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ON YOUR BEHALF

A sampling of activities and actions of interest to SFMS members

Notes from the Membership Department

The SFMS Tennis Mixer was a tremendous success. Members enjoyed sessions with tennis pros at the San Francisco Tennis Club. Off the court, they explored the other wonderful amenities of this top-notch club, savoring tasty appetizers and margaritas while enjoying lively conversation with fellow members. The event was a hit and will be repeated!

Over the coming months, an exciting array of social and professional SFMS events—including the reprise of such popular events as the Gallery Mixer and the SFMS Symphony Night—are being planned. Opera and/or Ballet Nights, a baseball game, wine tasting, a golf event, and lectures and seminars of interest to various sections of SFMS membership are being explored as well, so watch for announcements in your *Action News* and *San Francisco Medicine* over the coming months, and be sure to visit the website often.

Here's an opportunity to reach out to fellow members and help make membership more worthwhile! SFMS has embarked on a New Member Sponsorship program. Upon approval by the Board or Executive Committee, each new member is assigned a sponsor, an established SFMS member whose primary responsibility is to help the new member become better acquainted with the Society and its benefits. Sponsors are expected to connect at least once with the new member socially (over breakfast or coffee, for example) and to invite the member to at least one SFMS event (such as the Annual Dinner, Legislative Day, Candidate's Night, or a Mixer) during the course of their first year of membership. Sponsors will also be asked to report to the Board on the results of their interaction with the new member. Sponsors are currently drawn from the SFMS Board as well as the Executive and Membership Committees, but *all* members are encouraged to participate in this program. Contact Therese Porter in the

Membership Department at (415) 561-0850 extension 268 or tporter@sfms.org for more information or to volunteer.

Help grow the San Francisco Medical Society! Members who reach out to their physician peers form a tremendously effective means of gaining new members. If your physician peers are not yet members, encourage them to join!

Hiroshima Council Visits SFMS

In January, the Hiroshima International Council for Health Care of the Radiation-Exposed (HICARE) visited SFMS offices to enlist the society's help in finding physicians who would be interested in receiving training on the health effects of radiation exposure. HICARE, and related organizations, have conducted studies of the effects of high and low dosage radiation on Hiroshima survivors now living in Japan and in several other countries.

Founded in 1991, HICARE offers training to physicians on treating radiation-exposed patients and will dispatch radiation experts to areas in need. The organization also works with local governments when radiation exposure occurs and disseminates information around the world about radiation poisoning. The organization offers several training programs in Japan that run anywhere from one week to three months. HICARE offers a "sponsored" training program to a limited number of applicants, for whom the organization will cover travel and lodging expenses. In other cases they will simply facilitate the training. To learn more about the opportunities HICARE offers, please visit the organization online at www.hiroshima-cdas.or.jp/HICARE/en/or e-mail hicare@hiroshima-cdas.or.jp.

Save the Date: Legislative Leadership Day, April 24, 2007

CMA's thirty-third annual Legislative Leadership Conference is Tuesday, April 24, in Sacramento. This is the most important day of the year for physician advocates! A revamped schedule will include more time

than ever to meet with your elected officials in the State Assembly and Senate.

Attendees will receive a CMA health policy briefing and a short course on "Lobbying 101," which will train them to become strong physician advocates and will prepare them for the legislative meetings later in the day.

Don't miss the opportunity to meet one-on-one with your legislators to discuss important health policy issues that affect the practice of medicine in California.

For more information, contact Susan Bassett at (916) 444-5532 or sbassett@cmanet.org.

As Asthma Inhalers Are Phased Out, Shortages Expected

Physicians should be aware that asthma rescue medications are in short supply, as prescription drug manufacturers begin phasing out metered-dose inhalers containing ozone-depleting chlorofluorocarbons (CFCs). Physicians must prepare patients for this switch. In 2005, the FDA ordered drug makers to stop producing inhalers with CFC propellants by the end of 2008.

Beginning in 2008, only hydrofluoroalkane (HFA) propellants may be used in metered-dose inhalers. Several manufacturers have already slowed or halted production of CFC inhalers in preparation for the switch to HFA products. This shortage is expected to become more pronounced in coming months, as Schering-Plough, through its Warrick Pharmaceutical Division, announced it would stop production of CFC inhalers this spring.

Because of the shortage, patients with nonspecific prescriptions may unknowingly be switched to alternative HFA agents. Even though HFA propellant formulations are not generically interchangeable with their CFC counterparts, there have been some reports of substitutions being made without physician approval. Accordingly, physicians writing prescriptions for bronchodilators should be sure to indicate specifically which medication they are prescribing.

Physicians should also be aware that HFA propellants may "feel different" to

patients accustomed to CFC inhalers. Physicians and pharmacists should educate patients about what to expect when making the switch to avoid potential overuse, product waste, or patient dissatisfaction.

Medi-Cal has added HFA agents to its list of covered drugs and will only cover CFC inhalers with prior authorization. Many health plans, however, still do not cover HFA inhalers without prior authorization.

For more information, contact Teresa Stark at (916) 444-5532 or tstark@cmanet.org.

Coalition Formed to Advance Health Care Reform

California doctors, hospitals, health care workers, and insurers announced the creation of a coalition to work toward comprehensive health care reform this year. The coalition, comprised of CMA, Service Employees International Union (SEIU), Blue Shield of California, Kaiser Permanente, Catholic Healthcare West, and Health Net, joined in support of three core principles critical to achieving comprehensive reform: universal coverage, shared responsibility, and stable long-term funding.

"Doctors and patients throughout the state are increasingly concerned about the condition of our health care system. It has been neglected far too long. That this coalition, representing very different interests, is coming together is a sign of the depth and degree of support for reform," says CMA President Anmol Mahal, MD. "Time is a very precious resource in correcting ailments, and we must recognize that California's need for a health care remedy is long overdue."

While the coalition members have concerns about some specific elements of the reform proposals that have emerged thus far, they have pledged to work with the governor, the legislature, and each other to find common ground that will enable comprehensive reform to be enacted this year. The CEOs of the three health plans involved in the coalition—George Halvorson of Kaiser Permanente, Jay Gellert of Health Net, and Bruce Bodaken of Blue Shield—pledge their

support for this effort.

For more information, see www.cmanet.org.

CMA Endorses Free Online CME for Physicians Treating Victims of Domestic Violence

CMA has endorsed an innovative online education program to help California doctors better fulfill their important role in treating victims of domestic violence. The free CME program is now available at www.respondtoday.org.

The award-winning web-based education program fulfills two vital goals: It provides physicians with the tools they need to help patients who may be victims of domestic violence, while at the same time allowing doctors to meet state requirements for continuing education.

The Blue Shield of California Foundation (BSCF) is investing \$355,000 to make the training available for two years to all physicians at no charge. The BSCF grant has also enabled the program's authors to add important information on California laws and domestic violence resources. California-licensed physicians who use the program can receive up to sixteen continuing medical education (CME) credits—also at no charge—for completing the course.

The state-of-the-art, online CME program includes text-based simulations, multimedia tutorials, video presentations by domestic violence experts, downloadable practice tools, and links to scientific journal abstracts. It was developed under a grant from the National Institute of Mental Health, given to Medical Directions, Inc. (MDI) of Tucson, Arizona.

For more information, contact Susan Penney at (415) 882-3322 or spenney@cmanet.org. 

For Local Events of Interest, Please Visit Our Website, www.sfms.org.

Stephen Follansbee, MD



Taking a Global View

This month's topic of Global Medicine provides a very different perspective on health care than last month's issue, themed Neighborhood Medicine. The issues of global medicine are daunting compared to our country's current discussion of financing and resource allocation to ensure universal health care access in the U.S. As an infectious diseases and HIV specialist, I am aware of some of the roadblocks to progress in the control and treatment of the HIV pandemic. Every specialty meeting and nearly every medical journal focusing on HIV-related issues includes a focus on HIV care or research in communities around the world—and HIV is only one of the challenges facing global health. This issue of *San Francisco Medicine* reviews some of the problems and opportunities raised by a global view.

As physicians, can we afford to keep our focus on the narrow and familiar medical issues of treatment options, infrastructure, and personnel training? Can we afford to "export" our standard of care to the world? Although these issues are important and must be funded and expanded, I believe, based on my experience in HIV medicine, that the answer is a resounding "No."

Global health is linked to many other global issues, such as the status of women. If women have no control over their bodies and health, no economic independence or social status, it is nearly impossible to deliver services and expect positive outcomes. In many cultures where women lack status and independence, they are seen as mothers and sexual objects first and foremost. They are unlikely or unable to attend to their own health care needs under these circumstances. It is more than being "too busy." It is all too often dangerous for them to seek medical care, ask their partners to wear condoms, or reveal their health status to their families. Some global health care initiatives involve novel interventions that aim to give women options that are less obvious or require only episodic intervention. One example involves efforts to genetically alter *Lactobacillus* and commensal bacteria of the vaginal tract with plasmids that express anti-HIV proteins, including proteins that inhibit the fusion of HIV to the surface of uninfected cells.

Global health is linked to war and social instability. It is nearly impossible to provide basic health care in communities at war, given the interruption of services that we consider necessary for health care delivery. These services include clean water, sanitation,

power and generators, and transportation enabling patients to get to sites of service and supplies to be delivered to these communities. Service organizations such as Doctors without Borders (www.doctorswithoutborders.org) attempt to deliver medical care in these areas, with their providers often assuming great personal risk.

Global health is linked to economy. A healthy population is a working population. The recent attempts of the government of South Africa to deny its country's rampant HIV epidemic were fueled in part by a desire to encourage foreign investment by pretending that there was no HIV among the workers. Some corporations involved in global production understand this. The GAP, for example, is to be commended for its (PRODUCT)RED™ campaign, which supports health care clinics and services for its factory workers in Africa; worker safety is often ignored in countries with inexpensive labor.

Global health is linked to clean air and clean water, free from radiation and carcinogens. Environmental pollution from factories is another problem that is rarely prioritized in countries with an inexpensive work force. Global health is linked to prevention. Most of the treatment strategies for disease, once diagnosed, are not options for countries whose per capita health care budget may be literally a few dollars per person per month. In that regard, vaccine development against *Plasmodium* species, particularly *P. falciparum*, is an important goal. Likewise, better strategies to prevent tuberculosis and diarrhea are critical to the goals of global medicine.

The act of simply transporting our health care systems and interventions abroad is doomed to failure. I do not believe one can advocate for better global health without being an advocate for women's rights, worker's rights, peace, economic stability and jobs, environmental health, and disease prevention worldwide. This is indeed a daunting challenge. It is inspirational to read about people, clinics, and programs that are making a difference. *Sfm*

Dr. Follansbee is the 139th President of the SFMS. An infectious disease specialist, he practices with the Permanente Medical Group. He is Director of Travel Medicine as well as Director of HIV Services at Kaiser San Francisco. He has been Chief of Staff and Director of HIV research and treatment at Davies Medical Center, attending physician at SF General Hospital, Assistant Director of the Bay Area Consortium of AIDS Providers, and has served on the UCSF clinical faculty.

Mary Lou Licwinko, JD, MHSA



Traveling in China

In October 2006, I traveled with a group of executives from the United States and Europe to the People's Republic of China, on a mission sponsored by the American Society of Association Executives. The trip was arranged by People to People, an organization based in Spokane, Washington, that was started in 1956 by President Dwight D. Eisenhower to promote peaceful exchanges between people throughout the world. President Eisenhower's daughter, Mary J. Eisenhower, is the current CEO of the organization. China has a long and interesting history and has contributed numerous innovations to the world. In more recent times it has suffered from invasion, occupation, and revolution, but it still maintains its special culture. In keeping with *San Francisco Medicine's* focus for this issue on global medicine, I have narrowed my discussion to the economy, medicine, and health, although there is much more to say about China.


Our travels took us to Beijing, Shanghai, and Hong Kong over a two-week period. (As we visited the coastal cities, we were exposed to the most prosperous sections of China, although we learned that those living and working in the countryside did not enjoy the same level of prosperity.) The new mantra in China is "market economy"—we heard little discussion of communism, but everyone talked about the "market economy." With an economic growth rate of more than 10 percent in 2006, it is clear that China is racing to find a formula that will sustain its population of 1.3 billion people. Its economic growth has come at a price for China. The pollution in the cities was staggering. Years of using coal as the main fuel for factories and heating, the increase in autos as the major mode of transportation, and the fine dust blowing in from the Gobi Desert have all left their mark. When we arrived in Beijing, the sun was so clouded by smog that it was an orange disk in the sky. The city was busy preparing for the 2008 Summer Olympics, so I inquired about how the smog would be dealt with for that event. The answer was that all industry in Beijing would be shut down a month before the Olympics, and everyone in the city would be given a two-week vacation during the games. At a meeting with an American who has been doing business in China for many years,



I asked whether there were long-term plans for tackling the pollution. After telling me that this pollution was nothing compared to what he had grown up with in a large city in the United States, he said the Chinese did have plans for dealing with it—but we never heard any more about such plans.

The purpose of our trip was to learn about opportunities for developing associations in China. Currently, a number of professional associations exist in China, but all must be sanctioned by the government. We quickly learned that despite the new emphasis on the "market economy," the government still controls who does business in China. Foreigners are put through rigorous processes before they can start an enterprise, and we were advised to work with expatriates who lived in China and knew the ins and outs. We were further told not to view China as the land of opportunity but a land of "possibilities."

Among the association executives we met in China were the heads of the Chinese Medical Doctors Association, the China Nursing Association, and the China Mental Health Association. The major emphasis of these associations is to serve the professions through continuing education and research in order to provide better health care for the population. One of the more interesting discussions we had was about mental health care in China. The director of the Chinese Mental Health Association indicated that the Chinese government had not recognized mental health as a legitimate concern until about twenty years ago. This meant that mental health professionals had been busily working to bring the field up to speed over the last two decades. The director said that individuals treated for mental illness were stigmatized and often discriminated against in their workplaces and communities. He wanted to know if we had experienced anything similar in the U.S.

In many ways, my experience made me feel I had seen the future. China's economy is a juggernaut, and central government control has forced modernization at a pace not seen before. China is a fascinating country with charming people. I am already thinking about my next trip. 



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Healing Globally

For many years the Bayern Brewery Company in Missoula, Montana, had a motto: “Think Globally, Drink Locally.” We might notice that this slightly off-kilter slogan, like our theme of global medicine for this issue of *San Francisco Medicine*, inherently implies that everyone understands that the earth is round like a globe. Yet, historically it’s been a difficult task to convince people that the earth isn’t flat.

In myths of many ancient cultures, the earth is depicted as a kind of island surrounded by water. The ancient Egyptians, Greeks, Indians, and Chinese all imagined various configurations, including a cylinder with a flat top and a disc under a dome. Pythagoras and Aristotle thought that the earth was round, and in 240 B.C. Eratosthenes estimated the circumference of the planet by measuring shadows at different locations. By the 17th century, by direct observation through telescopes, Galileo proved that the earth was a rotating ball that circled the sun in an orbit between other planets.

Still, the issue wasn’t settled. Galileo himself, under the threat of the Inquisition, recanted his round earth concept until his death, and the flat earth theory was perpetuated by such stories as Columbus’s men threatening mutiny because they thought their ships were going to fall off the end of the earth. By 1850, the Flat-Earth Society was founded in England and later moved to Lancaster, California, and during the 20th century organizations such as the Christian Catholic Apostolic Church in Zion, Illinois continued to foster a doctrine of a flat earth.

In 1972, the issue seemed settled for all time when the American astronauts took the now-famous photograph of the “blue planet” in all its spherical glory, and Eugene Cernan, the commander of the flight, radioed to Houston Control, “We’re not the first to discover this, but we’d like to confirm, from the crew of Apollo 17, that the world is round.” That objective proof was followed, in 1974, by a more subjective lived experience when Dave Kunst became the first human to walk across the land masses all the way around the planet, returning from a westerly direction to Waseca, Minnesota after having left there four years earlier walking eastward.

One result of the confirmation of a round earth occurred in the 1970’s when biologists and ecologists Lynn Margulis and James Lovelock developed their Gaia Hypothesis, in which they demon-

Mike Denney, MD, PhD



strated the complexities of the planet Earth in its self-regulatory wholeness, and the intricate, intimate interdependency of all life on the planet. Margulis and Lovelock surmised that, in a complexity not measurable by objective science, a butterfly flapping its wings in Beijing might provoke a rainstorm in Chicago.

