ILWAUKEE ACADEMY OF MEDICINE

Volume XXIII / January 2009

Retiring President's Comments

by Jerome Van Ruiswyk, M.D.
President 2008

Irrational Behaviors: Why ask Why?

As a primary care physician, I get the privilege of coordinating the overall care of my patients and often being the first point of contact for new patients within the system of care. This work often provides me a front-line perspective on patient's health care, their lives, and their daily activities. I must admit that sometimes I'm at a loss for understanding why they do the things they do. In situations like these, I've found that it can be helpful to ask why. In particular, apparently irrational behavior sometimes becomes more understandable when you ask why.

As an example, I offer the case of a routine follow-up visit for a 72 year old man with achalasia, hypertension, binge drinking, and fluctuating but persistent hoarseness to illustrate how asking why may be helpful for understanding patient behaviors. When I first noted his hoarseness at our last visit I had empirically prescribed a proton pump inhibitor to see whether the hoarseness might represent reflux laryngitis. When his hoarseness persisted, I subsequently referred him to ENT clinic where he remained under regular surveillance over the next few months for leukoplakia of the left true vocal cord. When the appearance of the vocal cord changes became more worrisome, ENT scheduled him for a biopsy of the lesion. However, he cancelled the procedure when he found it would be done under general anesthesia. In the interim since the planned biopsy, he had no-showed for his ENT clinic visits and had failed to return multiple phone calls from the ENT physicians. Since he understood the observed changes could represent early cancer, these behaviors seemed irrational. When I asked why he hadn't returned for follow-up, three main concerns emerged: 1) he was concerned that his physicians would view him as a "guinea pig" while he was under

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Please Join Us...

123rd Annual Meeting
Tuesday, January 20th, 2009
University Club

6:00 p.m. cocktails
6:30 p.m. dinner
7:15 p.m. awards
7:30 presentation

Kim R. Pemble, MS
Executive Director, Wisconsin Health Information Exchange (WHIE)

How Wisconsin Health Information Exchange is Changing Medical Practice in Milwaukee

President's Award
H. David Kerr, MD

Humanitarian Award
St. Ben's Clinic

Contact the Academy office for reservations: amy@milwaukeeacademyofmedicine.org or phone 414/456-8249

President Elect's Comments

by Seth Foldy, M.D., M.P.H.
President Elect 2008

The Celebration of Milwaukee Health Champions included in the Academy's 1264th meeting in November embodied many ideas your Council has been exploring for the future of the Academy. Academy members mingled with scores of guests, including Milwaukee Mayor Tom Barrett, Deputy Secretary Mark Thomas from the Wisconsin Department of Health Services, healthcare CEOs, public health professionals, lay health activists, and health services students of various professions. Awards were distributed to outstanding public health programs. Policy and ethics analyst Emily Friedman then conducted a public dissection of the health policy environment at the dawn of the Obama presidency, a sobering view of the terrain between what is needed and what may be possible. At the end she reminded us of physicians' irreplaceable role advocating for patients and their access to care (saluting the Academy's 2000 white paper on this topic), and left everyone considering thoughtfully what actions they should take next.

Recently the Council brainstormed unique ways the Academy can add value for our members, colleagues and community. The list fell into six broad goal areas that I am recommending to the Council for refinement and action over the coming year.

These draft goals are all informed by one core vision: ***physician leaders are more important than ever***, and the Academy seeks to support them at every step.

I've listed and described these goals below. What is your feedback? Do they represent the Academy you desire? Is something important missing? Please send your feedback to Amy John (amy@milwaukee academyofmedicine.org or by mail to the Academy) right away.

Strengthen social networks across generations, medical specialties and health care systems. This is an embodiment of the Academy's motto, *non nobis nascimur*- we are not born unto ourselves. At base,

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Fall 2008 Meetings

The 1,262nd Meeting
September 16, 2008

by Nick Owen, M.D.

