Indianapolis Medical Society 1848

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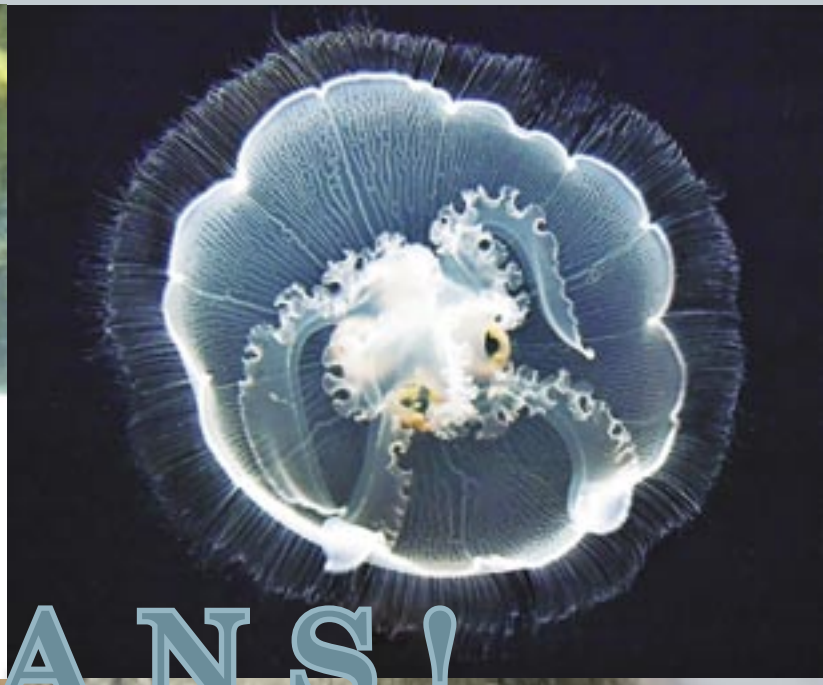
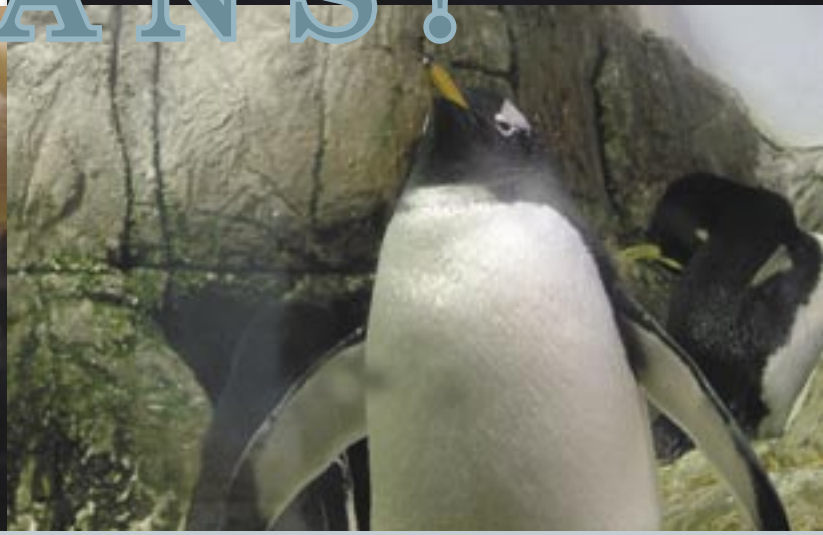
Bulletin



OCEANS!



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RSVP Inside!

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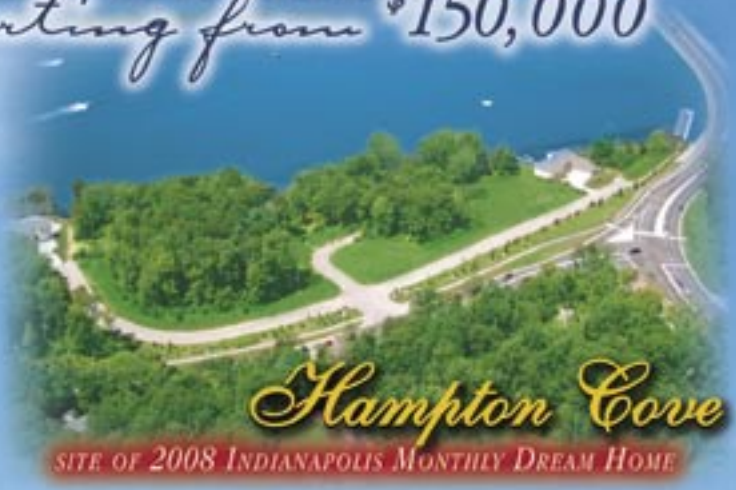

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Marcia K. Hadley

The Bulletin invites news from and about members of the Indianapolis Medical Society. Copy deadline: First of the month preceding month of publication.

Advertising: Rates available upon request. Advertisers should provide electronic files by the first of the month preceding publication. Placement of advertisements, except for premium spaces, will be throughout the publication at the discretion of the editor.

ATTENTION SOCIETY MEMBERS

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.

The Bulletin is your magazine. Share your views by submitting reprints of your published articles; articles written expressly for *The Bulletin*; quips; short stories; brief comments; ideas; cartoons, etc.

Remember the *Indianapolis Medical Society Foundation* when planning your will. *(Contribution form included in this issue.)* Unless otherwise specified, your contribution will be directed toward medical scholarships.

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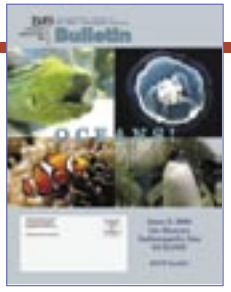
in this issue

Special Features

Departments

about our cover



7th District OCEANS!

June 6, 2008 is the 7th District Meeting at the Indianapolis Zoo OCEANS! exhibit. Our cover is enhanced by photographs courtesy of the Zoo of the Green Moray Eel, Clown Fish and the Moon Jelly. Please make sure to RSVP for this collegial family event.

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President's Page

Heidi M. Dunniway, MD

"The mission of the Indianapolis Medical Society is to promote professional growth, advocacy for all physicians, and quality health care for the community!"

Success

On March 5, 2008, we lost my dad after a fifteen year battle with prostate cancer. Throughout his life, he was our teacher, our greatest fan (along with Mom, of course), and, later, our friend. In reflecting on all of the gifts he gave me, I think perhaps the most significant is showing me through words and actions how to lead a successful life. While much of what follows may be self-evident, we often are in so much of a hurry that these simple tenets are easy to overlook, and for that reason, I decided to pay tribute to my dad by sharing the keys to success he taught me.

Family is always priority. My dad always made us his top concern. It may have meant a little less in the paycheck sometimes, but he took time to be at all of our important events – performances, graduations, etc. He and my mom also lived a great example of a good marriage. Respect for one another was a given. Certainly, my sister and I did our share of stupid things (especially as teens), but my parents were always there to help us clean up our messes and learn from our mistakes. As a by-product, they made our home a place where our friends always felt welcome and comfortable.

Work hard. The standards in our house were high but not impossible. Both of my parents taught us a strong work ethic from early in our lives. We generally did not question if we could accomplish something but rather how we would make it happen. Dad also showed us that effort and accomplishment did not only apply in school or career, but also in our faith and in our relationships with others.

Follow your dreams. When I decided I wanted to be a physician early in grade school, my dad was right there, encouraging me and helping me explore the possibility, even though there was no one even connected to medicine in our family. He helped me with numerous science fair projects and took me on special visits to research labs and hospitals. My career path bears a strong imprint from my father, and I could never thank him enough for encouraging me to pursue my goals and ambitions.

Be kind and gentle. If ever there was a true gentleman, it was my father. He exhibited a quiet strength and was always there as an inspiration and counselor. He had an uncanny ability to remember people he had met only once and the ability to make everyone he met feel important. When we were kids, my sister and I hated running errands with him on the weekend, because he knew nearly every person we would see, and a simple trip to the hardware store could take hours. As an adult, I grew to appreciate my dad's outgoing personality and gift for making others feel special.