Perhaps the Gaia principle applies also as we try to think about global medicine for human beings—viruses traveling with the migration of birds, other flu viruses originating in swine in China and transmitted by human contact in short weeks throughout the world, the AIDS epidemic, injuries as a result of international wars, telemedicine to reach the most remote corners of the earth, envisioning a global healthcare system that works for all—all intricacies and complexities of life on the planet never known before and difficult to imagine now.

One reason that it is difficult for us to think globally is a slightly off-kilter cognitive dissonance that although we know objectively that the earth is round and that it circles the sun, subjectively, in our everyday lived experience, we instinctively perceive the earth to be flat and at the center of our universe—the sun rises in the morning and sets in the evening over the flat stretch of land from which we observe the heavens. To compound this paradox, astrophysicists, using findings from the Hubble Space Telescope, conclude that there are an inestimable number of galaxies that stretch one after another through infinite space. Thus, perhaps our flat-lander instincts are correct after all—the earth is the center of the universe because in infinity *every* place is the center of the universe.

All of which means, of course, that the Bayern Brewing Company in Missoula, Montana, is also the center of the universe. And so it is that even as we physicians practice in a local lived experience we may find meaning in a slightly off-kilter beer slogan by acknowledging that all healing occurs on a global planet at the center of an infinite universe.

So, as in this issue of *San Francisco Medicine* we celebrate the complexities of global medicine, let us raise our glasses and offer a toast with that time-honored motto: “Think Globally, Drink Locally.” *sfm*



Transcending National Boundaries

A Closer Look at Global Health

Meg Jordan, PhD, RN

Global health is defined by the Institute of Medicine of the National Academies as health concerns that “transcend national boundaries, may be influenced by circumstances or experiences in other countries, and are best addressed by cooperative actions and solutions.” We are

Despite the headlines and increased awareness, however, the growing sense among global health experts is that things seem to be worse than ever. And



all vulnerable to disease no matter where it originates—whether it is the West Nile virus vector hopping a flight or Type II diabetes spreading from the encroachment of Western monoculture onto the rest of the world.

Last year, at a Time Global Health Summit, foundation directors, WHO officials, philanthropists, heads of state, and health ministers gathered to consider the massive health crises looming in developing countries. The U.S. Congress passed a resolution designating November as Global Health Month, and the Bill and Melinda Gates Foundation was publicly commended for gifting a billion dollars for vaccine and malaria initiatives.

rica, where three out of four children under five years of age die from causes rare in the developed world: pneumonia, infectious diarrhea, malaria.) Social scientists blame postcolonial legacies of resource exploitation, inefficient governments, corruption, and warlord-dominated factions, along with environmental mishaps caused by poorly designed dam and irrigation projects and the resulting deforestation, drought, and famine.

If you're watching from the sidelines, global health issues can appear insurmountable. Suffering is ushered into our living rooms as we flip through the TV channels. There he is again, the sick child with the swollen belly and flies on his eyes—this time

why is that? Even a cursory review of health indicators reveals that Africa is sicker today than it was thirty years ago. (How insignificant Western complaints such as body dysmorphic and sexual arousal disorders must seem to villagers in sub-Saharan Af-

in Ethiopia, last month in Ghana. But even though enormous disparities exist between wealthy and poor nations, a global view has brought with it successful new approaches and more conscientious policymaking. Health ministers of various nations report that they don't just need cash or medical drugs, they need help establishing infrastructure, or what's known as *capacity*: roads, skilled workers, distribution channels, educators, refrigeration, monitoring agents.

Drawing the Big Picture

The big picture of global health is littered with measurements used by the World Bank: rates of poverty, education, maternal mortality, infant mortality, incidence of HIV/AIDS, malaria, polio, tuberculosis, and other diseases. Countries are categorized as having a low, medium, or high “burden of disease” that is based on indicators such as access to safe drinking water, education rates, and the proportion of people going hungry. The most significant finding by international experts is that the preventive measures and effective treatments that we take for granted in developed countries have been sorely missing in impoverished nations. We now understand that inexpensive and relatively simple health care measures can be deployed to prevent millions of un-

necessary deaths. To that end, the United Nations identified eight Millennium Development Goals (MDGs) that relate directly to improving global health.

Nongovernmental organizations (NGOs) compete for resources and philanthropic dollars as they try to establish a network to strategize on social, economic, political, and ecological solutions to assure long-term sustainable improvements. *Sustainable health* and *ecological medicine* are highlighted by the medical change agents who have been in the trenches long enough to know that our crisis-oriented care of the present must not hamper the ability of future generations to meet their own needs.

Still, the instinct to treat the dying person in front of you is overwhelming, and the lion's share of attention and investments flow from organizations that continue to look through a reductionist lens. Although shortsighted, it is understandable. Visit areas of the globe where orphaned children wander aimlessly, the adults dead or too sick to care for them. In these cases, child survival is the logical starting point, and medical volunteers engage in talk about blasting with "drug arsenals," developing the "greatest weapons" to combat dangerous new strains of resistant disease. The race to stem the tide of super bugs with powerful new medicine requires unwavering commitment. In the global, life-and-death struggle, there seems to be no time to consider the fact that MDR strains continue to arise because a whole-systems view is often eclipsed.

As more money and more drugs are shipped to the saddest places on earth, a new breed of global health veterans, such as Stephen Lewis (U.N. Special Envoy for HIV/AIDS), Paul Farmer, MD, and Jeffrey Sachs, PhD, insist that we broaden the commitment to include dialogues on political will and distribution capacity. Once humanitarian shipments are received, do governments have the intention and clout to get them to the areas most in need? Will profiteers intercept? Tremendous gains can be made by community health workers with the means for delivering the medicines and resources, as evidenced by Farmer's training of Partners in Health workers in Haiti. The polio initiative of South India relied on such workers, supported by Rotary International.

Sometimes the simplest solutions are the most elegant. Unsung heroes crop up in every sector. For example, Barry and Andrea Coleman, cofounders of the U.K.-based Riders for Health, develop innovative models to get workers on off-road motorcycles to

"Improving the health of people in developing countries makes sense, as President Bill

Clinton summed it up: '... for moral reasons, for health care reasons, and for economic and security reasons ... you should care about this.'"

deliver help to previously inaccessible hot spots.

The vision of access to public health for every human being is noble and technically feasible. And significant gains are only achieved because someone had the faith and vision to set a goal and muster the forces. This happened recently with a measles goal set by WHO and UNICEF: A 2005 report revealed that global deaths from measles were reduced by 60 percent.

Health Equity

One of the major shifts in global health in recent decades has occurred in the way that wealth and health are connected. From the 1700s through 1950, there was a consistent measure for assessing the health and longevity of a society: socioeconomic status. According to WHO, how well you lived remained the number-one determinant. Nations with a per capita income (PCI) below five to ten thousand dollars annually had the poorest sanitation, worst malnutrition, and highest morbidity.

However, a big surprise arose when a new indicator took hold in 1950: health equity, defined as fairness in basic health care measures for people at every income level. In a brilliant analysis of nations measuring above that PCI threshold, per capita income was no longer the major determinant.

Rather, the gap between rich and poor was implicated. If the gap was great, even the wealthy found themselves living in a society with poorer access to safe water, adequate nutrition, immunizations, antibiotics, and reproductive health care. Health crusader John Robbins writes, "History shows that wherever inequality of wealth distribution becomes extreme, people tend to become divided against one another, and societies tend to spend less on public health, education, and social safety nets."

Why Care?

Improving the health of people in developing countries makes sense, as President Bill Clinton summed it up: "... for moral reasons, for health care reasons, and for economic and security reasons ... you should care about this." We care because we have to—for the obvious humanitarian reasons—and because the world is shrinking every day. International travel by one-third of the world's population means that a modest outbreak can become an international crisis within twenty-four hours. A mere two weeks was all that transpired before a SARS-infected Hong Kong traveler ignited a contagion in Toronto that quickly killed dozens of people in 2003. Whether or not you believe H5N1 will ever mutate to the point of an international outbreak, experts on pandemic preparedness warn that the clock is ticking toward the final hours preceding a return of an influenza pandemic, just as it has every ninety to ninety-six years.

Start with Women and Children

Global health experts have long known that when you improve the lot of women and their children, you improve the health of the society. Educational reform, along with the training of community health workers, can transform attitudes and gender-biased social norms. Women's empowerment in developing nations is now viewed as a playing a critical role in reducing violence against women, unwanted pregnancies, pregnancy complications, and sexually transmitted infections. In affluent nations, antiretroviral drugs have transformed HIV into a manageable disease. But in much of

Continued on page 13...



Maximum Happiness

A Guide to Design and Implementation in International Health

Kevin Starr, MD

A couple of years ago, the leaders of Bhutan announced their intention to use “Gross Domestic Happiness” as the primary measure of development progress. “Otherwise,” they said, “what’s the point?” News anchors mostly presented the news as a sort of isn’t-that-cute item at sign-off, and while everybody thought that it seemed like a pretty good idea, nobody—including the Bhutanese—seemed to have a very clear notion of how it was actually supposed to translate into real progress.

Whether Bhutan’s leaders go beyond a catchy sound bite or not, they are on to something important. As fuzzy as the word might seem, there is in fact an extensive body of research on happiness and the factors that influence it. The best work comes from new-school economists and evolutionary psychologists, in addition to more mainstream cognitive psychologists. The principles that have emerged come from both empirical data on what makes people happy and from a deeper understanding of human nature derived from increasingly well-designed and rigorous experiments.

It turns out that the big themes that emerge—those that cut across cultures, personalities, and circumstances—provide an excellent conceptual guide to the design of interventions in international health. The “big four” factors that exert a profound influence on happiness are security, prospects, keeping up, and loss. A close look at each of these reveals important lessons for those hoping to create positive change.

Security

When people don’t feel secure that their basic needs—decent food, clean water, safety, basic health care, adequate shelter—will be met, they are chronically

anxious and unhappy. Our efforts to meet those needs, if they’re to do any real good, must create sustained impact. It doesn’t relieve anxiety to have needs met temporarily—this is, of course, why medical tourism is such a bad idea. Overall, the notion of sustainability gives us a useful yardstick for worthwhile projects: the walk-away test. If, after delivering your intervention successfully, you can leave the scene knowing that the change you created will last and its impacts will continue to accrue, then you have probably increased net happiness over time. If not, then it’s time to go back to the drawing board to rework the incentives that drive behavior and the structure that maintains those incentives.

It’s worth pointing out, though, that in a monetized world, people need money to meet basic needs—they must pay for food, clothing, even water. We continually rack our brains to figure out how to improve the health of poor, but progress achieved in populations that remain impoverished often doesn’t last. Meanwhile, rising family incomes are virtually always accompanied by improvements in health—even if we don’t do anything else. Efforts that combine stable sources of income with effective health interventions generate a sense of security and can be a powerful source of lasting happiness.

Prospects

We’re wired to think continually about the future, and we accommodate very quickly to progress—think of how quickly

the euphoria from a new purchase or even a promotion can fade away. What makes people happy are better prospects, the notion that life will continue to improve,

and especially that their kids will have a brighter future. Projects that create steady progress toward a better future—even if that progress is slow and incremental—make people happier over time than those that create a sudden, single big impact but don’t keep delivering change. Projects that leave people more self-re-

liant leave them confident about the future, and this suggests another useful test for designers: Projects that leave people more self-reliant are probably worth doing; those that don’t are not.

Keeping Up

For better or worse, we’re also wired to be obsessed with keeping up with our peers. Slum dwellers consistently report themselves as more happy than middle-class people living in wealthy neighborhoods, and experimental subjects would rather get \$50 when everyone else gets \$25 than \$100 when others get \$200. It’s just the way we are.

For this reason, interventions need to be applied evenly, with attention paid to those on the margin. The great thing here for project design is that those most marginalized and vulnerable are usually the ones most amenable to change, and efforts on their behalf are often the most cost-effective. But just as important is the perception of fairness. We react with outrage to any

“As fuzzy as the word might seem, there is in fact an extensive body of research on happiness and the factors that influence it.”

sense of being shortchanged, and project design and implementation have to leave people throughout the spectrum feeling that they got a square deal.

Loss

The devastation from a loss hits harder and lasts much longer than the satisfaction from an equivalent gain. This of course focuses our work on issues such as child mortality; but in a larger sense it again points toward sustainability. If we do something to improve people's lives, we need to make sure that it lasts. In national surveys of self-reported happiness, the countries that occupy the cellar usually include the former Soviet Republics of Belarus and Moldavia, even though material conditions there are vastly better than anywhere in sub-Saharan Africa. Why? Because after the fall of the Soviet Union and the end of subsidies, they

lost ground, and it no longer matters where they are in absolute terms. We must not be agents of loss.

Finally, getting to maximum happiness requires that interventions be **scalable**, meaning that they create significant, **measurable impacts** in terms of basic needs; that those impacts are **cost-effective** to be affordable at scale; that efforts are **sustainable**, creating durable behavior change and leaving in place robust structures; and that interventions are **replicable**, meaning that they are simple, systematic, and broadly adaptable enough to be applied in a host of settings by a host of actors. Maximum happiness isn't a touchy-feely notion out of place in the field of international health. It's an excellent overarching guide to the work that we do, and it deserves to be the ultimate goal of all that we work toward. Otherwise, as they say in Bhutan, what's the point? **sfm**

Further Reading on Happiness:

Some of the best overviews include *Happiness: Lessons from a New Science*, by Richard Layard; two works, *The Moral Animal* and *Nonzero*, by Robert Wright; *Authentic Happiness*, by Martin Seligmann; and anything by behavioral economist Daniel Kahneman.

Kevin Starr is a graduate of UCSF School of Medicine and the San Francisco General Hospital Family Practice program. He is currently the Managing Director of the Mulago Foundation, which supports scalable solutions in health, development, and conservation in the third world; and director of the Rainer Arnhold Fellows Program, www.rainerfellows.org, which helps emerging social entrepreneurs working in the third world design for maximum scalability.

Global Health: Continued from page 11...

Africa, only two percent of pregnant women testing HIV-positive receive retroviral drugs. Most programs focus on preventing transmission to the child and offer no benefit to the mother. Education turns around a woman's chance for survival; curriculum reform is the only hope for rural areas where gang rape is considered "justice" for her brother's crime.

Lessons and Next Challenges

Some of the greatest lessons from the world of global health include the need for community-based health workers to help lift the stigma of shame and blame, and seek out those people living under discrimination. Another lesson is the stark realization that corporate profit has little place in the agenda of global health. Marketing breast milk substitutes in areas of contaminated water supplies undermines the health of babies. Likewise, one-sided political agendas are roadblocks to global health solutions. Restrictions on family planning have had disastrous results in South America, where nations receiving international aid were suddenly cut off. And finally, the postcolonial legacies of institutionalized racism and systematic mistreatment of any one group

over another result in continued social oppression, a fast-track to health disasters.

Mini-Movie View

If we were to shrink the history of global health into a ten-second movie, half the frames would be occupied with hunter-gatherers risking injury from large predators and starvation. Survival was not only predicated upon hardiness but upon cooperation.

The next section would portray the hazards of agricultural settlements: a wave of infections and parasites arising from cozy contact between domesticated animals and humans. With the growth of overcrowded, septic cities, we enter the age of filth diseases such as TB, a disease of poverty that never seems to leave us.

As trade routes flourished, conditions ripened for infectious diseases and plague. Smallpox and measles forced some degree of immunity among Europeans but caused a microbial genocide on New World continents and among the Pacific Islanders. Folk medicines are no match for the invaders.

The rise of allopathic medicine in the next centuries created a brief respite from pathogens. Biomedicine made great strides in the control of public health issues. But

in the next frame of our movie, lifestyle factors and individual behaviors surpassed communicable disease in some parts of the globe as chief killers. Throughout all periods, the insanity of war, oppression, slavery, and human trafficking exact their toll.

The final frames of our global health mini-movie herald a new challenge. We must fight not just the rise of resistant strains—those pesky microbes again. Instead, a gauntlet is thrown down for human beings to accept a new worldview, or else face unimaginable peril. The next frontier of global health will no doubt have to reweave ecological integrity with human health and well-being. But when that happens, we will have the ideal setting for greater numbers to enjoy full health. Global health could then become a reality. **sfm**

Meg Jordan, PhD, RN, is an author, medical anthropologist, international health journalist, editor of *American Fitness Magazine*, and clinician in behavioral health at the Health Medicine Center in Lafayette, California. She lectures on Holistic Health at the Institute for Holistic Studies at San Francisco State University. Her syndicated radio program, "Global Medicine Hunter," airs nationally on Health Radio Network.