The 1,262nd Meeting of the Milwaukee Academy of Medicine was held at the University Club on September 16, 2008. The business meeting was conducted after dinner by president Jerome Van Ruiswyk who solicited nominations for the Humanitarian Award and then welcomed new members Krishnan Unni, M.D. and Chandra Sheila Unni, M.D. by acclamation. The names of Peter Drescher, M.D., Karin Madsen Drescher, M.D., Mark Lodes, M.D., and Laura Roberts, M.D. were proposed for admission to membership at the October meeting. Art Derse was called upon to introduce the evening's speaker, Joseph J. Fins, M.D., Chief, Division of Medical Ethics; Professor of Medicine, Professor of Public Health and Professor of Medicine in Psychiatry Weill Cornell Medical College, and Director of Medical Ethics, New York-Presbyterian Weill Cornell Medical Center. Dr. Fins addressed the audience on Late Recovery from the Minimally Conscious State (MCS): Ethical and Policy Implications.

As Robert Burton said in The Anatomy of Melancholy, "They do not live but linger" and indeed the identification and description of the Minimally Conscious State has changed "lingering on" by adding an additional syndrome with specific clinical findings as well as defining diagnostic studies. Although the prognosis for recovery is a small fraction, it is better than for persistent vegetative state requiring a reconsideration of protocols for withdrawal of life support.

Dr. Fins cited Galen as having seen recovery from a severe head injury; with identification of the Minimally Conscious State we can anticipate better potential for some brain compromised patients' recovery. ❧

The 1,263rd Meeting
October 21, 2008

by H. David Kerr, M.D.

The 1263rd Meeting of the Milwaukee Academy of Medicine was held at the University Club on Tuesday, October 21st, 2008 and presided over by President Jerome Van Ruiswyk. Four applications for voting were presented and approved. He noted that one new application has been received. Nominations were requested from the membership for the Humanitarian Award to be presented at the January 2009 meeting. Dr. Van Ruiswyk then welcomed back the Academy's friend, colleague, and member of many years, Dr. Jeffrey Jentzen who was awarded the Academy's Distinguished Achievement Award for 2008. Dr. Jentzen, a forensic pathologist, was the Milwaukee County Medical Examiner for over 20 years and is presently Professor of Pathology and Director of Autopsy and Forensic Services at the University of Michigan. During his tenure in Milwaukee he raised the status of the Medical Examiner's Office to among the very finest in the nation and made many contributions to the science and practice of forensic pathology. Equally, he has contributed much as a thoughtful, diligent and enthusiastic member of the Academy.

As speaker of the evening Dr. Jentzen gave a detailed and very fascinating review of forensic medical practice entitled CSI Milwaukee: "Bullets and Brats: 20 Years of Death Investigation in Milwaukee."

Medicolegal death investigation involves development of a history, investigating the scene of the death, and determining the cause of death including an autopsy if necessary. In homicide investigations personal safety is an important issue as is maintaining contact with law enforcement and demonstrating conscientious involvement of the medical examiner's office. Death investigations involving children in the early 1990s resulted in the development of innovative methods for interviewing witnesses and in the development of trained Child Death Review Teams.

Thus the medical examiner has responsibility to the community at large in explaining the cause of death, the proper handling of remains, sensitive interaction with survivors and maintaining the highest professional standards. The development of a training program and standardization for death investigations has led to death investigators now being certified and to the creation of the UWM Forensic Science Program.

Education of the public and professionals in areas of public health is a key area of the medical examiner's office. Expertise in poisoning and infectious diseases are areas where determining cause of death can prevent other deaths. Using pharmacogenomics to identify fast or slow metabolizers can explain how some drug deaths occur. A successful program of organ procurement has been developed in following the philosophy that good organs should not be buried.

Dr. Jentzen's distinguished career in Milwaukee was evident in this stimulating and informative presentation. Many attendees commented on the quality of this very fine presentation. ❧

Book Review

by Nick Owen, M.D.