Persevere. Even facing a diagnosis of metastatic prostate cancer, my dad continued to keep a positive attitude and refused to let the disease take over his life. He taught us to remain optimistic, even in the face of adversity, and to look for the positive in every situation. His attitude and actions helped me feel nothing was impossible.

Finally, always keep your sense of humor. Even in the last days of his life, Dad was always ready with a quip or corny pun. He often used humor to lighten a tense situation and was a master at helping others feel at ease. We frequently greeted his jokes with a moan or groan, but we always appreciated his sense of humor and looked forward (more or less) to his next one-liner. Dad taught us to avoid taking things too seriously all of the time and to laugh at ourselves.

Through Dad's life, he showed us that success was not just how much money one makes or the size of one's house. He impressed upon us the importance of success as a whole person, building on faith, family and career, not just material accomplishment.

I was fortunate to have the opportunity to spend with my dad the last ten days of his life. While the depth of our loss is too great to put into words, I take solace in the legacy he left behind in his family and friends. I appreciate all of the expressions of sympathy that my family and I have received; my dad would have been overwhelmed.

Special Feature

Mark W. Timmis, PMP, INSPECT Program Director

INSPECT

What is INSPECT?

INSPECT is a stand-alone web-based software application that enables users to pull reports on patients at your discretion.

INSPECT stands for the Indiana Scheduled Prescription Electronic Collection and Tracking. The program that has become INSPECT has evolved through several iterations out of a piece of legislation passed in 1994 that requires the collection of dispensed controlled substance data into a central data repository specifically for controlled substances. At its inception only Schedule II controlled substance data was collected, but in 2004 legislation was passed that expanded data collection to include all Schedules II through V controlled substances.

INSPECT is partially funded through the Harold Rogers Federal Grant Program, which provides similar funding in other states. Additional funding for INSPECT is provided at the state level, derived from a percentage of controlled substance licensing fees.

All maintenance and some data collection activities for INSPECT are handled in-house, while the remaining data collection is done by pharmacies. The data repository is accessible only to registered users and available only through a secure Web site maintained by program staff.

What does INSPECT offer?

INSPECT users can get informational reports on patients. Those reports include patient information, patient prescription information, attending physician information, attending pharmacy information, and matching information on possible patient aliases.

By accessing the INSPECT Web Center, you will view detailed information about patient treatment history, which may help you offer more appropriate treatment regimes. For the first time, you will be able to look at records detailing all previous instances in which your patients were prescribed controlled substances.

To ensure confidentiality of patients' medical records, some restrictions will apply. For instance, any practitioner submitting a request for patient information must be providing medical or pharmaceutical treatment to the patient in question, or must be evaluating the need for such treatment. INSPECT does not violate federal HIPAA standards, or your patients right to privacy as long as you do not share the report with anyone except the physicians or pharmacists listed on the report.

Who can gain access to INSPECT?

Originally INSPECT was designed specifically to serve law enforcement, which can be defined as any local, regional, state, or federal law enforcement officer that has a current, or ongoing investigation that involves controlled substances.

Beginning July 1, 2007, however, legislation was passed to allow physicians, pharmacists, and other medical practitioners in Indiana to have report access to the INSPECT Web Center data, which is a vast storehouse of patient and prescription drug information. Other practitioners gaining access with the new law include medical specialists, dentists, veterinarians, scientific investigators, pharmacists and those licensed to research, distribute or administer controlled substances.

The INSPECT System and Reports are available to anyone that has a Drug Enforcement Administration and Controlled Substance Registration License.

Why use INSPECT?

INSPECT helps you track your patients' narcotic use.

What do you do when a new patient comes to you requesting controlled substances? Before INSPECT you did not have many choices. INSPECT will allow you to see if you are being duped by possible Doctor Shoppers. Finally you have a tool that will allow you to gain additional insight about whether the drugs you prescribe are being used for illicit purposes.

From a professional standpoint, INSPECT is a great risk management tool that costs you nothing except the time to sign up for it. Although physicians are not required to use INSPECT, they are immune from civil liability for an injury, death or loss to a person solely due to their seeking or not seeking information from the database. As always, though, a physician may not negligently misuse information obtained from it or engage in gross negligence or intentional misconduct.

"When INSPECT became available, I found patients who were prescribed multiple drugs from multiple physicians," said Evansville pain management physician Steven Rupert, D.O. "One patient was recently discovered being prescribed more than 6,000 pills of a narcotic over a 12-month period from physicians from New Albany to Evansville. Without INSPECT, this individual would have continued to abuse the system."

Here is how to sign up for INSPECT

If you type in the following URL: https://extranet.pla.in.gov/PMPWebCenter/Registration.aspx it will take you directly to the application page. Fill out the application and within 1 to 3 business days you will be granted access.

Registering for the program is very easy. Each practitioner only needs to establish one account, even if a staff member is chosen as a delegated INSPECT user. However, practitioners are held accountable for staff use of the program.

Continued on page 30.

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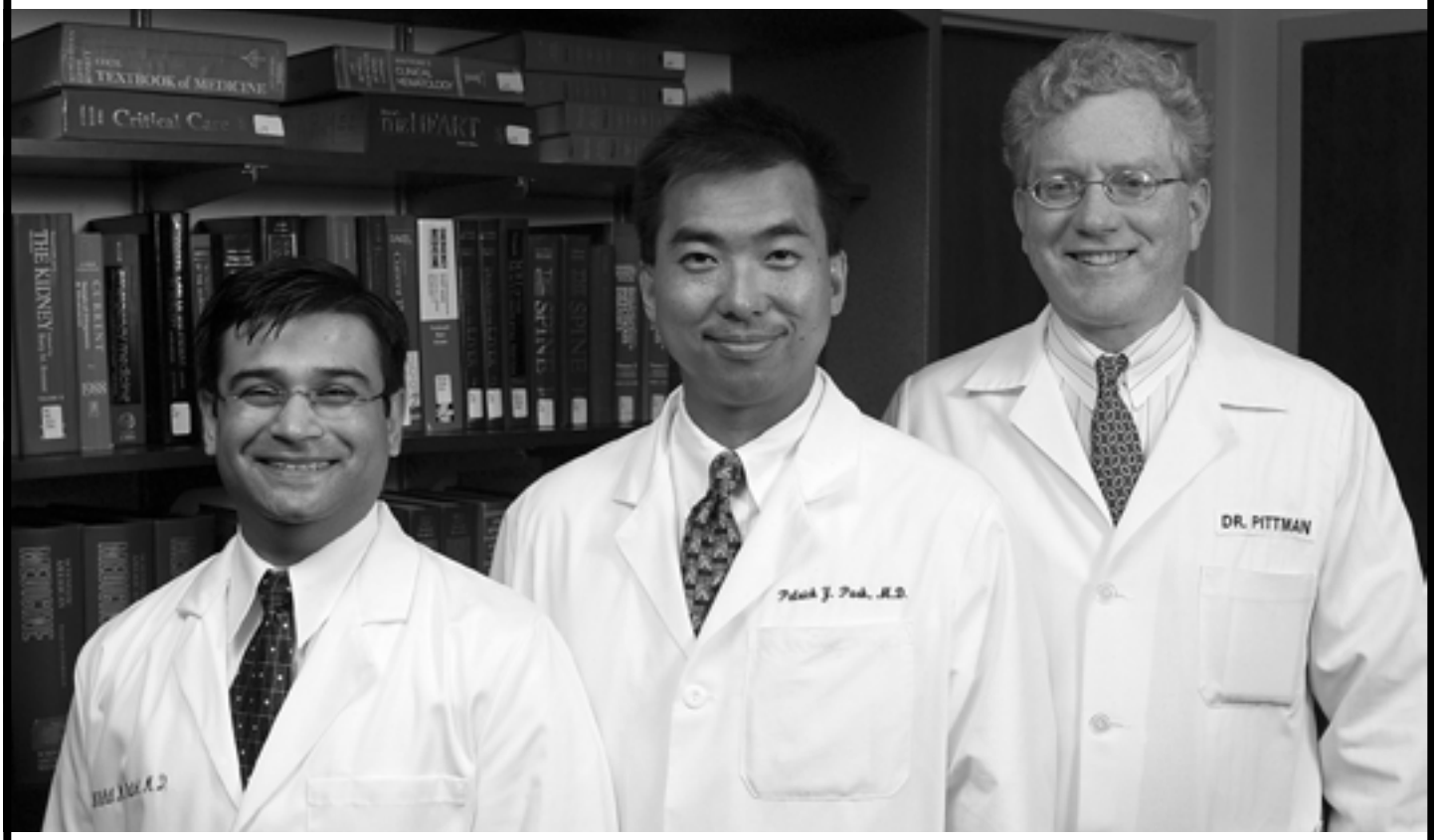

