

Boston University School of Law

## Scholarly Commons at Boston University School of Law

---

Faculty Scholarship

---

1995

### The Health of the President and Presidential Candidates: The Public's Right to Know

George J. Annas

Follow this and additional works at: [https://scholarship.law.bu.edu/faculty\\_scholarship](https://scholarship.law.bu.edu/faculty_scholarship)

 Part of the [Health Law and Policy Commons](#)



## LEGAL ISSUES IN MEDICINE

### THE HEALTH OF THE PRESIDENT AND PRESIDENTIAL CANDIDATES

#### The Public's Right to Know

GEORGE J. ANNAS, J.D., M.P.H.

In July 1995, presidential candidate Robert Dole celebrated his 72nd birthday by releasing a detailed nine-page summary of his medical records.<sup>1</sup> His personal physician told the press that despite the serious wounds Dole received during World War II, which left his right arm paralyzed and required the removal of one kidney, and despite his 1991 surgery for prostate cancer, his health was "excellent."<sup>1,2</sup> Dole was also photographed on his treadmill.

Since 1972, when George McGovern was forced to replace his vice-presidential running mate, Thomas Eagleton, after it was disclosed that Eagleton had been hospitalized for depression, the health status of presidential candidates has been seen as fair game by the press. In the 1976 presidential campaign, virtually all the candidates except Eugene McCarthy supplied summaries of their medical histories to the press.<sup>3</sup> Senator McCarthy argued that medical records were private, and in 1992 candidate Bill Clinton also appealed to privacy when he initially refused to release detailed medical information, saying he would release his medical records should he be elected President. But the day after physician-reporter Lawrence Altman wrote a front-page story in *The New York Times* asserting that "Mr. Clinton has been less forthcoming about his health than any Presidential nominee in the last 20 years," Clinton promised to make more medical information available to the press immediately.<sup>4,5</sup> Ross Perot, however, released no medical information during the campaign.

During every presidential campaign season (and this one has started very early), we ask the same question: How much information about the health of a presidential candidate does the public have a right to? Clinton's promise to open his medical records should he be elected President<sup>4</sup> poses a related question: How much does the public have a right to know about the health of the President?

#### MEDICAL PRIVACY AND THE PRESIDENT

It is a central legal and ethical principle that physicians should not disclose private medical information to people who are not involved in a patient's care without the patient's authorization.<sup>6</sup> The doctor-patient relationship is a confidential one, and a breach of confidentiality is unethical unless it is necessary to protect the public's health.<sup>6</sup> There is no exception to this rule for Presidents or presidential candidates. This does not, of course, mean that the President's physicians can ethically or legally mislead the public about the health of the President. Nonetheless, many have done so, and

these actions have led to increasing concern on the part of the public and the press about the health of the President. Franklin Roosevelt, for example, was a sick man during his third term, and the serious illness that led to his death only months into his fourth term was thought likely by his physicians before his reelection in 1944.<sup>7-9</sup> Some of Dwight Eisenhower's physicians thought he had only about a 50-50 chance to survive a full second term.<sup>9</sup> The existence of John Kennedy's Addison's disease was purposely obfuscated before his election.<sup>8</sup> And the extent of Ronald Reagan's health problems during his first term was not made public until after he completed his second term.<sup>9</sup>

Presidents have not always been pleased with the information their physicians have released, even when they authorized "complete disclosure." Eisenhower, for example, was greatly embarrassed when, after his first heart attack, his physicians announced that he had had "a good bowel movement."<sup>9</sup> And Reagan remained upset for years after one of his physicians at the National Institutes of Health announced, "The President has cancer," after his operation for colon cancer, instead of saying, "The President *had* cancer."<sup>10</sup> Presidential campaigns, of course, are based not so much on descriptions of the present as on predictions about the future. And this is what makes them especially problematic in terms of health information.