The Traveling Patient

Exploring the Growing Phenomenon of Health Care Outsourcing

Haile T. Debas, MD, and Maurice Galante, MD

A *Time* magazine article published on May 21, 2006, told the story of a man with severe whiplash injury from a car accident. The injured man “learned that it would cost him \$90,000 to get the herniated disk in his neck repaired. So, over the objections of his doctors, he turned to the Internet and made an appointment at Bumrungrad Hospital in Bangkok, the marble-floored mecca of the medical trade that—with its liveried bellhops, fountains, and restaurants—resembles a grand hotel more than a clinic. There a U.S.-trained surgeon fixed [the] injured disk for less than \$10,000.”

This story is a perfect example of the rapidly developing phenomenon of health care outsourcing, a trend the medical profession should take notice of. Some have expressed fear that medical professionals are sitting on top of a volcano that could explode at any time. They point out that a phenomenon that started out as benign medical tourism may be evolving into major outsourcing of clinical care, much as currently exists in the outsourcing of the manufacturing and service industries. The noted Princeton economist Uwe Reinhardt has suggested that “this has the potential of doing to the United States health care system what the Japanese auto industry did to American carmakers.” Is this idle fearmongering, or an accurate analysis of a phenomenon that should arouse serious

concerns and stimulate thoughtful discussion within the medical profession?

Health care outsourcing takes different forms. For some time now, hospitals have been outsourcing some of their services,

“A phenomenon that started out as benign medical tourism may be evolving into major outsourcing of clinical care, much as currently exists in the outsourcing of the manufacturing and service industries.”

such as transcription, insurance processing, medical billing, information technology, and supply-chain management. A second form of outsourcing involves clinical services. For example, the shortage of diagnostic radiologists and the difficulty in providing nighttime coverage have led

to a practice of sending, via the Internet, images of scans of patients in this country to India and other places. Radiological studies performed here in the middle of the night can be read by radiologists halfway around the world, where it is daytime. A third type of outsourcing, however, is rapidly increasing in popularity. This involves American patients actually traveling overseas to receive treatment.

To call this phenomenon medical tourism is to seriously underestimate its potential impact on American health care and the practice of medicine. What started out as a random practice of people who combined holiday with health care is rapidly becoming a major industry, involving some entrepreneurial, pioneering U.S. corporations and aggressive marketing by private hospitals in India, Thailand, Malaysia, and other countries. For example, *The Christian Science Monitor* reported on August 16, 2006, that

“Blue Ridge Paper Products, Inc., in North Carolina, is set to provide a health benefit plan that allows its employees and their dependents to obtain medical care overseas beginning in 2007.”

However, when the company completed arrangements through IndUShealth, an intermediary company based in North Carolina, to send one of its workers to have gallbladder and shoulder surgery in the plush Indraprastha Apollo Hospital in New Delhi, it came under severe opposition from the employee’s union, the United Steelworkers. In a letter to Senate and House health care committees, Leo W. Gerard, the president of the union, said, “No U.S. citizen should be exposed to the risks involved in traveling internationally for health care services.” *The New York Times*, which broke this story on October 11, 2006, goes on to make a sobering observation: “The union’s resistance has brought to the fore a critical question in the path of the globalization of the health care industry—who is liable if something goes wrong in an overseas hospital? And underlying all this is the even more explosive issue of potential job losses in the American health care industry, in an economy already sensitive to the large-scale shift of jobs to cheaper overseas locations.”

Health care costs in the U.S., and indeed in many industrialized countries, are escalating. The number of aging residents who require complex health care services is also rising. The U.S. is estimated to have 45 million uninsured and another 20 to 30 million underinsured. Employee health care costs are a significant fraction of the expenditure of large companies. It is said, for example, that Starbucks spends more on the health care costs of its employees than on the purchase of coffee. General Motors

spends more on health care than on steel, and health care costs add \$1,400 to the sale price of each vehicle.

To improve their profit margin and competitiveness, large companies see the need to reduce these costs. A potential solution is to outsource health care of employees to countries where the services can be provided much more cheaply, especially when expensive surgical procedures are required. Arnold Milstein, at the consultancy Mercer Health and Benefits, has estimated that elective surgical procedures cost only 20 to 25 percent as much as comparable procedures in the U.S. The cost in top-notch Indian hospitals is even lower. In addition, as employers transfer health care costs to employees, many uninsured working individuals are seeking treatment outside the U.S. At present, no reliable estimate of the magnitude of these practices exists.

Patients are going abroad not only for cosmetic and dental surgery but also for sophisticated heart surgery and joint replacement. But how safe is this? The knee-jerk reaction is that the practice is unsafe—and this contention is likely to be incorrect in many cases. The doctors performing these procedures have been well trained, for the most part, in the U.S., Britain, or Western Europe. The hospitals providing these

services increasingly have the imprimatur of approval by International JACHO. But even if the quality of care is good, questions still remain about aftercare and follow-up. However, if health care outsourcing is a



lucrative multibillion-dollar industry, we can be sure that the industry itself will find the solution for this problem as well.

The time for a serious and deliberate debate is here. The mere fact that outsourcing of American health care is a solution some are pursuing is an indication that the U.S. health care system has failed. Self-proclaimed experts on globalization say that what we are seeing is a movement toward the development of a global health system in which industry, insurance companies, and even governments will seek low cost and quality wherever they can find it. Can this prediction come true? Is it possible that

a global health workforce could be created? Could the day come when highly successful hospitals overseas would recruit our own physicians with attractive packages, thus creating a reverse brain drain? Even though this prospect seems unlikely at the present, the possibility that it could happen in the future cannot be dismissed.

The pressure is building for major outsourcing of American health care—and the signs are everywhere. The train is about to leave the station, if it has not already left. And the medical profession has not weighed in with new ideas and thoughtful debate. In its own self-interest, and in the interest of its patients, a discussion and a response are necessary now. The evolution of a global health system is not theoretical. If the cost and demand for health care continues to rise, and if American companies find themselves in a noncompetitive position because of health care costs, global health care will be attractive. It could be the twenty-first century's solution in a globalized world. **sfm**

Haile T. Debas, MD, is the Executive Director of the UCSF Global Health Sciences Department and Dean Emeritus for the UCSF Medical School. Maurice Galante, MD, is a distinguished surgeon and professor at UCSF.

Upcoming Events

SFMS Special Event!

April 5, 2007

The San Francisco Medical Society Tees up with the Presidio Golf Club!

SFMS members, as well as nonmembers, are invited to a cocktail reception at the Presidio Golf Club on Thursday, April 5, from 5:30 to 7:30 p.m. Get acquainted with this beautiful facility and its stunning views while enjoying beverages, hors d'oeuvres, and the camaraderie of the members of SFMS. For more information or to RSVP, contact Therese Porter at tporter@sfms.org or (415) 561-0850, extension 268 by March 30. Also, watch for details about a SFMS Golf Mixer event at the Presidio Golf Club later in April!

CMA Workshops

April 14-15, 2007

CMA Practice Management Workshops Monterey Marriott Hotel

- Fee Schedule Analysis: Maximizing Reimbursement and Profitability—Sunday, April 15
- E & M Coding for Physicians: Key Guidelines for Proper Payment—Saturday, April 14 or Sunday, April 15
- Electronic Health Records: Strategies for Success—Saturday, April 14 or Sunday, April 15
- Taking Charge: Third Party Payor Contract Analysis and Negotiation—Saturday, April 14 or Sunday, April 15

To register, call (800) 795-2262 or visit www.cmanet.org/leadership.

Other Local Events

April 12-14, 2007

Thirty-First Annual Symposium of the American Society of Breast Disease
Hotel Nikko, San Francisco
For information, visit the Society website at www.asbd.org.

April 19, 2007

Arthritis Foundation Presents Forty-First Annual Knowles Lecture
The City Club, San Francisco
Contact Mary Arnold for more information at (415) 356-1230 or marnold@arthritis.org.

June 26, 2007

Neuropathy Action Awareness Day
Mission Bay Conference Center at UCSF
See www.NeuropathyAction.org for more information.



Is There Still Hope amid the Ruins?

Can Baghdad's Health Care System Be Rebuilt?

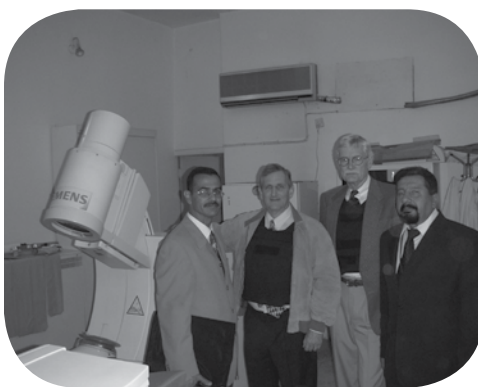
Thomas Cromwell, MD

Returning from Baghdad in February 2004, I wrote an article for the American Society for Anesthesiologists' bulletin entitled "Baghdad, Hope amid the Ruins." It mirrored our enthusiasm for our recent visit and our expectation of an imminent return to establish medical teaching centers throughout Iraq. That was three years ago, and I haven't been back. One question remains—is there still any hope amid the ruins?

Valentine's Day 2004, two short months after Saddam had been unearthed from hiding and less than one year after U.S. forces landed in Kuwait, four CPMC physicians flew into Iraq. We were Bud Alpert, Ira Sharlip, Assad Hassoun, and I, and we joined a group of 30 U.S. physicians attending the first Iraq Medical Specialty Forum, hosted by the Iraqi Governing Council. In his opening address, Paul Bremer, then U.S. Ambassador to Iraq and head of the Coalition Provisional Authority, heralded the forum as an historic event, the first nongovernmental conference to take place in Iraq since the "end of the war" as so publicly acclaimed by President Bush from the deck of the U.S.S. *Abraham Lincoln*. The physicians represented a variety of medical specialties and were selected based on their experience with medical society structure and function as well as their clinical expertise. As stated by the President of the Iraqi Society of Physicians, the goal of the forum, which was attended by 350 Iraqi physicians, was to "reestablish academic ties, reorganize and reinvent the health care system, and participate in a democratic Iraq." Lofty goals indeed!

Historically, the Iraqi medical system was generally recognized as the most advanced in the region, with patients journey-

ing there from throughout the Arab world. Many older Iraqi physicians had been educated in Great Britain, spoke fluent English, enjoyed their comfortable style of living and their status in society, and had a significant voice in the delivery of health care. All that took a dreadful turn for the worse with the rise of Saddam Hussein. In a mere twenty-




five years, through wars and embargoes, he managed to reduce medicine to a tattered remnant of its historical excellence. Favoritism, greed, and corruption were commonplace, and physicians were subjected to the terrors and intimidation inflicted upon all Iraqis. Some were incarcerated, some executed. Medical education and advancement essentially ceased. The results were predictable and devastating, condemning Iraqi medical care to that of a third-world country. The suicide rate increased by more than 400 percent, infant deaths rose fifteenfold, and those physicians that could do so left the country. During the last year of his power, Saddam allocated a total of \$16 million to medical care in Iraq. Even considering the population difference, that is a pittance compared to the \$1.3 trillion spent in the U.S. over the same period.

With that as a backdrop, it is easy to understand the enthusiastic welcome we received from the assembled Iraqis. They said that they would be forever grateful to the U.S. for ending Saddam's regime, and on a number of occasions they referred to us as their saviors. To a certain degree, their expectations were unrealistic. It was difficult for them to understand why they could not simply come to the United States for education and training, and why we could not rebuild their antiquated hospitals overnight. In our discussions we found it necessary to refocus their expectations, not on the largesse of the U.S. but on their need to develop their own vision, their own infrastructure, and their own medical societies to enable them to develop a participatory democracy that would allow them to speak with one voice as their new medical care system, and indeed their new government and society, emerged.

During our stay in Baghdad we were housed in the Green Zone on the banks of the Tigris River, in the largest of Saddam's roughly two dozen palaces scattered around the country. Under the protection of the Eighty-second Airborne and wearing our issued helmets and flak jackets, we never felt personally threatened, although the stresses of living in a heavily armed camp, complete with gunfire just outside the walls, were ever present. We were warned in no uncertain terms not to venture from the Green Zone and told that our protection would cease if we did so. Nevertheless, we did manage to visit the home of a close relative of Assad's for a marvelous feast of native dishes and a glimpse of what life had been like in Baghdad. (Much has since changed, we understand, as most Baghdad residents are afraid to leave their homes.) We also man-

aged a quick tour of Yarmouk Hospital, one of Baghdad's two teaching hospitals. As the recipient of the majority of the city's trauma cases, it is frequently the backdrop for many of the Western press accounts of civilian casualties. The condition of the hospital was, quite frankly, deplorable: dark, dirty, poorly equipped, and teeming with patients and family members. It was reminiscent of a hospital I had once visited in Haiti, the poorest nation in the Western hemisphere. Despite all their travails, however, the physicians were positive about the future.

And so it was that we left Baghdad three years ago, optimistic that we would be returning in the near future to inaugurate the first of three cooperative medical education centers, one in Baghdad, one in the south in Basra, and one in the north in Kurdistan. We bid farewell to our Iraqi colleagues at a dinner in the restaurant of the Al-Rashid Hotel in the Green Zone the evening before we left. Barely three days later, the restaurant was destroyed by an insurgent rocket attack fired from a donkey cart just outside the wall. As we are now painfully aware, the escalation of insurgent activity has destroyed not only a good share of Baghdad but, most probably, U.S. efforts to establish a democracy in that country.

Our medical efforts will continue, however. We have maintained Internet communication with many of the physicians we met during the forum, and several have visited CPMC and been invited to our national specialty meetings. Our plan to establish a teaching center has dimmed somewhat but has not been extinguished. As recently as one month ago, Bud Alpert and five other members of our original group revisited Iraq, this time traveling to Erbil in the Kurdistan north. Free of the chaos and destruction inflicted upon Baghdad, the physicians there are enthusiastic about continuing our cooperative efforts, and we hope to inaugurate that teaching center this spring, complete with Internet learning from CPMC, Massachusetts General, and Washington, D.C. Basra will follow, but Baghdad is another issue. 

NEW SFMS MEMBERS

THE SAN FRANCISCO MEDICAL SOCIETY WOULD LIKE TO EXTEND
A WARM WELCOME TO THE FOLLOWING NEW MEMBERS:

MICHAEL J. DANS, MD
ANNE FUNG, MD
DANNY Y. LIN, MD
GARY A. RUST, MD
DAVID PEIHANG SHU, MD
SCOTT C. SO, MD
MICHELLE THOMPSON, MD

FROM CALIFORNIA EMERGENCY PHYSICIANS:

LUCIA Y. CHEN-LUFTIG, MD
JONATHAN C. HOUP, MD

FROM THE PERMANENTE MEDICAL GROUP:

LESLEY AIKEN, MD
JAMES HARRIS, MD
TING-KUN MARK LIN, MD
JENNIFER PAWLOWSKI, MD
DAVID A. RAPKO, MD
RICHARD R. ROSTON, MD
MICHAEL VOSTREJS, MD

TRANSFERRED FROM ANOTHER MEDICAL SOCIETY:

ROGER ENG, MD
(FROM SAN JOAQUIN COUNTY)

STUDENT:

CHARLOTTE CARLSON
(STUDENT REPRESENTATIVE TO THE SFMS BOARD)

INTERESTED IN SPONSORING A NEW MEMBER?

SFMS has embarked on a New-Member Sponsorship program. Upon approval by the Board or Executive Committee, each new member is assigned a sponsor, an established SFMS member whose primary responsibility is to help the new member become better acquainted with the Society and its benefits. Sponsors are expected to connect at least once with the new member socially (over breakfast or coffee, for example) and to invite the member to at least one SFMS event (such as the Annual Dinner, Legislative Day, Candidate's Night, or a Mixer) during the course of their first year of membership. Sponsors will also be asked to report to the Board on the results of their interaction with the new member. Sponsors are currently drawn from the SFMS Board as well as the Executive and Membership Committees, but *all* members are encouraged to participate in this program.

Contact Therese Porter in the Membership Department at (415) 561-0850 extension 268 or tporter@sfms.org for more information or to volunteer.



A Tale of Telemedicine in Action

A Surgeon Works to Manage Medicine across Vast Distances

Karen Sandrick

At 11:41 a.m. on December 7, 1988, an earthquake measuring 7.1 on the Richter scale mercilessly shook the city of Gyumri in northwestern Armenia, leveling every building taller than three stories, demolishing more than twenty hospitals and clinics, and killing more than two hundred physicians as well as several hundred allied health workers.

