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## The Physical Exam

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AS ALL CLINICIANS KNOW, the physical exam has become increasingly undervalued in the evaluation of sick patients. Perhaps most doctors consider it a screening evaluation. If the liver seems enlarged, an ultrasound or imaging study is obtained. If a heart murmur is heard, an



echocardiogram is obtained. I believe there are smart phone apps that can be used to interpret cardiac auscultations.

I have often lamented the decreasing importance attached to the physical exam in general medicine. In this column I have contrasted it with the preserved importance we neurologists continue to attach to our neurological exam. Non-neurologists consider it an arcane skill. "Neuro consult needed prior to discharge," is not an uncommon request in teaching hospitals because the internist, or other specialty physician, can't perform a reliable one and, usually for risk-management reasons, a documented exam is thought necessary. Recently I was taken aback when a neurology colleague admitted that he didn't consider our exam very important anymore, except in certain fields, like movement disorders, my own little niche. In his field, the MRI determines everything. In movement disorders, there are rarely tests that make a diagnosis. Even for the genetic

disorders like Huntington's disease, the presence of an abnormal gene does not indicate that the person has the disease, only that he/she will get the disease. So what do I think when my colleagues and I see the same patient and find different abnormalities in our exams?

Recently I saw a patient with a very odd syndrome whom I had trouble even putting into the general classification of movement disorders. The referring neurologist, an excellent clinician who has a different area of specialization, found weakness in the legs, but I did not. While I wonder about his exam, he is wondering about mine. In another puzzling patient with a different disorder, I also found weakness, in this case a hemiparesis, which was not found on the exam by an esteemed movement disorders specialist in another city. It is not rare for us to disagree on whether a movement is organic versus psychogenic. We may disagree whether a twitch is a tic or a dystonic spasm, whether the rigidity is due to poor relaxation or extrapyramidal dysfunction, but weakness? We think of ourselves as pretty good at differentiating suboptimal effort, whether due to psychogenic reasons, poor compliance or pain. So, disagreements among experts on weakness in patients who are

**It's one thing not to know.  
It's another not to look.**

not limited by pain is a real problem for us. It shouldn't happen, like cardiologists disagreeing on whether there's a murmur.

There is a well known, allegedly true, but perhaps apocryphal tale of a simmering dispute between a famous British neurologist and his equally famous neurosurgical colleague in the days before angiography and CT scans, when neurosurgical planning was based on clinical judgment and ventriculography. The two clinicians strongly disagreed on the location of the presumed tumor but the surgeon, who obviously was performing the operation, got to choose the site, and, of course, chose his own. When it turned out that the surgeon was correct, he gleefully told the waiting neurologist, who disappointedly remarked, "perhaps I should give up neurology." The neurosurgeon quickly responded, "On the contrary, why not take it up?"

Every clinical neurologist thinks his neurological exam is accurate. We'll defer, of course, to other specialists in their subspecialty. If my eye exam differs from that of a neuro-ophthalmologist, I'd assume my exam was suboptimal and not correct. If I thought a tongue was not fasciculating and a neuromuscular expert in motor neuron

disease thought it was, I'd also think I was incorrect. Experience is important. But every first-year neurology resident can identify weakness. We may disagree on whether or not a patient is giving full effort. Sometimes we may simply assume the patient has full strength, since we may have come to a diagnosis before completing the exam, and not perform a complete and meticulous exam, but rather go through the motions, reducing the chance of finding a subtle abnormality. I like to think that I don't do that much, but, of course, I do it sometimes. I may say to myself, consciously or unconsciously, that the diagnosis is clear-cut, and if I find weakness or numbness, I'm not going to believe it, so why try to find something I won't believe?

