Welcome to Davidge Hall

The University of Maryland School of Medicine, formerly known as the College of Medicine of Maryland, was chartered in December 1807. It is the fifth oldest medical school in the United States. Davidge Hall was constructed in 1812 and survives as the oldest building in the United States continuously used for medical education. In 1970, Davidge Hall was designated an official historical site by the Maryland Historical Trust. Four years later, the building was entered on the National Register of Historic Places and, in 1997, was named a National Historic Landmark by the U.S. Department of the Interior.

Acknowledgment:
The MAA wishes to express its appreciation to Morton D. Kramer, Class of 1955, for his generous support of this program.
The Medical Alumni Association Reunion Scientific Program

Historical figures, whose illnesses/deaths have not been satisfactorily explained in the past, are subjects for the annual clinicopathological conference. The concept for this conference was developed by Philip A. Mackowiak, '70, professor and vice chairman of the department of medicine at the medical school and director of the medical care clinical center of the VA Maryland Health Care System, two additional sponsors of this program.

The 2013 Clinicopathological Conference Sequence of Presentation

- Historical Re-enactment
- Musical Performance: Tuckahoe Travelers
- Welcome: Philip A. Mackowiak, '70
- Case Presentation: Ryan Scilla, MD
- Clinical Presentation: Joseph J. DuBose, MD
- Introduction of James I. Robertson Jr., PhD, by Kelly Norsworthy, '09
- Historical Perspective: James I. Robertson Jr., PhD
- Questions and Answers
- Concluding Remarks: Philip A. Mackowiak, '70
- Musical Finale: Tuckahoe Travelers
- Reception on the Lawn
Although this patient was a college professor, a husband, a Sunday school teacher and a church deacon, he is remembered mostly as a soldier who drew his sword for his state and threw away the scabbard. He, perhaps more than any commander in history, bewildered his enemies and kept them bewildered, giving hope for a brief period to his people, that they might prevail in their desperate pursuit of a lost cause. When his light flickered and a week later went dark, only then did they begin to suspect that God would let them be defeated.

The patient was a Virginian raised by a series of relatives after losing his alcoholic father to typhoid fever when he was two and his mother to pulmonary trouble (presumed tuberculosis) when he was seven. An older sister died of typhoid fever when she was but six years old and an older brother of tuberculosis at age 20. Only a younger sister and half brother survived him, the former to age 85, the latter to age unknown.

The patient suffered with chronic dyspepsia most of his life, treated with an ascetic diet heavy in every kind of fruit. He was obsessed with his health throughout his early manhood, convinced that practically all of his organs malfunctioned intermittently to the detriment of his vision, hearing, swallowing, digestion, liver, kidneys, blood circulation, nervous system, muscles and joints. To counteract these perceived disabilities, he dosed himself with a
wide variety of medicines and compresses. He inhaled glycerin, silver nitrate and the smoke of burning mullein. He also ingested a number of ammonia preparations. For a time, he imagined that one side of him was wasting away and sought to remedy the asymmetry by exercising the withered arm and leg with pumping motions every morning. To some these complaints amplified a wonderful eccentricity. To others, they were symptomatic of an underlying insanity.

Not all of the patient’s physical complaints were imagined. When he was 17, he had a brief episode of paralysis of unknown etiology. He had attacks of uveitis in his 20s, otitis media in his mid-30s, the latter of which left him deaf in his right ear. After an attack of “bilious fever” at age 36 he took the “water cure.” War seemed to agree with his health. However, while campaigning the year before he died, he suffered briefly with fever and exhaustion, was battered and bruised as a result of a fall from his horse, and had a recurrence of his earache.

The patient was a graduate of the U.S. Military Academy. He did not smoke or drink intoxicating liquors. He married twice, first at age 28, then again at age 33, three years after his first wife died of post-partum hemorrhage. Two children from the first marriage both died—a son (still-born) and a daughter (newborn jaundice). His second wife bore him a daughter who died of typhoid fever at age 26.

