners) and alcohol-containing hand rubs (so-called waterless hand sanitizers). The spore can be destroyed in the environment only with bleach-based cleaners, and removed from hands with soap and water.

Antimicrobial exposure is the major risk factor for disease. Clindamycin, penicillins, and cephalosporins are most commonly implicated, but almost any antibiotic has been linked to CDAD. Disease results from acquisition and growth of *C. difficile* in the colon where normal flora has been suppressed by antibiotics. The organism elicits two large cytotoxins (called toxins A and B) that destroy intestinal lining cells (epithelium) in the colon. CDAD is diagnosed by testing liquid stool for the presence of toxins A and B using an enzyme-linked immunoabsorption (ELISA) test or by endoscopic examination looking for pseudomembranous colitis. CDAD is treated with oral metronidazole (Flagyl®) or vancomycin.

In the year 2000, literature from Europe, Canada, and the United States began reporting an increasing number of hospital outbreaks of CDAD. In an article in press from the Centers for Disease Control and Prevention, rates in US acute care hospitals were steady from 1995-2000. However in patients over age 64, the rate has risen from 175 per 100,000 population to 350 per 100,000 from 2000 to 2003. Worrisome in this trend are descriptions of increased severity of disease including more patients requiring colectomy, and deaths from toxic megacolon and sepsis.

Potential reasons for increased CDAD incidence and severity include: changes in underlying host susceptibility, changes in antimicrobial prescribing, new strain with increased virulence, and changes in infection control practice.

In a summary of hospital CDAD outbreaks from 2001-2004 (McDonald et al., *New England Journal of Medicine* 2005; 353: 2433-41), the authors describe the emergence of a new epidemic strain of *C. difficile*. The strain, dubbed North American 1, was the cause of 50% of hospital outbreaks and

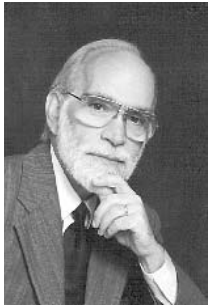
has now been found in 18 states including North Carolina (personal communication L. Clifford McDonald, CDC). This epidemic strain contains an 18 base-pair deletion in the toxin regulatory gene which results in the production 20-fold higher concentrations of toxins A and B than non-North American 1 *C. difficile*. In addition, it elicits a third toxin, known as binary toxin, whose role in CDAD remains unclear, but does cause cell damage under experimental conditions.

Finally, there have been increasing reports of CDAD in populations previously felt to be at low risk. This includes patients with community onset disease (rather than hospital-acquired), and patients with no prior antibiotic exposure. Cases of severe CDAD have been described in children, women in the peripartum, and cases of suspected transmission to household contacts. A report in the *Journal of the American Medical Association* in December 2005 (Dias et al. 294: 2989-95) noted increasing incidence of community-acquired CDAD in England. Interestingly, they also noted an association with stomach acid suppressing medications (both proton pump inhibitors and H2 blockers). Because this was a retrospective study, this latter observation remains inconclusive as confounding was possible.

These disturbing trends in CDAD have led to several new activities. The Infectious Disease Society of America and the Society for Healthcare Epidemiology of America will be publishing guidelines on the prevention, treatment, epidemiology, and surveillance of CDAD. Three states have made CDAD a mandatory reportable communicable disease. Finally, national programs in foodborne disease surveillance are asking the question: is *C. difficile* in the food supply? Clearly further study studies are needed on many fronts.

In the meantime control measures that are known to work should be rigorously practiced. In the healthcare setting, patients with CDAD should be placed in contact precautions (gown and glove isolation, private room) while symptomatic. The environment should be cleaned with bleach-containing disinfectants. Healthcare personnel and visitors should wash their hands with soap and water and alcohol-containing hand gels should not be used. Finally, hospitals should conduct surveillance for CDAD by tracking positive lab results so that outbreaks can be detected and controlled early. If possible, hospital laboratories in cooperation with infection control staff, should attempt to culture outbreak-associated *C. difficile* to send to the CDC to check for the presence of the North American 1 strain.

In the community setting, the possible emergence of CDAD in previously low risk patients serves as a reminder to providers to prescribe antibiotics judiciously. Certainly no one wants to see CDAD arising in a previously well outpatient receiving antibiotics for a respiratory infection that most likely is viral in origin.



Nicholas Stratas

## Vision

A distinct characteristic of this magazine, *The Wake County Physician*, since its foundation, is "vision". From the clarion call of the editorials and articles of the founding editor, Assad Meymandi to the cover art, and the substantial contributions in the areas of medicine, life, public health, science, the humanities and arts. When I Google the word, vision, I find 371 million entries ranging the whole gamut of technology, ecology, cosmology and anthropology. Over the years I have been privileged to not only provide consultation to but also to lead both small and large organizations. Most organizations have mission statements or statements of their vision. For the individual vision is most important. As I began my career, as a result of my training in medical school and in spite of a training background in psychodynamic, behavioral and biologic psychiatry, I focused on the problems patients brought to me. My evaluations were problem oriented and the work was around providing a treatment plan for those problems. My psychodynamic training and even my earlier college psychology and anthropology had poised me to have a developmental orientation to people. In the early years of my practice I was fortunately exposed to General System's theory which transformed organizational work. As exciting as that has been, even more exciting has been the application to individuals. In the problem focused orientation my patients and I found ourselves spending much time dissecting, understanding and working on the problems either in episodic or long term therapy. At the same time because of my early cognitive behavioral training in Virginia I could see that providing patients with tools to move forward catalyzed their work. I thus began a shift to growth oriented work. A distinct characteristic of my work with people whether patients, clients, or executives and employees of organizations for the past two decades has been to have them clarify and know their vision for themselves. In other columns and contacts I have written regarding the importance of self-awareness, self-monitoring and self-management. This time I write about vision and the self-growth and healing power which lies therein. Today I focus on the importance of how the individual sees the self.

My experience is that, except in persons who are significantly decompensated, *working on one's Vision of one's self bypasses and in many instances converts the problems into assets. My belief is that in the future, psychiatry and even medicine will be turned around and will be growth oriented with the problems which interfere with that growth dealt with only as they indeed do interfere with growth.*

So what does all this mean in a practical way? A 30 year old, single, African American female presented July of 2005 with complaints of negative thoughts about herself and her life. She had a history of suicidal thoughts never acted upon. She does not want to kill herself. She feels she sabotages herself. She has not been able to find a job after going through one job after another. She starts off working hard and then slacks off.

This is a woman who describes significant self-defeating thoughts, increasingly worse over the past several weeks. While she ruminates it would be better that she were not alive she has had no active suicidal plans never made an attempt. She talks about the pattern of being unable to get full-time work after graduation from college and wonders what she is doing to sabotage herself. She states her concentration is zero. Her energy is poor starting off the day but once she gets started it improves. Her

weight is 278 pounds at 5 feet 8" tall. She has weighed up to 300 pounds in the past. She has always seen herself as fat and recalls gaining weight in middle and high school. While she describes jumbled thoughts in the past her thoughts were lucid focused and responsive, her behavior appropriate. She is clearly frightened at the beginning of the session and cautious about sharing information. She goes to bed about 11 p.m. and sleeps within 30 to 45 minutes. She sleeps through the night and wakes at 6:15 a.m. not rested. She describes hypnopompic and hypnogogic hallucinations in the past for a brief period of time. As she describes a rape at age 6 years of age she becomes tearful. She describes difficulty, in her past, with her sleep occurring episodically from age 6. There is no evidence of psychosis.

Review of systems reveals being legally blind without glasses which she has always worn. She states she suffers from motion sickness. Past history includes menarche at age 12. She did not know what was happening as no one had spoken to her about it. She was raped by two teenagers at age 6. She told her mother who didn't do anything about it. She has not been pregnant. Grandfather was emotionally and physically abusive and mother was abusive. She has degree in Fine Arts from UNC-G. My initial impression was that she was an intelligent, resourceful woman with depression and depressiveness. I asked her to obtain a current physical and appropriate labwork including Thyroid panel. I reviewed with her my impression and my recommendations for cognitive behavioral therapy to be supplemented with insight therapy about dynamics operant and medications such as bupropion. She rejected the medications wanting to try more "natural" approaches. In addition to weight watchers, exercise, supplements including vitamins and fish oil, our plan was homework in the form of having her describe herself as she wanted to be when everything would be the way she would want. My assignment takes the form of my desire for a description of "if I had a magic wand and would touch you on your shoulder and you would become the person you would want to be" and I encourage words and phrases just as we might do for an architect who is to design our house. I also accept narratives.

At our next session we reviewed her "how I want to be". Of course her ability to produce this picture came from within and in my mind therefore she has that person inside her already and has only to picture her and live as she is that person whether she believes it or not. With this insight she became significantly heartened. Over the next 3 to 4 weeks she showed steady improvement although she found the old thoughts intruding. She was taught relaxation techniques, and introduced to meditation, her trance and to visualization as well as thought stopping techniques. An additional assignment was that she develop a set of affirmations, a set of statements about herself which were based on actual experiences of herself. These were to be used daily and repeatedly, to be duplicated on index cards and placed in locations where she could not but see them periodically. By the fourth week she was interested in the medication and she was placed on bupropion 75 mgm each morning. By the end of the second month she had obtained part time employment at IBM. She had shared with me her talents in music and photography and she was encouraged to expand her vision of herself in these areas.

To shorten this anecdote, at the most recent visit, in February she has just resigned her part time job at IBM because a position she obtained teaching singing at a local music studio has been so successful that she will make that full time. She has also created a website featuring her photography. She feels good about herself, is



Marc Benevides

In his 2006 State of the Union address, President Bush again called on Congress to act on medical liability reform. However, the future of Congressional action in 2006 is uncertain. National attention on the War in Iraq and immigration legislation has stolen the national lime light. During 2005, 48 state legislatures introduced 400 bills addressing medical malpractice reform. In 2005 alone, 32 states enacted 60 bills dealing with medical liability. In 2006, it appears all meaningful North Carolina reform legislation will die in committee (HB 1359, HB 1344, SB 44 and SB 989). All the bills can be viewed

and printed from PDF files on [www.ncleg.net](http://www.ncleg.net).