In the 1992 presidential election campaign, Paul Tsongas's history of cancer was central to his quest for the Democratic Party's nomination. Both he and two of his physicians said he was "cancer-free" after a 1986 bone marrow transplantation for lymphoma at the Dana-Farber Cancer Institute in Boston. Tsongas was the first candidate for President to announce that he had had cancer. A major question was whether the American public would accept a survivor of cancer as a candidate. After Tsongas suspended his unsuccessful campaign, he and his physicians at Dana-Farber told the press that he had actually had a recurrence of lymphoma in 1987, which had been successfully treated with radiation. Shortly after this announcement, Tsongas wrote that if he should rejoin the campaign he would make "all" his medical records available for "public inspection" even though he thought that this would set a precedent "that all candidates [would] have to follow."<sup>11</sup> He wrote further that if there was any doubt remaining, he would "submit to an examination by an independent group of doctors," something he thought other candidates would then be forced to do as well.<sup>11</sup>

In fact, Tsongas never rejoined the race, and shortly after the election he announced that his lymphoma had recurred. He underwent treatment just before Bill Clinton's inauguration. Tsongas called on President-elect Clinton to appoint a special commission to define what should constitute full medical disclosure for presidential candidates.<sup>12</sup> Clinton has taken no action on this or any other recommendation on making medical information about presidential candidates public.

Commenting on the December 1992 disclosures by Tsongas, Lawrence Altman wrote, "No less than the outcome of the 1992 Presidential primaries, and thus the election itself, could have been influenced by the

Dana–Farber doctors’ withholding of critical information.”<sup>13</sup> Tsongas had won the New Hampshire Democratic primary, and Altman believed that other candidates might have performed better and “emerged in a stronger position to challenge Bill Clinton for the nomination” had the recurrence of cancer been disclosed.<sup>13</sup> Of course, no one knows. Dana–Farber responded by developing a new medical-disclosure policy for public figures. It involves preparing a written summary of the patient’s medical history, which the patient may review but may not edit. If the patient approves, the statement is made available to the press, and a hospital spokesperson familiar with the relevant area of medicine — not one of the treating physicians (who might face a real or apparent conflict of interest in cases of full disclosure) — is made available to the press to comment on the statement.<sup>13</sup> This procedure is not too different from the one followed by George Washington University Hospital after the attempted assassination of President Reagan. There was no contingency plan for an attempted assassination, and so with the approval of White House officials, the hospital appointed a sole spokesperson to give bulletins on the President’s health to the press. Reagan’s White House physician reviewed these 27 press releases but made virtually no changes in them.<sup>14</sup>

Whatever one thinks of the medical privacy of candidates for the presidency, both Eisenhower’s heart attack and the attempt on Reagan’s life demonstrate that Clinton was correct to assert, as a candidate, that the health of the President is a more legitimate subject of public concern than the health of candidates for the office. This does not mean, however, that the President’s medical records or the President’s physician should routinely be made available to the public, only that adequate and accurate information should be supplied when illness or injury strikes the President. Rumors spread quickly when facts are not made available, as Boris Yeltsin discovered during his hospitalization in July 1995. Moreover, the provisions of the 25th Amendment to the Constitution, which provides for the President’s disability, apply only to the President, not to candidates.

### THE 25TH AMENDMENT

The transition of authority from President to Vice-President in cases other than death or resignation, as well as the possibility that the President and Congress might need to fill a vacancy in the office of Vice-President, was not dealt with until the passage of the 25th Amendment to the Constitution. Serious work on this amendment began after President Eisenhower’s heart attack, but it was not passed until after the assassination of President Kennedy. The 25th Amendment provides that when there is a vacancy in the office of Vice-President, the President “shall nominate a Vice President who shall take office upon confirmation by a majority vote of both Houses of Congress.” This procedure was followed when President Richard Nixon nominated Gerald Ford to replace Spiro Agnew and again when President Ford nominated Nelson Rockefeller to fill the vacancy left when Ford himself became President. Both

vacancies resulted from resignations in disgrace because of illegal activities, not death or disability. Two other sections of the amendment deal with the temporary transfer of power to the Vice-President when the President is “unable to discharge the powers and duties of the office.” This can be done either with or without the President’s consent.

The provision for the voluntary transfer of power, section 3, applies when the President will predictably be temporarily unable to perform his or her duties, such as when the President is out of communication with subordinates (with satellite communications, this no longer seems to be an issue) or under or recovering from general anesthesia. When the President transmits to the House and the Senate a written declaration to this effect, the Vice-President becomes the “Acting President” until the President later transmits a written declaration to the contrary. The only time this provision has been used was when President Reagan underwent surgery for colon cancer; Vice-President George Bush was Acting President for approximately eight hours.<sup>15</sup> President Reagan’s letter to Congress unfortunately questioned whether the 25th Amendment was applicable to “brief and temporary periods of incapacity” such as his situation, although this was just the type of situation the amendment was meant to cover.<sup>9,14,16</sup>

Most of the controversy over presidential health has involved discussions of when a President’s power can be involuntarily removed because of physical or mental incapacity. Specifically, section 4 of the 25th Amendment provides that a declaration of the President’s inability to “discharge the powers and duties of his office” be transmitted to the House and the Senate by “a majority of either the principal officers of the executive departments or of such other body as Congress may by law provide.” The Vice-President then becomes the Acting President until the President submits a written declaration that he or she is able to resume the presidential duties.