In our CME courses, we rarely, if ever, brush up on our examination techniques. With video, we neurologists do get to see eye-movement abnormalities that we rarely see otherwise, and

with the voiceover of the knowledgeable neuro-ophthalmologist who both describes and explains the findings. This is one of the ways in which we do learn to improve our exam. We also see seizures, epileptic and non, with concurrent EEG, which help us distinguish and understand these spells better, thus leading to better history taking and diagnosis. In the movement disorders field, videos can be crucial for teaching us how to recognize and better interpret abnormal signs. In movement disorders this is crucial. How a muscle jerk is labeled determines the differential diagnosis, which determines the testing and treatment. When a gait disorder is thought to be Parkinson's disease but is really due to a cervical myelopathy, the wrong treatment is given and time is lost in fixing a potentially treatable problem. There is no scan to do it for us.

It's one thing not to know. It's another not to look. And it's different still

when you look and don't see. I hate being wrong, but hate even more the idea of not learning from my mistakes. I am beside myself waiting to see these patients in follow-up, to see which of their doctors was wrong.

What I know will not make me a good doctor if I don't see, or if I do see but don't interpret correctly. I think that if I had an app to check a tremor or a muscle jerk, I wouldn't hesitate to use it. ❖

#### Author

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#### Erratum

The Brown University Traumatic Brain Injury Research Consortium and the Norman Prince Neurosciences Institute.

Rogg J, Spader H, Wilcox BJ, Ellermeier A, Correia S, Chodobski A, Szmydynger-Chodobska J, Raukar N, Machan JT, LaFrance WC Jr, Crisco JJ; Brown University Traumatic Brain Injury Research Consortium.

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ABSTRACT: This article provides an overview of the Brown University Traumatic Brain Injury Research Consortium (TBIRC) and summarizes the multidisciplinary basic and clinical neuroscience work being conducted by investigators at Brown University and the affiliate hospitals in association with the Norman Prince Neurosciences Institute (NPNI).

KEYWORDS: Traumatic brain injury (TBI); biomechanics of head impact; concussion  
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# Annual Physicals Are Crucial...

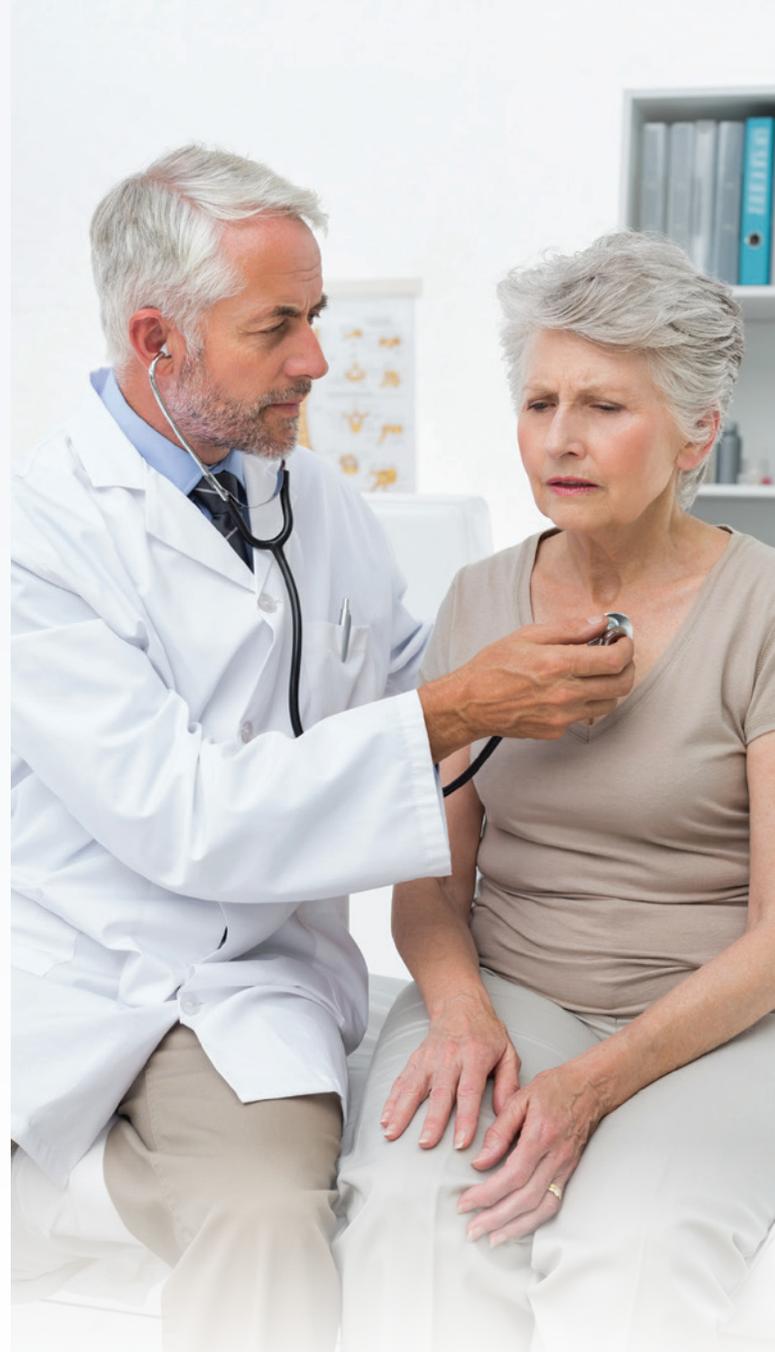
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## Time and its Many Divisions

