Milwaukee Academy of Medicine

Volume XII / June 2005

From the Academy's Rare Book Collection

Anatome Corporis Humani

By Juan Valverde de Hamusco

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

First published in Rome in 1556 this controversial anatomical text was widely read and widely circulated in the Renaissance world. The text was criticized for what appeared to be portions, both of text and illustration, plagiarized from De Humani Corporis Fabrica Septum, the celebrated text of Vesalius (1514-1564) published in 1543 in Latin in seven volumes. Fabrica was done with great care and was expensive to produce and to purchase. Valverde's (1525-1588) text first appeared in a Spanish edition and was both smaller and cheaper than Fabrica. Anatome was a commercial enterprise involving several specialists, including Gasparo Becerra, a celebrated artist who had worked with Michelangelo. The woodcut illustrations of Fabrica were copied for use in many other texts of the period including Ambroise Pare's Anatome Universelle du Corpse Humain (Paris 1561) (1). Vesalius directed strenuous objection only at Valverde's text. This may have resulted from personal animosity toward Realdo Columbo, Valverde's anatomy teacher.

Then, as now, students needed summaries of the methods of dissection and illustrations to use as references. Anatome quickly gained popularity and eventually appeared in twelve editions including Dutch, Italian, and Latin. The Academy's copy is dated 1581. The text included the first description of the pulmonary circulation and other features differing from Fabrica.

Although born in Spain, Valverde was trained in Italy. He followed his anatomy teacher from Padua to Pisa and eventually to Rome. There he taught medicine at the Hospital of Santo Spirito. He published his Anatome while serving as the personal physician to the first Grand Inquisitor of Rome, Cardinal Juan Alvarez de Toledo. The book was dedicated to Pope Paul IV and to his patron the Cardinal.

Since antiquity anatomical dissection has remained a point of friction between the general views of society and physicians. Until Vesalius redefined anatomy as a science based on direct observation, dissection had been conducted as a philosophical exercise using uncritical readings from Galen to govern the conclusions. Obvious differences between Galen's text, much of which was based on animal dissection, and the realities of human dissection were ignored or rationalized. Medieval anatomical models and drawings such as the Zodiac Man, the Blood-Letting Man, the Gravid, the Wound Man, and the Disease Man likewise perpetuated ancient dogma. The first illustrations involving human anatomy based on dissection appeared in France in the 1300s. Pollaiuolo's painting "Battle of the Naked Men" (1465) was based on details of dissections where skin was removed (flaying). Valverde's most celebrated illustration depicts a living cadaver, muscle displayed, looking toward his skin which he holds in his

Continued on page 6

FALL 2005 MEETING DATES: SEPTEMBER 20 • OCTOBER 18 • NOVEMBER 15

MEETING LOCATION: University Club of Milwaukee • 924 East Wells Street • 6:00 p.m. cocktails • 6.30 p.m. dinner • 7:30 p.m. speaker presentation

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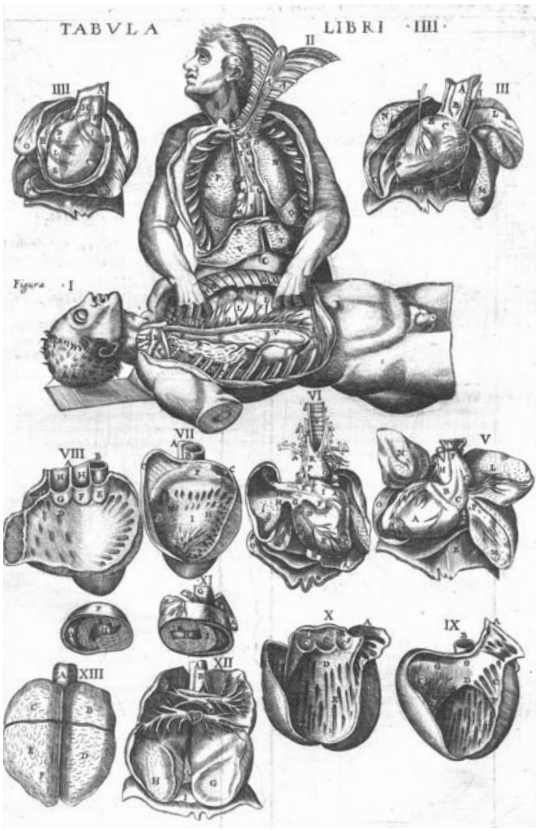
To Cure, Sometimes. To Comfort, Always

by J.M. Cerletty

Edward Trudeau received his medical degree from Columbia University School of Medicine in 1871. He began a general practice in upstate New York. Several years later, his brother developed pulmonary tuberculosis. Edward took charge of his care, but soon contracted the disease himself. He devoted his life to fighting the white plague. He opened the Trudeau Sanatorium in Saranac Lake, New York, where he organized the first laboratory in this country to study this infectious agent. He espoused the open-air treatment, which remained popular well into the twentieth century. While reading a biography of the man as a medical student, I was struck by one of his aphorisms regarding patient care. "To cure sometimes. To relieve often. To comfort and support always."