In recent issues of WCP Political Action Committees (PAC's) were discussed. The fact that we are all extremely busy practicing medicine and do not have the luxury of being able to make daily rounds on our local state representatives was mentioned last issue. This is a luxury enjoyed and exploited by our trial lawyer counterparts. A Wake County PAC could be an instrument of daily representation for us as physicians. Despite the last article in WCP and Dr. Dan Albright's article, only one physician expressed interest supporting the idea of a Wake County PAC. I am sure the trial lawyers must get quite a chuckle out of our lack of organization. The nature of a busy physician practicing medicine is the trial lawyer's secret weapon in defense of meaningful malpractice reform.

## RLS Foundation Continued

- NightWalkers: a quarterly newsletter that features articles on research, awareness, and treatments.
- Restless Legs Syndrome Causes, diagnosis and treatment: a patient-oriented booklet with information on RLS diagnosis, treatment options, healthy lifestyle tips, and a sleep diary.
- Healthcare Provider Directory: a list of physicians who have expressed interest or previous experience in treating patients with RLS.

Materials for healthcare providers include the RLS Medical Bulletin, a diagnosis-related CD-ROM, and information on specialty treatment situations including depression, pregnancy, and surgery. The Foundation's Healthcare Provider Membership includes a subscription to the new RLS Scientific Bulletin, Power Point presentations, a secure healthcare provider discussion board, and free copies of the Foundation's brochures for display in medical offices.

The RLS Foundation is dedicated to improving the lives of the men, women, and children who live with this often devastating disease. For more information, visit [www.rls.org](http://www.rls.org) or contact: RLS Foundation, 819 Second Street SW, Rochester, MN 55902 (phone 507-287-6465).

## MANAGED CARE

*Is it time to terminate your participation in managed care arrangements?*

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Thomas Cooper, M.S., healthcare executive, trained at Dartmouth College and Columbia University, with 25 years practice management and insurance company experience, provides personalized, guided consultation to physicians on this process. He serves on the Editorial Board for *Managed Care Contracting & Reimbursement Advisor*.

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## Excerpts from Letters To The Editor continued

The writings and thoughts are absolute gifts. The writer is a gift and a national treasure. I do know a good number of people who are honored to know him and to serve on various boards with him. In my book, he is right up there with Salk, Edison and all the greats.

Carol Wiggs, Pinehurst, NC

The Editor:

Thank you for continuing to send Everett and me the email edition of the Wake Forest Physician. I heartily endorse your conviction that English should become the required language of preference in all schools in the USA. Beyond that, I feel that if the education budget allows, it is good to offer a second elective language at the elementary school level. Our children had that opportunity in New Hampshire schools before we moved to NC. My husband actually learned Swedish in high school in Worcester, Massachusetts. In his day, b.1923, the population of Worcester was one-third Swedish. That knowledge, together with another employee of the UNC School of Medicine (He held dual positions of Director of Development of the UNC School of Medicine and Director of the Medical Foundation of North Carolina, Inc.), enabled him to translate the late Dr. George Hitchings and Gertrude Elion Nobel Prize acceptance speech into Swedish. Dr. Hitchings said it brought a smile.

Mary Elizabeth Nordstrom,  
Free Lance Music Critic/Writer, Kennebunk, ME

The Editor:

Enjoyed your Editorial on page two. I read your writings with great interest and appreciation. Thank you for all the good things you do and now for this excellent magazine.

George W. Miller, Jr.  
Haywood, Denny and Miller, LLP, Durham, NC

The Editor:

I read your magazine cover to cover. Also, I loved your talk this morning on "Music, Genomic and Healing". Please consider publishing the talk. Now with this new knowledge, listening to classical music will become even more central and compelling for me. Thank you so much.

Terry Reeves, Raleigh, NC

The Editor:

Fantastic reading.....it is an honor to receive WCP. Cheers!

Scott Maitland, Chapel Hill, NC

The Editor:

Thank you for e-mailing the copy of Wake County Physician. I enjoyed reading it, but most of all I like the biographical essay about you and your singular accomplishments in the Jan 2005 issue. The content of the magazine is very deep and instructive.

Joseph C. Porter, Ph.D., Chief Curator  
North Carolina Museum of History, Raleigh, NC

The Editor:

Congratulations on the anniversary of The Wake County Physician. And thank you so much for including me on the mailing list. I must tell you that I did not know the magazine existed. Judging by the excellent content of this edition, including Dr. Leuchtenberg's article and several provocative letters to the editor, I'm sure I have missed some fascinating reading over the years. I'll certainly look forward to future issues!

Anne Bryan, Raleigh, NC

The Editor:

I have received the January Issue of WCP and enjoyed it immensely. Thank you for the gift of an intellectual boost--better than an afternoon cup of tea.

Theo W. Coonrod  
Head of School, Saint Mary's School, Raleigh, NC

The Editor:

This issue looks terrific! Although I have not had time to read it all, I am again impressed with the variety and depth of the material----so many fascinating subjects to read about. I can't wait for the real thing.

Thanks once again for selecting the NC Writer's Network as a NC Treasure. I loved writing every word, and we are proud to be published in WCP.

Cynthia Barnett  
The NC Writer's Network  
Raleigh, NC

The Editor:

Another terrific issue of WCP. Your response to the N&O's article on Mental Health should be given the widest circulation. Thank you.

Joseph Pagano, MD,  
Emeritus Director, Lineberger Cancer Center, Chapel Hill, NC

The Editor:

You are certainly right. In respect to the severely mentally ill, reform seems to lead to more neglect. I thought Lucy Daniel's letter on Sunday was also quite right in pointing to the need of an integrated system, something the private sector seems ill-equipped to provide.

Thad Monroe, MD, Chapel Hill, NC

The Editor:

I have not seen today's paper but I know without reading it that your response is accurate, timely and important. Kudos to you for continuing to be a true civic leader and a beacon for the rest of us. I suggest that you recruit a composer for this opera and write the libretto yourself. As I write this, the Prisoner's Chorus from Fidelio is playing in my head. Too bad Mr. Beethoven is not available.

KC Ramsay, AIA, Raleigh, NC

The Editor:

Thank you for your leadership. I hope your letter receives wide distribution.

Katayoun Tabrizi, MD,  
Forensic Psychiatry, Durham, NC

The Editor:

I pray that Mr. Moseley will show appreciation for all you and your colleagues have achieved in and for North Carolina, for the birth of Community Psychiatry, and for the plans being developed for Mental Health. I know mental illness and thank everyday for the progress the needy seeks and finds in Community Psychiatry.

M. Javad Meymandi, PhD, Malibu, Ca

The Editor:

Excellent letter. Well done. Our people deserve better mental health care.

Tom Fetzter, Former Mayor of Raleigh, Raleigh, NC

The Editor

Thank you, Dr. Meymandi, for your letter to the Editor about mental health in our state. You have nailed the problem on the head, although in my view it extends up the food chain, to Carmen & to our esteemed Governor - and the legislature shares much of the blame, for it could well have forced changes on the pols & appointees. In any event, I value - cherish, indeed - your advocacy. Something must be done! Thank you.

Name withheld, Raleigh, NC

The Editor:

Your letter to News & Observer about our sorry state of mental health program and your leadership reminds me of this quote by Margaret Mead

"Never doubt that a small group of thoughtful, committed citizens can change the world; Indeed, it's the only thing that ever does."

I am sure we can change things if we work together.

Name withheld  
Raleigh, NC

# Earthquakes and Aftershocks

## Reflections of a relief volunteer in Kashmir

By Amer Adam, M.D.



Amer Adam



Donated supplies included medication (600lbs, mostly antibiotics), water purification supplies and emergency survival blankets.



U.S. Army provided Dr. Adam helicopter transport into the devastated region.

On October 8th, 2005 an earthquake measuring 7.6 on the Richter scale struck northern Pakistan. The magnitude of the earthquake was such that it wiped out entire villages, altered the course of waterways, and destroyed roads. Some 400,000 houses were destroyed and over 79,000 people perished - including some 35,000 children, and 135,000 people were injured. To add to the mounting crisis, the disaster arrived at the cusp of a Himalayan winter with nearly 3 million refugees now homeless at risk for hypothermia, malnutrition and worsening mortality.

Almost a year after the Tsunami, the scope of this disaster seemed just as great, but aid has been slowed by the difficult terrain (mostly accessible only by helicopter), hampered by weather, and to some extent a certain amount of donor fatigue.

In disaster relief, there is something known as the three 'R's': rescue, relief, and rehab. There are many groups involved in the relief effort including the United States and Pakistani military, USAID, the Red Cross, non-governmental organizations (NGO's) such as Doctors without Borders and the Association of Pakistani Physicians of North America (APPNA).

I had planned for a two-week trip during the first week of December to volunteer. I focused on three areas: medication (600lbs, mostly antibiotics), water purification supplies and emergency survival blankets.

I was amazed by the generosity of individuals; many who without direct solicitation came forward and offered money or supplies for my mission. Perhaps the greatest benefit of volunteerism is to the volunteer who is in effect enriched by the act of giving and witnessing acts of generosity in others. Already, without having even left for my trip, I was witness to many acts of benevolence that left me overwhelmed.

After nearly 2 days of traveling, I arrived in Islamabad and reported to the relief headquarters at Shifa Hospital. After a de-briefing, I loaded supplies and was off to the Qasim airbase in Rawalpindi where a joint USA and Pakistani military coordinate relief flights to the earthquake zone. After several hours of military security clearance I was allowed access to the airbase and soon my ride had arrived courtesy of the US Army.