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THE PASSAGE OF TIME, amongst primitive peoples, was first given dimension when they exploited a visible instrument of measurement, the recurring phases of the moon (lunation). The prehistoric language, called Indo-European, then created a single word – *menes* – to give definition to the moon, its visible cycle, the word month as well as still other recurring phenomena such as menstrual cycles. A Latin word, meaning shining, *lucere*, evolved into *lunaris*, also meaning the moon. The subsequent European languages then devised variants of these two root words.

The recurring perigee and apogee of the sun then defined the duration of the year. But the declared beginning of the year varied amongst the many Eastern Hemisphere cultures. Thus, the Egyptian and Phoenician civilizations began their year with the autumnal equinox, the early Greeks inaugurated their year with the winter solstice, and the Mesopotamians, about 2000 BCE, began theirs with the vernal equinox.

The Romans established the onset of their year in the month of March, spelling



it as *Martius*, thus honoring the Roman god of war. April, the second month of the Roman year, derived its name from *Aphro*, the Greek goddess of love (in English, Aphrodite). And the month of May is named after *Maia*, the wife of Vulcan and the Roman goddess of fertility.

Juno, wife to Jupiter and goddess of marriage, was the source of June's name, first as *Junius mensis*, then in Old French as *juin*, and in English as June. July had originally been called Quintilius, literally the fifth month since their year began in March. But after his assassination in 44 BCE, Julius Caesar underwent deification by senatorial decree and the name of the month was

then altered to *Julius*; thence in Old French to *Julie*; and in English to July.

The Roman Senate, in 27 BCE, gave their emperor Octavian, the honorary title of Augustus; and then named their sixth month as *Augustus*; and in English, August.

The Latin names given to the months of September, October, November and December all reflect their earlier statuses as, respectively, the seventh, eighth, ninth and tenth months of the pre-Julian Roman year. Thus, the Latin words, *septem*, *octobris*, *novembris* and *decem* form the etymological basis for the final four months of the Gregorian year.

The Romans assigned different numbers of days to their months and then declared certain days to be given a specific title. Thus, the first day of each month was called *kalendae*, Latin for account-book, the time when

bills and other contractual agreements were due. Then there were the *ides*, which is either the thirteenth or fifteenth day of the month ("Beware the *ides* of March," prophesized Caesar.). And finally the *nones*, the ninth day before the *ides*. These three calendric sentinels provided the citizens of Rome with unchangeable and reliable dates. ("We'll begin our journey three days after the *nones* of *novembris*.")