Two weeks later, the National Aeronautics and Space Administration of the U.S. (NASA) launched Spacebridge, a telemedicine initiative that would provide expert medical consultation on plastic and reconstructive surgery, physical and psychological rehabilitation, pub-



Dr. Merrell (right) works with an astronaut during ground training before the actual C-9 reduced-gravity research flight to study the effects of microgravity on surgical skills.

lic health, and epidemiology to what remained of the Armenian medical community. And in a matter of days, American-based global communications companies donated free access to uplinks and satellite transponders

for downlink channels in what was then the Soviet Union. A ground station for fax, video, and voice communications—rented from the Stars Company in Houston, Texas—was set up in a command center in Yerevan in the USSR, and ground communication lines were connected to U.S. medical centers so they could coordinate local signals to satellite feeds in Armenia. Over this communication net-

work, more than four hundred physicians and medical personnel from the U.S. and USSR would participate in fifty-one telemedicine linkups, consulting over the next three months on 253 representative cases of the medical

Telemedicine: Then and Now

In its original conception, telemedicine linked a patient and caregiver with a consultant through a two-way video and audio hookup in real time. Although Dr. Merrell and other telemedicine physicians still do that, they also obtain information through sensors that act as a stethoscope or the surgeon's eyes and ears in real-time or synchronous videoconferencing. Telemedicine systems are evolving into electronic question-and-answer sessions that permit flight surgeons to load a question into a data set and forward it electronically to a consultant's server, who responds



In January 2006, Dr. Merrell visits the Telemedicine for Disaster Relief center in Pakistan.

electronically the next day. "This is especially practical when you're covering several time zones and wide expanses of space," Dr. Merrell says.

In store for the future is a software

database that captures the expertise and experience of clinical specialists and makes them available to build clinical skills in flight surgeons on long-term space travels. "Much of current research is aimed at trying to find the instructional devices, the training machines, and the skill simulators that would maintain or refresh or even create de novo a set of credible skills so caregivers on the way to Mars could respond to whatever comes along," Dr. Merrell says. "You can't send an entire medical staff on a spacecraft, but software is so light, you can send an awful lot of knowledge and wisdom."

problems affecting people in the quake-torn countryside.

One of those physicians was Ronald C. Merrell, MD, FACS, who, as vice-dean of the University of Texas Medical School in Houston, gathered a team of physicians together in a television studio to speak via satellite with their counterparts in Armenia about how to restructure the all-but-nonexistent medical system. Dr. Merrell also traveled with NASA to Armenia and Moscow to help set up communications details for the first large-scale, long-term project that would use telecommunications for practicing medicine remotely.

Now, as professor of surgery and director of the Medical Informatics Technology Applications Consortium at Virginia Commonwealth University (VCU) in Richmond, Dr. Merrell continues to work with NASA to explore ways of managing medicine across vast distances.

His work with NASA has taken on projects in the Gobi Desert, the jungles of Ecuador, Kenya, Mt. Everest, and other often-unforgiving earthbound sites to test circuitry and telemedicine communications tools in extremes of temperature and humidity, pounding wind, and driving rain. It allows him to establish electronic networks to improve health care delivery in isolated areas on the borders of civilization here on earth and to monitor the health of astronauts remotely.

Reaching Common Ground

For telemedicine to operate seamlessly so physicians can handle specific medical problems in orbit and manage the health of astronauts and cosmonauts in weightlessness, it must have a common, underlying language. Yet while working in Armenia, Dr. Merrell learned how variably medicine is practiced around our world.

Although the American and Russian health systems arose from the same core scientific base, they have followed diverse paths. "In the days of Pavlov, the world leader in physiology, physi-

cians in this country and in Russia were all working from the same script or from the same set of questions. But with the Russian revolution, we separated from a common scientific background and had seventy years of divergent medical evolution, so some ideas that we didn't believe in became integral to the practice of medicine in Russia, and vice versa," Dr. Merrell explains.

The strict definition of informed consent, which is so strongly followed in the U.S. and Western Europe, is not necessarily the same in Russia and other parts of the world, Dr. Merrell points out: "There are many medical cultures where patients rather expect to be told not a series of options or a menu of things they might do for their condition but to be told by the physician what their problem is and what they're to do about it."

And whereas Russian physicians have great confidence in certain aspects of ancillary care (such as massage therapy) and make them part of academic, scientific, and practical medical care, American physicians tend to lump them in with reflexology and other forms of alternative medicine.

There also are language issues that affect the differences between U.S. and Russian medicine, such as differences in standard units of measure or laboratory values, medical terms, and abbreviations.

Teams of physicians from the U.S., Russia, and Japan, as well as members of the European Space Agency, consequently must consider cultural differences in medical practice as they fashion electronic communication protocols and joint clinical practice principles that govern the way medical care is delivered from Moscow and Houston to cosmonauts and astronauts working on the same space station. "There has been a lot to sort out so that we wouldn't be throwing barbs at one another but would be practicing medicine in a way that was comforting and supportive for the real client, who is a cosmonaut or an astronaut someplace off in orbit," Dr. Merrell says.

Flight surgeons from various countries also have been working together over satellite feeds or in face-to-face meetings to establish a universal approach to on-the-spot, real-time telemedicine consulting. "Space medicine has learned to develop common electronic protocols for communication and a common practice ground. And, in fact, the space program has never had a disruption or a true failure or an impasse in practicing medicine together electronically in the whole history of the shuttle Mir. Actually, that is true for the entire history of the space program," Dr. Merrell says. "Space medicine is a great success story of which we should all be proud. The ability to devise ways of handling specific problems in orbit has grown out of a common practice of medicine through telemedicine in the shuttle Mir and continuation with medical operations on the space station."

Down-to-Earth Test Beds

Sometimes testing electronic and long-distance medical protocols can only be done in space with someone who has to directly confront a problem. But making caregivers comfortable with electronic networks and an electronic continuum can be done in down-to-earth test beds in Russia or Ecuador, on the slopes of Mt. Everest, or on a delta in the Danube in Romania. (A test bed provides a platform for testing concepts and designs before they are implemented.) "We can better understand cultural diversity and patient expectations by handling fifty real diagnoses with five hundred real patients than by speculating around a table about the possibilities that might happen with astronauts and cosmonauts," Dr. Merrell says.

Earth bound test beds also can serve as proving grounds to make sure distance, moisture, motion, and dust don't interfere with telecommunications tools. "NASA can't test everything on spacecraft and space stations. It has to do a lot of ground-based work to look

Continued on page 34...



Making Global Connections

One Organization Attempts to Mend the Disconnect in Disaster Response

Lynn Fritz

Until it was sold to UPS in 2001, Fritz Companies, Inc., a global logistic services company with 11,000 employees deployed across 120 countries, provided supply chain services to more than half of the Fortune 1,000 companies, as well as to hundreds of small, local organizations in every corner of the globe. We ourselves began as a small, local customs house brokerage firm in San Francisco. To achieve success, we had to convince companies to change the fragmented way in which they historically did business.

As we grew, we found that, like most international companies, every year we had at least one office or warehouse, in some part of the world, that experienced typhoons, earthquakes, hurricanes, or other natural disasters. As more and more incidents occurred, it became clear that leaving the safety of our employees and their families to local civil and humanitarian organizations during and after disasters was not meeting our fiduciary responsibilities. We then discovered that virtually no company, large or small, had prepared a collaborative plan with local governments or humanitarian organizations, even in areas where natural disasters were almost an annual event.

Further research disclosed that local governments and even the largest and best-funded humanitarian organizations had not developed standards of preparedness in advance of disasters and had little in the form of outcome measurement. As a result, effectiveness and accountability were anecdotal at best, even as an ever-growing percentage of the world's population was being affected by natural disasters (from 1.6 billion people ten years ago to 2.6 billion today).

The Birth of Fritz Institute

We started Fritz Institute in 2001 as the only nonprofit organization dedicated to the operational effectiveness of the organizations responsible for disaster response. We were not addressing public policy or the development of medicines and vaccines but the internal systems and processes that would enable humanitarian organizations to perform their important



and much-needed mandate in an effective manner. We decided not to compete with such organizations as the United Nations, Red Cross, Oxfam, or Care, but, instead, to help them help themselves. We committed ourselves to making improvements that would benefit all providers and to increasing the efficiency and impact of the whole sector of disaster relief.

We spent another year on research, conducted by a crack body of logistics and business professors from around the world, focusing only on the operational and back-room execution aspects of aid and emergency relief. As a result, we documented that there was

1. No sector wide professional organization or association made up of the operational management of humanitarian

aid organizations;

2. No academic research or case studies about operations;

3. No set of standards of acceptable performance or best practices;

4. No qualitative or quantitative measurements of impact or outcome;

5. No formal training or certificated courses in operations;

6. Little institutional knowledge gained over the past forty years in operational practices;

7. Little evidence of interagency collaboration;

8. Little to no structure for preparation of preventive measures in anticipation of disaster;

9. No third-party body to develop or maintain objective standards; and

10. No specialized operational software available to the sector that encompassed the entire supply chain.

We found these findings to be disturbingly similar to the issues of fragmentation, lack of organization, and absence of standards that faced the medical profession in the early part of twentieth century, before Abraham Flexner's now famous report. The influenza epidemic of 1918 seemed to have had the effect of catalyzing those historic improvements. We hope some of our efforts may result in even a fraction of the results that the medical community has achieved in the ensuing decades.

Building Systems

We began by creating a professional association for the operational and logistics management of the larger humanitarian organizations. During the past five years, it has become the center point for identifying and acting on issues common to the sector.

It has also become the connection between business and academia, which supports and helps professionalize the sector. We have gathered the best logistics, operations, and business systems professors from around the world. We have funded and written white papers about best practices, and we have funded and initiated teaching case studies so that business schools throughout the world could begin to develop a curriculum for interested students. We have also started "Corporations for Humanity," which is an association of top companies that wish to leverage their corporate social responsibility by assisting us in our efforts to invest in preparation and support in advance of crises.

Together with the largest humanitarian institution in the world, the International Federation of the Red Cross and Red Crescent Societies (IFRC) in Geneva, we next created the first humanitarian-focused logistics technology (HLS, or Humanitarian Logistics System). This system was fully operational and in place by the time of the tsunami in 2004, and the IFRC reported being five times more effective in its response because of the software. Headquarter operations, suppliers, donors, and field operations throughout the vast tsunami region were able to get the right medicines and materials to the right places at the right time, with instant communication among everyone involved in the effort.

In late 2006, we completed Helios, a web-based system with most of the features of HLS but with additional flexibility. It can be used by any group, from the smallest NGO on the ground to the largest organization's headquarters. Like all our initiatives, this effort was led by and funded by Fritz Institute but designed and put in place by leaders from the sector, which made up all our beta testers and our users' group.

Humanitarian organizations have long recognized that many of their key operating positions were filled by very talented and well-meaning individuals who had little formal training. There were never enough trained people in time of crisis, and the turnover rate often exceeded 50 percent per year. Therefore there is a need for training throughout the year, and a certifiable standard of competency is critical for the

community. We were asked to develop distance-learning training courses that could be used by any and all organizations in the sector, which we did, working in union with highly competent and experienced personnel from many agencies.

Research and Results

For years, African NGOs have asserted that one of the key reasons for their dreadful lack of results is that most interventions have been designed, financed, and supervised by donors instead of building capacity within Africa and allowing local organizations to take responsibility. To address this long-standing issue, we formed an association of fifteen African Red Cross Societies with the mission to demonstrate competency and build their local organizations into independent and viable entities. In order to do this, every member agreed to take three tests that the Fritz Institute developed, which would prove if they were working to world-class standards or not. Some passed and some failed. The test scores indicate exactly what section of the organization passed or failed, which allows us to get focused, private-sector assistance to shore up the identified weak areas. This association (NEPARC, the New Partnership for African Red Cross Societies), is growing every year and has initiated a sea change in the dynamic between donors and recipients.

In the last two years, two events in the humanitarian sector were equivalent to the epidemic of 1918: the tsunami and Hurricane Katrina. After each disaster, we sent teams to the field to interview thousands of families, thus creating the first research-valid inquiries aimed at the victims. We obtained details of their satisfaction with the humanitarian response and found out what could be done better, from their point of view, so that the community could use these findings and data for future preparedness efforts.

Needs at Home

The universal attention and concern created by these two disasters has brought the humanitarian sector's system weaknesses into full view, creating a strong and ongoing demand for change. Katrina, embarrassingly, woke the United States to the fact that

even in our own advanced country, there are no standards of preparedness and no functioning collaboration efforts among all pertinent players; and that, notwithstanding incredible amounts of effort, good intentions, material, and money, the operating ineptitudes resulted in tragic gaps in the support of the victims, their families, and their possessions.

The results of our research are being requested by parties throughout the world, and we authored an article in the *Harvard Business Review* in November 2006 on how the private sector can be useful in disaster preparedness and response. Based on the success of our activities and the global recognition of our expertise, we are now being asked to consider developing disaster preparedness analyses and standards here in the U.S., so that there would be means of determining preparedness before a disaster strikes. There are many vulnerable sites in this country, not the least of which is our own Bay Area. **sfm**

Lynn Fritz is past CEO of Fritz Companies, Inc., a global logistics service company, and is founder of Fritz Institute, a nonprofit dedicated to global humanitarian operations. Fritz serves on the United States HELP Commission, the World Economic Forum's Disaster Response Network, and the Boards of Directors of Integres Global Logistics, Georgetown University, San Francisco's Exploratorium, and the University of California at Davis' Department of Viticulture and Enology.

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Global Health Diplomacy

A Call for a New Field of Teaching and Research

Thomas E. Novotny, MD, MPH, and Vincanne Adams, PhD

"Medicine is a social science, and politics nothing but medicine on a grand scale."

Rudolf Virchow, the nineteenth-century Prussian physician now recognized as the father of modern pathology, is famous for this aphorism. He espoused that social, economic, and political inequality, more than biological causes, were at the root of the 1848 typhus epidemic in Upper Silesia, Prussia. Only political reforms, he felt, could solve the health crises of his day (Taylor 1985).

The relationship between medicine and foreign relations has a long and complicated history. From missionary medicine to postcolonial efforts to establish health systems, health assistance has been used to help keep armies functional, support some semblance of altruism in colonial governments, and stabilize crisis situations where politics have failed. Politics are often a root cause of health crises, especially in conflict settings resulting in genocide, social violence, and egregious inequality. At the same time, medicine can provide the first steps toward bridging cultural gaps, not only to alleviate human suffering but to defuse international conflict.

This, however, requires political commitment, educational commitment, and resource commitment to maximize the impact of direct humanitarian assistance and long-term development investments. With recognition of the critical interaction between health and foreign policy, today's global health professionals need to be diplomats as well as providers, investigators, and managers. Given the changes in global health wrought by the new philanthropies and by the egregious failures of U.S. diplomacy in recent years, there is hope for a

new approach to global health grounded in sensible, ethical, and informed health diplomacy. This approach requires a full understanding of the political, historical, cultural, religious, economic, and ethical contexts of health assistance and development efforts.

Global Health Diplomacy

This is a field in the making that may provide interdisciplinary training of health professionals to improve delivery of global health services, development assistance, and scientific investigation. Such training will support the U.S. Department of Health and Human Services's call for global public health preparedness, security, and responsiveness, as well as the larger global health community's efforts to grapple with the new resources available in international health philanthropy (Garrett 2007). Recently, the U.S. Public Health Service, in its annual professional meetings, has called for increasing the capacity of public health professionals in the skills of diplomacy to serve as a "bridge for peace and security" (Couig 2007).

Although one can identify historical efforts at health diplomacy in missionary, bilateral, and multilateral health aid, the field of global health diplomacy is still poorly defined. Consider the shifts in international relations and health development that make health diplomacy training and research more important today. These shifts include:

•The Globalization of Infectious Diseases

Although many infectious diseases have always been considered "international" problems (McNeill 1989), there is a shift in

intensity and rapidity of the spread of many emerging and established pathogens (Garrett 1995). These conditions suggest a need for new responses that require cooperative efforts across geographic, political, national, and ethnic borders. The effects of epidemics include unseen economic and human consequences, such as AIDS- and war-caused orphans in Africa or impoverishment of Chinese chicken farmers who eradicate their flocks because of avian influenza. These consequences need to be understood as problems of globalization, with a critical need for global governance to manage not only the biologic threats but also the political and social fallout that accompanies such efforts (Fidler 1996).

