Life after Medicine
By Ted R. Kunstling, MD, FCCP

Alzheimer’s Disease, The Latest
By Assad Meymandi, MD, PhD, DSc (Hon)

WCMS Society News

WCMS New Members

Project Access Thank You’s
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The Wake County Medical Society
Legislative Advocacy Committee

NEEDS YOUR SUPPORT AND NEEDS YOU TO JOIN IN!

The WCMS Legislative Committee advocates for Wake County Physicians with the Wake County Delegation to the NC General Assembly. The Committee will be active now and through the 2016 legislative session.

Key issues include:

1. Maintain physician led and local quality care initiatives
2. Support the NC Community Care Program and its care management activities
3. Prevent a 3% reduction in Medicaid allowed amounts for physicians
4. Prevent “scope of practice” legislation that would allow non-physicians the right to practice medicine.
5. Work in concert with the NC Medical Society’s legislative advocacy agenda

INTERESTED?

Please contact
Paul Harrison, WCMS Executive Director
(919) 923-2442 or by email at pharrison@wakedocs.org

**Any physician currently living in or practicing medicine in Wake County may participate. Membership in the Wake county Medical Society is not a requirement.**
L. Jarrett Barnhill, MD is a professor of Psychiatry at the UNC School of Medicine and the director of the Developmental Neuropharmacology Clinic within the Department of Psychiatry. He is a Distinguished Fellow in the American Psychiatric Association and Fellow in the American Academy of Child and Adolescent Psychiatry.

Assad Meymandi, MD, PhD, DSc (Hon) is an Adjunct Professor of Psychiatry, University of North Carolina School of Medicine at Chapel Hill, Distinguished Life fellow American Psychiatric Association; Life Member, American Medical Association; Life Member, Southern Medical Association; and Founding Editor and Editor-in-Chief, Wake County Physician Magazine (1995-2012). He serves as a Visiting Scholar and Lecturer on Medicine, the Arts and Humanities at his alma mater the George Washington University School of Medicine.

Ted R. Kunstling MD, FCCP has practiced pulmonary medicine in Raleigh from 1975 until 2009 and served as chief medical officer of Duke Raleigh Hospital from 2008 through 2013. Now retired from medicine, he is president of the Raleigh Civil War Round Table and serves on the boards of the NC Symphony Society and Urban Ministries of Wake County.
The Wake County Medical Society is inviting its members to write articles for upcoming issues of the Wake County Physician Magazine. Wake County Medical Society members wishing to write an article for publication are asked to submit a brief five sentence proposal.

Proposed article summaries could focus on your first person accounts of the personal side of practicing medicine (e.g., a patient overcoming all odds and achieving a positive outcome, experience with grief/overcoming grief, your best day practicing medicine, or care management success stories, etc.) or any other human interest story that might appeal to our readership- keeping in mind that anything resembling promotion of a current practice or practitioner, or taking a political stance would not be useable, with the final say on such matters resting with the editorial board. Please email your brief proposal to Paul Harrison, editor, by March 6, 2016 at pharrison@wakedocs.org.

We would like to include your article in our next publication—April 2016, which will be posted on our website. Thanks!
What Are Scientific Myths?
By L. Jarrett Barnhill, MD

In ancient times, myths explained the origins of the universe, human beings and sanctioned rituals, religious beliefs and socio-cultural practices. Today such explanations are based on scientific evidence. Scientists have replaced priests, mystics, magicians, shamans, and story tellers in our evidentiary chain of higher being. Yet many still believe in the power of myth in many updated versions. This article will lay the foundation for a modern oxymoron—scientific mythmaking. It arises when our scientific evidence is ambiguous or incomplete and reflects the persistence of mythmaking in our modern psyche. For us, hypothesis generation, imagination, creativity and myth are ancient bedfellows.