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In this mankind-oriented civilization of ours, it is well to recall that the duration of our months, the length of our seasons and the span of our years are all determined by observing and measuring cosmological forces well beyond our control.

The same cannot be said for the week or its duration. The word, week, is of Germanic origin and has no counterpart in Latin. And the length of the week was determined by some cultures to best fit with their religious and socioeconomic customs. In the earliest of recorded data in the Babylonian, Jewish and

Zoroastrian theological documents, for example, there was agreement on seven days, approximately one-fourth of the lunation interval.

The days of the week, in Western Cultures, are named after celestial bodies or mythological figures. Sunday, for example, honors the sun: in Latin, *dies Solis*; in Spanish, *domingo*; in Italian, *domenica*; in Irish, *An Domhnach*; and in Welsh, *dydd sul*.

Consciousness of time must have been an early resource for sentient humans even before they climbed out of trees. And so, fulfilling a scriptural

instruction, they gave names to time and its many cosmological and human-contrived subdivisions. But even giving names to the parts of time did not slow its relentless advance. And as humankind evolved, time became one of its many adversaries. An obscure poet said:

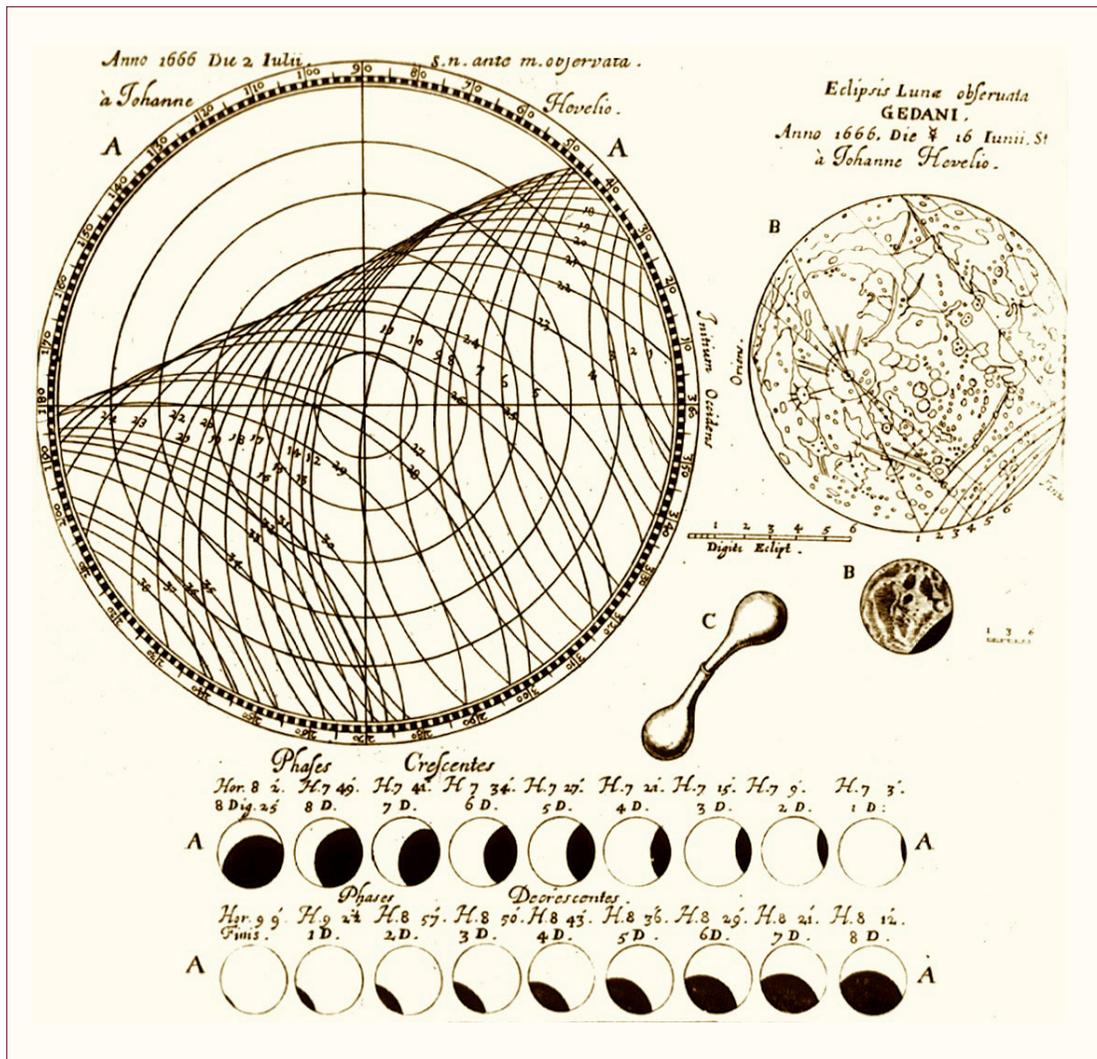
*Times goes, you say, Ah, no!  
Alas, Time stays; we go. ❖*