Early in my career as a physician, primarily caring for the indigent, I wanted to cure always. I looked upon death as a defeat. "Death is the poor man's doctor," goes an old German proverb, and I wanted to change that adage. But after many years of practice, it became apparent to me that death might be a welcome relief to many patients. I began to understand that it was often more important to comfort and support than to cure. I was back to curing sometimes. But was I going too far? Was I forgetting my role as a healer? I vaguely recall reading a quote from an early nineteenth century philosopher that still rings a hint of truth: "Young doctors kill their patients. Older doctors let them die." Is it that young physicians have yet to come to grips with their own mortality, and thus treat over-aggressively? Do older physicians, sensing their loss of control over their own health, fail to pursue what they consider extraordinary means of extending meaningful life? Was I letting patients die when an aggressive course might have saved them? Had I actually killed patients?



It was a different era. No magnetic resonance, computerized tomography or the vast array of diagnostic blood tests. Routine blood gases were a few years in the future. It was some years ago, and I was completing my year of chief residency at a county hospital. I was asked by an intern and junior resident to evaluate a demented ninety-year old woman in severe heart failure. She was moribund, *in extremis.* It was just the day before that one of our senior cardiology staff physicians had recounted the "old days" of medicine, focusing on heart failure. He noted that Withering had described the therapeutic efficacy of the leaves of the foxglove plant in the late 1700s. Our cardiologist had remembered using tincture of digitalis and then digitalis leaf tablets as the mainstay of therapy for heart failure. Years previously, he had treated patients in acute pulmonary edema with rotating tourniquets, purportedly to decrease effective blood volume or with phlebotomy. He had used mercurial diuretics with some effectiveness.

But this was 1965, the modern era of medicine, I thought. We certainly were not going to use leeches or do any blood letting on this anemic patient. She had received the recently released thiazide diuretics, and the highly reliable digoxin. There were no clinical or electrocardiographic findings to verify digitalis toxicity, so perhaps she would benefit from more of this mainstay of treatment for heart failure. Desperate situations demand a desperate response. I recalled a recent article, describing a therapeutic test in this situation, using intravenous strophanthidin which contained ouabain, a rapidly acting and metabolized form of digoxin. If there were a positive response, more digoxin could be given. There was no strophanthidin in our pharmacy, so we would use our only available intravenous cardiac glycoside, deslanoside (Cedilanid).

I walked to her bedside. The frail elderly woman was gasping for breath. Her startled and panicked look projected a feeling of impending doom. Her skin was cold and dry as parchment. Her neck veins were so distended I feared they might burst. Every few seconds, she would spew out a bit of frothy red sputum. Further exam revealed a gallop

rhythm, poor aeration of her lungs and a falling blood pressure. "We must help her or at least make her more comfortable," I mumbled to my cohorts. I injected the dose slowly over three minutes, withdrew the needle, and reached for my stethoscope to auscultate her heart. The woman slumped forward. There were no heart sounds. I had killed her.

Gerda was eighty-five years old at the time of her death. I had cared for this strong-willed woman for over a decade. She initially came under my care for consultation for a minor episode of thyroiditis. When that resolved, she informed me in no uncertain terms that I was going to be her primary care physician. Gerda Himmelhoch had been born in Germany. She came to Milwaukee in 1921, and worked as a maid and cook for a well-to-do family in the suburbs. She had left Europe mostly for financial reasons, but the key precipitating factor had been the death of her mother. Her mother had a long, lingering painful death from cancer, and Gerda felt the need to literally escape from the site of those agonizing memories. After several years in our city, she married Klaus, a skilled carpenter. She regretted that their marriage had been childless, but she had many happy years with her soul mate, that "stubborn Kraut" as she put it. Klaus had died the year before our meeting from pancreatic cancer. Like her mother, his death had been too painful and much too prolonged.

