ILWAUKEE ACADEMY OF MEDICINE

Volume XXXIV / May/June 2013

President's Remarks

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

We worked together at the Underground Switchboard Free Medical Clinic in the late '60's and early 70's. She and I and many others (largely physicians, nurses, and med techs) tried to provide episodic care to the "Flower Children" who thronged Brady Street and environs. They neither looked nor smelled like flowers, but they brought their engaging, bizarre, and dangerous lifestyles with them and we smiled, accepted, and sometimes helped. It was a fascinating once-a-week change from a suburban home with a bunch of well-scrubbed toddlers, and a pediatric practice that catered to their schoolmates and neighbors.

The then St. Mary's Hospital donated space in what is now the Heritage Building and we treated their phlebitis and their abscesses, their colds and coughs, their frost bite and burns, their discharges and VD (not STDs in those days), and all too often they would leave our fairly warm quarters to go back on the street on a winter eve not knowing where they would sleep that night. After a paediatric residency in which it was verboten to examine a girl between her symphysis and her knees, I was forced quickly to master gyn exams on the job. Those of us who worked there became comrades and pals, and shared a certain rueful questioning pride in what we were doing. Then she sued me.

She had sought me out as the paediatrician for her newborn daughter, and I enjoyed both the hippy mom and the cute healthy baby. She didn't continue coming to me after the baby's first birthday and I missed both seeing them and the $5 office visit fee which I could use in my fledgling practice, but didn't give it a lot of thought until I received the notice that she had commenced a malpractice suit against me.

It was alleged that her daughter had developed a stubborn case of thrush because of my inappropriate prescribing of antibiotics and that her daughter would never fulfill her mother's dream of her becoming a ballerina because I had not treated her internal

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2013 Meeting Dates

September 17
Annual Bioethics Lecture
Jerome Lowenstein, M.D.
Editor, Bellevue Literary Press,
New York University
School of Medicine

October 15
Distinguished
Achievement Award
To be announced.

November 19
Susan Lederer, Ph.D.
Robert Turell Professor
of Medical History and
Bioethics, Chair, University
of Wisconsin -Madison,
Annual History of
Medicine Lecture.

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 1,297th Meeting

January 15, 2013

by H.D. Kerr, M.D.

On January 15th, 2013 at the University Club, the Milwaukee Academy of Medicine held its 127th Annual Meeting which was also the 1297th meeting of the Academy. Alonzo Walker, M.D., the outgoing President called the meeting to order and introduced the nominated officers, council members, and trustees for 2013. The complete list of these members can be found on the back page of the newsletter. They were duly elected by acclamation. Dr. Walker announced that Dr. Bruce Campbell would present the Humanitarian Award. Theodore MacKinney, M.D., M.P.H. received the award for his work in providing health care and building a hospital in an impoverished area of Nepal. Noted was that he had also worked among the poor in Milwaukee. Dr. Walker then announced that the Nominating Committee had selected Rita Hanson, M.D. to receive this year's President's Award. The award is given annually to a member of the Academy who has immeasurably enriched the Academy by their presence, their work and their personification of our motto--non nobis nascimur--we are not born unto ourselves. After his remarks on his term as president, Dr. Walker then turned the podium over to Dr. Edwin Montgomery, M.D., the new president, who presented Dr. Walker with a plaque in recognition of his service to the Academy and his outstanding work as President.

After his remarks Dr Montgomery introduced the speaker of the evening, Kimberly A. Strong, PhD, Assistant Professor of Bioethics, Program in Genomics and Ethics, Center for Bioethics and Medical Humanities, Medical College of Wisconsin. She spoke on the topic "Where Do Bioethical Questions Fit in the Exciting World of Whole Genome Sequencing?"

The more one scrutinizes bioethical possibilities in this new area, the more it seems that they are central to the use of this new technology. What information should be shared and what withheld? Who should decide? Her talk focused on how this work is progressing locally and nationally.

