20th Century Giants in Medicine in the St. Louis Area

A look back at prominent physicians and scientists.........................page 18

Divided ... And Conquered!  page 4
Speakers discuss end-of-life issues  page 10
Congress and non-conventional medical services  page 22
Harry’s Homilies

Harry L.S. Knopf, MD

ON LIFE

The road through life is full of potholes. Keep your "spare" in good repair.

Life is never static. Even those who complain of being bored by their lives will admit that there are variations -- ups and downs -- each day. If your psyche is healthy and your purse is full, it is easier to weather the daily storms of our existence. But sometimes there are major disasters -- big "potholes" that wreak havoc and cause a breakdown. And life comes to a halt for a while. "FOR A WHILE" is the operative phrase. When there is a breakdown, there is need for repair. (Almost everything is repairable.) Once accomplished, you can be, as the song says "on the road again ..." As long as there is a road to travel, keep your "vehicle" in good condition, have your spare tire ready for emergencies, and keep on truckin.’

Dr. Knopf is editor of Harry’s Homilies. He is an ophthalmologist retired from private practice and a part-time clinical professor at Washington University School of Medicine.

SCAM-Q*

* How insurance companies, hospitals, government, etc. Slice Costs And Maintain Quality

If It Ain’t Broke, Keep Fixing it Until it is Broke

By Richard J. Gimpelson, MD

Yes, this seems to be the goal of H.R. 3962, titled “Affordable Health Care for America Act.” If you have the ability to read and understand all 1,990 pages, you should come to the conclusion that there is nothing affordable in this bill; it does very little for health care, and nothing for medical care. In fact, I don’t even think it is American.

Let me first go over what is not included in this proposed legislation. There is no fix of the Medicare payment formula. This means a 20 percent reduction in Medicare reimbursement after January 1, 2010 or more likely a patronizing 0.5 percent in medical payments to physicians by Congressional legislation; an increase that does nothing to cover the costs of delivering medical care by physicians.

The second missing legislation is realistic Tort Reform. In Section 2531 (p. 1431) “Medical Liability Alternatives,” it is written “…the Secretary will make an incentive payment, in an amount determined by the Secretary, to each state that has an alternative medical liability law in compliance with this section.” This sounds like there is a real effort being made until one gets to paragraph (4)-(B) which states, “The contents of an alternate liability law are in accordance with this paragraph if – the law does not limit attorney’s fees or impose caps on damages.” Read it, and weep, my colleagues.

Now let’s get to some of what is included in H.R. 3962, the 1,990 page “Affordable Health Care for America Act.”

Section 202 (C) states, “Only insurance approved by the Federal government may be offered.” (Forget about keeping your current plan.)

Section 223 establishes a Health Benefits Advisory Committee, which will control what benefits are in approved health plans. (A physician does not have to even be one of the bureaucrats on this committee.)

Section 321 establishes the public health insurance option. (We know how well Medicare and Medicaid have increased in cost. There is no reason to expect this plan to do any better.)

Section 330 allows, but does not require, members of Congress to enroll in the public health insurance option. (I bet we can count on one finger of each hand how many members of Congress jump at this opportunity.)

Section 345 requires verification of income for individuals wishing to receive federal health care subsidies, but does not require verification of identity which may allow “undocumented immigrants” to receive taxpayer subsidized affordable health benefits. (Who lied?)

Section 501 imposes a 2.5 percent tax on all individuals who do not purchase “approved” health insurance. (What happened to no increased tax on individuals with income under $250,000? Who lied?)

Section 512 imposes an 8 percent tax on employers who either will not purchase or cannot afford to purchase “approved” health insurance for employees. (How many workers will lose their jobs because of this 8 percent tax?)

