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<th>Category</th>
<th>Test Description</th>
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about our cover

Photo by Bernie Emkes, MD. An unnamed monument on the Western Park Roadside in Southern Utah. Taken from car window on Highway 14 from Bryce Canyon to the East and connects with Highway 24 to Canyonlands. (Dr. Emkes believes he asked wife, Marta, to stop the car for this gorgeous pic!)

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Dr. Maisel welcomes suggestions from physicians, IMS Members and non-members. Simply click on the suggestion box icon and

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We like to feature photographs or other artwork shared by IMS members on the cover of The Bulletin. Submit photographs, artwork, etc., to Beverly Hurt at the Society Office, bhurt@imsonline.org.

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“MOC”ery!

My inspirational moments seem to occur most frequently when I am away from the busyines of work. I am writing this month’s President’s Page in Colorado while attending my Annual Aspen Pediatric GI Mentorology Conference for the 27th consecutive summer. The purpose of this conference is to present new research in the field of Pediatric GI from the previous year, to establish its clinical relevance and application, and to review and update current guidelines. The meeting has always been limited to 80 participants, many of whom have been attending the conference for as long as I have, many of whom I trained under, trained with, or taught. The format consists of presentations of the research followed by lively discussions that include challenges to presented studies, further questions created by the studies, anecdotal experiences, and then updating of current guidelines. This is where new standards of care are established. This is where minds are stimulated, collegial friendships and collaborations are forged, and where we discuss and share different perspectives and treatment approaches for our most challenging patients.

On my flight to Aspen, I spent time reading about the growing physician uprising against the current maintenance of certification (MOC) requirements used for state licensure, insurance participation and medical staff membership. Then, after my first day of the conference, I had my inspirational moment. Although some of what we do in our daily practices can be gleaned from a text book or Google, most of what we do as physicians from day to day has to be creatively tailored and woven from not only established guidelines but from experience, mentoring and creative approaches to not-so-text-book patients. The current standardized exams for MOC recertification test our memories for factoids that any patient can find in Google, but fall short of testing our creative clinical skills and technical/procedural skills that make us effective as healers. We loudly protest the thousands of dollars spent in exam registration fees, the time spent away from work to study and take the MOC recertification exams and modules, and the high stakes attached to passing the exams. Yet, there is widespread agreement in the importance of keeping up-to-date with our diagnostic and treatment skills, and having measures that more accurately reflect the ability to “practice” and not just recite medicine. What should we be seeking as a replacement for what is currently being dictated by the American Board of Medical Specialties (ABMS)? How do we start influencing and controlling the recertification process so it is translatable to what we do everyday, and reflects experience, mentoring, effectiveness, and growth.

We are now in the second decade of MOC recertification modules and exams administered through one of 24 medical specialty boards of the ABMS and 18 medical specialty boards of the American Osteopathic Association (AOA). My web search on MOC recertification exams led me to a staggering 693,000 sites, most of which were related to expensive courses guaranteeing passage of the exams, and registration sites for approved modules, associated with fees. The MOC controversy is centered around proponents claiming that the “voluntary” program improves physician knowledge and demonstrates a commitment to lifelong learning, designed to help physicians keep abreast of advances in their fields and develop better practice systems; the critics claim that MOC is expensive, burdensome in both time and expense, “involuntary” and clinically irrelevant to the individual physician’s practice. Tremendous effort is required to relearn material not useful to daily practice, only useful for passing the board exam. Of note, there is no data suggesting MOC is in any way superior to a number of self-assessment programs, sponsored by physician specialty societies that are significantly less expensive than MOC. A recent meta-analysis showed a decline in physician performance associated with time elapsed since the physician’s initial training; however, there is no evidence MOC participation has any effect on this alleged age-related decline in performance, and no evidence MOC is as good as any other intervention or no intervention.** Additionally, there is no evidence to support any efficacy for MOC in enhancing patient safety and patient care quality. It is commonly alleged that MOC recertification was created primarily as a money-making scheme for the ABMS and the AOA.