The costs of sequencing an entire human genome have fallen drastically. As a direct result its use is burgeoning. From use of several family genomes to research and treat a baffling condition come ethical and legal questions as to the ownership of one's own genome and whether results should be returned to participants. What obligations are owed to participants regarding inadvertent findings? What should govern the future use of samples taken for whole genome sequencing?

Such sequencing could radically increase the volume and scope of prenatal genetic data as well as enhance decision making. Its existence could change the norms and expectations of pregnancy. It could distort the role that genetic determination plays in child rearing. Their future autonomy could be undermined if they are not given the option of having access to their own genetic information, and it could be distorted if they are.

Dr. Strong's talk was quite interesting and thought provoking. The audience appreciated her enthusiasm and the clear explanations she included to illuminate this growing and often baffling area.❧

The 1,298th Meeting

February 19, 2013

by Nick Owen, M.D.

On February 19, 2013, President Ed Montgomery called the 1,298th meeting of the Milwaukee Academy of Medicine to order. He requested nominations for the Academy's Distinguished Achievement Award to be presented at the October 2013 meeting (letters to be submitted by April 1, 2013 to the MAM office). He next introduced Dr. Jon Lehrmann, the Acting Chairman of the Department of Psychiatry, Medical College of Wisconsin who in turn introduced the evening's speaker Jan Fawcett, M.D., Professor of Psychiatry, University of New Mexico School of Medicine whose topic was Reducing Suicide in Medical Practice.

Citing his and his wife's data based studies and those of others, Dr. Fawcett outlined factors that promote suicide. In 90% of cases an underlying psychiatric diagnosis is involved. Psychotropic drugs have not been found useful in preventing suicide. Circumstances and events which trigger suicide were listed. Factors which differentiate suicidal attempts from successful suicides were discussed.

While emphasizing that suicide is not predictable or treatable, in some patients risk factors, e.g. depression and anxiety, can be modified by long-term treatment lessening the risk of suicide. Denial of intent and contractual pledges are of no value.

Caregivers, while dismayed by the limited " handles" available for management of this risky population, can be grateful that Dr. Fawcett and others are working to provide better insight to this problem as well as working to improve DSM5.❧

The 1,299th Meeting
March 19, 2013

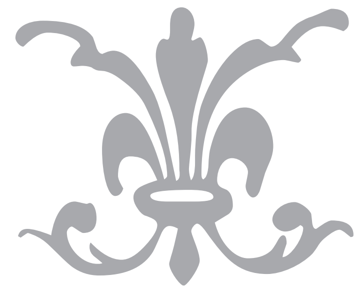
by Nick Owen, M.D.

The 1,299th meeting of the Milwaukee Academy of Medicine was held at the University Club on March 19, 2013. Dr. Ed Montgomery, President, opened the meeting by reminding the membership that nominations for the Distinguished Achievement Award are due on April 1. He then introduced Dr. John Raymond, President of the Medical College of Wisconsin, who presented an update on the school's developing upstate project which is moving along well with multiple longterm benefits: more students studying to be doctors, decreased cost to educate each student, and shortening of the duration of education.

Dr. Montgomery then introduced Dr. Sheldon Wasserman, Chairman, State of Wisconsin Medical Examining Board who spoke to the topic of "The Medical Examining Board and How it Affects Your Practice". Dr. Wasserman outlined the structure of the board and its role and operation and reminded us that the board enforces rules by monitoring performance and restriction of privileges, not by punishment.

He reviewed the revision of Chapter 10 which updates the administrative rules on professional conduct. He strongly recommended that retiring physicians maintain their licenses. In discussion of board operations he noted that Wisconsin has the lowest requirement for continuing education of any state and is low on the list of frequency of disciplinary action. He anticipates updating including biennial recertification and some measure of monitoring ongoing education whether by examination or recertification by specialties. ❧

The 1,300th Meeting
April 16, 2013



by H.D. Kerr, M.D.

On April 16, 2013, the 1,300th Meeting of the Milwaukee Academy of Medicine was held at the University Club in conjunction with the Medical College of Wisconsin Beta Chapter of Alpha Omega Alpha's 2013 Induction Ceremony.

