AN ABBREVIATED ACCOUNT

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It is obvious that I am indebted to the innumerable skilled and devoted persons who devised, planned, arranged, supported, and attended this unusual meeting. Was it fair that I should punish those angelic characters by inflicting an additional lecture on them?

It was declared, and presumably expected, that I should comment on each of the day's presentations. Such a plan suggests that my knowledge equals or exceeds the combined knowledge possessed by all of the speakers who preceded me—a concept that implies an impossibly dangerous degree of cerebral or cranial dilatation. Instead, I attempted to describe the way in which some of the contributions, generously discussed by the presenters, came into existence. In brief, this presentation deals with genesis, if not pathogenesis.

AUTOBIOGRAPHY

Genealogical studies, begun by my sister, Mrs. Daniel Ross, and extended by her son, James Ross, show that in the late Middle Ages the paternal component of our family lived in the town of Lunel, near Avignon, France. There is faint evidence of a relation to Jean Astruc (1684-1766), the son of a Protestant minister, but later known as a Roman Catholic. A graduate of Montpellier, he served as professor of medicine in Toulose and Paris. The most famous of his innumerable works are *De morbis venereis* (1736) and a six-volume treatise on gynecology (1761-1765).

By the 18th century, the Jarchos were living in Belarus (formerly known as White Russia), where my father was born, and later they were starving in the Ukraine. Three of my paternal uncles served in the army of Czar Alexander III. The maternal kin lived near Riga, in Latvia. At the end of the 19th century, both families moved to New York. In the late 20th century, the atomic disaster at Chernobyl threw its cloud northwestward from the Ukraine toward Latvia.

After preliminary medical studies in the Ukraine, my father entered the College of Physicians and Surgeons (Columbia University) in 1900. At that time, the

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conversion to a full 4-year course was started. Instruction in anatomy lasted 2 years. In 1926, when I entered the same school, the dissections lasted only 1½ years. In 1937, when my brother Leonard entered, it lasted 1 year. In 1979, when his son John studied at the University of Utah, anatomical dissections lasted only a few months.

In elementary school in New York, I started to study German, but with American entry into World War I, patriotic politicians canceled the course. In high school, no politician interfered with 4 years of Latin (compressed into 3½ years). Greek was requested, but was unavailable. Perhaps the aid of city hall should have been invoked.

We had French at home with our mother and with governesses. We had several years of ancient and modern Hebrew at home, for reasons of tradition and not for religion. Favorite biblical books were Genesis, Exodus, and Ecclesiastes.

I was admitted to Harvard College in 1920 but, since our father considered me too young for Cambridge, entry was postponed to 1921, just before my 15th birthday. In the autumn of 1922, as a sophomore student, I unexpectedly found enough courage to attend one of President Abbott Lawrence Lowell's receptions, held in the presidential mansion. Here, I heard one sentence directed to me. Mr. Lowell said, "Were I you, and intending to enter medicine, I should concentrate in anything but chemistry or zoology." Perceiving that this was important advice, I escaped from the reception, ran back to the lodging house, tore up all the plans, and changed to a concentration in English literature. Courses in chemistry, required for admission to medical school, therefore had to be taken in the summers. This was done mostly at Columbia, and anthropology and elementary Greek were added. At the Harvard summer school in 1924, there was a fetching course in elementary Anglo-Saxon.

The winter and spring sessions in Cambridge, although devoted mainly to English literature, managed to include elementary German, advanced French, and 2 years of Latin. A thoroughly traditional course in history strove to include everything that happened between the fall of Rome and the Wednesday preceding the final examination. There was not a word about the nature or purposes or values of history. This led to an oath that I would never touch history again. One of the summer courses in chemistry dealt with a branch of knowledge that has disappeared, colloid chemistry.

A supplementary year at Columbia led to a master's degree in Latin; it was stretched to include advanced Anglo-Saxon and the history of Italian painting. The subsequent summer, spent at the American Academy in Rome, was devoted to Roman monuments and aroused the desire (*in pectore*) for the study of Italian.

Four years at the College of Physicians and Surgeons, Columbia University (1926–1930), were followed by a summer—the first visit of three—at the School

of Tropical Medicine in San Juan, Puerto Rico, where it was usual to see women afflicted with filarial elephantiasis of the legs trudging past the windows of the laboratory. The neotropical studies were motivated by the observation that the hospital wards in New York harbored an increasing number of Puerto Ricans, and the hospital physicians understood neither their diseases nor their language nor their lives.