•The Emerging Ethical Vacuum

Although there is growing need for institutions capable of assuring ethical decision making at the local and global levels, very few institutions such as this exist in the developing world. Questions over what is fair and equitable (regarding distribution of resources, obligations, health outcomes) are debated but often unresolved (Farmer 2001, Novotny 2006). Other ethical challenges include protection of human subjects and use of newer technologies (stem cell research, genomics, etc.) (Adams 2006, Emanuel 2004). These ethical challenges require the skills not only of scientists but of ethicists who think at the global level. For example, how can we alleviate the "brain drain" of qualified health professionals from resource-poor countries while still attending to health care manpower shortages in the developed world? There are extraordinary needs for equipoise in global health interventions, with complexities extending beyond bioethics to include politics, history,

and economic concerns.

•Nonstate International Assistance

The new philanthropies and non-governmental organizations (the Bill and Melinda Gates Foundation, Rockefeller Foundation, *Médecins sans frontières*, Rotary International, etc.) have altered the traditional missions and relative roles of bilateral and multinational organizations alike in the twenty-first century (Cohen 1999, Garrett 2007). Health professionals must retool their thinking about the relationship between national/state organizations (such as the Centers for Disease Control and Prevention or the U.S. Agency for International Development) and these nonstate organizations. There are also new private-public partnerships, such as the Global Fund for AIDS, Tuberculosis, and Malaria, with unclear accountability patterns and shifting responsibilities that affect national health sovereignty. The field of health diplomacy must explore the new alignments of governance that emerge from these shifts and help define what critical skills are needed to work within these new relationships.

In response to these and other global health developments, we identify three possible areas for emphasis in research and training in today's health science education:

Postconflict Health Assistance

Effective health interventions can serve as a diplomatic tool to reduce violence, inequality, and conflict, no matter how large or small the intervention. Health aid can work where political efforts alone fail. Global health professionals have long understood that in situations of ongoing war, violence, and genocide, health and scientific assistance can improve political outcomes (including nation-building) through both relief efforts and the establishment of good institutional relationships (Jones 2006). Health diplomacy can help create political will for social and democratic reform, especially in the postconflict environment (Adams 1998). Examples of this sort of health diplomacy are numerous (for example, Doctors without Borders, various AIDS advocacy organizations, and faith-based health groups), but there is no

systematic training program that focuses on providing these skills to students in the health professions.

Social Determinants of Health


Training in health diplomacy must address the social determinants of health, providing contextual approaches to politics, history, economics, religion, ethics, and culture needed for successful health intervention programs. Reducing global health inequality requires a clear understanding of these contextual issues and a clear vision of mutuality, instead of antiquated donor-recipient power relationships (Farmer 2004). Health diplomacy identifies the key social and political determinants that play a role in successful health development projects as a basis for success.

Building Global Health Governance

Health diplomacy can promote political solutions as a truly collaborative global effort. Increasingly, there is a need for such political policy-making across nations, regions, and cultural divides for maximum impact on health. Global health objectives have been prioritized as collective activities in the Millennium Development Goals in order to galvanize action by various players (United Nations 2002). An example of this is the L-20 Declaration of 2006, wherein heads of state committed to specific Global Action Plans in health, education, and environment (Bradford 2004). Other recent examples are the Framework Convention on Tobacco Control (the world's first health treaty) (Novotny 2006), the revised International Health Regulations (Fidler 1996), and the Global Health Workforce Alliance (WHO 2006). Global health diplomacy functions within these instruments of governance to solve health problems as multinational alliances of health organizations and governments. However, this cooperative effort must also be understood in the proliferating NGO and private-public partnerships that operate beyond the state and international channels of health governance (Garrett 2007).

Effective health diplomacy requires new pedagogy and research priorities, including perspectives on globalization,

cultural competence, research translation to the developing world, macroeconomics, and political negotiation. The new cadre of students entering health sciences training institutions today will become leaders in our health system tomorrow. As global health professionals with these new skills, we might anticipate improved leadership at the national level, both in international health and in academic research. The results of this new leadership (which we might call the "Peace Corps Effect") will be an emphasis on health diplomacy as a tool to support international stability, reduce conflict, and secure economic development across nations through health cooperation.

In order to further define the field of global health diplomacy, we at UCSF have undertaken a new initiative with support from the Institute on Global Conflict and Cooperation (IGCC) at U.C. San Diego (a multicampus research unit) and the U.S. Centers for Disease Control and Prevention. We will hold a workshop of major international health and diplomacy experts in March 2007, during which papers and discussions will be presented with multidisciplinary perspectives. Based on findings from that workshop, we hope to develop a global health diplomacy training program that may be offered in 2008 through IGCC's summer training programs or UCSF's proposed master's program in global health sciences. There are now many new programs in global health education across the United States, as well as an extensive project to develop on-line educational modules by the Global Health Education Consortium (GHEC 2007). Health diplomacy may be a critical new field to address in all these activities, and, as with all good international health interventions, this effort will benefit from cooperative actions. We invite reader input. 

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Twenty-Five Years Later

The HIV/AIDS Epidemic is Still a Major Challenge in Global Health

Kristin J. Razzeca, MD

This article focuses on current dimensions of the global AIDS epidemic and the need for continued funding for expanded treatment. It also discusses the importance of prevention programs directed to people at high risk for HIV infection. Private foundations have become major financial supporters for these programs in underdeveloped countries and are discussed. Issues relevant to HIV prevention and infection in our own country are presented.

The end of 2006 marked the twenty-fifth year of the HIV/AIDS epidemic. Global statistics released by the joint United Nations AIDS Program (UNAIDS) and the World Health Organization (WHO) in December are alarming.

An estimated 39.5 million people worldwide are currently living with HIV, with 4.3 million new infections occurring in 2006. In that same year, there were 2.9 million AIDS-associated deaths. Among children (less than fifteen years of age), there are approximately 2.3 million infected with HIV, and in 2006 there were 380,000 deaths. The number of newly infected children in 2006 was 530,000.

More than 11,000 new HIV infections occur daily, with 95 percent of these in low- and middle-income countries. Among adults, 48 percent of total infections are in women. Young people between fifteen and twenty-four years of age comprise 40 percent of the newly infected.

Sexual transmission continues to be the primary mode for the spread of HIV in both heterosexuals and in men having sex with men (MSM). However, injection drug-using men less than thirty years old comprise three of four new infections in the Russian Federation. In the United States, 60 percent of newly HIV-infected people are MSM,

and in this population recreational drug use and the use of selective phosphodiesterase inhibitors (Viagra, Cialis, and Levitra) are important factors contributing to transmission. Public health measures to reduce transmission rates must focus interventions on all of these factors to decrease new HIV infections.

The XVI International AIDS conference opened in August 2006 in Toronto, with keynote speakers Bill and Melinda Gates from the Gates Foundation. Bill Gates was optimistic about progress in the fight against AIDS in underdeveloped countries. He noted that the Global Fund, the President's Emergency Plan for AIDS Relief (PEPFAR), and other groups have initiated antiretroviral treatment in 1.6 million HIV-infected people in low- and middle-income countries (as of June 2006). The number of people receiving treatment in these countries has increased fourfold since December 2003. This is a significant accomplishment, although it falls far short of the "three by five initiative" (the hope of having three million people in treatment by 2005), set at the XIV International AIDS Conference held in Barcelona. This represents just 24 percent of the 6.8 million people needing treatment in these countries.

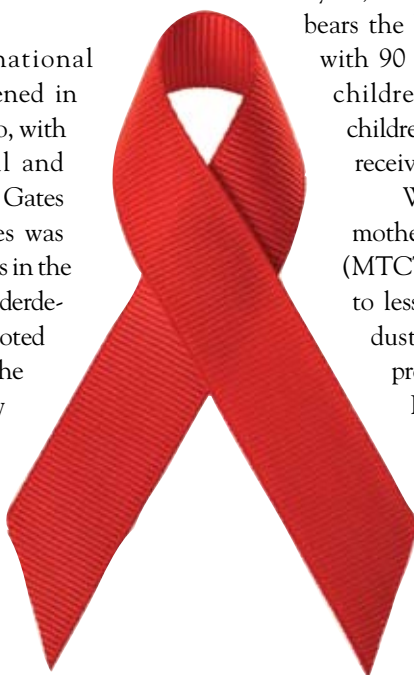
One million HIV-infected people in sub-Saharan Africa, the focal point of the HIV epidemic, were receiving antiretroviral

treatment as of June 2006. This is a tenfold increase from 2003. There has been a less positive result for HIV-infected children in these countries. More than 800,000 children require antiretrovirals (ARVs). However, treatment has been initiated in only 65,000–75,000 children. Africa bears the brunt of the epidemic, with 90 percent of all infected children. Only 8 percent of children needing treatment are receiving ARVs.

With the use of ARVs, mother-to-child transmission (MTCT) rates have declined to less than 1 percent in industrialized nations. Pilot programs treating pregnant HIV-infected women in Botswana, Brazil, and Thailand have been very successful. In the majority of underdeveloped countries, only 10 percent of HIV-infected pregnant women are receiving ARVs to prevent

transmission of the virus to their babies. Limited access to ARVs is also seen in drug users in Eastern Europe and Central Asia.

The goal of universal treatment is not achievable unless prevention of new infections is addressed. The number of HIV-infected people receiving treatment increased by approximately 450,000 per year in the last two years. New infections increased by 4.6 million per year. For every person starting treatment, ten people were newly infected with HIV. Bill Gates showed that a conservative cost estimate for the treatment of those currently infected would



be \$13 billion per year. It is not feasible to treat everyone infected with HIV unless we reduce the new infections that are occurring. He concluded, "Treatment without prevention is simply unsustainable."

Mr. Gates remarked on the promising results of recent studies documenting decreasing HIV transmission through male circumcision. The limitations of the

ABC prevention program (abstain, be faithful, and use condoms) are especially evident in underdeveloped countries, where social disadvantages for women are more prevalent. He stressed that women should be given more resources to prevent HIV, thereby protecting them and their unborn children. He called for more research and clinical trials on microbicides and ARVs that could be used as prevention drugs.

Melinda Gates focused on prevention as well. A vaccine is being sought aggressively and the Gates Foundation is funding this research heavily. An efficacious vaccine that can recognize and protect against the many different clades (subtypes) of HIV remains elusive. She emphasized the need for preventive tools that will become available quickly. Three major candidates for effective microbicides are already in advanced trials. One of these trials had to be discontinued recently when the microbicide failed to prevent HIV infection. These gels and creams are odorless and can be used vaginally and/or rectally. They can be used by women without a partner's knowledge, allowing a woman to protect herself from infection. Oral prevention drugs are also in trials. Melinda Gates emphasized the need for increased clinical trials.

Many people at highest risk for HIV infection do not have access to prevention programs. These programs include availability of condoms, clean needles, education, and testing. Limited access is often secondary to the stigma associated with HIV and with certain populations, such as commercial sex workers, MSM, and drug users. Melinda Gates stressed that to control the

epidemic we need to include disenfranchised groups in clinical trials and ensure they have access to existing programs. She suggested, "Let's agree that every life has equal worth, and saving lives is the highest ethical act.

If we accept this, then science and evidence—untainted by stigma—can guide us in saving the greatest number of lives."

There have been successes in

countries that have focused their prevention programs in high-risk populations. In recent years there has been a decline in HIV transmission among young people in Botswana, Kenya, Malawi, Rwanda, Tanzania, Cote d'Ivoire, and Zimbabwe. Prevention programs have promoted condom use, fewer sexual partners, and later age of initial sex. Favorable behavioral changes are occurring in these countries. Infection rates decreased by 30 percent among IV drug users in Portugal following an HIV-prevention campaign coupled with a clean needle exchange program. Increased condom use in China has demonstrated a decline in sexually transmitted diseases, including HIV, in commercial sex workers. Prevention programs should be sustained to mitigate new infections. A resurgence in HIV infections in Uganda coincided with the discontinuation of funding for prevention programs.

Less positive trends are seen for MSM in countries where programs have not addressed issues for gay men. In Latin America, China, Cambodia, India, Nepal, Pakistan, Thailand, and Vietnam, there has been a surge of new HIV infections among gay men. In the Russian Federation, HIV is increasing at an alarming rate among IV drug users. Prevention programs must direct their efforts toward people at high risk for infection. Individual countries need adequate surveillance programs to determine where to focus their efforts. Dr. Peter Piot, UNAIDS executive director, stated, "Knowing your epidemic and understanding the drivers of the epidemic, such as inequality between men and women, and homophobia, are absolutely fundamental to the long-term

response to AIDS." Melinda Gates closed her remarks in Toronto urging AIDS activists, governments, health care workers, pharmaceutical companies, and researchers to collaborate and strive for new preventive tools and to ensure that people at highest risk for infection have access to currently available programs.

Foundations are now a major source of funding to help control the AIDS epidemic. The Bill and Melinda Gates Foundation awarded 165 investigators from nineteen countries a total of \$287 million to concentrate on vaccine development. The Gates Foundation has given an additional \$500 million over five years to the Global Fund to Fight AIDS, Tuberculosis, and Malaria. It is funding Avahan with \$200 million to initiate HIV education and prevention programs in India, focusing on commercial sex workers, MSM, and women. The Foundation gave \$50 million to ACHAP, a national HIV/AIDS treatment and prevention initiative in Botswana. Microbicide research is heavily funded by the Gates Foundation. It is a main source of funding for CREATE, a consortium that is conducting studies on multidrug-resistant TB in HIV patients. The Foundation has committed more than \$6 billion in global health grants, including immunizations for children, malaria vaccine research, and treatment for visceral leishmaniasis.

The Bill Clinton Foundation recently announced agreements with Cipla Pharmaceuticals and Ranbaxy Laboratories to supply a child-friendly three-in-one tablet (coformulation of the antiretrovirals lamivudine, stavudine, and nevirapine) for \$60 per year per person to underdeveloped countries. The Clinton Foundation has also negotiated a 45 percent reduction in price from the lowest rates currently available for nineteen additional pediatric formulations of ARVs going to sixty-two countries. The Clinton Foundation HIV/AIDS Initiative (CHAI) has teamed with UNITAID, an international drug purchase facility established by France, Brazil, Chile, Norway, and the United Kingdom, to expand HIV treatment for 100,000 children in forty countries. UNITAID funds will also supply laboratory instruments and tests for HIV diagnosis and monitoring for these children. CHAI is

"There have been successes in countries that have focused their prevention programs in high-risk populations."

working with the Gates Foundation to expand pediatric programs, focusing on ARVs, basic health care, nutrition, and educational support for HIV/AIDS orphans.

Similar issues regarding prevention, education, and limited access are present in the United States in inner cities and disenfranchised populations. A disproportionate number of African Americans, male and female, are newly HIV-infected. African Americans comprise more than 50 percent of new HIV infections but represent only 15 percent of the U.S. population. The National Minority AIDS Council (NMAC) published an analysis detailing the complex social and economic factors that fuel the African American AIDS epidemic. Recommendations addressing these factors include eliminating discrimination against African American gay males; focusing on HIV education, prevention, diagnosis, and treatment programs; evaluating the role the prison system plays in the epidemic; and reducing injection drug use. They also promote strengthening communities with additional funding for education and affordable housing.

Mother-to-child transmission (MTCT) rates declined dramatically with the introduction of AZT, and they continue to decrease to less than 1 percent with ARV

use in industrialized nations. A recently published report (Echezona E. Ezeanolue, MD et al., *The AIDS Reader*, Vol. 17, No.1, January 2007) presents four cases of MTCT occurring in Las Vegas from October 2005 to June 2006. Several issues were discussed, detailing the failure to reach women of childbearing age with HIV education, prevention, and treatment programs. A major problem is lack of HIV testing and lack of knowledge of HIV status. It is estimated that a quarter of the 1.2 million HIV-infected people in the U.S. are unaware of their infection. The number of HIV-infected women giving birth is between 6,000 and 7,000 annually. Forty percent of these women do not know their HIV serostatus. The majority of these women do not seek prenatal care. The CDC has finally addressed this issue by recommending routine HIV screening in people ages thirteen to sixty-four. This would result in earlier appropriate care,

counseling on safer sex practices, initiation of ARVs when needed, and careful monitoring for pregnant HIV-infected women. The

“The AIDS epidemic is not showing signs of abating, although progress is being made. We need to concentrate aggressively on education and prevention to curb the epidemic while expanding treatment to those already infected.”