After dinner, the meeting was called to order by President Edwin Montgomery. Dr. Tony Thrasher was elected to membership in the Academy. The speaker for the May meeting will be Michael McCrea, Ph.D. who will speak on the topic of Scientific Advances in Sport-Related Concussion.

Dr. Montgomery then introduced Dr. Jim Sebastian who thanked the sponsors, the parents of the inductees, and the executive directors Amy John of the Milwaukee Academy of Medicine and Lesley Mack of AOA. Student nominators of this year's group of outstanding teachers selected the following from the faculty and house staff for induction into AOA:

Matthew Tews D.O.
Emergency Medicine Faculty
Ravi Misra Ph.D.
Biochemistry Faculty
Erin Chinnock, M.D.
Obstetrics/Gynecology Housestaff
Rohit Loomba, M.D.
Pediatrics Housestaff

Dr. Sebastian was joined by Dr. Ed Duthie and Lesley Mack. They proceeded to introduce each senior student inductee into AOA. Each was presented with a certificate, and notation was made of their undergraduate school and degree. Their intern destination and planned area of medicine were noted, and an anecdote related by Dr. Sebastian about each one. The AOA ceremony concluded with the reading of the names of the junior medical students who will be inducted next year.

Dr. Daniel J. McCarty M.D., M.A.C.P., M.A.C.R., F.R.C.P.(I), Will and Cava Ross Professor of Medicine, Emeritus, Medical College of Wisconsin, was the distinguished speaker of the evening. He spoke on the topic of "Evolution of Medicine From Hippocrates To The Present--Quo Imus?" (Where are we going?). He led the audience through practices and successes of ancient times to modern medical practice. The search for quality and the establishment of standards led to improvements gradually. The emphasis on physicians working together when the need arose led to the development of organizations such as the Royal Society of Medicine. At its founding in the 1600s its nucleus included such multitalented luminaries as Thomas Willis, Christopher Wren, Robert Hooke, Robert Boyle, and Thomas Hobbs. Centuries later William Osler set high standards for medical education. Despite much progress medicine is now in crisis. Dr. McCarty noted that our modern hospitals are described as dangerous. Hospital based nursing schools have collapsed. Morning Report, heretofore done on the wards patient by patient with attendings, house staff, medical students, and nurses has been moved to a room where flesh and blood patients are represented by oral summaries or written words. Modern advances seem to have crippled many elements of medical education. The most important loss is the lack of a genuine history and physical as well as the fading central dictum to "touch each patient." Half of Americans now see non-allopathic practitioners. Dr. McCarty's talk was timely, warning of critical danger ahead to patients and our system. He touched a nerve of many in the audience who appreciated his candor and acknowledged his long experience gained in medicine and his sharp perspective.❧

From the Academy's Rare Book Collection

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

Johannes de Ketham (15th Century)

The Fasciculus Medicinae of Johannes de Ketham Alemanus

Fasciculus Medicinae was the first printed book with medical illustrations and was acclaimed as the best illustrated printed book published since the Gutenberg Bible in 1456. The text contained brief medical treatises believed to have been edited for the use of practicing physicians by Johannes de Ketham, a German physician living in northern Italy. Little else is known about him. The book quickly became very popular and eventually became one of medicine's most famous works. It was described from its title as "a little bundle" of medical knowledge. It was practical, and had the imprint of authority. The detailed and realistic illustrations were immediately sought after in comparison to crude medieval predecessors. Publication in Venice by the de Gregorii brothers of this first such volume was a heralded event that led to six more editions over the next twenty-five years. The illustrator was believed to have been Gentile Bellini (1429-1507), a respected Venetian artist or one of his students.

Medieval illustrations sold in a series of five pictures representing osseous, nervous, muscular, venous, and arterial systems were common in the late middle ages. Sudhoff found examples in a German manuscript from the cloisters at Prufening (AD 1154) and a "blood-letting man" illustration dated 1432 in a Munich library. The Fasciculus contained 30 folio pages largely of text, and six full page illustrations. For the first time illustrations were linked by a line to detailed text explanations in the margins.

