



MILWAUKEE ACADEMY OF MEDICINE



Volume XXXV / September 2013

President's Remarks

By Edwin G. Montgomery, M.D.
President 2013

History seems not merely to repeat, but to recycle. The accumulated minutes from our 127 year old Academy reflect sine waves of prosperity and peril, currently a paradoxical combination of the two. In the Spring of 1912,

a motion to raise the dues from \$10 to \$15 because of a \$200 operating deficit was rejected, as was a motion to levy a \$2.00 assessment.

Convoluting real estate dealings in the 20's seemed to indicate that our Academy had as much interest in finance as it did in Medical Science, and

only the ongoing generosity of Horace Manchester Brown kept us afloat. In the mid thirties dues caused the membership to dwindle significantly "because of financial necessity." Ultimately, under the guidance of trustee Attorney Carl Rix (my mother's boss at the time!), our Academy got out of the real estate business, invested \$25,000 in bonds, and began our current endowment.

We are now in that paradox. We have a rare book collection worth over a half million dollars, and currently about \$400,000 invested and carefully tendered by our Board of Trustees. The Medical College of Wisconsin generously

provides us with office space and houses our books, at no cost to us. My right hand and the heart of our Academy, Amy John, has declined a raise in her salary for the last 6 years. Membership dues cover the costs of payroll and general operating expenses as well as speaker honorarium, travel and lodging.

But our dues do not come close to covering our expenses. One hundred seventy-eight active members pay \$195 annually (i.e., \$35,000); 70 seniors (over age 65) are not required to pay dues, though some do. The median age of our members is 66, and the median age of those who regularly attend dinner meetings is 71. Over the past several years we have tapped our investment fund annually for \$40,000.

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Fall 2013 Meeting Dates



September 17

Jerome Lowenstein, M.D.
Professor Medicine, Chief,
Edward C. Franklin Firm,
Founder and Director of the Humanistic
Aspects of Medical Education
Program at NYU School of Medicine
**Shifting Paradigms: The Oldest Art
Became the Youngest Science**

October 15

2013 Distinguished Achievement Award
James E. Youker, MD, FACR
Robert C. Olson, MD,
Professor of Radiology
Department of Radiology
Medical College of Wisconsin
**Medical Imaging:
Past, Present and Future**

November 19

Susan Lederer, Ph.D.
Robert Turell Professor
of Medical History and
Bioethics, Chair, University
of Wisconsin -Madison
**"Fun in Bed": Keeping Patients Happy
in the 20th Century Hospital**

All meetings are held at the
University Club, 924 East Wells Street,
from 6 to 9 p.m. unless otherwise noted
on the program announcement.



Contact the Milwaukee
Academy of Medicine office for
reservations: amy@milwaukee
academyofmedicine.org
or phone 414/456-8249

The 1,301st Meeting

May 21, 2013

by Nick Owen, M.D.

On May 21st, 2013, the Milwaukee Academy of Medicine met for its 1,301st meeting at the University Club. The meeting was opened by Dr. Ed Montgomery, President, who after announcing that the speaker for the annual bioethics lecture on September 17th would be Dr. Jerome Lowenstein, then introduced the evening's speaker, Michael McCrea, Ph.D., Professor of Neurosurgery and Neurology, Director of Brain Injury Research, Medical College of Wisconsin, who discussed Scientific Advances in Sport-Related Concussion.

Case series (both retrospective and prospective) with serial examinations, brain scans and measurements of impact have established that while 20% of concussions recovered in 24 hours, only 85% had fully recovered in 7-10 days. Evidence of injury (by exam or scan) may persist for several days after clearing of symptoms. Long term risks and outcomes were discussed. Points of interest: heading of soccer balls is not a cause of injury for soccer players; for boxers, the number of hours of sparring is more predictive of damage than the number of knock-outs; multiple concussions predict increasing damage; and re-injury during the 7-10 day recovery period produces more damage than new injuries acquired subsequent to recovery.

During the discussion period after the talk, it became clear that audience interest came from involvement in sports medicine and head injury at different levels: personal, family, acting as team physicians, and others. All were delighted to hear from one of the pioneers applying scientific method to situations which have been largely managed anecdotally.