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Case #8

Patient: 36 yr old male w/ severe sharp pain and slight BRB w/ BM on toilet paper worsening over the last 3 months. No crampy abdominal pain, diarrhea or weight loss (no symptoms of Crohn's dz)

Exam: Enlarged posterior midline anal tag and a chronic fissure immediately internal to the tag. Digital exam-enlarged 1 cm anal papilla in addition to above, with tenderness at fissure site reproducing and confirming the diagnosis.

Presumed Cause: hypertensive internal anal sphincter

Treatment Options:
1) fiber diet plus fiber supplements & fluids
2) calcium channel blocker-topical
3) Botox injection, outpatient w/sedation
4) Internal anal sphincterotomy & excision of tag & papilla

Treatment Chosen: #1 & #2 above failed after several week trial. Option #4 then done.

Result: At 3 wk follow up visit – complete healing and resolution of symptoms

Carmel: 844-5273 **www.midwestcolon.com** **Naab Road: 872-1577**

Bulletin Board

Rick C. Sasso, MD, Indiana Spine Group, had six scientific papers presented at the American Academy of Orthopaedic Surgeons, 75th Annual Meeting held March 5-9, 2008 in San Francisco. Most of the papers involved the clinical outcome of cervical artificial disc replacement.

William J. Berg, MD, cardiologist, Indiana Heart Physicians at St. Francis, recently successfully performed the new minimally invasive laser ablation procedure using a device developed by Spectranetics on a patient with severe peripheral artery disease. The procedure uses an excimer or "cool" laser that produces pulsed bursts of light energy transmitted along fibers encased in catheters.

John T. Munshower, MD, Josephson-Wallack-Munshower Neurology, was a nominee in the "Physician" category for the recent Health Care Heroes Award.

K. Donald Shelbourne, MD, presented "Incidence of Subsequent Injury to Either Knee Within 5 Years After ACL Reconstruction" and "Return to Activity and Subsequent Injury After ACL Reconstruction in School-Age Athletes, " at the ACL Study Group in Engleber, Switzerland. He also spoke on "ACL Reconstruction Technique," "ACL Rehabilitation and Long-Term Outcomes" and "Treatment of Multiple Knee Ligament Injuries," at the American Academy of Orthopedic Surgeons, Instruction Course Lecture in March 2008.

Stephen W. Perkins, MD, spoke at the 5th International Congress of Facial Plastic Surgery, in Cartagena, Columbia. The meeting was hosted by the International Federation of Facial Plastic Surgery Societies and the Columbian Society of Facial Plastic Surgery and Rhinology. Dr. Perkins presented "Basic Secondary Rhinoplasty," "Mid Face Lift: Why Do It and How" and "Facial Resurfacing with a Combination of Modalities."

John B. Meding, MD, was elected into membership in the Hip Society. The Hip Society, founded in 1968, promotes and maintains professional standards to provide the best care to patients suffering from disorders of the hip joint. The Hip Society stimulates the exchange of knowledge concerning education, research and treatment on disorders of the hip.

John-Pierre Mobasser, MD, presented "Minimally Invasive Spine Surgery" at the Indiana Academy of Family Physicians Annual Meeting in Indianapolis in January. He also presented "Surgical and Nonsurgical Management of Low Back Pain" at St. Vincent's Hospital Department of Surgery, as well as "Minimally Invasive Spine Surgery – What is it?" at St. Vincent's Spine Center.

The Indiana University School of Medicine Department of Ophthalmology celebrated 100 years of patient care with a free Healthy Eyes open house on April 5, 2008 at the Indiana Historical Society. **Louis B. Cantor, MD,** (photo unavailable), presented on Glaucoma; **Robert D. Yee, MD,** presented on "Epidemilogy of Eye Disease," at the morning session.


William J. Berg, MD


George W.M. Feliciano, MD


Kurt R. Martin, MD


John B. Meding, MD


Jean-Pierre Mobasser, MD


John T. Munshower, MD


Stephen W. Perkins, MD


Rick C. Sasso, MD


K. Donald Shelbourne, MD


Edward P. Todderud, MD


Robert D. Yee, MD

The Indianapolis Medical Society
Salutes these Members Running for Public Office
in the May 6, 2008 Primary


Frank P. Lloyd, Jr., MD


John P. McGoff, MD


Woodrow A. Myers, Jr., MD


David Orentlicher, MD


John E. Pless, MD


Kenny E. Stall, MD

News from Community Hospitals ...

Edward P. Todderud, MD, was named medical director of the new Center for Joint Health at Community Hospital East. Dr. Todderud, orthopaedic surgeon, served as chief of staff at Community Hospitals East and North 2004-2006.

George W.M. Feliciano, MD, orthopaedic surgeon, was named medical director for the new Center Joint Health at Community North.

IMS

Resident & Medical Student Abstracts

Your Indianapolis Medical Society is pleased to continue to present abstracts written by internal medicine residents and students for the 2007 Indiana ACP Abstract competition. The competition was judged by the separate categories with the top five in each category receiving awards. We want to thank the members of the ACP Associate Council for their help; in particular, Craig Wilson, MD, St. Vincent Internal Medicine Program Director; Lia Logio, MD, Indiana University Internal Medicine Program Director; Matthew Neal, MD, Ball State Internal Medicine Program Director; Robert Lubitz, MD, Governor, ACP Indiana Chapter and Brent M. Toney, DO, Chair, ACP Indiana Associates Council. *The Editor*

Third Place Research:
Vincent Songco, MD, Ziad Jaradat, MD, Jo Mahenthiran, MD

Stress SPECT Findings by Stage of Chronic Kidney Disease and the Prognostic Impact of Creatinine Clearance in Patients Evaluated for Coronary Artery Disease

Background: Chronic kidney disease (CKD) portends poorer outcomes in patients (pts) with coronary artery disease (CAD). However, the extent of stress SPECT abnormalities and the prognostic impact of creatinine clearance (CrCl) among pts referred for a stress study are not known. Hence, we examined this in pts with various stages of CKD by CrCl calculation who had undergone a stress SPECT study for evaluation of suspected CAD.

Method: A cohort of 501 pts (mean age 62 ± 12 yrs, males, n=280 (55%)) who underwent a stress SPECT study and had a CrCl measured within ±90 days were studied. The stage of CKD was defined by estimation of GFR as determined over a period of 3 months or greater. Normal, Stage 1 and 2 CKD were grouped together as early CKD based on CrCl ≥ 60 ml/min/1.73 m^2 while Stage 3, 4 and 5 CKD were grouped together as late CKD defined by GFR < 60 ml/min/1.73 m^2. CrCl as an estimation of GFR was calculated using formula [(140-Age)*Wt (kg)]/(72*Cr). Single day rest, stress with Technetium Sestamibi with s standard 17 segment, 5-point perfusion analysis was performed. Total sum difference score (SDS) was calculated as sum stress score (SSS) – sum rest score (SRS). SSS ≥ 3 and SDS ≥ 2 was considered an abnormal scan for ischemia. Post SPECT events for non-fatal myocardial infarction and death (hard events, n=98 (20% of total pts)) were obtained over a mean follow-up of 2.1 ± 0.8 years.

Results: SPECT differences between early and late stage CKD is summarized in Table. Late stage CKD patients demonstrated greater SPECT perfusion abnormalities in spite of normal similar global left ventricular systolic function.