The first illustration (*Figure I*) depicts a professor, Petrus de Montagnana, who had been a popular faculty member at the Padua medical school. Near him are many of the books used for learning medicine

Facsimile of the first (Venetian) edition of 1491 with introduction by Karl Sudhoff; Translated and adapted by Charles Singer with XIII plates. Milan; R. Lier & Co. , 1924. A reproduction of the Munich copy of the edition of 1491: Venetiis, par Joannem et Gregorium de Gregoriis.

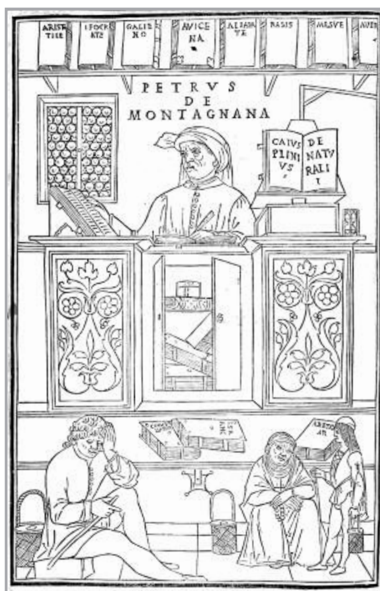


Figure I

and medical practice. The authors included Pliny, Aristotle, Hippocrates, Galen, Avicenna, Razi, and Averroes. His own Consilia medica, a collection of case studies used in the instruction of his students was at his side. Nearby may be the Consiliator differentiarum by Petrus

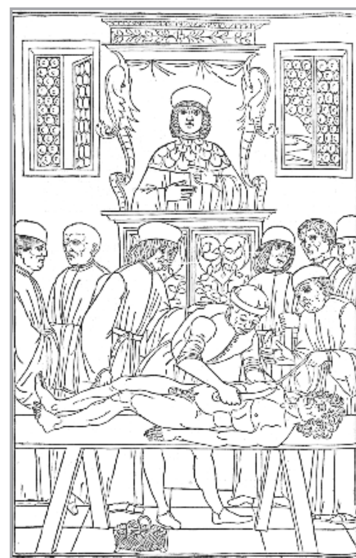


Figure II

Abano (1257-c1315) who worked to reconcile differences between philosophers and physicians. Three ill patients sit below him. Each carries a small metal basket with hot coals to provide warmth and ward off evil humors.

Another illustration (*Figure II*) depicts the dissection of a cadaver as part of an anatomy lecture held at a university. The lector, a junior doctor, recites passages from Avicenna, then Galen, and finally from Mondino dei Luizzi's Anathomia. The organization of the text parallels the sequence of the dissection. A basket sits at the foot of the table to receive debris to be included in the burial. The sector, the only figure in academic gown, holds the knife. He leans over the body of the youth and will do the dissection. Some may not be paying attention. A discussion will follow the dissection (1).

Two illustrations (*Figures III & IV*) involve urine. A senior doctor in full academic dress with hat, toga, and stole uses a flask of urine to instruct junior colleagues