The patient was nearly 6 feet tall and weighed approximately 170 lbs. He had dark brown hair, which tended to curl, a fair complexion turned bronze by outdoor life, a high forehead, curved Indian nose and thin lips. Large blue-gray eyes dominated a face whose natural expression was a combination of thoughtfulness and fatigue. His frame was solid and erect, his feet several sizes larger than normal. His general appearance was more that of a well-to-do farmer than a general, who might pass through a crowd without attracting attention.

The patient was 39 when struck simultaneously by three .69 caliber bullets fired inadvertently by his own men. One entered his left arm 3 inches below the shoulder, splintering the bone and tendons of the upper arm before exiting. Another entered the left forearm an inch below the elbow, ripped through the lower arm and exited on the opposite side just above the wrist. The third passed through the right palm, fractured two fingers and lodged just under the skin of the back of the hand. During the incident his head slammed into a tree branch when his horse bolted, knocking off his cap, lacerating his face, and nearly unseating him. Somehow he managed to catch the reins and bring the horse under control.

On initial examination, the left arm was markedly swollen but not bleeding. A handkerchief was tied around the upper wound, and the arm placed in a crude sling. When the patient tried to walk, his legs were rubbery; his thinking was foggy. Soldiers gingerly placed him on a canvas stretcher, raised it to their shoulders and hurried to escape enemy fire that was being directed at them. Almost immediately the man supporting the left front corner of the litter was shot and fell, pitching the patient to the ground—in all probability landing on his left shoulder. When a replacement for the injured bearer was found, the patient was again placed on the litter, only to be dropped a second time on his shattered arm when one of the bearers got his foot entangled in a vine and fell. By this time there was heavy bleeding from the left arm, likely due to a torn brachial artery.

A rough tourniquet was applied to the left upper arm to control brisk hemorrhaging. The patient’s excruciating pain was treated with a little whiskey mixed with water. He was
then placed in a crude wagon with metal-rimmed wheels and inadequate (if any) springs and bounced over a rutted road to the nearest aid station. When examined by his personal physician, his clothes were saturated with blood still oozing from the wound in his left arm. His skin was clammy, his face pale. His thin lips were compressed so tightly, his teeth could be seen through them. Whiskey and morphine were administered. The patient was placed back in the wagon and pitched and bumped another four miles to a field hospital.

Five hours after the injury, the patient’s left arm was amputated just below the shoulder under chloroform anesthesia. A round ball from an old smoothbore musket was extracted easily from the sub-cutaneous of the right hand; isinglass plasters were applied to the facial lacerations. Thirty minutes later, the patient was awake, alert and able to drink a cup of coffee. Within six hours, his pain had subsided, and he felt strong enough to take a little food. Neither chills nor fever were present. He appeared to be regaining strength rapidly. However, by mid-morning he complained of pain in his side (laterality not recorded), for which no evidence of injury could be detected. The lung was functioning well, and the pain soon abated. The general became his old self, issuing a rash of orders. His physician was encouraged greatly by his appearance.

The patient slept well that night and awoke refreshed and in admirable condition. He was then transported by wagon 27 miles further to the rear. The trip took 14 hours, during much of which the patient was bright and talkative. However, by the end of the journey, the jolting ride had taken its toll. The patient’s stump was not bothering him, but he had renewed pain in his side and nausea. A wet towel placed over his abdomen gave him relief. When finally placed in a double rope-trellis bed in a little frame house, he eagerly ate some bread, drank a little tea and soon drifted into a sound sleep.

He awakened the next day in good condition. The wound in the hand was draining and painful. A stabilizing splint and simple lint and water dressing were applied. The patient was cheerful and ate a hearty breakfast. The next day he continued to improve. However, at 1:00am on the fourth post-operative day, he was feverish and nauseated and complaining of intense pain in his left side. Towels soaked in spring water were placed on his painful side, this time to no effect. Paroxysms of pain in the side grew worse; every breath caused a piercing sensation. When finally he was examined by his physician, the bed beneath him was saturated with spring water; he was breathing heavily and gasping; his pulse was rapid. Although he was apparently not coughing (nor is cough recorded at any time during his terminal illness), his physician was convinced that dreaded pneumonia had developed, and applied mustard plasters, wrapped the patient in blankets and began administering regular doses of laudanum (a mixture of opium and whiskey). The latter alleviated the patient’s pain but also put him in a stupor from which he never fully recovered.