As a consequence, a huge multi-society physician grassroots movement has evolved, unifying efforts to demand engagement by medical societies and representatives in state legislatures to provide relief from and provide alternatives to MOC, particularly for hospital credentialing and insurance network membership. The movement has been influential in spurring medical societies to propose legislation to ban mandatory MOC requirements by hospitals and insurers in at least 17 states this year. In response, pro-MOC forces composed of the ABMS and its 24 member boards have mounted lobbying campaigns to convince state legislators that hospitals requiring MOC for physician credentialing and insurers requiring MOC for physician reimbursement and network participation should be permitted to continue in the interest of quality of care and patient safety. ABMS believes that anti-MOC legislation puts patients at risk. “Patients deserve to know that their physicians are up to date. Faced with a physician who was initially certified after residency but who has not kept the certificate current, patients will be in the dark. They will not know whether that physician chose not to participate, or failed to earn recertification, or was denied the certificate for unprofessional behavior,” per Susan Morris, ABMS director of communications.*** The anti-MOC movement agrees that initial board certification is a legitimate requirement, however, alleges that MOC has evolved into a money-making scheme that forces payment of the recertification testing fees that are “too costly and are required too frequently.”

“ABMS has tried to meet the doctors halfway by adopting several changes that lower the costs, increase the relevance of the process to practice, increase flexibility for meeting the standards, and make the whole process more convenient. The changes include remote proctoring or online assessment and other innovations that eliminate the expense and time cost of the exam; the use of resources to simulate the way physicians practice at the bedside; new testing approaches that are more customized to practice and more formative to help doctors focus their learning; a focus on clinical judgment and decision-making rather than recall of medical facts; and more convenient access to practice-relevant learning and improvement activities. However, anything short of making MOC non-mandatory, is not stopping doctors in the anti-MOC movement from seeking legislative relief.”****

So, where are we with legislative efforts at this point? Last year, medical societies in Arizona, Kentucky, and Michigan attempted to pass proposed legislation to stop MOC from being used as a precondition for hospital credentialing and insurance network membership. The bills that were passed, however, fell short of this goal.

They only stipulated that state medical boards “may not require a specialty certification or maintenance of a specialty certification as a condition for licensure,” as the Arizona law put it.

Mention of hospitals or insurers was dropped. Interestingly, the passed legislation was meaningless because no state currently conditions medical licensure on MOC! In Michigan, the legislation didn’t go anywhere. After a hearing, the proposal never went to a vote or even got out of committee, attributed to the pressure from the insurers and the hospitals. This year, four significant attempts to get anti-MOC legislation passed have taken place in Oklahoma, Tennessee, Florida, and Georgia. In Oklahoma, the win was subsequently overturned. The Oklahoma State Medical Association (OSMA) supported anti-MOC legislation in 2016, co-authored by Rep Mike Ritze, DO, a family physician. The legislation did not eliminate MOC, but offered alternative pathways that would still allow hospitals and health plans to “fast track” someone who has MOC; in addition, it stated, MOC can’t be the only way in and would require hospitals and health plans to have some alternate pathway by which physicians could be credentialed. Examples cited included the National Board of Physicians and Surgeons’ alternative to ABMS recertification testing: A doctor is required to take 100 hours of continuing medical...
Physicians are Essential for Vital Records

The Marion County Public Health Department’s Vital Records office strives to continually collect accurate statistics needed by many different organizations that use the data to improve the health of our community. We need help from physicians and coroners when they enter “cause of death” in the state’s Death Registration System and certify a death record. Virginia A. Caine, M.D., director of the Marion County Public Health Department, needs your support for timely and accurate certification of death certificates.

Physicians are vital to us having life-saving information to give to the Centers for Disease Control and Prevention (CDC), Labor of Love (working to reduce infant death and premature deaths), Indiana Cancer Consortium, Epidemiology, and Maternal and Child Health, just to list a few. One example of the importance of this valued information is the current epidemic of opioids, not just in Marion County, but in the entire state. If physicians overlook the possibility of drugs being a factor in the cause of death, the data cannot be gathered and shared. Coroners must include more details about drug overdoses, no matter the type of drug used, to help develop strategies for quelling the drug abuse epidemic. Physicians should not overlook the signs/symptoms of an overdose. They should relay the message to the coroner’s office that an overdose has occurred to make sure it is recorded properly. The Marion County Public Health Department cannot emphasize enough the importance of record keeping and data management.