What Are Scientific Myths?
Myths are usually defined in terms of accounts of events filled with supernatural forces and creatures. In the eyes of many scientific rationalists, myths are persistent stories that belong to the imaginations of children. Most of us lose sight of the unconscious role myths play in political as well as religious lives. Many Christians would take offence if someone referred to the biblical account of creation ex nihilo in Genesis 1 as a creation myth. On the other hand, we would be perfectly comfortable classifying Native American creation stories as myths. This brings us to another truth: the boundary between religious and mythological truths depends on the point of view of the participant. In this sense, one person’s myth is another’s religious truth. To cosmologists, the Big Bang is a well-supported scientific theory about the origins of the universe. There is plenty of scientific evidence to support it and most cosmologists would accept theories about singularity, inflation and cosmic background radiation that is consistent as valid hypotheses based on scientific evidence and mathematical rigor. Each new discovery at the Large Hadron Collider at CERN brings us to the moment of the grand unification and the big bang. In this sense the LHC is both a particle accelerator and a time machine. The Higgs boson was predicted in mathematical models but observed indirectly at CERN. The presence of the Higgs field plays a role in one of the key features of matter—namely mass. Yet this hypothesis also has the ring of a scientific creation myth—a manifestation of universe arising ex nihilo told to laypersons as predicted by creative scientists using quantum mathematical model. In other words, human imagination and creativity at work in a quantum world that none of us can see or intuit.

So how do cope with this eeriness? In a metaphorical sense, the difference is faith in an explanation based on command from God. Some time ago we explored the role of Belgian priest-physicist, Lemaitre, in the formulation of the Big Bang model. His elegant theory described events that occurred before the emergence of force carriers associated with the strong nuclear, weak/electromagnetic and gravitational forces.

Lemaitre faced two different quandaries:
1. Einstein initially rejected Lemaitre’s model considering it too close to the Genesis account. He changed his mind later and declared this Lemaitre’s model as an elegant explanation of these events. He then devoted much of his remaining life to develop a Grand Unification theory that would explain the unity that occurred before 10-33 seconds in the life of our universe (moments after conception).

2. Rather than condemn his discovery as undermining theological truths, the Pope lauded his theory based on its scientific merit. This acceptance put Lemaitre in a bind. He feared that papal recognition would play into the hands of those claiming his model is one of intelligent design. In quantum terms the superposition of religion and scientific thought created very strange bedfellows.

Quantum theory helped create a new universe of imagination and creativity about things that most of us
can neither see, understand nor intuit a microscopic universe that runs on statistical probabilities and oddly behaving matter. Gravity is a stumbling block but attempts to reconcile its role has opened the door to even more exciting and imaginative hypotheses. For us; do these unusual hypotheses about unification and multiverses represent a useful form of scientific mythmaking?

What seems like science fiction to some, is an open door to imagination and call for experimentation and exploration in search of proof for others. Historically the scientific method is much older than most of us realize (we will return to this in later articles). The scientific method evolved through phases that culminated in a package of methodologies that called for hypothesis, experimentation to prove or disprove, reformulation and re-synthesis. Although nothing is immutable, the danger of reification and the rise of scientific dogma do arise from time to time. In the neurosciences the analogical thinking of earlier pioneers fell victim to new evidence but still lingers in our scientific unconscious. The relationship between brain development and metaphorical observations and explanations of Freud, Jung and Piaget remain. Even our best neuroscience has not fully explained how a fertilized ovum develops into a Mozart, Picasso, da Vinci or quantum physicists. We are left to rely on a form of scientific mythmaking or find another organ to study.

The boundary between myth and science is particularly vexing for paleoanthropologists and evolutionary biologists. A careful reading of published interpretations of scarce fossil remains presents a confusing picture. Bones and stone tools do not tell us what these beings thought, felt, feared and loved. This is the realm of scientific mythmakers. Joseph Campbell hints at the intellectual framework of myth-science in the *The Hero with a Thousand Faces*. An analogous set of mythologies linger about the romantic, heroic paleoanthropologist battling the odds in search of universal truth, necessity and certainty.