CDC broadened recommendations for reducing MTCT by suggesting repeat third-trimester HIV testing for women considered at high risk for infection and living in areas with a high prevalence of HIV. Hospitals should have established

protocols for use of rapid HIV testing for women presenting with unknown status at the time of labor and delivery. An accurate and early diagnosis of an HIV-exposed infant as actually being HIV-infected requires appropriate laboratory testing. This includes the HIV DNA PCR test (polymerase chain reaction, a blood serum viral load test) performed at birth, at four weeks, at eight weeks, and at four months. Pediatricians should be educated to recognize signs of HIV infection in infants and to involve

Continued on page 41...



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On the Frontline

San Francisco Physicians Serve as Primary Sources for Disease Detectives

Sandra Haung, MD

Editor's Note: As ease of travel around the globe increases, so does the ease with which diseases spread from one area of the world to another. In this issue, themed "Global Medicine," we at SFM thought it appropriate to include information from the SFDPH on how San Francisco is prepared to deal with such new diseases, and what practicing physicians need to know in order to identify and report suspicious cases.

The tip of the outbreak iceberg could be the patient in your office—the source or the victim of an epidemic affecting tens, hundreds, or even thousands of people in San Francisco and around the world. Whether you are a primary care provider or a subspecialist, office-based or hospital-based, a pediatrician or a geriatrician, you may give public health investigators the critical clue to detecting or preventing an outbreak—if you call us. (415) 554-2830—that's the number to call, twenty-four hours a day, 365 days a year, when you suspect an outbreak or a communicable disease that is unusual, severe, or highly infectious. It's also the number to call to notify us of an urgently reportable disease. Your call activates an immediate response by the San Francisco Department of Public Health Communicable Disease Control Unit (SFDPH CDCU).

Outbreak Detection: The "Tipsters" Network

The most effective outbreak detection system is comprised of clinicians making early reports to SFDPH CDCU. Clinicians are legally required to report more than ninety diseases to Public Health (find the list at www.sfdph.org/cdcp). Laboratories are excellent and reliable "tipsters," but they are legally required to report only a subset

of approximately twenty-five diseases. Lab reports do not replace clinician tips, since clinicians have key data that don't come with a lab report, such as the patient's address and phone number, symptoms and signs, exposure history, treatment, and employer and emergency contact information. Sometimes we receive tips from a member of the public whose family and/or associates become ill after attending a common event. Schools, preschool programs, long-term care facilities, and assisted living facilities may report outbreaks of gastrointestinal or respiratory illness. Family members of children or elderly persons who attend these facilities may also contact us about rumors of cases or outbreaks of communicable diseases.

Though media reports have highlighted new data mining systems that detect statistical deviations from baseline patterns of emergency room visits or over-the-counter drug sales, the usefulness of these systems—the positive and negative predictive value of a statistical "alarm"—is still unknown and under study. In contrast, there are many examples of outbreaks being detected by an observant clinician reporting an unusual pattern to public health authorities. For example, the observation of unusual clusters of cases of Kaposi's sarcoma and pneumocystis pneumonia occurring in young, previously healthy men led to the recognition of Acquired Immunodeficiency Syndrome in 1981; the reporting of several encephalitis cases in combination with wild bird die-offs in New York City led to the detection of West Nile Virus in North America in 1999; and the report of possible anthrax meningitis in Florida uncovered the anthrax outbreaks of 2001. Please tip us off early and as often as you think necessary about potential outbreaks or urgent and

severe communicable diseases. HIPAA does not require you to obtain patient consent to disclose information to health authorities who are conducting a public health investigation. SFDPH maintains the confidentiality of protected health information to the full extent required and permitted by the law.

Global Cast of Bad Actors

The SFDPH CDCU regularly responds to cases of disease that can cause outbreaks or may be related to outbreaks occurring elsewhere in the nation or the world. Some of the diseases are familiar to San Francisco clinicians, such as salmonellosis, shigellosis, *E. coli* O157, pertussis, amebiasis, meningococcal infection, norovirus, influenza, and hepatitis A. Other less common diseases more often originate from other countries, e.g., typhoid fever, cholera, dengue, or leptospirosis. In a city filled with international visitors, residents who travel globally or have immigrated from around the world, and imported goods, the distinction between domestic and foreign sources of outbreaks is perhaps irrelevant. A case of disease brought to our city—meningococcemia in a returnee from the Hajj, or norovirus in a cruise ship passenger—can easily be propagated domestically.

In addition to the diseases that spread rapidly and cause sudden, dramatic increases in cases and deaths, SFDPH is also tracking a more insidious outbreak that affects our community: chronic hepatitis B. This is truly a global disease that follows human migration patterns. More than 30 percent of San Francisco residents were born in countries where chronic hepatitis B infection is endemic and so may be at increased risk for the disease. Sixty-one percent of foreign-

born San Franciscans (175,302/285,541) counted in the 2000 census were born in Asian countries where hepatitis B is highly endemic and where infection may have been acquired at birth or in childhood, leading to a much higher risk of chronic infection. Fortunately, chronic hepatitis B is detectable, treatable, and preventable. This year, SFDPH will be partnering with health care providers and organizations and community groups to support the goals articulated by the SF Board of Supervisors and the SFDPH Health Commission: to screen and vaccinate San Franciscans of Asian Pacific Islander background, and to improve public and provider awareness of screening and prevention guidelines. SFDPH has separate programs to track, investigate, control, and prevent tuberculosis, sexually transmitted diseases, and HIV/AIDS. Contact information for these programs may be found at www.sfdph.org/cdcp.

The Disease Detectives

SFDPH's core team of disease detectives is staffed by disease control investigators, health workers, and epidemiologists with many years of experience in interviewing clinicians, cases, and contacts. Physicians with training and experience in epidemiology and communicable disease control guide and provide consultation to the team, particularly in investigating and managing outbreaks and urgent cases. A physician takes calls at night and on weekends and holidays and can be reached at (415) 554-2830 to receive and respond to urgent reports of disease or outbreaks. Expert microbiologists and virologists at the SFDPH Public Health Laboratory provide specialized diagnostic support for investigations, and an infection control nurse and physician provide consultation for development of infection control recommendations to control outbreaks. SFDPH Environmental Health inspectors conduct special inspections of food-handling establishments that are implicated in food-borne outbreaks and work closely with CDCU to generate and investigate hypotheses regarding the cause of such outbreaks.

Investigate, Control, Prevent

SFDPH CDCU's disease investigation

team will follow up with the patient's health care provider to confirm the diagnosis. They may ask about symptoms, signs, other diagnostic tests, treatment, and known contacts to the patient. They will also interview the patient to find out about exposures and risk factors for acquiring the infection, their occupation, and the contacts to whom they might have transmitted the disease. For some diseases (e.g., norovirus, avian influenza A [H5N1], pertussis PCR, measles PCR), we may request specimens for specialized confirmatory testing by the Public Health Laboratory (PHL) network, especially when these tests are not available through commercial clinical labs. Testing by the PHL is not for individual patient diagnostic purposes but is an epidemiologic tool for outbreak identification and management. When PHL testing is needed, the disease investigation team will coordinate specimen collection and transport with the patient, clinician, and labs.

As part of the investigation, we will also look for cases. In a defined setting such as a catered private party or a long-term care facility, this may be simple. However, for outbreaks caused by a widely distributed product or an exposure at a large public event, the cases must be located with the help of the treating clinicians. If you are signed up to be in our Health Alert Network Database (HAND), you will receive a faxed health alert that describes the situation, how to recognize and report cases, how to prevent disease transmission through infection control practices, and recommendations for preventive antibiotics or vaccinations. If you aren't already part of HAND, you can sign up on-line at www.sfdph.org/cdcp (click on the Health Alerts quick link on the left side).

If an outbreak appears suddenly, with a dramatic increase in cases, and it appears to be from a common but unknown source rather than slowly spreading through a community, a special investigation may be needed. In these situations, CDCU epidemiologists will rapidly set up a case-control or retrospective cohort study to identify exposures that are significantly associated with disease. Once the source of an outbreak is identified through the investigation, the CDCU will make recommendations

to control the spread of disease and stop the outbreak. Tools and strategies that may be recommended include isolating an infectious case at home or in the hospital, implementing infection control precautions in the home or hospital, and identifying and locating contacts to the case to ensure that they receive preventive antibiotics or vaccines. If necessary, the team will go out to restaurants, day care centers, assisted living facilities, and homes or shelters to assess the situation, find contacts, or determine how to tailor disease control recommendations to the site.

For some diseases, SFDPH is required (by law or by standard of public health practice) to officially restrict the activities of persons who are in certain Sensitive Occupations or Situations (SOS) until they are no longer infectious. Examples of people in SOS are food handlers, health care providers, caretakers for the elderly, or children in day care settings. In specified situations, SFDPH must show that the person is no longer infectious by conducting microbiologic "clearance" examinations of the stool or other bodily fluids at the Public Health Laboratory. We recognize that this process may be inconvenient for individuals, families, and employers, and we take these actions because they are either explicitly required by law and/or are prudent to prevent morbidity in the community. We work with our lab and with the persons being restricted to make the process as efficient and as minimally burdensome as possible. We ask for your patience and support if we need to restrict you, your staff, or your patients.

Last but not least, prevention: We counsel cases and contacts about how to avoid or minimize their risks for contracting disease. Where a vaccine is available, we recommend it. If an outbreak is related to a food establishment's practices, our Environmental Health Inspector colleagues will provide recommendations and instructions on how to correct deficiencies.

Please contact us if you have questions and please report communicable diseases and outbreaks! Call (415) 554-2830, fax us at (415) 554-2848, or check our website at www.sfdph.org/cdcp. We look forward to working with you to protect the health of San Franciscans. 



An International Perspective

A Conversation with Philip R. Lee, MD, about Health Care Access and Reform

Steve Heilig, MPH

Philip R. Lee is one of the most widely known statesmen of American medicine and public health. Trained as an internist at Stanford, he has been Chancellor of UCSF, twice a United States Assistant Secretary of Health, chair of the federal Physician Payment Review Commission, the first President of the San Francisco Health Commission, founder and director of the UCSF Institute for Health Policy Studies, and a dedicated teacher as a longtime professor at both Stanford and UCSF. Author of many books and articles and recipient of numerous prestigious awards, he is also Chair of the Collaborative on Health and the Environment, a national network founded at the SFMS.

Steve Heilig: *Health systems reform, with a focus on universal access, is now back in the news on the local, state, and national levels. Why do you think that is?*

Philip Lee: I'd say it's for at least three reasons. Costs are driving more and more people out of having access to insurance, and thus they get less care and worse outcomes. Kids without access is a closely related issue, with more attention to that at the present time. The 1996 Budget Reconciliation Act has now provided a decade of experience with what can be accomplished in covering kids through the State Child Health Insurance Program (SCHIP). Finally, there are cycles: With the extended failure of the federal government to provide coverage, we saw individual states trying to step up and fill that gap many years ago—as Justice Brandeis described, states are “the laboratory of democracy.” Some states, like Iowa and Minnesota, are already ahead on this. Now we see California and Massachusetts, for example, moving forward or hoping to move

forward. Polls show that Americans support universal coverage and politicians are taking note of that in various ways.

The last truly sweeping reforms were



Medicare and Medicaid, forty-two years ago. You were very much involved in those reforms, and I wonder how you look at those programs now—with pride, worry, or both?

I can't really take credit or blame for these programs, as I was still a general internist and geriatrician practicing at the Palo Alto Medical Clinic when they were developed. While Medicare (the King-Anderson Bill at the time) was being considered after Kennedy's election, I moved to Washington, first joining the Agency for International Development, then DHEW in 1965. I was first recruited to be Assistant Secretary of Health in 1965, when the programs were already approved by Congress.

In terms of the number of people covered, obviously they are doing a very good job. The scope of benefits is more mixed—when they added prescription

drugs, for example, it was a flawed benefit. Putting the issue in the hands of pharmaceutical and insurance companies without the benefit of direct negotiation and with no formulary requirement is a big problem. The hospitalization benefit is quite good, but the biggest problem is in how Medicare reimburses physicians—over time, primary care reimbursement has lagged far behind. The whole process is dominated by specialists, and Congress has got to do something in recognition of the fact that primary care is still the foundation of medical care. In some countries, primary care is paid at a higher level than specialists.

But I would say that my most important contribution to Medicare was probably the desegregation of hospitals following the start of the program—discrimination was a huge problem prior to then.

In your SFMS membership file is a 1965 report on a debate where you took on the then-President of the AMA as he derided Medicare as “socialized medicine.” Now the AMA fights to preserve it. Many people note that irony, and the fact that while the AMA was fighting a specter, the businessmen sneaked in and really hit medicine hard—with “managed care” and all that.

Well, clearly the principal financial beneficiaries of Medicare have been hospitals and physicians. If you look at incomes, specialists in particular were well reimbursed by Medicare. The current AMA perspective reflects that flow to physicians, even with the problem of oppressive regulations, some of which were unfortunately needed due to abuses and inferior care.

You're currently teaching a course on

international health systems at Stanford, and you have traveled all over the world to look at how things are done. How does the U.S. compare with other Western nations in terms of health care access?

Again, back when the AMA was attacking Medicare, they pointed to the British system as representing the end of the world. Yet country after country—France, Germany, Canada, Japan, Israel, Italy, the Scandinavian countries, and, more recently, Korea and Taiwan—have set up national systems in various ways, either incrementally or in a more sweeping way. In Europe, the systems are based upon values of mutual aid—the healthy take care of the sick. More than a hundred years ago, Bismarck and others developed the notion of solidarity, where the rich pay for the care of the poor, and the care is provided on the basis of need. That solidarity is being somewhat eroded in Europe now, but each country still has some sort of system based upon the solidarity principle.

The slogan I used to hear was that the U.S. is the only Western nation, other than South Africa, without universal coverage. Is that still true?

The developed Western democracies—we can leave Russia out, for example—all have some form of universal insurance, yes.

And how do they compare in terms of cost?

On average, they spend about half of what we spend, give or take some percentage, on a per capita basis. The leading journal *Health Affairs* reports on this annually. We spend about double that of any other country.

One of the counterarguments made to comparisons with Canada, for example, is that they don't spend the amounts we do on research, for one thing.

Actually, there is lots of research done in Canada, and again, on a per capita basis, they spend as much on real research as we do. Much of U.S. research is actually paid for by drug companies, and they charge more

here to pay for that. And of course that industry actually spends more on marketing than on research as a whole—and much of their so-called research is really research on “me-too” drugs, which is more a form of marketing a copycat drug than truly developing something new.

What can you say about health outcomes in a comparative sense?

By just about any ranking, we rank low; we are below Japan and most OECD countries—in infant mortality we are down around twentieth among these nations; in term of life expectancy we are below countries like Canada, Great Britain, Germany, France.... Now, you can say that once you get over the age of sixty-five, our life expectancy is higher than in some of those countries, but some epidemiologists would counter that this is because so many of the less healthy people have died off already.

So why don't we have any such universal system here?

We have at least two strong characteristics at play—one is a distrust of authority, including government. Recall that in the attacks on the Clinton proposals, antigovernment sentiment was a strong component: “Do you want your health care to be like the Postal Service?” and so forth. The other is a very strong streak of American individualism, so that this notion of solidarity has never taken hold in this country. And our pluralistic system is dominated by special interests, which contributes to the kind of corruption we've seen exposed lately. All these factors make it very difficult for us to institute any kind of universal access system here.

What might be the way to best overcome those factors and concerns and achieve universal access here?

One option is some sort of Medicare for all, which could avoid some of the economic issues, as you'd save huge amounts of money by lowering administrative costs if you did it right. But if you do simply that expansion of coverage, you'd still have the dysfunctions of our system—the gross inequity of payment


between specialist and generalists already mentioned, the lack of care for chronic diseases, and so on. Another option is “pay or play,” which gives individuals more choices but requires much government regulation as well. A third option is an individual mandate—everybody has to be insured, like members of Congress are—funded via a value-added tax. These will all be debated heavily over the next five to six years, and I think we will come to a decision and ultimately have universal insurance.

So would you agree that this is not a question of technology, or even cost, but ultimately one of political will?

