

A white male what?

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The United States is the most diverse and ethnically mixed country in the world. We need to know more about the family background and genetic history of our patients than whether they are “white males” or “black females.” When the department chair during my residency would hear someone at morning report describe someone as a “white male” he would say at the top of his voice from the back of the conference room “A white male WHAT? Cocker spaniel?? Cockatoo?? He is either a white MAN or an Italian-American MAN, or a Portuguese-American MAN, or whatever.” Today, it is even more important that we go beyond lumping people together by skin color and look into details that might raise issues of screening or risk that we had not imagined previously.

Those of us who are old enough to remember when the first inborn errors of metabolism linked to racial or ethnic background of patients and families began to be widely recognized remember that it suddenly became important to know the race and ethnic background of our patients. Tay-Sachs, sickle cell anemia and trait, spherocytosis, thalassemia, and many other diseases changed the way we took histories in the 1960s. It suddenly became important to know something about whether a patient was an Eastern European Jew or of Mediterranean origin or whether there was any African-American heritage. One was not a good doctor unless one knew something of the patient’s ethnic and racial history.

The article in this issue of the *Journal* describing a metabolic defect that is unexpectedly high in infants who are Hmong-American (van

Calcar S, et al. 2-Methylbutyryl-CoA Dehydrogenase Deficiency in Hmong infants identified by expanded newborn screen. *WMJ*. 2007;106(1):12) highlights that describing an infant as an “Asian child” is insufficient. There are examples, as in this important syndrome, where specific ethnic background, such as being Hmong, carries a reason to go further into testing or risk categorization. Asking patients in more detail about their origin and ethnicity is not merely curiosity but a medical necessity. As we do more and more metabolic and genetic screening in large populations, we may, as in van Calcar and her colleague’s work, find illnesses linked to race and ethnicity that we had not suspected. Diversity in America has genetic as well as cultural implications.

Learning New Things

A quick look through issues of the *Wisconsin Medical Journal* of over 100 years ago finds that what now is called Continuing Medical Education was a major function of the Medical Society even then. Coming together to hear of new developments has been a part of medicine forever. That is a good thing. Through Society meetings and specialty seminars, doctors from all over the state would meet, talk, and learn about each other and about new developments. Never mind that the new developments were often scientifically invalidated in the years following, the profession believed that science was important and hearing new ideas and approaches to patient problems was one way of learning science.

Today, we rely on medical journals for a great deal of our continuing

scientific education. However, as recently as the 1950s, medical journals contained little empirical research but were mostly filled with case series and case reports of medical or surgical treatments. Medical journals that report science as we have come to know it are a relatively recent development.

Pohlmann’s article (Pohlmann G. Continuing medical education in Wisconsin: current status and future directions. *WMJ*. 2007;106(1):20) discusses shortfalls of the older pedagogical method of CME (I sit in the audience and get talked at for 5 hours in 30 minute segments by a series of experts) and advocates new approaches that use technology, evidence based learning, and curriculum focusing on quality of care. He also mentions the ever-growing influence of big Pharma on who the “experts” are in the old method. The potential for conflict of interest is increasingly problematic whether in development of practice guidelines, sponsorship of medical research, or inviting guest speakers. Pohlmann describes some suggestions for decoupling sponsorship from delivery in a way that might keep information flowing but monitor the delivery of that information to avoid bias.

However, moving CME or CPE too far away from the pleasures of interacting with professional colleagues and onto our iPods or cellphones would be a mistake, I believe. We still need the collegiality of human interaction, coffee breaks, and clinical small talk to keep us connected as people and a profession. But, as Pohlmann points out, there are more effective ways to do that than sitting in a dark auditorium for hours on end.

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