Section 551 imposes a 5.4 percent surcharge (tax) on the rich, defined as individuals making over $500,000 or couples making over $1,000,000. (“It’s okay to soak the rich.”) This section also imposes a 2.5 percent sales tax on any medical device. (Remember this is the Affordable Health Care for America Act.)

continued on page 5
20th Century Giants in Medicine in the St. Louis Area
A look back at prominent physicians and scientists and their contributions to medicine

Features

Medical Ethics and End-of-Life Care
Speakers tackle issues at SLMMS symposium

Arthur Gale, MD, to Receive Robert E. Schlueter Leadership Award
Has served at local, state national levels, written extensively on managed care

Patient, Consider Yourself Lucky Today!
By Elie C. Azrak, MD, FACC, FSCAI, SLMMS President

Improving Outcomes for Chronic Kidney Disease Patients
Physician teamwork, early detection and greater use of fistulas recommended

Will Congress Repeat Itself? Previous Legislation Supports Non-Conventional Medical Services
By Lawrence O’Neal, MD, SLMMS Past President

Columns

President’s Page: Elie C. Azrak, MD, FACC, FSCAI
Divided … And Conquered!

Executive Vice President: Thomas A. Watters, CAE
Medical Society a Giant in Local Health Care

SCAM-Q: Richard J. Gimpelson, MD
If It Ain’t Broke, Keep Fixing it Until it is Broke

News

SLMMS Installation Banquet January 16
Notice of Meeting on SLSMSE Bylaws Revision
SLMMS Position on Health System Reform
Q&A with AAIM

Departments

Harry’s Homilies
Newsmakers
Alliance
Calendar

Minutes of the SLMMS Council
Obituaries
Birthdays
Welcome New Members

The advertisements, articles, and “Letters” appearing in St. Louis Metropolitan Medicine, and the statements and opinions contained therein, are for the interest of its readers and do not represent the official position or endorsement of the St. Louis Metropolitan Medical Society. SLMMS reserves the right to make the final decision on all content and advertisements.
Divided ... And Conquered!

The course of recent events unfolding on the stage of the health care debate (I want to say debacle), particularly the disparate reactions among the medical community to those events, cannot help but remind me of a remark which was said almost 200 years ago, during different times, and under different circumstances, yet resonates a striking cord of resemblance to my own impression of the current climate in our profession:

“...A house divided upon itself – and upon that foundation do our enemies build their hopes of subduing us.”

Indeed there is much to be said about the current state of the house of medicine. In July of this year, the American Medical Association, representing fewer than 20 percent of practicing physicians in the country, issued what appeared to be an unqualified endorsement of U.S. House of Representatives Resolution 3200, good parts and bad parts together: public option, super MedPAC, surtaxes, and all, but no tort reform or SGR fix. Since then, long lists of state and local medical societies have expressed their dissatisfaction with the AMA's position, and droves of AMA members have threatened to rescind their membership in protest.

More recently the AMA Board of Trustees again did not wait long to endorse the health care reform bill passed by the House of Representatives. Yet at the last interim meeting of the AMA House of Delegates in early November, when the anger of many in the physician community was expressed in a resolution calling for the Board of Trustees to withdraw its endorsement of the bill, the resolution was defeated by a large majority of the Delegates.

This speaks of an ideological rift within the medical community: on the one side a large number of practicing physicians who are either not members of the AMA, or members deciding to leave in anger; and on the other side what remains in the AMA of a skewed membership mix, with a disproportionately large number leaning toward single payer health care, a strong public insurance option, or varying shades of government-run health care.

I have one observation to make regarding this state of affairs: “A house divided against itself cannot stand.”

With the promise of good treatment for some in the medical community – partly with improved payments – at the expense of others, one more step has been achieved in the path to “subduing” the medical profession. We … swallowed the bait!

The unhappiness with the AMA’s position on issues is exactly the reason why more of us should be members, and more of us should become involved, in order to have a more representative association of American physicians, and to shape its views.

AMA members leaving its ranks at this time are perpetuating a self-destructive behavior which has plagued the medical profession for decades, and has led to the current erosion and weakness of organized medicine. Past apathy is the cause of today’s weakness, and today’s resignations are the precursor of tomorrow’s collapse!

It is in such a time as ours that physicians need to unite firmly, and stand together, or else they cannot stand!

For my part, I have renewed my AMA membership, and I intend to be present at the next meeting, the next battle, the next fight … and not as a spectator!

Going back to my introductory quotes, in case you wonder who said them, and when, here is the answer: the latter was part of a famous speech – the so-called House Divided speech – given by Abraham Lincoln on June 16, 1858, in Springfield, Illinois, in acceptance of his nomination for U.S. Senator. The former, written in a letter from Abigail Adams to Mercy Warren in 1812, reflected on the events of the then-ongoing Anglo-American war. Both quotes are derived from the Bible!