Variable	Early CKD (n=355)	Late CKD (n=146)	p-value
Age (years)	56 ± 11	67 ± 12	<0.001
Hypertension	227 (64%)	121 (83%)	<0.001
Diabetes	128 (36%)	73 (50%)	0.03
LVEF	58.1 ± 12.8	55.7 ± 17.0	0.6
SSS	5.5 ± 7.2	7.7± 7.8	0.01
SRS	4.1± 5.9	5.8± 6.6	0.01
SDS	1.6± 2.7	2.0 ±	0.2
Hard events	57 (16%)	41 (28%)	0.001

On Cox regression survival analysis, GFR as estimated by CrCl was a univariate (p=0.01, HR:6.7) and left ventricular ejection fraction (p=0.005, HR:1.4) and CrCl (p=0.01, HR:1.7) were multivariate predictors of hard cardiac events following their stress study.

Conclusions: Pts with later stages of CKD have greater stress SPECT perfusion abnormalities compared to normal or early stage CKD with similar global left ventricular function. Hypertension and diabetes were also more prevalent in patients with late CKD and are independently associated with the SPECT perfusion abnormalities seen. CrCl remains an important prognostic marker of greater risk of subsequent cardiac events among pts evaluated for CAD with stress perfusion analysis independent of the scan findings.

Fourth Place Research: Veronika Gagovic, MD, Douglas Rex, MD

Gastroenterologists' patient instructions for oral sodium phosphate solution for colonoscopy preparation: A survey among gastroenterologists in the state of Indiana

Purpose: Oral sodium phosphate solution (OSPS) has been associated with acute renal failure when used as a bowel preparation for colonoscopy. Our aim was to determine whether gastroenterologists in Indiana follow recent recommendations for safe and effective use of colonoscopy.

Methods: The study, conducted from May to September 2006, included practicing gastroenterologists in Indiana. Our office reviewed each physician's written instructions on the use of OSPS for bowel preparation with respect to dosages, timing of dose, hydration instructions and type of hydration solution recommended to patients receiving OSPS. These were compared to safety recommendations developed by American Society of Colon and Rectal Surgeons, The American Society of Endoscopy and The Society of American Gastrointestinal and Endoscopic Surgeons which included use of no more than two 45 ml bottles given at least 6-12 hours apart, approximately 960 ml of fluid given with each dose of OSPS and preference given to carbohydrate-electrolyte solutions. Descriptive statistics was used for our data analysis.

Results: 193 (97.5%) physicians participated in the study. 80.3% used OSPS in their practice, with a mean total amount of solution given 87.3 ml. There were no physicians that recommended more than 90 ml of OSPS. The mean interval recommended between doses was 7.6 hours. 35.5% physicians prescribed two 45 ml bottles of OSPS at an interval less than six hours apart. 9.7% of physicians using OSPS specified the amount and type of fluid prior to first dose of OSPS, with a mean (range) of 660 ml (120-1440 ml). 93.7% of physicians specified the fluid amount to be taken with or after the first dose of OSPS with a mean (range) of 1002 ml (120-3000) ml. 89% of physicians specified an amount of fluid to be taken with

Continued on page 36.

Rule Watch

At the March 27, 2008 meeting, the Board adopted the proposed rule as published in LSA Document # 07-723. Under the authority of IC 25-22.5-2-7 the Board has determined that the current requirements under 844 IAC 4-4.5-12 should be modified to:

1. Allow for a ten-year window in which to pass all three attempts. Previous application of this rule has been determined to have barred otherwise qualified candidates from receiving licensure. By extending the length of time, it would allow those candidates the opportunity to enter the practice of medicine and assist Indiana patients without compromising patient safety; and

2. The Board has determined that three attempts at each step of the USMLE is adequate to meet the minimum requirements of licensure.

Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W072 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

Legislative Update

Senate Enrolled Act 302 included language that provides a tool for the Board to deal with the applications that fall outside of the typical application for initial license, renewal or reinstatement of a license. A provisional license allows the applicant to receive a non-restricted license to practice medicine as long as they are compliant with the terms of the provisional license.

In order to qualify for a provisional license, the applicant must meet certain qualifications such as the applicant's:

- Deficiency does not constitute a violation of the practice act
- Deficiency is such that it may be monitored to satisfaction of the Board
- Deficiency did not result in death, serious harm or other serious outcome for a patient or patients.
- Deficiency did not represent an intentional or willful commission or omission of an act that constitutes a violation of the practice act.
- Actions did not involve sexual misconduct

With guidance from the Board, the applicant shall develop a re-entry program. This may require the applicant to pass formal exams, full-scale assessments, engage in training programs or secure supervised practice arrangements or other proof of competence.

The duration of the provisional license is determined by the Board.

Upon completing the terms of the provisional license, the applicant will be released from the provisional license and hold an unlimited license.

A provisional license is a non-restricted license and the issuance of a provisional license issued under this section shall not be construed as a disciplinary action taken by the Board.

The provisional license is subject to discipline if after a hearing the Board finds that:

- Licensee failed to comply with any term of the provisional license

Continued on page 30.

The strength, defense and century-long solutions of Medical Protective.

The security and resources of Berkshire Hathaway.

…On June 20, 2005 we bought Medical Protective, a 107 year-old medical malpractice insurer based in Fort Wayne. Malpractice insurance is tough to underwrite and has proved to be a graveyard for many insurers. As part of Berkshire, Medical Protective has financial strength far exceeding that of its competitors, a quality assuring healthcare providers that long-to-settle claims will not end up back on their doorstep because their insurer failed….

– from Warren Buffett's Letter to Shareholders, February 28, 2006

…We want Medical Protective to continue to be the company that thinks like a doctor and behaves with the same integrity and individual care as a doctor....

– from Warren Buffett, April 26, 2006

…We're proud to have Medical Protective as part of the Berkshire family....

– from Warren Buffett, May 30, 2006

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Web – www.headache.stvincent.org
Neurology
Indiana University, 1998

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In Memoriam

Dennis James Nicholas, MD
1921 - 2008

Dennis James Nicholas, MD, 87, died March 11, 2008. Dr. Nicholas was born on January 30, 1921 in Wood River, Illinois and was raised in Rockville, Indiana.

Dr. Nicholas graduated from Indiana University with a degree in Chemistry in 1942. From 1943 to 1946, he served his country in World War II as a sergeant in the US Air Force. Dr. Nicholas earned his medical degree from Indiana University School of Medicine in 1951. He interned at Indianapolis General Hospital and completed his residency in Surgery and Medicine at Indianapolis General Hospital.

For most of his professional career, Dr. Nicholas practiced at St. Francis Hospital in Beech Grove, Indiana as an anesthesiologist. He served as Marion County Coroner for numerous terms from 1960 – 1992. Other professional activities included: Indianapolis Police-Fire Merit Board, 1967 – 1969; President, Indiana State Coroners Association 1964, 1975, 1976, and 1978; President, St. Francis Hospital Medical Staff, 1976; Comprehensive Health Planning Council, 1974; Member, Indiana State Medical Legislative Committee, 1979-1980; Medical Director, Reagan-Bush, National Convention, 1980 and 1984; National Advisory Council to the Public Health service of HHS 1982-1984; Member, Board of Trustees, Indiana State Museum, 1982-1986; Chairman, Sites Committee, Indiana State Museum, 1982-1986; Chairman, Indiana State Museum Foundation; Member, Board of Directors AHEPA HUD Project 202; Chairman, Indianapolis-Marion County Forensic Science Agency; Dr. Nicholas helped establish the forensic laboratory in Marion County, which bears his name. Dr. Nicholas also served in the leadership of the Republican Party both nationally and within the state on numerous committees and task forces.

Dr. Nicholas was a member of the Indianapolis Medical Society Board of Directors from 1974-1977 and served as an Alternate Delegate to the State Convention 1960-1971 and from 1974-1977.