Gerda was a corpulent woman with a round cherubic face. Her pink cheeks flared to a bright red when she was animated. And this vivacious woman was animated almost all of the time. She was excited about her garden, her pride and joy. She had planned over the years that there would be constant blooms, ranging from the courageous crocuses, that pushed their blossoms through the dwindling piles of snow in late March to her glorious display of asters and roses that survived even through the first frosts of October. She also had a most productive vegetable garden, with which she supplied her immediate neighbors with the harvests of tomatoes, squash and peppers. She was a last minute baby sitter for the neighborhood children, the woman who washed and ironed the altar linens for her church, a book reader in the children's library and a nurse and caregiver for many of the elderly and ill in the area. This dynamo thrived on these activities.

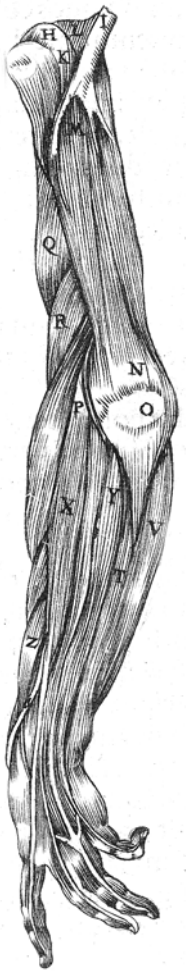
During a routine follow-up, a breast mass was detected. It was malignant. She was stolid when she heard the news. But I sensed that this impassive exterior was masking the emotional reaction tied to the memories of her mother and husband. She went along with radiation treatment and the chemotherapy, but had little response. "I've had a good life" she told me. "I'm ready to die." The tacit, unspoken message was clear to me, "Don't prolong my death." What was my role in helping her? She was experiencing significant pain, which I treated with increasing doses of oral morphine. At each follow-up visit, I asked if the opiate was creating major problems with constipation. She denied this. Despite the escalating morphine dosage, her pupils were never constricted nor were her respirations slowed. When a chest film showed rib metastases, I suggested she consider local radiation. She declined. At her last clinic visit, she gave me a hug. "Thank you for helping me," she said. She died two days later; almost certainly from respiratory arrest after her ingestion of the massive amount of morphine she had stockpiled. I had helped this woman kill herself.

Robert Kujawa was 54 years old at the time of his death. I had followed him as a patient for fifteen years, working with him to control his insulin dependent diabetes. Bob strayed from his diet on occasion, but had evaded the complications of his metabolic disease. He was an outgoing, ebullient man who seemed to enjoy every second of life. He was a back slapper. Every time I saw him, he would shout "How ya doin, Doc!" to be immediately followed by a forceful slap on the back. As the years went by, I entered the clinic room housing him with my muscles tensed, fearing possible rib fractures from his enthusiastic punches. On one of his March visits, he commented on the tan I had acquired the prior week during a brief vacation to Sarasota. Soon he was regaling me with the story of his honeymoon trip to the West Coast of Florida years earlier. He and his wife regularly planned a return trip, which always seemed to be thwarted because of financial reasons or other family obligations.

Three years ago, he presented with painless jaundice. Medical evaluation revealed that he had a pancreatic mass with liver metastases. His obstructive jaundice was relieved with a stent. The surgeons discussed a variety of operations that might prolong his life, and the oncologists enthusiastically reviewed the variety of protocols for chemotherapy available to him. Bob asked for my opinion. I hedged, but I believe I conveyed some skepticism about the offered interventions. Two days later, I met with Bob and his wife. "We have decided," said Bob. "We're going to Florida. We are going to walk along the beach, scattering the sandpipers. We are going to sit in beach chairs, trying to spot dolphins cresting on the water surface. We are going to marvel at the squadrons of pelicans. We are going to hug a lot and cry a little." Bob spent two weeks in Florida. Shortly after his return, he developed a deep venous thrombosis and died of a pulmonary embolus. Had my input shortened his life?

Our discourse on end of life issues continues in our clinics, our hospitals and on the national scene. The discussion and debates generally have been productive, with learned, ethical individuals espousing their ideas. Accuse me of naivete', but when the issue focuses on one health care provider, one patient and one family, the words of Trudeau have provided me with a guide that has proved useful over the years. "To cure, sometimes. To relieve often. To comfort and support always."

Francis F. Rosebaum, M.D.



by Wayne Boulanger, M.D.
Former Columbia Hospital
Chief of Staff

When asked why he had purchased a Porsche, said our Fran:

"It's expensive of corsche,
But it has a nice ride,
It's roomy inside,
And it eats much less than a horsche."

The above lines were inspired by the appearance one day, in the Columbia Hospital staff parking lot, of a brand new bright red Porsche, the property of Dr. Francis Rosenbaum.