The Indiana State Department of Health’s centralized electronic registration and data system eliminates the potential loss of data. It allows health departments across the state to move into new technology more efficiently and pushes the state to meet federal standards. The electronic death registry is a much faster process; entries only take a few minutes instead of days. Families are able to acquire death certificates for their loved ones in a timely manner when settling an estate or collecting various death benefits. The system works best when everyone is able to do their part in an accurate and timely manner.

Certificates of Death filed by a funeral director where the cause of death is missing or is an unqualified condition will not be accepted for registration and will be queried for additional information. Examples of unacceptable cause of death terms, when reported alone in Part 1 of the medical portion of the death certificate, are: Cardiac Arrest/Failure; Cardiopulmonary Arrest/Failure; Cardiac Respiratory Arrest/Failure; Failure to Thrive; Heart Failure; Multi-System Organ Failure; Natural Causes; Old Age/Advanced Age; Pulmonary Arrest/Failure; Pulse-Less Electrical Activity; Respiratory Arrest/Failure; Sudden (Cardiac) Death; and Unknown. This is not a comprehensive list, but this is what can delay finalizing a death record and delay a grieving relative’s closure.

When a physician should contact the coroner: Deaths stemming from any wound or injury (trauma, whether homicidal, suicidal or accidental in nature), and deaths following an accident or injury, either old or recent, that is the primary contribution to the cause of death.

Getting the information in a timely manner is very important. In fact, according to Indiana law, you only have five days to certify a death record that has been assigned to you.

IC 16-37-1-3.1 (e)

(e) Death records shall be submitted as follows, using the Indiana death registration system:

(1) The:
(A) Physician last in attendance upon the deceased; or
(B) Person in charge of interment;

Shall initiate the document process. If the person in charge of interment initiates the process, the person in charge of interment shall electronically submit the certificate required under IC 16-37-3-5 to the physician last in attendance upon the deceased not later than five (5) days after the death.

(2) The physician last in attendance upon the deceased shall electronically certify to the local health department the cause of death on the certificate of death not later than five (5) days after:
(A) initiating the document process; or
(B) receiving under IC 16-37-3-5 the electronic notification from the person in charge of interment.).

IC 16-37-1-13 Violations; sanctions
Sec.13. (a) Except as provided in subsection (c) or (d) or as otherwise provided, a person who recklessly violates or fails to comply with this chapter commits a Class B misdemeanor.
(b) Each day a violation continues constitutes a separate offense.
(c) A person who:
(1) is licensed under IC 25 in a profession listed in section Indiana Code 2015
Class “B” Misdemeanor: A Class “B” misdemeanor conviction carries a penalty of imprisonment for a fixed term of up to one hundred eighty (180) days and a fine up to $1000.00.

When a physician receives an email notification of a death from a funeral home and the decedent listed was not his or her patient, or was not seen by the physician, that physician must contact the funeral home. The funeral home’s information is included in the email that is received by the physician and it only takes a minute to respond. When physicians ignore these details, families are put on hold from getting the certified record to complete final arrangements or access bank accounts and handle financial matters. This can be frustrating for the physicians; the funeral home sometimes does not get the correct information from the hospitals, facilities or family members. The funeral homes find it difficult to verify information and have to rely on the information they are given.

Physicians have asked why they should be the ones to certify the death certificates. The first reason is because they are the most qualified. A patient’s medical chart should have all of the information needed about the decedent. Nursing home physicians say it is hard to know what caused the death of a resident; however, nurses should be charting patient information on a regular basis and physicians have access to this. The other reason why is because physicians are required by law to certify death certificates. Death certificates are packed with very important information. When done correctly, the information benefits many people (the living). Marion County has wonderful physicians who take time to enter the correct cause of death and provide useful statistics. For those physicians who might struggle with following the process for any reason, there are answers to your questions and solutions to help.

Physicians, coroners, funeral directors, and public health/vital records professionals each have an important role to bring closure to grieving families and provide vital statistics for better public health outcomes. If you would like training information, or just need answers to questions, please call the Marion County Public Health Department’s Vital Records office, 317-221-3018.
How do we Create the Medical Culture that is Conducive to Physicians’ Health?

Jamie Katuna | Video | July 18, 2017; Jamie Katuna is a medical student. She can be reached on Facebook. Article from KevinMD.com

On June 30th, a physician entered a hospital in New York City with an assault rifle. He killed one person, a physician, and wounded six others. He then set himself on fire and shot himself in the chest, dying by suicide.