Continued on page 5

Figure III

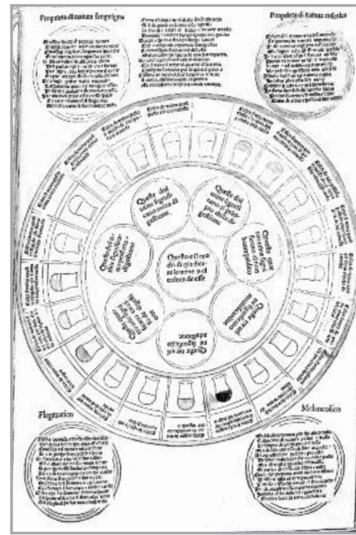


Figure IV

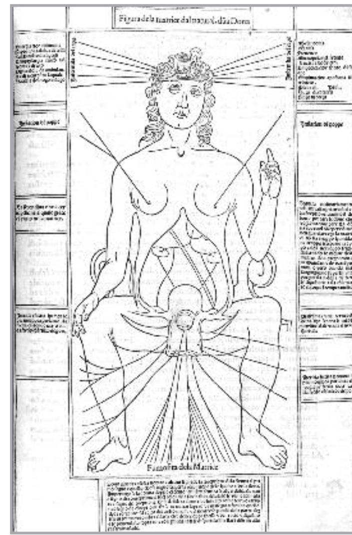


Figure V

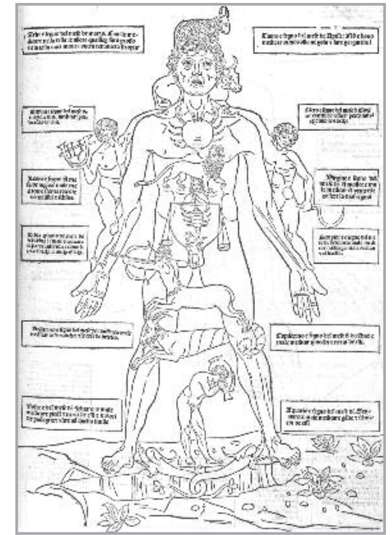


Figure VI

on uroscopy, the reading of urine. Messengers bring flasks from patients at home for the physician's visual analysis.

Various urine colors are arranged in wheels and compared to the urine sample . The color may reflect one of the four humors thence indicating the temperament of the patient (sanguine, choleric, melancholic, or phlegmatic). Other characteristics are noted. If the urine is black the patient may be melancholic, prone to depression, and possibly suffering from a chronic disease such as cancer.(2)

Next the reader is ushered into the sick room of a plague sufferer. Both valets are holding torches for lighting and to purify the air. Communal plague was called epidemic in that it appeared suddenly and involved a large part of the community. The conflicts between caring for a dying patient and protecting oneself are shown clearly. The basins must be emptied. The physician must touch the patient in taking his pulse. Kindness is evident and so is the bowl held up and likely containing aromatic vinegar to purify the air in the room. The sufferer displays Hippocratic facies with pinched expression, sunken eyes, hollow cheeks and temples, relaxed lips, and a far off look in evident detachment. The messages conveyed by the scene are to treat the patient as best you can even if the problem is beyond control. (3)

Several other illustrations involve the realities of problems in practice. The Bloodletting Man illustrates locations where a vein could be accessed for bleeding the patient whether by phlebotomy, venesection, or use of leeches. Physicians delegated this task to surgeons or barbers. This was a useful chart as favorite veins may be astrologically contraindicated, thus risking the patient's life. A safer location must be chosen.

The Wound Man illustration displays numerous knives thrust into him in many locations from feet to scalp. The text warns the surgeon to not try to treat wounds of the trachea, esophagus, or large bowel as these are nearly always fatal. Wounds from kitchen knives, swords, daggers, and arrows are included as are injuries from rocks and clubs. The text advises the removal of dirt or putrefaction with a soft cloth and sewing the wound. The lines extending from the illustrations identify and discuss the most daunting surgical challenges. Many possible injury situations are presented including single or multiple wounds and would likely be useful for discussions of underlying anatomy, associated injuries, and treatment. The text adds a droll postscript on treatment of deafness consisting of "a penny's worth of salt...perforate a radish and add the salt...bury this in the earth for three days...and use as an ointment in the ear."

The Disease Man illustration is introduced as "a fine tract on all the illnesses of the human body." Four columns are arranged on each side of the figure with the diseases listed alphabetically but with the list organization having no relation to illness location or pathology. Diseases that are local are listed on the figure from head to toe. Quinsy affects the throat, and gout the feet. Cancer can involve the testicles. This concise but long list would pose a daunting challenge to students and practitioners engaged in "describe and discuss" testing.

The Disease Woman illustration (*Figure V*) depicts a woman sitting on what may be a birthing chair. Listed are diseases or problems particular to women including pregnancy and delivery, breast swelling, jaundice, running eyes, and problems of conception. The text notes that conception can be revealed by aching kidneys and the desire to eat dirt or coal.