I wrote that limerick more than 40 years ago to tease that complex individual about his other life, the one which I could never understand. I could never figure out how he had the time to do all he did and still have his sports car hobby. He was, at that time, a senior Columbia staff member with a busy practice, who was one of the premier cardiologists in the country.

Fortunately for me, we both tended to grow hungry about the same time every day as we made our rounds, and occasionally we would eat lunch together in the Columbia Hospital Medical Staff dining room. He always had the chili – a proclivity I chose not to emulate – and we had a chance to discuss wide-ranging topics, an opportunity which I enjoyed immensely in my position as a very junior staff member.

Dr. Rosenbaum was at Columbia every morning, since it was his duty to interpret all of the electrocardiograms done at Columbia, and submit the official report, and in the process to teach the residents how to read electrocardiograms. His qualifications for that task were impeccable, since his researches at the University of Michigan (his alma mater) were in that particular field. He had also had additional training in cardiology and electrocardiography at the Peter Bent Brigham Hospital before returning to Ann Arbor at the Heart Station of the University Hospital, where he functioned first as research associate, and eventually as assistant professor. He came to Wisconsin in 1946.

In addition to sports car interests, living as he did in Michigan it's easy to understand his adoption of sailing as a hobby. The move to Milwaukee allowed him to continue that practice, which he did with gusto, winning the Universal Fleet Championship at the Milwaukee Yacht Club twice.

Even as an intern in 1952, I had been impressed with his clinical acumen – not just as a cardiologist, but as a doctor. His handwritten consultations were detailed, thorough, extremely legible, and right on the mark. His patient care philosophy was clearly expressed in his presidential address at the Academy of Medicine in 1963:

"We have gotten so far away from the bedside that ward rounds are no longer made on the wards, but in conference rooms and assembly halls, which are never violated by the presence of a patient. We have left the era of bedside diagnosis, since it is no longer necessary for anyone but technicians to approach the patient beyond the foot of the bed.

Despite the predictions we have heard, I maintain that no computer can record a history as meaningful as that taken carefully by a perceptive physician. I believe the physical examination done by an experienced physician who knows how to use his God-given sense continues to disclose significant phenomena which escape the most elaborate instrumentation."

Such was the nature of the man. He was right in 1963, and he is still right today.

Many meaningful scientific papers, textbook chapters, and monographs were authored by Rosenbaum, some of them in collaboration with other Columbia staff members, such as Elston Belknap, whose industrial medicine expertise blended with Rosenbaum's cardiology as they explored "work and the heart", and with Santer and Claudon who described the carcinoid syndrome. (The carcinoid syndrome report was based on the case of a Columbia patient with right heart failure which was due to metastatic carcinoid tumors.)

In the late '50s cardiac valve replacement came on the scene, and Dr. Rosenbaum's cardiology practice turned up several patients who qualified for that operation. At the time there were no surgeons on the Columbia staff who performed that procedure, so Dr. Rosenbaum established a referral channel with Dr. John Kirklin at the Mayo Clinic. It worked out well, but when Dr. Derward Lepley joined the staff, after having been trained in cardiac surgery by Dr. Walton Lillihei at the University of Minnesota, he had to compete with Dr. Kirklin for the Columbia cardiac surgery patients, and he did not fare well.

One day at lunch with Dr. Rosenbaum, having been a co-resident in surgery with Lepley at the VA Hospital, I put in a plug for him as a possible replacement for Dr. Kirklin, but somewhere along the line Lepley had made a poor impression on Rosenbaum, and without his referrals Lepley's practice never got off the ground at Columbia. (Keep in mind that coronary artery surgery really hadn't developed at that time, and cardiac valve surgery cases were not numerous.) In any event, Lepley became discouraged and moved to St. Luke's Hospital where Mr. Kniseley's administration and the medical staff, especially Dr. Howard Correll, welcomed and supported him. The rest is history. It wasn't until 1987 that cardiac surgery was again done at Columbia.

I suppose those of us who knew the doggedly determined Lepley and respected him could have predicted he would succeed and pull his chosen hospital into national prominence as a cardiac surgery center but to criticize Rosenbaum for his failure to support a man in whom he had no confidence would be unfair.

Dr. Rosenbaum died on November 7, 1972, at the age of 60.

This article originally appeared in the Columbia St. Mary's Physician Staff Newsletter, March 2005

Book Review

by Nick Owen, M.D.