Flying over the village by helicopter, I had a birds-eye view of the region, and in a word it was devastation. Basking in the corona of nature's beauty, juxtaposed by the majesty of Himalayan peaks, was destruction as far as the

eye could see. I had seen news footage, but seeing it in person made me understand the true scope of the disaster.



We flew to the devastated village of Kathai in northern Kashmir in a US Army Chinook helicopter loaded with the supplies as well as a massive tent to set up a field hospital.



Most of the patients were elderly and children. I saw the gamut of illness from dysentery, to pneumonia, trauma and infected wounds to malnutrition. By sunrise, nearly a hundred patients had gathered outside my tent. Some walked for miles, all patiently waiting in near freezing weather in the hopes of receiving medical care.

These humble villagers were mostly farmers and like mountain people everywhere exhibited a simplicity that exuded grace and dignity. It struck me, that of all the orphan children that I treated, some with serious infections and painful wounds, I never saw a single child cry once. They all had a stoicism that belied their age.

The local army officers explained to me that their initiative was to assist these victims in survival but also to help empower them so as to not create a culture of beggary and that ultimately meant returning the children to school in makeshift tents.

At night it was freezing. I had a polar sleeping bag and at times even I was cold. With the arrival of winter, I shudder to think how those villagers would survive without winterized tents, clean water or electricity.

## Issues on Care at the End of Life continued

with the change of circumstances so that the AD's are no longer applicable to the present situation. (Faegerlin & Schneider, 2004) However, if it is the desire of a patient to die a peaceful, natural death, not having made an advance directive of some sort virtually assures that their wishes will not be followed. It is critical for all heart patients to have AD's, and, although it is such an important aspect in the care of a heart patient, most cardiologists and their patients overlook this crucial part in the management of end-stage heart disease.

*Bob, with the help of his wife and his physician, created the necessary documents and made copies for their children, their minister, their attorney, and his medical record. Over the next two years, Bob's heart disease progressed slowly, requiring occasional adjustments to his medication regimen and careful monitoring of his weight, blood pressure, and cholesterol. He developed a tria fibrillation, a cardiac arrhythmia requiring anticoagulation or "thinning of the blood" to prevent strokes. Simultaneous with this development, he also found that his breathlessness intensified, further limiting his activities. He developed fluid retention with swelling of his ankles. Later, when he began to have fainting spells, heart studies revealed that there were times when his pulse dropped into the 30' and 40's. The studies also revealed the hidden presence of potentially fatal arrhythmias called ventricular tachycardia during which the heart raced in quick short bursts to rates over 150 beats per minute. The remedy for these new complications was the placement of a cardiac pacemaker and automatic defibrillator; the pacemaker to pace the heart electronically when his rate dropped too low and the defibrillator to send a powerful electric charge through the heart to halt the dangerous and life-threatening tachycardia and return the rate and rhythm back to baseline.*

*Fatigue and lethargy became prominent disabilities in Bob's life. His depression worsened, requiring an increase of his antidepressant. He began to lose interest in food, his family events, and his friends. He lost weight and spent more of his day dozing in front of the TV set. This trend was punctuated by increasingly frequent trips to the hospital for bouts of increasingly severe pulmonary edema where fluid backed up into his lungs. He began to think more about dying than living as he now found himself short of breath with the simplest of activities: conversation and rest.*

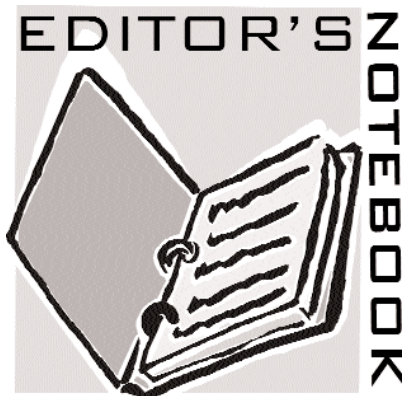
This sequence of changes occurring with Bob is frequently the experience of patients with late stage heart disease and congestive heart failure. Depression is very common and may not be discovered unless the simple inquiry is made, "Do you feel depressed?" or "Do you find yourself feeling blue some days?" Reversal of this debilitating symptom is imperative to providing an optimal quality of life. The late stages of heart disease are marked by changes which accompany many diseases: increasingly frequent trips to the hospital to manage acute decompensation of organ function, loss of appetite accompanied by weight loss and sometimes true cachexia, withdrawal from their surroundings during daytime sleep, and families distraught over their not being able to feed and nourish a dying loved one. This latter problem is often one of the greatest sources of sadness, frustration, and guilt for family members. It is very difficult to accept that refusing food and fluids is the final common pathway to death for all chronic diseases, including heart disease. Few patients with chronic illnesses will die without the cessation of eating and drinking.

*As Bob became weaker with the progression of his disease and his disinterest in food, he began to talk about dying and wanted to*

*know from his physician how much time he had as well as what he might expect in the process. Dr. Thomas looked through his medical file, noting the recent changes in Bob's condition and carefully raised the option of hospice. He knew that Bob's prognosis had to be within the required six months range as determined by Bob's clinical status as well as his functional status. The simple question, "Would I be surprised if Bob were alive in six months?" was quickly answered, "Yes." After including Bob and his family in a conversation to determine goals of care, Dr. Thomas referred Bob to the local hospice for home hospice care. With a sense of relief, Bob accepted his future. He was cared for at home with the goal of staying at home and refused additional trips to the hospital. Palliation of distressing cardiac symptoms became paramount and a hospital bed, a bedside commode, and oxygen were brought into the home. Dr. Thomas prescribed morphine for breathlessness and pain, a common symptom for heart patients at the end of life. Bob's family told stories about their lives with Bob, helping him to bring closure to and identify a sense of meaning for his life. As Bob approached his last days, Dr. Thomas made a home visit with a cardiac technician to turn off Bob's cardiac defibrillator. As part of palliation, the pacemaker was left on to coordinate the heart's maximum function. Bob died two days later with his family around him, grieving appropriately but also celebrating his life and their lives together.*

Prognostication is both an art and a learned skill not taught in medical school. Prognostication must never be specific but may be given as an average length of time. It may also be given in a range of time, from hours to days, days to weeks, or weeks to months, finishing with, "one never knows for sure." Fortunately, the National Hospice and Palliative Care Organization has provided evidence-based guidelines for physicians and hospice staff to use for determining eligibility for hospice admission. (NHPCO, 2004) In regard to heart disease, patients must have debilitating symptoms with the least exertion or even at rest; have an ejection fraction of less than 20% (the fraction of the volume of the left ventricle expelled from the heart with one contraction); and have been optimally treated with diuretics and vasodilators, including angiotensin-converting enzyme inhibitors. Symptomatic cardiac arrhythmias resistant to therapy, a history of cardiac arrest and resuscitation, and unexplained syncope (fainting) all decrease survival, further emphasizing the urgent need for end of life planning. An implantable cardiac defibrillator (AICD) is a device to terminate potentially fatal cardiac arrhythmias, thus prolonging the life of patients who are otherwise functional and enjoying the best possible quality of life at their stage of disease. AICD's are a means of artificial life support much like a ventilator or hemodialysis and its termination must be included in end of life decisions, a process that more than half of physicians forget to consider (Goldstein et al., 2004). In order for patients to have a peaceful, pain-free death, AICD's must be turned off to prevent a painful shock in the last minutes of life. This is usually performed at a time when healthcare personnel can be around to assist patients in the rare case that the turning off of the defibrillator results in discomfort.

This case presentation and discussion highlight many of the issues important to patients with serious heart disease. Heart patients should request, complete, distribute, and periodically update pertinent advance care directives. Enough information found in many books and websites devoted to end of life care allows physicians and patients to determine how they would like to live out their final days. Timely and repeated conversations with their physicians are important to have their wishes carried out in a manner



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

## In Case You Missed This In The Press:

### FIGHTING POVERTY AND HUNGER

I have always wondered why whenever there is talk about programs on "war on poverty and hunger", almost invariably, the administrators of the programs who appear in the media are clad in button down well fitted suits, well fed if not outright obese, and laughing. Why are they fat and I don't know what they are laughing about? And, yes, they carry black briefcases and attaches. It seems the same, whether they are church representatives, United Nation employees or plain folks from the private sector. I am sure there are a lot of people who feed the hungry without any of these pretenses. But one wonders why feeding the hungry takes all these layers of bureaucracy, reams of position papers and executive summaries to be carried around in black briefcases and attaches. We need to feed the poor and the hungry and do away with all these pretentious brigades of high salaried and overweight bureaucrats.

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### LAMBETH PALACE/LIBRARY

Have you ever been to the Lambeth Palace/Library? If not, you should go. I have been there on several occasions. The last time I went there was to look over the original Lambeth Report to learn more about the historic document. I found the staff to be most cordial. They admitted me to the stacks and let me look at a copy of the 1867 report. It is a report on the "State of the State of the Anglian Church". In several hours spent there, I found that the essence of the 1867 report to be basically the same: although there are no same gender issue marriage debate in the 1867 report, and no emerging ultra-conservative faction from African nations, the report's attempt in conciliation and definition of the power structure (and struggle) of the church remains the same. Yes, the language is a bit more arcane, but the issues are strikingly similar. At any rate, going to Lambeth Palace/Library is a must for all who have curiosity on matters religious. Besides the grounds are most beautiful and the buildings imposing. A vatican in the middle of London!

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Medical terminology may become extremely confusing. This is not to assess the merits of various categories. It is intended to be short course in proper use of terminology. Many people refer to the Speaker of the NC House as an ophthalmologist. That he is not. He is an optometrist. Ophthalmology is a medical specialty that trains medical doctor (MDs) to diagnose, treat and operate on eyes. They are better known as eye surgeons. Optometry is for performing refraction and fitting glasses, but never performing invasive procedures such as eye surgery.

