The More Things Change...

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This issue of the *WMJ* reprints, in its entirety, an article by H.P. Greeley first published in the *Wisconsin Medical Journal* 100 years ago.[1] It is remarkable. The article serves as a window on history just after the 1911 publication of the Flexner report, which was used by organized medicine early in the 20th Century as a rationale to radically reform medical education and shrink the number and variety of schools in the United States.[2] Doctor Greeley, who received his medical degree before that time, reflects on the rapid changes in medicine in the late 19th and early 20th Centuries. Wisconsin had 3 medical schools in 1911: the University of Wisconsin Medical College with 49 students; the Milwaukee Medical College, loosely related to Marquette University, with 191 students; and the Wisconsin College of Physicians and Surgeons, affiliated with Carroll College, with an enrollment of 60 students. The quality of medical schools nationally was extraordinarily varied. Flexner describes the available clinical facilities in the Wisconsin schools from "ill equipped" to "utterly wretched."[3]

Greeley's article was both a vivid description of the life of the general practitioner in communities and a thoughtful explanation of why, even in the early part of the last century, the "old time practitioner" was being pushed aside. "His practice was his school, in which he was continually learning. Life was his laboratory. The natural result was one of the noblest works of God, a physician whose human kindliness was his most glorious attribute, of whose passing the world may say 'Oh, the difference to me'."

But science and increasingly hospital-based training was influencing education, diseases were changing and, in many cases, new ones were rising. Infectious diseases were already beginning to decrease and surgical treatment of many previously fatal problems was on the rise. The increased visibility of specialists was driven by the experiences of pre- and post-World War I physicians spending anywhere from a few weeks to 2 or 3 months in Europe which, Greeley wrote, gave them a "halo of superiority" by being able to say they had "studied abroad in Vienna." For economic reasons, it was very unlikely that general practitioners (GPs) would "study abroad" anywhere but Milwaukee or Chicago so the prestige associated medical travel "abroad" would not trickle down to a GP in Little Chute or Randolph.

But that changed when, as Greeley wrote, one of the consequences of the Great War was the development of post graduate education in the United States. He also wrote about the need for practicing physicians to "go back to school" to keep up, and he celebrated the increasing quality of education that new physicians had compared to their older colleagues. He also wrote that "human hearts do not change with the development of science. They cry out for sympathy and encouragement as they always did."

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One hundred years ago, Greeley's solution lay in his emphasis in cooperation in medicine, with physicians from different backgrounds meeting daily, consulting with each other, supported on a fixed and adequate salary, doing the work of caring for a community together. He hoped the "public" would demand and support this idea of a group of clinicians banded together for the common good, but in the end, expressed doubt whether the public or the profession had the courage to pull it off. We are still waiting.

Beyond the Medical Schools

Greeley's vision of collaborative groups of physicians has always informed the practice of

medicine in Wisconsin. Large groups have been a distinguishing characteristic of organization of medicine in the state almost since his time, and 2 articles in this issue of the *WMJ* demonstrate that these organizations can deliver quality care for even the most complex medical and surgical problems.

Smith and colleagues from the Gundersen Health System describe their experience with the use of an anterior exposure for spinal surgery in the surgical training program at their organization.[4] The rate of intraoperative and postoperative complications in their 15 year experience is comparable to national benchmarks and demonstrates that nonmedical school-based centers can engage in training and clinical care at a high level. A second report from Gundersen discusses the implementation of evidence-based protocols for enhanced postoperative recovery for colorectal surgery.[5] Bray and colleagues show how the adoption of a team approach that involved surgeons, dieticians, anesthesiologists, and nursing resulted in a shorter length of stay, which avoids unnecessary exposure to hospital pathogens, which was associated with increased patient satisfaction and was not associated with adverse effects. Cooperation, as Greeley wrote, really can be a source of better and more satisfying care.

The low uptake of screening for colorectal cancer continues to vex the emphasis on prevention advocated by US preventive guidelines. The reasons are complicated – cultural, cost, and ease of screening have been found to affect different populations.[6] Bray and colleagues[7] outline the state of screening, the new modalities and their benefits, and challenges and evidence-based screening protocols for early detection of colorectal cancers. New screening technologies that are less invasive have the potential to increase the acceptance of screening, particularly in groups that have historically suffered from adverse outcomes related to colon cancers.

A creative approach to the serious problem of getting families and children to eat more wholesome foods is described by researchers from University of Wisconsin – Eau Claire.[8] They used economic incentives in cooperation with local stores in the community and gave coupons for fruits and vegetables to 4th graders from low income families. While the redemption levels were not as high as investigators had hoped, they moved the needle somewhat on what we all know are difficult habits to change. Their study represents a community-wide effort that brought together schools, families, and business.

Finally, drug side effects continue to be one of the most common causes of iatrogenic illnesses and hospital admissions in this country. Two case reports in this issue of the *WMJ* add more examples. One by Rafiullah and colleagues describes a bowel perforation as a result of aggressive treatment for lung cancer with erlotinib.[9] A second from Fan and colleagues[10] demonstrates that contaminants in street drugs, in this case levamisole in cocaine, can cause significant and life-threatening psuedovasculitis. In both cases, stopping the drug helped save the patients' lives. Sometimes, less is better.

Editor's Note: We want to thank Dr. H.P. Greeley's grandson, Hugh and his family, all of whom have deep Wisconsin roots, for sending us their grandfather's article from 1917. From the editor's perspective, it shows how much of what we see as "new" dilemmas of medicine are really not.

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WMJ

WMJ (ISSN 1098-1861) is published through a collaboration between The Medical College of Wisconsin and The University of Wisconsin School of Medicine and Public Health. The mission of *WMJ* is to provide an opportunity to publish original research, case reports, review articles, and essays about current medical and public health issues.

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