**Author**

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**

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The sun and the moon with the 'phases' of the progress of a solar eclipse in a 1667 British journal.

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## Reflections on 30 years with the Rhode Island Medical Society

NEWELL E. WARDE, PhD  
RIMS EXECUTIVE DIRECTOR

**T**O BE HONEST, MY PREFERENCE would have been that nobody noticed, but somehow the cat slipped out of the bag. Yes, it was 30 years ago June that I first reported to work for the Rhode Island Medical Society. I had hardly given the anniversary a second thought until a bunch of former RIMS



presidents and other good friends, some of whom came from as far away as Chicago, Maine and even Belgium, shocked me with a wonderful surprise party in July. (I wondered a little if it was a hint.)

On that festive evening someone naturally put the question to me, "What's the biggest change you've seen in 30 years?" It's a good question, and one I myself might be asking if the 30-year shoes were on other feet.

Given that I have had 30 years to think about it, it surprises me that it's so hard to answer. In a way, it's akin to a question I get when non-physicians learn what I do for a living. They ask, "What does the Medical Society do?" The fact that RIMS does so much (maybe too much) makes that answer difficult, too. RIMS is in at least 10 different "businesses": the government relations business, the advocacy business, the peer review business, the association management business, the insurance business, the education business, the public relations business, the

community service business, the publishing business, the meetings and conferences business, the networking business, etc.

I know I need to come up with a profound-sounding answer eventually, but 30 years offer way too many candidates for the "biggest change." Actually, a chief reason I love

my work is the fact that hardly anything I do is routine. The novelties and challenges never cease – and they are never trivial. Maybe the means and speed by which we move and store information would qualify as the top mega-trend of the past 30 years.

But at least as impressive as the changes, and possibly more instructive to contemplate, are the constants. After 30 years (indeed, after a full century and more), we are still struggling with the question: How to pay the doctor? Lately we have been circulating a good deal of old wine through new bottles we call "innovative payment models." The Affordable Care Act's ACOs include features of what used to be known as managed care, managed competition, capitation, bundled payments and gain-sharing. And oh, what a payment apparatus we have constructed with relative value scales, geographic adjustment factors, tens of thousands of diagnostic codes, episodes of care, utilization review, etc.

Despite the enormous, creative energy that has gone into rationalizing payments and controlling costs, we have been hearing for decades that Americans pay more for healthcare and get less than people in other developed countries. The validity of those comparisons may be debatable, but I do believe that three historical factors have combined to massively distort the US healthcare system. Each of these three factors is uniquely

**After 30 years (indeed, after a full century and more), we are still struggling with the question: How to pay the doctor?**

American, and we pay a heavy price for them every day.