The same confusion of terms exists with psychiatry and psychology. Psychiatrists are medical doctors (MDs) specialized in diagnosing and treating nervous and mental disorders, many of which are caused by physical conditions, like hyperthyroidism, various brain tumors and many other hormonal and neurological disorders. Psychologists are not medical doctors. They are skilled in many other areas including measuring intelligence and assessing behavior. Finally, Orthopedists and chiropractors: Orthopedists are medical doctors (MDs) trained in diagnosing, treating and operating on bone and joint diseases. Chiropractors are not medical doctors. We have a whole host of other "doctors" such as podiatry, naturopathy, etc all of whom are not medically trained.

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### CORRECTING THE HERITAGE DICTIONARY

Dearest Sir/ Kirkpatrick\*

We do love you, and you are dearest to us. Yet, you are a "Sir", because we have been reading you and learning from you since you were a newspaper editor in Va. prior to your days on 60 Minutes debating the ultra-liberal-what's her-name! We have known you, your beloved late wife, your grand daughter, Heather, etc...

I read in your today's syndicated column, N&O, Raleigh, your exhortation about vocabulary. I was a bit distressed that you did not correct The Random House College Dictionary. They ought to know that the word ULAMA is plural. Its singular form is AALEM. So, it is incorrect to say "an ulama" as you did! It is an aalem. I rest my case and send you our love. By the way how are your kidneys?

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*\* Emeritus Editor of the Richmond newspaper, now a syndicated columnist specializing in English syntax, writing and word smithing. His column appears on Mondays in the Raleigh News and Observer.*

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### VISION FOR RALEIGH

The discussion of the Director of NC Museum of Art, Larry Wheeler's salary should be tempered by several observations: We are on the verge of creating a world class museum that would make Raleigh a destination not only for this region and for America but for the world. With establishing the Cantor collection of Rodin, for example, NCMA will host scholars and tourists from all over the world to come to Raleigh and use the

Museum's educational facilities.

Personally, I am very happy to see Larry's talents at work for the citizens of this region. We must do all we can to transform Raleigh into an area like the late fifteenth century Florence where the arts, music, poetry and dance flourish; where brisk intellectual conversation and children's laughter fill the air of its vast parks; where fountains flow with life and energy and where academia and business meet their maximum potential. NCMA is an essential part of that equation. Wake County and Raleigh are the essence of the NC State's Motto, "Esse Quam Videri", to be rather than to seem. The potential of this region is only limited by the finite imagination of the citizens. Pedestrian, slow pace maintenance mentality lead us to grim graveyard of mediocrity and inaction. Please let the Department of Cultural Resources and the NCMA Foundation Board do what is necessary to complete the masterpiece they are working on.

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## FEMINISM

Our civilization has regressed. 2500 years ago, Cyrus the Great, in order to hold the Persian Empire together, created postal service and added the office of postmaster to his already 11 member cabinet. His first appointee to the job was a woman, "banoo", a postmistress who joined four other women on Cyrus' cabinet as a "vizir."

Persia and the rest of the world have slipped in honoring and observing the equal status of women since Cyrus, and I submit religious oppression is to be blamed.

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## MISGUIDED MANDATE

House Speaker Jim Black's midnight assault on the pocket-books of all North Carolina citizens—required eye examinations for kindergartners—was the subject of a Jan. 22 Associated Press report (and previous coverage in The N&O).

The subject of vision screenings versus complete eye examinations was addressed by a task force of interested citizens, experts and eye professionals in response to a charge from the legislature to the state Department of Health and Human Services to review the current Medicaid standards for vision screening. Among the task force's conclusions, published in 2004, was that Medicaid policy is adequate to continue the comprehensive and effective vision screening program already in place, not to change current policy.

Black disregarded the advice of the panel by adding language to last year's appropriations bill without allowing for public scrutiny or debate. His stated reason for doing so, as quoted in the AP article, was to prevent early vision problems from becoming serious learning disabilities.

His statement is misguided and incorrect. Early vision problems started in the first few months of life and are almost always picked up in screenings well before kindergarten age, using our present screenings methods. More to the point, vision problems do not cause learning disabilities.

Black should have recused himself from the issue of mandatory eye examinations for kindergartners, because, as an optometrist, he has a manifest conflict of interest in the subject and cannot objectively represent the people of North Carolina in

the matter. The citizens now face a \$75 million price tag annually. To say that we citizens have not been well served stops short of the mark.

John D. Wright, Jr., M.D.  
Chapel Hill

*The writer is a pediatric ophthalmologist.*

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## IGNORANCE OF SUICIDE

I was choked and appalled by the prejudice and ignorance displayed by Ruth Sheehan in her Jan. 5 column about the suicide of accused murderer Drew Planten ("Selfish exit leaves questions"). She wrote that "Where I come from" people who commit suicide are viewed as "cowardly" and are viewed with "contempt."

People do not commit suicide because they are cowardly and selfish – they commit suicide because they are in incredible mental and often physical pain. Most of them try desperately to fight their illness or circumstances, and sometimes they lose. Suicide is almost always the result of mental illness, especially depression. Unfortunately when people are depressed, they see things as hopeless and have impaired decision-making abilities. This can lead them to seek a permanent solution to what can be a treatable problem.

Speaking generally, people who have lost a loved one to suicide are often bitter and angry – believing that the person did this to hurt them. Nothing could be further from the truth. Suiciding people actually believe that their loved ones will be better off without such a miserable failure (they think) in their lives.

The last thing the mentally ill need is our contempt. Unless we can overcome ignorance about mental illness we are doomed to see unnecessary suffering from treatable conditions such as depression.

Elizabeth W. Oates, M.D.  
Staff Psychiatrist, John Umstead Hospital, Butner, NC

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## A DOCTOR'S LEGACY

It was a singular pleasure to see the recognition of Dr. William "Billy" Dunlap as Tar Heel of the Week on Dec. 25. Your article ("Old-school doctor offers end-of-life TLC") described Dunlap's contribution to our community, and the realization of his dream of better care for the terminally ill in the Triangle, with the establishment of Hospice of Wake County.

His unwavering dedication and enthusiasm recruited many others, myself included, to this nonprofit agency. The fact that we have this community jewel, Hospice of Wake County, is due in no small way to Dunlap's single-minded belief in hospice care and his love for this particular organization and all associated with it.

His unselfishness has not been restricted to hospice, however. I returned to Raleigh as a newly trained oncologist in 1979. At that time Dunlap was providing most of the medical oncology care in Raleigh, and my practice was direct competition for him. I saw no professional jealousy from Billy Dunlap. He welcomed me to town with gracious and open arms. In fact, he often referred consultations to me when he was too overwhelmed with the volume of his own practice to see a patient on the day requested.

His attitude has never wavered. Billy has always been a true profes-

# TRAVEL

By Assad Meymandi, MD, PhD, DLFAPA

We spent the Holidays in South America, concentrating on Chile, Argentina and Brazil. The Republic of Chile is the longest country in the world, 2700 miles in length. Its widest girth is only 100 miles. Minerals are the main export of Chile, with copper, iron ore on top of the economic list. Coal mining also contributes to government revenues.

Reading the health history of Chile is interesting. In 1886 the Juntas Beneficencias, equivalent to our Social Services, built charity hospitals for the poor. In 1924 Chile was the first developing nation to establish social security for all citizens. Later in the early 1980's under Augusto Pinochet, the Social Security Program was privatized. The program has been so successful that the in 2005, the Bush administration tried to emulate it and import it to America. In 1952, the Chilean Servicio Nacional de Salud (SNS) was established as a national health system serving the poor. In 1968, the Curative Medicine Law provided medical coverage for the middle class as well, though it required a high patient co-pay.

Until 1980, the ministry of Health was in charge of the health of the population. The process of "municipalization" of the primary healthcare centers, moving responsibilities down to the local level thereby creating community and neighborhood health centers, was completed by 1988.

However, examining the system and interviewing people randomly, one learns that all is not well. Chile's health is clearly three tiered. Those who can afford healthcare--about five to ten percent--go to private doctors and hospitals. Another 20 to 30% of the population is covered by private insurance and HMOs. The vast majority has limited access to care. The healthcare cost is 4% of the GNP compared to America, which is now approaching 17%.

We found the Pre-Columbian Museum of Art of Santiago a very impressive, comprehensive and well exhibited collection. The Nahser Museum of Duke University has a large collection of pre-Columbian art. The fishing villages of Puetro Montt and Puetro Varas (the city of roses) were most

inviting and beautiful.

Argentina's capital, Buenos Aires, is known as the most European city in South America. Its wide boulevard and impressive architecture rival the Champs Elysee of Paris. The longest and widest boulevard in the world, Libertador is almost 20 miles long and at the narrowest has 12 lanes of traffic. But the two most impressive attractions of Argentina are the Opera House, circa late 1800s, and Iguazzi Falls. The Falls are spectacular. For millions of years they have shown the grace, consistency and benevolence of nature with unstoppable generosity and majesty. Niagara Falls pales in comparison. There are over 200 falls of various heights that empty into a central point called the Devil's Throat. The sunset at Iguazzi Falls was memorable and beautiful. It looked as though the sun did not want to quit looking at the falls...It lingered and the colors produced cried for the brush



of a Monet or the skillful hand of a colorist like Henri Matisse....The Andes and the region of Patagonia are masterpieces of creation.

Argentina's population of 37 million live in 37 self governing provinces. The rate of literacy is 96%. Health issues are very much the same as Chile. In 2004-2005, Argentina went through seven different presidents.

One Argentinian intellectual explained, "This is not instability, this is democracy in its extreme. If we don't like our president, we kick him or her out!" Unemployment in Argentina is 14%.

