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Memory Feats

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I ATTENDED A CONFERENCE last October with Dr. Stanley Aronson, a neuropathologist and former chair of pathology at Downstate Medical Center, editor emeritus of this journal, and 91 years old. Stan gave a talk about his personal history in the field of medicine, focusing largely on his



experiences at Downstate, where the talk was held. He mentioned several colleagues he had worked with. At the end of his talk, an audience member noted that a faculty member who had featured prominently in his talk had a daughter who became a neurologist and was in attendance. Stan immediately noted that in his talk he had not had time to describe the contributions her mother had made. The mother, he noted, was an extraordinarily devoted nurse, who had run a particular children's unit. He recalled the college she had graduated from and the nature of her work. He then added that in his discussion of the neurologist's father, he had not had time to remark on his skills as a fencer, and his role as physician to the U.S. Olympic fencing team in 1964. Stan had not had contact with these people in 40 years.

It was a remarkable feat. Several months prior, I brought our new chair of neurology at Brown to visit Stan. He described her husband's research project, required for graduation from the Brown

Medical School at that time, 25 years prior. He remembered the topic and the collaborators.

My other notable observation of a memory feat involved Raymond Adams, MD, former chair of neurology at Harvard, and, like Stan, a noted neuropathologist. I had encountered an 80-year-

old woman with an atypical parkinsonian condition, whose family history included her father having had a diagnosis of Parkinson's disease (PD). I noted that when the father had been ill, the various subcategories of parkinsonism had not been created, and what passed for PD in the 1950s might be diagnosed very differently today. I learned that the diagnosis had been made by Ray Adams, who was famous for his clinical pathological studies, and assumed, correctly, that an autopsy had been obtained. With family approval, I contacted the hospital where the autopsy had been done, which unfortunately was at a Boston Hospital, which, back in the day, had had several university services ensconced. The records had never been computerized. All entries were hand-written, by date only, without cross referencing. I was able to get someone to read through a year's worth of autopsies for one pathology service, and then another, without success. I called the chief of neuropathology, who was a professional friend. He suggested

contacting Dr. Adams, who was about 90 at the time, and retired. "He remembers a lot."

I briefly wrote up the case and solicited his help. About two weeks later, in 2005 or so, I received a typed note, not a computer word processed letter, from Dr. Adams, telling me that the case I was interested in was case 1 in a series of four patients he wrote up for a Swiss journal, published in French, in 1961. He apologized for not having a reprint

**Not all of us are bound to forget.
Not all of us will continue to
forget faces and names.**

to include. And, sure enough, that case was my patient's father.

When I got back from Brooklyn, having experienced Stan's recollection of his nurse's college days, I went through my emails to discover that I was late on delivering a promised article for our Rhode Island PD support group. I didn't know when I'd have time. I had submitted Part 1 a few months before and couldn't recall what I had planned for Part 2. I scanned my files to find Part 1 so I could write Part 2, and discovered that I had already written Part 2. I didn't recall what I had written, but, as usual, when I review things I've written, it was with a great deal of relief, that I agreed with what I had written a few months prior. Unfortunately, it is not too uncommon for me to not recall that I've

written these things, which prompted this article.

All readers of this column over the age of 60, and many who are younger, have dealt with increasing concerns about their memory. "I forgot to get the milk when I went to the store for milk. I got everything else. Is it Alzheimer's?" Certainly all of us who practice clinical medicine with elderly patients run into this every day. We reassure them that their friends have the same problem. I have the same problem. Not to worry. But, unfortunately, some of us really do have this problem, and this is how it starts, and not until something dramatic happens, like getting lost driving, that we begin to really worry.