Medical Society President
Elie C. Azrak, MD
Section 1161 may allow for cuts of more than $150 billion from Medicare Advantage Plans. (Didn’t someone promise you could keep your present plan if you desire? Who lied?)

Section 1401 establishes the Center for Comparative Effectiveness Research. This Center will control the delivery of medical care from before birth until death of every individual in the United States. There will be a Comparative Effectiveness Research Commission to advise and evaluate the activities carried out by the Center. There may be only a single physician on the Commission. (Nothing in the bill prohibits the Center from taking cost into consideration in denying access to medical treatment. Lucky there are no death panels.)

I have not even gone through half of this proposed legislation. I am tired and will have to review the rest later, or one of you can review it for me.

In summary, this bill H.R. 3962 “Affordable Health Care for America Act” is anything but affordable, is not really about health care, and should not be enacted on Americans. I believe the AMA has some serious explaining for supporting the earlier proposed legislation H.R. 3200, and should not be supporting this legislation.

Note: Much of this column has been obtained from a House GOP Conference chaired by Mike Pence (Republican, U.S. House of Representatives, Indiana, 6th District) and verified in H.R. 3962 by me.

Anybody hoping for change now?

Dr. Gimpelson, a past president of SLMMS, is a gynecologist in private practice.
Speaking of giants in health care (this magazine’s cover story), we need to risk immodesty by mentioning ourselves – the St. Louis Metropolitan Medical Society. We have been the voice for tens of thousands of medical and osteopathic physicians in the city of St. Louis and St. Louis County for 175 years! That officially makes us one of the oldest medical societies in the United States.

The St. Louis Medical Society began in 1835, and operated virtually unchanged until 1979, when it merged with the St. Louis County Medical Society, forming one of the strongest and longest-running metro Societies in the country. Many of the “giants” of St. Louis medicine have been presidents of our Society through the years. In 1840 our members participated in national conventions that gave birth to the AMA. Eventually three of these members served as AMA president. We also played a key role in the formation of the Missouri State Medical Association.

For nearly a hundred years our Society was housed in a gargantuan building that was a giant in its own right. It still sits in the 3800 block of Lindell Boulevard across from Saint Louis University, and our name is still engraved in the limestone facade at its top, a tribute to the strength and respect the Society has held in St. Louis through the decades.

Throughout all these years, our objectives have remained mostly unchanged. We advocate on your behalf and make sure your voice is heard during the formation and adoption of legislation affecting medicine. (We are the largest component of the Missouri State Medical Association.) We closely monitor legislative and regulatory developments. We maintain a positive relationship with the news media, and regularly provide important information and increase their awareness about issues impacting patient care and your ability to practice medicine. In recent times, representing you in critical issues involving managed-care and third-party payers has also become a priority.

We provide continuing medical education and provide professional networking opportunities. With the help of our foundation, the St. Louis Society for Medical and Scientific Education, we regularly present educational symposiums, and through our Hippocrates Society, bring in an outstanding national speaker each year for the Hippocrates Lecture.

Since its beginnings in the 1800s, the Society has done its part in improving our community – especially in areas of need regarding health care. We have supported programs on smoking cessation, drug abuse, STDs, disaster and pandemic planning and teen pregnancy. We have been a force for many decades in helping our community deal with community health problems.

We are the only organized medical group in the area that can assist physicians in matters of patient arbitration. Each year we deal with numerous patient complaints, and through our unique arbitration process frequently are able to prevent minor issues from going to a higher level and becoming major problems. Similarly, we deal with physician-to-physician complaints, and physician complaints regarding managed-care issues. Dealing with these issues locally is frequently the best resolution.

Through the Medical Society, you can be assured your voice has been heard, and will continue to be heard. Our track record speaks for itself. A hundred and seventy-five years is nothing to be scoffed at – when it comes to giants, SLMMS ranks with the biggest and the best.
Physicians gained insights into handling end-of-life issues with their patients at the SLMMS fall symposium on Saturday, Nov. 7. The session was co-sponsored by the Saint Louis University School of Medicine Albert Gnaegi Center for Health-Care Ethics as part of its 30th anniversary. The session was moderated by SLMMS President Elie C. Azrak, MD, FACC, FSCAI.