Four months as assistant house surgeon at the New York Lying-In Hospital were spent mainly in obstetrical deliveries in the slums and included one patient on a coal barge in the East River. No one then revealed that part of a program to be delivered 65 years later would include a section on the problems of New York.

The next 3½ years were devoted to a 30-month rotating internship—a valuable arrangement unhappily obsolescent, but possibly renascent—followed by a year in pathology under Dr. Paul Klemperer. A minor part of the duty consisted of assisting in the preparation of specimens for the hospital's wonderful anatomical museum. This haven was eradicated about 1974 for lack of space. Later, I was to see the anatomical collection at the Harvard Medical School in ruins, and in 1946, I saw the gross specimens in the Pathology Department at Columbia being discarded. In some instances, it had taken an entire lifetime to create a single specimen. The collection at Mount Sinai supplied two ideas that are still at work 62 years later.

At this stage—it might be called the postdoctoral stage—one unavoidably wondered what kind of further training was necessary for full development of an internist and, incidentally, would lead to membership in the attending staff of the hospital. Traditionally, promotion was through the laboratory, preferably a laboratory in Germany or Austria, but in 1934, the presence of the Nazis made this impossible. Moreover, reading of 18th and 19th century clinical writings, almost all of which were European, showed that the basis of sound knowledge of internal medicine was pathology—a conclusion based on historical inquiry, whether or not this aspect was consciously apparent to the young inquirer at that time.

Good fortune then provided an opening for 2 years in the pathology department of Johns Hopkins, directed—1 year after the death of Dr. William Welch—by Drs. William MacCallum and Arnold Rich. Both men were acute observers and remarkable teachers. MacCallum, while a medical student, had discovered exflagellation of the malaria parasite and later had made an important contribution to knowledge of the parathyroids. Rich was a leading investigator of allergy and immunity. At the start of each academic year, the young instructor was given his own group of a dozen second-year students to lead through the entire course. In addition, one took turns on the lecture platform.

Returning to New York, I entered medical practice and became a part-time instructor in pathology at my alma mater, the College of Physicians and Surgeons, and also worked in the clinics and wards of the Mount Sinai Hospital, rising gradually to the rank of associate physician.

In 1940, the hospital established a military unit. While awaiting the call, I reflected that since the war was active in North Africa, our army might be able to use a physician who knew Arabic. Unaware of the simultaneous existence of both classical Arabic and a row of colloquials, I borrowed three books from the Columbia University library and set to work. Then came the acquisition of a set of the admirable Linguaphone records, followed by admission as an advanced student to a course in colloquial Egyptian Arabic, given at Columbia under the Intensive Language Program of the American Council of Learned Societies.

Active military duty as a captain began in October 1942 and ended with discharge as lieutenant colonel in June 1946. Most of this period was served in the Medical Intelligence Division, of which I became commander late in 1945. A later event was the capture in 1948 of the lady who handled Latin American Medical Intelligence, and who became my wife.

In 1946, I returned to medical practice, retiring from it in 1980 after having been mugged twice while making house calls. Moreover, voracious landlords were being replaced by implacable cooperatives.

Intercurrent with activity in medical history was participation in the work of the Armed Forces Medical Library, the National Library of Medicine, the National Institutes of Health, the American Association for the History of Medicine, the Society of Medical Consultants to the Armed Forces, the College of Physicians of Philadelphia, and the New York Academy of Medicine.

INVESTIGATIONS AND PUBLICATIONS

What was to emerge from these comings and goings?

In 1936, anatomical and clinical observations produced a review of a type of tumor that was given the name diffusely infiltrative carcinoma.[1] The subsequent eponymous glory proved transitory.

In 1958 or thereabouts, Dr. Erwin Ackerknecht requested a history of American medical education in the post-Flexner period. This essay was published in 1959.[2] With one minor exception, it is, as far as I am aware, the earliest writing in the American medical literature that discusses discrimination against blacks, Roman Catholics, women, and Jews. Other authors later contributed more extensive investigations of the same subject.