The first is the application and misapplication of antitrust law to healthcare. No other single factor has done so much to rob physicians of their voice and prevent them from asserting not only their value in the marketplace but also their professional values in the healthcare system, where their role is to advocate for patients. The consequences include fragmentation of care and the fact that physicians and patients alike are quite impotent in the face of insurance monoliths and hospital systems, both of which continue to consolidate.

The antitrust imbalance could even take a sweeping turn for the worse next fall when the U.S. Supreme Court is expected to rule on a case that pits

the Federal Trade Commission (FTC) against the North Carolina Dental Board. The FTC reasons that because that board is dominated by practicing dentists, its efforts to stop non-dentists from practicing dentistry violate anti-trust. The ramifications of the case are unsettling and potentially enormous. Depending on how the high Court comes down, Rhode Island's medical board could be the only one in the nation left standing. That is because, as it happens, Rhode Island is the only state with a medical board where physicians are not in the majority. (By a law passed in 1986, the RI Board of Medical Licensure and Discipline is fifty-fifty lay/professional.)

The second distorting factor, of course, is our American system of liability. That intractable monster hurts us at every turn. It drives up costs, diminishes access, and creates barriers to improving quality. Every state's attempts to tame the monster are never safe from challenge. After two epic battles in the past 30 years, we in Rhode Island remain effectively checkmated in the

state legislature. But this is a national problem, not just a Rhode Island one.

The third factor is the linkage between employment and health insurance coverage, which by an accident of history became ingrained in America during World War II. As a result, the US has been the only developed western nation where a person who loses a job also loses health coverage. We have cobbled some safety nets, but every major attempt to universalize coverage, from Hillarycare in the 1990s to Romneycare and Obamacare, has found it necessary to accept this linkage as a building block and invent ways to fill the gaps. As a result, we have a complicated and confusing system of "exchanges," graduated subsidies, mandates and potential fines for employers and individuals.

Every developed nation struggles with the crushing cost of healthcare, and clearly nobody has the answer. But most would agree that America's cost problem is the world's worst, thanks largely, I would argue, to the three factors above. Concern about cost, of course, is another perennial of the last 30 years. I recall

hearing the Princeton economist Uwe Reinhardt address the AMA House of Delegates in June 1985. He showed a graph of cost trends in Medicare and Medicaid, and said, "This is what makes [Ronald Reagan's budget director] David Stockman's hair go gray: it's this little line right here." Back then everyone was alarmed that US healthcare spending had grown to 10.1% of GDP. Today we are at 17.9% and counting.

There is another thing I have noticed. It may seem trivial, but I suspect it contains meaningful clues to the evolution of our concept of healthcare – much as the shift in American usage after the Civil War from "the United States are" to "the United States is" reflected a fundamental shift in our concept of ourselves as a nation. Thirty years ago, we talked about "health care." In the last several years, it has mysteriously become one word: "healthcare." What does that say about the evolution of our concept of health in relation to caregiving? That's a question for a wiser man than I – like Stan Aronson! – to reflect upon. ❖

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## One WaterFire Torch, One Life Remembered

MARY KORR  
RIMJ MANAGING EDITOR

I WAS INVITED BY DR. Lynn Taylor to be a torch-bearer at WaterFire last Saturday night, along with many other more worthy individuals who are on the forefront of hepatitis C research, testing and treatment.

It was an honor to represent the *Rhode Island Medical Journal* at the event. But as we ringed the basin of Waterplace Park, and lit one torch at a time, I thought of my brother Johnny. A flicker here, a flicker there, memories of when we were kids ignited with the flames.

He died of hepatitis C in 2000; contracted several decades prior, it is assumed, after a possible tainted blood transfusion following an auto accident when he was a teenager. He was on the waiting list in Boston for a liver transplant when he died.

To be honest, when we were little,



he was what was then called a "brat." My older brother and I were the well-behaved ones. Once the principal of our grammar school summoned me to her office. Johnny sat on a big chair fidgeting and looking quite guilty. The principal held up a ribboned ponytail he had cut off from the student who sat in front of him.