I, nor anybody else, knows this man’s motives or what was going on in his head. But one detail in the story stuck out to me. According to CNN, before the physician opened fire, he yelled: “Why didn’t you help me when I was getting in trouble? Why didn’t you help me?”

I think something all of us could agree on is that this man needed help. And we can also conclude that he didn’t get the necessary help. Unfortunately, for physicians, not getting adequate help seems to be the norm and not the exception to the rule. Not only because it’s not available, but because they fear the repercussions from seeking out what they need.

I want to use this particular, tragic story to address a bigger issue in general: caring for the mental health of physicians.

First, let’s look at the numbers. According to US News & World Report:

- One-third of physicians report experiencing burnout at any given point. This is 15x more likely than professionals in other lines of work.
- Medical students have a rate of depression that is 15 to 30 percent higher than the general population — which ultimately leads to poorer performances with patients.
- Physicians have a divorce rate 10 to 20 percent higher than the general population.
- 45 percent of primary care physicians say they would quit if they could afford it.
- And 300 to 400 physicians die by suicide each year. To put that into perspective, that’s about three medical school graduating classes worth.

So what’s going on? The US News & World Report article cites “the culture of medicine” as the main culprit. But, what’s that? First, it’s dealing with high-stress situations and death on a regular basis with no time to reflect, mourn, or even slow down. Also, it’s a lack of autonomy over one’s schedule or time — physicians are constantly being pressured to see more patients in less time and produce better health outcomes. That’s an impossible situation. It results in sleep deprivation, absence from family activities, and an inability to engage in any self-care. It is a culture where physicians have low autonomy but high responsibility. And that is an extremely problematic combination.

Why don’t physicians get help when they are struggling? US News & World Report says it’s due to fear. We often penalize physicians by denying them privileges or licenses if they’re being treated for substance abuse or depression. Their source of livelihood and sense of identity would be stripped from them. There is also a sense of stoicism and pride with regards to one’s own health that goes, “I can’t be seen as unhealthy because I am a physician.” Because of this, many try to self-medicate.

There are well-intentioned interventions that promote meditation, exercise, or group therapy among physicians, but these aren’t feasible because, as mentioned before, doctors do not have time for this. And that paradigm puts the burden of wellness on the physician when the source of the problem is structural.
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**Bulletin Board**

**News from Goodman Campbell Brain and Spine...**

Goodman Campbell Brain and Spine will host its annual "Mealey Lecture" on August 30 at 5:00 pm. This year's lecturer will be Maciej S. Lesniak, MD, chairman of the Department of Neurosurgery at Northwestern University in Chicago. Dr. Lesniak will discuss "Developmental Therapeutics: A Neurosurgeon’s Perspective." The lecture will be held at the Goodman Hall Auditorium in the Indiana University Health Neuroscience Center.

The IU Department of Neurological Surgery was proud of its play in the 14th Annual Neurosurgery Charity Softball Tournament held June 3 in New York City. Forty neurosurgery programs from around the country competed to benefit the Neurosurgery Research and Education Foundation and for year-round bragging rights. The IU team of physicians and residents, in their first year of competition, defeated players from Yale, Duke, and Alabama to advance to the Sweet 16 round, where it loss to the University of South Florida—the tournament’s ultimate second place finisher.

Nicholas Barbaro, Thomas Witt, and Aaron Cohen-Gadol, MD, recently published new research titled "Enhanced classical complement pathway activation and altered phagocytosis signaling molecules in human epilepsy." The paper appeared online ahead of print in Experimental Neurology on June 7.

Aaron Cohen-Gadol, MD, also reported new research with co-authors in the Proceedings of the National Academy of Sciences of the USA. “Intraoperative assessment of tumor margins during glioma resection by desorption electrospray ionization-mass spectrometry,” was published online on June 12 ahead of print.

The Third Annual Goodman Campbell Brain and Spin Brain Bolt 5K Run/Walk will be held on October 7 at 10:00 a.m. at the Carmel Gazebo at Civic Square in Carmel. This year's race will once again benefit the treatment and care of traumatic brain injuries. The family-friendly event will take on a festival atmosphere featuring musical entertainment, food trucks, and activities for kids on the gazebo's grass lawn. Register at: www.brainbolt5k.com

Stephen W. Perkins, MD, of Meridian Plastic Surgeons, recently spoke at the Indiana University School of Medicine’s 102nd Annual Anatomy and Histopathology of the Head & Neck Course in Indianapolis. He presented a talk on the topic of “Facial Analysis and Management of the Aging Face.” Additionally, he was the featured faculty in the Anatomy Lab for the Facial Plastic Surgery Day, demonstrating a facelift on “live video” to the participants.