Brazil is a country of 173 million people located in Eastern South America. Rio De Janeiro boasts the Ipanema Beaches where the mountains meet the sea, Copa Cabana, an elegant hotel where dining in its civilized and quiet atmosphere reminds one of the ambiance of the Peninsula Hotels in Hong Kong and New York, and of course, the huge statue of the Redeemer. Sugar Loaf Mountain, the summit of which can be easily reached by a funicular, offers a stunning view of the city. The healthcare in Brazil is most primitive and even behind Argentina and Chile. Leprosy, Dengue Fever and cholera, once thought to be controlled, are resurging. Also the spread of HIV and AIDS in Brazil has been rapid and out of control. In Brazil, it is a heterosexual STD.

Next, I will be reporting from India and the Taj Mahal.

# UNC-TV Has Brought North Carolina 50 Years of Life-Changing Television

By Tom Howe  
Director and General Manager UNC-TV



Tom Howe

Tonight, someone in North Carolina will sit down in front of the television, pick up the remote, and with the press of a button be swept up into a fantastic world of knowledge, experience, and emotion that will change the way that person perceives the world. That person will be watching UNC-TV.

From arts and culture to history and science programming, along with a safe haven for children to learn and grow, UNC-TV brings the best that television has

to offer into the homes of North Carolinians 24 hours a day, every day of the year. But it wasn't always so. It all began with a vision.

When the network's original station – WUNC-TV Channel 4 in Chapel Hill – signed on the air January 8, 1955 as North Carolina's first "educational station" and the tenth in the nation, no one could foresee the statewide public television network it would become. The pioneers who were instrumental in getting the station off the ground had to overcome more than a few obstacles just to turn the dream of "educational TV" into a reality in North Carolina. But they persevered and prevailed, and from that initial start in Chapel Hill UNC-TV has grown through the years to become North Carolina's statewide public television network, with 11 transmitters bringing the excellence of public television programming to all 100 counties of the state, as well as parts of Virginia, South Carolina and Tennessee.

It is with that same spirit of faith in the future of public television that UNC-TV celebrated its 50<sup>th</sup> anniversary in 2005. Although there are always obstacles to overcome, UNC-TV is proud to serve more than 4 million viewers each week, and today, the network provides a family of digital public television services, including UNC-TV, UNC-KD, a 24-hour children's channel, UNC-ED, a dedicated educational channel, UNC-HD, featuring all high-definition programming, and UNC-NC, a channel now dedicated entirely to original North Carolina productions.

In addition to familiar PBS programs like **NOVA**, **Masterpiece Theatre**, **Antiques Roadshow**, **The Nightly NewsHour** and so much more, UNC-TV is also a leader in the public television industry in the production of original program content. In fact, last year UNC-TV and its partners developed and produced 426.5 hours of programming for and about North Carolina, 20 hours more than the previous year, an increase of five percent. Programs included many regular series, such as **North Carolina Now**, **North Carolina People with William Friday**, **The Woodwright's Shop with Roy Underhill**, **Legislative Week in Review**, **Black Issues Forum**, **North Carolina Visions**, **North Carolina Weekend**, and a new series, **Our State**. Specials included a series of monthly **HealthWise** call-in programs underwritten by Blue Cross/Blue Shield, **Matisse**, **Picasso**,

**and the School of Paris** produced in conjunction with the North Carolina Museum of Art, coverage of the 20<sup>th</sup> annual **Emerging Issues Forum** from the McKimmon Center on the campus of North Carolina State University, and live coverage of **The Hickory Choral Society Christmas Concert 2004** from the Corinth Reformed United Church of Christ, among many other programs.

Furthermore, original programming from UNC-TV was nominated for five regional Emmy Awards during the past year, winning two. **Thank You, Eddie Hart** won a Midsouth Regional Emmy in the Documentary/Historical category, and **North Carolina's Dependence on Tobacco** won in the Documentary/Topical category. Also nominated were **Folkmoot USA** in the Documentary/Cultural category, **Faces from the Flood** in the Documentary/Historical category, and the premiere episode of **North Carolina Weekend** in the Special Event/Live category for its coverage for Fourth of July festivities in Wilmington.

In fact, through the end of 2004, UNC-TV had received more than 100 industry awards. UNC-TV's overall accomplishments were perhaps best recognized through two awards bestowed on its director and general manager Tom Howe – the Distinguished Service Award in 2003 from the North Carolina Association of Broadcasters and the Lifetime Achievement Award from the Board of Governors of the Mid-South Region of the National Academy of Television Arts and Science. These prestigious industry awards are reflections of the excellent work of every individual connected with UNC-TV.

Of course, the true measure of any public television network's value is in how well it serves the needs of those who use its services. As UNC-TV moves forward in the twenty-first century, it does so with an appreciation of its proud history, but also with a mission that has been rewritten to bring focus on the needs of the future. Carefully developed by the UNC-TV management team and Board of Trustees, the new mission statement that guides North Carolina's statewide public television network provides a fitting conclusion for this history – which is, after all, still very much a work in progress.

## UNC-TV's Mission:

*Television has the power to change lives. Public television has the responsibility to change lives for the better: a child far from urban resources is inspired to become a scientist, a high school dropout earns a GED, a homebound senior citizen remains connected to the world of the arts and culture, the family of an Alzheimer's patient finds strength and support. UNC-TV's unique programs and services provide people of all ages with enriching, life-changing television.*

## Editor's Notebook continued.

sional colleague, and I am also proud to call him my friend.

You have made a great choice in Billy Dunlap as Tar Heel of the Week.

William R. Berry, M.D.  
Cancer Centers of North Carolina, Raleigh, NC

*Editor's Note: Dr. Dunlap will be featured in Profile of the Month.*

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Reprinted From JAMA



Richard Weisler, M.D. a Wake County psychiatrist and adjunct faculty member at Duke University Medical Center and UNC Chapel Hill Departments of Psychiatry, Jonathan Davidson, M.D. and Allan Chrisman, M.D. with the Duke University Medical Center Department of Psychiatry, and Edna Foa, Ph.D. at the University of Pennsylvania Department of Psychiatry after Hurricane Katrina joined together to organize a practical disaster mental health guide. "We wanted it to be concise, up-to-date, and referenced, which would be a useful

resource for both primary care and mental health providers after any type of natural or man-made disaster." A JAMA Medical News and Perspectives January 18, 2006 story featured the work and the web site can be reached at <http://psychiatry.mc.duke.edu/Clinical/disastermental-health.ht> or <http://unc.edu>. The web site includes links to some key resources on how to diagnose and deal with post-traumatic stress disorder and other anxiety disorders, stress associated with relocation, bipolar disorder, depression, as well as suicide prevention. Links are also provided for other psychiatric consequences, including substance abuse, which frequently follow natural disasters and terrorist attacks. Links to psychotherapy approaches and pharmacotherapy treatment options, which can be effectively used by primary care and mental health providers, are included.

"Even in the best of circumstances, most individuals with psychiatric problems are seldom properly diagnosed and treated. Therefore, it is our hope that healthcare providers who review information in these links and our planned disaster mental health guide (being submitted for review) may improve their routine care of patients.", Weisler said.

In the spring of 2005, Drs. Weisler and Davidson had, as volunteers, been asked to assist Pamela Tucker, M.D. of the Agency of Toxic Substances and Disease Registry/CDC in the editing of her section of a web based national training course for first responders to disasters located at <http://www.phppo.cdc.gov/phtn/webcast/stress-05/>. Then after Hurricane Katrina Drs. Foa and Chrisman joined the other authors as volunteers in assisting Dr. Tucker on a Relocation Stress Guide for those impacted by disasters, which is now available at <http://www.atsdr.cdc.gov/publications/100233-RelocationStress.pdf>. After the severe damage inflicted by the recent hurricanes including Katrina and Rita among others, all of the authors immediately realized that the frequency of significant and often debilitating mental health problems would most likely eventually equal, or surpass, the disaster related morbidity and mortality associated with physical problems. Collectively we began to work on developing an article that could be a brief to guide mental health treatment following disasters. The authors all had extensive experience having worked or conducted research with individuals impacted by hurricanes, abuse, accidents, or other types of man-made or natural disasters.

The Centers for Disease Control and Prevention (CDC) Needs Assessment Survey conducted in New Orleans for the Louisiana Governor's Office in late October 2005 supports the view that disasters can significantly impact mental health of an area. A staggering 48.1 % of

the population the CDC surveyed in Orleans Parish acknowledged a significant degree of mental distress on the Individual Assessment of Mental Health Symptoms (SPRINT E) instrument, and 70% of those impacted would be anticipated to accept a mental health referral if offered. At the time of that CDC survey, only 1.6 % of the Orleans Parish was actually receiving mental health services. The Substance Abuse and Mental Health Services Administration has estimated 500,000 people have significant mental health problems in the wake of Hurricanes Katrina and Rita. The mental health infrastructure in the effected Gulf areas was often stretched in the areas impacted by the hurricanes even prior to their hitting, and mental health response capability has been further reduced since Hurricanes Katrina and Rita.

"ATSDR/CDC suggested to us that we would be of more help to them if we could share what we have learned clinically than by our offers of direct patient care volunteer service post Katrina/Rita. Ultimately, if the web site and planned fact sheet guide raise awareness of mental illness and treatment options facing medical responders and their patients, then we will have done our job. The medical profession and society can ill afford to fail to reach out to disaster impacted residents and those responders who may have serious, yet very treatable, mental disorders." Weisler said.

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## A Strange System

Imagine my surprise when I recently discovered that Central Prison in Raleigh has its own 144-bed psychiatric in-patient hospital embedded within the prison hospital system. What a relief! Finally a solution to the mental health reform process.

Instead of Wake County spending so much energy, time and money in efforts to replace Dorothea Dix Hospital's acute-care beds for county residents by building a freestanding psychiatric hospital, I have a more cost-effective, quicker solution. Let's send all individuals who need acute psychiatric care to the prison hospital.