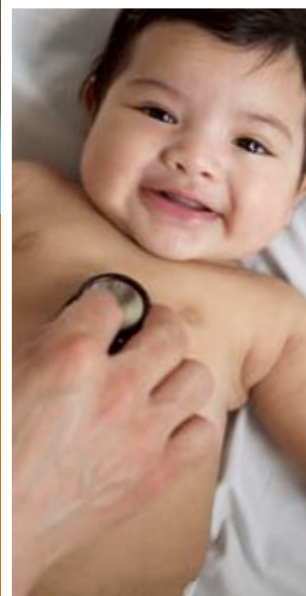
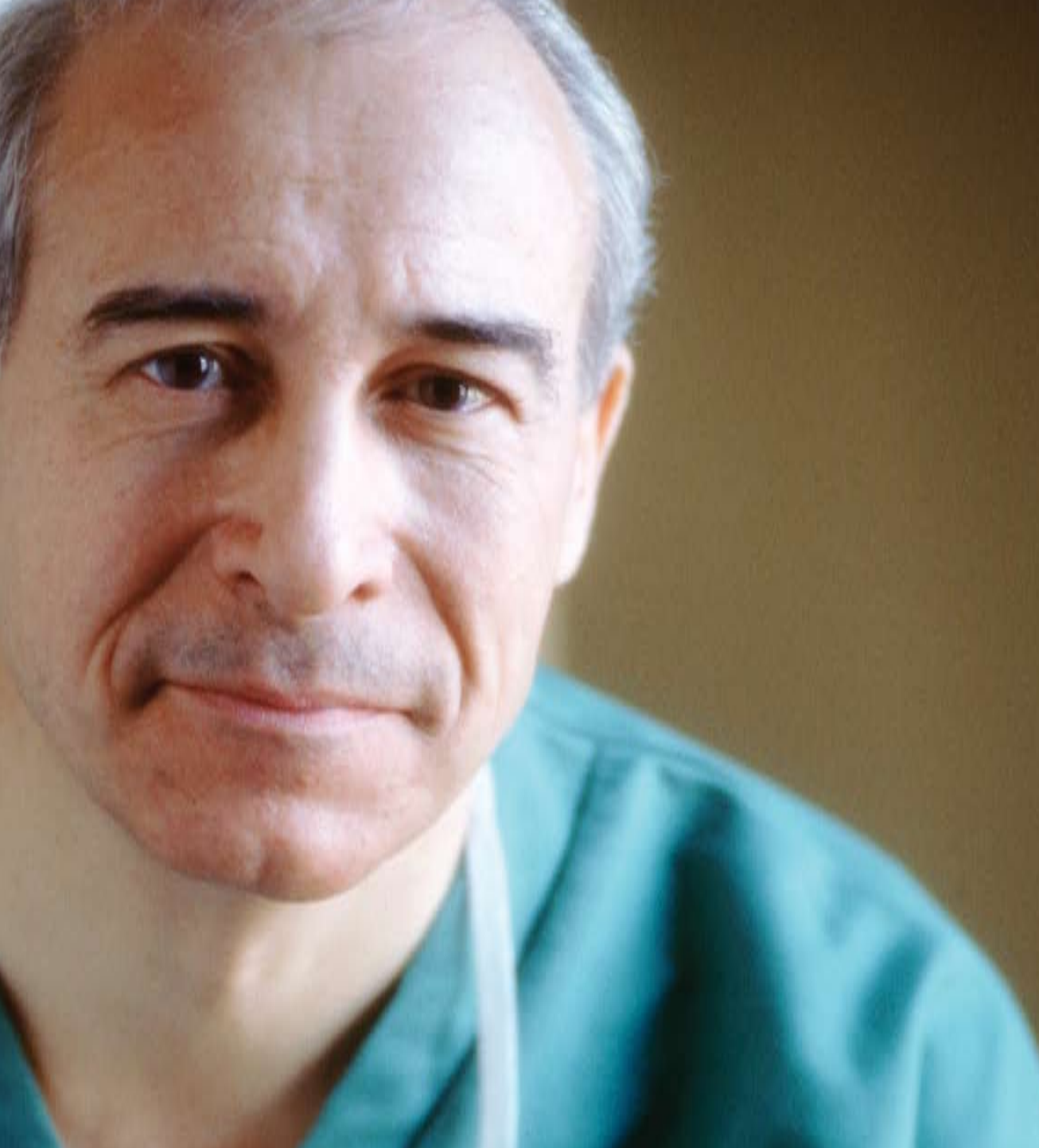
Yes. And the question underlying that is whether we can align our values with the objectives of getting some level of health care to every American.

Finally, What do you think of the President's just-announced approach to health reform, focusing on tax breaks and health savings accounts?

First, it is important that he put the uninsured on the agenda in his State of the Union address. People will have to take it seriously, at least for awhile. There's really nothing new in there, but the thing most likely to move might be approaches to covering kids. And that's very important, as if we can take that step nationally, it would be a big one. As for HSAs, those appeal to certain people, but but it simply is a way for more affluent to spend their healthcare dollars and will have little impact on the real issues. It should also be noted that his proposals are more limited than what's already been accomplished in some states, and what's been proposed in California and Massachusetts. Clearly some support for these ideas will come from the business community—which means lobbyists will push it and congress will have to address it at some point.

Second, the democrats have already suggested that his proposals are dead on arrival, which is fairly typical of opposition party responses to Presidential State of Union addresses. So we'll just have to wait and see how the politics play out, as usual. 

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Tracking a Killer That's Deadlier by the Day

The Epidemic: A Global History of AIDS

By Jonathan Engel

SMITHSONIAN/COLLINS; 388 pages; \$28.95

This very ambitious book is full of both memories and warnings. Coming at the twenty-fifth anniversary of the first reported cases of AIDS in the United States, it is a timely, useful, one-volume compendium of the major events and controversies of the most covered and feared, if not most lethal, new disease to arise in modern times thus far.

For those who lived in places where AIDS struck hardest, especially in the early years, *The Epidemic* might provoke many flashbacks, most of them unwelcome. Engel, a Harvard- and Yale-trained medical historian, has done much digging into media reports, medical literature, and the archives of former presidents and others to provide a largely chronological recount of the spread of HIV and the suffering and controversies it engendered. Both at the time and in retrospect, even a partial list of those battles is overwhelming:

Where did the epidemic begin? Who really discovered the virus? Did someone sinister, even the CIA, "invent" it to kill certain kinds of people? How did the virus spread? Does it spread among heterosexuals as easily as among gay men and needle users? What "bug" causes it? Can mosquitoes spread HIV? Who should be tested, and should they have a choice in the matter? For those infected, what restrictions on their lives are warranted? Can HIV-positive kids endanger other students in schools? Should gay bathhouses be closed as public health hazards? Should HIV-infected people be tattooed to warn others, or even quarantined? Are HIV-infected health professionals a risk to patients? Should we distribute clean needles to interrupt the spread of HIV, or will that encourage drug abuse? Are health and other government authorities doing enough about it? Is the whole HIV model a scam? What should be done about prostitutes and those who expose others? Do condoms and sex education really help stop HIV? What drugs or other treatments work? How much is fair to charge for them? Should the testing of new drugs be sped up to get them to patients faster, even if that might be more risky? What is really happening with AIDS in the developing parts of the world? Will a vaccine ever become available? Has the epidemic peaked or leveled out?

Many of these questions have been answered sufficiently to satisfy most informed people, but some have not. In retelling and summarizing each controversy, Engel strives for some sense of balance among competing advocates, whether they are gay-oriented groups such as Act Up; right-wing and fundamentalist ideologues such as Jesse Helms, Lyndon LaRouche, Pat Buchanan, Charles Krauthammer, or William F. Buckley (who seriously proposed the tattooing); and the many scientists and doctors often

caught in the middle. Engel also seeks to assess the records of the leading politicians of the time, such as Presidents Reagan, Bush, Sr., and Clinton, and concludes, for example, that "in the end, Reagan's record on AIDS was middling to poor." That is hardly a stellar review, but also far from the charges of genocide by neglect leveled at Reagan at the time.

Engel often prefaces his conclusions with such phrasing as "the truth was more ambiguous" or "in fact, proponents on both sides of the issue were getting their facts wrong." His moderate conclusions may offend some who spent so much time and effort in these arenas, but Engel's research and perspective are sound, even if he occasionally lapses into equating HIV with AIDS in writing that people "catch AIDS." But that's a quibble with what is, overall, an astute and balanced review of a tremendously complex and emotional realm. Even though there are now more than one million Americans living with AIDS, the epidemic seems to have peaked overall in the United States. Engel writes that by the end of the 1980s, "through community-based initiatives, self-policing, and expansive educational efforts, the gay community had practically stopped AIDS in its tracks," although he later notes that some minority groups and drug users have been slower to stop the spread, and that with a new generation of gay men, some backsliding on preventing transmission has occurred.

But in the developing world, it's an entirely different and far more harrowing story. And the latter part of the book details the continued spread of AIDS, to the point where it is responsible for shocking declines in life expectancy in entire nations. Engel is not optimistic, even as masses of money belatedly flow to those stricken areas. "The West faces a conundrum. Having essentially solved its own AIDS problem, it now faces a humanitarian disaster produced largely by the countries in question."

Engel's writing is clear if workmanlike, and he allows for some more elegant reflections only at the end of his book. "Like most natural disasters, AIDS teaches no obvious lessons and lends itself to no glaring moral pronouncements," Engel concludes. Yet many readers may draw their own conclusions from this book, which itself might become a landmark in the vast literature on the AIDS epidemic—a story that, in a global sense at least, probably has just begun. **sfm**

Steve Heilig, MPH, is on the staff of the San Francisco Medical Society and is coeditor of the Cambridge Quarterly of Healthcare Ethics.

This review originally appeared in the San Francisco Chronicle on September 11, 2006.

at the reality of resources and need and create the software and the education that can be quickly adapted to a novel situation," he explains.

Dr. Merrell and his colleagues in telemedicine consequently have traveled to the Gobi Desert and the grasslands of Kenya, to the sites of Hurricane Katrina and earthquake-ravaged Pakistan to find out the limits of information management and clinical skills of medical personnel when they're suddenly separated from their central information sources and have to put communications networks back together serially.

"Getting a system to be intuitive so someone with common sense can use it is a huge challenge in computing and in technology. People who work in information, as I do, can sit around a laboratory and make it seem that almost anything will work. Where it gets interesting is when you take a database or a computer interface or a telecom protocol to someone who is actually trying to practice medicine and make it helpful so they can use it," Dr. Merrell says. In addition to cost, Dr. Merrell and other telemedicine physicians examine the ease of use of a device or a protocol in the real world. "For a technical advance in information or robotics to be practiced and adapted, it has to have a certain degree of utility so people can practically afford to use it," he explains.

Working in the test beds has allowed Dr. Merrell to collaborate with practicing clinicians and find ways for technology to overcome isolation. Ecuador, for example, is an ideal test bed for telemedicine because health care facilities and clinicians are not mobile. Paved roads are only now being built in many parts of the country; air transport is haphazard and expensive; and ambulances, if they exist, are in disrepair. "In Ecuador, NASA figured out how we can use telemedicine and telecommunications to manage medical situations in faraway places but also to support humanitarian projects in provinces on the border of the jungle where the road ends," he said. *(sfm)*

This article and its sidebars and photos were reprinted with permission from the October 2006 Bulletin of the American College of Surgeons, Volume 91, Number 10.

Trauma Care in Ecuador

As part of his work with NASA, Dr. Merrell and a team of surgeons from Virginia Commonwealth University have built a telemedicine outpost in Sucua, Ecuador, consisting of a mobile unit equipped with cameras, computers, and telecommunications linkages that could bring diagnostics and treatment expertise to villages in the Amazon basin that can be reached physically only by small planes or canoes. Dr. Merrell also has proposed

a trauma program that may cross-fertilize NASA space medicine projects by adapting Advanced Trauma Life Support® (ATLS) and Advanced Life Support® (ALS) to microgravity, just as he modified trauma training in Ecuador to match the environmental challenges of the jungle.

In 2003, Dr. Merrell and Michel Aboutanos, MD, an intensivist and trauma surgeon at VCU Medical Center, created a trauma training program for Ecuadorian physicians that was geared to the injuries they see—snakebites, motor vehicle crashes, and machete wounds. The course built on the resources in the country, beginning with distant health posts that are little more than huts staffed by a medical resident or nurse auxiliaries and equipped with bamboo sticks for splints, ham radios for emergency communications, and donkeys for transporting patients along paths cut through jungle underbrush to grass airstrips just long enough for a small fixed-wing aircraft to land. And it included so-called subcenters of health, or one-floor clinics, sometimes housing aged and broken-down X-ray equipment, and provincial hospitals with ambulances and hit-or-miss X-ray units sitting idle because no one knows how to repair them.

"We pretended we were the patient and followed the entire pathway across the health system, starting in the jungle to see where patients were injured, what kind of care they get, how they are transported, and what kind



Dr. Aboutanos teaches chest tube insertion to general practitioners in the open jungles of Ecuador.

of communications they have—and it was eye-opening," Dr. Aboutanos says. It takes most trauma patients eight to twelve hours to get to the hospital. Sometimes patients walk six hours just to get to a road, or they bleed to death before they get out of the jungle.

Based on a formal assessment of each site, Dr. Abou-

tanos and lecturers trained in ATLS and ALS (from VCU and from the local Ecuadorian Universities of Azuay and Cuenca) planned lectures and live patient scenarios, teaching clinicians in some areas how to insert a chest tube and in others how to create a Heimlich valve or how to use an endotracheal tube instead of a chest tube to evacuate a pneumothorax or hemothorax. Rather than concentrate on the golden hour for trauma care that is gospel in developed countries, the course focused on stabilizing and preparing patients for transport by teaching basic airway management, bleeding control, and immobilization. With Dr. Merrell's encouragement and support from the VCU department of surgery, Dr. Aboutanos established the International Trauma System Development Program (ITSDP) and began collaborative training and research programs in injury control, prehospital care, and basic trauma management, along with the Ecuadorian ministry of health and the various hospitals and universities in the eastern provinces of Ecuador. Dr. Aboutanos has since gone back numerous times to give the basic trauma course to the health care workers and physicians in the region.

"We designed the course to feed into the clinical needs and resources available. So I don't see why the same principles of being responsive to needs and resources couldn't be moved to the Arctic or the desert or to space," Dr. Merrell says.



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Mary Lou Licwinko and Stephen Follansbee (standing) greeting the keynote speaker of the evening, Mark Smith, MD, MBA, and his wife, Pamela Calloway



(From left to right) SFMS Executive Director Mary Lou Licwinko, JD, MHSA; SFMS Treasurer Charles Wibbelsman, MD; SFMS Immediate-Past President Gordon Fung, MD, MPH; SFMS President Stephen Follansbee, MD; *San Francisco Medicine* Editor-in-Chief Mike Denney, MD, PhD; SFMS Secretary Michael Rokeach, MD; and SFMS President-Elect Steven Fugaro, MD



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SFMS members Herbert Peterson, MD, and Steve Walsh, MD, playing music during the cocktail reception



Past SFMS President Edward Chow, MD, and Past SFMS President Dexter Louie, MD



Rolland Lowe greeting Mark Smith



Roland Barakett and Senator Carole Migden



Stephen Follansbee presenting a gift to 2007 Honorary Member and Honored Guest Rolland Lowe, MD, Past President of SFMS and CMA



Gordon Fung, Senator Carole Migden, and Stephen Follansbee



SFMS members enjoying food, wine, and good company



Joan Watson, RN, and Past SFMS President Hugh Vincent, MD



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Mark Smith, MD, the keynote speaker of the evening



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SFMS members talking over dinner

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HOSPITAL NEWS

Chinese
Joseph Woo, MD



CPMC
Damian Augustyn, MD



Kaiser
Robert Mithun, MD



In almost anyone's memory, this is the first column from Chinese Hospital not composed by Fred Hom. At this point I think it is fitting to pay tribute and give thanks to Fred for his many years of service, not just for writing this column but also for his contributions to the hospital and the community. Fred has been Vice-Chief of Staff for the past fifteen years under past Chiefs Kenneth Chan, Francis Tse, and now myself. I can attest firsthand his dedication to the hospital and his patients. Fred's efforts in hospital preparation have resulted in our stellar joint commission reviews. Moreover, I cannot count the number of times I have seen Fred coming in late at night to care for yet another respiratory emergency. Again, I would like to extend our thanks and appreciation to Dr. Fred Hom.

2007 promises to be another good year. On our MEC, I have the honor of serving with such excellent Chiefs of Department as Gustin Ho (Medicine), Sam Kao (Surgery), and Ho Tan (FP-Peds). James Yan oversees our PI activities. Shu-Wing Chan, Roger Eng, Seck Chan, Dong Lin, Rachel Shu, Raymond Li, Martin Leung, and Francis Tse provide a wealth of knowledge and experience.

