working under post-World War II conditions in a wooden hospital in Siberia, was the first to treat nonunited fractures by counter-intuitively pulling the ends of the bone apart. Even though his results were astonishing, his theory was contrary to everything previously held about bone regeneration. We now think that fibroelastic disease of the breast, which occurs clinically in 50% and pathologically in 90% of women, is not a disease at all.

To return to my Lancet letter, no advice for the first dissenting doctor was ever published, nor did I receive any from readers. I asked the question directly (enclosing a Lancet copy) of about nine movers and shakers, some with a Harvard connection. They never answered it; most never answered at all.

In 1992, again in the Lancet, I suggested that in the present atmosphere it is thoughtless or dishonest to encourage curiosity in the young. Again, no reply.

One cause of our problems is the virtually complete abandonment by academic physicians of intellectual and scholarly independence. These doctors, now falling all over themselves to adjust to the new arrangements, should have fought tooth and nail against peer review, utilization review, quality assurance, managed care, and similar enslavement techniques. (But maybe they didn’t want to commit suicide, either.) At the very least, they should have demanded that no action be taken against a physician who has not caused harm, no matter how unorthodox his methods. That would be consistent with the current emphasis on outcomes. No one should have to defend success.

I don’t know Dr. Stobo at all, but I was seduced and abandoned by physicians who, like him, issued rousing calls for ethical fidelity and professional independence. Without knowing anything about my work, these immoral doctors declined to consider testifying for me, even for a fee, when I did what they said to do or followed what they appeared to stand for, then I faced a proceeding to take away my civil service job. In contrast, the much-maligned Christian Right sprang to my aid.

Dr. Stobo, get real.

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I Am Real

To the Editor:

I appreciate Dr. Carlen taking the time both to read my article, “Why Is the Sky Blue,” (CHEST 1995; 105:565-69) and to write a response.

As I interpret his letter, he believes that my call for physicians to be “intellectually curious” ignores the reality of what society and the marketplace wants. He states that “Patients want cures and care nothing about how they are achieved, nor should they.” I agree with this. Society has a right to expect that a profession charged with guarding its health will indeed find cures to illness. My point is, in order for us to achieve what society has a right to expect, we must be intellectually curious. Without curiosity, medicine would not develop cures. In a recent debate in Congress, Senator John Glenn captured this sentiment when he said, “all advancement in human kind, wherever it is, comes because someone is curious.” So, I think we agree that society has a right to expect that the medical profession will address issues related to health and disease including the development of cures. Again, my position is that this cannot be done if we do not have a commitment to intellectual curiosity.

He goes on to say that, despite this, “peer reviewers” care little about curiosity. Instead, they care only about adherence to norms. Again, I am sympathetic to his viewpoint. There is no doubt that much of what is being done, cloaked in the guise of quality and outcome, is simply a demand to adhere to certain norms of behavior which serve best the economics of the marketplace instead of the quality of care. This is a major challenge to our profession and we must vigorously and effectively argue against and prevent this. However, I would argue that to abandon our commitment to intellectual curiosity and simply cede to the guidelines and constraints of “peer review” would mean that we would have to abandon what is in society’s and our patients’ best interest. Once we have done this, we will most certainly lose our professional status and simply become like any other trade union.

Recently, I relinquished one of the most prestigious chairs in American medicine, the William Osler Professor of Medicine, to lead the development of an Integrated Delivery System for Johns Hopkins. I did so because I was concerned, like him, that medicine has found itself squarely in the marketplace and the forces associated with this are inducing behavior among physicians, which is not in our patients’ and society’s best interest. I believe that Johns Hopkins had an obligation to put together an Integrated Delivery System that is exemplary, that is consistent with Hopkins’ commitment to quality, and that fosters intellectual curiosity and innovation. This is my attempt to, as he puts it, “get real.”

I enjoyed reading his letter, particularly his historic vignettes. While I agree with many of the points he has raised, I have not changed my conclusion that intellectually curious physicians, who best serve the needs of our society, will allow our profession to sustain itself and rise above the quagmire of the marketplace.

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Diagnosing Pulmonary Embolism
Indeed, When Will We Ever Learn?

To the Editor:

We were disturbed by the editorial from Drs. Robin and McCauley published in CHEST (1995; 107:3-4). They start off with criticism of P(A-a)O2 tension and its clinical utility in the diagnosis of pulmonary embolism but the discussion turns rapidly to ventilation-perfusion scan. The thrust of our communication is mainly to focus on the comments of the authors on ventilation-perfusion scintigraphy. Robin and McCauley describe a medicolegal case of a 55-year-old patient who suffered cardiopulmonary arrest after a normal perfusion scan and before a ventilation scan could be performed. The defense believed that the arrest was the result of pulmonary embolism and “four experts agreed.” In support, they testified that without a ventilation scan one could not eliminate a