Dr. McCrea and co-workers have produced rational guidelines and promoted legislation at the state level to protect athletes.~

Call the Midwife

Review by H.D. Kerr, M.D.

Currently, PBS is presenting an excellent British series, "Call the Midwife". Set in the poverty stricken London docklands of post war Britain, it depicts the struggles of young nurse midwives and their sometimes grim Anglican nun supervisors, all aided by one obstetrician. The phone rings announcing that someone is in labor. Off goes one or more of them on bicycles through the crowded streets, dodging cars, pushcarts, and people. Some of those in labor are their patients, and others have had no prenatal care. They encounter concerned husbands or friends, prostitutes, hostile angry husbands, those very poor and alone, and the gamut of happy and fearful deliveries. An aging woman deformed by rickets in childhood had lost all of her pregnancies. With difficulty she finally succeeds. A 15 year old without a friend in the world has her baby taken from her by authorities and put up for adoption without her consent because she was alone and too young to give it. Undaunted she finds the child and takes it back. Police are involved. Two midwives are called to the waterfront where a woman in the ship's crew is in labor. They climb the rope ladder 40 feet to the main deck and find their charge, the captain's daughter, speaking mostly Swedish. He has prostituted her to his own crew. Despite denials of pregnancy and assertions that she always forced them to use a "rubber", she with difficulty is aided in delivering her baby. "Now I'll have a friend for life" she says. The younger midwife royally upbraids the captain. Based on one of the midwives' experiences, the program presents real problems and real people. It is based on Jennifer Worth's 2008 book "Call the Midwife: A Memoir of Birth, Joy, and Hard Times."~



President's Remarks

Continued from page 1

Your executive committee and the Board of Trustees, and a couple “ad hoc” groups have tussled with the issue, but would like input from all the membership, voting (dues paying) and seniors alike. Increasing the membership from the current 248 to the authorized 350 would go a long way to resolving our financial problems, but despite heroic efforts by Matt Lee, Membership Chair, and several others, our attrition rate continues to exceed our new membership enrollment.



Expenses could be pared a little (e.g., e-mail this newsletter), but the savings are modest at best. Dues can be increased from the current \$195 to \$250, or so, in line with such outfits as the Milwaukee Gyn Society (\$450) or the Milwaukee Academy of Surgery (\$325). Perhaps bill the Seniors \$150, though several may find this onerous. We have looked at selling our book collection book-by-book, or as a whole, but to some of us that seems almost Faustian. We can continue to deplete our reserves, but that will only postpone the inevitable.

OR, is it time to shut our doors after only a century and a quarter in this era of social media and internet education, and with so many families in which both parents are at work all day and not enthused about leaving the kids for evening meetings? (My own physician children have zero interest in coming to dinner meetings such as ours.) Have we become as anachronistic as the Hayden-Hauser hemoglobinometer, the per fontanelle contrast media injections, and the wet readings, up with which I grew?

Let us hear from you, preferably by e-mail.

Mine is: montg07@sbcglobal.net

Amy's is: amy@milwaukeeacademyofmedicine.org

In October we'll devote some time to discussing these issues and, perhaps, request a by-laws change to save our current President Elect, Dr. Ellen Blank, from having to clean up my mess and allowing me to stew for ONE more term. ~

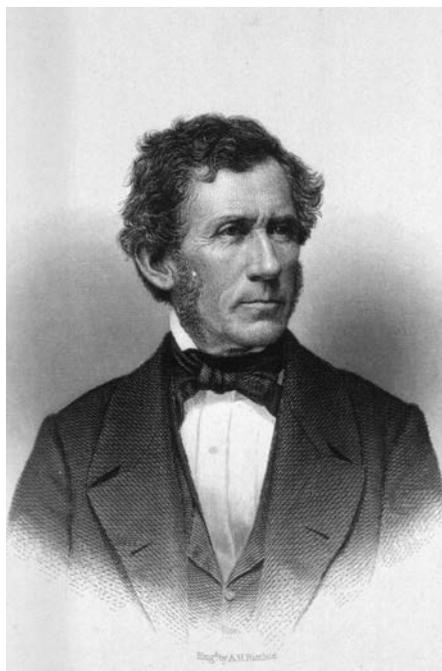
From the Academy's Rare Book Collection

Review by H.D. Kerr, M.D.