Why should anyone read **Worried Sick: A Prescription for Health in an Over-treated America** by Nortin M. Hadler, M.D., University of North Carolina Press, Chapel Hill, 2008? I'll give you three reasons:

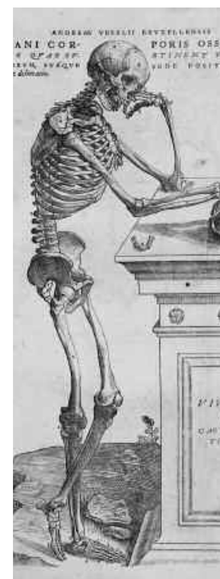
1. Nortin Hadler is a master clinician, a rheumatologist, and occupational medicine specialist on the faculty of the University of North Carolina who has studied and published extensively on the diagnosis and treatment of what he terms "regional pain syndromes" and the management of "functional versus organic" disease and illness. This portion of Worried Sick is an outstanding source on this subject.

2. A frequent criticism of our healthcare system is that physicians order too many unnecessary tests and procedures, the validity of this charge being contingent on the definition of unnecessary.* As an outspoken contrarian, Hadler attacks the current management of many of the big killer diseases. He espouses more rigorous evaluation of the efficacy and utility of the procedures which are used in invasive care of coronary artery disease, cholesterol screening, and screening for cancer of the breast, prostate, and colon, the care of type II diabetes mellitus, and metabolic syndrome, back surgery, and joint replacement, and the use of alternative and complementary medicine. His arguments are logical and make one think about the status quo.

3. Hadler posits that through developing better strategies we can hopefully obviate the current situation in which the choices of modalities are perceived as enriching the involved physicians, compromising their integrity, and playing a major role in increasing health care costs.

Read it and see what you think. ❧

* For an excellent discussion of usefulness, see: "Waste, We Know You Are Out There" by Henry J. Aaron, PhD, NEJM, 359:1865, 2008



The 1,264th Meeting November 18, 2008

by Nick Owen, M.D.

The 1,264th meeting of the Milwaukee Academy of Medicine conducted jointly with the "Celebration of Milwaukee Health Champions" was chaired by Seth Foldy, the 2009 President-Elect of the Academy at the University Club on November 18, 2008.

Dr. Foldy first introduced Milwaukee Mayor Tom Barrett, whose laudatory remarks included the recently announced decrease in Milwaukee teenage pregnancies-a tribute to joint efforts of the public health establishment. He was followed by Mark Thomas, Wisconsin Division of Health Services, Deputy Secretary who conveyed the good wishes of the Governor and the State Division of Health.

The winners of the 2005, 2006, and 2007 Health Champion Awards, their projects, and their teams were introduced by Mayor Barrett and duly applauded (the background of the Champions competition and the list of awardees can be obtained, if desired, from the Academy office).

On the conclusion of the award ceremony, Dr. Foldy introduced Leo Brideau, President & CEO of Columbia St. Mary's Inc., who spoke in his role as Co-Chair of the Milwaukee Healthcare Partnership. He outlined the membership of the partnership and summarized its role in the Milwaukee healthcare picture and its early accomplishments. At this point, the audience adjourned to dinner.

Re-assuming the Chair, Dr. Foldy conducted the Academy's business of the evening, Drs. Brian Peterson and Jonathan Ravdin were voted into membership and the following slate of officers for 2009 was received from the Nominating Committee:

OFFICERS:
Seth Foldy, President
Matthew Lee, President Elect
Daryl Melzer, Treasurer
Kurt Pfeifer, Secretary

Council Members:
Donald Beaver
Kavita Mundey
Alonzo Walker
Jerome Van Ruiswyk,
Immediate Past President

COMMITTEE CHAIRS:
Finance
Daryl Melzer
Fund Development
Carol Pohl
History
Rita Hanson and Ray Zastrow
Membership
Edwin Montgomery
Newsletter Editors
Nicholas Owen and
H. David Kerr
Program
Helmut Ammon
Bioethics
Art Derse

BOARD OF TRUSTEES
Trustees
Elaine Drobny
James Hartwig
Erwin Huston
Geoffrey Lamb
Ralph Schapira
George Walcott
Mary Wolverton
Walt J. Wojcik

Dr. Foldy then introduced Emily Friedman, the distinguished health policy analyst whose post-election address was entitled "A New Political Landscape: What Could – and Should – Change?" Alas, in an elegantly argued discussion beautifully illustrated, her reprise of the situation was largely negative and featured as talking points: 1) healthcare reform was neither a high priority for either political party at election time nor was the multi-faceted problem easy of solution in part because it was not clear what to fix, much less how to fix it, 2) finally it was unlikely that money would be available due to the economic crisis for what would prove to be very expensive improvements.