Physician commentators generally seem to favor getting physicians more directly involved in monitoring the health of the President. It has been suggested, for example, that Congress should use its authority under the 25th Amendment to set up a blue-ribbon national panel of physicians to monitor the President’s health and to make the referral to Congress if necessary.<sup>7,14</sup> This procedure might have the advantage of taking the initiation of such a referral out of the political realm, where it may look like a betrayal by a disloyal Vice-President and his or her supporters. But this is its disadvantage as well. Taking away the powers of the President involuntarily, even temporarily, is an issue that should be decided in the political arena, because this is the arena in which we determine who should be President. Nevertheless, most involuntary suspensions would probably involve cases of mental instability or dementia, and medical expertise in these areas would be essential to making a reasonable evaluation of the President’s condition.

Proposals have accordingly been made that a mental health unit be formed in the White House as part of the medical office “to assist the White House physician in

diagnosing and treating psychological problems.”<sup>17</sup> The desirability of such a unit has been described as “indisputable — as is the political impossibility.”<sup>18</sup> Americans still seem unable to accept a President who has had occasion to consult a psychiatrist. Other proposals to monitor the President’s health have also been widely discussed. One is for Congress to create a broader, standing “inability commission” of respected medical experts and senior government officials. This proposal, however, lost much of its momentum in 1958 when Chief Justice Earl Warren sent a letter to Congress advising against putting any member of the Supreme Court on such a commission.<sup>19</sup>

### THE ROLE OF THE WHITE HOUSE PHYSICIAN

What role should the President’s White House physician have in making information about the President’s health available to the public in general, and in making a determination of presidential disability in particular? In terms of what should be disclosed to the public, I agree with those who believe the White House physician should act as the President’s personal physician and, as such, should be bound by the same rules of confidentiality as all other physicians. Exceptions designed to protect the public seem unnecessary, since the President’s closest advisors and senior cabinet members will certainly be aware of his or her ability to function mentally.

It has been suggested that the physician to a national leader might have an obligation to disclose

when the leader is not competent to decide his own fate, as for example in circumstances of dementia or severe functional psychiatric disorders, such as mania or severe depression; when the leader is about to commit a major act of illegality because of medical impairment; and when the leader is about to commit a grossly immoral act because of medical impairment.<sup>7</sup>

Although the first of these three cases is potentially compatible with both medical ethics and the 25th Amendment, it is unnecessary, and the latter two fall outside the role and expertise of physicians. They involve interpreting the law and acting as a judge of the President’s morals, areas in which medical expertise is not useful.

The White House medical unit was expanded under President George Bush to include four physicians (a physician to the President and three White House physicians) as well as five physician’s assistants and five nurses.<sup>14</sup> Like Bush, President Clinton has developed a detailed contingency plan for implementing the provisions of the 25th Amendment, which spells out the role of the physician to the President in this process. The plan is classified. It is, of course, good to have such a plan; the fact that it is classified, however, makes it impossible to tell how sound the plan is. In any event, the primary role of the physician to the President, who is usually chosen more for political connections than for medical prowess, should be in assembling the appropriate specialists needed to make an accurate diagnosis of the President’s condition and to determine the prognosis. It is not the physician’s job to determine whether the condition makes the President unable to discharge

his or her duties. If the senior staff and Cabinet members believe the President can perform his or her duties, who is the physician to disagree? This is different from the situation in which a physician treating an airline pilot or school-bus driver is the only one who is aware that the patient’s medical condition poses a risk to the public. In such a case, if the patient will not voluntarily cease the dangerous activities, the physician may disclose to the patient’s employer information that is necessary to protect the public.<sup>6</sup>

Although physicians cannot predict with any degree of certainty how a candidate’s medical condition will affect his or her ability to perform politically, the public may take very seriously their views on the likelihood of death or disability in office. President Eisenhower, for example, had to make a decision about running for a second term after his heart attack. His most famous cardiac consultant, Paul Dudley White, found himself in a position where he could essentially have had veto power over the decision by saying publicly that Eisenhower should not run for reelection because of his health.<sup>9</sup> White did try privately to persuade Eisenhower not to run (and instead become the world “ambassador for peace”) but ultimately accepted that the final decision should be made by the President, not the President’s physician.<sup>9</sup> Eisenhower had many medical problems during his second term, but he survived them all and lived another eight years after he left office.