Rick C. Sasso MD, Indiana Spine Group, had his 19th patent issued by the United States Patent and Trademark office. US Patent number 9,066,751 was issued to Dr. Sasso as the sole inventor. This patent covers Minimally Invasive Spine Surgery and the use of Intraoperative Navigation techniques.

Dr. Sasso just returned from Cabo San Lucas where he served as an invited faculty member for the 14th annual Cabo Meeting: State of Spine Surgery Think Tank that occurred June 15-17, 2017, in Los Cabos, Mexico. He lectured in 2 debates on the surgical treatment of Degenerative lumbar spondylolisthesis and multilevel cervical radiculopathy and also lectured on the most current cervical artificial discs undergoing FDA testing.

**In Memoriam**

George F. Parker, MD

Dr. Parker was born October 17, 1918 in Terre Haute and passed away June 25, 2017 in Franklin. He was 98 years of age.

He earned his medical degree at the University of Cincinnati Medical School in 1943 and remained in the area for medical training. Upon completion, he moved his family to Indianapolis where he practiced Pediatrics and Pediatric Allergy from 1948 to 1990.

Dr. Parker served in many roles throughout his medical career. He was one of the founding doctors of Community Hospital, their first director of Medical Education, and he founded the Association of Retired Physicians at Community Hospital. In addition, he established the Family Medicine Residency Program there. He also served on the Indianapolis Medical Society Board of Directors and was an Assistant Professor of Pediatrics at IU School of Medicine.

In his spare time, Dr. Parker enjoyed time with his family, farming, raising cattle and forestry.

He had been a member of IMS since 1949.

Kenneth Rau Woolling, MD

Kenneth Rau Woolling, M.D., Indianapolis, IN, died Sunday, April 16, 2017. A thoroughly good and kind gentleman, he was adored by his family and patients and highly respected by his medical colleagues. With the exception of his deep love for his family, his lifelong passion was medicine. He was always fascinated by the subject and inspired by its principles. A superb clinician and scholar, he dedicated his life to this profession, for which he had a true calling.

Born in Indianapolis, Dr. Woolling earned a B.A. in Zoology-Chemistry, magna cum laude, Butler University, 1939. Postgraduate work was done at Harvard University, 1939-40. He earned his M.D., Indiana University School of Medicine, 1943, and M.S., Med., University of Minnesota, Mayo Clinic Graduate School of Medicine, 1951.

Dr. Woolling interned at Indianapolis City Hospital, 1943-44. He served as a captain in the Medical Corps, U.S. Army, World War II, 1944-46. In 1947, his residency was in internal medicine, Indianapolis General Hospital (Lilly Research Clinic). From 1948-52, he was a fellow and first assistant in internal medicine, Mayo Clinic, Rochester, Minnesota.

In 1952, Dr. Woolling entered private practice in Indianapolis, specializing in internal medicine and cardiovascular diseases with emphasis on peripheral vascular diseases. He was a member of the medical and teaching staffs of Methodist and Indianapolis General Hospitals.

He was the founder and director of the Peripheral Vascular Diseases Clinic, Indianapolis General Hospital, 1952-68. He also was the founder and director of the Peripheral Vascular Diseases Clinic, Methodist Hospital, 1967-72, and the Vascular Laboratory, Methodist Hospital, 1970-73. Dr. Woolling was also a member of the medical staffs of St. Vincent, St. Francis, Community, and Winona Memorial Hospitals, and a visiting consultant at Riverview Hospital, Noblesville. He served as a member of the medical advisory committee of Butler University.

He was a fellow of the American College of Physicians, American College of Chest Physicians, Council on Clinical Cardiology of the American Heart Association, International Union of Angiology,
Community Hospital East
First Wednesday Critical Care Conference
Second Medical Grand Rounds
Tuesday CHE Theater, 1:00 – 2:00 p.m.
Community Hospital North
First & Third Psychiatry Grand Rounds
Wednesday Multi-Service Room, 12:30 – 1:30 p.m.