Encountering feats of memory like those above, especially in the elderly, are wondrous but reassuring. Not all of us are bound to forget. Not all of us will continue to forget faces and names. Age does not mean that, absent a disease, we will all slowly have our memories whittled away by time. Unfortunately, I don't think I'm going to be one of those people. I fully expect that in one year, if I review my columns, I'll marvel that I wrote this one and can't recall it. I worry now that I may have written this column before, although not using the very recent Brooklyn event. That really did happen recently. I take comfort only in knowing that you, the reader, if you read this once before, probably don't remember it either. ❖

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Disclosures

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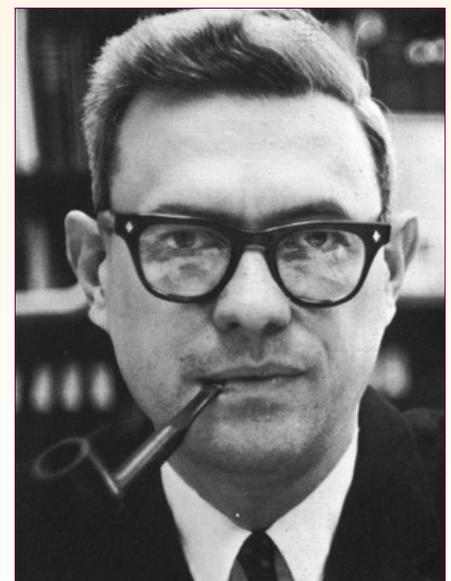
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Dr. Aronson in 2007 receiving Doctor of Medical Science (DMS) at Brown in 2007.



Stan Aronson, MD, in the early years in the 1950s at Downstate Medical Center in NYC.



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An Exaltation of Offshore Islands

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THE EMINENT ENGLISH jurist, Edward Coke (1552–1634), declared – in magisterial Latin – that a man’s home is his castle, his ultimate refuge. Humans need homes for protection from weather and predation, to provide some measure of privacy; and, not least, for a privileged place to fulfill all of



the many of their domestic and hygienic needs. And of all the geographic sites to place a privileged and secure home, none seems more suitable than an island.

There is something magical about an island (especially if it bears the name, Rhode): One feels a sense of splendid insularity, of separateness from the mundane world on the mainland; certainly the many ills of a contentious humanity seem to cluster more on the mainland than on the set-apart islands; and no matter which shore you choose on your special island, the vista is always aquatic.

However small, an island becomes more than a site for a home; it becomes an independent kingdom unto itself with defined boundaries, its own idiosyncratic moral code and a protective ocean to distinguish it from the continental territories. If situated on an isle, even a rude hut is magically transformed into a castle.

Think of the many historical islands, either real or fabled, populated or

deserted, serene or even bedecked with streams of molten lava. They are each special in their own way.

Some islands have become sanctuaries of human imagination: Monte Cristo, Elba, St. Helena, Ceylon and Capri. The isolated island of Kos in the eastern Mediterranean,

home of Hippocrates, was identified with the origins of medicine as a distinct profession. Others, such as

Alcatraz and Ile d’If, were notorious as prisons. Still others, such as Pitcairn Island, in the southeast Pacific, were made unique by their geographic remoteness. This remote volcanic island – one of four – had been inhabited by Polynesians until the 15th Century when unknown circumstances, probably famine, caused the Pitcairn inhabitants to abandon the island and seek residence elsewhere. The island remained uninhabited until the early months of 1790 when nine mutinous sailors of the HMS Bounty, along with 18 Tahitians, sailed the Bounty east seeking any remote isle to escape the



Public Health Service physicians on Ellis Island in New York Harbor check the eyes of immigrants for signs of trachoma.

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vengeful jurisdiction of Great Britain.

Ellis Island, in upper New York harbor, stands apart from other islands as a place of judgment, determining whether its foreign visitors may enter this nation. The island was established as this nation's primary immigration processing center in 1892, and in its six decades of operations, about 12 million immigrants entered this nation. It is estimated that one-third of American citizenry can claim Ellis Island as the portal of admission of one or more ancestors.

And then there are islands made immortal by some curious happenstance, some event of historic importance. The story of a tiny Micronesian atoll, part of the Marshall Islands, begins in 1946. This was the dawn of the nuclear age, when the United States used the atoll as a testing site for its atomic bombs. When Russia developed its own functional

atomic bomb in 1949, President Harry Truman initiated Operation Castle Bravo to devise still more powerful nuclear weapons, these to be tested on the same remote, uninhabited isle.