On this basis, she deemed the likelihood of major reforms / changes slight and felt that no coherent national healthcare policy was likely to evolve but that individual state programs might be developed. She finished by advocating more healthcare dollars be directed to the care of needy patients rather than to research. ❧

From the Academy's Rare Book Collection

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

Mondino dei Luzzi: Anathomia Mundini

The Academy Library holds a copy of Anathomia Mundini, per Carpum Castigata.Venetiis: Octavianus Scotus, 1529.

In addition there are two copies of the Anathomia Mundini translated from Latin to English: one by Howard Kelley, Professor of Latin of Johns Hopkins University, Baltimore, 1897 and the second by Horace Manchester Brown, Milwaukee, Wis, 1917.

Mondino dei Luzzi (aka: Mundinus) (c1275-1326) was a Professor of Medicine at the University of Bologna and celebrated for more than two centuries for his guide to anatomical dissection, Anathomia, written in 1315. He had early medical exposure at the knee of his apothecary father and his uncle, a professor of physic at Bologna. Mondino was an apothecary's apprentice prior to enrolling in medical school. At Bologna he was taught by Taddeo Alderotti (c1210-1290), a highly respected Florentine physician, a famous educator and scholar and one of the founders of the medical school at Bologna. Alderotti was mentioned by Dante (1265-1321) in the Divine Comedy as a follower of Hippocrates. He introduced bedside teaching and clinical case discussion to the medieval medical curriculum. Mondino became a professor in 1306 at Bologna and remained there until his death.

By all accounts Mondino was a popular and talented teacher. His lasting fame and influence stemmed from his development of a systematic guide for the details and the process of human dissection that was used with little alteration for the next 2-3 centuries. In so doing he reintroduced the methods of the ancient Alexandrian School and the words of Galen to students of medicine. Dissection had been abandoned in Europe for centuries. Contact with Arab physicians via the Crusades, travel, and contact with the medical school at Salerno advanced the process of reviving the ancient texts.

The appearance of his guide, an unillustrated folio of 22 leaves, marked the beginning of formal anatomy instruction in medieval universities. Church and civic permission for human dissections had developed earlier for forensic reasons and was expanded slowly to permit "public dissections" with a focus on teaching(1). Anatomy soon became an essential part of the curriculum of medieval medicine. Dissection allowed students to visualize and memorize parts of the body more easily. Anatomical knowledge was not regarded by Galen or medieval medical school faculties as being directly useful for diagnosis or prognosis (1). Mondino followed Galen closely and based Anathomia on his translation from Arabic to Latin of Galen's "On the Use of Parts".

Mondino's dissection divided the body into three cavities: abdomen, thorax, and "upper" (head and appendages) (2). The sequence of dissection began with the abdomen, containing the areas of the recently deceased that were deteriorating most rapidly, and ended with the extremities in three to four days. His practice as lector was to read Galen's description while an assistant (the sector) did the actual dissection, and another assistant (the demonstrator) pointed out the features from the readings. The demonstrator mediated between the word (lector) and the deed (sector). The students observed, probably made sketches and took notes. His guide also specified particular incisions to obtain an optimal view. One of Mondino's assistants was Alessandra Gilliani (1306-1326), a Bologna University student who served as a prosector in preparing dissections for anatomical study. She devised a method of injecting heated colored wax in liquid form into blood vessels and other tubular systems. When the wax cooled the cast was dissected intact out of the vessels for use by students as a three dimensional model.