This brings us to our story. How do understand our species-specific talent for myth building as a means of filling in the gaps. In subsequent articles we will explore myths like this one: the noble autralopithicine bravely trekking across the East African savannah to find the trail to the *Human Spark* and Shakespeare or Einstein. Next we dissolve to our first contact with the monolith in the opening scene of *2001: A Space Odyssey*. We end with the Piltdown Hoax.
Contact us for more information on advertising your practice in the upcoming April issue of The Wake County Physician Magazine. We’ll even help you create the perfect ad.

contact: tina@tinafrost.com
Forty years ago medicine entered a “golden age” of growth in Raleigh. In the mid-1970s, the News & Observer seemed filled with proud new practice announcements as scores of young doctors hung out their shingles. Hospitals and medical practices began a construction boom that has continued until this day. Raleigh’s medical community became populated by specialists and sub-specialists of all disciplines. No longer was it necessary for patients to journey to Durham or Chapel Hill for sophisticated specialty care. New physicians eagerly sought memberships on hospital medical staffs, in the Wake County Medical Society, and in the Raleigh Academy of Medicine - all opportunities to meet colleagues and establish professional relationships that would endure for decades.

Things were different then. Most new doctors had served in the military during the Vietnam War era. Cell phones, the internet, EMRs, CT scans, endoscopy suites, catheterization labs, CAGB surgery, hospitalists, AIDS, and other developments too numerous to list were in the future. Primary care doctors still came to the ED to treat their own patients, attended them if admitted to hospital, and took responsibility for admission of unassigned patients. Follow-up office visits cost less than $20. What an exciting time it was as we began our professional careers, purchased homes, and began raising our families! During those years Raleigh’s physicians and surgeons knew one another personally and enjoyed belonging to a genuine medical community.

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Brief History:
Alzheimer's disease is the most common form of dementia (forgetfulness/inability to recall) that afflicts more than 100 million worldwide, and five million in America. The dementia-causing brain disorder is named for its discoverer, German psychiatrist and neuropathologist, Aloysius (Alois) Alzheimer (1864-1915). The first case of Alzheimer's disease was of course presented in the form of a scientific paper to the Conference of Southwest German psychiatrists in Tubingen, Germany, on November 4, 1906.

Dr. Alzheimer discovered little bits of goo, starch-like substance, the chemical composition of which we now know to be amyloid, accumulated around the nerve cells (neurons) in the brain. These bits grow and coalesce into bigger pieces called plaques and later on neurofibrillary tangles, all of which disrupt the works of the brain which are primarily memory, intellectual functions, such as thinking and communication. As the result, nerve cells die (are choked to death) and the brain literally shrinks in volume. The patient with Alzheimer’s disease experiences loss of memory both for recent and distance events, as well as deficit in perception, mental processes, cognition and comprehension in a progressively worsening mode until the patient dies. Alzheimer’s disease is a slow but major killer. In mid to later stages, the Alzheimer’s patients do not even remember or recognize their children and other close members of the family.

Clinical course:
Alzheimer’s disease is brutal. It robs the afflicted of experiencing joy, communication, and connection with life. The patient turns into a zombie. Most important loss is loss of dignity and
nobility of the soul preceded by urinary and fecal incontinence. We now have five million Americans suffering from this disease (worldwide over 100 million). It is more prevalent in women because of female hormonal and body chemistry. There may be accompanying mood disorder such as depression; or behavior disorder such as violence; and thought disorder such as paranoia and delusions.

Interpersonal relationship, let’s say between a husband and wife is based on ability to talk (communication). And talking is about memories of the past, plan for the future and enjoyment of here and now. After attending a party, we chit chat about whom we saw at the party and who said what...And plan for the future, trips, vacations, grandchildren, etc. With Alzheimer’s all this is taken away in a brutal and irreversible manner. Conversations are reduced to asking and answering the same questions limited in scope and variety, repeatedly, randomly and aimlessly. The “conversation” exercise soon becomes exhausting. In Alzheimer’s disease, meaningful communication, the central alchemy of relation and love, is one of the first things to disappear.