The Zodiac Man illustration (*Figure VI*) shows the zodiac signs superimposed on the man. The Crab is the sign of June. The practitioner must avoid treating the stomach, the spleen, the lungs or the eyes during this month. Capricorn is the sign of the month of December; it is bad to treat the knees during that time or their nerves. (4)

Fasciculus medicinae has survived so long because of its tangible links with the present and the deep past.❧

References:

1. Carlino, Andrea. Books of the Body: Anatomical Ritual and Renaissance Learning. The University of Chicago Press, Chicago, 1999.
2. National Library of Medicine. Historical Anatomies on the Web. Click on K for the author. www.nlm.nih.gov/exhibition/historical anatomies/browse.html#k.
3. Southgate MT. Fasciculus medicinae. JAMA;1998;280, 18, 1552.
4. Whitfield, Peter. Astrology: a history. Harry N. Abrams, Inc. Publishers, New York, 2001.

Book Reviews

by Nick Owen, M.D.

**Bad Pharma:
How Drug Companies
Mislead Doctors
and Harm Patients**

Ben Goldacre,
Faber & Faber,
New York, 2012

Like their predecessors, the snake oil barkers, contemporary pharmaceutical companies place marketing and profit above concerns for their fellow man. Goldacre explicates their "dirty tricks", and it behooves caregivers and consumers to familiarize themselves with them for protection. ❧

**The Universal Sense:
How Hearing Shapes
the Mind**

Seth Horowitz, PhD,
Bloomsbury,
New York, 2012

Have you wondered why one can't tickle oneself? Horowitz provides the answer: the same neuro-reflex which attenuates auditory volume when one shouts (to prevent noise damage to one's ear) also disrupts self-tickling. Other than multiple similar asides, his book encompasses a broad review of observations regarding sound and the brain. He points out the unique characteristics of hearing in regard to range and speed of transmission compared to other senses and investigates comparative anatomy and auditory function to illustrate evolution, also noise, music, brain localization and odd bits e.g. alteration of music to subconsciously promote sleeping or nausea.

He finishes with a discussion of the relative merits of growing hair cells from stem cells and transplanting them as opposed to cochlear implants. ❧

**The Cost Disease:
Why Computers Get Cheaper
and Healthcare Doesn't**

William J. Baumol,
Yale University Press,
2012

The Cost Disease introduces a different take on solving the healthcare cost crisis. Baumol, an economist at the Stern Business School NYU and an emeritus professor at Princeton, with his associates make the point that susceptibility to the cost disease is endemic in those human endeavors in which services are dependent on and delivered by technically trained educated individuals who cannot be replaced by less expensive surrogates, either people or machines. He cites healthcare delivery, live performing arts, and higher education as principal examples.

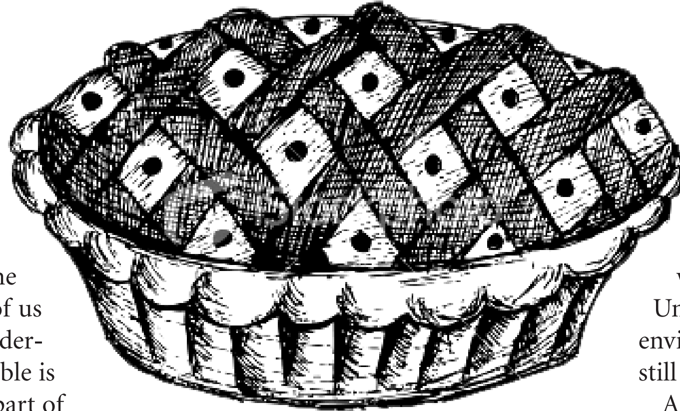
Their thesis, clearly elaborated, is that increased productivity in other areas of the economy as well as pursuing a list of fiscal improvements ranging from better healthcare outcomes secondary to medical progress, to application of better business practices by the medical establishment in healthcare delivery will permit society to reduce the accelerating cost of "the cost disease" and bolster the general economy to achieve a viable balance.