Polynesians had called this atoll Pik-inny, meaning the place to grow coconut trees, although European mapmakers designated it as Bikini. A French bathing suit designer, Louis Reard, knowing that a competitor of his had manufactured a bathing suit called *Atome*, named his new two-piece swimsuit bikini. The sobering historic remembrances of the atolls of Bikini and Eniwetok have now been tempered by the memories of an engaging swimsuit.

Islands have earned their glamour by providing a sense of detachment from madding crowds, an isolated place that offers fresh breezes, lonely beaches, a novel perspective and little bureaucratic

supervision. Ask committed islanders for the virtues of island-life: "Distance from the mainland," they will declare; but then, after a pause, they will add: "But that distance should not be too great. Our connection to the mainland should not be compromised." It is much like the first-year college students demanding a physical separation from their parents – but not too much of a distance. ❖

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Stanley M. Aronson, MD, is Editor emeritus of the *Rhode Island Medical Journal* and dean emeritus of the Warren Alpert Medical School of Brown University.

Disclosures

The author has no financial interests to disclose.

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Contributions report on an issue of interest to clinicians in Rhode Island. Topics include original research, treatment options, literature reviews, collaborative studies and case reports.

Maximum length: 2000 words and 20 references.

PDFs or Jpegs (300 dpis) of photographs, charts and figures may accompany the case, and must be submitted in a separate document from the text. Color images preferred.

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PDFs or JPEGs (300 ppi) of photographs, charts and figures may accompany the case, and must be submitted in a separate document from the text.

POINT OF VIEW

The writer shares a perspective on any issue facing clinicians (eg, ethics, health care policy, patient issues, or personal perspectives). Maximum length: 600 words.

ADVANCES IN PHARMACOLOGY

Authors discuss new treatments. Maximum length: 1000 words.

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Authors discuss a new laboratory technique. Maximum length: 1000 words.

IMAGES IN MEDICINE

Authors submit an interesting image or series of images (up to 4), with an explanation of no more than 400 words.

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Morning Report in Kigali – November 20, 2013

ONYEMA OGBUAGU, MD

The following column was written by a colleague with whom I recently worked in Kigali, Rwanda. We attended morning report together and shared several patients. His observations are accurate to my western eyes, but his greater experience, having attended morning report the previous year, brings a sense of optimism to the Rwandan endeavor that is based on observation, a stronger foundation than mere hope. I hope it may encourage some readers to consider a teaching experience in some resource-poor country.

— Joseph H. Friedman, MD



YALE MEDICAL GROUP

It starts as a trickle. Some postgraduate residents come into the conference room, including the more senior PGY2 and PGY3 residents, half of whom have blood shot eyes and are visibly tired from an overnight moonlighting shift, which is necessary to supplement their meager internal medicine residency stipend. The *muzungu* doctors, mostly from US Ivy League schools, and here to support residency training, arrive like a flood. Being on time is a concern to them, maybe only them. The local consultant physicians keep arriving, some show up just before the last sentence of the session is spoken.

"I am presenting the case of Mr. XYZ..." the presenter begins. While the statement is being uttered, a willing volunteer leaps off a chair to document the important details of the presentation on the small hanging white board in the room. He may not appreciate it but he has accepted the herculean task of transcribing a mixture of medical and true street slang spoken in a mix of different languages – French, Kinyarwanda and English – in a manner that can be comprehended by onlookers. Words

in the latter language are transcribed phonetically by the volunteer scribe. The output is disastrous. English was only recently adopted as the nation's primary language 5 years ago. I recall the poor advice given by my elementary school English teacher who always encouraged me to spell words as they sounded, but failed to appreciate that the strategy leaves the

speller at the mercy of how well and appropriately a word is pronounced by the speaker. It is written on the white board – the patient has fever, weight loss, cough, and shortness of "*breathe*."