What is Futility? End-of-Life Decision-Making

Griffin Trotter, MD, PhD, professor of health-care ethics at Saint Louis University School of Medicine, laid a theoretical context for the discussion over what is a futile treatment.

The concept of futility pertains whenever there is a goal, a proposed action, and virtual certainty the action will fail to achieve the goal. Disagreements arise in part over which goals are appropriate to particular situations and in part over what should count as virtual certainty that the action will fail.

While some thinkers have proposed a "quantitative" criterion for futility – fulfilled when there is less than a 1 in 100 chance that the action will achieve the goal – quantitative standards can vary by circumstances, he noted. These circumstances include the amount of benefit to be gained and the magnitude of the expense. Thus, standards for virtual certainty would be higher if the endpoint is highly valued, there is a well-established therapeutic relationship and little effort required by the physician.

He gave several examples such as a patient with multiple organ failure whose chance of survival to hospital discharge is less than one percent. CPR for such a patient may not be physiologically futile in the moment, in that it may succeed in restoring a spontaneous circulation (which arguably is the immediate physiologic goal of CPR), but may be regarded as futile if one views the goal as survival to hospital discharge.

Ultimately, the determination of the goals and standards of certainty that dictate particular futility judgments is typically influenced by social consensus, he said.

Organ Donation After Cardiac Death: Ethical and Psychological Issues

There are special considerations in procuring organs from patients who are dying by circulatory death, said James DuBois, PhD, DSc, chair of the Department of Health Care Ethics at Saint Louis University.

Currently, 100,000 people in the United States are on the waiting list for organs; 70 percent are in need of kidneys. While people who have been chronically ill for a long period of time do not provide suitable organs, persons in otherwise good health are qualified donors. Ethically, the concerns are to make sure the patient is dead before the organ is procured, and that nothing is done to cause death in order to facilitate organ donation, he said.

The universal definition of death as adopted by the President’s Commission in 1981 is either irreversible cessation of all circulatory and respiratory functions, or irreversible cessation of all functions of the entire brain including the brain stem.

Helping Patients Complete Advance Directives: What Is the Physician’s Role?

Advance directives are important in laying out an individual’s wishes, said Erin Bakanas, MD, MA, associate professor at Saint Louis University School of Medicine and associate director of the school’s Bander Center for Medical Business Ethics. This can be especially significant when the patient becomes seriously ill and there is disagreement among family members. While having a "power of attorney" is necessary for handling financial matters, a "durable power of attorney for health care" is a type of advance directive that helps patients make their wishes around end of life care more clearly known.
Her co-presenter Miguel Paniagua, MD, noted that 79 percent of hospital deaths occur from withholding treatment as a result of a do-not-resuscitate order. However, 46 percent of advance directives are written within two days before death. Also noteworthy is data showing that 50 percent of patients are in moderate to severe pain in the last three days of life. Advance directives are important not just for the elderly, but for people of all ages because accidents and sudden illness can strike people of any age.

Dr. Bakanas said the so-called “death panel” provision that was struck from the federal health-care reform legislation would have provided Medicare reimbursement to physicians for the time they spend in counseling patients in advance-care planning and end-of-life issues.

Ethics and Palliative Care at the End of Life

Edward L. Burns, MD, MA, FACP, discussed the principles of informed consent as the foundation of how physicians handle end-of-life issues. Informed consent is an ethical doctrine that respects individuals and their right to self-determination. It also is a legal doctrine developed over time in case law, he said.

Informed consent involves assessing the medical decision-making capacity of the patient, providing adequate disclosure of the relevant medical information by the physician to the patient or surrogate, meeting the professional practice standard (the information that most physicians would concur would be needed by the patient or surrogate), and assuring that patient is able to voluntary, without coercion, make decisions.

Surrogate decision makers for patients should take into account the patient’s known wishes, in other words, “what the loved one would want.” They are not asked to make the “best” medical decision for the patient but to make the decision that the patient would have made if they had medical decision-making capacity. If this is not known then surrogates should make the decision based upon their intimate knowledge of the patient as it would relate to a given situation. If neither of these can be utilized, then surrogates should rely on “best interest” of the patient given all the information from the medical team.