Daniel Drake, MD

Daniel Drake (1785-1852) was one of America's most notable early physicians. He was born in Essex County, New Jersey into a family that had settled in America in the late 1600s. His father Isaac and uncles Abraham and Cornelius had fought in the Revolutionary War. After the war his parents found themselves quite poor and decided, along with family members and other New Jersey neighbors, to travel west to the new lands beyond the colonies. There, land was available at low prices. Daniel was three when this journey began. Along went his newborn sister and his mother, a sturdy and able Quaker. They drove their two horse wagon more than 400 miles across the Appalachians to Pittsburgh, and floated downstream to Kentucky on flatboats with their horses and wagons on board.

Fifty-two people from east Jersey settled eventually near Mayslick in Kentucky, south of the Ohio River and near the nascent city of Cincinnati, founded in 1788. Daniel had much to say later about the "school of the woods" and all one could learn and contemplate within its confines. His father bought 36 acres of land, all he could afford. They built their cabin, cleared their land, bought animals, farmed, produced and gathered their own food, and were largely self sufficient. Itinerant teachers taught the children to read, write, and count. At home they read the Bible, Pilgrim's Progress, Aesop's Fables, Watt's Hymns for Children, and sometimes their father's Love's Geodaesia or the Art of Surveying and Measuring Land Made Easy. Buoyed by their devoted parents Daniel and his sister were free to learn anything and everything. (1).



Drake, Daniel.

A Systematic Treatise, historical, etiological, and practical on the principal diseases of the interior valley of North America.

Ed. by S Hanbury Smith and Francis G. Smith Philadelphia: Lippincott, 1854.

Drake, Daniel, 1785-1852. Practical Essays on Medical Education, and the Medical Profession, in the United States. Cincinnati, Roff & Young, 1832.

The children's cousin, John Drake, seven years older than Daniel, had also made the journey west. His father became a successful tavern keeper and merchant. John had apprenticed and studied medicine under Dr. William Goforth (1766-1817) in Kentucky in 1796-7. Dr. Goforth too was from New Jersey and became acquainted with the Drake family during their trip down the Ohio River. After his apprenticeship John studied medicine at the University of Pennsylvania in Philadelphia. Benjamin Franklin's "Proposal for the Education of Youth in Pennsylvania" of 1749 aimed at providing knowledge of the arts and practical skills necessary for making a living and doing public service. (2) This differed markedly from the goals of the other three colleges in the colonies at that time which aimed at educating clergy. The curriculum and teaching of medicine at Pennsylvania was based on methods used in Edinburgh and London. John returned to Mayslick, tutored Daniel for a time, and then began medical practice. But very soon thereafter he died of typhus (1800). Daniel inherited his books and manuscripts and studied them diligently. His father wanted him to study medicine and made the appropriate arrangements and payment. At age 15, they rode to Cincinnati to begin Daniel's apprenticeship with the admired and talented Dr. Goforth. In the ensuing years he was very pleased with Daniel's progress and in 1804 made him his partner in his extensive practice. Daniel wished to continue his education and arranged to enroll at the University of Pennsylvania medical school. With the encouragement of Dr. Goforth and traveling there on horseback, he arrived

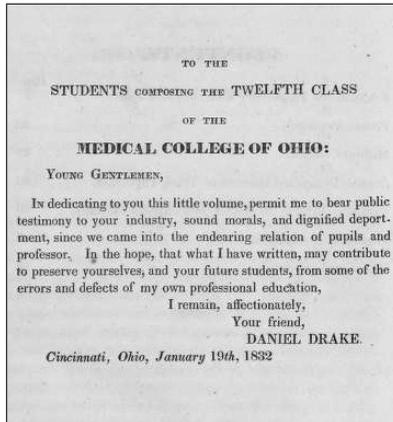
Continued on page 5

in 1805 and completed one series of lectures. He returned to practice but resumed his studies in 1815. With this further education he received his Doctor of Medicine degree in May 1816.