"The patient *consulted* the hospital for..." the speaker goes on, really meaning to say that the patient *presented* to the hospital on account of... He speaks at a rate of 15 words per minute and the speller is writing at half the pace. It is obvious that speaking is easier than writing in a new and foreign language. Important points are not all transcribed. A good memory for the listener is key. He has reported the patient's presenting complaints. I am waiting for the history of presenting illness (HPI), but it never comes. The presenter doesn't know the difference.

He goes on to discuss the other pertinent parts of the patient's history. It is important to highlight that the patient is a heavy drinker of the local beer "*urwagwa*," which is their equivalent of moonshine, as he cannot afford the locally manufactured, legally produced beer brands or more expensive imported beers. The patient is in his forties and

unmarried, he must be a playboy who is having a hard time "settling down" as they say. Definitely needs an HIV test! He can afford to but did not sign up for the means-tested national health insurance scheme or "*Mutuelles de Sante*," bummer! Okay, I admit these were my thoughts but I am pretty sure they weren't mine alone.

Consultants: The *muzungus*

Some consultants listen intently, clinging on more to the spoken than the written word while others are more interested in their smartphones. We have trained ourselves not to interrupt resident presentations, things have changed since the *muzungus* arrived. This is hard. The medical history needs to be expanded, wrongly used terms need to be corrected, some spelling errors on the board are inducing an acute and progressive retinopathy, we are almost blinded. Sometimes we cannot hold off; one consultant blurted out, "How long had the patient's cough lasted prior to presentation? It makes a difference if this is known." "The cough had been present for 1 month," the presenter replied and "I forgot to mention previously that he had mild hemoptysis with some episodes." The questioner no longer regrets interrupting the presentation, the response had more useful information than she had bargained for.

We are now at the review of systems portion of the medical history. The presenter reports that it is non-contributory. I am thinking... "yeah right!" The system needs to be reviewed! There is a reason why the quality of resident medical education leaves much to be desired. If more funds, faculty and better facilities were available for your training, this case presentation should be

better. I have to remind myself, for now, that we are talking about a patient, not the system. I miss hearing about the patient's vital signs during my musing, but luckily they are written on the board. The oxygen saturation always seems to be reported as 96% on room air. I keep my suspicions to myself. It is not like we measure and document respiratory rates accurately in the US all the time.

"The patient is asthenic" seemed to be the starting description for all the patients. I thought I had a good grasp of the English language but I don't know what the word means. Just like the early student in medicine, rarely used terms and syndromes seem to be learned and recalled first. "He has logorrhea," the presenter continues. Now I am concerned, I must be illiterate. How can they know and use more sophisticated English words than I do? Surely the word does not exist. I google logorrhea using my smartphone, quite dubious of its existence in any dictionary. Yes, there is internet service. I almost fall back in my chair in surprise. Logorrhea is actually an English word and is defined as a tendency to extreme loquacity. "Who in the world explains a difficult word using another difficult one?" I wonder. However, somehow I get it. The patient talks a lot! I have a lot of friends with this disorder.

The physical examination report goes quite well. I must admit that it was even better than I expected. Among other things, the presenter mentions diminished breath sounds, and crackles in the right lung base; and also notes the presence of egophony. I am really impressed as someone had examined the patient rather thoroughly. I don't even recall when last I included assessing for egophony on lung auscultation – maybe when I was a medical student? I keep my embarrassment to myself and chide myself for becoming sloppy over the years with my physical examination skills.

Differential diagnosis

Next is the generation of a differential diagnosis. Common things are

mentioned – pulmonary tuberculosis (TB), *Mycobacterium avium* intracellulare (MAC), bronchiectasis, fungal disease like histoplasmosis. No "zebras" are mentioned. But it is internal medicine rounds and this is residency training; we need to expand the list to a hundred differential diagnoses in exact order of likelihood – okay, maybe ten. Consultants chip in – lung cancer, chronic bronchitis, vasculitis, paragonimiasis, recurrent pulmonary thromboembolism ...the list grows.