Community Heart & Vascular Hospital
First Imaging Conference:
Wednesday of every month CHV 3rd Floor Boardroom rotates to CHV Anderson, CHV East Conference Room (Ste. 420), CHV South Conference Room (Ste. 2400), CHV Kokomo, 7:00 – 8:00 a.m.

Second M&M Conference:
Wednesday of every month rotates the Echo & Nuclear Q/A, CHV 3rd Floor Boardroom rotates to CHV Anderson, CHV East Conference Room (Ste. 420), CHV South Conference Room (Ste. 2400), CHV Kokomo, 7:00 – 8:00 a.m.

Third Ken Stanley CV Conference:
Wednesday of every month CHV 3rd Floor Boardroom rotates to CHV Anderson, CHV East Conference Room (Ste. 420), CHV South Conference Room (Ste. 2400), CHV Kokomo, 7:00 – 8:00 a.m.

Fourth Disease Management Conference:
Wednesday of every month rotates CHP & EP Case Presentations, CHV 3rd Floor boardroom rotates to CHV Anderson, CHV East Conference Room (Ste. 420), CHV South Conference Room (Ste. 2400), CHV Kokomo, 7:00 – 8:00 a.m.

2017 Cancer Conferences
Community Hospital East
Fourth Tuesday East Multidisciplinary Breast Cancer Conference - CHE 8:00 – 9:00 a.m.

Community Hospital North
First & Third North Multidisciplinary Breast Cancer Conference - CHN 8:00 – 9:00 a.m.
Second & Fourth North Multidisciplinary GI/Colorectal Oncology Conference - CHN 8:00 – 9:00 a.m.

Community Hospital South
Second South Multidisciplinary Breast Cancer Conference - CHS
Wednesday 1440 E. County Line Rd., Community Room, 8:00 – 9:00 a.m.

Community Hospital East
First Critical Care Conference
Wednesday CHE Administrative Conference Room, 12:00 – 1:00 p.m.

Indiana University School of Medicine/Indiana University Health
IU – Methodist – Riley
Online HPV Documentary:
CME Someone You Love: The HPV Epidemic
Activity http://cme.medicine.iu.edu/hpvdocumentary

July 9-14 102nd Anatomy and Histopathology Course
Felser Hall

July 21 Review and Interpretation of the 2017 ASCO Meeting
Hine Hall Auditorium

Oct. 19-20 Fundamental Critical Care Support
IU Health Methodist Hospital

Nov. 3 24th Annual Eskenazi Health Trauma and Surgical Critical Care Symposium
Eskenazi Hospital

Course dates and locations are subject to change. For more information, please visit http://cme.medicine.iu.edu or call 317-274-0104.

The Indiana University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

We have more than 100 recurring meetings available. For a listing or more information, please visit http://cme.medicine.iu.edu or call 317-274-0104.

To submit articles, Bulletin Board items, CME & events, opinions or information, email ims@imsoline.org. Deadline is the first of the month preceding publication.

In Memoriam
(Continued from page 11)
American College of Angiology (Governor, Indiana, 1979-80), and a member of the American Heart Association, American Medical Association, American Society of Internal Medicine, American Diabetes Association, Indiana Diabetes Association, Indiana State Medical Association, Indianapolis Medical Society, Northwest Clinical Society, Mayo Cardiovascular Society, and Mayo Alumni Association. He was named in The Best Doctors in the U.S. and was honored with a Lifetime Achievement Award from Marquis Who’s Who.

He was a Diplomat of National Board of Medical Examiners, American Board of Internal Medicine, and American Board of Cardiovascular Disease.

Beginning in 1950 while at the Mayo Clinic, and continuing through the years, Dr. Woolling contributed many scientific articles to professional journals. He retired from private medical practice in 1987 but continued to write, focusing primarily on medical history. He contributed a number of his articles to the Indianapolis Medical Society Bulletin and Indiana Medicine. In 2010, his book Recollections of a Mayo Clinic Fellowship at Mid-Twentieth Century, 1948-1952 was published.
education (CME) in the previous 24 months, and prove it with either CME certificates or transcripts from the CME provider. The cost of a recertification certificate is $169.