With the death of Dr. Goforth in 1817 Daniel, his wife and children travelled to Lexington, Kentucky where he was invited to join the faculty of Transylvania College as Professor of Materia Medica. He returned to Cincinnati the following year and pursued an opportunity to participate in the founding of the Medical College of Ohio and hospital, chartered by the state of Ohio. The doors opened in 1820. Drake was named president of the faculty of five professors and served as Professor of Medicine and Obstetrics. The college had a stormy future with faculty members coming and going (including Drake). Eventually it became the College of Medicine of the University of Cincinnati. Over the next thirty years at various times he served on the faculties of Transylvania College, the Medical College of Ohio, the Medical Institute of Louisville, and Jefferson Medical College in Philadelphia.

During those years he pursued his broad academic interests and inquiries. He founded the Western Journal of Medicine and Surgery with its name altered several times. Drake was described as a brilliant man with many friends and many interests. The frontier was not isolated from the scientific progress being made in Europe and the American east. Dr. Drake demonstrated an immense knowledge of contemporary science notably the discoveries of Humphrey Davy, Von Helmholtz and many others. He was acquainted with Ephraim McDowell, a surgeon living in Kentucky who had been trained in Edinburgh and using a clean and meticulous technique had succeeded in removing a twenty-two pound ovarian mass from a rural patient. She survived to live thirty-two more years.

Dr. Drake advised potential contributors to the Western Journal of twelve particular topics of the journal's interest: rare or new diseases, annual or seasonal epidemics, new medicines, native



22 THE PRINCIPAL DISEASES OF THE

The British returns* are more limited, for the number of posts are smaller, and the range of country and climates less. They do not, moreover, give the relative number of cases in different seasons, or at the separate stations, and therefore express the prevalence of autumnal fever in Canada, generally, not in particular localities.

TABLE
EXHIBITING THE ANNUAL PREVALENCE OF AUTUMNAL FEVER AMONG THE BRITISH TROOPS IN CANADA.
Ratio of cases to the mean strength of 1,000.

LOCALITIES.	Autumnal Fever.	Remittent Fever.	Annual Average of both.
Canada, between the latitude of 42° and 47°, from 1817 to 1830, inclusive—20 years,	79	5	84
Upper Canada, the principal Posts—Kingston, East end of Lake Ontario, N. Lat. 44° 30'—Fort George, North side of same Lake, in 44° 25'—Fort George, mouth of Niagara River, in 43° 15'—Auburnburg (Malden), West end of Lake Erie, in 42° 19'—from 1818 to 1827, inclusive,	178	32	310
Lower Canada, principal posts on the River Richelieu, which connects Lake Champlain with the St. Lawrence, latitude from 45° to 46°—Montreal, latitude 45° 25', and Quebec, latitude 46° 47',	26	1	27

This table, by embracing the Peninsula north of Lakes Erie and Ontario, together with the banks of the St. Lawrence, down to its estuary, completes what the other left unfinished; and enables us to estimate the relative prevalence of autumnal fever, through every parallel of latitude, from the mouth of the Mississippi, to that of the St. Lawrence, and from Cape Florida to Gros Cap, at the entrance of Lake Superior.

We should be aware, however, that the numbers in the tables do not always express, correctly, the cases of fever originating in the localities with which they stand in connexion. Thus, Maj. Tulloch, the compiler of the British Report, informs us that many of the cases of fever returned from the posts of Lower Canada, were relapses in patients from the posts of Upper Canada; and in the United States, our troops are often sent to more northern posts to recover from the fevers of the south; and thus by relapsing, add not a little to the number of cases at posts which otherwise might have presented but few.