When looking at the incarcerated population psychiatric illnesses are already over represented. Many individuals there probably should have been diverted to mental health care rather than the prisons. But why buck a trend? If we are already sending some of the mentally ill to prison, at least they get psychiatric in-patient care. Let's not discriminate! Everyone should have access to that care. Send them all to the prison.

Now all we have to do is raise more money for more prisons. This seems a much easier task.

Seth E. Tabb, MD  
Child, Adolescent and Adult Psychiatrist, Cary, NC

**Check out the new  
Wake county Medical  
Society web site at  
[www.wakedocs.org](http://www.wakedocs.org)**

## NC Treasures continued

dren's concerts, judge of auditions and students' art shows, community worker and troubleshooter, fund-raiser, Symphony Chapter organizer, office manager, orchestra and personnel manager, on-the-road-advisor, publicity and P.R. coordinator, hostess, and more. Many years ago, Dr. Swalin stated that "Maxine can do anything - she is the linchpin of the whole outfit."

It was Maxine's responsibility to find suitable places for rehearsals - and overnight accommodations for the orchestra. Rumors sometimes circulated that there were insufficient funds for hotel tabs, so Maxine, with all her charm and charisma, would telephone the Symphony's most loyal supporters. And given the Swalins' social conscience, there were often apropos stipulations - black children, orphans, and those from the "lower part of the totem pole" had to be included.

Dr. Swalin held the conviction that taking great music to the people was as important as rural electrification. (I must tell you that I am living testimony to that idea, for having grown up in rural Ohio during the depression, we had neither. We seemed to manage quite well without the electrification---but Oh! great music would have enriched our lives so much!)

After the war, the Symphony was on wheels and on the move regularly. Within the next ten years, over 1,300 concerts were given - and many thousands of miles traveled. Records show that the children's audience in the 1963 season alone totaled nearly 150,000.

Expansion and development along with adversity and financial struggles occurred during the 33 years that the Swalins gave to their musical mission. They were musical missionaries with missionary zeal, vision, talents, and dedication, taking music to the masses - and the masses were, above all, the children!

Another milestone that catapulted the NCS into its modern-day period started in 1965, when Dr. Swalin learned about the Ford Foundation's plans to give million-dollar grants to orchestras that met their requirements. For the next five years, there was an intense, all-out, "do or die" effort - primarily by the Swalins. The success of this grant, acknowledged in 1971, was of the utmost importance to the Swalins because they could then retire with a million-dollar endowment in place. (By 1976, when the Ford Foundation actually disbursed its fund, including interest, to the qualifying orchestras, the North Carolina Symphony received \$1,725,324---which, when transposed into turn-of-the-century

dollars, would nearly have built the new concert hall!)

Until the mid '70s, when the Symphony found a permanent home in the then-newly-renovated Memorial Auditorium in Raleigh, Maxine was still searching for adequate rehearsal halls for every concert. An orchestra without a home was almost too much for the Ford Foundation officials to believe!

It is sad to realize that we live in a culture where the total "bottom line" is money. Both the Swalins gave their lifetimes - 66 years, combined - to establish a North Carolina State cultural gem. Its capital city did not remember or honor the Swalin name at any time or in any place in the concert hall it built to house the very institution that would not have existed were it not for the Swalins. But for private donors, there would be no mention of the Swalin legacy in the new hall.

Governor Terry Sanford said it most succinctly: "But for Ben Swalin, the North Carolina Symphony would not be. But for Maxine, Ben would not have prevailed. Bravo!"

Though her monetary compensation was virtually non-existent, her awards are prestigious and numerous: Honorary Doctorates from the University of North Carolina and Duke University; the North Carolina Award (1989); the Order of the Long Leaf Pine; The North Caroliniana Society Award (2003); The Carolina Performing Arts Lifetime Achievement Award (2005); and many more.

In her childhood reminiscences, she has mentioned the hymn, "Will There Be Any Stars, Any Stars in My Crown?" Maxine now has her own galaxy!

Now, in the twilight years of her life, she tries to heed the advice of her late lifetime companion: study; improve your mind; share your knowledge and help others; keep friendships in repair; and think, act, and move in minuet time. To this, she adds her own philosophy: each one has divine worth, and what lives on should be bigger than oneself; be a special being; surpass yourself by accomplishing something that will carry on without you; and stay engaged. Now, nearly 103, she has had the courage of her convictions, and she practices what she preaches.

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*Recommended Reading: Hard Circus Road, The Odyssey Of The North Carolina Symphony, by Benjamin Swalin; & An Ear To Myself, an autobiography by Maxine Swalin. Copies of Hard Circus Road are available at symphony the North Carolina Symphony's Box Office and Store at North Hills in Raleigh.*

## Mental Health Corner continued

marveling at her change and experiencing her self as never before in her 30 years. Importantly she feels ownership of these changes and sees that this is very much who she is. In our work she has been able to describe her idealized parents and realize this as a result of what she did not experience and as something she needs to provide for herself rather than seeking it outside in other people.

In another case, a 48 year old architect presented with mixed anxiety/depression. He is a workaholic and very successful and wants to get away from the day to day pressures. He has a history of an aloof father and an abusive mother. Siblings have had problems getting their lives straightened out. He has an equally successful spouse who is very supportive. He is very close to his children. Using a very similar approach as above he has been able to act upon his vision of himself and is having fewer panic episodes and is optimistic about balancing his life.

Another example is an extremely successful president of a sales company in his early 50s who presented with feelings of being overwhelmed, pressure of speech, alcoholism, and sleeplessness. In describing how he wanted to be his insight was that he was squandering his life and not being an appropriate steward of his many gifts. Again working on how he wanted to be proved successful. He rejected AA and medications at first but as he began to

experience self-mastery he agreed to discontinue consumption of alcohol and speak to a friend who was in a recovery process. He has initiated a regular exercise program and has gone from 210 pounds to 160. He went 13 months without alcohol and when he had a relapse agreed to take acamprostate which reinforced another dry period. His family describes his change from an angry inaccessible person to one who is empathic, kind, and helpful.

Unfortunately due to space constraints of this column I present this material in a rather cryptic way. This is not magic. There are many insights we could elaborate about a growth oriented approach. There are analogies in other medical specialties. I reiterate how one sees one's self determines one's experience. To see only our problems creates an experience as a problematic person. *To have a vision of one's self is to create a design which we can implement. Working on one's Vision of one's self bypasses and in many instances converts problems into assets. My belief is that in the future, psychiatry and even medicine will be turned around and will be growth oriented with the problems which interfere with that growth dealt with only as they indeed do interfere with growth.*

*Suggestions, comments, questions are welcome - 3900 Browning Place, t-9197877125; f- 9197819952; e-mail stratas1@mindspring.com*



## "Great Satan" vs. "The Mad Mullahs"

### How the United States and Iran Demonize each other

By William O. Beeman  
Praeger Publishing Company, Connecticut/London  
298 pages, Published in 2005

Reviewed by Assad Meymandi, MD, PhD, DLFAPA

*Editor's note: This Book review is in the form of a letter I wrote to my good friend, Dr. James Peacock, Professor of Anthropology, UNC at Chapel Hill.*

Dear Jim:

"I don't know if I am braggin', complainin', cussin' or discussin'...I stayed up two nights to finish reading "The Great Satan." I am impressed by its accuracy and the author's reverential devotion to substance and not hype, the case with many books of this genre. The book made its way to the pile waiting to be reviewed. I will send you a copy. Several points:

1) USA was loved by all 50 years ago. The positive programs of Marshall Plan, Point 4 Truman and many other altruistic US forcing policies made Pax Americana to parallel and even surpass the ancient Pax Romano...However, we did not demand our ambassadors and those who represented America to learn the language and the culture of the host country. The notion of if you do not speak our language you are not worthy of a conversation, an unwelcome and consequential attitude by Americans, made us come across as arrogant and self-centered. We continue to ignore these two very important issues--language and culture-- in our foreign policy. The fact that we imported through the expertise of Richard Helms, especially to Iran, after 1953, techniques of torturing, maiming and killing in establishing SAVAK is another matter and subject for another essay...

\*\*2) I remain suspicious of these "authorities" who expound on the literary content of let's say Rumi, and do not know how to read, write and speak Farsi. Or those imbedded reporters with US forces who do not know the first word of the language of the country where the war is fought. Or, the scholars who choose to write prodigiously on the affairs of a foreign country without knowing the words, grammar, and the basic syntactic architecture of the host language. I loved and admired Margaret Meade and Ruth Benedict because they went through the discipline and hard work of learning the languages of their host countries. Bernard Lewis, before becoming contaminated

with politics, when he was a pure scientist and academician, also learned the languages of his host countries before writing about them. Given all these suspicions and prejudices, I still think Beeman has done a good job.

3) But here are some powerful telltales that evince the flaws, pesky as they are. Here are some examples: the name or word "Mahdi" has been repeated (pages 71, 72, 73 etc.,) means "cradle or related to cradle." The word that Beeman wants to use is "Mehdi" which means "Guide, leader" very much like the word Tao in Toaism. "Mehdi" and not "Mahdi" is the name of the 12th Imam whose arrival is eagerly anticipated (Bahauallah, 1817-1892, the leader of Bahai religion came to claim that he was Medhi, but this is fodder for another folder and another essay). In Aramaic, Arabic and Farsi, very often the inflection or the sound of a single vowel or consonant can make a world of difference in meaning. Another example that I see frequently made by either ignorant (those who do not know the language) or careless scholars is the word rakaba which means to ride and rakkaba (mere rolling the letter k) which means to mix and compound. There are literally hundreds of thousands of words like these in the above three languages. The book has many of these subtle clues that whisper to me that Beeman does not know Farsi, Arabic and Aramaic, or he is, at least in this instance, careless.

4) In the '50s as a college student, I worked for the UN as a simultaneous translator. The weight of responsibility of letting folks know what the speaker is really saying was great. That experience made me very sensitive to the importance of fidelity of the language spoken and the language translated. It involves a special area of ethics, integrity and grave responsibility. I found the same gravity and heft of responsibility when I worked for CIA, again in the '50s, translating documents from one language to another. I am afraid not many people appreciate this.