The bill passed the state House of Representatives and the state Senate unopposed. On April 12, 2016, Governor Mary Fallin signed it into law. Oklahoma became the first state to enact legislation aiming to remove MOC as a requirement for physicians to obtain a license, get hired and paid, or secure hospital admitting privileges.*** However, hospitals found a loophole in the language allowing them to continue enforcing MOC on some doctors while exempting “grandfathered” doctors. Dr. Ritze introduced a new bill earlier this year to clarify the language for hospitals. It appeared that the legislation would again pass unopposed. In the final 24 hours before the vote, however, the OSMA was caught off guard by an unexpected ABMS and Oklahoma hospitals lobbying and misinformation blitz. The talking points provided by the ABMS to the hospitals and insurers that opposed the legislation included the following: “The bill, as drafted, unnecessarily interferes with the ability of Covered Hospitals to select the best-trained and most appropriate individuals to staff their facilities and unduly burdens their ability to contract with such individuals. Please do not let Oklahoma become the only state in the nation that puts its patients’ quality of care at risk by removing Maintenance of Certification requirements for physicians practicing specialized medicine.” The new bill failed 71-22, with the old bill still standing in “legal limbo.” Dr. Ritze is urging physicians to support new legislation that will be introduced in 2018, and to contact and educate their legislators now.

In 2016, the Tennessee Medical Association passed a resolution to “oppose and defeat efforts by American Board of Medical Specialties and the Federation of State Medical Boards to require physicians to impose mandatory Maintenance of Certification (MOC) and Maintenance of Licensure (MOL) as conditions of employment, licensure, reimbursement or professional insurance coverage. Imposing such certification requirements upon the practice of medicine in Tennessee amounts to interference in the patient-physician relationship and threatens to interpose needless regulation between physician and patients in Tennessee. There is no evidence that MOC and MOL requirements improve patient care, but rather decrease access to physicians by excluding non-certified licensed physicians who do not repeatedly re-certify, thereby placing an undue time and financial burden on physicians and encouraging early retirement.” The resolution was incorporated into an anti-MOC bill that was introduced in the Tennessee State Assembly in April, but due to the lobbying pressure of the hospitals and insurers, the bill was stripped of any mention of hospitals and insurers and now simply states that MOC can’t be required for a medical license.

A bill drafted by the Florida Medical Association (FMA) was introduced in the Florida legislature in April. It precluded the state board of medicine, department of health, licensed health care facilities, and health insurers operating in Florida from requiring recertification “as a condition of licensure, reimbursement, employment, or admitting privileges for a physician who practices medicine and has achieved initial board certification in a subspecialty.”*** However, the legislation that came out of committee did not address the MOC concerns of the doctors but rather shockingly directed the state to direct and regulate the subspecialty boards with a complicated plan to control a now non-voluntary MOC. The 52,000 Florida physicians feel betrayed. Plans to re-introduce anti-MOC legislation is being developed over this summer.

The Medical Association of Georgia (MAG) proposed anti-MOC legislation in January stating that MOC “shall not be required as a condition of licensure to practice medicine, employment in certain facilities, reimbursement, or malpractice insurance.” The legislation was co-sponsored by Rep Betty Price, MD, an anesthesiologist, who is married to Health and Human Services Secretary Tom Price. The state House of Representatives passed the bill on March 1 (171-2). The state Senate passed the bill on March 29 (52-1). Governor Nathan Deal signed the bill into law on May 8, making Georgia the first state to lift MOC requirements for staff privileges at “certain” hospital facilities and for insurance network membership, as well as for medical licensure. The “certain hospitals facilities” are the 6 Georgia State hospitals. General hospitals were not mentioned, eliminating the lobbying against the legislation by the Georgia Hospital Association.

Anti-MOC legislation is currently pending in Maryland, Missouri, North Carolina, and Texas, and bills have been introduced earlier this year in Alaska, California, Maine, Massachusetts, New York, and Rhode Island.*** The Texas legislation passed the Texas House unanimously, has passed the Senate Public Health Committee, and is now waiting for a general vote. The Alaska legislation is expected to pass due to the undue burden placed on physicians to travel long distances for review courses and testing, leaving single physician practices behind for weeks unattended by their physicians.