* Tulloch's Statistical Reports on the Diseases, Mortality, and Invaliding among the Troops in the United Kingdom, Netherlands, and British America, prepared from the Returns of the Army, Militia Departments, and War-Office Returns, by command of Her Majesty, London, 1829.

medicinal plants, chemical and therapeutic accounts of mineral springs, diseases prevalent on ships and steamboats, reports on diseases in penitentiaries, and new minerals that are in any way useful as pharmaceuticals. For essays or dissertations he recommended that they most importantly be truthful, second having perspicuity (clarity), next conciseness, and finally originality. Fifty dollars was paid to the best dissertation each year. Dr. Drake nourished his abiding interest in cholera and made many inquiries and encouraged studies concerning its causes and treatment. He continued to study Hippocrates, in particular the importance of the locale on the manifestations of diseases. His editorials were detailed, and he crusaded against incompetence. He was persuasive rather than imperious.

As he knew from experience, students were generally compounders of prescriptions in the Doctor's office. Sometimes they are qualified for the task, he wrote. He asserted, however, that physicians must read those prescriptions after writing them to eliminate errors and correct unclear words or writing. He was more harsh with apothecaries who "take small boys on as apprentices and clerks, who are often illiterate and always unacquainted with chemistry and botany...to place a small boy behind the counter of a druggist...is homicidal; and no physician should sanction it...working among poisons with as much confidence and unconcern as a confectioner's apprentice beats up eggs, or licks the syrup from the ends of his fingers." (3 p.193) On the problem of quackeries he noted that "To eradicate them would be more difficult than to root out the sour dock and Canadian thistle of our own fields while the soil continues to favor their reproduction." (3 p.197) He was a powerful and inspirational speaker and had a similar impact with the medical journal he founded. One annotated bibliography lists 730 publications (3).

Late in life at his children's request he wrote "Pioneer Life in Kentucky" (1) a very interesting memoir of his early days and done as a series of letters to each of them and their spouses.

Dr. Drake saw the best in rich and poor and believed that hard and honest work would make a better world. He was not searching for a rigid world of laws and endless rules. ☺

References:

1. Drake, Daniel. Pioneer Life in Kentucky (1785-1800). Henry Schuman, Inc. 1948.
2. Franklin, Benjamin. Proposals Relating to the Education of Youth in Pennsylvania. Philadelphia 1749. www.archives.upenn.edu/primdocs/1749_proposals.html.
3. Schapiro, Henry D and Miller, Zane L eds. Physician to the West. Selected Writings of Daniel Drake on Science and Society. The University Press of Kentucky, Lexington, Kentucky, 1970.



Book Reviews

by Nick Owen, M.D.

The Autistic Brain: Thinking Across the Spectrum

Temple Grandin,
Houghton, Mifflin, Harcourt,
New York, 2013

Temple Grandin writes with authority about autism as she is autistic. With the help of her mother in an era when there was little or no professional advice available, she has coped with it receiving a Ph.D from the University of Illinois. She is now on the faculty of Colorado State University and is the author of several books on the subject.

Grandin established that autism is a spectrum of behaviors which afflict each individual differently and are manifested as gaps in behavior or functioning and/or exaggerated dysfunctional behavior and sometimes by exceptional ability in other areas. She has taken autism from the hands of the psychiatrists. She advocates enhancement of skills over correction of deficits and for the most part, integration in schools with “normals” although she indicates that some individuals do better learning and working with their peers.

She reviews what we know of the neuroanatomy, circuitry and localization of some of the various dysfunctions.

To this reader it looks as though there is a reasonable handle on management; now we need to determine the cause and means of prevention. An excellent read! ~

The Panic Virus: the True Story of Medicine, Science, and Fear

Seth Mnookin,
Simon & Schuster,
New York, 2011

Based on a later retracted article in *The Lancet*, public fears of harm from childhood immunizations became an issue.