Anatomical studies of the Klippel-Feil vertebral anomaly in an American black family[3] and later study, at Mount Sinai in New York, of a family of black and

Cherokee origin[4] was supplemented by data found in the anthropological literature, which reported evidence of the anomaly in aborigines of the Western Hemisphere for many centuries. This work pointed toward paleopathology as an attractive field of study, and it formed the basis of the Fielding H. Garrison lecture of 1964[5] and of a seminar held at the National Academy of Sciences–National Research Council in 1965.[6,7] Other studies included one on mummies, which was presented in Cairo and Alexandria in 1978 and published in 1981.[8]

A boy who went sledding struck an obstacle, ruptured his spleen, underwent splenectomy, and died 8 years later of appendicitis. At autopsy, he was found to have approximately 80 tiny spleens in his peritoneal cavity. The specimen was a prized item in the Mt. Sinai museum. This case and one other were reported with the collaboration of Dr. Dorothy H. Andersen.[9] It led to some experimental efforts, which were unsuccessful and were never published. Historical studies initiated at about the same time led to research on Giuseppe Zambeccari,[10–12] apparently the first successful splenectomist (of animals). This was followed by work on Morgagni,[13-15] Lancisi,[16,17] Albertini,[18,19] Lampronti,[20] and other Italian physicians, and also by a study of Italian broadsides on public health.[21] A recent essay discusses the medical imprints of Giambattista Bodoni.[22] The whole Italian series, now extending over almost six decades, began with a boy, a sled, and a spleen.

Work done in Puerto Rico in 1930, 1938, and 1941, with intercurrent visits to other areas in the Caribbean and Central America, supplemented by observations made in the Army Medical School and the Medical Intelligence Division, led to a permanent interest in malaria[23–26] and other fevers, which expressed itself, *inter alia,* in an essay on the history of semitertian fever,[27] one on contemporary tendencies in the history of malariology,[25] and also a slender volume called *A Plain Treatise on the Peruvian Bark,*[28] a study based on a late 17th or early 18th century Latin writing. Soon afterward came a book on Francesco Torti,[29] about whom research is continuing actively.

An essay on insect-borne diseases was contributed to a volume on preventive medicine published in 1942.[30] A more extensive version appeared in a periodical called *War Medicine* in 1943.[31] I later found this essay being used by military colleagues, and I requested the publisher, the American Medical Association, to send me a copy. It complied.

Active duty in the Medical Intelligence Division included the preparation of official surveys, each of which was designated as a "Technical Bulletin Medical" and set forth medical and sanitary data about an area of military importance, such as the Aegean Islands, Albania, Rumania, Bulgaria, Algeria, and Tunisia.[32–37]

Assignment to medical intelligence necessarily involved the use of maps.

Someone had previously commissioned, and later published, some world maps of diseases such as malaria, cholera, and tsutsugamushi. Unfortunately, all were on the same projection, and also, unfortunately, this was the Mercator projection, designed in the 16th century for mariners and used in later centuries by schoolchildren. The maps of cholera and tsutsugamushi, for example, show these oriental diseases at either end of the respective map, while the unaffected area, three-fourths of the world, is a blank in the middle. Study of the literature soon disclosed the superior merits of the azimuthal equidistant projection for our special purposes.[38] These preliminaries led in later years to studies of old maps and especially early maps that have medical or epidemiological implications. One of these was drawn by Leonardo da Vinci about AD 1514.[39] Other studies concerned early demographic maps,[40] a medicostatistical map by Malgaigne,[41] and a brief essay, with map, on linguistic diversity in Manhattan.[42]

Cercarial dermatitis, known colloquially as swimmers' itch, a disease caused by larval trematodes transmitted to human beings by snails residing in glacial lakes and infected by migratory birds, proved to be an excellent cartographic subject and was studied and mapped with the collaboration of Dr. Anastasia Van Burkalow.[43] The cartography of yellow fever and cholera were studied historically in 1970.[44]

In 1969, a house visit to a woman dying of pulmonary edema led, 11 years later, to a publication on the history of the concept of heart failure.[19] Interest in Arabic made possible the inclusion of a chapter on Avicenna.

A request from the *American Journal of Cardiology* eventuated in 105 brief articles on the history of cardiology.[45] Not utterly remote from this were several articles on the history of physical diagnosis.[46–48]

For readers with other interests, there were articles on Dr. Cadwallader Colden, the last lieutenant governor of colonial New York,[49–51] and on Spanish colonial medicine,[52–54] a translation of a medieval Hebrew treatise on medical ethics,[55] a few articles on medical numismatics,[56–64] a short paper on workmen's compensation among pirates and buccaneers,[65] a note on homicide committed by means of plague bacilli,[66] an article on the treatment of insomnia by means of the medical literature,[67] and a discussion of Cicero's essay on old age.[68]

CODA

This medico-historical Cook's tour has left many subjects uncooked or half-baked, and awaiting proper research from others, many of them, perhaps, among those who attended the *Festschrift* and honored me. I hope that we will meet again many times in this world or the next.

FECI QUOD POTUI FACIANT MELIORA POTENTES.

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