Critical Condition: How Health Care in America Became Big Business & Bad Medicine

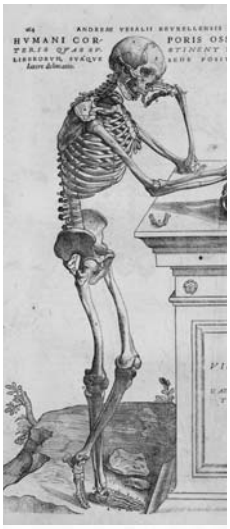
Donald L. Barlett and James B. Steele
DoubleDay, 2004

In Critical Condition: How Health Care in America Became Big Business & Bad Medicine, Donald L. Barlett and James B. Steele outline the contemporary problems in U.S. healthcare delivery by recounting numerous anecdotes of malfeasance and reporting some data.

Most physicians will be aware through the 1999 Institute of Medicine report and its spin-offs of health care professionals' contributions (hand-writing, abbreviations, mis-transcription, mis-interpretation, mistakes-as in wrong limb or patient, inadequate record-keeping, and more) but will be less familiar with the disasters wished on us by business oriented peers, politicians, and the business community. These include: overly stringent utilization review, non-professional call centers, over-pricing of drugs and unnecessary drugs, over-marketing drugs to physicians, and direct consumer advertising, and depreciation and corruption of the FDA, organizations and institutions whose charges and profits are disproportionate to the services produced. For poly-pharmacy, we must accept partial responsibility, and we must apologize as well for those of our colleagues whose greed places their charges out of reason, or who set up self-serving for profit health care entities.

In short, attempts to modify a pre-existing disorganized service-oriented collection of cottage industries into cost-effective service-oriented businesses while maintaining professional proficiency and to produce profit at all levels has been unsuccessful.

The author's proposed solution is different and interesting.



President's Comments

by George Walcott, M.D.
President 2005

I was taken by a couple of possibly related items recently. The first was the "Journal Sentinel" story that $1500 per General Motors vehicle represented allocation of health expenses for families and retirees. Some might say General Motors has a lot of employees and sells a lot of cars. Furthermore that isn't excessive considering the high price of pharmaceuticals and diagnostic studies. Others would argue that considering our massive trade deficit we should "reduce" the cost of automobiles to be more competitive. Health expenses should be borne elsewhere. A monopoly payer could beat down prices and improve access. Are high quality medical care, accessibility, and modest cost incompatible ?

Achieving one option detracts from one of the others. It depends on who pays what. Who is included? How much do we get? How good is what we get? How long do we wait?

The second was attending the monthly regular hospital case conference scheduled at a convenient hour. The topic was timely, the case most interesting and well presented. The problem was attendance. Other than a couple of specialists and friends of the presenter, the conference room was practically deserted. Does that mean that physicians are too busy with patient care or family responsibilities? Is there a lack of desire for medical knowledge and interaction? An opportunity to be involved in discussion, analysis and learning as we all have experienced throughout our careers is missed. Perhaps we are witnessing an erosion of professionalism. Some doctors have always neglected their families for medicine. We need to encourage our colleagues to support scholarly medical activities in our hospitals, our daily lives, and the Academy of Medicine.

The Milwaukee Academy of Medicine was asked by the Wisconsin Medical Society to endorse the following positions. After due consideration, your board did so at its May meeting. (The full text of the position statements is available upon request from the Academy office.)

Position Statement: The Academy of Medicine supports increasing the cigarette tax $1 per pack and earmarking the proceeds for Health-Related state expenditures.

Position Statement: The Academy of Medicine supports continued protection of the Injured Patients and Families Compensation Fund, as it is a critical element in maintaining Wisconsin patients' access to care and the currently stable medical liability environment.

The editors would be happy to consider any original submissions from members for publication.

Continued from page 1

outstretched left arm. In his right hand is a dagger, the instrument of his own flaying. The various muscles are labeled with letters or symbols.

Apparently, more than an anatomy lesson is involved here. Wolfe (2) points out that lay or physician contemporaries would recognize readily in this figure both the method of martyrdom of St Bartholomew (also included in Michelangelo's fresco "Last Judgement" located over the alter of the Sistine Chapel) and the punishment of the mythological character Marsyas, a presumptive satyr flayed to death by the god Apollo. The latter was a popular myth from Ovid's Metamorphoses. Both church history and pagan myths were employed to make contemporary points about human behavior.