During the next three days, the patient wandered in and out of consciousness. His breathing was heavy. For a brief period the pain in his side abated. He appeared more comfortable and rational and evinced optimism that he would recover. His wounds were healing naturally with moderate suppuration. However, the fever, labored breathing and delirium soon returned. He became progressively weaker, slipped into a deep coma and died on the seventh post-operative day.
2013 Participants

Joseph J. DuBose, MD, is clinical assistant professor of surgery at the R Adams Cowley Shock Trauma Center at the University of Maryland. He received a BS in chemistry from the Virginia Military Institute in Lexington, Va., in 1996 and his MD from the University of Virginia School of Medicine in Charlottesville in 2001. Both his internship and residency training in general surgery were performed at Keesler Air Force Base in Biloxi, Miss., and afterwards he returned to the University of Virginia for a year as chief resident. In 2007, DuBose completed a one-year fellowship in surgical critical care at the University of Southern California in Los Angeles. Promoted to the rank of lieutenant commander in 2009, he participated in Operation Iraqi Freedom in Balad, Iraq, in 2009; Operation Enduring Freedom in Kandahar, Afghanistan, 2010; and Operation Enduring Freedom in Bagram, Afghanistan, from 2011 to 2012.

James I. “Bud” Robertson Jr., PhD, retired in 2011 as alumni distinguished professor of history at the Virginia Polytechnic Institute and State University after a 43-year career at the institution. A native of Danville, Va., Robertson earned a BA from Randolph-Macon College in 1955 and MA from Emory University in 1956 where he later earned a PhD. Recognized as one of the most distinguished names in U.S. Civil War history, Robertson served as executive director of the U.S. Civil War Centennial Commission, working with Presidents Truman, Kennedy, and Johnson in marking the war’s 100th anniversary. He has authored more than 20 books including his seminal, 950-page volume Stonewall Jackson, The Man, the Soldier, the Legend which claimed eight national awards. In addition, he has been a contributor to National Public Radio, Public Television, and National Geographic. He taught the largest civil war history class in American higher education at Virginia Tech, averaging 300 students per semester.

About our Music

Dr. Banjo and the Tuckahoe Travelers bring to life vibrant music of mid-nineteenth century, recreating the spirit in which songs were played and sung when American popular music was born. The group consists of four Virginians: Dr. Banjo—Dean Havron—from Winchester, who plays five-string banjo, guitar and sings vocals; Kyle Contento, also from Winchester, on the fiddle; Darline DeMon, from Paw Paw providing vocals and percussion; and Rob Schuweiler, from Bunker Hill, playing guitar and also singing vocals. Special thanks to Maestro T. Herbert Dimmock, for his assistance in bringing Dr. Banjo and the Tuckahoe Travelers to Maryland for this conference.

About our Actor

Wayne Millan has been working behind the scenes of the CPC for more than a decade and periodically appears during the conference as a historical interpreter. His roles have included Dr. Samuel Mudd, an ancient Egyptian priest, and Commodore John Barry. His column, “Medicina Memoriae” appears regularly in the Medical Alumni Association’s Bulletin magazine, and he teaches Classical Latin at the George Washington University.
The Medical Alumni Association, in continuous operation since 1875, is the nation's oldest independent medical alumni association in the United States. It is a charitable organization dedicated to supporting alumni, students and faculty of the University of Maryland School of Medicine and Davidove Hall.

Subjects of Past Historical Clinicopathological Conferences

2012  Vladimir Lenin
2011  Charles Darwin
2010  Simon Bolivar
2009  John Paul Jones
2008  Akhenaten
2007  Abraham Lincoln
2006  Booker T. Washington
2005  Christopher Columbus
2004  Heinrich Schliemann
2003  Florence Nightingale
2002  Joan of Arc
2002  King Herod
2001  Claudius
2000  Mozart
1999  Pericles
1998  George A. Custer
1997  Beethoven
1996  Alexander the Great
1995  Edgar Allan Poe

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