The first clear signs of bladder cancer were not found in Hubert Humphrey until 1969, after he had lost the 1968 presidential election to Richard Nixon. It has been suggested that had molecular diagnostic techniques been available, they could have detected the aggressive cancer by May 1967 and that if Humphrey had known about it, “he might have withdrawn from the presidential race.”<sup>20</sup> Whether to withdraw, however, should have been Vice-President Humphrey’s decision, not that of his physicians. Humphrey died in 1978.

### LIMITS ON PUBLIC CURIOSITY?

Presidential candidate Paul Tsongas suggested that by making public all medical records and submitting to a medical examination by an expert medical panel, any presidential candidate could force all the other presidential candidates to do the same. To the extent that Tsongas was right, presidential candidates wind up playing a public game of chicken with their medical records and thus their medical privacy. Clinton’s position as a candidate is the proper one: there should be limits on what presidential candidates should be expected to disclose about their physical and mental health. These limits cannot be imposed by law (since the candidates could always make voluntary disclosures) but must be imposed by the candidates themselves, and by their advisers and physicians. If these limits are seen as reasonable, they will be respected by the public even if they are challenged by the media, which seem much more interested in private medical information than the public is. The public will learn much more about a candidate’s fitness for the presidency by the candidate’s performance in the campaign<sup>21</sup> than by the release of his or her medical records. More-

over, the public is likely to be best served by candidates and Presidents who seek medical care when they need it, without fear that doing so will jeopardize their political future.

Some medical information is obvious or nonstigmatizing, and its disclosure is probably harmless. Both Clinton and Dole, for example, have made public their serum cholesterol levels, weight, and blood pressure, and these numbers have already been used in presidential politics. Senator Dole remarked at the July 1995 meeting of the National Governors' Association, "My weight is lower than Clinton's. My cholesterol is lower than Clinton's. My blood pressure is lower than Clinton's. But I am not going to make health an issue in 1996."<sup>22</sup> Clinton, who spoke to the same gathering a few hours later, said that he believed his resting pulse rate was actually lower than Dole's, but that this was not Dole's fault because "I don't have to deal with Phil Gramm every day."<sup>22</sup> However, to the extent that cholesterol levels and weight are used as measures of virtue, all this is nonsense and is likely to distract us from focusing on the substantive policy differences between the candidates.

Much more serious issues are raised by sensitive medical information that is inherently embarrassing or invites irrational prejudice. The fact of having consulted a psychiatrist is one such area, and I believe this should not be disclosed by candidates. A history of institutional mental health care is even more prejudicial, as the Eagleton case illustrates. We should encourage our leaders to seek such help whenever they feel they need it, both for their own sakes and for ours, and protecting their medical privacy is essential if this is to happen. Three other types of sensitive information also deserve attention. The first is abortion. Since there have been few women candidates for the presidency, this issue has not yet come up; we should agree now that it never should. The second is status with respect to the human immunodeficiency virus (HIV). Presidential candidates may, of course, wish to know their own HIV status, but there seems no reason for anyone other than their personal physicians and their sexual partners to know it. Of course, at some point AIDS may develop in an HIV-positive person, and this would be difficult, if not impossible, to keep secret. The only suggested rationale for presidential candidates to be tested for HIV is that this test is routine in the military and the President will be the commander-in-chief of the armed services.<sup>1</sup> But the military reasons (saving on disability benefits and — incredibly — the possibility of a battlefield transfusion) do not apply to the President.

Third, and perhaps most important, there is an entire new set of tests — genetic tests — that will soon become available and will be able to make at least some probabilistic, though not definitive, estimates of the odds of a person's having certain diseases, such as early-onset Alzheimer's disease, breast cancer, and colon cancer.<sup>23,24</sup> These tests have the potential for much mischief in presidential politics. Their results could be used to play to the fears and prejudices of the electorate, even though by themselves they cannot accurately predict how good or bad a President will be or whether the

person will be able to do the job. Everyone will die, and if they live long enough will die of a genetically influenced disease, because we all carry at least some genes predisposing us to death and mental disability. It would be pointless and distracting to search for those that evoke the most fear in the electorate, since this is a reflection not of the fitness of a person for the presidency but of our own fears of death and disability. A good rule to adopt now is for candidates (and their physicians and advisors) to put the results of genetic tests off limits in any disclosure of the health status of a candidate or of a President.