The guide circulated as hand written manuscripts, until the first of the printed editions appeared in 1478. The "Fasciculus medicinae" of Johannes de Ketham (1491), the first illustrated and printed medical book, included a "bundle" of six medieval medical treatises including Anathomia with illustrations of the dissection process. Because it was clearly written and echoed the respected past, Anathomia went through about 40 editions and was used officially at many medical schools. Mondino's pupil, Guido da Vigevano (1280-1349), produced the first plates used to illustrate dissections. Leonardo da Vinci (1452-1518) used Mondino's guide and method as did Vesalius in teaching students at Padua in 1540, a few years before the publication of his own Fabrica (3). Two hundred years after Mondino, Johannes Guinter (1505-1574), a professor of medicine at Paris and teacher of Vesalius, completed the first modern translation of Galen's "On Anatomical Procedures" into Latin. It contained Galen's detailed comments on his dissections of animals and a comment that he regretted not having been permitted to dissect a human corpse. This book opened the gates to acceptance of factual criticisms of Galen.

Much of the criticism aimed at Mondino involved his not revising the often obvious errors of Galen but rather carrying them forth (3). Contemporary surgeons such as Henri de Mondeville (1260-1320) who studied at Bologna and William of Saliceto (1210-1277) a professor at Bologna strongly condemned perpetuation of "ancient errors" and justified obtaining precise anatomical knowledge "so that you can proceed without error" (3). They challenged the authority of Galen. Written instructions to the dissector of a human cadaver or the surgeons of a living human were akin to sailing directions as Galen's very detailed descriptions testify. When illustrations were added to later editions and by other

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anatomists the process was made easier for the learner or the surgeon confronted with the unfamiliar or the unknown. Mondino was criticized for not noting Galen's mistakes but his was first and foremost the reintroduction of a system of dissection first used in Alexandrian Egypt that was falling into disrepute in Galen's time. It was passed forward by Avicenna, and revitalized by Mondino and the 14th century medical faculty of Bologna. ❧

Addendum:

Horace Manchester Brown (1857-1929) was a celebrated surgeon of this city who upon his death in 1929 bequeathed his library of 347 books to the Academy with money to maintain it. Born in New Bedford, Massachusetts he was left an orphan at age 8 when his father, a major, was killed in the Civil War. His mother died soon thereafter. Raised by his maternal grandfather, he received a splendid education, studied medicine in New York and traveled widely. He was a Latin scholar, a translator, and an expert in the French, Spanish, Italian and German languages. Dr. Brown was a leader in the community and an active member of the Academy for many years (4).

References

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2. Crivellato E, Ribatti D. Mondino de' Liuzzi and his Anathomia: a milestone in the development of modern anatomy. Clin Anat 2006;19: 581-587.
3. Infusino MH, Win D, O'Neill YV. Mondino's book and the human body. Vesalius 1995;1(2): 71-76.
4. Boulanger, Wayne J. History of the Milwaukee Academy of Medicine, June 1988.

The Character

by J.M. Cerletty, M.D.

One of the immense joys of the practice of medicine is the opportunity to meet a great variety of interesting and unique people. I especially enjoy the ones that do not fit the usual mold, the true characters of our society. The prototype of this sort of individual was Ed Wilinski. You all have had patients like Ed. Not the same health problems, of course, but the same charismatic appeal, the same special charm. Ed would have throttled me if he could hear me describing him as charming.

I was on a roll with unique and special patients when I first met Ed. Our inpatient service had just discharged Donna, a young woman with pneumonia. She had told the junior medical student that her occupation was that of an "ecdysiast." The student thought she worked in a dermatology clinic until he was told that this was a euphemism for an exotic dancer or "stripper" ("one who sheds the outer lining"). Upon auscultation of her chest, I could not help but notice that she likely was very popular with her audience. At the time of her discharge from the hospital, she issued an invitation to our team to view her next performance. I do not often visit patients in their workplace, but I must admit I was sorely tempted. I think the medical students on our team followed up on her offer.

In my clinic, I had previously evaluated a young woman with Turner's syndrome (gonadal dysgenesis). Since her ovaries were not making estrogen, she appeared as a tiny, attractive prepubertal girl, rather than the twenty-one year old woman she was in reality. She was started on estrogen and developed the standard secondary sexual characteristics (read that as larger breasts) within several months. At her most recent visit, she asked for a refill of her estrogen, and also thanked me for helping her get employment. When I inquired about the nature of her job, I was taken aback somewhat to learn that she too was an exotic dancer. Seemed like my patients were handling most of the adult entertainment in the area.