The leit-motif of *The Panic Virus* is the dichotomy between parental anxiety about and devotion to their young children and the patriarchal unitarian integrity of the forces of Public Health. This devolved into an expensive drawn out emotional brawl between an organized group of protesting patients and the forces of organized medicine and was finally terminated by putting the issues into the justice system where the rules of evidence in a court battle favored scientific facts over emotional angst. The side effect was disruption of community immunization by destroying herd immunity. It is not a pretty story but epitomizes day to day discontent between patients and doctors over alternative care and resistance to authority. Mnookin writes well and his book is worth reading as history but better as a guide to dealing with fervent disagreement. ~

An Epidemic of Absence: A New Way of Understanding Allergies and Auto-Immune Diseases

Moises Velasquez-Manoff,
Scribner,
New York, 2012

Velasquez-Manoff takes us through his collection of observations, reports of experiments, and hypotheses which are clues to explanation of the epidemics of asthma, dermatitis, inflammatory bowel disease, sprue, multiple sclerosis, autism and other auto-immune or allergic phenomena which are increasingly attacking society.

Scientific thinking has evolved from positing an invasive agent for each disease, through immune system over-reaction to invasive agents, to misidentification of self as an invader, to mixed genetic and epigenetic changes which permit or facilitate anomalies of the immune system which in turn result in allergic or auto-immune disease.

Insights include the benefits to the child of a dirty versus clean environment (e.g. vaginal delivery versus c-section) and the direct impact of maternal infection during pregnancy on the development of the fetal immune system. Very interesting are the multiple anecdotes of complete remission of serious auto-immune phenomena by induction of whipworm or hookworm infestation in the subject.

In turn, these findings challenge our current handling of defending or changing our microbiome and suppressing our immune system. Most fascinating are the demonstrated changes in cellular and protein-immunity and their correlation to genetic abnormalities. ~

Dirty Snowballs or Icy Dirtballs? Clinical heuristics and daily life.

by David Shapiro, M.D.

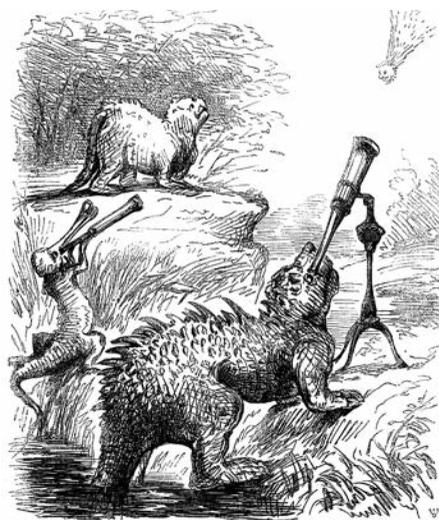
Newsflash:

Dartmouth Scientists reveal that a comet not an asteroid caused the great dinosaur extinction.

Well, maybe it isn't mindboggling news to most of us. But for the dinosaurs it was a really big deal. 66 Million years in a remote part of the Yucatan there was a cosmic event that caused the creation of a crater 110 miles in diameter. The force of that event caused climatic changes that are now believed to have decimated the large reptiles and allowed a few smaller mammals and the small reptiles and most of the fish and insects to survive. So I guess for those of us remaining to learn and tell this tale, it is a pretty big deal also. It is all a matter of perspective.

A comet is a combination of ice and rock that classically when illuminated by being close to our closest star has a tail. For some comets the tail can be bigger in size than either the core or even the sun itself. For the most part they are formed in a belt just beyond Neptune, though some from further out in the solar system and some rarely from outside our system. Depending on where they are formed they will have varying periodicity and paths. Some are in relative terms newly discovered, others like Halley's Comet have been visiting since antiquity. We still know very little about them, hence the lack of agreement as to whether they are principally dirty snowballs or icy dirtballs.

Asteroids, on the other hand, get all the respect nowadays. Not only are they generally assumed to have offed the dinosaurs, but the relatively recent event in Russia, once again brought them dramatically to the public eye. Approximately 18 meters wide, it struck with a force 20-30x that of the first atomic bombs which were exploded in Japan. Most asteroids are close neighbors of ours, being formed just beyond Mars and since they are nice enough to stick around after they land it is a rare



child that hasn't held one in their little hands or viewed a fragment in a museum.