Great theory; makes sense; but can it be made to work? ❧

From David Shapiro's CMO Corner, Columbia St. Mary's Physician Newsbrief

The Tragedy of the Commons, From Aristotle to Hardin, From Berwick to Ostrom. Who will leave us some pie?

by David Shapiro, M.D.



Whoa, that sounds heavy. On the other hand, as has been pointed out so many times before, health-care is complex and we are not just part of the problem but to a large degree maybe we are the problem. The inability of those of us who provide the care and the leader-ship to pony up and be accountable is a part, almost certainly a major part of the current mess. The fact that this mess is for the most part still providing all of us with comfortable incomes is also part of the issue and one of the reasons that there has, up until now, been no sig-nificant change in the way we provide care, one might argue since Lyndon Johnson (remember him?) signed the Medicare bill that provided much of the impetus for growth of governmental payment for the elderly and infirm. Interestingly it had been the post WW II economic boom and growth of trade unions that to large extent fueled the growth of private employment based health insurance. Ironically the AMA fought the Medicare bill thinking it the beginning of a creeping socialism (sound familiar?) that would bring down the insti-tution of modern American healthcare. Didn't exactly work out that way.

The Tragedy of the Commons generally is dated back to 1833 and a pamphlet dis-cussing medieval land use by an Englishman named William Foster Lloyd who proposed a construct as follows: There is a large plot of land owned equally by a number of sheep farmers all of whom are attempting to maximize their profits for the good of their families, etc. The way to do this is for each one of them to intro-duce more sheep (I don't know, maybe read PCPs or MRIs) into the grazing field. The basic logic of which is that, though the degradation of the field that will occur with the addition of more sheep will be felt by everyone, at least at first, the introducer's profit will outstrip their guilt at having diminished the value of the field itself. In other words the per-sonal gain will overshadow any societal concern for others. Aristotle and Thucydides a bit before him despaired at their fellow (well they really were pretty much talking about men – perhaps fodder for a different column) citizens' inability to put the common good above their unen-lightened greed and self-interest.

Fast forward. Well, maybe not so fast, to George Hardin, who in 1968, in Science, published an article bringing to the fore-front this notion. He argued that free access and unrestricted demand for a finite resource ultimately reduces the resource through over-exploitation, temporarily or permanently. In his last address to the IHI as its CEO a few years ago Don Berwick discussed this, as well as the refinement of this argument by Elinor Ostrom, the only woman to have won a Noble Prize in Economics (a few years before her death just last June). She attempted to formulate by 8 postulates the ways in which the tragedy of ultimate resource destruction could be avoided. Rather than taking a purely regulatory approach, as many had done before her, hers was a more nuanced approach with decision-making pushed toward the providers of service rather than centralized. With a pie that, through the realization that those of us who live in a world of limited resources had better learn how to share, she analyzed the forces that would allow that to happen.

Unfortunately, looking out at the current environment, it is easy to believe we are all still adding sheep to the field.

As we move northward of 17%GDP, twice what other industrial nations spend there is a lot of noise and not much signal. We do about twice as many CT Scans, MRIs, joint replacements, and cardiac sur-gery than any comparably developed country. Yet our citizens live, on an aver-age, and even income adjusted, a bit less long than in those countries. There are some confusing data as well. We have fewer doctors, less doctor visits, less hospital beds and a shorter length of stay, than the average of these countries. We prescribe about the same amount of medicines, though we certainly pay more for those medicines. The average cost for much of the above is up to (cardiac surgery and joint replacement here) twice as much as in those countries. Each piece of this pie, as Berwick pointed out, is owned by some-one. Physician, hospital, hospital adminis-trator, industrial vendor, pharmaceutical company, insurance agent, venture capital-ist, physical therapist, nurse practitioner, psychiatrist, physiatrist, Jack and Jill and John and Jane and Jose; who among them would give up a bit of their pie? Aristotle knew the answer, just as you do. No one wants less pie. Everyone wants a bigger and then bigger piece. Figure that one out and…