Notice of General Society Meeting
To Amend SLSMSE Foundation Bylaws

A general Society meeting has been called for Tuesday, February 9, for the purpose on voting on revisions and amendments to the Bylaws of the St. Louis Society for Medical and Scientific Education (SLSMSE). SLSMSE is the charitable, not-for-profit 501(c)(3) foundation closely affiliated with the work of the St. Louis Metropolitan Medical Society.

It has been many years since a complete review and revision of the foundation Bylaws has been undertaken by the Bylaws Committee. Their final recommendations will be voted on at this meeting. A complete copy of the proposed revised Bylaws will soon be published on the SLMMS website for advance review.

The meeting will be held at 7:00 p.m. in the conference room at the offices of West County Radiology, 11475 Olde Cabin Road, Suite 200, in Creve Coeur. This building is located directly across the south parking lot of the SLMMS office on Craig Road.

For more information, contact the SLMMS office at (314) 989-1014.
Arthur Gale, MD, to Receive Robert E. Schlueter Leadership Award

Arthur Gale, MD, will be honored for his many contributions to organized medicine and physician advocacy with the Medical Society’s Robert E. Schlueter Leadership Award. It will be presented at the January 16, 2010, SLMMS Annual Meeting and Installation Banquet.

Named for the late Robert E. Schlueter, MD, the award recognizes leadership in organized medicine; scientific attitude through excellent clinical practice; advocacy for patients on social, economic and political matters; and community service on behalf of the medical profession.

Elie Azrak, MD, SLMMS president, said: “Dr. Gale has been an example in leadership for many of us. He has relentlessly advocated for our profession, and in this he has led me and many others to believe in the cause and mission of organized medicine.”

“It is very heartwarming to receive this recognition,” Dr. Gale said. It has been a privilege and an honor to serve the Medical Society. I believe that organized medicine is the only venue where a physician can speak freely and express one’s views. This is a great honor.”

Jeffrey Thomasson, MD, SLMMS and MSMA past president, said, “Art has made an outstanding lifelong contribution to organized medicine and patient advocacy. He is a role model for how advocacy should be done. In addition, he is a pleasure to work with – you can always count on him to get the job done. I and others have relied on him for much sage counsel.”

Dr. Gale is an SLMMS past president (1993) and has been active in organized medicine at the local, state and national levels. He has served as a 3rd district AMA delegate or alternate delegate since 1995. Locally, he established the SLMMSS Grievance Committee which arbitrates disputes between physicians and patients, and started the Hippocrates Society, which is devoted to preserving and promoting the ethical principles contained in the Hippocratic Oath. The Hippocrates Society sponsors one lecture per year.

Longtime colleague Edmond Cabbabe, MD, SLMMS and MSMA past president, said, “Art is an accomplished writer and outspoken critic of managed care and ERISA. Representing Missouri in the AMA House of Delegates, he has to his credit multiple resolutions passed by the HOD that are current AMA policies.”

Dozens of Dr. Gale’s articles on managed care have appeared over the past 12-plus years in St. Louis Metropolitan Medicine and Missouri Medicine. Dr. Gale recently summarized his position, “The collapse of primary care was not inevitable. It was caused by the policies of managed care. Managed care in turn implements the rules of the Federal Trade Commission – the real and overlooked culprit in this matter.”

His articles have been compiled into two books, The Hijacking of American Medicine by Managed Care and The Hijacking of American Medicine by the Federal Trade Commission. Dr. Gale is donating proceeds from the sale of the books to the Missouri Physicians Health Program.

Board-certified in internal medicine, Dr. Gale has been in the private practice of internal medicine for over four decades. For many years he was one of the physician owners of Overland Medical Center where he chaired the executive committee and served on the primary care team. Currently he is in independent private practice. He is an associate professor of clinical medicine at Washington University School of Medicine and serves on the staffs of Barnes-Jewish Hospital and Missouri Baptist Medical Center.

After earning his medical degree from the University of Missouri-Columbia in 1959, he completed both his internship and residency in internal medicine at the former Jewish Hospital of St. Louis. In addition, he was a research fellow in the Department of Allergy, Immunology and Arthritis at Scripps Clinic and Research Foundation in California.