"Mary, you are to tell your mother she must get control of him," the principal directed me. That's what they did in New York City schools then. Call in the big brother and sister. "You better not tattle," he said as we left the office.

Then there was the time my mother went into labor prematurely. They rushed the three of us kids over to our grandfather's house nearby. He was on his way to the courthouse, where he was a judge. He put us in the back seat

of his Buick and at the court, sat us in the front row with a stern admonition to be mum when the proceedings began. I sat with my doll and combed her hair. My older brother read a book. It was not long before Johnny shot rubber bands at the plaintiffs.

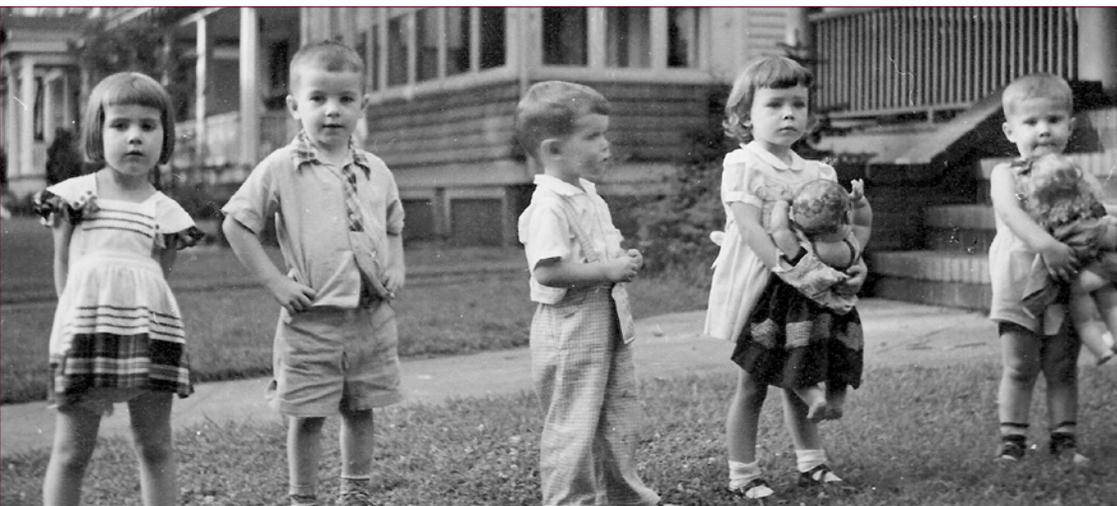
Grandfather signaled to the security officer. He locked us up in a holding cell behind grandpa's chambers. On our way home in the Buick, I protested neither I nor my doll nor Jim had done anything to deserve jail time. "You are known by the company you keep," grandfather said sternly. "And you and Jim are your brother's keepers. You both are older."

As I extinguished the WaterFire torch, I thought of my late mom in her very old age who had lost her recent memory. "Where's Johnny?" she would often ask. "He doesn't come to see us anymore."

"Oh, you know him, he's probably getting into some kind of trouble somewhere," I would answer. My siblings and I were/are Baby Boomers, most at risk for Hep C as I learned while helping Dr.

Taylor with RIMJ's July special theme: RI Defeats Hep C. Thanks to Dr. Taylor and her colleagues, the July 26th WaterFire raised awareness for so many of the tens of thousands who attended, with information and screening sites set up.

I told my sister she should get tested, since she cared for my brother at the end. She is afraid to. Then I told her there is a cure although it is expensive, right now at \$1,000 a pill, for a total cost of over \$80,000. "I don't think my health insurance will cover it," she said. "I will wait until the price drops to get tested." ❖



Johnny, who died of Hep C many years after this photo was taken, is on the far right; siblings Mary and James are on the left. The children in the center are the neighbors on 97<sup>th</sup> Street in New York.