Ed was not an exotic dancer, but he clearly was the type who would have been in the crowd, hooting and howling at their performances. I first met him about twenty-five years ago in our Emergency Room, when he presented with severe hyperthyroidism. He almost seemed to be a caricature of the classic manifestations of Graves disease with his bulging eyes, a goiter reminiscent of a turkey's wattle, heart thumping away at a hundred miles an hour and a labile mood that ranged from the frenetic to sobbing depression over the course of seconds. His heart rhythm was abnormal, and he sported a sizable blood clot in his left leg. I insisted that he needed to be in the hospital. He reluctantly agreed. Thirty minutes after admission, he was pacing the floors and insisted that he would stay only if he didn't have to eat the hospital food. We agreed he could get his meals in the cafeteria. One hour later he said he would stay, only if he didn't have to sleep there. His metabolic mania was such that I felt he would never sleep anywhere. After a short time, he signed out against medical advice.

Ed did follow up in my clinic, and, after three or more radioactive iodine treatments, his thyroid status finally came under control and his mania mellowed, but never quite disappeared. He had grown up in a blue collar neighborhood on our city's south side, and had dropped out of school after the tenth grade ("Hell, I flunked out!" he bragged). He worked to support his mother who was "crippled by arthur-itis" in his words. Ed tried to enlist during the second world war, but the Army refused him because of that "god damn hernia." His work was in construction, factories, maintenance and a host of other jobs, but he was always the first to be laid off, perhaps because of mild alcohol abuse or his carefree attitude about work of any sort. He finally landed a job as a bartender shortly after I became involved in his care. He kept urging me to come to his workplace. "Hell, I come out to see you all the time at your job. How about returning the compliment?"

His tavern was across the street from a large factory. At 7 am, when the night shift got off duty, hordes of workers would pour into the pub. Ed tended bar from six in the morning till just after noon. Late one Saturday morning, I visited his workplace. The night shift had gone home to bed, and the tavern was filled with what appeared to be the neighborhood regulars, grizzled codgers whose major interest seemed to be their alcohol. The place was dimly lit, and the dank atmosphere made me shiver. One stool was unoccupied, almost as if it had been reserved for me. All the patrons had a partially filled schooner of beer in front of them. These glasses were about the size of a large fish tank. A majority of the denizens also had whiskey glasses near their right hand. "Doc, how the hell are you?" bellowed Ed as I walked into the establishment. "It's about time you showed up."

No sooner had I eased myself onto the stool, than a schooner of beer appeared in front of me, along with a two ounce jigger of bourbon. Ed announced that the house was buying, and an immediate shout of joy arose from the crowd. Toasts ranging from *Prosit* to *Skol* to a Polish word I could not decipher filled the air. With some trepidation, I sipped at the bourbon. No hesitation on the part of my new compatriots. I marveled at their ability to curl their lower lips under the bottom rim of the glass and snap their heads back with such speed, literally hurling the alcohol down their gullets without losing a single drop. After several minutes, it became apparent that I should buy the next round. And so it went. By the time there were four full glasses of whiskey plus the one I had been sipping in front of me, it became obvious that I was either going to have to make a premature exit or be directly admitted to a detoxification unit.

Ed showed up faithfully for his follow-up visits. He always had a few humorous and slightly ribald stories for me, but he specialized in truly corny jokes and groan-evoking puns. His atrial fibrillation required anticoagulation, and he reveled in referring to his Coumadin medication as his "condom pill." He was retired by now, and spent his time mowing his neighbor's lawns, griping about

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politics and boy-sitting his two-year old grand-nephew. For reasons that are hard to explain, I really loved this man. What did he represent to me? A variety of feelings and sentiments, such as an absence of pretentiousness, and a abundant dose of reality, accepting ourselves as we are. He was uneducated, and felt it was too late to change so he had no qualms or regrets, or perhaps it was just that he had a stubborn macho pride in his faults and deficiencies. Maybe I saw in him a reminder of my own family's background and origins. Whatever the reasons, I certainly looked forward to his clinic visits and tried to schedule him as my last patient so we could spend more time together.