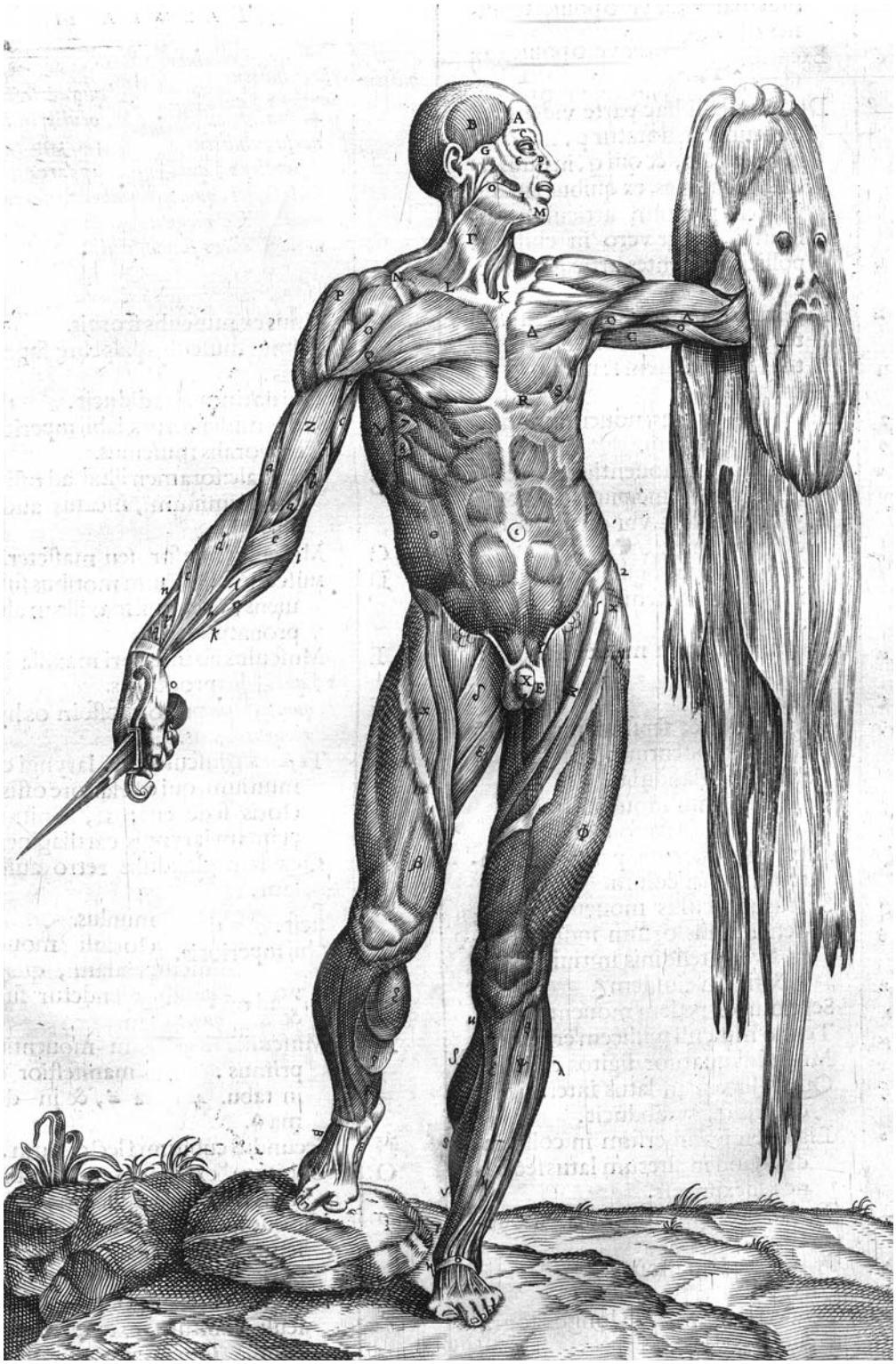
Dissections were guaranteed by religious and civil authority but were never supported by public opinion. Dissections most often used the bodies of executed criminals and were viewed as an integral part of punishment. The soul was rewarded by masses and received ritual purification for offenses committed on the body during dissection. Seen from this angle, dissections demonstrated the continuing power of the church (3). Valverde's text, his medical and artistic contemporaries, and his church sponsors offer an interesting vantage point for studying this important period of history.

References

1. Wolfe, Susan. Juan Valverde de Amusco. On the website, "The Boundaries of the Body and Scientific Illustration in Early Modern Europe," http://www.bronwenwilson.ca/physiognomy/pages/biographiesall.html.

2. Wolfe, Susan. Peeling off the skin: revealing alternate meanings of Valverde's muscle man. On the website, "Boundaries of the Body and Scientific Illustration in Early Modern Europe," http://www.bronwenwilson.ca/body.catalogue#susan

3. Carlino, Andrea. Books of the Body: Anatomical Ritual and Renaissance Learning. University of Chicago Press, Chicago, 1999.