Someday in a Galaxy Far Away, resources will be allocated and collected according to need. Here, though, in this galaxy, could be a while. ❧

Officers and Members of the Council for 2013

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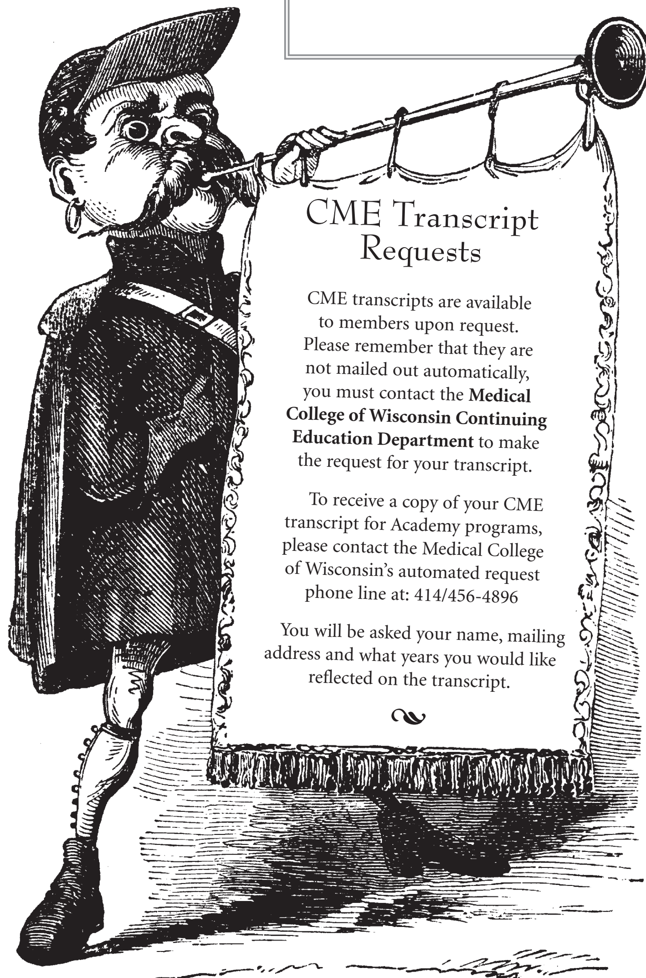

CME Transcript Requests

CME transcripts are available to members upon request. Please remember that they are not mailed out automatically, 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.

President's Remarks

Continued from page 1

tibial torsion. It was the era of using twisters to straighten out such "deformities," but the more recent literature questioned the necessity or effectiveness of the treatment. I had mentioned but not suggested it. I immediately turned to my insurance carrier, who scoffed, said they would take care of it, and "not to worry."

For days every orthopod who was a friend of mine was buttonholed for his thoughts on the non-treatment of internal tibial torsion, and my wife and the 5 rascals learned to avoid their crotchety father. I really thought it was a frivolous case, and soon the litigant's pro bono rookie attorney refused to pursue it. But 50 years later I still dwell on it, a little.

What is seldom mentioned in the debates and proposed legislation on malpractice tort reform is the toll it takes on the physician-defendant. The costs of "defensive medicine" are debated as are the ethics of almost unimaginably high jury awards; and the inability of a genuinely harmed patient with a less than half million dollar claim to find counsel is discussed at length. Only in the medical literature, rarely in the lay literature, is the emotional, mental, and physical toll on health care defendants taken into account; nor is the impact on the patient when her doctor needs to make a compassionate difficult decision, with that wee-little attorney perched on her or his left shoulder.

Currently the Georgia and Florida legislatures are considering a bill to create a patients compensation panel, and to institute a no fault administrative model. The savings from such bills, projected nationally, could save "the American health-care system $2,600,000,000.00 over a decade," according to Wayne W. Oliver of Patients for Fair Compensation. Imagine the savings to physicians' coronary and cerebral arteries.