He missed three consecutive clinic appointments some years ago. I called his home, but received no answer. There was no response to my letters. His pharmacy had been calling me for refills so I at least knew he was alive. When he finally did return, he looked disheveled and unkempt. He had lost weight, and appeared haggard and exhausted. "I'm having problems, Doc. I'm not sure I want to live." It took some time for the story to evolve. His grand-nephew had been crushed to death by an automatic garage door at a neighbor's house. It clearly wasn't Ed's fault, but he felt that it had happened on his watch. He was inconsolable. All the humor, the enthusiasm and the joy of life had been sapped from this man. He sobbed as he told me the story, which only subsided when I held him in my arms and hugged him.

Time really does not heal all wounds. But as the years went by, Ed slowly came to life again. Using the vernacular, he would tell me about politics, health care, television and the various elderly women he had been dating. He loved to dance and would polka and waltz for hours, stopping only when his exertional dyspnea flared. Then came the rectal bleeding. It wasn't hemorrhoids as we had hoped, but an especially virulent form of colon cancer. The surgery and chemotherapy slowed this dynamo down considerably.

He was hospitalized in late December with nausea, vomiting and more weight loss. "I feel like crap!" he growled as I entered his room. His language was improving, I thought. He spent thirty minutes describing the dance he had been at the prior week till he got to the point he really wanted to discuss.

"I know I'm dying, Doc, but I have one more wish. I want to go fishing when the season opens next May. I'll be too sick to drive, and all my old fishing buddies are gone. Will you take me fishing?" I quickly agreed as I held back my tears. I've never been more flattered by a request.

Ed Wilinski died a week later. ❧

New Members in 2008

Deborah Bletzinger, MD
Nancy Bratanow, MD
Carlyle Chan, MD
Elizabeth Ciurlik, MD
Karin Drescher, MD
Peter Drescher, MD
John Fish, MD
Mark Lodes, MD
John Meurer, MD
Linda Meurer, MD
Anthony Norelli, MD
Brian Peterson, MD
Mary Beth Phelan, MD
Peter Plantes, MD
Jonathan Ravdin, MD
Laura Roberts, MD
Dennis Sobczak, MD
Chandra Unni, MD
Krishnan Unni, MD
Douglas Woo, MD

President Elect's Comments

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medicine is a social enterprise; we continually learn the *art* of medicine and retain a healthy perspective through storytelling. Hospital system competition, time pressure and specialization threaten to alienate each of us from our professional community. To serve the community well, we must ourselves remain a community. The Academy will provide a place to share our tales, celebrate our common identity, and resist social and professional isolation.

Support lifelong education, the quality of health care, and the quality of medical life. Life is short, the art is long, the science ever-changing. The Academy will continue to support lifelong education to ensure our care is of the highest quality, and to understand, use and enjoy advances in science, technology and the art of medicine. The constant pressure for excellence is punishing, thus the Academy will also support time and space for reflection and self-healing, in addition to instruction.

Support medical professionalism, humanism, ethics and history. Medicine's ethical, humanist and scientific philosophical foundations are constantly threatened with erosion by economic and other pressures. Historical memory and philosophical inquiry enrich our understanding of our science and practice. The Academy will continue to preserve our medical heritage; engage it in dialog as our profession re-invents itself; and share it with others who share our interests and passions.

Engage emerging health policy issues. Medicine's scientific and ethical perspectives must help shape health policy. This can only occur if physicians are fully conversant with policy alternatives and the decision-making process. The Academy will help both physicians and non-physicians become better-informed participants in policy decisions.

Recognize achievement in our profession and in our community. Election to Academy membership is an honor bestowed on those who embody the best aspects of the profession. The Academy will also continue to call attention to extraordinary service to medicine and the community through awards and celebrations.