Robert Elliott Cravens, MD
1941 - 2008

Dr. Robert Elliott Cravens 67, of Carmel, died in his home Thursday, March 20, 2008. He was born in Evansville, IN, March 6, 1941

Dr. Cravens graduated from Bosse High School in Evansville, Indiana. He earned his undergraduate degree from Indiana University in 1963 and his medical degree from the Indiana University School of Medicine in 1966. He completed his internship at St. Vincent Hospital in Indianapolis, Indiana in 1967. Dr. Cravens served as a Captain in the United States Air Force and stationed at the North American Defense Command (NORAD) from 1967 through 1969. He then completed his residency at Indiana University School of Medicine in 1972.

Dr. Cravens was a member and noted speaker at the American Academy of Orthopaedic Surgery, the Clinical Orthopaedic Society, American Medical Association, American College of Surgeons, American Orthopaedic Society of Sports Medicine, the American Orthopaedic Foot and Ankle Society, the American College of Surgeons, and many other professional organizations. Dr. Cravens also served on the Board of the Acacia Fraternity and was honored with the Order of Pythagoras and Distinguished Alumnus Awards. In addition, he received the Sagamore of the Wabash award, the highest honor bestowed by the Governor of Indiana.

DeWitt W. Brown, MD
1916 - 2008

DeWitt W. Brown, MD, 91, died at his home March 30, 2008. Born in Emporia, Kansas on August 1, 1916, "Bill" moved to Indiana as a child and grew up in Irvington. He attended Park School and graduated from Tech High School. Dr. Brown received his BA, MS and MD (1941) from Indiana University. He interned at Methodist Hospital in Indianapolis and served his residency at the General Hospital and the Indiana University Medical Center.

From 1942 to 1946, he served his country in the US Army Air Corp Medical Corp with the rank of Major.

Certified by the American Board of Psychiatry, Dr. Brown had a private practice from 1949 to 1981 in an office across the street from Methodist Hospital. He was a Life Fellow of the American Psychiatric Association, Professor Emeritus Clinical Psychiatry at the Indiana University School of Medicine, and past president of the Indiana Psychiatric Society. Dr. Brown served his profession as a Psychiatric Board Examiner for many years. Dr. Brown assisted the Indianapolis Medical Society on the Executive Committee from 1960-1963 serving as Vice Chairman from 1960-1961. IMS

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380 BREAKWATER DRIVE • $1,850,000
Magnificent home in desirable Breakwater w/boat dock, pool & cabana! Grand foyer, fabulous kitchen open to fam rm w/built-ins, gorgeous master ste & bath, dynamite walk-out lwr lvl & more! (2803894)

10674 GRINDSTONE DRIVE • $679,900
Gorgeous home on beautiful Lake Stonebridge in Fishers w/breathtaking views! Bright & open flr plan, great rm w/flr to clng windows, fabulous kit open to awesome fam rm, daylight w/o lwr lvl has screened porch & more! (2818982)

4909 MERIDIAN STREET • $909,900
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3216 S. 975 EAST • $879,900
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Letter to the Editor

Healthcare: Outcome vs. Quality

Ted L. Grayson, MD

Healthcare has three major components; medical care by providers (doctors and hospitals), patient compliance and patient self-abuse. Outcome is about the only way to evaluate health care. Outcome is significantly affected by patient noncompliance and self-abuse. Some politicians and academics don't grasp this concept. In their publishing and speaking, they quote the World Health Organization (WHO), the Center for Disease Control (CDC) and the Central Intelligence Agency (CIA) statistics, which measure outcome only. From these statistics, they infer that the quality of medical care available in the United States is inferior to some other world countries. No or minimal mention is made of patient noncompliance or self-abuse.

Approximately 50% of the health care dollars in the United States are spent treating illnesses related to patient self-abuse. These abuses include tobacco, lack of exercise, drugs and obesity. It is estimated that 60% of babies born in Indiana are born to unwed mothers. A large number of these unwed mothers are never seen by a physician until they arrive for delivery. Wishard Hospital is a good example of this problem. Only about 50% of the students who enter high school in Marion County continue on to graduation. These statistics are examples of the failure of personal responsibility. Lack of personal responsibility results in patient noncompliance and patient self-abuse, which adversely affects healthcare outcome. Ranking the quality of medical care based on outcome alone is not a fair measure of the quality of medical care. As stated above, some politicians and academics don't seem to understand this.

WHO recently ranked the world's health systems and rank the United States number 37. This infers that the quality of medical care available to patients in the United States is inferior to 36 other countries. These rankings, of course, were based on outcome alone and no consideration was given to patient noncompliance, self-abuse and waiting times, etc. This represents flawed metrics and inadequate data. Minimal or no mention of this flaw is found in the speaking and writing of some politicians and academics. I have visited 13 of these 36 countries and the medical care available in all 13 is inferior to the medical care available in the United States.

It is time that we challenge politicians, academics or anyone else when they criticize the quality of medical care available in the United States and suggest that it is inferior to other world countries. They need to be made aware that quality is only one part of the measure of outcome. It is also time that we point out to these academics that some of their research efforts should be directed to developing a better measure of the quality of health care. They should not use outcome alone. In their writing, speaking and teaching, they should mention that there are factors other than quality, which significantly affect health care. They should also be advised to spend more research effort on patient noncompliance and patient self-abuse.

Editor: Our apologies to Dr. Grayson for typographical errors in the original publication of this article in the April 2008, IMS Bulletin. IMS

Project Health

Carrie Jackson Logsdon, Director

Thank you, William E. Whitson, MD

William E. Whitson, MD, Whitson Vision, is Project Health's Volunteer for the month of May. Dr. Whitson has done numerous cataract removals for our patients. He is originally from Milwaukee, Wisconsin and attended the University of Wisconsin and the Medical College of Wisconsin before his residency in ophthalmology at the University of Washington in Seattle and Fellowship in Cornea and External Diseases at the University of Iowa. He considers Jay Krachmer, MD, the Director of Corneal Services at the University of Iowa, as his mentor.

Dr. Whitson said, "I blundered into medicine completely." No one in his family was in medicine, and among some 40 cousins, only a few even went to college. His father worked for Wisconsin Electric and Dr. Whitson says he was a man of very few words. But in his senior year of high school, he sat his son down and said, "Bill, I don't want you to do what I did – go to college and graduate." His father started but never finished college.

He began majoring in oceanography, influenced by Jacques Cousteau. But, in his second year, he decided there weren't enough viable career opportunities. He knew some of his classmates were getting into medical school and thought, "If they could get into medical school (with their grades), surely I could get in." And the rest is history. In medical school, he thought about a career in cardiovascular surgery but did a rotation in ophthalmology and was hooked. "I had no idea how fascinating ophthalmology was."

In 1994 or 1995 he says there were only about 10 doctors performing Excimer laser surgery in the country. All of them were at a meeting, sitting around just chatting, when they agreed that they needed to have a better name for it, something that would market better. "So we kind of morphed the names of procedures into LASIK, which stands for Laser Assisted In-situ Keratomileusis." LASIK is much easier to pronounce!

Dr. Whitson was doing charity care long before Project Health came along. In 1997, he did a double cornea transplant on a 3½ year-old Haitian boy that a colleague, Terry Ridge, NP, CDE, brought to this country after a mission trip. The boy was totally blind and couldn't walk because no one ever paid any attention to him. They just let him sit all day long so he didn't have the muscles developed for walking. Terry ended up adopting the boy.

Dr. Whitson also does mission trips, mostly to Honduras. He was looking forward to going to Haiti last year, but the day before they were to leave; there was a major coup so the trip was cancelled. He will soon be treating a 22 year-old Russian man who was severely injured in a house fire. Dr. Joe Fraiz is bringing the young man to the US. The fire left him without hands or a nose, and he has a hole in the center of his forehead that extends into his sinuses. "He'll need major league plastic and ophthalmologic surgery. We are forming a team to take care of him now." "We all need to use our God-given talents to help everyone in society. We need to walk the walk of doing good work for others." He was asked how he found time to do so much. He replied, "We tend to get called to our passions, so it's not like work, it's a passion." We are so thankful that all of our volunteer physicians obviously possess this same passion. THANK YOU!