At a dinner sponsored by WUNC, when Anne Garrell, an imbedded reporter for NPR was effusively pontificating her wisdom about Iraq etc., I simply asked is she knew Arabic language and without language how she could understand the public and claim insight in their culture. She was stunned. It had never occurred to her! I am reminded of the time the then President Carter went to Poland. He spoke of his warmth and affection for the people of Poland. The translator said the President "has lust in his heart" for the men and women of Poland. The wire services picked up the story and corrected the mess. I do not know if that translator is still on the government's pay roll!

5) To exacerbate matters, America has not treated the Arabs and the Israelis even-handedly (but this is subject for another essay or book).

6) The solution for America's present dilemma is for America to elect officials who know history, and are at least intellectually equipped to listen, learn, and be tolerant, flexible and understanding. America should come off its/her high horse of delusional super power intoxication, and send ambassadors and representatives to other nations who have some degree of humility, know and speak the language and have studied the culture of their host countries. I believe we should invite the "enemy--the insurgents" to the table to talk with them eyeball to eyeball, and let them know that as members of the family of man all six billions of us are equal and we all need love, affirmation and

acceptance, and that all of us worship the same God, Allah, Yahweh, and we are all brothers and sisters. I think that is the only path to lasting peace. And I believe this is the teaching of Christ. Guns, bombs and missiles have failed.

Again, thank you for the thoughtful gift. It is not my intention to demean or discredit Beeman's labour intense piece of work. in the early '80s, I completed a book about my personal relation with the late Shah of Iran (as his friend and physician). In spite of insistence from my publisher to go ahead, It has remained in my safe for the last 23 years. There are ethical, professional and confidential issues that need to be worked through. I may send you a copy of the publisher's blurb on the book. Love to Florence."

PS Bottom of 124 (the last tow lines) should read "in 1924, the oil sector contributed 9.7% of the total GNP, by 1974 it contributed 42%, and by 1980 80% or more.

Other errors: page 133" Kamal Kharrasi...after America's invasion should be Iraq and not Iran..."

\*\*Middle page 125



## Cato (A Tragedy in Five Acts)

Cato the Younger  
(died 46 B.C.E.)  
Original text By Plutarch  
Written 75 A.C.E.  
by Joseph Addison (1672 - 1719)

Reviewed by Assad Meymandi, MD, PhD, DLFAPA

One of my ambitions Is to discover and develop a bibliography of the books America's Founding Fathers read. This intellectual journey has been most fun. Readers recall review of History of England by Paul de Rapin-Thoryas (1661-1725) in the last issue of WCP. This was one of Thomas Jefferson's most favored books. In his notebook, Jefferson named Rapin as "the greatest historian of England."

I thought in this issue we would take a look at Joseph Addison's play, Cato, written in five acts and premiered in 1713. It was without doubt one of George Washington's most referred and quoted pieces of literature.

The namesake, Cato the younger (born 120, died 46 B.C.E.), was a Roman statesman and stoic. Joseph Addison in 1713, wrote the play Cato in five acts without knowing that someday the character of Cato will become George Washington, the father of America's role model. It is recorded that GW saw Cato several times from early adolescence through maturity. George Washington was so taken with the character of Cato the younger that he made the Roman republican his role model. Several reports say that he even had it performed for his troops in the heat of battle of Valley Forge. Historians, including David McCullough's book, 1776, state that Washington included lines from Cato in his private correspondence and even in his farewell address

This is a brief review of the play Cato from the National Library of Medicine and the internet:

"Joseph Addison's Cato premiered on April 14, 1713, and was an immediate success. In fact, it went on to become one of the most popular English plays of that period. In addition to being a dramatist and poet, Joseph Addison was also a prominent essayist and was noted for his graceful writing style. Samuel Johnson once wrote: 'Whoever wishes to attain an English style, familiar but not coarse, and elegant but not ostentatious, must give his days and nights to the study of Addison.'

"Cato the younger (95-46 B.C.) was a Great Roman Statesman and Stoic. General and later President Gorge Washington's stoic department of staying aloof and above fray is definitely credited to Cato.

In the play, Cato took sides with Pompey in his unsuccessful civil war against Julius Caesar. To GW, George the third was Julius Caesar. After Pompey was defeated at Pharsalus, Cato and Scipio moved their forces to northern Africa. The play takes place in the city of Utica, located in the kingdom of Numidia. Scipio has been defeated at Thapsus, and Caesar and his legions are advancing towards Utica, where Cato and a small Roman senate stand ready to defend the last vestige of the Roman Republic."



## 1776

David McCullough  
Simon & Schuster  
New York, 2005  
386 pages, \$32.00

Reviewed by George M. Stephens, MA\*

David McCullough, "master of the art of narrative history," chronicled the Johnstown Flood, the building of the Panama Canal and of the Brooklyn Bridge and wrote biographies of Presidents John Adams and Harry Truman. The books were noted for their research and narrative detail. Though all of the subjects had been written about, he undertook to do them better. 1776 is in that tradition.

Detail makes histories interesting and gives the reader the feeling that he is learning things not known by others. McCullough's books have that quality, but his particular genius is that he makes us believe we are there. This he does by describing the surroundings, happenings, characters and reputations. He draws us into the minds of his subjects based on their statements and writings, often adding well-informed speculation. He is a master of mise en scene..

His subject is not only the events of the year 1776 in the American Revolution and the passions which drove it in America and Britain. Those elements are the setting for a remarkable biography of General George Washington in that crucial year. He was the consummate leader, who held his ill, poorly-equipped and trained army together by sheer force of character. Without him we would not have gained our nation. He would not quit, nor would he let his troops do so. No one who reads this book can entertain the dignified-man-with-the-wooden-teeth caricature of him.

In October, 1775 King George III addressed Parliament concerning the war in America. He declared that the colonists were

Continued on page 29

*Solidas et amice, ave atque vale*

## Eugene A. Stead, Jr.—A Reflection

By Stuart Bondurant, MD

Eugene A. Stead Jr. had a formative influence on American medical education, research and clinical practice in the 20th century and on those of us privileged to have known him and worked with him.

We are all of course biologically unique but Gene's uniqueness was perhaps better expressed than most. To a remarkable degree, he examined people and the world around him with a clear eyed candor and honesty that was not diffracted by ego, self interest, defensiveness or convention. He used the databases so generated to create analyses and interpretations that were often startling in their real or apparent departure from convention. As our friend and colleague John Hickam pointed out, he thought of things in more different ways than anyone we knew. Many of his formulations were "off the wall" and he was really not very consistent in differentiating good ideas from bad. Generations of research fellows in the Department of Medicine learned that a visit to the laboratory by Gene likely meant the interesting development of several years' worth of possible research of which a relatively small portion might, on reflection, have the potential to be truly seminal. But, what fun to watch him think!

Gene's analytical ability along with his independent and creative thinking were the basis for profound influence on the National Institutes of Health during the formative years of that great institution and of the Institute of Medicine of the National Academy of Science, as well as his creation of the current model of the physician's assistant.

Gene's clinical genius began with his attention to the whole person long before "holistic medicine" came into vogue. At the bedside, he practiced the same kind of systematic acquisition of clinical data minimally contaminated by his own perspectives or bias that characterized his research. He weighed and orchestrated clinical and personal data with finesse to produce succinct and definitive diagnostic and management plans which were dictated often at the bedside into the patient's chart, always beginning "Just say for me."

In addition to clinical competence of the highest order, Gene taught, managed and practiced with a very broad and yet personal view of the scope of health care. He illustrated the scope of his perception of health care once to me in the mid-1950s. For many years, Gene was physician to the Methodist Retirement Home near Duke and he would occasionally invite me or others to walk to the Home and see patients with him. One day, as we approached the Home he asked "Stuart, who do you think is most important to the health of the people in the home?" Since it was a rhetorical question, I asked for his answer and he responded, "the hairdresser, because she makes more people feel better about themselves and they in turn make others feel better and behave more healthily." Though he didn't say so, I have no doubt that Gene sometimes prescribed visits to the hairdresser in preference to drugs.

While some students and physicians would mistake Gene's extraordinary objectivity for arrogance or hostility, he was in fact a kind and caring physician. Gene Stead was a wise and warm companion, a mentor whose goal was to stimulate not mold, and a person of towering commitment and integrity.

## Harry A. Guess, MD, PhD

Age 65

Harry Guess was born and raised in New York. But he quickly adapted southern ways soon after coming to RTP in 1979 as the head of Epidemiology Department at Merck Research Laboratories. He retired from that job in 2003. Those who knew him well speculated his instant transformation to a bottle of IV grits thought to have received in Raleigh's Big Ed Restaurant! Another part of his humor, we used to tease him about being a "paradox", really a "pair of docs--MD, PhD."

Harry was the scientists' scientist. He received his PhD in mathematics and MS in Operational Research from Stanford in 1972. His MD was from University of Miami, and residency training at UNC in pediatrics to which he later added certification in preventive medicine and public health. His stellar career included the first director of the UNC-Glaxo-Smith-Kline Center of Excellence in pharmacoepidemiology and Public Health at UNC. He led the UNC Centers for Education and Research on Therapeutics (CERTS), which focused on optional use of drugs, medical devices and biological products in pediatrics. He also obtained NIH funding to lead UNC as a part of a large NIH roadmap initiative to study the dynamic assessment of patient-reported chronic disease outcome (PROMIS). His career straddled pharmacoepidemiology and public health, truly a rare breed of scientist-clinician.

Repeated data generated by the US Department of Labor Statistics show that our region has surpassed all other parts of the world in concentration of MDs and PhDs except for Israel. We have outstripped Boston/Harvard/Cambridge, California's Stanford and Europe. In addition to his scientific and teaching excellence, Harry was a remarkable goodwill ambassador for this region. He attracted many other colleagues to make their home in RTP, thus contributing to the intellectual supremacy of this region.