Furthermore, Hospital activities would not function without the efforts of our Committee Chairs, including Ervin Wong (Multidisciplinary Practice), Catherine Eng (Credentials), Derrina Wu (Interdisciplinary Practice), Clifford Chew (Ops and others), Mai-Sie Chan (CME), Dexter Louie (Well-Being), Kenneth Chang (Patient Care), and Rod Snow (Bylaws). Gung Hay Fat Choy in the Year of the Pig.

Dr. Gregory Buncke was recently appointed Chair of the Department of Plastic Surgery. Dr. Buncke is a graduate of Georgetown University School of Medicine and has been a member of the CPMC medical staff since 1998.

Dr. Thomas Peitz was recently appointed Chair of the Department of Emergency Medicine. Dr. Peitz is a graduate of UCLA School of Medicine and has been a member of the CPMC medical staff since 1996.

Dr. William Snape, member of the CPMC Division of Gastroenterology, will be honored along with twenty-five other AGA Foundation for Digestive Health and Nutrition members this year at Digestive Disease Week (DDW). Dr. Snape is being noted for his achievements in mentoring others in the area of GI research. DDW is the world's largest gathering of physicians and researchers in the fields of gastroenterology, hepatology, endoscopy, and gastrointestinal surgery.

New ultrasound technology is now at CPMC: The noninvasive labs in both the Kanbar Cardiac Center and at the Davies Campus are now using the latest Philips cardiac ultrasound machine. The iE33 intelligent echo system will address the growing requirement of higher image quality with complementary 2-D and volumetric live 3-D imaging and quantification tools that help answer the major questions related to cardiac disease management: structure, efficiency, size, and function. The iE33 uses PureWave crystal transducer technology that is far superior to traditional PZT (piezoelectric) ceramics, providing the best-quality cardiac ultrasound images.

As the borders between global medical communities become increasingly blurred, health care providers have the opportunity to more easily extend their expertise overseas. Several physicians and staff at the Kaiser Permanente San Francisco Medical Center have volunteered for a variety of international projects that offer much-needed medical assistance and equipment in areas often deprived of basic health care services. Both Steven Masters, MD, and Diane Sklar, MD, regularly volunteer overseas, offering gynecological skills and equipment. In June 2006, the doctors worked with Esperanza, Inc.'s Volunteer Surgical Program in Tarija and Camargo, Bolivia, where they performed a variety of gynecological surgeries and taught at the local medical school. Kaiser Permanente's support extended to the loan of surgical instruments necessary for procedures. The physicians plan to return to Bolivia in 2007 and have found the experience of working with foreign health care providers to be invaluable from a cultural and a professional perspective. Carlos J. Felix-Fretes, MD, has also taken advantage of international medical volunteer opportunities, having offered his urological expertise in China, Mongolia, and, more recently, Vietnam. On both occasions, Dr. Felix-Fretes found the eager reception and chance for cross-cultural exchange, in addition to "hands-on" medical experiences with local surgeons, to broaden his scope of practice and inform his technique.

The Kaiser Permanente physicians who choose to volunteer internationally do so on their own time and at their own expense. They bring with them the ethic and spirit of giving more than is required of them on a regular basis, an attitude that is fostered and encouraged at the San Francisco Medical Center and throughout the larger organization. We commend their efforts and feel very proud to count them among our most valued colleagues.

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HOSPITAL NEWS

Saint Francis
Guido Gores, MD



St. Luke's
Jerome Franz, MD



St. Mary's
Kenneth Mills, MD



The New Year has brought a lot of changes to Saint Francis Memorial Hospital. On January 18, we went live with CPOE and eMAR, following the successful launch of the CareConnect electronic medical record system on December 7. The transition went very smoothly, earning staff commendations from our parent, Catholic Healthcare West. We'd like to thank Gifford Leoung, MD, for serving as physician leader.

We are gearing up for a number of staffing changes as well. We have held interviews for a new Vice President of Medical Affairs, and we hope to select a candidate in the next couple months. This will be a shared position with our sister hospital, St. Mary's Medical Center. In addition, we have begun the recruitment process for a new President at Saint Francis. It will be hard to fill the shoes of interim President/CEO Tom Hennessy, who has done a wonderful job stewarding us through 2006 and into 2007. Tom is a Catholic Healthcare West veteran, and we're very grateful for all his hard work at Saint Francis.

As committee appointments change, we'd like to thank our medical staff members for their service. Thanks to Susan Wilson, MD, and Gerald Schall, MD, who will soon be ending their terms on the Medical Executive Committee. In the near future, active medical staff will elect a new Chief of Staff, Secretary-Treasurer, and four new Members at Large. Nominations have already been presented. We thank Cody Fisher, MD, for chairing the Physician Well-Being Committee. Mel Blaustein, MD, will serve as Chair moving forward. And we welcome Mary Romeyn, MD, as Physician Advisor of Quality and Care Management.

Congratulations to everyone for all their hard work.

By the time you read this, St. Luke's will have held its second annual Heart Symposium on February 22, organized by Ed Kersh and featuring panelists Richard Hongo, Eric Lim, and Richard Shaw on the subject of congestive heart failure. There is to be a reception in the Cardiovascular Center, where the paintings of six artists are on view. Called "Barrio de Corazón," the exhibit features well-known artists Juan Fuentes, Michele Ramirez, Calixto Robles, Gilberto Osorio, Mario Rosales, and Omar Soto, whose works here are all related to the heart theme.

Dave Atkin, surfer, Chair of Orthopedics, and head of the orthopedic division of the Health Care Center, had a baby boy in December. He is current president of Operation Rainbow, which sends teams to underserved countries for two weeks every year. During those trips over the last ten years, he has spent long hours in the operating room fixing bones and training local people to provide care after he leaves. He has truly served as a model for doctors in our community.

I'm afraid I was too glib in my last column about the effectuation of the merger between St. Luke's and CPMC. Some snags have slowed down the planning for St. Luke's as the fourth campus. Our medical executive committee is actively pursuing efforts to show that we can remain viable as an acute care hospital. More to follow.

For more than a generation, the traveling public has turned to the San Francisco Airport (SFO) Medical Clinic. As a service of St. Mary's Medical Center, the SFO Medical Clinic provides travel medicine, urgent care, and occupational health services. The nurses and physicians are attentive, helpful, and available to address the patient's most urgent health care needs.

The SFO Medical Clinic helps passengers stay healthy while traveling. It offers the most complete travel and wilderness medical program in the Bay Area. The certified travel vaccination center provides access to all immunizations advised by the World Health Organization and the Centers for Disease Control (CDC). Patients have access to customized reports on health advisories and information by specific country. The physicians and nurses provide individualized medical advice for those with special health concerns, as well as recommendations and prescriptions for avoiding travel-related illnesses.

Along with travel medicine, the SFO Medical Clinic has a comprehensive list of clinical services, such as physical examinations, diagnosis and treatment of work-related injuries, on-site physical therapy, urgent care, immigration physicals, radiology services, hepatitis vaccines, and tetanus and influenza shots.

As we celebrate our 150th anniversary this year, our mission and goals remain the same. At St. Mary's, we dedicate our resources to delivering high-quality, compassionate, affordable health care and partnering with others in the community to improve the quality of life. The SFO Medical Clinic serves patients who are passing through San Francisco for a visit or those that call it home.

UCSF
Ronald Miller, MD



Veterans
**Diana Nicoll, MD,
PhD, MPA**



A vaccine for treating gliomas has shown promising results in preliminary data from a clinical trial at UCSF Medical Center.

Findings from the first group of six patients in the study, being conducted at the UCSF Brain Tumor Research Center, showed that vitespen (trademarked as Oncophage®), a vaccine made from the patient's own tumor, was associated with tumor-specific immune response in patients with recurrent, high-grade glioma. All six have exceeded the historical overall survival benchmark of 14.6 months from the time of diagnosis.

Another group of six patients has entered the trial, which will open up to more patients in the spring.

"This is the first documentation of a glioma-specific immune response after vaccination with vitespen," said Andrew T. Parsa, MD, PhD, Assistant Professor in the UCSF Department of Neurological Surgery, and principal investigator of the trial.

Derived from each affected individual's own tumor, vitespen contains the "fingerprint" of the patient's particular cancer and is designed to reprogram the body's immune system to target only cancer cells bearing this fingerprint. The vaccine is intended to leave healthy tissue unaffected and limit the debilitating side effects typically associated with traditional cancer treatments. Vitespen has been granted fast-track and orphan drug designations from the Food and Drug Administration in both metastatic melanoma and renal cell carcinoma.

The clinical trial was funded the American Brain Tumor Association and the National Cancer Institute's Specialized Program of Research Excellence. For more information on UCSF's brain tumor clinical trials, e-mail Valerie Kivett at kivettv@neurosurg.ucsf.edu.

San Francisco VA Medical Center supports a number of research initiatives that have a direct bearing on global health. The most wide-ranging effort focuses on HIV/AIDS. SFVAMC Chief of Medicine Paul Volberding, MD, a leading international authority on HIV patient care, clinical research, and professional education, is Codirector and Principal Investigator of the UCSF/Gladstone Institute for Virology and Immunology Center for AIDS Research (CFAR). "The VA plays a really important role in HIV research," he says. "We contribute patients to some very important current pathogenesis studies. The VA electronic medical record database is an incredibly powerful research tool—the control group can be literally millions of healthy, uninfected patients. And through CFAR, we're actively participating in the rollout of antiretroviral therapies in developing countries." Dr. Volberding points to the "spectacular" contributions of SFVAMC basic researchers including, Joseph Wong, MD, who investigates mechanisms of HIV infection, and Lynn Pulliam, PhD, who specializes in the pathogenesis of HIV dementia.

Parasitic diseases are a leading cause of death worldwide and threaten the health of U.S. troops overseas. In response, SFVAMC Staff Physician James H. McKerrow, MD, PhD, cofounded the Tropical Disease Research Unit, which conducts drug company style research in an academic setting. The consortium has had promising results with drugs for Chagas disease and leishmaniasis, known to returning veterans as "Baghdad Boil."

Hepatitis B and C, which are major health problems around the world, are studied by SFVAMC Chief of Pathology T.S. Benedict Yen, MD, PhD. "Viruses are wily enemies," he says. "Of course the goal is to find a cure. But at the very least, we hope to prevent hepatitis from damaging the liver."

AIDS/HIV Continued from page 27...

HIV specialists early in the care of the infant. Comprehensive programs to ensure that families are adhering to prophylactic therapy for the infant are essential for successful outcomes. The four cases of MTCT occurring in Las Vegas recently are a tragic reminder that our education, prevention, and treatment programs are not reaching some of the people most in need.

The AIDS epidemic is not showing signs of abating, although progress is being made. We need to concentrate aggressively on education and prevention to curb the epidemic while expanding treatment to those already infected. Underdeveloped countries need our guidance and resources to be successful. Many of these countries are implementing their own programs and are having a positive influence on behavior and prevention. We must also continue to be mindful of ongoing problems here in our own country. Stigmatized, underserved populations worldwide have similar education, prevention, and treatment needs. **sfm**

Dr. Kristin J. Razzeca is an immunologist and HIV specialist who has combined basic science research on T-cell receptors at Stanford University School of Medicine with a clinical HIV practice at Camino Medical Group. She has served on several committees, including the Santa Clara County HIV/AIDS Task Force, the SCC AIDS Commission, and the Committee on HIV/AIDS in Women and Children. She has been chairperson of the HIV/AIDS Committee of the SCC Health Commission and of the NIH Advisory Panel on Women and HIV/AIDS. She has initiated HIV education and prevention programs for middle schools and high schools and hosts an online STD education site for teens. Dr. Razzeca received the Leslie David Burgess Lifetime Achievement Award from Santa Clara County for her work in education, prevention, and treatment of HIV/AIDS.



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Nancy Thomson, MD

Richard K. Friedlander, MD

Dr. Friedlander, a distinguished San Francisco psychiatrist, passed away on June 3, 2006, at his home in Geyserville after a long illness. He was 82.

Born in Chicago on August 20, 1923, he was a graduate of Harvard University and received his medical degree from Yale University in 1947. After an internship at the University of Wisconsin, and a year of surgery at the University of Pennsylvania, he served as a house physician at the American Hospital in Neuilly, Paris. He returned to San Francisco and trained as a resident in psychiatry at Langley Porter Neuropsychiatric Institute from 1950 to 1953. He joined the San Francisco Medical Society and began his private practice in San Francisco in 1954. In addition to private practice, Dr. Friedlander volunteered his services at the Richmond District Maxi-Health Center (now known as RAMS, or Richmond Area Multi-Services), which was founded in 1974 to serve the mental health needs of the diverse community there. He also worked in the emergency psychiatric services at San Francisco General Hospital and the student health services at UCSF. He retired to his ranch in Geyserville in 1983. Having passed his Boards in Psychiatry and Neurology in 1958, he was a Distinguished Life Fellow of the American Psychiatric Association.

As a psychiatrist, in a field in which cures and results can be a long time coming, "Dick" liked to create something specific. He landscaped an elaborate miniature train in the attic of his San Francisco home. He also enjoyed gardening and had a large bonsai collection that traveled with the family to Geyserville in the summers. Family was a top priority, and Dick enlisted his three children in helping him with remodeling projects and gardening. The family also enjoyed traveling together in the summers, a tradition that has continued. He loved animals (except skunks); enjoyed riding Buck, the trail horse, around the ranch; and, with his son, Eric, taught Buck to jump (with Eric showing the horse how). Eric also learned to ride Snowflake, their goat, and to keep him from putting his horns under ladies' skirts and scaring them to death! Dick also enjoyed reading and playing his viola, as well as sailing. Finally, driven by his interest in world peace, he worked with the World Federalists and Physicians for Social Responsibility, although he became discouraged by the world's lack of progress.

He is survived by his wife, Nancy; a son, Eric (wife Nicole); and two daughters, Lisa and Anne (David), all of the Bay Area; and by a brother, Theodore, of Milwaukee.

Roger W. Westmont, MD

Dr. Westmont passed away December 16, 2006, aged 76, at his home in Piedmont. He was born April 24, 1930, in Lompoc,

California, where his father, a chemical engineer, was manager of the Johns-Manville Plant. He graduated from high school in Lompoc and kept up with many of his friends there.

Dr. Westmont attended the University of Redlands, joined Phi Beta Kappa at U.C. Berkeley and graduated in 1952, and graduated from Stanford University School of Medicine in 1956. He used to say that when the Big Game rolled around, he had a dual allegiance. After completing his residency training in 1960, he became a pediatric anesthesiologist at Children's Hospital Medical Center in Oakland, later serving as Chief of the Department of Anesthesiology. He was also a clinical instructor of anesthesia for both UCSF and Stanford Medical Schools, training approximately one thousand physician-anesthesiologists until his retirement in 1985. He was a member of the San Francisco Medical Society and the California Society of Anesthesiologists and was certified by the American Board of Anesthesiology.

In 1956, the year he graduated from medical school, Dr. Westmont developed constant headaches. He was diagnosed with an astrocytoma of the brain stem, for which he received experimental radiation on the linear accelerator developed by Dr. Jake Hanberry of Stanford. He had four major brain surgeries for hydrocephalus and shunt revision. Friends and colleagues called his full and productive life "a profile in courage." In his last years of retirement he battled ongoing radiation breakdown, which destroyed his sense of balance and, in recent months, his ability to sleep. His gentleness and quiet dignity belied his stoic, steely will in battling brain cancer for fifty years. He used this personal experience as a longtime cancer survivor to volunteer his counsel and support to other adults with brain tumors.

Roger made his family a priority. He worked to provide a secure and nurturing home for his three children, taking them to museums and repairing their toys. Roger's love for the outdoors and nature made him a conservationist before the term was widely applied. The family also made trips to the San Juan Islands and enjoyed hiking on Mt. Tamalpais. He enjoyed sailing on San Francisco Bay in a small boat he owned with a friend and colleague. He also deeply loved music, particularly piano, and enjoyed listening to his wife Lois play jazz and opera. A devotee of Dave Brubeck, he amassed a library of jazz recordings. He and Lois attended the San Francisco Opera regularly, meeting some of their dearest friends there. At the fiftieth reunion of his medical school class last spring, Roger said to his assembled classmates, "Life has been good to me. I hope it has been good to you, too."

He is survived by Lois, his wife of 53 years, whom he had met at the University of Redlands and who also went to U.C. Berkeley; his three children, Jeffrey, Clark, and Karen; two daughters-in-law and two grandchildren; and his brother, sister, and two brothers-in-law.



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