Build respectful bridges between medicine and the rest of the community. Tackling difficult health and ethical problems requires common understanding between physicians and the community at large. The Academy will open its resources and programs to the public to the greatest extent possible, and engage in conversation with community leaders. ❧

CME Reminder

CME transcripts are available to members upon request. Please remember that they are not mailed out routinely, you must contact the Medical College of Wisconsin Continuing Education Department to make the request for your transcript.

To receive a copy of your CME transcript for Academy programs, please contact the Medical College of Wisconsin's automated request phone line at: 414/456-4896

You will be asked your name, mailing address and what years you would like reflected on the transcript.

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general anesthesia; 2) he thought that surgical manipulation of a cancer would accelerate its growth and contribute to its spread; and 3) he thought that if the lesion turned out to be cancerous the subsequent treatment would leave him without the ability to speak—and he preferred hoarseness to total loss of speech. All of these concerns were assuaged with further explanation and he has since scheduled follow-up with ENT clinic for a repeat exam with possible biopsy.

At other times, exploring the "why's" of patient behaviors may not yield actionable information, but it still might provide some interesting insights into their outwardly irrational behaviors. For example, at a recent new patient visit, a 49 year old man with schizophrenia reported that he spent his days shopping for clothes. When I asked "Why?", he answered that he couldn't bring himself to do laundry for the last 1.5 years since it reminded him of doing laundry for his long-term [21 years] significant other who had died 1.5 years ago. Consequently, his car was full of dirty laundry and he avoided doing laundry by buying new clothes. While this behavior still met my criteria for irrational, I did gain some empathy for his situation and some insight into this particular behavior by hearing his answer to "Why?".

This effort to understand the context of patient behaviors and concerns is sometimes labeled 'patient-centered' or 'motivational' interviewing. The goal of medical interviewing, no matter what style is adopted, is to create rapport, collect good data, and improve patient compliance. A study of patient communication preferences found that 70% prefer this patient-centered style of interviewing, while 30% prefer a more biomedical style [Patient Educ Couns 2006 May; 61:200-11]. Ideally, physicians would tailor their communication style to patient's preferences and situations. Unfortunately, physicians often miss or inappropriately respond to patient's cues or concerns [Psychol Bull 2007 May; 133:438-63], contributing to a breakdown in communication and subsequent patient behaviors that are perceived as irrational. So how can we do better? Training in communication skills can help. A review titled 'Educating for Empathy' published in 2006 in Journal of General Internal Medicine[J Gen Intern Med 2006; 21:524-30] found that communication skills workshops that address the behavioral aspects of empathy showed the greatest increase in participant's subsequent empathic behaviors, and that this change in behavior persisted up to 12 months. Another technique that may be helpful is increasing physicians awareness of their internal reactions to patient interactions. The basic premise of authors that espouse this approach [Acad Med 2007 Apr; 82:422-7 & J Gen Intern Med 2005; 20:201-7] is that physicians often don't even recognize how their internal reactions impair their communications resulting in consequent harm to the physician-patient relationship. While this hypothesis is certainly plausible, there is currently a dearth of evidence-based techniques for fostering this physician self-awareness. Still, since effective physician-patient communication is one of the linchpins for improving both patient outcomes and physician satisfaction, it is reasonable to advocate trials of self-awareness techniques for enhancing patient-centered care.

So, in the spirit of inquiry and self-discovery, and in pursuit of improved patient communication, when you observe seemingly irrational behaviors keep asking why. Sometimes asking why may reveal the root causes of the behavior. In other cases it may provide only a clue or a partial explanation. In either case, the perspective that you gain from this empathic inquiry strengthens the physician-patient relationship which is good for the health of your patients.

2009 Meeting Dates

January 20
February 17
March 17
April 21
May 19
September 15
October 20
November 17

123rd Annual Meeting
January 20th, 2009
6:00 – 9:00 p.m.,
University Club of Milwaukee
$7.00 cocktails
$43.00 dinner
Complimentary Parking

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

Email Reminder

If you have not already done so, please email your current email address to the Academy office, amy@milwaukee academyofmedicine.org