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Jared Duncan
Broker, GRI

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Mike Duncan
Broker, ABR, ASP, CRS, MGRI, SRES

AMA Supports Coalition's Call for Transparency and Accurate Reporting Among Health Insurers

Statement attributed to: Nancy Nielsen, MD, AMA President elect

"The American Medical Association applauds efforts by the Consumer-Purchaser Disclosure Project to raise the bar on the reliability and validity of information that health insurers provide to patients.

"The Patient Charter drafted by the Consumer-Purchaser Disclosure Project requires health insurers to be more transparent and balanced when providing information to patients. These crucial principles offer hope that patients will be able to trust the information to make informed health care choices. Safeguards must ensure that physician rating information does not result in reduced access to care or disrupt patients' longstanding relationships with their physicians.

"Efforts by health insurers to rate physicians must not be driven solely by costs and economics. The primary goal of these programs must be to promote quality care using meaningful measures. The AMA has long been involved in these efforts through the Physician Consortium for Performance Improvement and National Quality Forum.

"Instead of tiered and narrow networks, the AMA believes that providing valid data to physicians and patients will better improve the quality and efficiency of care.

"The work of the Consumer-Purchaser Disclosure Project reinforces the need to protect access to care and the patient-physician relationship by requiring insurers to open their physician rating programs for careful evaluation to assess accuracy, integrity and fairness.

"Although additional work must be done to accurately and fairly evaluate the individual work of physicians, the AMA sees the Patient Charter as an important step in the right direction and we offer our assistance in ensuring its criteria are appropriate and measurable." IMS

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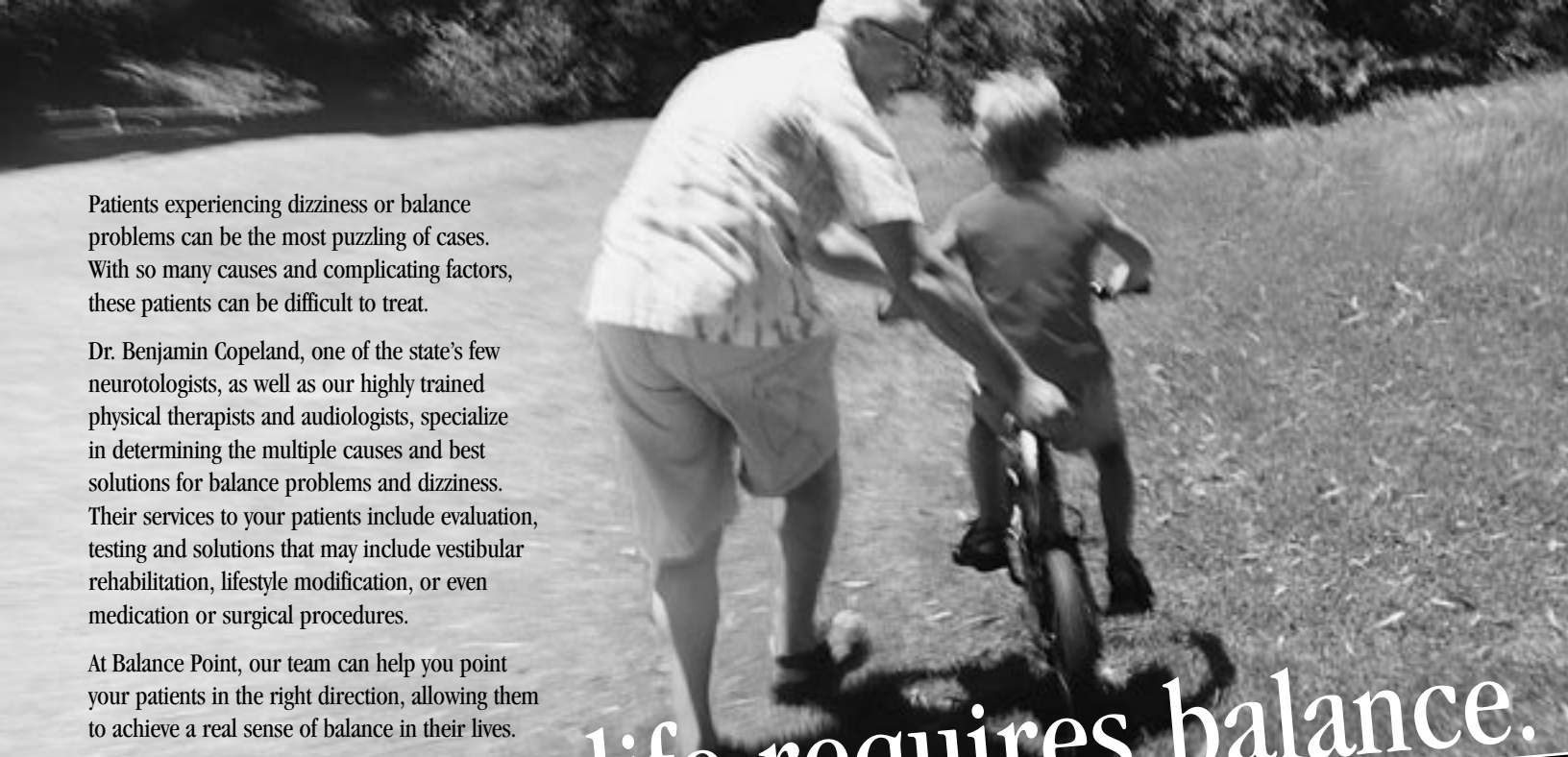

Patients experiencing dizziness or balance problems can be the most puzzling of cases. With so many causes and complicating factors, these patients can be difficult to treat.

Dr. Benjamin Copeland, one of the state's few neurotologists, as well as our highly trained physical therapists and audiologists, specialize in determining the multiple causes and best solutions for balance problems and dizziness. Their services to your patients include evaluation, testing and solutions that may include vestibular rehabilitation, lifestyle modification, or even medication or surgical procedures.

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A healthy young adult may not appear to need a hearing screening. Yet that vibrant 30-year old has exposed himself to years of damaging, everyday noise. Lawnmowers. Concerts. MP3 players. And a host of workplace noises droning on day after day. In fact, 65 percent of hearing loss occurs in people under the age of 65. Most medical exams don't include hearing tests—yet people count on their doctors to pick up such health issues.

Now is a perfect time to begin testing patients' hearing, no matter what their age. If you detect a potential problem, the Whisper Hearing Centers can help. Whisper Hearing Centers is a division of Otolaryngology Associates and specializes in hearing solutions for people of all ages. Please call us today at **866-831-5967** or visit our website at **www.whisperhearingcenters.com.**

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A Division of Otolaryngology Associates

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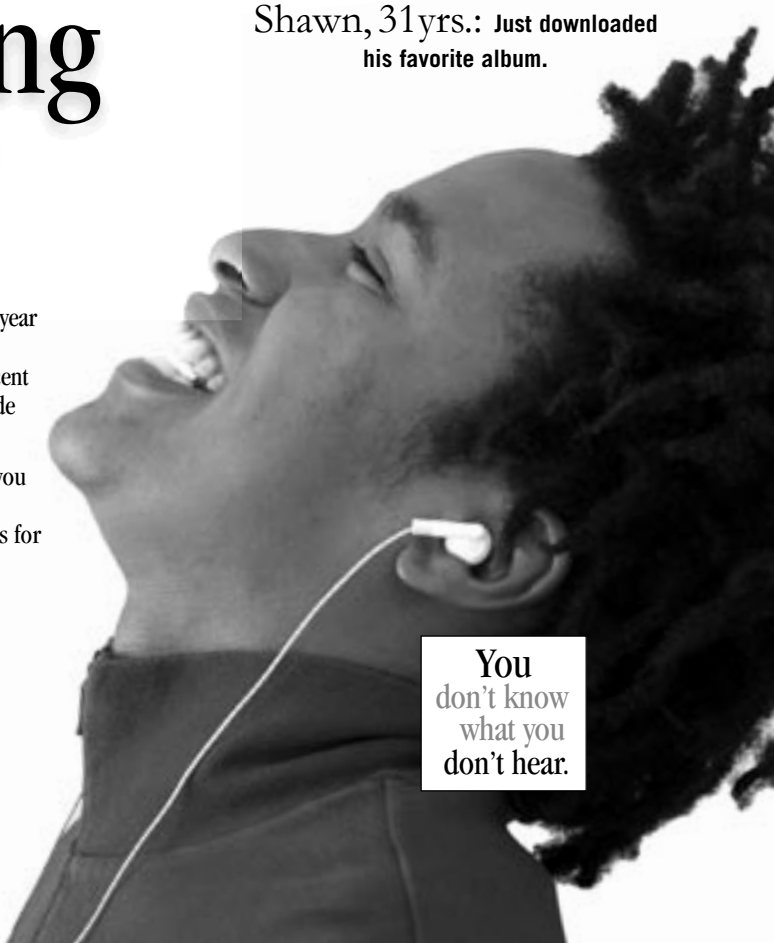
Shawn, 31yrs.: **Just downloaded his favorite album.**



You don't know what you don't hear.