**Diagnosis and treatment:**
Diagnosis is through neuropsychological testing, mental status examination and brain scans. Besides magnetic resonance imaging (MRI), we now have other radiological instruments such as positron emission tomography (PET scan) and functional MRI (fMRI) that not only visually demonstrate existence of the plaques and the amyloid bits, but can measure the physiological function of the brain. It is now well known that Alzheimer’s related changes in the brain begin 10-15 years or more before people show signs of detectable memory loss. Scientists at University of Pittsburgh and the Johns Hopkins University have developed a BIOCARD which study and predict onset of the disease in volunteers through long term monitoring and testing. Therefore, treatment is primarily through brain exercise, reading, memorizing, and classical music, doing crossword puzzle, Sudoku puzzle, physical exercise and activities, staying socially active, interactive, and engaged.

**Chemical Treatment:**
In the past few decades, we have had a number of chemicals, among them Aricept and Namenda. These drugs are designed to fight the progression of the disease and bring symptom relief. In essence they slow down the deterioration of the brain, but, unfortunately, not very successfully. More recently, a new group of drugs—the Zumab family of drugs—have been introduced with the promise that they attack the plaques directly by dissolving and removing them from the brain. They belong to a group of chemicals called monoclonal antibodies. Their expected function is to just like a chemical vacuum cleaner get in the brain and sweep away the goo, the plaques and the neurofibrillary tangles. The Zumabs supposedly are those chemical vacuum cleaners. The first one of these drugs Bapineuzumab which is still in trial has not shown glorious results. The fuss last week in Washington, DC was over another drug from the same family, Solanezumab, a drug made by Eli Lilly & Co. The first clinical trial of the drug is near completion, and the preliminary results offer some promise. More and bigger clinical trials are on the way. Now, critics, pharma pundits and stock market analysts alike, are awaiting with bated breath the results from Solanezumab—the second antibody-based vaccine drug marketed by Eli Lilly, currently in clinical trials. The hopes and dreams of a worldwide population of nearly 100 million (and growing) people with AD rides on these trials. A lot of money rides on these trials, too, given that the number of people with AD is steadily growing. The profits for any company that comes up with a reasonable drug for AD would be unimaginable. With all the hype in last week’s global conference on Alzheimer’s Disease, it remains unclear how solanezumab will fare in subsequent clinical trials. Hot on the heels of the failed bapineuzumab trials, the solanezumab trials carry the burden of possible failure and extra scrutiny.

**Personal Thoughts Not Only As A Practicing Psychiatrist, Teacher, But As A Care Giver:**
It is a distinct privilege to care for a beloved afflicted with Alzheimer’s. The opportunity to be exposed to deeper strata of love is unique and instructive. One learns patience, compassion, and care—feeling for—the victim with relentless constancy. There is nothing like experiential learning...However, personally, I believe that with the American ingenuity, and the vast resources of a mature capitalist society at our disposal, we will find a cure for Alzheimer’s.

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Paul Worley, Rail Division Director, NC Department of Transportation (right) joins Bob Munt, MD, 2016 Wake County Medical Society president at the Society annual dinner December 3, 2015. The title of Mr. Worley’s address was “North Carolina’s Railroads—Past and Present” with a focus on North Carolina’s pathways of communication and rail commerce from the early 19th century through the 20th century.
Robert Munt, MD, 2016 WCMS president (right), offers a plaque to Andrew, Wu, MD, outgoing 2015 WCMS president (left), for his year of leadership service to the Wake County Medical Society at the society’s November 17, 2015 Executive Council meeting.
WakeCounty Medical Society welcomes our newest members

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Justin J. Wu, MD
Mark Yoffe, MD
Nathan C. Sheets, MD
Nirav Dhruva, MD
Oludamilola A. Olajide, MD
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Roger F. Anderson, MD
Susan G. Moore, MD
A. John Fakiris, MD
Charles W. Scarantino, MD
Courtney Bui, MD
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Leroy G. Hoffman, Jr., MD
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Maha A. Elkhordy, MD
Amanda Sherrod, MD
Charles F. Eisenbeis II, MD, PhD
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John Sorge, MD
Keith Nance, MD
Keith Volmar, MD
Preeti Parekh, MD
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Vincent Smith, MD

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Rex Pulmonary Specialists
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William Hall, MD
Kakvitha Kadumpalli, MD
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Thoracic Surgery
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Urogynecology
UNC Pelvic Health Center
John F. Boggess, MD
John T. Soper, MD
Kenneth H. Kim, MD
Linda Van Le, MD
William Goodnight, III, MD

Hospital
Duke Raleigh Hospital
UNC-Rex Healthcare
WakeMed Health & Hospital
those years.

