

UNDER MY SKIN

Second Impressions

My first contact with Denise was a ringing beeper at 4:30 a.m. “My acne is out of control,” her voice mail message said. “The antibiotic I’m on isn’t helping. I get to work at 5:30.”

Predawn acne? I held off till 7 before getting back to her. When she came in later that week, Denise showed me some pretty awful cystic acne, with lakes of pus running under her cheeks and rivers of tears coursing over them. We agreed on isotretinoin as the best treatment. What followed was more weeping, lots of questions (“Why can’t I start now?” “When will it start working?”), many phone calls and extra visits for intralesional steroids, and still more questions (“Why isn’t it working yet?”).

Four months later, not only is Denise’s face remarkably clear but her manner is utterly different. She’s calm and reasonable, with no more emotional outbursts. I hardly recognize her.

Recently, I saw another young woman, Marianne, who described an odd history

of intermittent showers of papulonodules. Dermatologists hadn’t been able to offer a specific diagnosis but reassured her that it didn’t have systemic implications. Then she saw a new primary care physician, who told her the rashes were “a serious infection.” This caused much agitation, especially because her job as a nurse in a neonatal ICU made the possibility of transmitting this “infection” a major concern. (In fact, her supervisors banished her from the unit until she got dermatologic clearance.)

Like Denise, Marianne presented with impressive lesions and many tears. Assurance that no infection could produce lesions like hers off and on for years did little to calm her down. A skin biopsy, predictably enough, was nonspecific, consistent as usual with arthropod bites and other entities that were not clinically relevant.

A week after her first visit, though, she returned both clear skinned and calm. Reassurance had sunk in that she was indeed not Typhoid Marianne and that she could

keep her job. She was so composed that she too was almost unrecognizable from the week before.

As the adage goes, you don’t get a second chance to make a first impression. Many patients are anxious at a first visit, but most don’t present with uncontrollable sobbing (or midnight pages). When Denise and Marianne did introduce themselves this way, I had to wonder about their mental stability. After all, I hadn’t met them before and so had no way of knowing what they were really like. At first, I had doubts about whether I ought to be treating Denise with isotretinoin. Seeing both women after they had calmed down gave me a chance to reconsider my first impressions and realize that they had been not so much unstable as distraught.

In other social situations, we may choose not to bother reconsidering first impressions. If someone acts unpleasant at a dinner party, we don’t invite them back. If they make us uncomfortable at a job interview, we don’t hire them. That’s why people spend so much time and effort on haircuts, makeup, tooth whitening, and interview coaching to ensure that they’ll get the chance to make a second impression.

In many medical interactions, we do get

to see people again, whether or not we liked them the first time (though heaven knows we may wish we didn’t have to).

Sometimes this helps us realize that our first impressions were wrong. There’s the fellow who attacks you for keeping him waiting or the woman who berates the receptionist for taking someone else first or for asking to update demographics or insurance information. Maybe they really are aggressive, obnoxious people. Or maybe they’re just scared, convinced they have cancer or leprosy. Once they find out that they don’t, their manner might change altogether. Sometimes they even apologize.

It’s only natural for us to form a judgment about the patients we meet, especially when their behavior lies outside the range of what experience has taught us to expect. Still, it’s helpful to leave mental room to reconsider first impressions and to be willing to put greater stock in second or third ones. When the shoe is on the other foot, we will hope for no less. ■

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BY ALAN ROCKOFF, M.D.

GUEST EDITORIAL

Slashing Research Money Won’t Help, May Hurt

Times are tough ... belts must be tightened ... everyone should sacrifice. These are the messages Congress conveys as it debates the next year’s federal budget. But indiscriminate across-the-board cuts harm areas that promote the general welfare and help stimulate the nation’s economy.

Biomedical research is one such area. Our nation’s strong commitment to the National Institutes of Health and our system of funding has been the envy of other nations. Grants awarded by the NIH fulfill two extraordinarily important needs. They allow scientists to independently explore bold, creative ideas about health and disease and—perhaps just as important—nurture the next generation of researchers. Stipends and salaries bring young scientists into the lab who might not otherwise find their way. They become the teachers and investigators of the future or the pharmaceutical and biotechnology researchers who bring new medicines to patients.

The NIH granting mechanism creates an entrepreneurial environment, in which investigators bring their hypotheses to the marketplace of ideas. Proposed research projects compete head to head and only the most worthy rise to the top. Indeed, many worthwhile projects are not funded, even in the best of times.

In tight times, though, more and more

important proposals go begging. The natural result is a dramatic decrease in the number of submitted proposals, a decreased willingness to propose or fund high-risk/high-payoff projects, frustration on the part of scientific reviewers, and discouragement on the part of investigators—particularly young ones.

This was the pattern in the mid-1990s, before Congress realized the damage being done and compensated by nearly doubling the NIH budget over a 5-year period. That move paid off—a 2006 study concluded that federal investment in the research program at the National Institute of Neurological Disorders and Stroke earned a 4,600% return over 10 years (Lancet 2006;367:1319-27).

Now, however, the damaging pattern of arbitrary cuts is being repeated. NIH appropriations can’t even keep pace with the 3.5% inflation rate for biomedical research costs. President Bush’s proposed budget for fiscal year 2009 calls for flat-funding NIH—a substantial cut in inflation-adjusted dollars and another huge step toward reversing earlier gains.

The effects of these cuts are very real. In my own laboratory at Harvard, our work on the molecular basis of Alzheimer’s disease and strategies to intervene therapeutically has already been hampered. The National Institute of Aging slashed all grant budgets by 18%, giv-

ing us 18% less money to carry out one of our critical projects aimed at understanding the biology of gamma-secretase, an enzyme involved in the production of neurotoxic amyloid- β_{42} peptide found in the cerebral plaques of Alzheimer’s and an important therapeutic target. Other NIH grants of ours have taken comparable hits, and our lab is not alone: Many other biomedical research investigators face a similar plight. These setbacks have undoubtedly slowed the pace of essential research and ultimately will delay the availability of treatments and cures for devastating diseases. Truly, millions of lives are at stake.

But even from a strictly economic view, strong support for the NIH is in the nation’s best interest. Pharmaceutical and biotechnology companies take their cues from discoveries that are reported openly by federally funded researchers. Although these companies can’t afford to carry out long-term basic research, they ultimately reap great profits from the research carried out in academic labs. And start-up companies often spring from academic discoveries. Slowing the pace of basic biomedical research translates into fewer start-ups, fewer jobs, and a weaker economy.

In the long run, pharmaceutical and biotech companies enjoy the biggest financial gain from NIH research monies. Given this situation, it seems appropriate for these companies to reinvest a portion of their profits directly into NIH-funded research. I say reinvest because, ultimate-

ly, the industry as a whole prospers when academic labs can continue their work. Culling a very small portion of their enormous profits would not harm those industries but would make a tremendous difference in supporting the basic research that enables them to bring life-saving medicines to market.

Perhaps time is too short to implement these solutions for next year’s budget. In the meantime, nickel-and-diming the NIH will not help solve the federal deficit. In the interest of saving federal dollars today, we ultimately lose the larger return on the tomorrow’s investment. The proposed flat funding—actually a substantial cut—truly will be disastrous. Even a 3.5% funding increase, while an improvement over flat funding, would only allow researchers to keep up with inflation.

To ensure that progress moves at a reasonable speed, predictable, sustainable increases above the rate cost of biomedical inflation are needed. Is there the political will to accomplish this in the current fiscal climate? Let’s hope so: Times are indeed tough—so tough that we simply cannot afford to shortchange basic biomedical research. ■

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