So this column is about perspective and how we view the world. One of my patients recently had the good fortune to not be seen by me. As I believe I would have perceived her condition with somewhat less urgency than my partner who saw her. Not that I would have gotten it wrong, but that I think I would have been less urgent in its evaluation. And why would that be? We are both reasonably, well at least he is, good docs. A few of my colleagues and I have been discussing the role of heuristics, primarily as it relates to diagnostic or therapeutic errors. Heuristics, you might remember, are the shortcuts we take in our decision making process. As you might have observed yourself, not all of our decisions are rational, well thought out, or scientifically verifiable. We don't live or practice in a world where that would be possible. Neither our patients nor our families or co-workers have time for such a thing. Those people who wait for every available shred of pos-

sible input are still waiting. Therefore we cut corners, if you will, and we do that in very predictable ways, and these ways are heuristics. Some are very well known, such as the Familiarity Heuristic, which is just what it sounds like. Horses being far more common than Zebras, we might say. There is the Anchoring Heuristic which connotes that the first piece of information can be proved to be seen as more important than subsequent data. There are about 20 of these in all, and we all use them on a daily basis to help us with our work, and in fact with our lives. This is all to the good, except when it isn't, and that is when rather than helping us see a situation as what it is, it obscures the underlying nature of that situation. As we have come to understand, the errors we make are predictable, they occur each time in more or less the same way. We pay too little attention to one thing and too much to something else. Our awareness of clinical (or life, for that matter, events) is blown about by a thousand thousand things. Culture, bias, previous experience or lack thereof, what we had for breakfast, the car ride to work, what someone is wearing that reminds us of something else... The list in fact is the endless experience of life itself. For my patient, and her need for urgent neurologic intervention, the diagnosis and treatment of her aneurysm, and my partner's heuristics, maybe the planets themselves, were aligned

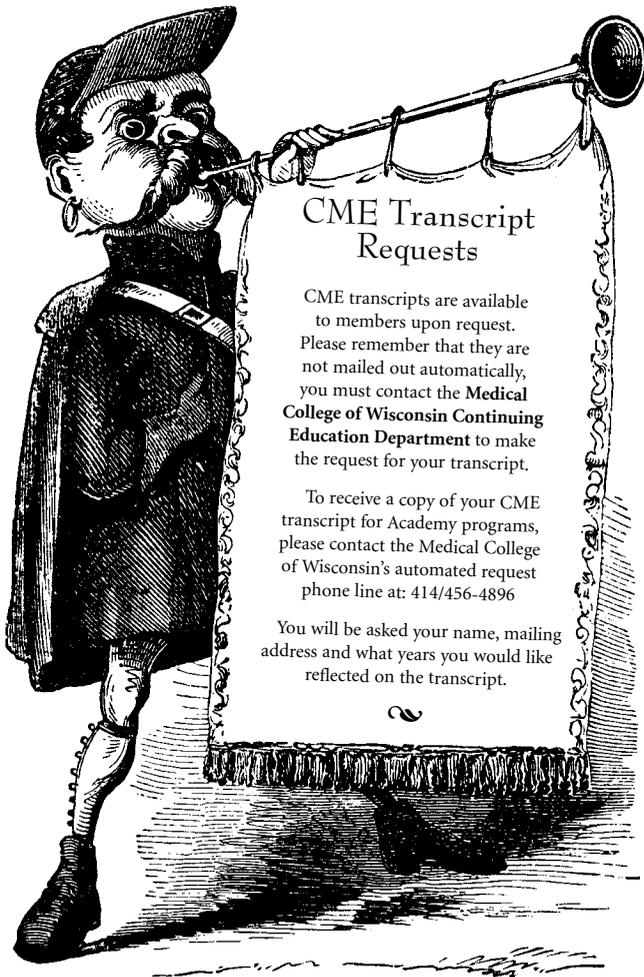
Of what value might this be, perhaps is obvious. Clear thinking, overcoming tendencies toward close-mindedness, appropriate attention to the right details, is what all clinicians strive towards. Understanding our heuristics as a window into the possibilities of clear and not so clear seeing, is a tool on this journey. ☺



2014 Meeting Dates



January 21
February 18
March 18
April 15
May 20
September 16
October 21
November 18



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