Dr. Gale and his wife Marilyn have been married for 54 years and have three children.
A patient came to the office today for a routine follow-up visit. She had coronary artery disease, hypertension, and had had previous coronary bypass surgery. She is a good patient, follows recommendations, and takes good care of herself.

I prepared to ask her how she felt, if she had any symptoms since her last visit. I saw tears in her eyes. Then she cried. She was not taking her medications as recommended, heart medications every day. She was taking her medications every other day, she explained – she could no longer keep up with the cost of her blood pressure, cholesterol and blood thinning medications. She had feelings of humiliation, frustration and helplessness. She had to pay $345 for every prescription refill of her blood pressure medication alone; there was no generic available for her blood thinner. She had tried a generic cholesterol medication; it did not work well enough for her. She needed a stronger, newer drug.

She did have insurance; she was one of the lucky ones. She had government insurance, good insurance, she thought. She had Medicare part D and AARP supplemental insurance. But today she did not feel that lucky. She felt alone and scared. She was certain of her risk of heart trouble if she did not take her medication properly. What a feeling to have!

I have heard many a story like this over and over. Not an uncommon one to have among my patients; those who have good insurance too, let alone those with Medicaid, and those without insurance. I do not accept to see many patients without insurance in my office; I cannot help them. The care I provide demands that I give heart patients certain medications, and run tests on their hearts. Medicaid patients have insurance, they believe; but Medicaid pays physicians something like 20 percent of Medicare rates. Not enough to cover my overhead. My practice needs to stay solvent.

I listened attentively to my patient today. I stopped her important, but expensive blood thinner – the cost outweighed the benefit, I convinced myself. I gave her a short supply of samples of her cholesterol medication from my office medication cabinet. She thanked me. She was lucky today. I had some samples for her. She felt better. I made her feel better.

I consider that today I practiced good cardiology. I made my patient feel better. This is more and more the cardiology that I practice: I listen as usual to my patient, I convince myself to stop needed but expensive medications, and scramble for samples from my medication cabinet. Often, I also convince myself to postpone important heart tests.

I felt lucky today. I helped my patient!

---

Elie C. Azrak, MD, FACC, FSCAI, is a cardiologist with Saint Louis Cardiology Consultants. He is SLMMS 2009 president and MSMA vice councilor.
20th Century Giants in Medicine in the St. Louis Area

A look back at prominent physicians and scientists and their contributions to medicine

St. Louis has been a historically important medical center. Who are some of the area’s most influential medical leaders from the 20th century? Following are profiles of some key contributors.

The choices of individuals to highlight for this article are entirely subjective. Easily, many other important contributors are left out. In addition, there are more key figures in the story of 20th century medicine in St. Louis – hospital executives, business leaders, government officials and more whose stories would require more space than this magazine affords.

Thanks to the Bernard Becker Medical Library at Washington University School of Medicine and to SLMMS past president Lawrence O’Neal, MD, for contributing information for this article. As longtime St. Louis Metropolitan Medicine readers recall, Dr. O’Neal wrote history features for the magazine for many years and has published some of his writings in his book Vignettes of St. Louis Medicine.

Evarts A. Graham, MD

Dr. Graham (1883-1957) was Bixby Professor of Surgery and head of the Department of Surgery at Washington University School of Medicine from 1919 to his retirement in 1951. He was recognized internationally.

He played a major role in the development of chest surgery in the United States and in the world, performing in 1933 at Barnes Hospital the first successful operation for the removal of an entire lung.

His other achievements include the development of cholecystography (X-ray visualization of the biliary tract) and a series of experiments on cancer in mice induced by the application of cigarette tars obtained from an automatic smoking machine.

Among the prominent surgeons trained by Dr. Graham are Warren H. Cole, Nathan A. Womack, Brian Blades, Thomas H. Burford and many others. He also was the founder of the American Board of Surgery and the Board of Thoracic Surgery.

Dr. Graham studied medicine at Rush Medical College (MD, 1907) and received additional training in chemistry at the University of Chicago.

Over his lifetime Dr. Graham received many awards including election to the Royal College of Surgeons, the British Lister Medal, the French Legion of Honor, the Gold Medal of the American College of Chest Physicians and many others.

Edward A. Doisy, PhD

Dr. Doisy (1893-1986) founded the Department of Biochemistry and Molecular Biology at Saint Louis University in 1923 and remained as chair for five decades until his retirement in 1965.