All illustrations in this newsletter are from *Anatome Corporis Humani.*

The 1,233rd Meeting • January 18, 2005

by Nick Owen, M.D.

The 1,233rd meeting of the Milwaukee Academy of Medicine was opened by outgoing President James Woods on January 18th, 2005 at the University Club. Jim presented the slate of officers (see the last page of this newsletter for this listing) proposed by the Nominating Committee; the slate of officers was elected unanimously.

The next item of business was the presentation of the Humanitarian Award to Janis Hoeksema honoring her for the creation of Heart Love Place, an inner-city institution which provides an after-school secure place for children and includes a diversity of recreational, educational, and rehabilitative activities.

The following order of business was the presentation of the President's Award to Elaine Drobny, M.D. for outstanding service to the Academy. She will serve on the Board of Trustees of the Academy.

Jim made some parting remarks and introduced our new President, George Walcott who set the tone for the year in his introduction of Robert E. Nesse, M.D., Associate Professor of Family Medicine, Mayo Medical School, Consultant, Department of Family Medicine, Mayo Clinic, Consultant, Division of Health Policy Research, Mayo Clinic. Dr. Nesse addressed the Academy on the topic "Exploiting Change in Health Care".

After pointing out that we (the medical profession) are quite good at technological adaptation to change, he suggested that we have not done as well in adapting to changes in healthcare delivery. Specifically, we have been defeated by the change in demographics with the resulting burden of chronic illness and dramatic cost shifts in the provision of care. Referring principally to business school and business models, he suggested that we need to switch from a for-profit provider-oriented model to a consumer-oriented model which breaks even, supporting necessary medical institutions, providers, and research, but is not capital accumulative. He emphasized that we must maintain quality care and suggested that a quality element be incorporated into the reimbursement process.

The 1,234th Meeting
February 15, 2005

by Paul Hankwitz, M.D.

The topic presented at the 1234th Meeting of the Milwaukee Academy of Medicine on February 15, 2005 was "Management of Obesity: A Team Approach" by Doctors Dennis Blom, James Burhop, and Safak Guven.

The speakers defined obesity and discussed non-surgical and surgical treatment.

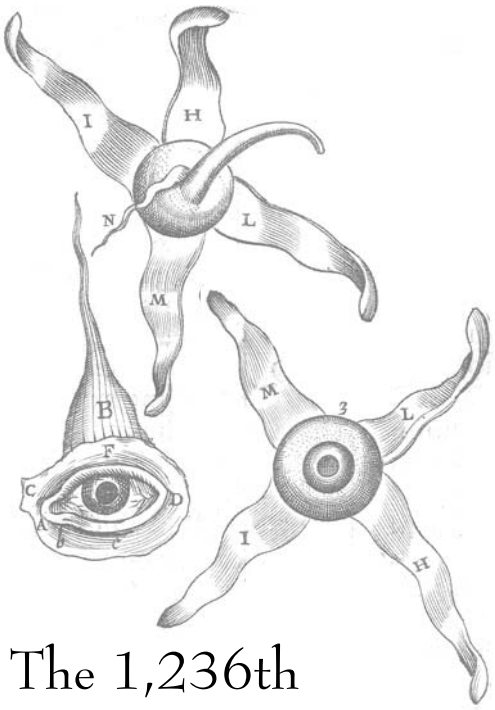
A detailed summary by Dr. Paul Hankwitz (past-president of the Academy) is available from Amy John at the Academy office.

The 1,235th Meeting
March 15, 2005

by Nick Owen, M.D.

On March 15, 2005 Sidney Wolfe, M.D., Director, Health Research Group of Public Citizen addressed the Milwaukee Academy of Medicine on "The Pharmaceutical Industry and the FDA: The Problems and the Solutions".

Dr. Wolfe left the NIH in 1971 and affiliated with Ralph Nader's group in Washington, D.C. Starting with the septicemia epidemic caused by Abbott Laboratory's contaminated intravenous fluid through this year's battle over Cox II's. His organization has taken on the FDA for inadequately protecting the public from unsafe drugs and medical products. Many cases were handled in court, some by jaw-boning through the press. The FDA's performance appears to physicians to be negligent. To consumers it is a part of the current government's dominance by manufacturers and stock holders.



The 1,236th Meeting
April 26, 2005

by Nick Owen, M.D.