We discuss the patient's admission laboratory tests. We are pleased when results of a full blood count, electrolyte panel and INR are reported. A chest radiograph is available and shows a left upper lung cavity and a right lower lung infiltrate. Appropriate investigations are usually ordered in the emergency room; the problem is that they are not always done for varying reasons. This time everything had worked perfectly. While we celebrate the available labs, we now consider additional tests to narrow down the list of differentials. Two expectorated sputum smears have returned negative for visualized acid fast bacilli (AFB); we would like the newer and more sensitive GeneXpert test. It cannot be performed as there are no more cartridges available to run samples. The mycobacteriology lab is not performing AFB cultures. The patient cannot afford a CT scan of his chest as the copay is too high. Bronchoscopy is possible but only a bronchoalveolar lavage can be performed, and no biopsies can be taken. I shudder when I recall that it is performed without sedation. A urine Histoplasma antigen test is not available. Our enthusiasm fades, our diagnostic capabilities are limited.

An argument erupts among consultants on the appropriate medical treatment of the patient. Half of them want to start an anti-tuberculosis drug cocktail now as TB is the leading diagnostic possibility; the other half want more data to justify use of the same. The patient remains febrile with ongoing hemoptysis despite a 5-day

course of ceftriaxone and erythromycin initiated in the emergency department obviously oblivious to the chronicity of his complaints. There is pressure to "do something." Residents watch with glee; the arguments are equally weighty. They aspire to join the vigorous debate someday. Somehow, the final decision is made, the managing team would decide on the best course of treatment based on the evolution of the patient's clinical condition and with consideration of limitations in performing appropriate diagnostic testing. Class dismissed.

Seven months later

I return 7 months later. It is morning report again. It is at the same time, same place, and there are new seats in the conference room. More residents are in training, most arrive on time. Local consultants are still late. As the saying goes, old habits die hard. Another case is presented. There is an HPI after the presenting complaint. The case presentation is rather excellent and the scribe has improved. Diagnostic testing is still limited but the presenter advocates for samples for testing to be sent to national reference laboratory where they can be performed. Things are getting better. It is the second year of the *muzungu* presence. Dare I say, "mission accomplished!" Okay, maybe that is too exuberant, so I will say rather, "something accomplished!" ❖

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Secure Email Communication between Patient and Physician Associated with Better Glycemic Control

Dear Editor,

Communication by email between patient and physician can be used as a strategy to improve personalized care in diabetes which can lead to better glycemic control. Moreover, involving patients in the decision-making process may increase their motivation and confidence to carry out their regimens.¹ There has not been enough research in this area and therefore not much is understood about the impact that secure email communication between patient and physician has on the glycemic control.

In an effort to study the association of HbA1C with secure email communication between patient and physician, a pilot study was conducted in a private group practice in Worcester, MA between January 1, 2006 and January 1, 2009. Patients with type 2 diabetes mellitus who were web-enabled were included. These patients were divided into two groups: group 1 (n=43) communicated and group 2 (n=125) did not communicate with their doctor via email regarding their finger-stick blood glucose levels

(FSBGL). Crossover only occurred from group 2 to group 1. The primary outcome was a change in HbA1C in 3-6 months after the web-enabled patients started communicating.

Forty-three (25.6%) patients used secure email to communicate with their doctor during the study period (n=168). Of the 43 people who were using the web, 16 were on insulin and 27 were not. Of the 125 patients who were not using the web, 73 were on insulin, and 52 were not. Communication by secure email system regarding their FSBGL was associated with a reduction of HbA1C increased from 7.7 to 6.5. Interestingly, HbA1C increased from 6.5 to 7.5 in patients who were not communicating by secure email with their doctor regarding their FSBGL. The result was significant with a P-value of less than 0.0001.

Though there are several limitations of this study, the findings of this study can profoundly influence and improve the way to manage diabetes and thereby its complications. Secure messaging may serve as an important part of care for

patients with diabetes and an opportunity to support them in self-management outside of routine visits.² By incorporating secure email communication between physicians and the diabetic patients regarding their blood glucose level, we can enhance the care given to them as seen in our simple and inexpensive study.

Neha Alang, MD
Nitin Trivedi, MD

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