He was awarded the Nobel Prize in Physiology or Medicine in 1943 along with Henrik Dam of Copenhagen for their work in determining the chemical nature of vitamin K, which is an essential component in blood coagulation. This discovery set the stage for a lifesaving treatment for patients who were bleeding profusely – giving injections of vitamin K to clot blood.
In 1929, Dr. Doisy reported the isolation and chemical characterization of estradiol, a female sex hormone that is critical for reproduction and normal bone structure. He also improved methods used to study insulin and contributed to understanding more about antibiotics, the system that regulates blood pH levels and how the body processes food.

Dr. Doisy reassigned much of the income derived from commercializing his discoveries to the medical school. The income annually provides millions of dollars to research and teaching infrastructure.

The university’s new Edward A. Doisy Research Center building and the Edward and Margaret Doisy College of Health Sciences are named for him.

James B. Brown, MD

Dr. Brown (1899-1971) helped to establish plastic surgery as a respected specialty. Entering private practice in 1925, he served as clinical professor of surgery at Washington University School of Medicine from 1948 to 1968 and professor emeritus until 1971.

He developed split-thickness skin grafts; previously, grafts were small islands of skin placed in the wound. His other contributions to surgery include treatment of cleft lip and palate, hemangiomata, osteomyelitis of the jaws, cancer of the mouth, burns, and management of compound injuries of the face and jaws, along with reconstruction of the injured hand and correction of facial paralysis. In later years he wrote a series of papers on post-mortem skin homografts, their successful use as dressings for extensive burns, and the establishment of skin banks for their preservation.

During World War II he served as senior consultant in plastic and maxillofacial surgery for the U.S. Army in Europe, where he advocated for a sound reconstructive surgical program and established several plastic surgery centers. In 1943 he was assigned to the Valley Forge General Hospital where he helped to establish the hospital as an outstanding center where 15,000 operations were done successfully over the next four years.

Carl F. Cori, MD
Gerty T. Cori, MD

Drs. Carl F. Cori (1896-1984) and Gerty T. Cori (1896-1957) received the Nobel Prize in Physiology or Medicine in 1947 for their discovery of the catalytic conversion of glycogen. They served at Washington University School of Medicine from 1931 until her death in 1957 and his retirement in 1966. She was the first American woman to win the prize.

The couple met while both were medical students at the German University of Prague. They received their medical degrees in 1920 and were married in August of that year. The year 1920 also marked the publication of their first joint scientific paper, which was based on an immunological study of the complement of human serum.

In 1922 Dr. Carl Cori emigrated to the United States to join the staff of the New York State Institute for the Study of Malignant Diseases in Buffalo, N.Y. Dr. Gerty Cori emigrated a few months later, starting as an assistant pathologist at the institute and later rising to assistant biochemist.

They moved to St. Louis and Washington University School of Medicine in 1931 when he accepted the position of chairman of the Department of Pharmacology. Because university rules at the time prohibited faculty appointment of two members of the same family, Dr. Gerty Cori was hired as a research fellow in pharmacology. Later they moved to the Department of Biological Chemistry, and in 1943 Dr. Gerty Cori was made an associate professor and eventually professor.

The Coris’ research focused on discoveries showing the pathway of glycogen breakdown in animal cells and the enzymic basis of its regulation. Those discoveries formed a linear sequence that fell into four parts: the Cori Cycle – “cycle of carbohydrates” (1922-31); the Cori ester – glucose 1-phosphate (1931-37); phosphorylase and the cellular pathway of glycogenolysis (1937-44); and the regulation of phosphorylase (1945-52).
Henry G. Schwartz, MD

Dr. Schwartz (1909-1998) is remembered as one of the most important and influential American figures in the field of neurosurgery. His primary research interests were focused in anatomy, surgery, and physiology of the nervous system. Dr. Schwartz made important clinical contributions to neurosurgery in pain, intracranial aneurysms, and pituitary and cerebellopontine angle tumors. He designed one of the first spring vascular clips for aneurysm surgery and refined open surgical techniques for cervical cordotomy.

Dr. Schwartz chaired the Division of Neurological Surgery at Washington University School of Medicine from 1946 to 1974. He was August A. Busch, Jr. Professor of Neurological Surgery from 1970 to 1985.