IPLA *(Continued from page 14.)*

• The supervisor or monitor has documented non-compliance

• The supervisor or monitor has documented that the licensee failed to incorporate learned knowledge and skills into his or her practice or has continued to demonstrate the same practice deficiency that led to the provisional license.

The holder of the provisional license may petition the Board for modification, withdrawal or retirement of the provisional license.

Board welcomes newly appointed member
Donald Vennekotter, MD

Dr. Donald Vennekotter practices general surgery with Jasper Surgical Associates. He graduated from the Case Western Reserve University School of Medicine and has been in the profession for 20 years. He has also served as a Clinical Assistant Professor of Surgery with the Evansville Center for Medical Education.

Upcoming meeting dates:

May 22, 2008
June 26, 2008
July 24, 2008

For assistance with questions or comments please contact: Medical Licensing Board of Indiana, Michael Rinebold, Director, 402 West Washington Street, Indiana Government Center South, W072, Indianapolis, IN 46204, 317.234.2060/Fax: 317.233.4236 or email: group3@pla.in.gov.

IMS

INSPECT *(Continued from page 8.)*

How to use INSPECT

After registering, the program asks only for patient information, such as name and date of birth each time you conduct a search.

Fort Wayne pharmacist-turned-psychiatrist Jay Fawver, MD said his electronic medical record (EMR) system helps speed the process of searching for a patient. "There is nothing to it," he said. "All I do is copy and paste patient information from the EMR into INSPECT and I have it."

Physicians concerned that using INSPECT could somehow subject them to new scrutiny should know that law enforcement and state officials have always had access to physician prescribing data. INSPECT simply makes the data available to health care providers.

INSPECT Contact Information

For specific issues with the software call the INSPECT helpdesk at (317) 234-4458. If you have questions for the INSPECT Program Director you can reach Mr. Timmis at (317) 234-4457, or mtimmis@pla.in.gov. Mr. Timmis is available to give INSPECT Presentations to any type of healthcare group, organization, or company across the state that could benefit from the use of this tool. Please contact him directly to set up a speaking engagement for your organization.

IMS

Do You Know a Deserving Doc?

It's time to recognize your colleagues for the good works they do … Since 1976, the Indianapolis Medical Society has been acknowledging one individual member for his/her outstanding contributions to our community through volunteer service. In 1982, the Community Service Award was renamed to honor Dr. Otis R. Bowen in recognition of his outstanding contributions to our profession, community and country. In keeping with the ideals exemplified by Dr. Bowen, our Otis R. Bowen Award recipients have distinguished themselves beyond the practice of medicine through volunteerism. In 1999 the Bowen Award was expanded to give recognition to physician groups for their outstanding service to the community. ***It really is time to tell your colleagues … Thank you.***

2008 Otis R. Bowen Community Service Award Nomination Form

My Nomination for Individual Physician for The Otis R. Bowen Physician Community Service Award is:

Name of Individual Physician (please print) | Address or phone number of physician

My Nomination for Physician Group for The Otis R. Bowen Physician Group Service Award is:

Name of Physician Group (please print) | Address and phone number of physician group

Your Name (please print) | Phone number where you may be reached

Submit your nomination by *June 15* by fax (317-262-5609), phone (317-639-3406) or e-mail bhurt@imsonline.org

2008 ISMA Physician Community Service Award & 2008 Patient Health Advocate Award

Deadline for submission: June 4, 2008

For nomination forms and nomination submissions for each award:

Indiana State Medical Association
Attn: Rhonda Bennett, 322 Canal Walk, Indianapolis, IN 46202
If you have any questions, call Rhonda Bennett at the
ISMA (800) 257-ISMA or (317) 261-2060

ISMA Physician Community Service Award

The Indiana State Medical Association is seeking nominations for the 2008 Physician Community Service Award that is presented each year during the ISMA annual convention. Both physicians and citizens may submit nominations. This award honors an Indiana physician for outstanding volunteer activities who has made a civic, cultural, social or economic contribution to the community.
We encourage you to submit a nomination for a physician whom you feel best fits the nomination criteria.

Patient Health Advocate Award

In 1999, the Indiana State Medical Association established the Patient Health Advocate Award. This annual award is presented to a non-physician who has made great contributions to the health and well-being of Hoosier patients.

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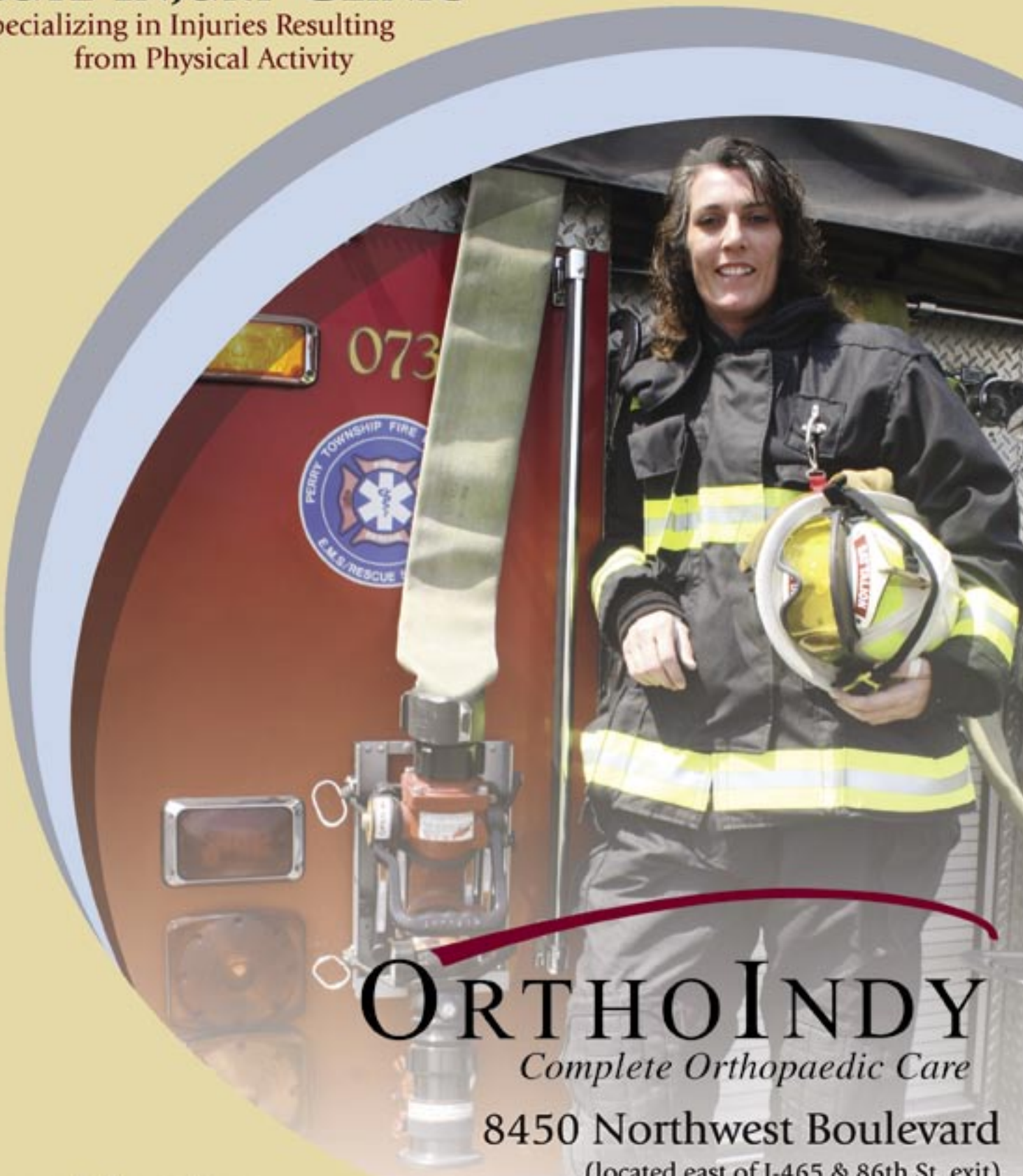