The annual joint meeting of the Milwaukee Academy of Medicine and the Beta Chapter of Alpha Omega Alpha was held at the University Club on April 26, 2005. The 1236th meeting of the Academy was opened by President Dr. George Walcott with a brief business meeting who then introduced Drs. Jim Sebastian and Ed Duthie who served as masters of ceremony for the introduction of the AOA awardees who were introduced individually including their home, type and place of internship, and an interesting snippet of personal information.

Dr. Mark Adams was honored as the outstanding faculty member of the year and introduced the evening's speaker, Dr. Julie A. Freischlag, The William Stewart Halsted Professor Chair, Department of Surgery, Surgeon-in-Chief, The Johns Hopkins Hospital. She was formerly Professor of Surgery at the Medical College of Wisconsin.

Dr. Freischlag is a petite, positivistic, dynamic speaker who has evolved a refreshing strategy of leadership and surgical training of which she gave us a brief overview interspersed with lots of humor and wisdom. I'm looking forward to hearing from her again.

MILWAUKEE ACADEMY OF MEDICINE
1886

Excellence in Teaching Award

Each year the Academy sponsors the Excellence in Teaching Award. The awardee is selected by the Medical College of Wisconsin graduating seniors.

This award is presented annually by the Milwaukee Academy of Medicine to a community physician in private practice who distinguishes himself/herself through exemplary teaching and serves as a role model.

This year the MCW Class of 2005 has selected Paul Fox, M.D., a surgeon in private practice in Waukesha. He was presented with a plaque at the MCW graduation dinner in May.

The 1,237th Meeting
May 17, 2005

by Helmut Ammon, M.D.

Speakers:
Seth Foldy, MD
Associate Clinical Professor of Family and Community Medicine and Health Policy Institute, Medical College of Wisconsin

Matthew Wynia, MD
Director, Institute for Ethics, American Medical Association and Assistant Professor of Medicine, University of Chicago

Drs. Wynia and Foldy reported on their experience aboard the US Navy's Hospital ship MERCY as Project Hope volunteers during the emergency medical relief efforts off the coast of Aceh Province, Indonesia in the wake of the December 26, 2004 tsunami. The mission was the first joint effort between a non-governmental organization and the US Navy. 126,000 people were killed, 114,000 injured and 514,000 people displaced. All infrastructures were destroyed including all hospitals and medical facilities. The site was an area of a fierce battle between the government of Indonesia and a fundamentalist Muslim insurgency and had been off limits to outsiders prior to the disaster. The MERCY, a floating 1,000 bed level 3 trauma center, was mobilized in 5 days and staffed by 100 volunteer physicians. It was provisioned while under way to the disaster site. Several escort ships and 2 helicopter squadrons provided logistical support and security. At the time of arrival there were approximately 5,000 local and international volunteer physicians working in the area, but their efforts were severely limited by the total destruction of all medical facilities. The medical efforts were hampered by a 3-month deadline imposed by the Indonesian government requiring foreigners to leave the area by March 26. Other problems included the need to respect local customs and sensitivities, and security concerns. Helicopter flights transporting patients and their relatives from shore to ship were restricted to certain hours of the day. This created major ethical dilemmas for the triage physician on shore, since only 1 in 10 patients could be cleared for transport to the ship. In spite of these constraints 9,500 patients were served between February 7 and March 16. 170 patients and their escorts were admitted. The spectrum of services provided ranged from neurosurgery to hernia repairs, dental care, and refractions and provision of prescription eyeglasses (the latter the largest service by volume). Although the medical impact was small when measured against the expenditure of costs and resources and the magnitude of the disaster, the mission was well received by the recipients of care and by the general population, who at the beginning had great reservations about a US presence.

New Academy Members

Please join us in welcoming the following new members to the Milwaukee Academy of Medicine:

Asriani Chiu, M.D.
Carl Eisenberg, M.D.
Eric Luy, MD
Kurt Pfeifer, MD.

If you would like to nominate a new member, please contact Amy John at the Academy office 414/456-8249.

To The Membership

We have three requests of all members of the Academy:

1) Have you heard an outstanding talk lately at a meeting or course which ought to be shared with fellow Academy members? If so, please let the program committee know.

2) Likewise, have you read a great book? Tell us and we'll read it and review it or better yet, write a review and we'll publish it.

3) We're always looking for original writing whether medical or general; send anything you are interested in sharing.

All communications should be directed to: Amy John at the Academy.

Email Reminder

If you have not already done so, please email your current email address to the Academy office, amyjohn@execpc.com, so that you can be easily contacted for general correspondence and feedback gathering. You will not receive program announcements or the newsletter via email unless you specifically make that request. Thank you.