In June 2016, at the AMA House of Delegates (HOD) in Chicago, a resolution was passed opposing mandatory ABMS recertification exams. It reads: RESOLVED, That our American Medical Association call for the immediate end of any mandatory, secured recertifying examination by the American Board of Medical Specialties (ABMS) or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination. The AMA also approved a resolution to continue working with ABMS to “encourage the development by and sharing between specialty boards” of alternate ways to assess medical knowledge, other than by a secure exam. The AMA HOD supported use of appropriate continuing medical education courses to maintain quality assessments of physicians.

As Indiana physicians, we are fortunate to have at our doorsteps multiple academic and teaching institutions, and state-of-the-art innovative private and not-for-profit hospitals and practices. We can be at the forefront in developing curriculums and tools that meaningfully measure our clinical and technical competencies. My attendance at my annual summer Aspen meeting reminds me that there is still no substitute for collegial round table discussions, and that medicine continues to be a cultivated and mentored art as much as a science, something that cannot be quantified solely by a multiple choice exam. I look forward to hearing innovative proposals from you over the next several months so that Indiana can start moving legislation forward that allows Indiana physicians to intelligently modify the current regulations that monitor our abilities and growth.

My one year term as President of the Indianapolis Medical Society will conclude next month. I am honored to have served you, and have appreciated your comments, commitment and participation, and have learned so much from you. With dedication and numbers we can move mountains! Thank you to the Executive Committee, the Board of Directors, and the Delegates to the State Convention. And a big thank you to our wise Executive Vice President, Beverly Hurt, who knows everything there is to know about getting things done!

*** The War over MOC heats up. Medscape. 2017 June 17.
New Members

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Marian University, College of Osteopathic Medicine, 2017

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Indiana University, 2017

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Fax – (317) 528-6916
Family Medicine
Marian University, College of Osteopathic Medicine, 2017

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Contact Rebecca @ 631-3466
or rkeller@imsonline.org
Delegates to the 168th Annual State Convention, September 16-17, 2017, Sheraton Indianapolis North
The year shown in parentheses indicates year in which the term expires following the conclusion of the ISMA Annual Convention.

Mary D. Bush (2017)
David R. Diaz (2017)
Bruce M. Goens (2017)
Nicholas F. Hrisomalos (2017)
Paul D. Isenberg (2017)
David A. Josephson (2017)
Randall A. Lee (2017)
Daniel E. Lehman (2017)
Mary Ian McAteer (2017)
Clement J. McDonald III (2017)
Robert M. Pascuzzi (2017)
Richard H. Rhodes (2017)
Kenneth N. Wiesert (2017)

Linda Feiwell Abels (2018)
Christopher D. Bojrab (2018)
C. William Hanke (2018)
David H. Moore (2018)
David M. Ratzman (2018)
Caryn M. Vogel (2018)
Steven L. Wise (2018)

Carolyn A. Cunningham (2019)
Ronda A. Hamaker (2019)
Mark M. Hamilton (2019)
Tod C. Huntley (2019)
Marc R. Kappelman (2019)
Jeffrey J. Kellams (2019)
Stephen R. Klapper (2019)
Susan K. Maisel (2019)
John P. McGoff (2019)
J. Scott Pittman (2019)

Alternate Delegates to the 168th Annual State Convention, September 16-17, 2017, Sheraton Indianapolis North
The year shown in parentheses indicates year in which the term expires following the conclusion of the ISMA Annual Convention.

Cariissa M. Barina (2017)
Brian D. Clarke (2017)
Ann Marie Hake (2017)
Douglas J. Horton (2017)
H.B. Harold Lee (2017)
Ramana S. Murthy (2017)
Maria C. Poor (2017)
Steven M. Samuels (2017)
Michael C. Sha (2017)
Jodi L. Smith (2017)

Nicholas M. Barbaro (2018)
Heather N. Berke (2018)
Charles W. Coats (2018)
John H. Ditslear, III (2018)
Robert S. Flint (2018)
Thomas R. Mote (2018)
Martina F. “Nina” Mutone (2018)
Timothy H. Pohlman (2018)
Michael A. Rothenberg (2018)
Jeffrey M. Rothenberg (2018)
S. Eric Rubenstein (2018)
Richard M. Storm (2018)
H. Jeffery Whitaker (2018)

Daniel J. Beckman (2019)
David M. Mandelbaum (2019)
David L. Patterson (2019)
Scott E. Phillips (2019)
Dale A. Rouch (2019)
Amy D. Shapiro (2019)
Jason K. Sprunger (2019)
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