Those days are long past, and so much has changed. Yesterday’s newcomers are today’s old timers. Yesterday’s old timers - what a colorful lot they were! – are gone. Today's new practitioners are likely to be employed by a health system. Hospital medical staff meetings are now sparsely attended; young doctors no longer seek membership in the WCMS and the Raleigh Academy of Medicine. The center of gravity of the medical community has shifted to hospital-dominated health systems, such as Wake County Duke Physicians, which now offer the rare opportunity for office-based practitioners to meet their hospital-based colleagues face to face. “Progress” has come with a steep price – a loss of physician autonomy. The EMR, purportedly the physicians' servant, has become a master. Many veteran physicians and surgeons are stepping down and retiring. However, as we wistfully look back on many memories, we can still eagerly look forward to new challenges, the next stage. What will come next in our lives? How do we manage crossing the great threshold to retirement?

Retirement significantly alters a physician’s role from who you were to who you will become. You are no longer “the Doctor.” You are no longer an active member of the priesthood. You have stepped down from the pedestal. People are no longer patients; they are just people, and so are you. You no longer have access to your patients’ innermost secrets. If you visit a hospital, you encounter fewer familiar and personnel are less likely to know you. Retirement requires psychological preparation, but you can, and should, embrace your new life. The fetters of call schedules, interruptions, expectations, regulations, and EMRs will fall away. Relationships undergo subtle changes. In retirement you relate to others on a human-to-human basis, rather than as doctor-to-patient. Colleagues transform into friends. Perhaps your MD degree counts for less, but you can be a regular person again. It feels pretty good.

Retirement requires many other adjustments, and the key to a successful transition lies in advance planning. Achieving financial security is obviously a prerequisite, but there are many other matters to consider. Of course, there are numerous details associated with winding down your practice: patients, medical records, office space and employees, insurance, license, memberships, etc. On a more mundane, but still very personal level, what is to be done with all those old books and journals in your office that you have saved to read some day? Well, they’re out of date and you are unlikely to ever read them. You don’t have room for them at home, so get rid of them and save your executor some trouble! It’s okay to save a few shelves of favorite books. Likewise, reconsider all those [expensive] professional association memberships. Most professional societies have a less expensive senior status that can be continued at modest cost if you ask. (I only continue to receive JAMA because I am a life member of AMA and New England Journal of Medicine because of its excellent “Perspective” section.) You should cut loose from past clutter and turn toward your new life.

Beyond these practical details, however, important existential questions must be addressed. How shall you fill your days? With whom will you spend time? What will give meaning to your life once you are no longer in the clinic or hospital? Obviously, there is no single answer. Some doctors attempt to stay in harness as long as they can because they love what they are doing; or they need the income; or they just don’t know what else to do. But they might be cheating themselves out of wonderful opportunities to spend more time with families and friends, to grow spiritually, to study new disciplines, to acquire new skills, to serve in new ways, to mentor, to serve church and community or just to reflect. Male physicians often rely on their spouses to organize their social activities, but they should build their own social relationships. I am delighted and amazed when I see the interests and activities that have engaged retired colleagues, including serious gardening to help alleviate hunger, railroading, goat farming, photography, politics, ranching, history, the arts, speaking, and writing. Grandchildren are a special blessing. Not only do you have time to develop new passions, but also you can revive old ones that were put aside decades ago for the demanding gods of medicine. Your retirement affords many wonderful opportunities. Perhaps you would like to share your retirement experiences with others and be someone’s retirement mentor. You can help show the way to the next stage of life after practicing medicine by sharing your story in The Wake County Physician Magazine. §
Remember in 1981 when the first case of auto-immuno-deficiency syndrome (AIDS) was diagnosed. In the 80s and 90s, tens of thousands died because of AIDS. Well, again this past week, at another scientific meeting re: AIDS, the speakers including our own Myron Cohen of UNC School of Medicine and Health, were talking about not only control of AIDS and minimizing mortality but curing AIDS. We are today with Alzheimer’s where we were with AIDS in the mid-1980s. I am reminded of St Thomas Aquinas (1205-1275) view of science: “Believing is good. Knowing is better.” What a privilege to be alive today, especially in America, and enjoy the experience of explosion of knowledge. §