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Every Tuesday — Tumor Board (Case Presentations)
Medical Staff Conf. Room, 12:00 - 1:00 p.m.

First Wednesday — Critical Care Conference
Medical Staff Conf. Room, 12:00 - 1:00 p.m.

Second Wednesday — Medical Grand Rounds
Medical Staff Conf. Room, 12:00 - 1:00 p.m.

Community Hospital South

Fourth Thursday — Medical Grand Rounds
Conf. Rooms A & B, 7:30 - 8:30 a.m.

3rd Wednesday — Tumor Board (Case Presentations)
Conference Room A, 7:00 - 8:00 a.m.

Community Hospital North

Second Wednesday — Tumor Board (Case Presentations)
Board Room, 12:00 - 1:00 p.m.

First Friday — North Forum
Board Room; 12:00 - 1:00 p.m.

North Cancer Pavilion

3rd Wednesday — Case Presentations
Melanoma Conference, 7:00 - 8:00 a.m.

For more information, contact Valerie Brown, (317) 355-5381.

St. Vincent Hospital & Health Services

May 6 — Musculoskeletal /Sarcoma Conference
Credit: 1.0 Contact: Peggy Cook, 338-2301
Medical Imaging Radiologists' Workroom
St. Vincent Hospital, Indianapolis

May 7 — Surgical & Anesthesia Services Quarterly Meeting
Credit: 1.0 Contact: Pam Payne, 338-3500
Schaefer Rooms A&B
St. Vincent Hospital, Indianapolis

May 7, 29 — Health Information Literacy
Credit: 1.0 Contact: Denise Rumschlag, 338-2095
Location varies
St. Vincent Hospital, Indianapolis

May 8-10 — Hand Care
Credit: 7.0 Contact: Nancy Keys, 471-4308
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May 16 — Emergency Medicine Symposium
Credit: 5.5 Contact: Suzanne Brown, 338-6089
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June 8-15, June 15-21, June 21-27
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The Diabetes Youth Foundation Camp
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June 12-13 — 32nd Annual Garceau-Wray Orthopaedic Lectures
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June 20 — 28th Annual J.K. Berman Essay Program and Bruce White Lecture
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June 27 — 2nd Annual Critical Care - 2008 Update
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July 11 — Review and Interpretation of the 2008 ASCO Meeting
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July 14-22 — 93rd Annual Anatomy and Histopathology of the Head, Neck and Temporal Bone
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Aug. 22-23 — Pleuroscopy Workshop for Pulmonary Physicians
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Resident & Medical Student Abstracts

Continued from page 12.

and after the second dose of OSPS with a mean (range) of 660 ml (120-1560 ml). Carbohydrate rich solution was preferred by 22% of physicians after the first and 16% of physicians after the second dose. 33.5% physicians using OSPS recommended more than 1920 ml of fluid to be taken with the OSPS prep.

Conclusion: Practicing Indiana gastroenterologists were universally consistent with recent guidelines in their written instructions to patients with regard to the total dose of OSPS for colonoscopy. They frequently recommended OSPS at intervals shorter than current guidelines and often did not give optimal instructions with regard to hydration during colonoscopy.

Fifth Place Research: Eric Morrell, Brandon Brown, Rong Qi, Katherine Drabiak, Paul R. Helft

The Do-Not-Resuscitate Order: Associations with Advance Directives, Physician Specialty, and Documentation of Discussion 15 Years After the Patient Self-Determination Act

Background: Since the passage of the Patient Self-Determination Act (PSDA) in 1991, there have been numerous policy mandates and institutional measures implemented. It is unknown to what extent those measures have had on end of life care, particularly with regard to the do-not-resuscitate (DNR) order.

Methods: To measure the impact physician-, patient-, and system-specific variables have on DNR ordering patterns, we conducted a retrospective cohort study of a total of 284 of 348 consecutive hospital deaths at an academic tertiary-care medical center. The primary outcome was assessment of associations between DNR order frequency and timing with advance directive status, patient demographics, physician specialty, and extent of documentation of discussion on end of life care.

Results: DNR ordering frequency was higher for patients on a medicine or medicine subspecialty service than on a surgical service (77.34% vs. 64.20%, $p = 0.02$), and medicine patients received a DNR order earlier in their hospital stay compared with surgical patients (adjusted mean ratio of the time from DNR orders to death vs. the total length of stay: 0.30 for internists and 0.21 for surgeons, $p = 0.04$). 22.18% of all patients had some form of an advance directive in their chart, yet this variable had no impact on DNR ordering frequency and timing. Multivariate analysis demonstrated that documentation of DNR discussion was significantly associated with the frequency of DNR orders (83.81% of extensive documentation of discussion patients went on to have a DNR order vs. 67.60% of patients with minimal or no documentation of discussion, $p < 0.01$) and the time from DNR order to death (2.10 days with none or minimal vs. 2.77 days with extensive, $p < 0.01$).

Conclusion: Physician specialty continues to have a significant impact on the frequency and timing of DNR orders, while advance directive status still has no measurable impact on DNR ordering patterns. Additionally, when documentation of end of life discussions does occur, it has a significant association with varying DNR ordering rates and timing. IMS

The Bulletin will publish additional Abstracts as space permits. Please let us know, if you appreciate reading these and other articles.

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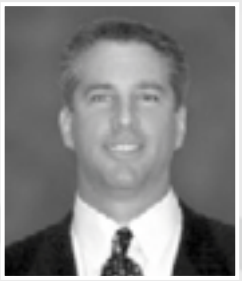

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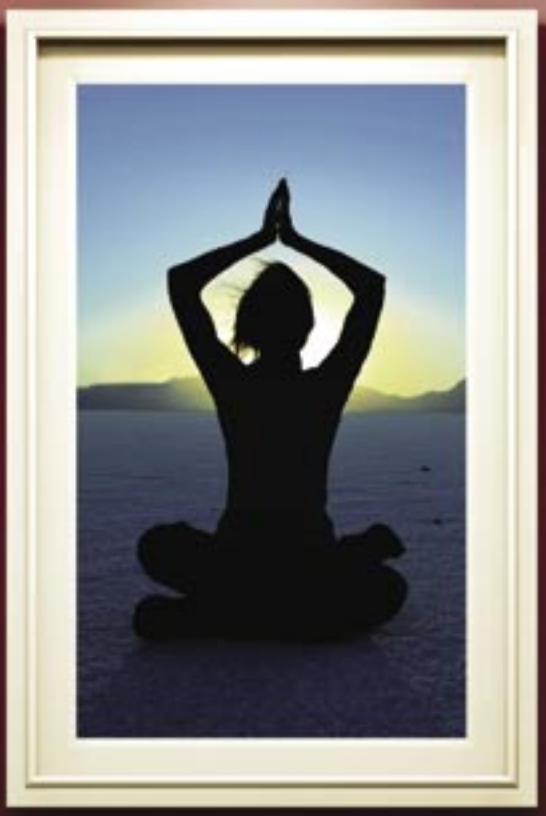

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