## CONCLUSIONS

Senator Eugene McCarthy was right to protect his medical privacy in the 1976 presidential campaign. He was also right to insist that a President be elected "on the basis of his or her record of service, of thought about the issues and programs to deal with them, and not on the basis of any private status such as that of patient."<sup>3</sup> U.S. Presidents have always been more likely to be killed or disabled by assassins than by diseases, and the Secret Service thus has more to do with the President's health and safety than the President's physicians.

The things we want to know about the health of Presidents and presidential candidates tell us much more about ourselves than about the Presidents and would-be Presidents. They tell us what we fear, and what we hope for. Reasonable medical disclosures are now taken for granted and may not be too harmful. But we are rapidly approaching the point of diminishing returns, and unless we want to discourage our Presidents, presidential candidates, and possible presidential candidates from seeking medical assistance in times of physical and psychological distress, we must show at least some respect for their medical privacy by setting limits to expected disclosures. There is no simple legal or procedural rule that can ensure this. The 25th Amendment provides what is probably as good a set of procedures as we can devise to deal with temporary presidential disability. Presidents will have to disclose the details of actual injuries and illnesses in office. But the 1996 election provides an opportunity for us to begin to curb our tabloid-press-fed curiosity about the private medical information of presidential candidates. We should take this opportunity; it may be our last.

## REFERENCES

1. Altman LK. Doctors say Dole is in 'excellent' health. *New York Times*. July 22, 1995:9.
2. Berke RL. Dole, 72 today, issues findings that his condition is excellent. *New York Times*. July 22, 1995:1.
3. Bloom M. Should the health of presidential candidates be a campaign issue? *Medical World News*. February 1976;17(3):34-54.
4. Altman LK. Clinton, citing privacy issues, tells little about his health. *New York Times*. October 10, 1992:1.
5. Clinton promises medical details. *Washington Post*. October 11, 1992:A35.
6. Annas GJ. *The rights of patients*. 2nd ed. Carbondale: Southern Illinois University Press, 1989.
7. Post JM, Robins RS. *When illness strikes the leader*. New Haven, Conn.: Yale University Press, 1993.
8. Crispell KR, Gomez CF. *Hidden illness in the White House*. Durham, N.C.: Duke University Press, 1988.
9. Ferrell RH. *Ill-advised: Presidential health and public trust*. Columbia: University of Missouri Press, 1992.

10. Reagan R. An American life. New York: Simon & Shuster, 1990.
11. Tsongas P. The cancer freed me: it freed me. New York Times. May 6, 1992: A29.
12. Knox RA. Tsongas responds: acknowledges cancer, urges full disclosure by candidates. Boston Globe. December 1, 1992:1.
13. Altman LK. Tsongas's health: privacy and the public's rights. New York Times. January 17, 1993:26.
14. Abrams HL. 'The president has been shot': confusion, disability, and the 25th Amendment in the aftermath of the attempted assassination of Ronald Reagan. New York: W.W. Norton, 1992.
15. Brown WF, Cinquegrana AR. The realities of presidential succession: 'the emperor has no clones.' Georgetown Law J 1987;75:1389-453.
16. Longaker RP. Presidential continuity: the Twenty-fifth Amendment. UCLA Law Rev 1966;13:532-63.
17. Gilbert RE. The mortal presidency: illness and anguish in the White House. New York: Basic Books, 1992.
18. Greenberg DS. Review of: *The mortal presidency: illness and anguish in the White House*. Nature 1993;361:125.
19. Curran WJ. Presidential inability to function: the medicolegal issues. N Engl J Med 1986;314:300-1.
20. Hruban RH, van der Riet P, Erozan YS, Sidransky D. Molecular biology and the early detection of carcinoma of the bladder — the case of Hubert H. Humphrey. N Engl J Med 1994;330:1276-8.
21. Cramer RB. What it takes: the way to the White House. New York: Random House, 1992.
22. As Dole counts calories, Gramm weighs in. New York Times. August 1, 1995:A10.
23. Annas GJ, Elias S. Gene mapping: using law and ethics as guides. New York: Oxford University Press, 1992.
24. Annas GJ. Genetic prophecy and genetic privacy: can we prevent the dream from becoming a nightmare? Am J Public Health 1995;85:1196-7.

## BOOK REVIEWS

### AUTOBIOGRAPHY OF A FACE

By Lucy Grealy. 223 pp. Boston, Houghton Mifflin, 1995. \$19.95. ISBN 0-395-65780-6.