*The writer is Adjunct Professor of Psychiatry, University of North Carolina School of Medicine at Chapel Hill, Distinguished Life Fellow American Psychiatric Association; Life Member, American Medical Association; Life Member, Southern Medical Association; and Founding Editor and Editor-in-Chief, Wake County Physician Magazine (1995-2012). He serves as a Visiting Scholar and Lecturer on Medicine, the Arts and Humanities at his alma mater the George Washington University School of Medicine and Health.
CURRENT PROGRAMS

Project Access - A physician-led volunteer medical specialty service program for the poor, uninsured men, women, and children of Wake County.

Community Care of Wake and Johnston Counties CCWJC has created private and public partnerships to improve performance with disease management initiatives such as asthma and diabetes for ACCESS Medicaid recipients.

CapitalCare Collaborative - The CCC program is a membership of safety net providers working corroboratively to develop initiatives to improve the health of the region’s medically underserved such as asthma and diabetes for Medicaid and Medicare recipients.

WHY JOIN

Membership in the Wake County Medical Society is one of the most important and effective ways for physicians, collectively, to be part of the solution to our many health care challenges.

A strong, vibrant Society will always have the ear of legislators because they respect the fact that doctors are uniquely qualified to help form health policies that work as intended.

It’s heartening to know the vast majority of Wake County physicians, more than 700 to date, have chosen to become members of the Wake County Medical Society.

HOW TO JOIN

To become a member of the Wake County Medical Society contact Deborah Earp, Membership Manager at dearp@wakedocs.org or by phone at 919.792.3644

A portion of your dues supports to the volunteer and service programs of WCMS. Membership is also available for PA’s. There is even an opportunity for your spouse to get involved by joining the Wake County Medical Society Alliance.

WCMS MISSION

To serve and represent the interests of our physicians; to promote the health of all people in Wake County; and to uphold the highest ethical practice of medicine.
ENJOY THE REWARDS OF BEING A MEMBER

JOIN TODAY!

The Wake County Medical Society (WCMS) is a 501 (c) 6 nonprofit organization that serves the licensed physicians and physician assistants of Wake County. Chartered in 1903 by the North Carolina Medical Society.

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BENEFITS OF MEMBERSHIP

Service Programs - The spirit of volunteerism is strong in Wake County. Hundreds of local physicians volunteer to help our indigent. The Society coordinates several programs that allow low income individuals access to volunteer doctors and to special case management services for children with diabetes, sickle cell anemia or asthma.

Publications - Members receive the peer-reviewed The Wake County Physician Magazine four times a year, and we keep you informed regularly via pertinent emails. The magazine focuses on local health care issues in Wake County, the Wake County Medical Society and the WCMS Alliance, a companion organization composed of physician spouses and significant others.

Socializing with your physician colleagues - Many physicians feel too busy to do anything except work long hours caring for patients. But, the WCMS provides an opportunity for physicians to nourish relationships through social interaction with one another at our dinner meetings featuring prominent speakers and at other events.

Finally, joining the WCMS is plain and simple the right thing to do - Physicians and the community benefit from our membership and our leadership in local affairs.
Are you interested in becoming a Wake County Medical Society member? Simply visit our website at www.wakedocs.org and complete the online application or contact us by phone at 919.792.3644.

A portion of your dues contributes to the volunteer and service programs of WCMS. Membership is also available for PA’s. There is even an opportunity for your spouse to get involved by joining the Wake County Medical Society Alliance.

JOIN TODAY!