In addition to his academic appointments, Dr. Schwartz was acting surgeon-in-chief at Barnes Hospital from 1965 to 1967 and chief neurosurgeon at Barnes and St. Louis Children’s Hospital from 1946 to 1974. As a well-respected educator, his training program attracted many talented students to Washington University.

During World War II, while serving at the U.S. Army 21st General Hospital, he developed a method for handling wounds to the head and nerves that became standard procedure for the military. For this accomplishment, he received the prestigious Legion of Merit in 1945. Other awards he received during his career include the Harvey Cushing Medal from the American Association of Neurological Surgeons and the Distinguished Service Award from the American Board of Neurological Surgery.

Helen E. Nash, MD

Helen E. Nash (1921-) broke down racial barriers when she became the first African-American doctor to join the staff of St. Louis Children’s Hospital in 1949. A native of Atlanta and graduate of Spelman College, Dr. Nash graduated from Meharry Medical College in Nashville in 1945.

Internships and residency opportunities were limited for non-white medical school graduates at that time. Homer G. Phillips Hospital, opened in 1937 as a segregated hospital, was the only hospital in St. Louis offering learning opportunities and clinical experience to African-American doctors. Dr. Nash began a rotating internship there in 1945, working on 12 services in one year. A three-year residency in pediatrics followed. In 1949 she was the only woman among the first four African-American physicians invited to join the staff of the Washington University School of Medicine.

As a pediatrician, Dr. Nash served for over 40 years on the clinical faculty of Washington University School of Medicine and on the attending staff at St. Louis Children’s Hospital. In addition, she served as pediatric supervisor and associate director of Pediatrics at Homer G. Phillips Hospital from 1950 to 1964.

After Dr. Nash’s retirement in 1993, she served as the medical school’s dean of minority affairs from 1994 to 1996.

Carl V. Moore, MD

Dr. Moore (1908-1971) was professor and head of medicine at Washington University School of Medicine from 1955 to 1971. He was dean of the medical school from 1953 to 1955 and vice chancellor for medical affairs from 1964 to 1965.

A 1932 graduate of the medical school, he returned to Washington University in 1938 to organize the hematology laboratory where he oversaw studies of iron metabolism. He was one of the pioneers in using radioactive iron for clinical investigations. By the late 1940s, his laboratory was recognized as a leading training center for hematologists.

Dr. Moore received awards from medical groups around the world.
Max C. Starkloff, MD

Dr. Starkloff (1858-1942) is best known for his leadership in managing the 1918 influenza epidemic in St. Louis and is credited with helping to save thousands of lives.

He was halfway through his 30 years as City of St. Louis health commissioner when the epidemic struck in early October. He urged mayor Henry Kiel to order that schools, churches, theaters, saloons and dance halls be closed starting Oct. 7. Despite heavy pressure from businesses, Dr. Starkloff prevailed on the mayor to continue the closure into November. Helpful to the cause was the support of St. Louis Medical Society president Ellsworth Smith, MD. The ban remained in effect until Nov. 11 when people poured into the streets in jubilance over news of the victory in World War I.

St. Louis’ death toll of 1,703 in the epidemic equaled 2.8 for each 1,000 residents, lowest among major American cities. In Philadelphia, the city with the highest death rate, the rate was eight times higher.

Max A. Goldstein, MD

In 1914, Dr. Goldstein (1870-1941) founded a small school for the acoustically handicapped in the building where he maintained his medical offices. Out of this school developed the Central Institute for the Deaf.

After a period of rapid expansion, the oldest portion of the present CID complex of buildings was constructed in 1929. A teacher training program, begun soon after the founding of CID, was affiliated with Washington University in 1931. Dr. Goldstein was made professor of research otology and speech pathology at Washington University that same year. He remained director of CID and professor until his death in 1941.

Dr. Goldstein was born in St. Louis and studied at Missouri Medical College, where he received his MD degree in 1892. He continued his medical studies in Europe, visiting universities and clinics in Berlin, Strasbourg, Vienna and London. Upon his return to St. Louis he was made professor of otology at Beaumont Hospital Medical College, an appointment that continued when the college became part of Saint Louis University in 1903 and lasted until 1912. He practiced at several hospitals in the city during these years.