Although physicians understand how a patient's definition of self and identity may be bound to the face, in *Autobiography of a Face*, Lucy Grealy writes about this topic from a unique and sobering perspective. At the age of 9, she underwent a partial mandibulectomy for Ewing's sarcoma, followed by 2½ years of chemotherapy and radiation treatments. In her book, written when she was in her 20s, Grealy describes the daily burden of physical and emotional pain she bears and explores how this helped define her persona.

Whether trying to eat after chemotherapy or withstand the jeers of boys in junior high school, Grealy struggled every day to maintain her dignity and self-awareness. She captures how a physician can so easily instill hope or destroy confidence. Her description of failed nasal intubation is alarming. Neither nostril was patent, "so they decided to go straight through my mouth. This required prying my mouth open and keeping it open, which hurt like hell, but worse was that at each attempt to pass the tube, my airway was temporarily blocked and I couldn't breathe, which put me into a panic." Grealy does not fault the medical establishment. Rather, her graceful and articulate prose describing a physician's routine reminds us of the sensitivity we must exercise in caring for patients. She has hope and faith in her physicians, who offer her a microvascular free-flap reconstruction. Grealy writes:

Maybe life was going to be all right after all. . . . What would it be like to walk down the street and be able to trust that no one would say anything nasty to me? My only clues were from Halloween and from the winter, when I could wrap up the lower half of my face in a scarf and talk to people who had no idea that my beauty was a lie, a trick that would be exposed the minute I had to take off the scarf.

Unfortunately, the flap reabsorbed, leaving Grealy thinking: "I felt like such a fool. I'd been walking around with a secret notion of promised beauty, and here was the reality."

As surgeons we like to believe we understand how our craft can affect a person's identity; as physicians we like to believe we understand the psychology of self-definition and self-perception; and as human beings we like to believe we understand how our words can comfort and can even soften the blows from disease and treatments. Grealy, however, forces us to look through her eyes and see her face. We are not as gentle as we would like to think.

Grealy describes how her self-awareness and identity evolved. As doctors, we can only benefit from her candid thoughts and better understand how our words and actions

help mold patients' perceptions of themselves. Finally, after arriving at a cosmetic solution, Grealy asks: "Where was all that relief and freedom that I thought came with beauty?" It is only after Grealy scrutinizes her inner self — that is, her personality, beliefs, and emotions — that the importance of her appearance fades and her true beauty is revealed.

ROSS I.S. ZBAR, M.D.  
University of Iowa

### REOPERATIVE AESTHETIC AND RECONSTRUCTIVE PLASTIC SURGERY

Edited by James C. Grotting. 1661 pp. in two volumes, illustrated. St. Louis, Quality Medical, 1995. \$395. ISBN 0-942219-25-2.

Never before has an entire textbook been devoted to the subject of reoperative surgery. Usually the subject is covered in a few paragraphs at the end of a chapter. Yet, as pointed out in the foreword of *Reoperative Aesthetic and Reconstructive Plastic Surgery*, "all surgeons face reoperations as a routine part of their practices." These reoperations are necessary to refine results, manage complications, or complete the final stage of a sequential procedure. The reoperative setting often tests even the most seasoned surgeon's skill and integrity. As stated in the preface, "The thread of commonality uniting all reoperative surgery is that the plastic surgeon finds himself confronting tissue planes biologically altered by the effects of wound healing."

Editors of multiauthored textbooks face a real challenge to maintain uniformity of quality. The editor of this book states that he has attempted "to draw on the cumulative experience of master surgeons to increase our chances of obtaining a favorable result." He has succeeded in doing just that. He has fashioned a mix of contributors consisting of senior professors, private practitioners, and plastic-surgery residents and fellows while maintaining a uniform approach and an excellent level of quality. The effort succeeds in part because of his supervision of manuscript preparation and in part because of his contributions as author or coauthor of nine chapters.

This book is much more than its title suggests. In order to foster a discussion of the philosophy, planning, and technique of reoperation, each author has reviewed the anatomy and blood and nerve supply of a specific body part and outlined the principles of the initial operation leading to the requirement for reoperation. This background and the clarity with which it is presented make this one of the most readable textbooks on plastic and reconstructive surgery. The illustrations are outstanding. Very clear drawings combined with color prints allow the reader to visualize what the text attempts to convey.

Having surgeons such as Horton discuss reconstruction of