Dr. Guess is survived by his wife of 41 years, Geraldine Graflund Guess and two daughters. He will be missed by his family, colleagues and friends.

## Dr. Howard Allen Jemison, Jr.

Age 83

Our good friend and delightful colleague, Howard Jemison, was a no non-sense former Chief gunner's mate in the US Navy during WWII on board the destroyer, USS Ordronaux. He came to NC from his private practice in Essex, MA to direct Student Services at Wake Forest University. He then entered private practice until 1985 when he assumed the post of medical consultant and quality assurance for Disability Determination Services of Raleigh, until his retirement in 1997.

He is survived by his wife, Melissa Jemison, three daughters and one son. Howard will be missed by all of us.



*Continued on page 29*

## Dr. Thomas Royle Dawber

Age 92

Few practicing MDs do not recognize the name of one of the most revered and beloved twentieth century cardiologist, Thomas Dawber. He offered the conceptual architecture of what later became the Framingham Heart Study, one of the most important research projects in understanding heart disease to the Cambridge medical community and later to the world. As the first director of the project, he traveled extensively and came to UNC and Duke rather regularly.

Under the guidance of Tom, Framingham researchers have published 1,300 scientific papers unlocking the mysteries of heart disease and stroke. A key finding came in 1962, when researchers linked serum cholesterol level and blood pressure to an increased risk of heart disease. A 1988 report associated heart disease with "type A" behavior, characterized by tenseness and aggression. Dr. Dawber's work and discoveries affected the lives of six billion inhabitants of this earth. His professional influence was remarkable in all medical specialties including psychiatry. It was sad that he died of complications of Alzheimer's disease.

## WHO'S news



**Arienne Farrelly**, daughter of our own volunteer staff writer, **Christy and husband Vince Farrelly**, granddaughter of WCMS Past President, **Dr. David**

**Gremillion** and sister to the three old Finley Farrelly, born December 27, 2005. Our love and heartfelt congratulations.

Condolences to **Dr. Leo Waldenberg** on the death of his mother, **Rose Waldenberg**.

**Dr. Mitchell Freedman** on the death of father, **Dr. Edward Freedman**.

Congratulations to **Steve and Kathleen Liebowitz** on the birth of their daughter, **Isabel Haley Liebowitz**, born January 14th.

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## Book Review continued

in open revolt for independence (while the Americans at that point were only asking for their British rights) and believed that any course other than compelling obedience by the Americans would be ruinous. In Parliament Edmund Burke, on the other hand, urged conciliation.

The King committed land and sea forces and foreign mercenaries to put down the rebellion. In response, Congress named George Washington commander of America's forces. He arrived at British-occupied Boston in July, where he found the New England troops undisciplined. To compound his problems there was fever and dysentery, little gunpowder and little money to pay the troops. Still, he managed to keep the British pinned down.

In the fall of 1775 Colonel Henry Knox heroically retrieved 58 mortars and cannon from Fort Ticonderoga 300 miles away across the Berkshires. With them the Americans attacked the British, who abandoned Boston in March, 1776 and sailed away. The happy news flew throughout the colonies - the last good news for a long time. Washington knew that they would attack New York, which John Adams called the key to the continent. It had strategic importance because it commanded the Hudson River waterway to the north and west, and it had great commercial value.

The New York campaign proved disastrous because of mistakes by Washington and his generals and by lack of coordination and military intelligence. Their only success was evacuation of the troops on Long Island across the East River to New York under cover of darkness undetected by the British, an amphibious feat to be repeated soon on the Delaware. It was at this time of weakness that Congress proclaimed independence. The British were proclaiming the end of the rebellion.

The Americans fled into New Jersey, where rains drenched

them. They had no tents. On December 1, their enlistments ended, 2,000 troops walked away. The remains of the army marched to Trenton. Incredibly, on December 13 British commanding general Howe suspended operations and retired to winter quarters in northern New Jersey and New York. Seizing the opportunity, Washington decided to cross the Delaware at night and attack Trenton on Christmas, a day on which it rained, hailed, snowed and froze. The troops were still poorly clothed and some had no shoes. The Hessian mercenary troops occupying the town were completely surprised, and in an hour they surrendered. The British retook it, but the Americans confronted and beat them at Princeton.

Trenton and Princeton were brilliant victories, certainly for a "rabble" army which had experienced little but defeat for most of 1776. It was later said that, "It may be doubted whether so small a number of men ever employed so short a space of time with greater and more lasting effects upon the history of the world."

To the American people Trenton was the first great cause for hope, a brave and truly "brilliant" stroke. A dark time had changed because of a small band of brave men and their determined leader.

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\* The writer is the author of "Locke, Jefferson and the Justices", 2002

# The Gift of America

By Assad Meymandi, MD, PhD, DLFAPA

*(Editor's Note: each day that the General Assembly is in session, a member of the North Carolina Medical Society takes turn to be the 'Doctor of the Day', tending to the ills of the legislators and their staffs. I was honored to be called upon to give a five minute speech at the beginning of the session in one of the days I had the duty of being 'Doctor of the Day')*

Ladies and Gentlemen :

Thank you for this high honor. In the few minutes allotted to me, I wish to submit that America is the best thing that ever happened in this world and to this world. While I do not have Lincoln's eloquence at Gettysburg, I do take inspiration from his every word. Not four scores and seven years ago, but about ten thousand years ago, the age of Neolithic man, God set out to send man on the road to perfection.

He sent the ancient Persian prophet, Zaratustra (Zoroaster), as early as 500 BC, to bring us the concept of good and evil which in modern day philosophy is known as epistemological dualism. The Sumerians brought us literacy and language. The Egyptians taught us social order and government; the Persians, participatory democracy; the Greeks city-state and citizen representation; the Babylonians gave us devotion and discipline; and Jesus came bringing us civility, hope and love. 1215 years later, the Anglo Saxons brought us the Magna Carta. And in 1756 we were given Mozart, through whom music flowed like water running through the fountains of Tivoli.

But it was not until 1776 that God commissioned, in a divine and mysterious manner, a group of faithful thinkers to lay the cornerstone of a new experiment that in a short span of time has become the envy of the world. The experiment is the Republic they created. It is our United States of America. I am convinced that God had a definite hand guiding the framers of our constitution in creating this profoundly decent and just document. The American Constitution, as a literary piece, combines Augustinian grace, Franciscan tenacity, Christian hope and possibility, Talmudic order and Zoroastrian aspiration for good deed and perfection. It is a talismanic masterpiece with magical powers. We have seen Sultans, kings, Shahs and potentates come and go. But governing by the rule of law, the unique legacy of the American Constitution and the nobility of Bill of Rights are here to stay.

We should all be proud to be Americans. As legislators, you, ladies and gentlemen, occupy the lofty position as guarantors of this sacred legacy, the legacy that in America, laws and not men rule. You are the law makers, and you are the ultimate governors of our people. As one American who enjoys the inalienable freedom and liberties bestowed upon me, I thank you for your leadership, sacrifice and guardianship of our sacred American Constitution.

Thank you and God Bless America.

## Intensive Care Nursery continued

that can image a heart the size of an acorn or that can examine the center of the tiniest baby's brain. We can now operate on intestines of the smallest of babies. Survival rate for prematures are also amazing. Almost all babies 2 pounds and over survive. Two-thirds to three -fourth of those 1.5 pounds to 2 pounds survive.

Over the years we have cared for thousands of babies from Wake County and hundreds from eastern North Carolina. We now admit around 600 babies a year to our 36-bed state of the art unit.

But I don't think it is all this technology that has drawn the Doggett's to our nursery. I think it was their experience with the staff that works in the trenches, as they are really the heart and soul of our unit. We have nurses that have been here since the beginning. Our turnover rate is the lowest in the hospital. Our nursing managers have been incredible, as we have had only 2 for 24 of the last 25 years. Our neonatologist staff has grown to 8 ranging in experience from 1 year to 28. None have left(one-for retirement!). We have highly skilled people who go with all those machines I mentioned. We have dedicated respiratory therapists, clerks, technicians, housekeepers, pharmacists, and developmental specialists. It is because of all these knowledgeable individuals that really care for babies and their families that have made us successful. So it is on behalf of all these many people that work in the Doggett ICN that I thank you for this honor.

Addendum:

In 1977, the Low Birth Weight Rate in North Carolina was 7.9% and the Infant Death Rate was 15.8 per 1000

live births. The Wake County numbers were essentially the same for the 3655 births that year. Rates for Black infants were almost twice that for white infants. There were 12 intensive care beds at then Wake County Memorial with two neonatologists. 53 live born babies between 500 and 1500 grams were admitted and 53 % survived.

In 2004, the Low Birth Weight Rate in North Carolina was 9.1% and the Infant Death Rate 8.8 per 1000 live births. The Wake County LBW Rate was 7.9% and the IMR 7.0 per 1000 live births. Rates for minority infants remain 50% greater than that for white infants. 11,751 births occurred in Wake County. Now there were 36 intensive care beds at WakeMed, 14 special care beds at Rex Hospital and 8 special care beds at Cary Hospital with eight neonatologists. 141 babies between 500 and 1500 grams were admitted to WakeMed and 92% survived. Only one of the 106 babies between 800 and 1500 grams died. Despite these amazing numbers the cost of these infants is substantial in terms of dollars and development.

North Carolina continues to be among the ten worst states for infant mortality despite multiple efforts to improve this. The United States remains among the worst developed nations for infant mortality. Our prematurity rate is actually going up. Racial disparities persist. This despite spending more for healthcare than any other country in the world. Clearly "Time for A Paradigm Shift" as outlined in the May/June volume of the North Carolina Medical Journal is way past due. We need to place greater value on children and their mothers. After all they are our future.

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